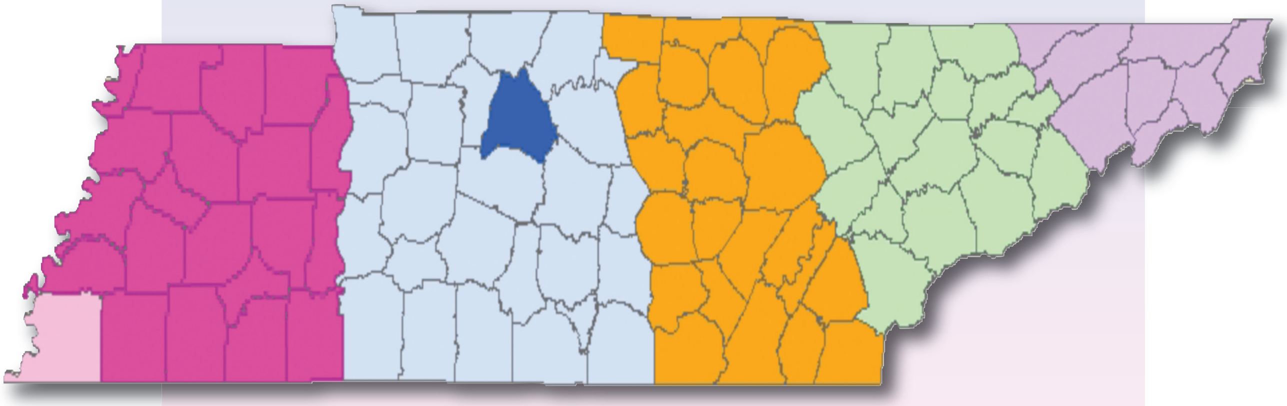
Best Practices



Behavioral Health Guidelines for Children and Adolescents from Birth to 17 Years of Age

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS)

Division of Planning, Research, & Forensics in collaboration with the Division of Clinical Leadership

FEBRUARY 2013

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Tennessee Department of Mental Health and Substance Abuse Services

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TDMHSAS BEST PRACTICE GUIDELINES

Introduction

Welcome to the 2013 revision of *Tennessee's Best Practice Guidelines to Behavioral Health Services for Children and Adolescents: Birth to 17 Years of Age*. Revision of these guidelines has been a labor of love by some of the most selfless experts in the state. They have given not only of their expertise, but of their time in providing the best available resources on working with children and adolescents with behavioral health issues.

This revision project began at the request of Commissioner Doug Varney and Deputy Commissioner Marie Williams. At the time of the request, the most recent best practice guidelines document was a 2008 update. Edwina Chappell was asked to spearhead development of the revision.

An Advisory Group was formed to identify the focus for these guidelines. Leadership from the Tennessee Department of Children's Services (TDCS), the Tennessee Department of Health (TDH), the Tennessee Association of Mental Health Organizations (TAMHO), East Tennessee State University's Center of Excellence, the Bureau of TennCare, and various divisions of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) provided direction and recommendations for workgroups that would develop the core of these guidelines.

A total of 19 workgroups were formed. Representatives came from all walks of the behavioral health community: professors from institutions of higher education, executives and staff from managed care organizations, staff affiliated with community mental health and substance abuse service organizations, behavioral health professionals in private practice, and individuals with behavioral health diagnoses, as well as personnel from various state departments. Workgroup members were further representative of the three grand regions of the state—East, Middle, and West. Each workgroup selected a chairperson to lead the group and ensure a finished product.

There are several new sections in these 2013 guidelines. Among them are *Infant and Early Childhood Mental Health*; *Trauma-Informed Care*; *Children in Child Welfare*; *Children and Adolescents with Mental Health and Physical Health Disorders*; *Children and Adolescents Who Identify as Lesbian, Gay, Bisexual, Transsexual, Transgendered and Gender Nonconforming , or Questioning*; and *Medication Safety*. Sections on youth with sexual behavior problems have also been expanded to include children as well as adolescents. The *Best Practices* section is more detailed too.

TDMHSAS has oversight for and/or handles contracts for many programs across the state that deliver behavioral health services to children and adolescents and/or their families. Brief overviews of those programs are included in the guidelines.

The intent of the guidelines is to inform and educate child-serving professionals in the state, promoting high quality behavioral healthcare aligned with evidence-based and/or evidence-informed practices. These guidelines maintain their clinical focus by delineating best practice when working with young people who have specific mental health and/or substance use disorders. In addition, screening tools that can be printed and/or downloaded for use by appropriate staff are again incorporated in the document.

Because the guidelines precede publication of the DSM-5, diagnostic criteria for disorders follow the DSM-IV-TR. Workgroups preparing guidelines for disorders in which changes were proposed have either included those changes or at least referenced them based on the information available at the time of writing. ***Users of these guidelines are encouraged to review the official DSM-5 product for current diagnostic criteria, once it is published and available***.

A draft version of the guidelines was distributed for review to the TAMHO Children & Youth Section, Managed Care Organizations (MCOs), and the Advisory Group, which includes representation from TDMHSAS, the Bureau of TennCare, the Tennessee Department of Children's Services (and Centers of Excellence), and the Tennessee Department of Health. Final review and approval were provided by executive staff of the TDMHSAS. The guidelines can be downloaded as a complete PDF or Word document or in sections.

We hope you find these best practice behavioral health guidelines useful. All contributors have worked diligently to ensure that this product provides relevant information and education for Tennessee professionals who deliver behavioral health services to children and adolescents that range in age from birth to 17 years. Direct questions or comments regarding this product to (615) 741-9476 or edwina.chappell@tn.gov.

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TDMHSAS BEST PRACTICE GUIDELINES

Best Practices: Evidence-Based

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Overview of Evidence-Based Practices

Since the children and youth version of these TDMHSAS guidelines (2008) were last drafted, the field of children's mental health, as a part of the children's system of care, has continued to expand the discussion and expectations for the use of evidence-based practice in the children's service delivery system. To facilitate a shared understanding of the increasing expectations for evidence-based practice (EBP), we look to the definition of evidence-based practice developed by the 2005 Presidential Task Force on Evidence-Based Practice of the American Psychological Association (EBPCA: APA, 2006) and to the report of the APA Task Force on Evidence-Based Practice with Children and Adolescents (APA, 2008), which builds on the work of the 2005 Presidential Task Force by focusing specifically on psychological practice with children and adolescents and encouraging a systems approach to enhancing care. The TDMHSAS through its Best Practices Guidelines supports an evidence-based orientation to practice and expressly adopts the definitions, guiding principles and assumptions promulgated by the APA Task Force on EBPCA and summarized below.

Definition of Evidence-Based Practice

The APA Task Force on EBPCA adopted APA's definition of evidence-based practice and delineated the principles and assumptions that currently guide EBP in children's mental health (APA, 2008). The adopted APA definition of EBP is the following:

> Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. This definition of EBPP closely parallels the definition of evidence-based practice adopted by the Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000). … The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological

> assessment, case formulation, therapeutic relationship, and intervention. (APA, 2006, p. 5)

While the APA definition is targeted for psychologists, the definition is shared by other mental health providers, including child psychiatry. For example, the American Academy of Child and Adolescent Psychiatry (AACAP) included a similar definition in their policy statement:

> Evidence-Based Practice (EBP) comprises empirically-validated processes that facilitate the conscientious, explicit and judicious integration of individual clinical expertise with the best available external clinical evidence from systematic research in making decisions about the care of individual patients. The ultimate goal of EBP is to base clinical decision making in the areas of causation, diagnosis, prognosis, treatment and guidelines on empirical evidence (AACAP, 2006, p.1).

The broader term "evidence-based practice" is chosen over the term "evidence-based treatment" because it goes beyond treatment to encompass evidence-based assessments (EBA) and evidence-based prevention and "extends to the systemic, cultural, and structural aspects of the settings, delivery mechanisms, and organizations and institutions through which EBTs and EBAs are developed and implemented" (APA, 2008, p. 18). The TDMHSAS through its Best Practices Guidelines adopts the broader concept of evidence-based practice. Tennessee's Best Practices Guidelines are also more inclusive than simply evidence-based treatment for specific disorders. The Guidelines focus on the children's system of care, including trauma informed systems, system of care initiatives, integrated health and behavioral health, targeted behavior problems, as well as traditional diagnostic categories.

Guiding Principles and Assumptions for Evidence-Based Practice for Children and Adolescents

The Task Force on EBPCA emphasizes that an evidence-based orientation to clinical practice requires "a scientifically minded approach" that includes applying psychological science and using an ongoing process of observation and evaluation. Early in its report, the Task Force identifies the following three primary elements of EBP for children and adolescents:

(a) assessment that guides diagnosis, intervention planning, and outcome evaluation;
(b) intervention that includes, but is not limited to, those treatment programs for which randomized controlled trials have shown empirical support for the target populations and ecologies; and ongoing monitoring, including client or participant feedback, conducted in a scientifically minded manner and informed by clinical expertise (e.g., judgment, decision making, interpersonal expertise) (APA, 2008, p. 9).

In summarizing the key issues surrounding EBP for children, adolescents, and families, the Task Force on EBPCA was guided by four principles. These principles, listed below, can be used by individual providers, organizations and children's services policymakers to provide a common language for evidence-based practice across systems.

Guiding Principles for Evidence-Based Practice for Children and Adolescents

> 1. Children and adolescents should receive the best available care based on scientific knowledge and integrated with clinical expertise in the context of patient characteristics, culture, and preferences. Quality care should be provided as consistently as possible with children and their caregivers and families across clinicians and settings.
>
> 2. Care systems should demonstrate responsiveness to youth and their families through prevention, early intervention, treatment, and continuity of care.
>
> 3. Equal access to effective care should cut across age, gender, sexual orientation, and disability, inclusive of all racial, ethnic, and cultural groups.
>
> 4. Effectively implemented EBP requires a contextual base, collaborative foundation, and creative partnership among families, practitioners, and researchers. (APA, 2008, p. 18)

In its report, the Task Force identifies its specific assumptions underlying evidence-based practice, assumptions it views as essential components to developing and disseminating care to youth and their families. Their assumptions of evidence-based practice include the following:

> (a) shared goal of effective child mental health care, uniting families, practitioners, policymakers, payers, and researchers;
> (b) importance of evidence- based assessment of childhood problems;
> (c) importance of prevention of child and adolescent problems;
> (d) need for systems-level changes to support EBP;
> (e) importance of collaborative, multidisciplinary-focused EBP;
> (f) imperatives of culturally responsive EBP; and
> (g) utilization of diverse bases of evidence for EBP (APA, 2008, p. 22)

The Tennessee Best Practice Guidelines are developed in accordance with the EBPCA principles and assumptions. The Guidelines for each disorder or problem address evidence-based screening and assessment and intervention while being mindful of prevention and cultural differences that must be considered with implementation. The importance of collaborative, multi-disciplinary evidence-based practice is an overarching value in these guidelines, and its importance is exemplified through the chapter summarizing the Children's Council on Mental Health. (The Children's Council on Mental Health was legislated in 2008 to design a plan for a statewide system of care for children (http://www.tn.gov/tccy/ccmh-home.shtml)).

The section below provides a summary of the benefits and risks of EBPs. It is followed by a section discussing the components of evidence-based practice and resources to assist with identification of evidence-based practices and interventions in children's mental health.

Benefits and Risks of EBPs

Benefit: Cost-effectiveness and Resources

The benefits of EBPs focus on efficiency as well as efficacy, both of which represent good stewardship of public funds and the ability to foster the mental health of children and youth. First, utilizing EBPs represents a **wiser use of limited resources** by focusing on practices that have "been *proven* to work as compared to what people *think* will work or what has traditionally been done" (Evidence based programs: An overview. *What Works, Wisconsin* Issue 6, 2007).

In cases where cost-benefit information is available for a particular EBP, this type of information conveys the **potential economic savings** that may accrue from the appropriate use of the specific EBP.

Third, the **credibility of EBPs is a strong influencer for funders, the community, and key stakeholders** so that their adoption as part of the offerings of child and youth serving agencies is likely to garner support as well as increase access to opportunities to apply for different types of funding.

That EBPs enjoy wider support from multiple disciplines spanning the biological, sociological and psychological also make their **implementation more attractive to funders** and decreases the degree to which they may be suspect to those who provide as well as those who receive services (http://escholarship.umassmed.edu/cgi/viewcontent.cgi?article=1014&context=pib)).

In a report prepared by the Washington State Institute of Public Policy, the authors summarized their findings about implementing EBPs thusly:

> **"Evidence-based treatment works.** We found that the average evidence-based treatment can achieve roughly a 15 to 22 percent reduction in the incidence or severity of these disorders—at least in the short term."
>
> **"The economics look attractive.** We found that evidenced-based treatment of these disorders can achieve about $3.77 in benefits per dollar of treatment cost. This is equivalent to a 56 percent rate of return on investment. From a narrower taxpayer's-only perspective, the ratio is roughly $2.05 in benefits per dollar of cost."

"The potential is significant. We estimate that a reasonably aggressive implementation policy could generate $1.5 billion in net benefits for people in Washington ($416 million are net taxpayer benefits). The risk of losing money with an evidence-based treatment policy is small." (Aos et al., 2006).

Choices for persons receiving services

Historically, persons receiving mental health care in both the public and private sector have been offered limited choices of treatment and interventions. Often the care is limited to the traditional "talking" therapies or interventions for which there is no level of evidence and medications which may not be approved for a particular population, or whose side effects are as challenging as the problematic behaviors they are intended to manage.

In institutional or congregate settings, the emphasis on controlling and managing symptoms often takes priority over protocols that help service recipients develop skills and abilities that people who do not receive services develop as a result of healthier relationships and interactions.

The addition of EBPs means that service recipients are now active participants in their own healing and recovery and the children and youth, along with their caregivers and families, begin to hear and weigh information about multiple options in development of a comprehensive treatment plan.

Reductions of time, trauma, and costs of mental health recovery

The work of providing care and interventions for children and youth with mental health issues can be lengthy, traumatizing for caregivers, families, and for those who provide or receive services and as a result even more costly. Efforts to make a difference for those who receive services must also work to help those who provide services manage the inevitable impact of this emotionally difficult work.

Effective prevention and treatment programs have been developed for a variety of mental health issues, including programs addressing disruptive behavior disorders, trauma exposure, post-traumatic stress disorder, depression, anxiety, and substance use and abuse. In addition, several family- and community-based programs are available to prevent placement into juvenile detention settings, residential treatment, and foster homes (http://www.cimh.org/Portals/0/Zellerbach%20report%20-%20EBP.pdf).

Evidence-based practices target improved outcomes for children and families in terms of symptoms, functional status, and quality of life. In response, progress is assessed both in terms of prevention of relapse and re-hospitalization, but also in terms of positive outcomes such as independence, employment, and satisfying relationships (Drake et al., 2001) which aligns with the mental health recovery guidelines provided by the Substance Abuse and Mental health Services Administration (SAMHSA) in their National Consensus Statement on Mental Health Recovery.

Over the years, evidence-based practices have been shown to improve healthcare outcomes as well as conserve resources by removing unnecessary and ineffective healthcare treatment (Agency for Healthcare Research and Quality, 2003). While they are far from “magic bullets,” and while there are challenges in terms of how effectiveness is determined, evidence-based practices are advances in the positive direction.

For example, there are three logical inferences of implementing practices that both conserve resources and improve outcomes:

1. Decreased time receiving services because of more effective and efficient methods of intervention.

2. Service recipients who are more functional and productive members of society more quickly, preserving capacity to learn, engage and earn.
3. Clinicians and service providers are less negatively impacted by the work of providing mental health care.

Provider and Organizational Considerations

1. Resistance to change. A key challenge in implementing EBPs may be both agency and provider resistance to change. While there is a considerable amount of evidence for any number of EBPs, the evidence is often doubted, rejected, or set aside.

There are many who believe that the empirical study of psychotherapeutic interventions or the need to base interventions on documented methods of treatment is not applicable to them as practitioners or to their agencies. As Kennair, Aarre, et al. point out in their 2002 article in the *Journal of Science and Health Policy*, there is "no reason to believe that the methods one was initially trained in were the best methods ever to be discovered. The approach also ignores the duty to revise professional attitudes in the light of new evidence (p. 2)."

Resistance to change is supported by three primary issues in the world of behavioral and mental health care:

1. Personal conviction to one's way of working without documented evidence from processes grounded in science (even if lesser evidence than Randomly Controlled Trials);
2. Adherence to "the ways things have always been done," and
3. The preference for what may be called "socially constructed consensus" over "empirically informed guidelines."

2. Quality and cost. In implementing EBPs, the question of what determines quality is paramount. Using less than optimal treatment usually means not optimally alleviating the individual's suffering, but it also means that the individual will continue to be sub-optimally productive and probably cause further costs to not only treatment agencies but also other child services such as education.

Thus determining which of the evidenced based interventions or therapies to offer requires some definition of "optimal" which must also take into account the challenges of research in the field. The U.S. National Registry of Evidence-Based Practices and Programs (NREPP) evaluation protocol is one such protocol, and is the basis of determining which interventions will be added to the NREPP database. NREPP will consider adding a practice or program only if it has been evaluated using an experimental or quasi-experimental study design. Additionally, the treatment must have outcome data that has been published in a peer-reviewed journal or an evaluation report, and should include documentation such as manuals and training materials available for assisting in dissemination.

3. Organizational change required. Implementing any new practice or program requires multiple changes, which may range from operating processes to policy change, environmental changes, staff behavior change, communication and record-keeping as well as changes to financial processes. Because the goal is to offer the optimal practices and programs with the fidelity required to achieve the desired outcomes, organizational change is a major issue for implementing evidenced based practices. There are numerous methodologies available for implementing organizational change that address the clinical as well as the administrative aspects of taking on new evidenced based practices in an agency or system (i.e. National Implementation Research Network: http://nirn.fpg.unc.edu/).

4. Fidelity to the model. The research on an evidenced based practice resulting in the attribution of a "promising," "evidence-informed" or "evidence-based" practice contains key information about specific practices, or frames, that are necessary for replication to be successful. Without these, the risk of attaining less than the optimal results offered by the EBP is high.

Adopting a model does not mean adapting it, and adaptation beyond the limits provided decreases fidelity and success, thus decreasing the cost-benefit ratios and potentially increasing frustration and disappointment by the provider. Investing in the manuals, the training, and the follow-up supervision/consultation requirements as well as working to ensure that adherence to key criteria occurs is critical to obtaining optimal outcomes for children and their families.

5. Risks. In recent years, the focus on present-focused, strength-based mental health recovery has increased. Models that focus on recovery may not yet have a body of empirical research even if they have a body of lesser-level evidence for effectiveness. Thus, a rigid implementation policy of using only EBPs can disenfranchise the voice of the child and his/her family. This risks a return to a more subtly coercive model, which is contrary to the SAMHSA National Consensus Statement on Mental Health Recovery and which may mimic the dynamics of factors contributing to mental health issues.

EBPs often focus on a **specific diagnosis rather than a broad population**. One risk of the need for interventions to be evaluated with Randomized Controlled Trials (RCTs) is that the research may limit participation to individuals with specific diagnostic criteria in order to enhance effect sizes. While serving the immediate research needs, addressing the effectiveness for the broader population may be beyond the scope of most RCTs (McKay, 2007). However, recently the field is making some progress toward modifying EBP to include cultural adaptations and address multicultural competencies to improve outcomes (i.e. Berg-Cross, L & So, D. Register Report, Fall 2011) http://www.nationalregister.org/trr_fall11_bergcross.html.

Issues of adequate funding to address training and implementation of evidence based practices to ensure fidelity to a the EBP model can impact the outcomes and sustainability of the evidenced based practice in the organization and must be addressed to provide the most successful outcomes for children and their families

Resources and Tools

A. Selecting/evaluating evidence-based assessments and treatments

As stated throughout this document, evidence-based practice is an approach that encourages consideration of empirical evidence, clinical expertise, and family and cultural values. Evidence for the effectiveness of a given practice exists on a continuum from treatments supported with the most rigorous high-quality experimental research to treatments supported by theoretical constructs that have general support in the professional community. When empirical evidence exists that establishes the efficacy of an assessment or treatment approach for a specific set of symptoms exhibited by a child or adolescent, the treatment provider has an ethical duty to discuss the strengths and limitations of the approach with the client and his/her caregiver. When empirical evidence does not exist to support the efficacy or effectiveness for an assessment or treatment approach, the treatment provider provides EBP by balancing the most current empirical evidence, clinical expertise, and the family's preferences (Association for Behavioral and Cognitive Therapies and the Society of Clinical Child and Adolescent Psychology, 2010).

1. Evidence-based Assessment

Mash and Hunsley (2005), in their introduction to the special section of the *Journal of Clinical Child and Adolescent Psychology* directed at developing guidelines for evidence-based assessment of child and adolescent disorders, noted that, in comparison to evidence-based interventions, little attention has been paid to developing evidence-based assessment guidelines. Their introduction enumerated several of the complexities that challenge the field when addressing evidence-based assessment.

> (a) the sheer number of assessment methods and processes for particular problems and outcomes relative to the number of available treatments and (b) the many purposes of assessment as compared with treatment. This challenge is compounded in assessments of children, where developmental changes in the domains being assessed (Lahey et al., 2004) and the embeddedness of children in the family and peer group require that a much larger number and variety of methods be developed and used than is the case for adults. (p. 364)

Because of the complexities of evidence-based assessment, Mash and Hunsley (2005) supported the idea that disorder or problem specific guidelines be developed that address what the goals of the assessment might be, such as diagnosis, treatment planning, treatment monitoring, and treatment evaluations. They noted the importance in attending to the "the psychometric properties of specific tests and measures, common assessment decisions associated with specific disorders, and the utility of assessment for treatment planning, design, and monitoring." (p. 375). Evidence-based assessment for specific disorders including anxiety, depression, bipolar disorder, attention deficit hyperactivity disorder, conduct problems, learning disabilities, and autism spectrum disorders were part of the special section. See *Journal of Clinical Child and Adolescent Psychology*, 2005, *34*(3).

Since that time, evidence-based assessment has had additional attention in pediatric psychology. APA Society of Pediatric Psychology published a special issue journal (2008) to both identify and evaluate assessment instruments available in the child health care field. Articles in the special section of Journal of Pediatric Psychology addressed evidence-based assessment in the following areas: quality of life, family functioning, psychosocial functioning and psychopathology, social support and peer relations, adherence, pain, stress and coping, and cognitive functioning.

In keeping with the idea of development of evidence-based assessment processes, not simply identification of evidenced based instruments, Kazden (2005) summarized the common themes in child and adolescent assessment that evaluators should keep in mind:

> 1. There is no "gold standard" to validate assessments.
> 2. Multiple measures need to be used capture diverse facets of the clinical problem.
> 3. Multiple disorders or symptoms from different disorders ought to be measured because of high rates of comorbidity.
> 4. Multiple informants are needed to obtain information from different perspectives and from different contexts.
> 5. Adaptive functioning, impairment, or more generally how individuals are doing in their everyday lives are important to assess and are separate from symptoms and disorders.
> 6. Influences (or moderators) of performance need to be considered for interpreting the measures, including sex, age or developmental level, culture, and ethnicity, among others. (p. 549)

2. Evidenced-based Intervention

The research literature for evidence-based psychosocial interventions continues to evolve and develop and can be overwhelming to individual clinicians who strive to be evidence- based in their treatment. Clinicians, after doing the work to identify an evidence-based treatment and looking at the strength of the science supporting the intervention, must also consider the child and family's characteristics and cultural factors in implementing the intervention.

Families have an important role on their child's treatment team. As difficult as it is for clinicians to wade through the literature on evidence-based treatments and identify evidence-based interventions, it may be even more difficult for families to navigate the evidence-based practice terrain. NAMI (2007) has developed a guide to assist families in understanding what is meant by "evidence-based practice", what evidence-based treatments have been identified for particular problems, and how to advocate for their child's needs when working with a provider to determine interventions that are the best fit for their child and family's needs.

Online resources that clinicians and families can use to identify evidence-based interventions for children and adolescents are listed below.

B. *List of online resources*

California Evidence-Based Clearinghouse for Child Welfare: http://www.cebc4cw.org/.

Effective Child Therapy: Evidence-based mental health treatment for children and adolescents. Sponsored by American Psychological Association, Division 53. http://www.effectivechildtherapy.com/.

Metz, A., & Bartelye, L. (2012). Active implementation frameworks for program success: How to use implementation science to improve outcomes for children. *Zero to Three*. http://www.zerotothree.org/about-us/areas-of-expertise/reflective-practice-program-development/metz-revised.pdf.

NAMI: Choosing the right treatment: What families need to know about evidenced based practices. Retrieved from http://www.nami.org/Template.cfm?Section=child_and_teen_support&template=ContentManagement/ContentDisplay.cfm&ContentID=47656.

National Child Traumatic Stress Network: Empirically supported treatments and promising practices. Retrieved from http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP): http://www.nrepp.samhsa.gov/.

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TDMHSAS BEST PRACTICE GUIDELINES

Infant and Early Childhood Mental Health

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Note: The use herein of the term "infant mental health" or "IMH" will include "early childhood mental health," just as most references to infants, toddlers, and young children can be interchangeable. Additionally, IMH "providers" and "specialists" are used without referring to a specific state's competency endorsement system.

I. ***Definition: What is infant mental health?***

Infant mental health (IMH) refers to the social-emotional well-being of children ages 0 to 5 years. A central tenet is that infant development cannot be separated from the caregiving environment, primarily the attachment relationships, as well as the culture in which the relationships develop.

Currently there are multiple programs across the Unites States that train infant mental health practitioners. Training is generally intensive, requiring at least one year of study plus ongoing supervision, and includes the following core concepts:

- **Relationship-Based Assessment and Intervention**: Infants and young children develop within the context of one or more dyad-specific attachment relationships. The physical, cognitive, social, and emotional capacities of the infant are mediated by the quality of the caregiver-child relationships.

  Similarly, the relationships between the infant mental health practitioner, the infant, and caregiver are prized. Thus, prevention and intervention occur within the context of relationships (i.e., between caregiver and provider, family and organization, etc.).

  - **Cultural Competence**: Just as infants cannot be understood outside of the context of their primary relationships, relationships cannot be understood outside of the culture in which they grow. The impact of socioeconomic or minority status, race, ethnicity, sexuality, and culture on the caregiver, child, and relationship must be acknowledged and explored. Infant mental health is an ecologically-valid discipline, accounting for all factors impacting the infant and the caregiving dyad. Therefore, not only do IMH providers offer preventive support and evidence-based intervention to the child, dyad, and family, but they also advocate for services and/or social change, as necessary, for infants/families to thrive.

- **Reflective Practice**: A large core knowledge base that includes child development, adult development, ability to observe behavior, ability to translate between caregiver and child, ability to work across service systems, etc. is required of an IMH specialist. This knowledge base is necessary but not sufficient; an IMH specialist must also have the ability to engage with a caregiver-child dyad while holding each in mind and being aware of what each member, including the specialist, brings to the relationships. Reflection is a necessary skill and responsibility involving the specialist's acknowledging and examining his/her own responses to the dyad and regularly accessing appropriate supervisory or consultative relationships.

- **Collaborative Systems:** The practice of IMH rarely occurs solely within a therapist's office; rather it is community based. Infants and young children are uniquely dependent upon their caregivers at all times. It is crucial that an IMH specialist be able to assess and coordinate intervention as part of a team of significant figures who interact with a child. This may include health and allied health professionals, educators, extended family members, etc. and is especially important where there are developmental concerns. Some of the most successful prevention and intervention programs have been developed in collaboration with child welfare/courts, education, and primary care practices (e.g., Zero to Three Safe Babies Court Teams, mental health consultation in Early Head Start, embedded mental health professionals in pediatric settings).

- **Trauma-Informed/Empirically-Based Assessment and Intervention:** Understanding trauma from a developmental perspective is a core competency of infant mental health. While young children do not have the words to describe traumatic events, they are impacted by trauma at a preverbal level (biological, cognitive, social, and emotional). Young children are especially impacted by interpersonal trauma because they experience the world through the lens of their primary caregivers. Early trauma may include exposure to domestic violence, community violence, parental addiction, or chronic maltreatment. Traumatized infants and dyads have a special need for trained providers who are sensitive to relational and developmental stages. An IMH specialist whose practice implements all of the core concepts previously stated will need additional training and supervision in working with trauma-exposed infants and their caregivers. For infants and young children, it is particularly important that evidence-based interventions be implemented in the context of relationship-based practice.

Why focus on infant and early childhood mental health?

- **Early development and vulnerability**: Advances in neuropsychology have led to an understanding of the "experience-dependent brain." The pace of brain growth and organization in the first three years is unmatched at any other time during the lifespan, with fully 83 percent of dendritic growth occurring after birth, mostly during the first three years of life. Given this early growth and later neuronal pruning, the "use it or lose it" principle may best describe how experience shapes the brain. Because early trauma and deprivation can derail lifelong functioning, positive relationships and stimulation are crucial in the early years. When children are exposed to trauma and/or neglect, developmental priorities shift from learning to vigilance. Violence exposure leads to smaller brain mass and less brain tissue connecting the hemispheres, difficulty with emotion regulation, motor coordination, language and learning (De Bellis et al., 1999). Young children exposed to trauma have a heightened "fight or flight" response due to increased hypothalamic-pituitary-adrenal reactivity (Perry et al., 1995; van der Kolk, 2003).

- **Early development and recovery**: While infants and young children may be particularly susceptible to adverse experiences (e.g. poverty, lack of resources, absence of an emotionally nurturing caregiver) and trauma (e.g. abuse/neglect, interpersonal violence, medical trauma, terrorism, natural disaster), the good news is that they are also more able to repair, learn, and grow from positive experiences than older children and adults. Early and appropriate intervention can improve lifelong functioning (Tronick et al., 1998). Recent research has shown that the first two years of brain development are especially sensitive to corrective psychological environments (Sheridan et al., 2012).

III. *What is healthy infant and early childhood social-emotional development? How do we promote it?*

- Infants are fully dependent on their primary caregiver(s) not only for instrumental care (feeding, clothing, etc.) but also for psychological nourishment. Without consistently responsive, nurturing attention, infants can be psychologically malnourished which in turn can stunt growth in all developmental domains (physical, cognitive, social, etc.). The healthy reciprocity of the primary attachment relationship is the essential psychological nutrient. Support for child well-being begins with communities where adults have what they need physically and psychologically in order to thrive and care for their children.

- Healthy social-emotional development and attachment are associated with (Anda et al., 2006):

    - Emotional Regulation
    - Optimal Cognitive Development
    - Academic Achievement
    - Physical Health
    - Mental Health

        - Relational Capacity (the ability to form positive parental, peer, and romantic relationships)
        - Developing optimal autonomous functioning
    - According to the Infant Mental Health (IMH) Task Force at Zero to Three, IMH is:

        - The developing capacity of the child, birth to 3 years, to experience, regulate, and express emotions;
        - The ability to form close and secure relationships; and
        - The ability to explore the environment and learn.

    - IMH specialists can recognize and advocate for environments where young children learn socially appropriate coping strategies to express and regulate emotions and where they can form secure relationships, explore and learn. IMH specialists can support parents in learning developmentally appropriate expectations and discipline techniques and guide parents in identifying family needs and resources, such as high-quality early childhood programs, timely medical and/or developmental screening, nutrition choices and sources, health-promoting activities, and age-appropriate cognitive stimulation.

IV. Screening and Assessment

- Universal screening of infants, generally in a primary care setting, has been mandated given the benefits of identifying problems early. With early screening (e.g. EPSD&T), successful prevention can occur. The American Academy of Pediatrics disseminated a policy on developmental surveillance and screening (AAP, 2006) and issued a reaffirmation of the policy in 2010 (AAP, 2010). TENNderCARE is a full program of check-ups and health care services for children who have TennCare and includes developmental/behavioral screening (http://www.tn.gov/tenncare/tenndercare/visits.shtml#2).

- Assessing social-emotional wellness in infants and young children can be more challenging than with older children because of the rapidity of growth, the small window of elapsed time between age-appropriate and delayed development, and the overarching impact of the primary attachment relationship. Close and frequent contact and evaluation is necessary for an IMH provider's assessment and recommendations to remain current.

- Methodology:
    - Interviews with caregivers
    - Standardized/Objective Measures
        - Caregiver-report measures regarding infant symptomatology, infant exposure to trauma and stressful life events, and parenting stress. The following is a non-exclusive list of some available measures.
            - Ages and Stages Questionnaire: Social-Emotional (http://www.pbrookes.com/tools/asqse/index.htm)

  - Parenting Stress Index (http://www4.parinc.com/Products/Product.aspx?ProductID=PSI)
  - Child Behavior Checklist (http://www4.parinc.com/Products/Product.aspx?ProductID=CBCL-PS)
    - Infant-Toddler Social and Emotional Assessment and Brief Infant-Toddler Social and Emotional Assessment (http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8007-387)
  - Observation
    - Given that children communicate primarily through behavior, careful observation of the child and caregiver is of utmost importance and is an essential part of all training protocols.

- A typical assessment involves office-based interviews and observation of the child with multiple caregivers in natural environments (whenever possible).
  - Background
    - IMH provider meets with primary caregiver and/or custodial caregiver to obtain history.
    - Child history includes prenatal, medical, temperament/sensory issues, behavioral issues, family composition and functioning, social relationships, school/daycare, trauma exposure, loss, etc.
  - Child Functioning
    - IMH provider first observes the child with caregivers in natural and/or clinical environments, then directly interacts with the child.
    - Observations and assessments help determine functioning in all developmental and social-emotional domains including motor, language, cognition, sensory processing, affective expression, emotional regulation, and social interaction with peers and adults.
  - Caregiver Functioning
    - IMH provider meets and evaluates caregiver(s) strengths and needs.
    - Caregiver history includes health, psychiatric, intellectual, adaptive functioning.
  - Caregiver's Perceptions of the Child
    - IMH provider meets with caregiver(s).
    - IMH provider administers a semi-structured clinical interview developed to elicit caregiver perceptions. This type of semi-structured interview requires advanced training.
  - Observation of family functioning, specifically, the child's interactions with each caregiver.
    - IMH provider facilitates interactions between the infant or young child and each significant caregiver.
    - These observational methods require advanced training.
  - Psychiatric Evaluation
    - IMH provider may refer to an IMH-trained physician or nurse practitioner who meets with the family to assess for the suitability

of psychopharmacological intervention. See **Appendix I**, **Pharmacotherapy in infant and early childhood mental health**; see also Gleason, et al. 2007, Psychopharmacological Treatment for Very Young Children: Context and Guidelines; for older references, see AACAP Practice Parameters for the Psychiatric Assessment of Infants and Toddlers (Thomas, 1998). The AACAP parameters are undergoing revision.

V. Diagnosis

- Diagnosis is an ongoing process requiring multiple sessions or contacts (as outlined in the assessment section).
- Diagnoses may change more rapidly in early childhood than for older children and adults.
- Diagnosis often requires a multidisciplinary team that can assess medical as well as developmental and psychological issues.
- The standard diagnostic manual is the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R)* (Zero to Three, 2005). IMH clinicians are trained to use this system as well as the DSM-IV (for older youth, caregivers and other adults who may be the focus of clinical intervention).
- The DC:0-3R is developmentally appropriate for infants and toddlers and focuses on caregiving relationships as a primary factor in children's emotional health.
- Many young children are referred for assessment for being "oppositional" or "hyperactive." IMH clinicians are trained to differentiate between developmentally appropriate stages during which children are expected to display certain behaviors, such as separation anxiety and bids for independence, and when those same behaviors might signal a problem. Likewise the IMH clinician can evaluate situational or timely expressions of grief, depression, trauma, etc. and identify behaviors that may be an early manifestation of a more pervasive diagnosis. The DC:0-3R recognizes the occurrence of disruptive behavior as a symptom of a multiple diagnoses.
- The quality of an attachment is relationship-specific. The DC:0-3R contains descriptors for the quality of an attachment relationship in the context of each relationship. It does not offer diagnostic classifications for attachment problems separate and apart from a relational context.
- To facilitate reimbursement, crosswalks have been developed for DC:0-3R and DSM-IV TR. (For example, see a crosswalk developed by the state of Florida at http://gucchdtacenter.georgetown.edu/Activities/TrainingInstitutes/2012/Resources/Inst_16_R2_FL%20Crosswalk%20June%202010%20PDF.pdf.)

Comparison of Five-Axis Categories in DSM-IV TR and DC:0-3R

	DSM-IV TR	***DC:0-3R***
Axis I	Clinical Disorders	Clinical Disorders
Axis II	Personality Disorders Mental Retardation	Parent-Infant Relationship Global Assessment Scale (PIRGAS) Relationship Disorders
Axis III	Medical Disorders	Medical & Developmental Disorders
Axis IV	Psychosocial & Environmental Problems	Psychosocial & Environmental Problems
Axis V	Global Assessment of Functioning	Functional Emotional Developmental Level (includes attention, mutual engagement, communication, problem solving, and symbolic thinking)

Source: Egger & Emde, 2011.

VI. Intervention

- There are many evidence-based primary, secondary, and tertiary interventions for infants and toddlers that address a wide range of presenting issues (e.g. developmental delays, feeding/sleeping issues, disruptive behavior disorders, symptoms associated with trauma exposure).
- Treatments may be as practical as case management and parent support or as intensive as dyadic psychotherapy.
- Multiple settings for intervention include home-based, school-based, agency-based, or a more traditional clinic.
- The following is a non-exhaustive list of empirically-based interventions for infants and young children. Web links for each intervention are included. These interventions are not generally available in Tennessee at this time, primarily due to the shortage of infant mental health specialists. Tennessee has, however, brought parent-led, professionally coordinated training and support programs for families with young children to communities statewide through the Regional Intervention Program (http://www.ripnetwork.org).

- Attachment and Biobehavioral Catch-up (ABC) (Dozier)
    - For caregivers and children (ages 0-5) who have experienced early maltreatment and/or disruptions in care: http://abcintervention.com
- Child-Parent Psychotherapy (Lieberman & Van Horn)
    - Home or clinic-based treatment for traumatized children (ages 0-5) and their caregivers: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=194
- Circle of Security (Cooper, Hoffman, Marvin, Powell)
    - An intervention program for caregivers and children designed to prevent insecure attachment and child emotional disorders (ages 0-5): www.circleofsecurity.org
- Nurse-Family Partnership (Olds)
    - Nurse home visitation program for low-income, first-time parents and their children (prenatal–infancy): http://www.nursefamilypartnership.org/
- Nurturing Parenting Programs (Bavolek)
    - Focused on prevention and treatment of child abuse and neglect for caregivers and children (ages 0-5): http://www.nurturingparenting.com/
- Parent Child Interaction Therapy (Eyberg)
    - An intervention or children (ages 2-7) with externalizing behavioral problems that focuses on improving the caregiver-child relationship: http://www.pcit.org/

- Key components of collaborative IMH intervention:
    - Concrete service support/case management
    - Emotional support/therapeutic engagement
    - Advocacy
    - Developmental guidance/parent education
    - Dyadic psychotherapy
    - Reflective supervision and consultation

Appendix I: Pharmacotherapy in Infant and Early Childhood Mental Health

M.M. Gleason, MD, Assistant Professor of Psychiatry and Behavioral Sciences,
Assistant Professor of Pediatrics, Tulane University School of Medicine

There is limited scientific evidence that supports or guides the use of psychopharmacologic treatment in preschoolers (3 -5 years old) and none in the infant and toddler ages. Challenges for physicians considering psychopharmacological intervention include:

- Complexity of diagnosing clinical disorders in very young children and the specialized skills such diagnosis requires.
- Relative limitations in the empirical base examining the validity of diagnostic criteria for some common disorders (including all anxiety disorders other than post traumatic stress disorder).
- Evidence that there is both continuity and discontinuity of preschool presentations of disorders with school age disorders.
    - Known and unknown risks because of metabolic and developmental differences, including the possible risk of disruption of central nervous system development.

- Extreme limitations in pharmacokinetic data about psychopharmacologic agents in preschoolers
- Lack of FDA indications for most medications in this age group (even those with empirical support)
- The sensitivity to context (especially caregiving) of young children's emotional and behavioral development.

Because the evidence base supporting dyadic and family psychotherapy exceeds the evidence supporting psychopharmacologic interventions for every disorder studied, psychotherapeutic treatment is the first-line intervention. All systems should make every effort to ensure that children with significant mental health disorders have access to quality psychotherapy. Unfortunately, in most parts of the United States, access to therapists trained in infant and early childhood mental health is extremely limited either by number of providers, their training, third-party payer barriers, or family schedules. In addition, as with all evidence-based treatments, a sizable minority does not complete or does not respond to the treatment.

The disorder with the most substantial evidence base for pharmacologic treatment is ADHD, for which two large randomized controlled trials have reported similar findings for different medications. In rigorous studies of methylphenidate (Greenhill et al., 2006) and of atomoxetine (Kratochvil et al., 2011), the medications were found to be more effective than placebo, but less effective with higher rates of adverse effects compared to older children. These findings reinforce the recommendations that the first-line treatment of ADHD in preschoolers is parent management training (Gleason et al., 2007, Charach et al., 2012) and that psychopharmacologic agents may be considered as second- or third-line interventions, used only with close monitoring of both effectiveness and potential adverse effects.

For other disorders, psychopharmacologic information is based on case reports, case series, and open trials, but not on randomized controlled trials. The use of non-pharmacologic treatment of disruptive behavior disorders as well as of ADHD is strongly supported by an extensive and rigorous empirical literature (Charach et al., 2012 and overview in these Guidelines). There is also evidence that children as young as four can participate effectively in modified cognitive behavioral therapy (Scheeringa et al., 2011) and that a modified version of parent management training is effective in treating preschool depression (Luby et al., 2012).

After a failure of an adequate trial of non-pharmacologic treatment (whether rigorously evidence-based, supportive or symptom-focused interventions), parents and clinicians must weigh the risks of an untreated disorder with the known and unknown risks of medication treatment. In such situations, use of pharmacotherapy is not contraindicated, but should be one part of a more comprehensive treatment plan and must be monitored closely. Medications that cause unacceptable adverse effects or those that are ineffective should not be continued. Polypharmacy should be used with caution and with caregiver understanding of the extent of the data supporting such treatments.

Systems of care may be able to improve the quality of care by using claims data to develop organized monitoring and reviewing of specific treatment approaches. Review of practices with limited support might include all use of psychotropic medications in children under three, specific treatment approaches in preschoolers, use of medications which are not supported by randomized controlled trials, failure to order recommended metabolic labs with such medications, or numbers of concomitant psychopharmacologic medications. It should be noted that review of such practices would ideally be a productive and collaborative process. These practices must be evaluated in the clinical context before a judgment about the level of appropriateness can be made. When lack of access to evidence-based treatments is cited as a reason for the use of pharmacologic agents, focused efforts to increase access should be a priority.

As with other providers of IMH intervention, physicians who prescribe psychoactive medications form part of a multidisciplinary supportive team. Systems that encourage and reimburse frequent communication between non-prescribing and prescribing mental health providers may develop the greatest flexibility and most enduring safety net for well-being in all domains.

Note: *Dr. Gleason wrote the foregoing paragraphs at the request of the IMH workgroup, which recognizes her expertise and experience and is especially appreciative of this generous contribution to Tennessee's Best Practice Guidelines.*

VII. ***Selected Resources/References***

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TDMHSAS BEST PRACTICE GUIDELINES

Trauma-Informed Care

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Introduction

What is Trauma?

According to the Diagnostic and Statistical Manual (DSM-IV-TR, 2000), trauma is defined as, the **experience** of a real or perceived threat to life or bodily injury **OR** the life or bodily injury of a loved one **AND** causes an overwhelming sense of terror, horror, helplessness and fear. (***Note***: The DSM-5 will include a new chapter titled "Trauma- and Stressor-Related Disorders". However, it is not available in either print or electronic format at the time of this publication.)

Types of trauma. Psychological trauma may include medical issues such as surgeries, living in combat zones, accidents, natural disasters, relational trauma, abuse, neglect, enduring deprivation, and urban violence, all of which involve major losses for children who rely on adults to meet their physical and emotional needs, including connection, safety, support, and soothing (Giller, 1999).The National Child Traumatic Stress Network (NCTSN, n.d.e) divides trauma into the following categories:

- Community and School Violence
- Complex Trauma
- Domestic Violence
- Early Childhood Trauma
- Medical Trauma
- Natural Disasters
- Neglect

- Physical Abuse
- Sexual Abuse
- Refugee and War Zone Trauma
- Terrorism
- Traumatic Grief

What is Child Traumatic Stress?

Blaustein (2010), co-developer of the Attachment, Self-Regulation, and Competency (ARC) treatment model, offers that "traumatic experiences are those that are overwhelming, invoke intense negative affect and involve some degree of loss of control and/or vulnerability." Child traumatic stress takes place when children and adolescents are put in view of traumatic events or traumatic situations, and when this situation overpowers their skills to cope with what they have gone through (NCTSN, n.d.c).

What is Trauma-Informed Care?

The Substance Abuse and Mental Health Services Administration (SAMHSA, n.d.) National Center for Trauma-Informed Care defines trauma-informed care as "an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives" (SAMHSA/NCTIC web site, n.d.). Trauma-informed care focuses on the provision of developmentally appropriate, gender-specific care through the lens of research and evidence of effective practice for children and youth who have experienced events that are psychologically overwhelming (Jennings, 2008).

Impact of Trauma

Prevalence

Trauma exposure prevalence rates vary widely, depending on the community and type of trauma. For example, more than 6 in 10 U.S. youth have been exposed to violence within the past year, including witnessing a violent act, assault with a weapon, sexual victimization, child maltreatment, and dating violence. Nearly 1 in 10 was injured (Finkelhor et al., 2009; SAMHSA, 2009). Nationally, an estimated 772,000 children were victims of maltreatment in 2008 (U.S. Department of Health and Human Services, 2010). Violence exposure rates in urban settings have been well-documented (Stein, Jaycox, Kataoka, Rhodes, & Vesta, 2003), but rural communities are also reporting higher rates of violence exposure (Dean, Wiens, Liss, & Stein, 2007). In a longitudinal general population study of children and adolescents 9-16 years old in western North Carolina, researchers found that one quarter had experienced at least one potentially traumatic event in their lifetime, and 6 percent within the past three months (Costello, Erkanli, Fairbank, & Angold, 2002). In a continuation of the North Carolina study, Copeland and colleagues (2002) found that more than 68 percent of children and adolescents had experienced a potentially traumatic event by the age of 16. Full-blown PTSD was rare, occurring in less than one half of one percent of children studied. Other impairments—including school problems, emotional difficulties, and physical problems—occurred in more than 20 percent of children who had been traumatized. In those who had experienced more than one traumatic event, the rate was nearly 50%.

Traumatic stress rates also vary and are dependent on a number of variables, including proximity to the event, the number of previous stressors or trauma exposures, trauma reminders or triggers, support system, and resources (La Grecca, Silverman, Vernberg, & Prinstein, 1996). A recent review of research on children exposed to specific traumas found wide ranges in rates of PTSD:

- 20 percent to 63 percent in survivors of child maltreatment.
- 12 percent to 53 percent in the medically ill.
- 5 percent to 95 percent in disaster survivors (Gabbay, Oatis, Silva, & Hirsch, 2004).

These numbers do not reflect the multitude of other consequences of trauma exposure, including physical health issues and other behavioral health consequences. Adverse childhood experiences (e.g., physical, emotional, and sexual abuse; family dysfunction) are associated with mental illness, suicidality, and substance abuse in youth, and with many of the leading causes of death in adulthood (Felitti et al, 1998).

Trauma and Development

Children respond differently to stressors, including traumatic stressors, depending on a number of factors such as: 1) Characteristics related to the individual child (e.g., temperament, cognitive abilities), 2) Characteristics related to the trauma exposure (e.g., proximity, "dose" of trauma), and 3) Post-trauma factors (e.g., supportive caregivers). A critical and ubiquitous factor in how children experience traumatic events and express their subsequent distress, however, depends in large part on the child's age and developmental level. The following paragraphs outline developmental information that can be used as a general guide when providing care for children from a trauma-informed perspective (Adams, 2010; Hodas, 2006; NCTSN, n.d.a, Schwartz& Perry, 1994).

In response to trauma:

Infants might …

- Become irregular in their biological patterns such as sleeping, eating, and voiding
- Become more fussy OR become disengaged (shut down, dissociated)
- Become more difficult to soothe
- Become less adaptive to changes in routine
- Show bodily symptoms (e.g., vomiting, looser stools or constipation)

Preschoolers and young school-age children often…

- Experience feelings of helplessness
- Are uncertain regarding the possibility of continued danger
- Experience generalized fear that extends beyond the specific trauma
- Show their distress through behaviors rather than through words
- Lose (temporarily) previously acquired developmental skills such as toileting and speech
- Generally regressive behaviors such as clinging, thumb-sucking or bedwetting
- Display sleep disturbance (e.g., fear of going to sleep, nightmares, frequent wakening)
- Display separation anxiety and a fear of doing things they once did freely (e.g., playing outside in the yard without a caregiver with them)
- Engage in traumatic play (e.g., repetitious play that is less imaginative than their normal play and may represent the child's continued focus on the trauma)
- Tend to react more to the reaction of the primary caregiver in relation to the trauma than to the trauma itself

School-age children might …

- Develop a persistent concern regarding their own safety and the safety of others close to them and may show signs of separation anxiety
- Become preoccupied with their own actions during the traumatic event, experiencing shame or guilt regarding what they did or did not do
- Experience sleep disturbances
- Experience trouble with concentration and learning in school
- Complain of headaches, stomachaches, or other somatic problems that appear to have no medical basis
- Engage in constant retelling of the traumatic event
- Describe feeling overwhelmed by feelings of fear and/or sadness
- Become more irritable and/or aggressive
- Become withdrawn

Adolescents might …

- Experience heightened anxiety and fear sometimes with flashbacks/intrusive thoughts
- Experience vulnerability that could:
    - lead to behaviors of acting out (aggressive) to gain a sense of control/power

      or
    - lead to avoidance behaviors such as staying at home instead of going to school or out with friends
- Have concern over being labeled "different" or "abnormal" from their peers
- Withdraw/actively avoid reminders of trauma
- Experience sleep disturbance
- Experience feelings of shame and guilt regarding the trauma vis-à-vis what they either did or did not do during the trauma
- Engage in revenge fantasies
- Have depressive symptoms including suicidal ideation

- Experience school/vocational decline
- Have a radical shift in their world-view (e.g., “Nowhere is safe”)
- Engage in self-destructive or accident-prone behaviors

Complex Trauma

In contrast to the earlier belief that early trauma had little impact on the child, it is now recognized that early trauma has the greatest potential impact, by altering fundamental neurobiological processes, which in turn can affect the growth, structure, and functioning of the brain. When trauma occurs in a chronic, persistent manner in the context of the young developing brain, the negative effects of such “complex” or “developmental” trauma have been shown to be cumulative, with damage from one stage of development affecting the successful navigation of developmental tasks at the next stage (e.g., van der Kolk, 2003). The majority of brain development is completed during the first five years of life, with the most critical development occurring within the first two years. Brain structures responsible for regulating emotion, memory, relationship security (e.g., attachment) and behavior develop rapidly in the first few years of life and are very sensitive to damage from the effects of emotional or physical stress, including neglect (e.g., Ford, 2009; Nelson, Zeanah, Fox, Marshall, Smyke, & Guthrie, 2007; Perry, Pollard, Blakeley, Baker, & Vigiliante, 1995; Teicher, Anderson, Polcari, Anderson, Navalta, & Kim, 2003). Thus, when thinking developmentally about a child’s symptoms across social, emotional, behavioral, somatic, and cognitive domains, it is important to learn as much as possible about the early history of the child with an eye toward traumatic experiences, losses, and most importantly, the early caregiving environment. It is important to ask, “Did the child experience early, multiple, or persistent overwhelming events that might have altered the actual neurochemistry and structure of the developing brain?” If the answer is “yes”, the child may have symptoms of complex trauma that will require a more comprehensive treatment approach.

Subtle Psychological Effects of Trauma on Children

While only a minority of traumatized children shows signs of Complex Trauma, many children manifest signs of pervasive *subtle* effects of trauma, and these signs may be missed without careful assessment. Consider the following from Hodas (2006):

> *[Youngsters] “who are required to adapt to dangerous and frightening circumstances, especially within the context of poverty, tend to develop subtle changes in their thinking, beliefs, and values. Such changes lead to attitudes and behaviors that are seen by adults as pathological, even though they may have been adaptive in the past, or in some cases continue being adaptive in the community environment. The subtle psychological effects of trauma on children represent yet another manifestation of the pervasive impact of trauma.... These internal changes and consequent behavioral manifestations, while appearing maladaptive to mainstream adults and child-serving professionals, actually have often been of adaptive benefit to the child, given the need for survival.*

> *Professionals working with children who have been exposed to trauma often encounter highly guarded individuals, who appear unresponsive to adult efforts to help. Not uncommonly, the trauma goes unrecognized and the child enters, or is at risk of entry into, the juvenile justice system. Many similar children are in Special Education as well. In addition to aggressive behaviors, these children are also at risk of self-injurious behaviors and suicide attempts…"*(pp. 24-25).

Resilience

Children who experience trauma display numerous responses, reactions and symptomology. Originally, researchers believed children to be resilient if they possessed a defined list of protective factors and were asymptomatic following a trauma. Recently, the definition has expanded to encompass certain characteristics within each child and his/her environment. Bonanno (2004) suggests resilient individuals are people who remain stable throughout the process of trauma. Resilience continues to be defined "not as immunity or imperviousness to trauma but rather the ability to recover from adverse experiences" (Truffino, 2010, p. 146). Multiple researchers define resilience as a cluster of personal characteristics and/or environmental strengths (Bensimon, 2012; Knight, 2007; Perry, 2006; Truffino, 2012).

Agaibi and Wilson (2005) noted the characteristics of "hardiness, optimism, self enhancement, repressive coping, positive affect and a sense of coherence" as the personal characteristics seen in resilient individuals. Perry (2006) published an article defining four key areas that affect a child's capacity for resilience, child temperament, attuned caregiving, healthy attachments and opportunities for practice. This view of resilience as a personal cluster of symptoms and environmental characteristics fits with what researchers know of development and trauma in children. These clusters explain children growing up in adverse situations being resilient and asymptomatic following a traumatic event. As a best practice for trauma informed care, it is imperative that clinicians assess for and strengthen the resilient characteristics and qualities within families and children. This poses a framework to "support children and families by fostering coping skills that empower them and become protective resources" (Knight, 2007, p. 543).

Assessment

Why Screen for Trauma?

As indicated in previous sections, childhood traumas vary from the sudden loss of parents, siblings, and other loved ones, life-threatening illness, natural disasters, physical and sexual abuse, to community and domestic violence. Though children are resilient, they are also profoundly affected by these experiences. With effective responses from caregivers and the community, they recover and thrive. Without it, trauma's effects can derail childhood and reverberate into adult life. Yet child traumatic stress remains one of our most under recognized public health problems(www.nctsn.org; www.acestudy.org). Youth impacted by trauma often do not receive appropriate mental health care, particularly children who internalize their experience and do not engage in "acting out" behavior. Alternatively, children who engage in disruptive behaviors may be labeled as defiant or inattentive. In either case, these youth are responding to intolerable feelings impacted by traumatized development in ways that help them cope and survive.

To adequately assess treatment needs for children who have experienced trauma, it is important to assess trauma exposure, posttraumatic stress disorder symptoms (PTSD) and the presence of other psychiatric disorders (Cohen, Mannarino, & Deblinger, 2006). It is also important to note that trauma experience is subjective; therefore, not every child who has endured what may seem to be a difficult situation will have experienced it as trauma. This makes individual assessment even more important. Instruments that measure traumatic experiences or reactions, diagnostic instruments that include PTSD subscales, and instruments that assess symptoms commonly associated with trauma should be considered (Wolpaw & Ford, 2004).

The "gold standard" for evaluating the presence of PTSD symptoms (AACAP, 1998) is the use of a detailed, semi-structured interview. The following self-report instruments have acceptable reliability and validity for clinical use. Because childhood traumatic experiences are typically underreported, routinely asking about traumatic history is recommended. Questions regarding trauma should be part of routine mental health intakes for children and adolescents. Self report, clinician directed questions, culture and developmental level should all be considered for potential impact (Wolpow & Ford, 2004). Whenever possible, screening of younger children should include the involvement of a parent, legal guardian, or involved adult; for an adolescent, a self report is appropriate if or when the collateral information is not available. If trauma screening identifies an area of concern or a need for further assessment, a comprehensive follow-up should occur (Hodas, 2006).

Trauma Exposure Measures

- NSLIJHS Trauma History Checklist and Interview (North Shore-Long Island Jewish Health System, Inc., 2006)
- Trauma History Checklist (THQ) Child Revised (Green, 1996)
- Traumatic Events Screening Inventory-Child Version (TESI-C: Ford et al., 1999)
- Personal Experience Screening Questionnaire (Winters, 1991)
- Childhood Trauma Questionnaire (Bernstein, 1997)
- PTSD simple screening measure (Winston, 2003)

Posttraumatic Stress Disorder Symptoms

- UCLA PTSD Index for DSM IV (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998)
- Child PTSD Symptom Scale (CPSS: Foa, Johnson, Feeny, & Treadwell, 2001)
- Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA: Newman, 2002)
- Trauma Symptom Checklist for Children (TSC-C: Briere, 1996)
- PTSD checklist for Parent (PCL-C/PR: Blanchard, 1996)

Assessing Other Psychiatric Disorders

- Children's Depression Inventory (CDI: Kovacs, 1992)
- Revised Child Manifest Anxiety Scale (RCMAS: Reynolds & Richmond, 2008)
- Child Behavioral Checklist (CBCL: Achenbach, 2001)
- Teacher Report Form (TRF: Achenbach, 2001)
- Diagnostic Interview Schedule for Children (DISC: Shaffer, 2000)
- Diagnostic Interview for Children and Adolescents- Revised (DICA-R: Reich, 1991)
- Parenting Stress Index Short Form (PSI: Abidin, 1995)

Assessing Caregiver Traumatic Stress

Assessing trauma issues in parents is also critical to engaging and tailoring the intervention for the caregiver. Caregivers who are overwhelmed, or for whom traumatic experiences are part of their own history, may have deficits in their ability to manage and modulate strong feelings; in creating, accessing and using strong positive connections when stressed; and in feeling worthy of life. The experience of having a child who has been traumatized often brings with it anger, shame, and embarrassment coupled with feelings of inadequacy. In many cases, access and support for change may be challenges (NCTSN, n.d.b).

Systems Approach to Trauma Informed Care

Overview

Trauma-informed care (TIC) is a systems-focused frame of reference and operating model appropriate in the care of all children and youth. TIC impacts:

- Organizational culture
- Staff practices and approach
- Policy and processes
- Technology (record keeping)
- Screening and assessment
- Staff learning and development in each component of care.

TIC also impacts interfaces among systems. For example, if an educator is not trauma-informed, the tendency to view disruptive behavior from a punitive perspective is stronger. If that educator engages with a trauma-informed behavioral provider, the differences in world views can be challenging. In one community, helping teachers shift their understanding of student behavior reduced suspensions by 85 percent (Stevens, 2012).

Infusing systems of care with trauma-informed knowledge and practice has dramatic results. Systems that become trauma-responsive reduce responses such as seclusions and restraints, model the post-system responses hoped for in clients, reduce the inevitable secondary or vicarious traumatization of staff, and distribute the responsibility among everyone involved rather than relegating it to mental health staff. Because the impact of trauma can undermine successful intervention, trauma-informed systems that address this impact are more likely to see treatment success.

Why TIC is Critical to Care: Incidence of Trauma

We are increasingly recognizing the importance of implementing trauma-informed care. Williamson, Dutch, & Clawson (2010) offer the following description of why TIC is critical to care:

> Trauma-informed services are a crucial part of a victim's recovery (Clawson, Salomon, & Grace, 2008). In trauma-informed care, treatment is guided by practitioners' understanding of trauma and trauma-related issues that can present themselves in victims. Trauma-informed care plays an important role in service delivery by providing a framework for accommodating the vulnerability of trauma victims. It is not, however, designed to treat specific symptoms or syndromes (Office of Mental Health and Addiction Services, 2008). The treatment of specific mental health symptoms and syndromes requires evidence-based therapeutic and sometimes pharmacological approaches (pp. 3-4).

Trauma is strongly associated with mental and substance use disorders (SAMHSA, 2009). Mueser and colleagues (1998) reported that 90 percent of public mental health clients have been exposed to multiple experiences of trauma. In response, trauma-informed services recognize and avoid coercive interventions that traumatize children, youth, and those who care for them. Organizations providing the new gold standard of care collaborate with those who receive services focusing on the present, identifying and enhancing strengths rather than working only on symptom management. They assume that service recipients do the best they can at every moment, and work to create authentic reconnection, reparation, and healing in the areas impacted (Fallot & Harris, 2006).

Another response to the prevalence of trauma and its context is the awareness that trauma-informed care is inherently relational aware of the impact of the work on all involved. As a result, a key focal point in trauma-informed care is the management of vicarious trauma and self-care for those who receive and provide services to optimize trauma-informed services.

Finally, evidence-informed or evidence-based trauma-specific treatments can be delivered in **any** operating model, whether traditional, medical or trauma-informed. However, the delivery of a trauma-specific treatment in an environment that is **not** trauma-informed may foster cognitive dissonance and confusion for those receiving services because of the dissonance between the environment and the intervention.

Foundational Principles in Trauma-Informed Care for Systems

These principles were identified on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses, Reed, Mazelis, & D'Ambrosio, 2003), literature on therapeutic communities (Campling, 2001), and others (Harris & Fallot, 2001; Fallot & Harris, 2002; Saakvitne, Gamble, Pearlman, & Lev, 2000; Bloom & Sreedhar, 2008).

Principles of trauma-informed care in systems include:

- **Understanding Trauma and its Impact.** Trauma impacts body, brain, judgment, frame of reference, beliefs, the ability manage feelings, experience healthy connection, and feel worthy of life; problematic behaviors (symptoms) in the present are adaptive responses to past traumatic experiences (Saakvitne et al., 2000).

- **Promoting Safety.** In trauma-sensitive organizations, provider responses are respectful, consistent, and predictable. The environment pays attention to physical and emotional safety, and to reducing barriers to access.

- **Ensuring Cultural Competence.** This includes understanding how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity within the program, providing opportunities to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.

- **Supporting Control, Choice and Autonomy.** Systems of care that are trauma-informed help children and youth (1) regain a sense of choice in their daily lives, (2) develop practical skills in managing feelings, developing internal connections, and feeling worthy of life, correct cognitive errors and develop autonomy (3)provide opportunities for them to make daily decisions and participate in the creation of personal goals, and (4) maintain awareness and respect for basic human rights and freedom.

- **Sharing Power and Governance.** Trauma-informed systems promote equalization of the power differentials. Persons who receive services and in the case of children and youth, their caregivers, are active fully empowered participants in advisory and board capacities.

- **Integrating Care.** Integrating systems of care across body, mind, and spirit is a hallmark of trauma-informed care. For example, a recent research study testing Risking Connection’s key principles in low-income healthcare clinics noted improved communication between patients and providers. Sidran Institute has partnered with faith-based communities to support adoption of a trauma-informed rather than stigmatizing perspective in responding to congregants in Jewish, Muslim and Christian congregations. Trauma happens to the body, and the use of interventions such as yoga and mindfulness practices have been used in re-regulation of the brain and body.

- **Healing Happens in Relationship.** Trauma often occurs in relationship. The recovery from all trauma involves relationships, and TIC incorporates establishing safe, authentic, and positive relationships can be corrective and restorative to survivors of trauma.

- **Recovery occurs.** Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for involvement at all levels of the system, facilitating support from a broad social network, focusing on strength and resiliency, and establishing future-oriented goals are key characteristics in TIC.

A general compare and contrast model for non-trauma informed and trauma informed systems follows (Gillece, n.d.):

Trauma-informed	**Non-trauma informed**
Recognizing high prevalence of trauma	Lack of education on trauma prevalence & "universal" precautions
Recognizing primary and co occurring trauma diagnoses	Over-diagnosis of schizophrenia, bipolar disorder, conduct disorder & singular addictions
Assessing for traumatic histories & symptoms	Cursory or no trauma assessment
Recognizing culture and practices that are retraumatizing	"Tradition of Toughness" valued as best care approach
Minimizing power/control - constant attention to culture	Keys, security uniforms, staff demeanor, tone of voice
Caregivers/supporters– ***collaboration***	Rule enforcers – ***compliance***
Addressing training needs of staff to improve knowledge & sensitivity	"Patient-blaming" as *fallback* position without training
Objective, neutral language	Labeling language: manipulative, needy, "attention-seeking"
Transparent systems open to outside parties	Closed system - advocates discouraged

Specific policy recommendations exist for agencies interested in implementing trauma-informed care, but that is beyond the scope of these guidelines. For more information, please visit the National Center for Trauma-Informed Care website at http://www.samhsa.gov/nctic/default.asp. For a full report of recognized, effective TIC models, see Jennings (2008).

Summary

The adoption of Trauma-Informed Care as an operating standard in the service of improved health in children and youth involves system transformation. This system transformation involves all aspects of the delivery and evaluation of care, including culture change. None the less, at a systems level, the outcomes of successful transformation include greater efficiencies in care provision, recovery of children and youth, and of staff, which in turn result in significant benefit to stakeholders in Tennessee in terms of cost-benefit ratios, improvement of community health, and increases in long-term successes in education, income stability, and health outcomes.

Evidence-Based Practice

As defined by the American Psychological Association (2006), evidence-based practice refers to "the integration of best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (see section on Evidence Based Practice elsewhere in this document for more details). In short, we are focusing on treatment interventions that are backed by solid research and clinical theory that take into account the child and family's culture, community, and beliefs. We start with common components included in evidence-based practices, and then provide a list of specific recommended interventions.

Common Components

With the surge of research into trauma-informed therapy increasing significantly in the past decade, there are a number of interventions for children and youth and many have similar, overlapping components. The National Child Traumatic Stress Network (n.d.c) has outlined the following "core components" of trauma-informed interventions:

- Screening and triage
- Systematic assessment, case conceptualization, and treatment planning
- Psycho-education
- Addressing children and families' traumatic stress reactions and experiences
- Trauma narration and organization
- Enhancing emotional regulation and anxiety management skills
- Facilitating adaptive coping and maintaining adaptive routines
- Parenting skills and behavior management
- Promoting adaptive developmental progression
- Addressing grief and loss
- Promoting safety skills
- Relapse prevention
- Evaluation of treatment response and effectiveness
- Engagement/addressing barriers to service-seeking

Recommended Interventions

The interventions outlined below range from those with more rigorous research (repeated randomized clinical trials) to those considered promising practices or emerging practices. The list is not exhaustive. Before considering which model to use, agencies and providers need to consider not only the evidence behind the model, but whether the model meets the needs of the family and the agency. The NCTSN outlines relevant factors to consider in choosing a treatment model:

- Prevalence of types of trauma and traumatic bereavement to which the population(s) is exposed
- Associated types and rates of mental distress and associated behavioral and functional impairment
- Cultural background(s) of the clientele and the surrounding community
- Developmental factors, including age, cognitive, and social domains
- Socioeconomic factors
- Logistical and other barriers to help-seeking
- Availability of individual/family/community strength-based resources
- Setting in which services are offered (school, residential, clinic, home)

In addition to treatment specific models, SAMHSA's National Center for Trauma Informed Care (NCTIC) also lists models for agency transformation and treatments for use in different settings. Below are two tables outlining some of the programs referenced by either the NCTIC or by NCTSN that are either:

1) **Trauma-informed care models** implemented across an agency or system. These models create a coherent container for many different treatment methods, and most focus on frame of reference, processes, policies, physical environment, empowerment and collaboration. In these models, effective treatments and interventions in place will work even better.

2) **Trauma focused treatments** are specific methods or interventions that may be delivered in any model of care, and that are more effective when delivered in a trauma-informed care setting. Unless otherwise noted, the trauma-focused treatment is suitable for male and female children and youth.

Trauma-Informed Care Model	Description/Contact	For
National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Settings	***All ages***. Assists child, youth, adult, and forensic mental health facilities in reducing the use of seclusion and restraint. Evidence supported (kevin.huckshorn@nasmhpd.org).	systems, agencies
Risking Connection®	***All ages***. Develops optimally helpful responses to trauma survivors of all ages and reduces impact of vicarious trauma on staff. Knowledge and skills acquired support overlaying of additional trauma-specific interventions and treatment modalities as well as change in all organizational areas. Evidence supported. Contact: training@sidran.org.	systems, agencies, specialized contexts
Sanctuary Model	***Age 4 and up*** (no limit). Trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community in which staff are empowered as key decision-makers to influence their own lives and the welfare of their constituents. Requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process (http://www.nctsn.org/sites/default/files/assets/pdfs/sanctuary_general.pdf).	systems, agencies
Sanctuary Model Plus (IRIS Project)	***Children and adolescents placed in residential treatment centers and their families***. Integrates a model of organizational change (Sanctuary®), trauma-informed, training-reorientation curriculum (START), and an activity-based life story approach to rebuilding attachments, establishing permanency, and reprocessing traumas (Real Life Heroes) (http://www.nctsn.org/sites/default/files/assets/pdfs/Sanctuary_Plus_IRIS_2_11_05.pdf).	group, systems

Trauma-Informed Care Model	Description/Contact	For
Using Trauma Theory to Design Service Systems	***All ages***. Step-by-step model systems and agencies to become "trauma-informed." Provides guidelines for evaluating and modifying all system and service components in light of a basic understanding of the role that trauma plays. Contact rwolfson@ccdc1.org.	systems, agencies
Trauma Informed Organizational Self Assessment	***All ages***. Self-Assessment of specific practices necessary for creating a trauma-informed system for the homeless, useful for other agencies. Assesses: supporting staff development, creating a welcoming and safe environment, assessing and planning services, involving service recipients, and establishing policies (http://www.familyhomelessness.org/media/90.pdf).	systems, agencies
Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth	***Ages 2-21***. Males and females, individual and group therapy for children, education for caregivers, parent-child sessions, and parent workshops. Provides a theoretical framework, core principles of intervention, and a guiding structure for providers (http://www.nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf).	individual, family, caregivers, agencies
Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP)	***Ages 0/18***. Incorporates assessment triage and essential components of trauma treatment into clinical pathways. Provides staff with knowledge and skills to incorporate standardized assessments into intake and ongoing treatment processes; provides a treatment model directed by the uniqueness of the child and his or her family, and provides decision making guidelines regarding trauma treatment strategies based upon the child's unique presentation (http://www.nctsn.org/sites/default/files/assets/pdfs/tap_general.pdf).	individual, family, systems

Trauma Focused Treatment	**Targeted Populations**	**For**
Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP)	***Ages 8-21.*** Adaptation of for youth with developmental disabilities whose lives include a wide range of traumatic experiences, requires standard Dialectical Behavioral Therapy (DBT) training first. Also referenced as "Modified DBT with Developmentally Disabled Children" for children 10-14 (http://www.nctsn.org/sites/default/files/assets/pdfs/dbtsp_general.pdf).	individual
Alternatives for Families - A Cognitive Behavioral Therapy (AF-CBT)	***Ages 5-17***. For physically abused children, offending caregivers. Appropriate for use with physically coercive/abusive parents and their school-age children. Although it has been primarily used in outpatient settings, the treatment can be delivered on an individual basis in alternative residential settings, especially if there is some ongoing contact between caregiver and child (http://nctsn.org/sites/default/files/assets/pdfs/afcbt_general.pdf).	individual, family, group, residential
Child Adult Relationship Enhancement (CARE)	***Children of all ages and their caregivers***. Modification of standard Parent-Child Interaction Therapy (PCIT) model to serve special circumstances and culturally diverse clients. CARE reflects a collaborative co-creation between the Trauma Treatment Training Center (TTTC) and a range of agencies (i.e., battered women shelters, foster care agencies, residential care facilities, medical care settings, homeless shelters) (http://www.nctsn.org/sites/default/files/assets/pdfs/care_general.pdf).	Families; children; all settings
Child and Family Traumatic Stress Intervention (CFTSI)	***Ages 7–18***. Children with their parent or caregiver as an early intervention and secondary prevention model that aims to reduce traumatic stress reactions and posttraumatic stress disorder (PTSD) after a potentially traumatic event (PTE). Children are referred by law enforcement, child protective services, pediatric emergency rooms, mental health providers, forensic settings, and schools (http://www.nctsn.org/sites/default/files/assets/pdfs/CFTSI_General_Information_Fact_Sheet.pdf).	individual, family, systems

Trauma Focused Treatment	**Targeted Populations**	**For**
Child Development-Community Policing Program	***Ages 0-18+***. Brings together police officers and mental health professionals for mutual training, consultation, and support so that they may effectively provide direct interdisciplinary intervention to children and families who are victims, witnesses, or perpetrators of violent crimes (http://www.nctsn.org/sites/default/files/assets/pdfs/ChildDevelopment-CommunityPolicingCDCP.pdf).	individual, family, systems
Child-Parent Psychotherapy (CPP)	***Ages 0-6***. For youth who have experienced a wide range of traumas and parents with chronic trauma; examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. Supports and strengthens the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health (http://www.nctsn.org/sites/default/files/assets/pdfs/cpp_general.pdf).	individual, family, systems
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	***Ages 10-15***. School-based group and individual intervention designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills. For children who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters (http://www.nctsn.org/sites/default/files/assets/pdfs/cbits_general.pdf).	individual, group, family
Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse (CPC-CBT)	***Ages 4-17***. For families with multiple referrals to Child Protective Services (CPS) with no substantiation; families who report using excessive physical punishment with their children; parents with high levels of stress, perceive their children's behavior as extremely challenging, and fear losing their temper with their children (http://www.nctsn.org/sites/default/files/assets/pdfs/cbpcbt_general.pdf).	individual, family, group

Trauma Focused Treatment	**Targeted Populations**	**For**
Community Outreach Program - Esperanza (COPE)	***Ages 4-18***. Home and school based treatment program for traumatized children who are presenting with behavior or social-emotional problem. The emphasis is on case management to enable clinicians to offer evidence-based trauma treatments in community settings. Combines TF-CBT, PCIT, and culturally-modified trauma focused treatment (CM-TFT) (http://www.nctsn.org/sites/default/files/assets/pdfs/cope_general.pdf).	individual, family
Culturally Modified Trauma-Focused Treatment (CM-TFT)	***Ages 4-18***. Latino/Hispanic; for youth who have experienced sexual or physical abuse; addresses spirituality, gender roles, familismo, personalismo, respeto, sympatia, fatalismo, folk beliefs. TF-CBT with additional modules integrating cultural concepts throughout treatment (http://www.nctsn.org/sites/default/files/assets/pdfs/cmtft_general.pdf).	individual, family
Family Advocate Program (2005)	***Ages 18-70***. Wraparound services for nonoffending caregivers (95% women) in families reported for sexual/physical abuse or domestic violence (http://www.nctsn.org/sites/default/files/assets/pdfs/FamilyAdvocateProgram_21105.pdf).	family
Forensically-Sensitive Therapy (FST)	***Ages 4-17*** (predominantly female). Used effectively with child sexual abuse victims when criminal and civil court cases are actively pending. FST begins at the end of the investigative process, when abuse has been substantiated and the case is being prosecuted, and the patient is exhibiting symptomatic distress (http://www.nctsn.org/sites/default/files/assets/pdfs/forensic_sensitive_therapy_general.pdf).	individual, family

Trauma Focused Treatment	**Targeted Populations**	**For**
Group Treatment for Children Affected by Domestic Violence (DV)	***Ages 5 and up (no upper limit).*** For children and nonoffending parents who have been exposed to DV; predominantly female. Parallel content for children and parents. Includes 11 topic driven modules. (http://www.nctsn.org/sites/default/files/assets/pdfs/GroupTreatmentChildrenDomesticViolence_fact_sheet_3-21-07.pdf).	group, family, systems
Honoring Children, Making Relatives	***Ages 3-7***. For American Indian and Alaska Native children; culturally informed adaptation of PCIT incorporating traditional beliefs about family, face, and non-interference. (http://www.nctsn.org/sites/default/files/assets/pdfs/honoring_children_making_relatives_fact_sheet_032007.pdf).	individual, family
Honoring Children, Mending the Circle	***Ages 3-18***. For American Indian and Alaska Native (AI/AN) children; blending of AI/AN traditional teachings with cognitive-behavioral methods (Trauma Focused Cognitive-Behavioral Therapy [TF-CBT]). (http://www.nctsn.org/sites/default/files/assets/pdfs/HonoringChildrenMending_the_Circle_HCMC_fact_sheet_3-21.pdf).	individual
Honoring Children, Respectful Ways	***Ages 3-12***. For American Indian and Alaska Native children who survive sexual abuse, historical and other traumatic experiences; incorporates American Indian and Alaskan Native world view of wellness, wellbeing, healing, and respect for self and others. (http://www.nctsn.org/sites/default/files/assets/pdfs/HonoringChildrenRespectfulWays_HCRW_fact_sheet_3-20-07.pdf).	individual
Integrative Treatment of Complex Trauma (ITCT-C, ITCT-A)	***Ages 2-21***. Both males and females. For Hispanic-American, African-American, Caucasian, Asian-American; for youth who may have complex trauma histories. (http://www.nctsn.org/sites/default/files/assets/pdfs/ITCT_general.pdf).	individual, family, systems

Trauma Focused Treatment	**Targeted Populations**	**For**
International Family Adult and Child Enhancement Services (IFACES)	***Ages 6-18***. For refugee and immigrant children who have experienced trauma as a result of war or displacement and their children. Goal is to meet the mental health needs of all refugee children seeking services, regardless of their background, by providing flexible and comprehensive services (http://www.nctsn.org/sites/default/files/assets/pdfs/ifaces_general.pdf).	individual
Parent-Child Interaction Therapy (PCIT)	***Ages 2-12***. Both males and females, an empirically-supported treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns (http://www.nctsn.org/sites/default/files/assets/pdfs/pcit_general.pdf).	individual, family, systems
Psychological First Aid (PFA)	***Ages 0-120***. For individuals immediately following disasters, terrorism, and other emergencies (http://www.nctsn.org/sites/default/files/assets/pdfs/pfa_general.pdf).	individual
Real Life Heroes (RLH)	***Ages 6-12, plus adolescents (13-19)*** with delays in social, emotional or cognitive functioning. *Real Life Heroes (RLH)* was especially designed for children in child and family service programs who frequently lack safe, nurturing homes and secure relationships with committed, caring adults. The intervention involves six-to-twelve months of weekly therapy sessions (http://www.nctsn.org/sites/default/files/assets/pdfs/rlh_general.pdf).	individual, family, systems
Safe Harbor Program	***Ages 6-21***. Comprehensive program designed to help students, parents, and schools cope with the violence, victimization, and trauma that occurs in their communities. Utilizes a "safe harbor" room in school as a low stigma, easy access entry point to attract distressed children/youth coping with violence. Multi-cultural applications, including LGBT (http://www.nctsn.org/sites/default/files/assets/pdfs/SafeHarbor_fact_sheet_3-20-07.pdf).	individual, group, family, systems

Trauma Focused Treatment	**Targeted Populations**	**For**
Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)	***Ages 3-11***. For survivors of sexual abuse exhibiting sexual behavioral problems many of whom have experienced multiple traumatic experiences; to date the model has been effectively used with primarily African-American children; majority of families are low income (http://www.nctsn.org/sites/default/files/assets/pdfs/SMART_fact_sheet_3-21-07.pdf).	individual, family, systems
Skills for Psychological Recovery (SPR)	***Ages 5-120***. Appropriate for both males and females. SPR takes into consideration the reality that many survivors may only be available for one or two contacts (http://www.nctsn.org/sites/default/files/assets/pdfs/spr_general.pdf).	individual, family
Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST)	***Adolescent girls ages 12-21***. For females who have experienced sexual/physical abuse and a range of additional traumas, including community violence, domestic violence, and sexual assault (http://www.nctsn.org/sites/default/files/assets/pdfs/STAIRNST_2-11-05.pdf).	individuals, group
Southeast Asian Teen Village	***Southeast Asian (mostly Hmong) refugee teenage girls***. Helps refugee Southeast Asian girls blend traditional values, beliefs, and customs with expectations of American culture. The program encourages adolescents to find healthy ways to cope with past traumas and bicultural issues, including the use of ceremony and ancestor work (http://www.nctsn.org/sites/default/files/assets/pdfs/SoutheastAsiaTeenVillage_21105.pdf).	group
Streetwork Project	***Ages 13-23***. Homeless and street-involved youth; harm reduction program good with a wide variety of ethnic/racial groups, religious group, and the LGBTQ community (http://www.nctsn.org/sites/default/files/assets/pdfs/StreetworkProject_fact_sheet_3-20-07.pdf).	individuals, group, system

Trauma Focused Treatment	**Targeted Populations**	**For**
Strengthening Family Coping Resources (SFCR)	***All ages, from infants to grandparents***. For all family members where complex family trauma exists for multiple traumas related to urban poverty. Uses family rituals, routines and traditions to support family posttraumatic recovery and growth (http://www.nctsn.org/sites/default/files/assets/pdfs/sfcr_general.pdf).	family
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	***Ages 12-21***. Designed to address the needs of adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning. SPARCS has been used with ethnically diverse populations including LGBTQ (http://www.nctsn.org/sites/default/files/assets/pdfs/sparcs_general.pdf).	family
Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents (TARGET-A)	***Ages 10 and up***. Strengths-based approach to education and therapy for trauma survivors who are looking for a safe and practical approach to recovery. Helps trauma survivors understand how trauma changes the body and brain's normal stress response into an extreme survival-based alarm response (http://www.nctsn.org/sites/default/files/assets/pdfs/target_general2012.pdf).	individual, group, family
Trauma and Grief Component Therapy for Adolescents (TGCT)	***Ages 12-20***. For adolescents who have experienced community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist event or traumatic loss. May be delivered in school setting (http://www.nctsn.org/sites/default/files/assets/pdfs/tgct_general.pdf).	individual, group, family, systems
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	***Ages 3-21***. For children with Posttraumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers (http://www.nctsn.org/sites/default/files/assets/pdfs/tfcbt_general.pdf).	individual, family

Trauma Focused Treatment	**Targeted Populations**	**For**
Trauma-Focused Coping in Schools (TFC) (AKA: Multimodality Trauma Treatment Trauma-Focused Coping-MMTT)	***Ages 6-18***. For children exposed to single incident trauma and targets posttraumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control. School based groups and can be offered in clinic settings as well. Multi-lingual (English and French) (http://www.nctsn.org/sites/default/files/assets/pdfs/mmtt_general.pdf).	individual, group
Trauma Systems Therapy (TST)	***Ages 6-19***. For children who are having difficulty regulating their emotions as a result of the interaction between the traumatic experience and the social environment. Community-based program with modules focusing on home-based services, legal advocacy, emotional regulation skills training, cognitive processing, and psychopharmacology (http://www.nctsn.org/sites/default/files/assets/pdfs/tst_general.pdf).	systems

Resources

- Child Trauma Academy (www.childtrauma.org)
- Child Welfare Information Gateway (www.childwelfare.gov)
- National Center for Trauma Informed Care (www.samsha.gov/nctic)
- National Center on Domestic Violence, Trauma & Mental Health (www.nationalcenterdvtraumacenter.org)
- National Child Traumatic Stress Network (www.nctsn.org)

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Guidelines for Selected Disorders involving Children and Adolescents

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TDMHSAS BEST PRACTICE GUIDELINES

Anxiety Disorders in Children and Adolescents

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1. Introduction

Anxiety is a normal part of growing up. Sometimes, though, people experience so much anxiety that it interferes with their ability to function normally. It is then that anxiety becomes a disorder for which treatment might be needed.

In children, this disorder can begin as early as 7-9 months of age with "stranger" anxiety. Perhaps the most troubling problem about anxiety is the fact that if left untreated, it may results in the manifestation of more serious mental disorders like depression (Huberty, 2004). About 13 percent of youth 9 to 17 years of age experience some kind of anxiety disorder, with females more affected than males. Further, close to half of the young people with anxiety disorders have a comorbid disorder (SAMHSA, 2006).

2. DSM-IV TR Criteria for Anxiety Disorders

Generalized Anxiety Disorder

- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)
- The person finds it difficult to control the worry.
- The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days than not during the past 6 months).

Note: Only one item is required in children.

1. restlessness or feeling keyed up or on edge.
2. being easily fatigued.

3. difficulty concentrating or mind going blank.
4. irritability.
5. muscle tension.
6. sleep disturbance (e.g., difficulty falling asleep, staying asleep, or restless sleep).

- The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder); being embarrassed in public (as in Social Phobia); being contaminated (as in Obsessive-Compulsive Disorder); being away from home or close relatives (as in Separation Anxiety Disorder); gaining weight (as in Anorexia Nervosa); having multiple physical complaints (as in Somatization Disorder); or having a serious illness (as in Hypochondriasis); and the anxiety and worry do not occur exclusively during Posttraumatic stress disorder.
- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Social Phobia (formerly called Social Anxiety Disorder)

- A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.

  Note: ***In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults***.

- Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or predisposed Panic Attack.

  Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

- The person recognizes that the fear is excessive or unreasonable.

  Note: In children, this feature may be absent.

- The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

- The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- In individuals under age 18 years, the duration is at least 6 months.
- The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Body Dysmorphic Disorder, or a Pervasive Developmental Disorder).
- If a general medical condition or another mental disorder is present, the fear in the first criterion is unrelated to it, e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Panic Disorder

- Recurrent and unexpected panic attacks. A panic attack is a discrete period of intense fear or discomfort, with four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:
    1. palpitations, pounding heart, or accelerated heart rate.
    2. sweating.
    3. trembling or shaking.
    4. sensations of shortness of breath or smothering.
    5. feeling of choking.
    6. chest pain or discomfort.
    7. nausea or abdominal distress.
    8. feeling dizzy, unsteady, lightheaded, or faint.
    9. derealization (feelings of unreality) or depersonalization (being detached from oneself).
    10. fear of losing control or going crazy.
    11. fear of dying.
    12. paresthesias (numbness or tingling sensations).
    13. chills or hot flushes.

- At least one of the attacks has been followed by at least 1 month of one of the following:
    - persistent concern about having additional panic attacks.
    - worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy");
    - a significant change in behavior related to the attacks
- The Panic Attacks are not due to the direct physiological effects of a substance (e.g., drug of abuse, medication) or a general medical condition (e.g., hyperthyroidism).
- The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations); Specific Phobia (e.g., on exposure to a specific phobic situation); Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination); Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor); or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Obsessive-Compulsive Disorder (OCD)

- Either obsessions or compulsions:
    - *Obsessions as defined by (1), (2), (3), and (4):*
        1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.
        2. The thoughts, impulses, or images are not simply excessive worries about real-life problems (as in generalized anxiety disorder).
        3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
        4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without, as in thought insertion).
    - *Compulsions as defined by (1) and (2):*
        1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
        2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors

or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

- At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.

Note: This criterion does not apply to children.

- The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
- If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).
- The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, medication) or a general medical condition.

Posttraumatic Stress Disorder (PTSD)
(*Note: In the new DSM-5, PTSD will be included in a new chapter on Trauma- and Stressor-Related Disorders. There will also be four distinct diagnostic clusters instead of three: avoidance symptoms, arousal/reactivity symptoms, intrusion symptoms, and negative mood and cognitions. The new DSM-5 criteria for PTSD are said to be more developmentally sensitive for children and adolescents as well [American Psychiatric Association, 2012; Falco, 2012; National Center for PTSD, 2012; NCTSN, 2012.)

- Person has been exposed to traumatic event in which **both** of the following were present:
    1. Participation in, witnessing or confrontation with an event(s) that involved actual/threatened death or serious injury, or threat to physical integrity of self/others.
    2. Response involved intense fear, helplessness, or horror. ***Note: In children, the expression may involve disorganized or agitated behavior***.
- Traumatic event is persistently reexperienced in at least one of the following ways:
    1. Recurrent/intrusive distressing recollections of the event(s). This could include images, thoughts, or perceptions. ***Note: Young children may exhibit these themes or aspects of the trauma through repetitive play***.
    2. Recurrent distressing dreams of the event(s). ***Note: Children may experience frightening dreams without recognizable content***.

3. Acting or feeling as though the traumatic event(s) was recurring. Manifestations might include a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, even when under the influence of alcohol. ***Note: Trauma-specific reenactment may occur in young children***.

4. Intense psychological distress when exposed to internal or external cues that symbolize/resemble an aspect of the traumatic event(s).

5. Physiological reactivity when exposed to internal or external cues that symbolize/resemble an aspect of the traumatic event(s).

- Persistent avoidance of stimuli connected with the trauma and numbing of general responsiveness (behavior not present prior to the trauma), as indicated by at least three of the following:

  1. Efforts to avoid thoughts, feeling, or conversations linked with the trauma.
  2. Efforts to avoid activities, place, or people that awaken recollections of the trauma.
  3. Inability to recall an important aspect of the trauma.
  4. Markedly diminished interest/participation in significant activities.
  5. Feeling of detachment/estrangement from others.
  6. Restricted range of affect (e.g., an inability to have loving feelings).
  7. Sense of foreshortened future (e.g., does not expect to have a normal life span).

- Persistent symptoms of increased arousal (behavior not present prior to the trauma), as indicated by at least two) of the following:

  1. Difficulty falling/staying asleep.
  2. Irritability/outbursts of anger.
  3. Difficulty concentrating/staying focused.
  4. Hypervigilance.
  5. Exaggerated startle response.

- Symptoms in bullets two through four last longer than a month.

- The disturbance causes clinically significant distress/impairment in social, occupational, or other important areas of functioning.

- Establish subtype of PTSD present.

  - Acute
  - Chronic

- With delayed onset

If the duration of symptoms is	The diagnosis is	Comments
Less than 1 month	Acute stress disorder (not PTSD)	These are symptoms that occur in the immediate aftermath of the stressor and may be transient and self-limited. Although not yet diagnosable as PTSD, the presence of severe symptoms during this period is a risk factor for developing PTSD.
1–3 months	Acute PTSD	Active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD.
3 months or longer	Chronic PTSD	Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of comorbid disorders. Such a presentation is known in the literature as Complex PTSD (Field, 2005) or Type II PTSD (Tremblay, Hebert, & Piché, 2000) and is most often associated with maltreatment trauma that is both chronic and inflicted within a close caregiver relationship.

Specific Phobias (Formerly called Simple Phobias)

- Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

- Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack.

  Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

- The person recognizes that the fear is excessive or unreasonable.

  Note: In children, this feature may be absent.

- The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

- The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

- In individuals under age 18 years, the duration is at least 6 months.
- The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination); Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor); Separation Anxiety Disorder (e.g., avoidance of school); Social Phobia (e.g., avoidance of social situations because of fear of embarrassment); Panic Disorder With Agoraphobia; or Agoraphobia Without History of Panic Disorder.

Separation Anxiety Disorder

- Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
    1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated.
    2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures.
    3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped).
    4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation.
    5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings.
    6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home.
    7. repeated nightmares involving the theme of separation.
    8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated.
- The duration of the disturbance is at least 4 weeks.
- The onset is before age 18 years.
- The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important area of functioning.

The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder with Agoraphobia.

Selective Mutism (formerly Elective Mutism)

- Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e. g., at school) despite speaking in other situations.
- The disturbance interferes with educational or occupational achievement or with social communication.
- The duration of the disturbance is at least 1 month (not limited to the first month of school).
- The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- The disturbance is not better accounted for by a Communication Disorder (e. g., Stuttering) and does not occur exclusively in the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder.

***Criteria Source**: American Psychiatric Association, 2000.*

Comorbidity of Anxiety Disorders

Most children with an anxiety disorder (79 percent) also suffer from other psychiatric conditions, mainly other anxiety disorders (Kendall, Brady & Verduin, 2001). Of course, some of this may be an artifact of the structure of the current nosological system (Achenbach, 1995). Other common comorbid conditions include the “externalizing behavior” diagnoses, including ADHD and ODD (Kendall, *et al.*, 2001).

3. Impact on Learning

Anxiety has both a positive and a negative impact on learning. The degree of anxiety as perceived by the learner will be the determining factor on which type of impact it has. According to the **Yerkes–Dodson law,** there is an empirical relationship between performance and physiological arousal (anxiety) such that performance increases with mental or physiological arousal, but only up to a point. Performance decreases when levels of arousal become too high. This law was developed in 1908 by psychologists Robert Yerkes and John Dillingham Dodson, both of whom were psychologists (Wikipedia, 2013).

Anxious students get caught in a cycle that includes cognitive interference and decreased engagement, which leads to poor achievement relative to potential, further decreasing the students' motivation to study or participate while increasing the students' negative self-evaluation and academic self-concept which leads to increased anxiety.

Specifically, Separation Anxiety Disorder and Generalized Anxiety Disorder may lead to learning problems because of refusal to attend school or pay attention in class. Since avoidance is common in all anxiety disorders, school attendance may suffer indirectly even if school performance per se is not anxiety-producing.

If it is determined that anxiety is having a negative impact on the child's school performance, the clinician may opt to go beyond client focused interventions and work with the school system directly to develop classroom based interventions and/or accommodations. These interventions and accommodations may even be written into a student's Individualized Educational Plan (Connolley & Bernstein, 2007).

4. *Differential Diagnosis*

General Medical	*Psychiatric/Environmental*
• Medication side effects (including akathisia)	Mood disorders
• Hypoglycemic episodes	Pervasive developmental disorders
• Hyperthyroidism	ADHD
• Cardiac arrhythmias	Substance abuse (including caffeine)
• Asthma/Chronic respiratory illness	Eating disorders
• Pheochromocytoma	Schizophrenia
• Seizure disorders	Personality disorders
• CNS disorders	Normal reaction to severe environmental stressors or dangers (e.g., ongoing victim of abuse, divorce)
• Pediatric autoimmune neuropsychiatric disorder associated with streptococcal infection	
•	Adjustment and other disruptive disorders
•	Factitious disorder

5. *Screening, assessment and/or evaluation*

1. Interview the youth as part of the initial mental health assessment. ***Direct interviews, using developmentally appropriate language, are essential in the screening and diagnosis of anxiety disorders***. Questions should be based on the DSM-IV-TR (Connolly & Bernstein, 2007).

2. Determine onset and development of symptoms, as well as the context in which the symptoms occur and are maintained.

    a. Is anxiety stimulus specific, spontaneous, or anticipatory?

    b. Are there “extreme” stressors/traumatic events?

    c. Is avoidant behavior present?

    d. Do comorbid syndromes exist?

    e. What is the adaptive function, if any, of the anxiety? (Bernstein, 2006).

3. Gather information from multiple sources, including the youth, parents, and/or teachers. Children may be more aware of their inner distress while parents or teachers may have more awareness of family or school functioning. For youth at least eight years of age, self-report measures like the Screen for Child Anxiety Related Emotional Disorders (SCARED) can help with screening and monitoring response to treatment.

4. If screening indicates significant anxiety, conduct further evaluation to differentiate anxiety disorders from developmentally appropriate worries or fears. Sections of available diagnostic interviews like the Anxiety Disorders Interview Schedule (ADIS) can assist with differentiation. Measures that tease out specific anxiety disorders are also available.

5. Ask the child and parent about impairment in functioning and symptom severity. The ADIS offers a great way for children to quantify and monitor their ratings of fear and problems in functioning.

6. Rule out physical conditions that may present with anxiety like hyperthyroidism, asthma, seizure disorders, and lead intoxication. Further rule out prescription and nonprescription drugs that may mimic anxiety.

7. Look for comorbid conditions such as attention disorders, Asperger’s, bipolar, and depression (Connolly & Bernstein, 2007).

6. Prevention

Anxiety is an unavoidable condition of being human. However, the “human” factor means that, as individuals, we have some power over the way we respond to anxiety-provoking events and situations (MyOptumHealth, n. d.). In children and adolescents, early detection can reduce symptom severity and/or manifestation and improve their quality of life (Children’s Hospital Boston, 2007). Learning to use active coping strategies, distraction strategies, and problem-focused rather than avoidant-focused coping have been encouraged in anxious youths (Connolly & Bernstein, 2007). It may also be helpful to regularly incorporate at least one of the following lifestyle strategies into the youth’s routine:

- Reductions in caffeine intake.
- Reductions in nicotine use.
- Regular aerobic exercise.
- Good sleep hygiene.
- Relaxation techniques.
- Encourage caregivers to receive treatment for their own anxiety disorders, if present.

Johns Hopkins Children's Center has released a study where they used a family-based program of cognitive behavioral therapy to prevent or alleviate anxiety disorders in children who had anxious parents. While this initial study was very small (40 children), the results suggest that a family based intervention may prevent anxiety in children whose parents have been diagnosed with an anxiety disorder. They are currently in the process of researching a larger number of participants (Ginsburg, 2009). The AACAP also state that "Parent skills-training programs that teach parents anxiety management and foster healthy parent-child relationships may reduce the development of anxiety disorders in young children at risk" (Connelly & Bernstein, p. 280, 2007).

7. Early Intervention

Parental awareness of the effects of stressful situations on development of anxiety disorders is key to early intervention. Since parental response may exacerbate anxiety in children, awareness on the part of caregivers about this phenomenon is important. Children, especially younger ones, may not have the life-experience to correctly assess and make proper attributions of the likelihood of realistic outcomes of stressful events, and thus may become anxious when there is little to be realistically feared. Parental stability and consistency should mitigate this.

8. Treatment

The goal of any treatment for anxiety in youth should be to return the child to a typical level of functioning (Huberty, 2004). ***Start with a multimodal treatment approach*** that includes psychoeducation for the child and his/her parents about the disorder; consultation with school and primary care professionals; and cognitive-behavioral interventions (Connolly & Bernstein, 2007). Some research promotes psychosocial interventions such as cognitive-behavioral therapy (CBT) as first line, especially in milder cases (Meyers, 2006). However, 2007 AACAP practice parameters add psychodynamic, family, and drug therapy to the first-line treatment options, depending on the presenting anxiety disorder. Whether used alone or in combination. selective serotonin reuptake inhibitors (SSRIs) should be the pharmacological intervention of choice (Connolly & Bernstein, 2007). If SSRIs are used, youth must be carefully monitored. ***SSRIs are antidepressants*** and carry a **"BLACK BOX" warning**. (Refer to the General Guidelines section for more information on "Black Box" warnings.)

Research has indicated that parents and families can have an impact on the development and maintenance of childhood anxiety. Therefore, child-focused interventions may need to be supplemented with interventions that address parent-child relationships, improve family problem solving and parenting skills and reduce parental anxiety. (Connelly & Bernstein, 2007).

Psychosocial Interventions for Specific Anxiety Disorders

Generalized Anxiety Disorder

- Psychoeducation for the child, family and other significant persons in youth's life. Treatment includes recognition of physiological and psychological symptoms. Youth further should learn to use positive "self-talk" as a strategy (The Child Anxiety Network, 2006).

Separation Anxiety Disorder

- A concerted effort for the child to continue attending school.
- A behavioral program involving service recipient, parents, and school personnel.
- Family interventions, including family therapy, parent-child interventions, parental guidance and psychoeducation.
- Cognitive-behavioral therapy (CBT).
- Consider the use of SSRI medication for resistant cases.
- In severe cases, consider short-term benzodiazepine use.

Social Phobia

- Cognitive-behavioral therapy (CBT).
- Group psychotherapy.
- Social Skills Training (Connolly & Bernstein, 2007)
- SSRI medication. Commonly prescribed medications include Celexa, Lexapro, Luvox, Paxil, Prozac, and Zoloft. Effexor is also prescribed. However, the FDA has not approved specific medications for the treatment of social phobia in children and adolescents

Specific Phobias

- Cognitive-behavioral therapy (CBT), specifically systematic desensitization. Also including cognitive modification of unrealistic fears and participant modeling (demonstrations by therapist and parent of approaching feared objects or situations) (Connelly & Bernstein, 2007).

Panic Disorder

- Cognitive-behavioral therapy.
- SSRI medication.
- In severe or treatment refractory cases, consider benzodiazepine.

Obsessive-compulsive Disorder

- Cognitive-behavioral therapy, specifically exposure and response prevention.
- SSRI medication. (Refer to the Table of Typically Prescribed Medications on the next page to identify FDA-approved medications.)
- ***In severe or treatment refractory cases, consider***:
    1. Combining cognitive-behavioral therapy with an SSRI, which has demonstrated superior effectiveness to either intervention alone.
    2. Augmentation with a second generation (atypical) antipsychotic medication or a tricyclic.

Posttraumatic Stress Disorder

- Psychoeducation involving the child, parents/caregivers, teachers and/or significant others that focuses on the symptoms, clinical course, treatment options, and prognosis.
- Individual trauma-focused therapy including cognitive-behavioral therapy (CBT) with desensitization/exposure techniques. (Insight-oriented, interpersonal, and psychodynamic therapies may be appropriate for some children.)
- Family trauma-focused therapy.
- Group trauma-focused therapy.
- ***When a comorbid psychiatric condition coexists with the PTSD,*** *first-line treatment should comprise a combination of psychotherapy and medication.*

	Recommended	Also consider
Frequency of psychotherapy sessions	Weekly	Twice a week
Duration of psychotherapy sessions	60 minutes*	> 60 minutes* or 45 minutes
Format of psychotherapy sessions	Individual	Combination of individual and group or family therapy
Frequency of medication visits	Weekly for the first month and every 2 weeks thereafter	Weekly for all 3 months Every 2 weeks for all 3 months

*Longer sessions may be needed for exposure therapy to allow for habituation.

Evidence Base for Psychosocial Treatment Recommendations

Problem Area	Level 1- Best Support	Level 2- Good Support	Level 3- Moderate Support	Level 4- Minimal Support	Level 5- No Support
Anxious or Avoidant Behavior	CBT, CBT and Medication, CBT with Parent, Education, Exposure, Modeling	Assertiveness Training, CBT for Child and Parent, Family Psychoeducation, Hypnosis, Relaxation	Contingency Management, Group Therapy	Biofeedback, Play Therapy, Psychodynamic Therapy, Rational Emotive Therapy	Attachment Therapy, Client Centered Therapy, CBT with Parents only, Eye Movement Desensitization and Reprocessing (EMDR), Psychoeducation, Relationship Counseling, Teacher Psycho-education
Traumatic Stress	CBT, CBT with Parents	None	None	Play Therapy, Psychodrama	Client Centered Therapy, CBT and Medication, CBT with Parents only, EMDR, Interpersonal Therapy, Relaxation

Adapted from *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit. (*American Academy of Pediatrics, revised June, 2011).

Other psychotherapeutic interventions have been developed and the evidence base for effectiveness continues to grow. Interventions promulgated within the provider network in Tennessee include Trauma-Focused Cognitive Behavior Therapy (TF-CBT), which is useful for children exhibiting anxiety symptoms from exposure to traumatic events; Attachment, Self-Regulation and Competency (ARC) therapy, working with fundamental processes for security and self-management of distress, Multisystemic Therapy (MST), disseminated over the last 20 years throughout statewide provider networks and used with a variety of problems, including anxiety symptoms resulting from abuse and neglect.

An excellent resource for information and evidenced-based interventions is the National Child Traumatic Stress Network (www.nctsn.org). Here training, learning collaboratives and access to the research literature can be found. The network has helped with advancing the quality and versatility of therapists across Tennessee via assistance in training in the last 5 years.

Additionally, the American Academy of Child and Adolescent Psychiatry (AACAP) publishes well-researched guidelines that focus specifically on diagnostic entities. Their guidelines on Anxiety Disorders (AACAP, 2007) cover the general category; there are additionally specific guidelines for Obsessive Compulsive Disorder (AACAP, 2012) and Posttraumatic Stress Disorder (AACAP, 2010).

Many of these guidelines have informed the preparation of this document. The guidelines are extensively annotated and referenced; they serve as an excellent elaboration of this document.

Pharmacological

Table of Typically Prescribed Medications

MEDICATION NAME		**MAXIMUM RECOMMENDED DAILY DOSAGE****		**NOTES**
Benefits: Useful for anxiety disorders, especially obsessive-compulsive disorder. Most of the medications on the list are SSRIs (Specific Serotonin Reuptake Inhibitors) that affect the neurotransmitter Serotonin.				
Side Effects: Appetite changes, nausea, headache, sweating, insomnia and occasionally tiredness, sexual problems including desire.				
Brand Name	**Generic Name**	**Children**	**Adolescents**	
Prozac Serefam	Fluoxetine	20 mg	40 mg	***Fluoxetine has FDA approval in the treatment of obsessive-compulsive disorder in children and adolescents***. It is indicated for youth 7-17 years of age (Brasic, 2012). Start with 10 mg/day. After two weeks, increase to 20 mg/day in adolescents and higher weight children, up to the recommended daily maximum. In lower weight children, keep the maximum between 20-30 mg/day (FDA, 2011; Texas Department of Family & Protective Services…, 2010).
Zoloft	Sertraline	200 mg	200 mg	***Sertaline has FDA approval in the treatment of children and adolescents with obsessive-compulsive disorder only for up to one year***. It can be used with children ages 6 to 18 years. The initial dosage for children (ages 6-12) is 25 mg/day while 50 mg/day for adolescents (ages 13-18). The maximum dosage is not to exceed 200 mg/day and should be based upon clinical response to treatment (FDA, 2012).
Luvox	Fluvoxamine*	200 mg	200 mg	***Fluvoxamine has FDA approval in the treatment of children and adolescents with obsessive-compulsive disorder only*** (FDA, 2011)***.*** For children ages 8 to 17 years of age, start with 25 mg daily, making gradual increments in 25 mg dosages every 4-7 days as needed, up to a maximum of 200 mg per day (Marks, 2005).
Paxil Paxil CR Pexeva	Paroxetine	(-) (-) (-)	40 mg 37.5 mg (-)	***Not approved for use in pediatric patients*** (FDA, 2012; Texas Department of Family & Protective Services…, 2010).
Celexa	Citalopram	40 mg	40 mg	***Not approved for use in pediatric patients*** (FDA, 2012).
Lexapro	Escitalopram	20 mg	20 mg	***No anxiety disorder indication for use in pediatric patients*** (FDA, 2011).
Anafranil	Clomipramine			***Clomipramine has FDA approval in the treatment of children and adolescents with obsessive-compulsive disorder only for ages 10-17 years.*** However, it is a ***<u>second-line treatment</u>.*** Careful monitoring is necessary because of the higher severity and rate of adverse effects when used in young people (Brasic, 2012).

*The New England Journal of Medicine published a study that showed fluvoxamine as a safe and effective treatment for children and adolescents with social phobia, separation anxiety disorder, or generalized anxiety disorder (The Research Unit on Pediatric Psychopharmacology Anxiety Study Group, 2001).

**Based on *Psychotropic Medication Utilization Parameters for Foster Children* (2010), as developed by the Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, and other reliable resources.

Because of the variety of medications and treatment approaches used to treat anxiety disorders, a doctor cannot predict in advance which combination will be most helpful to a specific patient. In many cases the doctor will need to try a new medication or treatment over a six- to eight-week period in order to assess its effectiveness. Treatment trials do not necessarily mean that the patient cannot be helped or that the doctor is incompetent (MyOptumHealth, n. d.).

9. Other Interventions

Parental involvement in the treatment of children and adolescents with anxiety disorders is a must. Some treatment specify a role for parent or caregiver (e. g., Trauma-Focused Cognitive Behavior Therapy) while others are predicated on the involvement of not just caregivers but the broader social system.

School based interventions are often useful as well; several evidenced based programs for anxiety treatment are based in that setting.

10. Bibliotherapy

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For Young People Experiencing Social Anxiety Disorder

- *I Don't Know Why . . . I Guess I'm Shy: A Story about Taming Imaginary Fears* by Cain & Smith-Moore, 1999
- *Cat's Got Your Tongue? A Story for Children Afraid to Speak* by Schaefer & Friedman, 1992

For Youth Experiencing Separation Anxiety

- *The Good-bye Book* by Viorst.
- *Into the Great Forest: A Story for Children Away from Their Parents for the First Time* by Marcus *Going to Daycare* by Rogers
- *What to Do When You're Scared & Worried: A Guide for Kids* by Crist (Fenton, 2004).

For Elementary School-Age Children Experiencing Obsessive-Compulsive Disorder

- *Blink, Blink, Clop, Clop: Why Do We Do Things We Can't Stop*? by Moritz and Jablonsky,1998

For Adolescents Experiencing Obsessive-Compulsive Disorder

- *Brain Lock: Free Yourself from Obsessive-Compulsive* Behavior by Jeffrey M. Schwartz, 1996

For Young People Experiencing PTSD

- *A Terrible Thing Happened* – A story for children who have witnessed violence or trauma by Holmes , Mudlaff, & Pillo, 2000
- *Uncle Willy's Tickles* by Aboff, 1996

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TDMHSAS BEST PRACTICE GUIDELINES

Attention Deficit Hyperactivity Disorder in Children and Adolescents

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Clinician Summary

- ADHD is a very common child and adolescent disorder.
- Problematic childhood disruptive behavior, hyperactivity, impulsivity and/or inattention should be evaluated for possible ADHD diagnosis.
- Diagnosis involves a detailed clinical interview focused on specific diagnostic criteria.
- Diagnostic information should be sought from multiple sources including teacher reports.
- Treatments usually involve stimulant medication but should also include behavioral interventions and classroom modifications.

Background

The Centers for Disease Control and Prevention (CDC) estimates that 4.4 million youth ages 4-17 have been diagnosed with attention deficit hyperactivity disorder (ADHD) by a healthcare professional. Overall estimates are that 5-10 percent of children may have ADHD. This figure includes 9.87% of youth in Tennessee. As of 2003, 2.5 million youth ages 4-17 were receiving medication treatment for the disorder. This includes 4.79 percent of children and adolescents aged 4-17 in the state of Tennessee (ADHD, 2005). In general, 60 percent of youth with ADHD carry their symptoms into adulthood (Medical News Today, 2004). The male-to-female ratio ranges from 2:1 to 6:1 (American Psychological Association, 2006).

Several recent reports suggest that ADHD rates are on the rise (MMWR, 2010; Akinbami, 2011). Approximately 9.5 percent or 5.4 million children 4-17 years of age had been diagnosed with ADHD as of 2007, representing a 22 percent increase in four years. Rates may be increasing because of greater knowledge and awareness about the condition, more frequent behavioral screening of children, or unidentified factors that may be causing more ADHD over time.

This Practice Guideline is focused on the treatment of ADHD in school aged children, particularly in the primary care/pediatric setting. Treatment of ADHD in pre-school children and adolescents may present added challenges.

Diagnostic Criteria (DSM-IV-TR)

- At least six of the following symptoms of inattention have been present for a minimum of six months ***to a degree that is maladaptive and NOT consistent with developmental level:***

1. Often fails to give close attention to details or makes careless mistakes in schoolwork.
2. Often has difficulty sustaining attention in tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow through on instructions and fails to finish schoolwork or chores (***NOT*** due to oppositional behavior or failure to comprehend instructions).
5. Often has difficulty organizing activities and tasks.
6. Often dislikes, avoids, or is reluctant to engage in tasks that require concentrated mental effort (e.g., schoolwork, homework).
7. Often loses items necessary for tasks or activities such as toys, assignments, pencils, or books.
8. Is often easily distracted by environmental stimuli.
9. Is often forgetful in daily activities.

OR

- At least six of the following symptoms of hyperactivity or impulsivity have been present for a minimum of six months ***to a degree that is maladaptive and NOT consistent with developmental level****:*

1. Often fidgets with hands or feet, or squirms in seat.
2. Often leaves seat in classroom or in other situations in which the expectation is to remain seated.
3. Often runs about or climbs excessively in situations in which such behavior is inappropriate.
4. Often has difficulty playing or engaging in leisure activities quietly.
5. Is often “on the go” or often acts as if “driven by a motor.”
6. Often talks excessively.
7. Often blurts out answers before questions have been completed.
8. Often has difficulty waiting turn.
9. Often interrupts or intrudes on others like butting into conversations or games.

AND

- Some symptoms that caused impairment were apparent before 7 years of age.

AND

- Some impairment from the symptoms is present in at least two settings (e.g., at school and home).

AND

- There is clear evidence of clinically significant impairment in academic, social, or occupational functioning.

AND

- The symptoms do ***NOT*** occur only during a psychotic disorder and are ***NOT*** better accounted for by another mental disorder (e.g., Mood or Anxiety Disorder).

Depending on a predominance of symptoms in either the inattentive category or the hyperactive/impulsive category the diagnosis may be classified **ADHD-Primarily Inattentive** (formerly referred to as ADD), **ADHD-Primarily Hyperactive/Impulsive** or **ADHD-Combined Type** (American Psychiatric Association, 2000).

Differential Diagnosis

- Age appropriate behaviors in active children
- Adjustment disorders
- Intellectual disability
- Under-stimulating environments
- Other environmental factors such as chaotic and/or disorganized environments
- Disruptive behavior disorders
- Substance-related disorders
- Petit mal epilepsy
- Past trauma/child abuse

Pervasive developmental disorder
Psychotic disorder
Medical conditions
Coordination or articulation problems
Hearing loss
Sleep difficulties
Stereotypic movement disorder
Bipolar disorder

(American Psychiatric Association, 2000; Krull, 2012; Mehl-Madrona, 2003)

Comorbidity of Attention Deficit Disorders

ADHD frequently co-exists with:
- Other disruptive behavior such as Oppositional Defiant Disorder or Conduct Disorder
- Learning Disabilities and Language Delays
- Anxiety Disorders, including Obsessive-Compulsive Disorder
- Tic disorders, including Tourette's Disorder

Some conditions may develop in addition to ADHD, especially in poorly controlled ADHD:
- Depressive Disorders
- Substance Abuse Disorders

Source: American Psychiatric Association, 2000; Kaiser Permanenté ADHD Guideline Development Team, 2009; Krull, 2012.

Screening, Evaluation and Diagnosis

The following may be the **chief complaints** from parents or teachers of a young person suffering from some form of attention deficit disorder. They indicate a need for further exploration:

School problems
Can't stay in seat
Difficulty taking turns
Can't follow instructions
Difficulty completing tasks
Interrupts, intrudes on others
Accident-prone
Difficulty being calm
Short term memory problems
Over active: fidgety restless
Easily distracted
Blurts out answers
Disruptive behavior
Talks excessively
Acts without thinking
Poor self esteem
"Doesn't listen"
"Someone thinks he has ADHD"

However, regardless of the nature of the chief complaint, the clinician should incorporate **screening for ADHD** as part of every youth's mental health assessment. Screening questions should ask about the major symptom domains of ADHD and whether the symptoms cause impairment. If rating scales/questionnaires will be used as screening tools, they can be packaged as part of the registration materials that parents/caregivers have to complete before visits or while in the waiting room. Any impairment as a result of symptoms or scores in the clinical range on screening instruments warrants a full evaluation. **Diagnostic evaluations** should be comprised of the following:

- ***Clinical interviews with the youth and the parent/caregiver***. The interviews should be detailed, focusing on each of the 18 ADHD symptoms listed in the DSM-IV-TR. Data detailing duration, frequency, severity and age of onset should be collected. Parents might complete measurement instruments that yield data about other psychiatric disorders as well as ADHD.

- ***Information should be gathered about the settings in which the symptoms occur***. Questions about impairment in the school and/or work setting are as important as any impairment that manifests in the home. Typically, youth with ADHD have academic impairment.
- ***Ask about comorbid psychiatric disorders***. Start with data regarding ODD and CD. Then explore about symptoms of learning disabilities, depression, anxiety, tic disorders, and/or substance abuse. Although they are much rarer conditions, explore for symptoms of psychosis or mania.
- ***Family history and family functioning is very important.*** ADHD and other psychiatric disorders often have a genetic component. Factors about the home environment indicative of inconsistency, disorganization or high levels of stress may indicate adjustment issues that resemble ADHD.
- ***Check youth's medical and social history.*** Include perinatal history and developmental milestones. Rarely, medical conditions, such as hyperthyroidism or seizures may mimic ADHD symptoms (AACAP, 2007).

Elementary school aged children should be interviewed along with the parent/caregiver. Older youth should be interviewed with their parents and also separately so they might disclose any significant symptoms. (Children and adolescents are less likely to accurately self-report disruptive behavior but parents are likely to under-report anxiety or depressive symptoms in their children.) A mental status examination assessing appearance, attention, behavior, affect, mood, sensorium, and thought processes should be performed by the clinician during the youth interview. **Psychological or neuropsychological assessments are necessary only if the youth's history suggests low general cognitive ability or low achievement in mathematics or language relative to his/her intellectual ability** (AACAP, 2007).

- ***ADHD-specific rating scales should be obtained from classroom teachers.***
  The tools in Table 1 can assist clinicians in diagnosing disorders of attention in youth. The instruments can further serve to monitor progress following interventions.

Table 1. Screening Tools and Rating Scales

Attention Deficit/Hyperactivity Symptoms				
Screening Tool / Rating Scale	**For Ages (Years)**	**Who Completes Checklist: Number of Items**	**Time to Complete (Minutes)**	**View Free Online ?**
Attention Deficit Disorders Evaluation Scale (ADDES-3)	4-18	Parent: 46 Teacher: 60	12 15	
ADHD Rating Scale-IV (ADHD-IV)	5-17	Parent, Teacher, Clinician: 18	10-20	
ADHD Rating Scale	6-12	Parent, Teacher, Clinician, Student: 18	10-15	YES
Vanderbilt ADHD Diagnostic Parent Rating Scale Vanderbilt ADHD Diagnostic Teacher Rating Scale	6-12	Parent: 55 Teacher: 43	10	YES
SNAP-IV Rating Scale - Revised (SNAP-IV-R) - A revision of the Swanson, Nolan and Pelham	6-18	Parent, Teacher: 90	10	
ADD-H: Comprehensive Teacher's Rating Scale: Parent Form (ACTeRS)	6-14	Parent: 24	5-10	
ADHD Comprehensive Teacher Rating Scale (ACTeRS)	6-14	Teacher: 24	5-10	

*Source: Massachusetts General Hospital, School Psychiatry Program & Madi Resource Center, 2010.

Note: Evaluation instruments can assist the clinician with diagnosis, especially of the "underdiagnosed" type of attention disorder—ADHD Primarily Inattentive Type (ADHD-I, formerly ADD). Such youth do not generally present as if they are "driven by a motor." Instead, ADHD-I youth more closely resemble the "space cadet" or the "couch potato" in his/her behaviors. As a result, they are frequently overlooked by teachers, become scapegoats for parents, and may be misdiagnosed by clinicians (Mehl-Madrona, 2003). In either case, multiple sources should be used to enhance diagnostic accuracy.

The diagnosis may require additional attention in **special populations**. In preschool children, the presence of environmental stressors should be completely understood. Very young children are more sensitive to negative environmental stress and may respond with symptoms that closely resemble ADHD. Adolescents are more likely to have co-morbid conditions such as depression, anxiety, substance abuse or conduct disorder. Identifying a primary condition (i.e. untreated ADHD may have resulted in depression) may help direct appropriate initial treatment.

Treatment

Untreated ADHD carries risk of poor adjustment. Without treatment, a child with ADHD may fall behind in school and have trouble with friendships. Family life may also suffer. Untreated ADHD can increase strain between parents and children and parents often blame themselves when they can't communicate with their child. The sense of losing control can be very frustrating. Teenagers with ADHD are at increased risk for driving accidents, substance abuse and delinquent behavior. Additionally, adults with untreated ADHD have higher rates of divorce and job loss, compared with the general population. Luckily, safe and effective treatments are available which can help children and adults control the symptoms of ADHD and prevent the unwanted consequences (AACAP, 2010).

Treatment planning for ADHD should take into account the chronic nature of the disorder as well as the most recent evidence concerning effective therapies. Family preferences and/or concerns should be considered as well. Treatment plans may consist of psychopharmacological and/or behavior therapy and should include psychoeducation of parents and children about ADHD and the various treatment options as well as school resources and linkage with community supports. Education about the diagnosis and the related issues is generally performed by the physician in the context of medication management and involves educating the parent and child about ADHD, helping parents anticipate developmental challenges that are difficult for children with ADHD, and providing general advice to the parent and child to help improve the child’s academic and behavioral functioning. The treatment plan should be reviewed regularly and modified if the patient’s symptoms do not respond (AACAP, 2007, AAP, 2011). Most treatment plans will involve:

- **Medication** (usually stimulants, see below)
- **Behavior Therapy** (including parent management training, see below)
- **Classroom or education modifications** (from minor classroom modifications to special education certification and the development of an IEP)

Primary treatment strategies for ADHD include a combination of medication and behavior therapy. Although professional groups have had differing opinions regarding the efficacy and importance of behavior therapy vs. medication in treating ADHD (e.g., AMA, 1998; AACAP, 2007, APA, 2007), both types of treatment have been demonstrated to be well-established with multiples studies to supporting their use as a first-line treatment (Pelham & Fabiano, 2010). Thus, providers should take a comprehensive, multimodal approach to treatment planning, including both pharmacological and psychosocial interventions. The severity and type of ADHD may be factors in deciding which components are necessary. Treatment should be tailored to the unique needs of each child and family (National Resource Center on ADHD, 2004).

In the American Academy of Pediatrics’ 2011 Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents, recommendations for treatment of ADHD vary depending on the age of the patient (AAP, 2011). For preschool-aged children (4-5 years), parent and/or teacher administered behavior therapy is recommended as the first line of treatment, with medication prescribed if the behavior interventions do not provide significant improvement and moderate to severe disturbance in the child's functioning continues. For elementary school-aged children (6-11 years), medication and/or evidence-based parent- and/or teacher-administered behavior therapy is recommended, preferably both. It is also recommended that the school environment, program, or placement be a part of any treatment plan. For adolescents (12-18 years), medication is recommended, preferably with behavior therapy (AAP, 2011).

Medication Therapy

Stimulant medications remain the first choice among pharmacological options in the treatment of attention disorders, especially ADHD, in young people. They are the most widely used and widely researched ADHD treatment medications, especially involving children (National Resource Center on AD/HD, 2008). Nearly three fourths of elementary school children with the disorder who are treated with stimulants respond positively to one or more doses. In the short-term, stimulants often lead to improved attention and task completion, as well as reductions in disruptive behavior and impulsivity. In some cases, aggression is reduced. Youngsters tend to stay on medication treatment for an average of two to seven years, depending on their age. Results for adolescents are less favorable (American Psychological Association, 2006).

Table 2 lists medications that are typically prescribed for ADHD symptoms. All listed medications have been approved by the Food and Drug Administration (FDA) for use with youth. **Psychopharmacological treatment of ADHD should begin with an agent that has been approved by the FDA** (AACAP, 2007).

Regardless of the particular medication chosen, obtaining baseline measures is recommended, such as the scales referenced in Table 1. These measures can be repeated once the youth has begun medication therapy to measure efficacy and adjust dosage. Informed consent (risks including possible side effects, benefits and alternatives) should be obtained from the parent/guardian and assent should be obtained from the patient prior to starting these medications. **There is no specific recommended dose of medication based on weight of child or severity of disorder.** Typically, treatment should start with low doses and should be increased gradually depending on response and side effects. A poor response to one stimulant is not an indication that other stimulants will be ineffective. The goal of treatment is to use the lowest effective dose balanced with the fewest for side effects. If a medication is not working, reassess the diagnosis, drug dosing and the treatment plan.

A **progression of medication trials** may be necessary to identify an effective treatment:

1. Begin **Stimulant 1** (either methylphenidate based or amphetamine based) and gradually increase to document lack of effect or significant side effects. If ineffective, discontinue.
2. Begin **Stimulant 2** (from the other stimulant class) and gradually increase to document lack of effect or significant side effects.
3. Begin **Non-stimulant** monotherapy or add alpha-agonist to partially effective stimulant.

Table 2. Typically Prescribed Medications – Attention Deficit Hyperactivity Disorder

STIMULANTS

Common side effects of stimulant medications include rebound, irritable mood, tics and decreased appetite which can lead to weight loss and decelerated growth in some children. Children on stimulant medications can have trouble sleeping, particularly those being dosed in the afternoon to cover the second half of the day and late afternoon (around homework time). Stimulants can are known to induce mania in vulnerable populations. All stimulants carry warnings about their abuse potential. The shorter acting the drug, the increase in abuse potential. The long acting drugs are much more likely to be misused than abused. Stimulants are not recommended in patients with known cardiac abnormalities or those patients with a family history of sudden death before age 30.

MAXIMUM RECOMMENDED DAILY DOSAGE

Brand Name	Generic Name	Children	Adolescents	Length of Action
Adderall	Mixed salts of single-entity amphetamine	40 mg	40 mg	FDA approved for children ages 3 and older (Texas Department of Family & Protective Services …, 2010). Lasts 3-6 hours (Hirsch, n.d.). Black Box warning for abuse/diversion potential, among other issues (ADHD Information Library, 2011).
Adderall XR	Mixed amphetamine salts	30 mg	40 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 8-10 hours (Hirsch, n.d.). Black Box warning for abuse/diversion potential, among other issues (ADHD Information Library, 2011).
Dexedrine	Amphetamine	40 mg	40 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 3-6 hours (Hirsch, n.d.). Black Box warning for abuse/diversion potential, among other issues (ADHD Information Library, 2011).
Dexedrine Spansule	Amphetamine	40 mg	40 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 8-10 hours (Hirsch, n.d.). Black Box warning for abuse/diversion potential, among other issues (ADHD Information Library, 2011).
Vyvanse	Lisdexamfetamine	70mg	70mg	FDA approved for children ages 6-12 (NIMH, 2010; Texas Department of Family & Protective Services …, 2010). Research shows it can last between 10-12 hours (National Resource Center on AD/HD, 2011). The medication carries a Black Box warning but abuse potential is expected to be lower because activation occurs only if swallowed (Hosenbocus & Chahal, 2009).
Ritalin	Methylphenidate	60 mg	60 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 3-4 hours (Hirsch, n.d.). Black Box warning for chronic abusive use, among other issues (ADHD Information Library, 2011).
Ritalin LA	Methylphenidate	60 mg	60 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 8-12 hours (Hirsch, n.d.). Black Box warning for chronic abusive use, among other issues (ADHD Information Library, 2011).
Metadate CD	Methylphenidate	60 mg	60 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 8-12 hours (Hirsch, n.d.). Black Box warning for chronic abusive use, among other issues (ADHD Information Library, 2011).

STIMULANTS

Common side effects of stimulant medications include rebound, irritable mood, tics and decreased appetite which can lead to weight loss and decelerated growth in some children. Children on stimulant medications can have trouble sleeping, particularly those being dosed in the afternoon to cover the second half of the day and late afternoon (around homework time). Stimulants can are known to induce mania in vulnerable populations. All stimulants carry warnings about their abuse potential. The shorter acting the drug, the increase in abuse potential. The long acting drugs are much more likely to be misused than abused. Stimulants are not recommended in patients with known cardiac abnormalities or those patients with a family history of sudden death before age 30.

MAXIMUM RECOMMENDED DAILY DOSAGE

Brand Name	Generic Name	Children	Adolescents	Length of Action
Methylin (chewable and liquid)	Methylphenidate	60 mg	60 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 3-4 hours (Hirsch, n.d.). Black Box warning for chronic abusive use, among other issues (ADHD Information Library, 2011).
Concerta	Methylphenidate	54 mg	72 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 8-12 hours (Hirsch, n.d.). Black Box warning for chronic abusive use, among other issues (ADHD Information Library, 2011).
Daytrana Patch	Methylphenidate	30 mg	30 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 8-12 hours (Hirsch, n.d.). Black Box warning for chronic abusive use, among other issues (ADHD Information Library, 2011).
Focalin	Dexmethylphenidate	20 mg	20 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 3-4 hours (Hirsch, n.d.). Black Box warning for chronic abusive use, among other issues (ADHD Information Library, 2011).
Focalin XR	Dexmethylphenidate	30 mg	30 mg	FDA approved for children ages 6 and older (Texas Department of Family & Protective Services …, 2010). Lasts 8-12 hours (Hirsch, n.d.). Black Box warning for chronic abusive use, among other issues (ADHD Information Library, 2011).

NOTE: Contents are based on *Psychotropic Medication Utilization Parameters for Foster Children* (2010), as developed by the Texas Department of Family & Protective Services…, as well as other reliable resources.

NONSTIMULANTS				
MAXIMUM RECOMMENDED DAILY DOSAGE				
Brand Name	**Generic Name**	**Children**	**Adolescents**	**Length of Action/other**
Strattera	Atomoxetine	100 mg	100 mg	FDA approved for children ages 6-17 (Texas Department of Family & Protective Services …, 2010). It has the potential to last 24 hours (Hirsch, n.d.). Black Box warning for suicidal ideation, among other issues (NIMH, 2009).
Catapres	Clonidine	0.4mg	0.4 mg	***Not approved for use in pediatric patients*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
Kapvay	Clonidine XR	.4 mg	.4 mg	FDA approved for children ages 6-17 (Texas Department of Family & Protective Services …, 2010). Can last up to 24 hours (WebMD, n.d.). Can cause low heart rate and blood pressure (Daily Med, 2012).
Tenex	Guanfacine	4 mg	4mg	***Not approved for use in pediatric patients*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
Intuniv	Guanfacine XR	4 mg	4 mg	FDA approved for children ages 6-17 (Texas Department of Family & Protective Services …, 2010). Lasts 24 hours (WebMD, n.d.). Can cause low heart rate and blood pressure (Daily Med, 2011).
Wellbutrin SR	Bupropion			***Not approved for use in pediatric patients*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
Wellbutrin XL	Bupropion			***Not approved for use in pediatric patients*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
Wellbutrin	Bupropion			***Not approved for use in pediatric patients*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).

NOTE: Contents are based on *Psychotropic Medication Utilization Parameters for Foster Children* (2010), as developed by the Texas Department of Family & Protective Services…, as well as other reliable resources.

Behavior Therapy

Behavior modification, or behavior therapy, is the only nonmedical treatment that has been found to be effective for ADHD. It may be effective as a sole treatment in mild cases of ADHD but most treatment plans should consider both medication and behavioral interventions. There are three components to effective behavior therapy: Behavior Parent Training (BPT), Behavior Classroom Management (BCM), and Behavior Peer Interventions (BPI). Although all three types of interventions have empirical support, BPT appears to be the most important aspect of psychosocial treatments for ADHD. BPT involves working directly with parents to establish rules and structure in the home, use praise and rewards for positive/desired behavior and appropriate consequences for undesired behavior, give appropriate commands, ignore behavior when possible, and other skills. BCM involves working with teachers and school personnel toward similar goals in the classroom. Preferential seating, frequent breaks, and increased attention and praise may be components of BCM. BPT often takes place in the school setting as well and involves teaching social skills, social problem solving, and decreasing undesirable and antisocial behaviors.

Although teaching parents more effective ways of dealing with their children is the most important aspect of psychosocial treatment for ADHD, ideally parent, teacher, and child interventions should be integrated to yield the best outcome. Several principles are common to behavioral interventions:

- start with goals that the child can achieve and improve in small steps;
- rewarding positive behavior is more effective than punishing negative behavior
- be consistent--across different times of the day, different settings, and different people;
- don't expect instant changes--teaching and learning new skills take time, and children's improvement will be gradual;
- constantly monitor the child's response and adjust treatment as necessary; and
- begin intervention as early as possible--although behavior modification works for all ages, early treatment is more effective than later intervention.

Family therapy can also be used to change family interactional patterns that may cause dysfunction and improve communication between family members, which functions to encourage the child to rely upon his/her strengths. Various forms of individual counseling may be indicated for children with problems coping or other comorbid conditions. Individual psychotherapy is not recommended as a primary intervention for children with attention disorders (AAP, 2001).

When medication is not part of the initial treatment plan and the youth continues to have problems with core symptoms of the attention disorder, a stimulant medication should be considered AND behavior therapy should be reinforced.

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TDMHSAS BEST PRACTICE GUIDELINES

Children and Adolescents with Autism Spectrum Disorders

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The Centers for Disease Control and Prevention (CDC, 2012) reports that one in 88 children have been identified with an autism spectrum disorder (ASD), a neurodevelopmental disorder, by eight years of age. There is continuing research into the apparent increase in prevalence rates of ASD. Much current research focuses on the possible biologic, genetic, and/or environmental factors that may lead to manifestation of the symptoms.

Although there is no current known cause or cure for ASD to date, accurate early diagnosis is crucial in obtaining early intensive behavioral treatments which are associated with improved outcomes for individuals with ASD (Harris & Handleman, 2000). This document is a general overview of ASD, assessment and screening for ASD, and evidence-based treatments. References and additional resources are also provided.

DSM-IV-TR Criteria for Pervasive Developmental Disorders

The following are the diagnostic criteria for the three most commonly diagnosed ASD - Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorders Not Otherwise Specified. Rett's Disorder and Childhood Disintegrative Disorder are also currently diagnosed as ASD. However, these less commonly diagnosed disorders possess unique characteristics and, as such, have not been included in this document.

Autistic Disorder *(DSM-IV-TR, 2000, p. 70)*

> *A. A total of six (or more) items from (1), (2) and (3) with at least two from (1), and one each from (2) and (3):*

1. Qualitative impairment in social interaction, as manifested by at least two of the following:
- Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures and gestures to regulate social interaction
- Failure to develop peer relationships appropriate to developmental level
- A lack of spontaneous seeking to share enjoyment, interests or achievements with other people (e.g. by a lack of showing, bringing or pointing out objects of interest)
- Lack of social or emotional reciprocity

2. Qualitative impairments in communication as manifested by at least one of the following:
- Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
- In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- Stereotyped and repetitive use of language or idiosyncratic language
- Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

3. Restricted repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least one of the following:
- Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- Apparently inflexible adherence to specific, non-functional routines or rituals
- Stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole-body movements)
- Persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:
- (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

Asperger's Disorder *(DSM-IV-TR, 2000, p. 80)*

Qualitative impairment in social interaction, as manifested by at least two of the following:

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

- Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures and gestures to regular social interaction
- Failure to develop peer relationships appropriate to developmental level
- A lack of spontaneous seeking to share enjoyment, interests or achievements with other people (e.g. by a lack of showing, bringing or pointing out objects of interest to other people)
- Lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least one of the following:

- Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- Apparently inflexible adherence to specific, non-functional routines or rituals
- Stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole-body movements)
- Persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment in social, occupational or other important areas of functioning.

- There is no clinically significant general delay in language (e.g. single words used by age 2 years, communicative phrases used by age 3 years)
- There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood
- Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia

Pervasive Development Disorder Not Otherwise Specified (PDD-NOS)

(DSM-IV-TR, 2000, p. 84)

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests and activities are present, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizotypal Personality Disorder or Avoidant Personality Disorder. For example, this category includes 'atypical autism' presentations that do not meet the criteria for Autistic Disorder because of late age of onset, atypical symptomatology, or sub-threshold symptomatology, or all of these.

Proposed Changes to Diagnostic Criteria in DSM-5

With the upcoming 2013 revision of the diagnostic coding system of the American Psychiatric Association (ApA), it appears that autism diagnoses will undergo significant changes in how patients are labeled. The class of disorders currently categorized as pervasive developmental disorder (not otherwise specified), Asperger's disorder, autistic disorder, and childhood disintegrative disorder will be classified as autism spectrum disorder (ASD) in the new DSM-5. Thus, children who have symptoms of Asperger's, for example, will no longer be told that they have Asperger's but instead ASD. The changes were recommended to help diagnose children in these categories in a more consistent way (Falco, 2012).

Some clinicians, such as Dr. Bryan King, director of the Seattle Children's Autism Center, believe the new diagnostic criteria will be more inclusive and result in more youth being diagnosed with ASD, thanks to the following three changes that have the potential to expand the diagnostic door:

- The new criteria will allow for children older than age three to meet diagnostic criteria for autism.
- Clinicians will be given actual examples of how children display the various diagnostic criteria in addition to having the criteria to reference.
- The patient's history can be considered in making a diagnosis of ASD. For instance, a teen exhibits sensory sensitivities and social impairments but at the time of evaluation is no longer preoccupied with spinning wheels or lining up toys. Nevertheless, the teen's history of repetitive behavior could be considered to make the ASD diagnosis (Falco, 2012).

Screening and Evaluation

Red Flags

Although ASD is a lifespan condition and may not be diagnosed in some individuals until later childhood, adolescence, or adulthood, symptoms suggestive of ASD are likely to be present in early childhood, often prior to 24 months. Among the most common early deficits are atypical nonverbal social communication, lack of or atypical social/emotional reciprocity, and speech/language delays (Stone, Lee, Ashford, Brissie, et al., 1999). Early deficits may also include delay or absence of relational play, decreased joint attention, and motor imitation delays (McConnell, 2002; Woods & Wetherby, 2003).

"Red flags" are frequently observed or unobserved behaviors that may warrant further professional assessment. The following are some of the red flags for ASD (Stone, Ousley, Yoder, Hogan, & Hepburn, 1997; Wetherby & Woods, 2002; CDC, 2012).

Qualitative impairments in social interaction

- Individual rarely shows things of interest to others or direct others' attention to things.
- Individual seems less likely to share enjoyment with others, or follow the attention of others.
- Individual exhibits decreased or inconsistent eye contact.
- Individual may imitate the actions of caregivers and peers less frequently than same aged peers.
- Individual may be socially withdrawn or have challenges navigating social situations.

- Individual frequently seems isolated from peers or unable to share in common interests or conversational topics.
- Individual may appear disinterested in others or may exhibit difficulty understanding or expressing shared emotions.

Qualitative impairments in communication

- Individual has very few spontaneous words or overall speech and language is delayed.
- Individual has lost some words or language skills that were previously gained.
- Individual may have reached speech and language developmental milestones on time, but has difficulty with specific areas of receptive, expressive, and pragmatic communication
- The quality of the individual's voice is unique, including all or some of the following: tone, intonation, volume, etc.
- Individual does not or infrequently points, especially at distant things or to express interest in something.
- Individual uses a decreased number of age-appropriate gestures to communicate.
- People have wondered if the individual has difficulty hearing based on his/her reaction to things in his/her environment and a decreased response to his/her name.

Restricted repetitive and stereotyped patterns of behavior, interests and activities

- When playing with objects, individual often engages in more repetitive actions (e.g., lining up objects, putting things in order, inspecting objects) rather than using the objects as they were intended.
- When playing, individual infrequently pretends with variation in play activities.
- Individual shows attachment or extreme interest in select objects.
- Individual has a highly developed special interest or knowledge of some preferred topics.
- Individual seems upset during transitions or when the routine is changed.
- Individual frequently displays stereotyped movement patterns (e.g., hand flapping, rocking, pacing).
- Individual often uses the same phrase or engages in the same action or behavior repeatedly.

It is important to note that no individual with ASD will express all of the characteristics listed. The characteristics that are expressed within an individual may vary greatly throughout his/her lifespan based on changes in factors such as age, environment, psychosocial stressors, and neurodevelopmental and physiological changes (e.g., puberty/adolescence) (McBride et al., 1998; Mayes & Calhoun, 2003).

Furthermore, just as there are significant differences among individuals who are typically developing, there are significant differences among individuals with ASD and the dimensions in which the symptoms of their diagnosis are expressed. Several factors contribute to these spectrum-wide differences, including proficiency in particular skill areas such as cognitive abilities and communication skills (Mayes & Calhoun, 2003). There are also associated challenges that often impact individuals with ASD; these include anxiety, emotional lability/mood concerns, self-regulation/executive functioning abilities, inconsistencies between expressive and receptive language skills, and motor planning difficulties (Ozonoff, 1996; Kim, J., et al., 2000; Hughes, 2006).

Screening

The "well-child" checkup by the pediatrician should include developmental screening as early as possible (NIMH, 2007). The American Academy of Pediatrics (AAP) and CDC recommend that all children be screened by their pediatrician or other primary care clinician with a standardized general developmental tool at specific intervals (i.e., at the 9, 18, and 24 or 40-month visits), regardless of whether a concern has been raised or a risk has been identified during the surveillance process. The AAP and CDC also recommend administering a standardized autism-specific screening tool on all children at the 18-month preventative care visit with a repeat screening performed at 24-month of age.

Multiple validated screening tools are available for clinical use (Johnson, 2007). Select screening instruments appropriate for young children may include the Modified Checklist for Autism in Toddlers (M-CHAT), the Screening Tool for Autism in Two-Year-Olds (STAT), the Autism Spectrum Screening Questionnaire (ASSQ) and the Social Communication Questionnaire (SCQ) among others (Johnson, 2007). A diagnosis of ASD should not be provided based upon screening results alone. If a screening suggests possible ASD, the individual should be referred for a comprehensive diagnostic evaluation (described below) to adequately assess symptoms of ASD.

Comprehensive Evaluation

A comprehensive diagnostic evaluation should be conducted to further evaluate for ASD or other developmental disorders regardless of the individual's age. It may be helpful for the evaluation to be performed by a multidisciplinary team that includes an appropriate medical doctor (i.e., a Psychiatrist, Neurologist, Developmental Pediatrician, or Pediatrician), Psychologist, Speech Language Pathologist, and/or other professionals who are qualified to diagnose individuals with ASD. The evaluation may entail extensive developmental, cognitive and language testing, as well as neurological and genetic assessment. This comprehensive evaluation should include evidence-based assessment techniques to evaluate for symptoms of ASD.

Evidence-based assessments are preferable to assessments based on tradition or convention because they take into account the research supporting the utilization of each assessment tool. Specific assessment tools that are appropriate for the evaluation of symptoms of ASD and have been shown to have adequate psychometric properties can be found in several review articles and book chapters (e.g., Ozonoff, Goodlin-Jones, & Solomon, 2005; Klin, Saulnier, Tsatsanis, & Volkmar, 2005; Campbell, 2006). Examples of measures specifically developed for evaluating symptoms of ASD include the Autism Diagnosis Interview-Revised (ADI-R); Autism Diagnostic Observation Schedule, 2nd Edition (ADOS-2); and Childhood Autism Rating Scale, 2nd Edition (CARS-2) (NIMH, 2007). In addition to utilizing a multidisciplinary assessment team and evidence-based assessment tools, a comprehensive evaluation should be conducted by professionals with knowledge of the symptoms, etiologies, and developmental course of ASD.

A comprehensive evaluation of any individual with atypical language development, including those suspected of having ASD, should also include formal audiological tests. A variety of other medical tests, including vision screens and metabolic testing, as well as assessments for specific medical findings, may also be conducted as indicated (Filipek, 2000). For example, if significant neurologic deficits are present or there are concerns that seizures may be present, further neurologic evaluation, possibly including neuroimaging, electroencephalography (EEG), or other tests, may be necessary. Genetic testing may provide information regarding etiology, particularly if there is a personal or family history of particular physical features or other developmental disabilities. The need for additional medical testing should be tailored to the individual child suspected of having ASD (Filipek, 2000). At the conclusion of the comprehensive evaluation, diagnostic recommendations need to be developed for the individual based upon their specific current and long-term needs.

Treatment

Early Intervention

Early screening and detection of ASD is important in identifying a child's treatment needs as early as possible. Research has indicated that beginning intervention at a young age may result in significant developmental improvements (Harris & Handleman, 2000), perhaps due to the neurological plasticity in younger children. Various forms of behavioral and educational interventions have been proven very effective for young children with ASD (Smith & Groen, 2000; Cohen, Amerine-Dickens, & Smith, 2006; Remington, Hastings, & Kovshoff, et al., 2007; Dawson, Rogers, & Munson, et. al, 2010). However, since each child with ASD demonstrates different areas of strength and areas of need, further research is necessary to determine which formats of treatment result in the greatest gains for particular profiles of children (Warren et. al, 2011).

Regardless of an individual's age when they are diagnosed with ASD, progress can be made through pursuing intervention and these gains can continue throughout the life span. Further, there will likely be a continued need for current or additional services targeting regressed skills, new skills, and/or maintenance of skills throughout the individual's lifespan due to developmental, physiological, neurological, and/or contextual factors.

Psychosocial Treatment

To date, behavioral and educational interventions are the most well-researched approaches to target symptoms related to ASD. Individuals with ASD will likely require behavioral and educational services to address impairments in social skills, communication, safety awareness, self-advocacy skills, self-regulation, and long-term independence skills such as transitional, vocational, and avocational skills.

In 2009, the National Autism Center (NAC) created the National Standards Report to address the need for evidence-based practice guidelines for ASD. Utilizing a Scientific Merit Rating Scale, studies focusing on intervention strategies for individuals with ASD were reviewed based on research design, measurement of the independent and dependent variables, participant ascertainment, treatment effects, and generalization of treatment effects. They were also reviewed based on the age of participant, diagnosis within the autism spectrum of the participant, and skills/behaviors targeted for each intervention strategy.

Based on these analyses, all reviewed intervention strategies were placed into 1 of 3 categories: *Established, Emerging, or Unestablished.* A fourth category, *Ineffective/Harmful*, was also developed, although no treatments were placed into that category. The National Standards Report indicates that research regarding treatment effectiveness should be considered in conjunction with professional judgment, family values and preferences, and the capacity of service providers. Listed below are the intervention strategies currently categorized as *Established Treatments* (NAC, 2009).

- Antecedent Package
- Behavioral Package
- Comprehensive Behavioral Treatment for Young Children
- Joint Attention Intervention
- Modeling
- Naturalistic Teaching Strategies
- Peer Training Package
- Pivotal Response Treatment
- Schedules
- Self-management
- Story-based Intervention Package

While the intervention strategies within these treatment categories have been established by research for implementation with individuals with ASD, it is important to note that they are only effective when the goals of the treatment interventions are integrated and individualized. No single treatment is likely to effectively or efficiently address all the core deficit areas of ASD expressed by an individual. As such, an integrated therapeutic approach is considered best-practice, i.e., multiple evidence-based treatments are implemented and adjusted or discontinued as appropriate to address the specific needs of each individual (NAC, 2009).

Applied Behavior Analysis

The majority of intervention strategies categorized as *Established Treatments* are based in the principles of Applied Behavior Analysis (ABA). As indicated by the variety of intervention strategies in this report, ABA is not a single intervention. Rather, it is the science of systematically applying interventions based on learning theory in order to improve socially significant behaviors and demonstrate that the interventions employed are responsible for the improvement in behavior (Sulzer-Azaroff & Mayer, 1991).

Pharmacological Treatment

There are no medications that cure ASD, though certain medications may be useful in treating specific medical conditions (e.g., seizures or disturbed sleep) or associated behavioral symptoms (e.g., overactivity, aggression, or irritability) (CDC, 2012). Many medications prescribed for individuals with ASD are prescribed "off-label," or provided for symptoms other than those for which the medication is typically prescribed or approved. Evidence for efficacy and safety of some of these medications is often limited or research is conflicting. (McPheeters, 2011; Carasco, 2012).

However, two antipsychotic medications (risperidone and aripiprazole) have been approved by the Food and Drug Administration (FDA) for the treatment of irritability associated with ASD in children of certain ages. Irritable behaviors may include severe tantrums, aggression, self-injury, or quickly changing moods (FDA, 2012). If medications are utilized, they should be part of a comprehensive treatment plan that includes educational and behavioral interventions. All medications carry the risk of side effects (NIMH, 2012). Careful attention to potential adverse effects of medication should be maintained with the understanding that the risks as well as benefits of medication therapy must be considered for each individual.

For more information regarding the symptoms, course, assessment, and treatment for individuals with ASD, please see the resources listed below.

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TDMHSAS BEST PRACTICE GUIDELINES

Disruptive Behavior Disorders in Children and Adolescents

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Disruptive Behavior Disorders include Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Sometimes Attention-Deficit/Hyperactivity Disorder (ADHD) is included in this category, but ADHD is treated in a separate section within these guidelines.

Contributing Factors

Recent literature identifies several factors related to the development of disruptive behaviors. It is important to note that separate pathways for the development of disruptive behaviors and impulsive/hyperactive behaviors have been proposed, with little genetic evidence emerging as a causal factor for conduct problems, while genetic links to ADHD are quite abundant. Although not discounted as a factor for the development of disruptive, currently there is little evidence for a genetic basis for behavior problems. Genetic contributions to childhood aggression appear to be relatively small (Jacobson, Prescott, & Kendler, 2002) and psychobiological influences are at best inconclusive (Hinshaw & Lee, 2003). Instead, a large emphasis is placed on the multifaceted and transactional causal factors for disruptive behaviors (Coie & Dodge, 1998; Hinshaw & Lee, 2003). The literature concerning underlying factors for disruptive behaviors converges on environmental factors. Most importantly, high levels of parental psychopathology, poverty, poor family functioning, dysfunctional parent-child interactions, and child abuse are thought to play a role in the severity of disruptive behaviors in children (Coie & Dodge, 1998). Associated variables with disruptive behaviors include, but are not limited to, cognitive deficits (Moffit & Lynam, 1994), difficulties in social-cognitive information processing (Crick & Dodge, 1994), and peer rejection (Coie & Dodge, 1998).

Prevalence

Although the prevalence of conduct problems varies depending on the definition used, in a literature review conducted by Hinshaw and Lee (2003), the prevalence in studies of children and adolescents with ODD ranged from 1 percent to more than 20 percent, while the prevalence for CD ranged from less than 1 percent to over 10 percent. The progression of conduct problems appears to remain somewhat stable from early childhood to later childhood (Broidy, et al., 2003; Campbell, 1991; Olweus, 1979). Furthermore, studies have shown that ODD characteristics emerge 2 to 3 years earlier in childhood than do CD symptoms (Lahey et al., 1997; Loeber, et al., 1992; Loeber & Farrington, 2000), with the average age of onset for ODD being 6 years compared to 9 years for CD behaviors. Approximately 33 percent of children with ODD subsequently develop conduct disorder, 40 percent of whom will develop antisocial personality disorder in adulthood (Loeber, et al., 2000).

Developmental Trajectories

Despite some evidence that ODD is a developmental precursor to CD, a majority of children with ODD symptoms never develop the more severe conduct problems associated with CD (Loeber, Lahey, & Thomas, 1991). Specifically, about 67 percent of youth with ODD do not meet criteria for the diagnosis after a 3-year follow-up (AACAP, 2007). Adding evidence to this finding, Frick et al. (1993) conducted a meta-analysis of factor analyses of disruptive child behaviors, resulting in four clusters of conduct problems: oppositional, status violations, property violations, and aggression. The behaviors were categorized by the overlay of two continuums representing the dimensions of overt-covert behavior and destructive-nondestructive behavior. As the majority of ODD symptoms fell into the quadrant of overt-nondestructive behaviors, Hinshaw and Lee (2003) suggest that ODD appears to be a separate and coherent pattern of behaviors from other antisocial behaviors.

Concerning the developmental trajectories of conduct problems, the early starter and late starter pathways are becoming increasingly accepted (McMahon, 1994) and are reflected in the CD subtypes of Childhood-Onset and Adolescent-Onset in the *DSM-IV-TR* (APA, 2000). The early starter pathway is characterized by conduct problems and social skills deficits originating in school-age years with increasingly severe behaviors developing through adolescence and adulthood. This is evidenced by results from the Oregon Youth Study (OYS) longitudinal data demonstrating that antisocial behaviors by boys in grade 4 significantly predicted future delinquency (Patterson, Capaldi, & Bank, 1991). The early starter pathway is thought to consist of a relatively small group of children, mostly boys, who are at high risk for accelerated and chronic conduct problems and psychopathology (Moffit, 1993).

On the contrary the late starter pathway represents a larger group of children and is thought to begin in adolescence rather than childhood, consist of less serious conduct problems, be influenced by a deviant peer group, and have a short duration (Moffit, 1993; Patterson et al., 1991). The tendency for late starters is to experience a surge of antisocial behavior during adolescence; however, they are supposedly at less risk for chronic offending and continued conduct problems into adulthood, as they presumably possess higher levels of social skills. Further, this same research has demonstrated that late starters do not have the childhood history of cognitive deficits, learning difficulties, preexisting family adversity, or motor skill problems such as early starters exhibit (Patterson et al., 1991).

Conclusions regarding the viability of the early and late starter models, although gaining in popularity, are also challenged with competing models. Specifically, Loeber and Hay (1997) found evidence identifying three developmental pathways for conduct problems. These included the Overt Pathway with increasing levels of aggression, the Covert Pathway with concealed problem behaviors, and the Authority Conflict Pathway with oppositional and avoidance behaviors towards authority figures. Much like the early starter model, the overt pathway is thought to better describe children who experience a progressive escalation of conduct problems over time compared to those who are experiencing transitory or temporary ones. Thus, regardless of the model used to explain the progression of conduct problems, the prognosis appears to worsen with signs of early aggressive acts that are likely to predict more severe problems over time (Moffit, 1993; Serbin, Schwartzman, Moskowitz, & Ledginham, 1991).

Epidemiological Theories

Despite the contributing influences to the initial appearance of disruptive behaviors, their maintenance may depend on complex cognitive processes and environmental interactions. Two such well-researched mechanisms for continued behavior problems are social-information processing (Crick & Dodge, 1994; Lemerise & Arsenio, 2000) and coercive parent-child interactions (Patterson, 1982, 2002). The social information-processing model describes how cognitive distortions and deficiencies combine with emotional processes and social contexts to result in socially incompetent behavior for children. This pattern holds true for both peer relationships and responses to authority figures (Dodge & Price, 1994). In a coercive parent-child interaction, bi-directional exchanges between the parent and child become increasingly coercive and cyclical in nature, further intensifying the child’s disruptive behaviors and the parent’s inconsistent discipline practices. In addition to affecting family functioning, the coercive cycle also begins to generalize to the child’s interactions with peers and teachers (Patterson et al., 1992).

DSM-IV-TR Criteria for Disruptive Behavior Disorders

(American Psychiatric Association, 2000)

Oppositional Defiant Disorder (ODD)

- A pattern of negativistic, hostile, and defiant behavior that lasts at least 6 months and at least four of the following behaviors are present (Criterion A)*:
  1. often loses temper
  2. often argues with adults
  3. often actively defies or refuses to comply with adults' requests or rules
  4. often deliberately annoys people; often blames others for his or her mistakes or misbehavior
  5. is often touchy or easily annoyed by others
  6. is often angry and resentful
  7. is often spiteful or vindictive

*Behaviors (items 1-7 above) must occur more frequently than is typically observed in children with similar developmental level and of comparable age

- Behavior causes clinically significant impairment in social, academic, or occupational functioning (Criterion B)

- Behaviors do not occur exclusively during course of a Psychotic or Mood Disorder (Criterion C) and criteria for Conduct Disorder or (if older than 18 years) Antisocial Personality Disorder are not met (Criterion D).

Differential Diagnosis

- Mood disorder
- Conduct disorder
- ADHD
- Substance abuse
- Intellectual Disability
- Impaired language comprehension
- Psychotic disorder
- Severe delinquent behavior
- Normal individualization (i.e., in adolescence)
- Intellectual Disability (mild to moderate forms)

Comorbidity

- 36 percent of females and 46 percent of males with ODD met criteria for at least one other disorder (Oppositional Defiant & Conduct Disorders, 2005)
- 50-65 percent of ODD youth have an accompanying diagnosis of ADHD
- 35 percent develop some form of affective disorder
- 20 percent exhibit some form of mood disorder

Developmental Considerations. Typically, ODD is not diagnosed in children between the ages of 18-36 months when similar behaviors are considered normative for that age group (Rapoport & Ismond, 1996). For example, temper tantrums are one of the DSM-IV criteria for ODD. Yet, temper tantrums are common behaviors in children between the ages of 2 and 3 years. After age 3, children become more able to express their frustrations in socially acceptable ways (Hall & Hall, 2003). ODD is better diagnosed in late preschool or early school years (AACAP, 2007).

Conduct Disorder (CD)

- The DSM-IV-TR (APA, 2000) categorizes CD behaviors into four main groupings: (a) aggressive conduct that causes or threatens physical harm to other people or animals, (b) non-aggressive conduct that causes property loss or damage, (c) deceitfulness or theft, and (d) serious violations of rules. CD consists of a repetitive and persistent pattern of behaviors in which the basic rights of others or major age-appropriate norms or rules of society are violated. Typically the youth exhibits at least three of the following behaviors within the past 12 months, one or more of which occur in the past 6 months (Criterion A).

Aggression to people and animals

1. often bullies, intimidates, or threatens others
2. often initiates physical fights
3. has used a weapon that can cause serious physical harm to others (e.g., a gun, knife, broken bottle, bat, brick)
4. has been physically cruel to people
5. has been physically cruel to animals
6. has stolen while confronting a victim (e.g., extortion, mugging, purse snatching, armed robbery)
7. has forced someone into sexual activity

Destruction of property

1. has deliberately destroyed property of others (but not by fire setting)
2. has deliberately engaged in fire setting with the intention of causing serious damage

Deceitfulness or theft

1. has broken into someone else's car, house, or building
2. often lies to obtain favors or goods, or to avoid obligations (i.e., "cons" others)
3. has stolen items of nontrivial value without confronting a victim (e.g., forgery; shoplifting, but without breaking and entering)

Serious violations of rules

1. beginning before age 13, often stays out at night despite parental prohibitions
2. has run away from home overnight two or more times while living in home of parent or surrogate parent (or once without returning for a lengthy period)
3. beginning before age 13, is often truant from school

- The disturbance causes clinically significant impairment in academic, social, or occupational functioning (Criterion B)
- If the person is at least 18 years of age, criteria are not met for Antisocial Personality Disorder (Criterion C)
- CD is further indicated by age of onset as Childhood-Onset Type (onset of at least one characteristic of CD prior to age 10 years), Adolescent-Onset Type (absence of CD characteristics prior to age 10 years), or Unspecified Onset (age of onset unknown)
- CD is also specified by level of severity as being Mild (few conduct problems), Moderate (intermediate symptoms between “Mild” and “Severe”), and Severe (many conduct problems or conduct that causes considerable harm to others).

Differential Diagnosis

- Oppositional Defiant Disorder
- Mood Disorder
- ADHD
- Substance abuse
- Intellectual Disability
- Impaired language comprehension
- Psychotic disorder
- Severe delinquent behavior
- Normal individualization (i.e., in adolescence)

Comorbidity of Conduct Disorder.

- Comorbid ADHD is found in 25 percent of youth diagnosed with CD (Oppositional Defiant & Conduct Disorders, 2005)
- Children with ADHD are 2.5 times more likely to have early onset CD (Coghill, 2007)
- 39 percent of girls and 46 percent of boys with CD meet criteria for at least one other disorder
- An almost equivalent proportion of girls (12 percent) and boys (14 percent) with CD also have depression
- Girls diagnosed as CD are at greater risk of anxiety and depression
- More girls (16 percent) with CD have comorbid anxiety than boys (10 percent) (Child Research Net, 2004)

Disruptive Behavior Disorder Not Otherwise Specified (DBD NOS)

If conduct and oppositional defiant behaviors do not meet criteria for ODD or CD, a diagnosis of DBD NOS may be warranted. However, if the youth's behavior problems are subclinical to a diagnosis of ODD or CD, the behaviors must contribute to clinically significant impairment in the youth's functioning to constitute a diagnosis of DBD NOS. A diagnosis of DBD NOS should not be given if the symptom can be better accounted by a mood disorder, anxiety disorder, adjustment disorder, or ADHD.

Screening/Evaluation for Disruptive Behavior Disorders

AACAP Screening/Evaluation Recommendations

The AACAP (2007) delineated recommendations that address screening and/or evaluation for ODD and provided 11 recommendations for clinicians. Of the 11 AACAP recommendations, the first 6 recommendations focus solely on screening/evaluation, while the remaining 5 recommendations address treatment issues and are presented later in the treatment section. Although the AACAP recommendations are specific to ODD, they are based on a thorough review of the literature and clinical consensus regarding disruptive behaviors in general. Each recommendation falls into one of the following categories of endorsement: 1) **MS** – minimal standards; 2) **CG** – clinical guidelines; 3) **OP** – options; or 4) **NE** – not endorsed (AACAP, 2007).

- **MS**-designated recommendations are based on substantial empirical evidence (as obtained in well-controlled, double-blind trials) and expected to apply more than 95 percent of the time. The medical record should be well documented when the clinician does not adhere to standards of this nature in particular cases.
- Open trials and case studies typically provide evidence for **CG** standards. These standards tend to be applicable 75 percent of the time and there are typically exceptions to their application.
- **OP** standards might be considered, but are not required. For certain cases, they may offer the best treatment option, but there are times when these practices should be avoided altogether
- **NE** identifies that the practice is known to be ineffective or contraindicated.

- ***Recommendation 1***. *Therapeutic alliances with the child and his/her family must be established to ensure successful assessment and treatment of disruptive behavior disorders.* Alliances with the parents and the child need to be established separately. Clinicians must quickly clarify their role as “helper” to the child. The best way to engage the youth is to empathize with his/her anger and frustration while failing to sanction oppositional/aggressive behavior. Likewise, the clinician must convey empathy with the parents’ frustration without making them feel accused, judged, or that they have an ally. (**MS**)
- ***Recommendation 2***. *Active effort must be made to address cultural issues in the diagnosis and treatment of disruptive behavior disorders.* Different ethnic subgroups have different standards of obedience and parenting and these differences are can be overlooked if the clinician and client do not share the same backgrounds. Therefore, clinicians should make every effort to be sensitive to areas of mismatch and be prepared to be educated. This sensitivity is especially critical in disruptive behavior disorders because discipline becomes a core point of discussion in every case. (**MS**)
- ***Recommendation 3***. *Assessment of disruptive behavior disorders must include information obtained directly from the child, as well as from the parents/caregivers, regarding the core symptoms; age of onset; duration of symptoms; and degree of functional impairment.* It is important to distinguish ODD from typical oppositional behavior, transient antisocial acts, and CD. A functional behavioral analysis will assist in the identification of antecedents and consequences of the youth’s behavior, as well as behaviors of parents’ and others in the child’s life. The youth’s access to weapons and involvement in bullying should also be evaluated. In all cases, multiple settings, processes, and informants need to be considered for an exhaustive screening and/or evaluation. (**MS**)
- ***Recommendation 4***. *Clinicians should pay careful attention to significant comorbid psychiatric disorders when diagnosing and treating disruptive behavior disorders.* Comorbidity of disruptive behavior disorders and ADHD is common and results in a poor prognosis. Young people with both disorders tend to show more aggression, a wider range

and persistence of problem behaviors, greater rejection by peers, and more underachievement in academics than youth with disruptive behavior problems alone. Concurrent substance use should always be considered in youngsters with disruptive behavior disorders, but especially in teens and when interventions do not yield the expected response. (**MS**)

- ***Recommendation 5***. *Include information obtained independently from multiple outside sources.* External observations solidify the ongoing nature of the problem behavior. Clinicians need to be aware that parents and educators tend to agree more with each other on externalizing behaviors than with the youth. Children's self-reported behaviors are better predictors of stability after one year, especially when covert acts are involved. (**CG***)*
- ***Recommendation 6***. Use specific questionnaires and rating scales in evaluating children and/or adolescents for disruptive behavior disorders and in tracking progress. An array of tools has been developed to measure disruptive and other aggressive behaviors of children and adolescents for diagnostic and symptom tracking purposes. Most have good-to-excellent psychometric qualities (i.e., have exceptional validity and reliability for the intended purpose). Some tools offer abbreviated versions that can be completed quickly by the respondent. Nearly all tools are designed to evaluate oppositionality, hyperactivity, and impulsivity in young people of school age. (**OP**)

Clinical Interview

The interview with the youth should include family history, the patient's personal substance use and sexual history (including sexual abuse of others). DSM-IV target symptoms may not be apparent or acknowledged by the youth during the interview, but may be detected by interviewing parents and other informants. The interview with the youth should also include assessment of the youth's capacity for attachment, trust, and empathy; impulse tolerance and control; ability to accept responsibility for actions and experience guilt or remorse. Additionally, assessment of cognitive functioning, mood, suicidal potential, and substance use should occur. A urine or blood drug screen may be indicated, especially when clinical evidence suggests substance abuse that the patient denies. Self-report instruments might provide useful information (AACAP, 1997).

Evaluation of a youth to determine whether s/he meets criteria for a Disruptive Behavior Disorder diagnosis can be accomplished via thorough review of collateral information and a comprehensive clinical interview. The evaluator should interview both the youth and the parents to obtain history information about the youth. Comprehensive family assessment is an especially important part of the evaluation, particularly when the problems are not acknowledged by the youth, and should include information such as the family's coping style, resources, stressors, social support, parenting style, socioeconomic status, and family history of mental health and/or substance abuse problems. Additionally, interviews with other collateral sources (i.e. other family members, professionals) familiar with the patient and assessment of the youth's social functioning and peer relationship, as well as standardized assessments using caregiver and teacher informants, are indicated. History-taking should also include the patient's prenatal and birth history, including substance abuse by the mother, maternal infections, and medications. Developmental history should include problems with attachment, temperament, aggression, oppositional behavior, attention, and impulse control. Assessment of physical and sexual abuse, both as a victim and perpetrator, should occur (AACAP, 1997).

Tables 1 and 2 include evidence-based questions for assessing the likelihood of meeting DSM-IV-TR criteria for a Disruptive Behavior Disorder.

Table 1: Caregiver Interview Questions to Assess Oppositional Defiant Disorder (Angold & Costello, 1996)

1. Has your child in the past 3 months been spiteful or vindictive, or blamed others for his or her own mistakes? *(Any "yes" is a positive response.)*
2. How often is your child touchy or easily annoyed, and how often has your child lost his/her temper, argued with adults, or defied or refused adults' requests? *(Two more times weekly is a positive response.)*
3. How often has your child been angry and resentful or deliberately annoying to others? *(Four or more times weekly is a positive response.)*

Note: A positive response for all three is 91% specific for meeting DSM-IV criteria on full interview. Any negative response is 94% sensitive for ruling out oppositional defiant disorder.

Table 2. Youth Interview Questions to Assess Conduct Disorder (Searight, Rottnek, & Abby, 2001)

1. Have you had any run-ins with the police? If yes, what were the circumstances?
2. Have you been in physical fights? If yes, what were the circumstances? How many?
3. Have you been suspended or expelled from school? If yes, what were the circumstances?
4. Have you ever run away from home? Overnight? How many times?
5. Do you smoke, drink alcohol or use other drugs? If yes, what is the frequency and duration of your use? Which drugs?*
6. Are you sexually active?*

*Age should be taken into account for Questions 5 & 6.

Note: If the child is 10 to 14 years of age, cigarette smoking, sexual activity, and alcohol or drug use can serve as "red flags" for conduct problems (Searight, Rottnek, & Abby, 2001).

Standardized Assessments

Central to every clinical assessment utilizing psychological instruments is the process of test selection, administration, and interpretation. Although professional ethical guidelines speak directly to these issues, readers are nonetheless strongly encouraged to review the manuals of the instruments in the next paragraph to ensure that the instrument has been normed on similar populations to the youth being assessed, the instrument has been subject to peer review, administration procedures are followed, and the limitations of conclusions that have been drawn are identified.

Although time consuming, a clinician may wish to use the **NIMH Diagnostic Interview Schedule for Children Version IV** (**DISC-IV**; Shaffer, et al., 2000) to arrive at a DSM diagnosis. Additionally, several standardized instruments provide general information on a broad range of characteristics for children and adolescents. A sample of commonly used evidence-based assessments is as follows:

Screeners (parent informant, unless otherwise specified)

- **Brief Infant-Toddler Social and Emotional Assessment (BITSEA) –** (Briggs-Gowan & Carter, 2006): Identifies social-emotional and behavioral problems/delays, and social-emotional competence deficits in children ages 12-35 months. Also available in a more comprehensive version (ITSEA; Carter & Briggs-Gowan, 2005).
- **NICHQ Vanderbilt Assessment Scale** – (National Initiative for Children's Healthcare Quality, 2002): Although primarily used to screen for ADHD symptoms in children ages 6-12 years old, it also includes screening items for symptoms of oppositional-defiance and conduct problems for school-age children. Parent and teacher ratings should be considered in the context of age-appropriate behaviors.
- **Pediatric Symptom Checklist (PSC) –** (Jellinek, Murphy, et al., 1988): Screens for cognitive, emotional, and behavioral problems to inform appropriate early interventions for children ages 4-16 years. A Youth-Self Report (Y-PSC) is available for adolescents ages 11 years and older.

Broadband Sociobehavioral Assessments (parent informant, unless otherwise specified)

- **Behavior Assessment System for Children, Second Edition (BASC-2) –** (Reynolds & Kamphaus, 2004): Evaluates the multidimensional aspects of behavior, adaptive functioning, and self-perceptions of children and young adults age 2-25 years. Additionally, teacher and self-report rating scales are available, as well as a Structured Developmental History (SDH) and Student Observation System (SOS).
- **Child Behavior Checklist (CBCL) –** (Achenbach & Rescorla, 2000, 2001): Measures diverse aspects of behavioral, emotional, and social functioning in children ages 1.5-5 years (Preschool Form) and ages 6-18 (School-Age Form). Also available are teacher and self-report questionnaires for some ages, as well as a semi-structured clinical interview for children and adolescents (McConaughy & Achenbach, 2001).
- **Child and Adolescent Functional Assessment Scale (CAFAS)** – (Hodges, 2000a, 2000b): Assesses the degree of impairment in youth ages 7-17 years with emotional, behavioral, psychiatric, or substance use problems. It is frequently used for youth who access services across the System of Care (mental health, child welfare and social services, youth & adolescent justice, education, prevention, and community-based programs).
- **Conners 3rd Edition (Conners 3)** – (Conners, 2008): Assesses cognitive, behavioral, and emotional problems in children ages 6-18 years, with a focus on ADHD and comordbid disorders, such as ODD and CD. Includes additional teacher and self-report

questionnaires. Also available for children ages 2-6 years (Conners Early Childhood; Conners, 2009).
- **Eyberg Child Behavior Inventory (ECBI) and Sutter-Eyberg Student Behavior Inventory – Revised (SESBI-R)** – (Eyberg & Pincus, 1999): Measures the frequency and intensity of conduct problems in children ages 2-16 years. The ECBI is the parent informant form, while the SESBI-R is the teacher informant form.

Personality Assessments (self-report informant)

- **Adolescent Psychopathology Scale (APS)** – (Reynolds, 1998): Assesses psychopathology, personality, and social-emotional problems in youth ages 12-19 years.
- **Jesness Inventory – Revised (JI-R)** – (Jesness, 1996): Measures personality and psychopathology in children and adolescents age 8 and older with more severe behavioral problems, including those with potentially violent behaviors. It differentiates between social maladjustment and emotional disturbance.
- **Millon Adolescent Clinical Inventory (MACI)** – (Millon, Millon, Davis, & Grossman, 2006): Assesses personality patterns as well as self-reported concerns and clinical symptomsfor ages 13-19 years.
- **Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)** – (Butcher, et al., 1992): Aids in the assessment of a wide range of clinical conditions for children between the ages of 14-18 years with a minimum reading level of 4.4 grade.

Assessing for Cognitive and Academic Deficits

Evaluation of learning disorders and academic functioning is an important component in the assessment of children with Disruptive Behavior Disorders. Although the exact percentage is lacking, a significant number of children with disruptive behavior disorders have learning problems, especially in the area of verbal skills. Difficulties in reading and language may contribute to academic difficulties, especially in more advanced grades when so much depends on understanding and using the written word. Language deficits may also contribute to an inability to articulate feelings and attitudes, resulting in a child resorting to physical expression in lieu of verbal expression. Additionally, unrecognized and untreated learning disabilities and cognitive deficits create deep frustration for a child, which can lead to school avoidance/truancy. Moreover, for some children, delinquent behavior, however unlawful or unacceptable, may provide them with both the status among their peers and the opportunity for some reinforcement that they are unable to find at school (AACAP, 2010).

Treatment of Disruptive Behavior Disorders

AACAP Treatment Recommendations

- ***Recommendation 7****. Clinicians should develop individualized treatment plans based on the specifics surrounding each case.* In the case of Disruptive Behavior Disorders, interventions should target the behaviors that have been evaluated as dysfunctional. Because of comorbidity and multiple dysfunctions, effective treatment is often multitarget, multimodal, and extensive, combining individual therapy, family therapy, pharmacotherapy, and ecological interventions (like placement and interventions designed for the school setting). (**MS***)*

- ***Recommendation 8****. Parent interventions recommended by the clinician should conform to evidence-based practice (EBP).* Parent management training techniques are the most empirically supported programs for school-age youth. The principles underlying these approaches are: 1) reduce positive reinforcement of disruptive behavior; 2) increase reinforcement of prosocial and compliant behavior; 3) apply consequences and/or punishment for disruptive behavior, where punishment typically takes the form of time out, loss of tokens, and/or loss of privileges; and 4) make the response of parents predictable, contingent, and immediate. (**MS**)
- ***Recommendation 9****. Pharmacotherapy may be helpful as an adjunct to treatment, for symptomatic treatment, or to treat comorbid disorders.* When considering a medication trial, ensure that strong treatment alliances have been established first. Medications are often used in treatment when the Disruptive Behavior Disorders co-occur with some other disorder like ADHD. (**CG**)
- ***Recommendation 10****. Depending on the severity, persistence, or unusualness of the disruptive behavior, intensive and prolonged treatment may be necessary.* Occasionally ODD cases will reach the subthreshold level for CD. These are cases in which youth have failed to demonstrate progress under the current treatment regimen. Hence, increased levels of care such as day treatment, residential, or hospitalization may be warranted, with an emphasis on the least restrictive setting for the shortest possible interval. Risks and benefits of placement in structured settings should be weighed carefully because gains typically do not continue when the youth returns to family and the community. (**CG**)
- ***Recommendation 11****. Certain kinds of interventions will not work, for example, one-time, time-limited, short-term interventions or inoculation approaches (i.e., boot camps, shock incarceration).* Such approaches are ineffective at best, and sometimes become injurious for the youth. Shock strategies, in particular, tend to result in heightened fear and/or aggression. (**CG**) – (AACAP, 2007)

General Treatment Issues

Critical to the application of any treatment modality is sensitivity to individual and group differences. As the field of mental health assessment and treatment advances, individual characteristics and histories will likely play an increasing role in diagnoses and in the selection of treatment modalities. Currently, the DSM-IV-TR emphasizes the need for practitioners to consider cultural variables prior to making a diagnosis. Illustratively, a child from an impoverished or war-torn area who may have needed to engage in antisocial practices for survival (e.g., stealing food) would not necessarily be appropriate for a CD diagnosis based on that behavior. Regarding treatment, gender specific interventions will likely continue to experience growth, and mental health practitioners are strongly encouraged to stay abreast of developments (e.g., Weis, Whitemarsh, & Wilson, 2005).

Psychosocial/Psychotherapy

Evidence-based practice (EBP) points to therapy as the first-line and usual treatment for Disruptive Behavior Disorders (AACAP, 2007; Eyberg, Nelson, & Boggs, 2008; SAMHSA, 2011a, 2011b). Garland and colleagues (2008) identified 21 common core elements that contribute to the success of evidence-based parent training and individual youth skills training treatments for children with disruptive behavior problems. In terms of therapeutic content, effective behavior problem treatments incorporate teaching behavioral principles of positive reinforcement and punishment, building the parent-child relationship, using problem-solving skills, developing anger management skills, and providing affect education. Likewise, effective techniques used by therapists when working with children with disruptive behavior problems and their caregivers include implementing behavioral principals, teaching through didactic instruction, assigning and reviewing homework, roleplaying or engaging in behavioral rehearsal, modeling, providing psychoeducational materials, and reviewing goals and progress.

For mild to moderate disruptive behaviors, often the therapy is behavioral and may be implemented through parent training to address coercive parent-child interaction patterns. Recent research also confirms the effectiveness of parent training conducted in a group setting, compared to family therapy involving the parent and the child (MentalHealth.net, 2006). Cognitive-behavioral therapy is typically the individual psychotherapy that is used to help the children/adolescents decrease their negativity and oppositional behaviors, while improving their social-information processing skills (Behavior Guide Staff, 2006). Additionally, while a review of the literature provides support for both parent-training and child-training EBPs for youth with disruptive behavior, clinicians are recommended to consider parent training as the first line of approach for young children and reserve direct child-training approaches for older youth who presumably have greater capacity to benefit from the cognitive-behavioral approaches of child training programs (Eyberg, Nelson, & Boggs, 2008).

For more significant conduct problems, a multidisciplinary and multimodal approach to treatment is highly recommended. CD typically develops due to an interaction and gradual accumulation of risk factors, and there are a number of interactive risk and protective factors that can influence outcomes. Assessment of these factors is important not only in diagnosing CD, but in guiding treatment interventions. Overall, the greater the number of risk factors and earlier they appear, the higher the risk for serious conduct problems (Offord & Kraemer, 2000). In general, treatment is not brief since establishing new attitudes and behavior patterns takes time. Early treatment is recommended in order to increase treatment efficacy and long-term outcomes (AACAP, 2012).

Categorizing EBPs

To determine how much evidence exists to support a particular treatment, the Hawaii Department of Health, Child and Adolescent Mental Health Division (2004) combines criteria used by the American Psychological Association along with a broader range of evidence. This results in five categories for EBPs: 1) best support, 2) good support, 3) moderate support, 4) minimal support, and 5) known risks. To achieve the level of best support, a treatment must be supported by at least two studies (conducted by two independent teams of investigators) showing the treatment to be superior to a placebo or another treatment, or equivalent to an already established treatment. The research must also clearly specify the client sample and the treatment protocol using a manual. A treatment with a good level of support must have at least one study as outlined above, or two studies showing the treatment as superior to a waitlist control group. Moderate support is established by one research study as indicated for best support sans a treatment manual.

Best Support

Parent Management Training – Oregon (PMTO). PMTO (Patterson, Reid, Jones, & Cogner, 1975) is a well-established behavioral parent training program based on social learning theory that teaches caregivers basic behavioral principles to reward positive behavior while setting limits with consequences. It typically is implemented in 20 sessions over the course of 13 months in both the clinic and home settings. It has five essential components: skill encouragement, discipline, monitoring, problem-solving skills, and positive involvement. Outcome studies have indicated decreasing significant reductions in child behavior problems, coinciding with positive effects in reducing coercive parenting and increasing effective parenting (Bernal, Klinnert, & Schultz, 1980; Patterson, Chamberlain, & Reid, 1982). The treatment targets children ages 4-12 and its effectiveness has been evaluated mostly with populations of White children and parents, although a culturally-sensitive adaptation of PMTO has also been evaluated (SAMHSA, 2011).

Mulitsystemic Therapy (MST). MST (Henggeler & Lee, 2003) is a home-based approach that is the most effective treatment for CD to date. It incorporates techniques that foster these youth to "detach" from their deviant peers while simultaneously building stronger bonds to family and school. In addition, it enhances family management skills such as discipline and monitoring. MST is an evidence-based practice program and listed among the model programs for CD (SAMHSA, 2011a). Researchers evaluating MST delineate the following criteria for successful outcomes: 1) adequate supervision; 2) training of therapists; and 3) institutional program support studies (Hoagwood, Burns, Kiser, Ringelsen, & Schoenwald, 2001). Juvenile offenders demonstrated lower recidivism rates after more than a year of treatment and a decrease in arrest rates following more than 2 years of treatment with MST. Lower rates of psychiatric hospitalization and improved youth and family functioning were observed in other studies (Hoagwood et al., 2001).

Good Support

Brief Strategic Family Therapy (BSTF). BSFT (Robbins & Szapocznik, 1999) is a structured, problem-focused, directive treatment approach for conduct problems, associations with antisocial peers, early drug use and the accompanying maladaptive family interactions (relations), and other recognized youth risk factors. BSFT is designed to target both the problem behaviors of the youth as well as family functioning. BSFT addresses family behavior, affect, and cognitions in order to restructure interactions and change systems. BSFT strategies and treatment plans are designed specifically for each family and are based on a structured diagnostic plan. BSFT has demonstrated effectiveness for children & adolescents ages 6-18 in decreasing substance abuse, improving engagement in therapy, decreasing problematic behavior, increasing family functioning, and decreasing socialized aggression and conduct disorder (SAMSHA, 2011).

Coping Power Program (CPP). CPP (Lochman, Barry, & Pardini, 2003) is a school-based, multicomponent cognitive-behavioral intervention delivered to aggressive children and their parents during the children's transition from elementary to middle school (Office of Juvenile Justice and Delinquency Prevention, 2011). It targets children between the ages of 9-11 and its effectiveness has been studied with White and African American children, although some research was conducted with children in the Netherlands (SAMHSA, 2011). The program aims to increase competence, study skills, social skills, and self-control in aggressive children as well as improving parental involvement in their child's education. The child component of CPP consists of 34 group sessions and periodic individual sessions that lasts approximately 15-18 months, although an abbreviated version that is implemented across one school year is also available. The child curriculum focuses on anger management, problem-solving skills, attributions, and peer pressure. The parent component is administered over 16 sessions and emphasizes parenting skills on rule-setting, appropriate punishment, stress management, and family communication, as well as stress-management skills. Outcome studies report decreases in substance abuse, improvement in social skills, and a less aggressive belief system (SAMHSA, 2011a).

Functional Family Therapy (FTT). FTT (Alexander & Parsons, 1973) is a family therapy intervention for the treatment of delinquent, violent, behavioral, academic, and conduct problems with youth and families. FFT targets the family system as the entry point for systematic and individualized treatment. The FFT service delivery system consists of an integrated set of guiding theoretical principles, a systematic clinical intervention program, and well-developed, multi-domain clinical assessment and intervention techniques. FFT also has a systematic training and supervision system for therapists, implementation protocols, and a systematic quality improvement system. FFT has demonstrated effectiveness for children ages 11-18 in reducing recidivism and out-of-home placements and improving family communication style, family concept, and family interaction (SAMSHA, 2011).

Incredible Years (IY). IY (Webster-Stratton & Reid, 2003) is group intervention for children ages 2-12 with aggressive behaviors. It is intended to improve social competence at home and school through a series of Child Training, Parent Training, and Teacher Training groups. The IY curriculum is distinguished from other parent training and social problem-solving training methods by its use of videotaped vignettes. The Child Training focuses on children problem-solving conflicts at home and school while encouraging the development of social skills. With a duration of 20-26 weeks, the Parent Training component emphasizes social learning and child development principles as caregivers are taught child-directed interactive play skills and behavioral management techniques. IY uniquely addresses social and emotional coaching, bridging communication between home and school, and developing coping skills for caregivers to better manage their own interpersonal issues. The Teacher Training occurs in a 6-day workshop for teachers and counselors that addresses managing difficult child behaviors in the school setting and promoting positive peer relationships by building social skills. Outcome research shows increases in parent limit-setting, nurturing, and supportive parenting, improvements in teachers' use of praise, and decreases in conduct problems at home and school (Webster-Stratton, Reid, & Hammond, 2001, 2004). IY has been used with White, African American, Hispanic, and other multiethnic groups (SAMHSA, 2011).

Multidimensional Treatment Foster Care (MTFC). MTFC (Chamberlain & Smith, 2003) is a community-based program for youth with chronic and severe delinquent behavior. It has also been adapted to preschoolers (MTFC-P) to meet the developmental needs of children who exhibit early aggressive or externalizing behavior. In combination, the MTFC intervention spans the ages of 3-18. It is delivered by therapeutic foster families who receive 20 hours of preservice training on a specific token reinforcement system and who provide intensive treatment to youth in their care for a 6-9 month placement. Foster care providers attend weekly meetings and maintain daily contact with a MTFC-trained case manager. The youth also meets at least weekly with an individual therapist to address anger management, problem-solving, and educational/vocational planning. Additionally, the youth works with a behavioral support specialist for 2-6 hours weekly to enhance prosocial skills during one-on-one interactions in the community. Youth also receive periodic medication management appointments with a psychiatrist. MTFC aims for the youth to sustain contact with their biological family and for the biological family to receive intensive parent management training services while the child is in placement to improve reunification efforts and aftercare adjustment. Research indicates fewer runaways, decrease in arrest rates, decrease in violent activity involvement or incarceration after completing the program, and fewer permanent placement failures (Chamberlain & Reid, 1998; Leve, Chamberlain, & Reid, 2005). The treatment has been shown effective with White children, while African American, Hispanic, and American Indian children have been represented in smaller numbers in available research studies (SAMHSA, 2011).

Parent-Child Interaction Therapy (PCIT). PCIT (Eyberg & Funderburk, 2011) is a behavioral family-oriented therapy for children ages 2-6. It integrates concepts from social learning theory, traditional play therapy, and attachment theory to enhance the parent-child relationship, increase children's prosocial behaviors, and increase parents' behavior management skills. The program is implemented in two phases: The first phase is the Child-Directed Interaction (CDI) phase during which caregivers develop child-centered interaction skills. The second phase is the Parent-Directed Interaction (PDI) phase during which effective discipline skills are the focus. A critical goal of PCIT is to increase positive, nurturing interactions by including the child and caregiver in treatment, both in session and during daily homework assignments. In contrast to traditional approaches to parent training that focus on discussion and role play of techniques, caregivers in PCIT rehearse skills weekly in session through live interactions with their children. Further, during parent-child interactions, immediate feedback is given by the therapist from an observation room, while the parent wears a radio frequency earphone. Outcome studies show improvements in parent-child interaction style and child behavior problems (Nixon, Sweeney, Erickson, & Touyz, 2003; Schuhmann, et al., 1998). Regarding cultural differences, PCIT has been studied with White and African American families, as well as adapted for use with Puerto Rican and Mexican American families (SAMHSA, 2011).

Problem-Solving Skills Training (PSST). PSST (Kazdin, 2003) is a behavioral treatment designed for children ages 7 to 13 years with disruptive behavior. In PSST, children are taught problem-solving strategies and are encouraged to generalize these strategies to real-life problems. Skills include identifying the problem, generating solutions, making a decision, and evaluating the outcome. Therapists use in-session practice, modeling, roleplaying, corrective feedback, social reinforcement, and token response-cost to gradually develop problem-solving skills (Eyberg, Nelson, & Boggs, 2008).

Moderate Support.

Helping the Noncompliant Child (HNC). HNC (Forehand & McMahon, 2005) targets children between the ages of 3 and 8 who exhibit noncompliant behavior. The caregiver and child are typically seen twice a week for 10 weeks of conjoint sessions concentrated on differential attention and compliance training. The therapist provides caregivers feedback through modeling, roleplays, and in-vivo exercises at home and in the clinic setting. Positive treatment outcomes include increased parenting skills and improvement in child behavior and compliance (Wells & Egan, 1988).

Mentoring. Mentoring programs (Jekielek, Moore, Hair, & Scarupa, 2002) involve use of trained adults who serve to provide positive role modeling and leadership for youth. Mentoring programs vary in terms of specific training, length of services, and other programming, but generally have no cost for youth served. Mentoring programs, such as Big Brothers Big Sisters of America, have some effectiveness for youth ages 6-18 in increasing confidence in school performance, improving family relationships, and increasing prosocial behaviors (SAMSHA 2011).

Rational Emotive Behavior Therapy (REBT). REBT (Ellis & MacLaren, 2007) is a cognitive-behavioral, short-term treatment (10-20 sessions) and is designed to improve the moral reasoning and judgment skills of youth with conduct disorder. REBT focuses on cognitive restructuring through use of techniques which challenge the youth’s thinking and irrational beliefs, while promoting rational self-talk and various strategies to achieve these goals. Some strategies include disputing irrational beliefs, reframing, problem solving, behavior reversals, roleplaying, and modeling. Research has found that children and adolescents who received REBT demonstrate fewer disruptive behaviors and higher school achievement as compared to adolescents who received client-centered therapy or no treatment (FFTA, 2008).

Group Therapies for Disruptive Behavior Disorders

Group treatment seems to be effective when youth diagnosed with disruptive behaviors are younger. Some of the most effective treatments involve a group parent management training for the parents/caregivers in conjunction with group social skills training for the children. Group treatments involving adolescents, on the other hand, tend to worsen their behavior, especially if the group discussions focus on oppositional and illegal behaviors (Bernstein, 2012).

Pharmacotherapy

Medications should NOT be prescribed as first-line treatment for children and adolescents with ODD UNLESS the child or adolescent has a comorbid condition that is better treated through pharmacology. For example, a youth with ODD may additionally be diagnosed with ADHD. Stimulant medication may be prescribed for ADHD, as an adjunct to parent/family education and training for ODD (Oppositional Defiant & Conduct Disorders, 2005). As with a diagnosis of ODD, medications should NOT be the sole treatment for youth with CD. ***At most, medications should be adjunct to behavioral interventions for CD***. Pharmacological therapy is recommended only in cases of comorbid disorders, particularly ADHD because it has the most frequent connection to CD (Bernstein, 2012). Research does not indicate a single effective pharmacological treatment for CD. In comorbid situations, the other disorder should be treated first (Oppositional Defiant & Conduct Disorders, 2005).

Although the evidence for using medications to treat Disruptive Behavior Disorders continues to expand, the evidence used to prescribe medications for these youth is not as robust as it is for psychosocial interventions. Much research remains to be completed before the multifaceted aspects of disruptive behaviors can be fully addressed (SAMHSA, 2011b). Recently, however, the *Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth* (TRAAY; Jensen, MacIntyre, & Pappadopulos, 2004) compiled available evidence and expert consensus to develop pharmacological treatment guidelines that address aggressive behaviors, one symptom associated with Disruptive Behavior Disorders.

TRAAY (2004) emphasizes conducting a thorough initial diagnostic evaluation and determining whether the aggressive behaviors are acute or chronic in nature. For acute aggressive behaviors, it is recommended to use crisis management techniques before consideration of medication or emergency treatment. For chronic aggression, TRAAY clearly indicates beginning with psychosocial and educational interventions and assessing treatment effects prior to instituting medication management of symptoms. If pharmacological treatment is deemed appropriate, primary disorders (such as ADHD) should be treated before a first-line atypical antipsychotic is prescribed for aggression. TRAAY (2004) indicates to “start low, go slow, taper slowly” in terms of dosage, while routinely assessing for side effects and drug interactions. Physicians are cautioned to ensure an adequate trial of the medication and avoid using four or more medications simultaneously. If aggressive symptoms persist, then a different first-line atypical antipsychotic could be used or the medication regimen could be augmented with a mood stabilizer. If the aggressive symptoms respond to a first-line atypical antipsychotic by going into remission for a period of 6 months or longer, then the medication can be tapered or discontinued.

(***In the event of comorbid ADHD,*** please refer to the Table of Typically Prescribed Medications in the section on Attention Deficit Disorders for recommended medications and maximum dosages.)

Prevention of Disruptive Behavior Disorders

As for most disorders, early intervention is the most effective way to prevent disruptive behavior disorders in children. Prevention programs typically employ multi-level interventions across the home, school, and clinic environments. Several evidence-based prevention programs exist, including:

- Adolescent Transitions Program (Dishion & Kavanagh, 2003)
- Early Risers: Skills for Success (August, Realmuto, Hektner, & Bloomquist, 2001)
- First Steps to Success (Walker, Golly, McLane, & Kimmich, 2005)
- Project ACHIEVE (Knoff & Batsche, 1995)
- Promoting Alternative Thinking Strategies (PATHS; Greenberg, Kusché, & Mihalic, 1998)
- Second Step (Committee for Children, 2012)
- Triple P – Positive Parenting Program (Sanders, Markie-Dadds, & Turner, 2003)

Other prevention strategies involve the clinician in consultation with primary care physicians (PCPs), teachers, and other professionals. Parent management strategies that contain psychoeducational packages (including social skills and various cognitive interventions) have also shown promise for school-age children that are at risk for the disorder (AACAP, 2007). Further, home visitation strategies have produced very positive outcomes in areas related to ODD in preschool children when employed as a preventive intervention. Typically, nurses functioned as the home visitor (Olds, et al., 2007).

Self-Help Resources

Tips for Parents

AACAP additionally offers simple, inexpensive ways parents can help their child with Disruptive Behavior Disorders, as shown in Table 3.

Table 3: Tips for Parents of Children with Disruptive Behavior Disorders (AACAP, 1999)

- Build on the positive. Find ways to praise your child and provide positive reinforcement.
- Be a good model for your child. If you may make the conflict worse, TAKE A BREAK!
- Choose your battles wisely.
- Prioritize things you want your child to do.
- Set reasonable, age appropriate limits with consequences that can be easily and consistently enforced.
- Seek and obtain support from other adults, especially those that also interact with your child, like your spouse, teachers, and coaches.
- Always manage your own stress.

Bibliotherapy for Disruptive Behavior Disorders

Parenting Books for Preschool through School-Age Children.

- *Families: Applications of Social Learning to Family Life (Revised)*, by Gerald R. Patterson (1975).
- *Living with Children: New Methods for Parents and Teachers (Revised)* , by Gerald R. Patterson (1977).
- *The Incredible Years: A Trouble-Shooting Guide for Parents of Children Aged 2-8 years,* by Carolyn Webster-Stratton (2006).
- *The Kazdin Method for Raising the Defiant Child,* by Alan E. Kazdin (2009).
- *Parenting the Strong-Willed Child: The Clinically Proven Five-Week Program for Parents of Two- to Six-Year-Olds*, by Rex Forehand & Nicholas Long (2002).
- *Raising an Emotionally Intelligent Child*, by John Gottman, Joan Declaire, and Daniel Goleman (1998).
- *Survival Guide for Preschool Parents: How to Manage Challenging Behavior,* edited by Jerry Heston & Melissa L. Hoffmann (2007).
- *Your Defiant Child: Eight Steps to Better Behavior*, by Russell A. Barkley & Christine M. Benton (1998).

Parenting Books for Adolescents.

- *Parents and Adolescents Living Together: Part 1, The Basics (2nd Edition)*, by Gerald R. Patterson & Marion S. Forgatch (2005).
- *Parents and Adolescents Living Together: Part 2, Family Problem Solving (2nd Edition)*, by Marion S. Forgatch & Gerald R. Patterson (2005).
- *Your Defiant Teen: 10 Steps to Resolve Conflict and Rebuild Your Relationship* by Russell A. Barkley and Arthur L. Robin (2008).

Clinician Resources.

- *Helping the Noncompliant Child, Second Edition: Family-Based Treatment for Oppositional Behavior* by Robert J. McMahon and Rex L. Forehand (2005).

- *Defiant Children, Second Edition: A Clinician's Manual for Assessment and Parent Training by* Russell A. Barkley (1997).

- *Defiant Teens: A Clinician's Manual for Assessment and Family Intervention* by Russell A. Barkley, Gwenyth H. Edwards, and Arthur L. Robin (1999).

- *Parent Management Training: Treatment for Oppositional, Aggressive, and Antisocial Behavior in Children and Adolescents*, by Alan E. Kazdin (2008).

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TDMHSAS BEST PRACTICE GUIDELINES

Disturbances/Disorders of Attachment in Children and Adolescents

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1. Introduction

In the normal course of events children become appropriately attached to their caregivers. From birth to three months of age infants have only a limited ability to discriminate among attachment figures, however by three to six months of age, infants smile socially and carry on conversations with their attachment figures consisting of cooing and intense looking with mutual eye contact. Usually, by eight to nine months of age infants express clear preferences for important attachment figures. From the end of the first year until approximately three years of age, children insist on maintaining close proximity with their caregivers. They use their important attachment figures as a **secure base** from which they can explore the world and a **safe haven** to which they can return when distressed, fearful, hungry, or tired. After three years of age, children use communication and their interactions with caring, sensitive caregivers to develop a keen sense of self and an important sense of being cared for. This allows children to become confident that they are worthy of attention and affection, laying the groundwork for positive future relationships. Secure attachment is seen as a protective factor for healthy development generally.

There are individual differences in how children develop attachment. Ainsworth and colleagues (1978) developed the Strange Situation Procedure (SSP) which has developed into the gold standard for the assessment of infant attachment, delineating how children differ. In this procedure, the child's behavior is rated during periods with the caregiver, with a stranger, alone, and upon reunification with the caregiver. During this mildly stressful situation, the assessment focuses on the child's attempts to seek contact with the caregiver, the physical proximity of the child to the caregiver, the child's resistance to or avoidance of the caregiver, and the child's level of distress. From these observations a child's attachment behavior is given a classification rating. Children with **secure attachment** use caregivers as a secure base and return quickly to them after they have been separated. Children who can be classified as having **insecure-avoidant attachment** relationships are oblivious to a caregiver's presence and may not seek proximity nor greet the caregiver upon her return after separation. These caregivers are often rejecting in their general style of providing care. Children who are classified as **insecure-resistant attachment** seem preoccupied with their caregivers but they are not comforted by the caregivers' return after separation. They may rush to the caregiver yet quickly struggle to get away remaining distressed and angry. These caregivers are often inconsistent when providing care for their children. Children with **disorganized and disoriented attachment** relationships lack a coherent way of dealing with stressful events. They may be calm one minute and angry the next. They may begin to approach the caregiver and then dart away or freeze in apprehension. In some cases, these children may show fear of the caregiver. These caregivers are often abusive and neglectful. These children have notable behavioral/psychiatric problems. Disorganized attachment is seen as a risk factor for poor development generally.

Reactive Attachment Disorder (RAD) is a disturbance in the attachment relationship between a child and the caregiver and describes a constellation of aberrant attachment and other social behavioral abnormalities. This disturbance directly results from pathogenic care which is characterized by persistent neglect, persistent disregard of the child's basic needs, repeated changes of primary caregivers that prevent formation of stable attachments, or rearing in institutions where child/caregiver ratios limit opportunities for selective attachments (American Psychiatric Association, 2000; World Health Organization, 1992). An attachment disorder is warranted when a child who is *developmentally capable* of forming attachments, with a minimum cognitive age of 9 months, does not because of an aberrant caregiving environment.

Common features of RAD found across the DSM-IV-TR and the ICD-10 diagnostic manuals include: 1) aberrant social behavior that is cross contextual, 2) pathogenic care, and 3) two clinical subtypes -- indiscriminately social (e.g., they may show excessive familiarity with relative strangers or show a lack of selectivity in their attachment choices and emotionally withdrawn (e.g., persistent failure in their ability to initiate or respond to most social interactions). ICD-10 divides the subtypes into two distinct disorders, Reactive Attachment Disorder of Childhood (RAD), describing the withdrawn subtype, and Disinhibited Attachment Disorder of Childhood (DAD), describing the disinhibited subtype.

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2. *Diagnostic Criteria and Diagnostic Issues*

Formal Diagnostic Criteria for Reactive Attachment Disorder of Infancy or Early Childhood from the Diagnostic and Statistical Manual -4th edition-text revision (DSM-IV-TR; APA, 2000):

A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before 5 years of age, as evidenced by (1) or (2):

(1) Persistent failure to initiate or to respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to the caregiver with a mixture of approach, avoidance, and resistance to comforting or may exhibit frozen watchfulness).

(2) Diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures).

B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet criteria for a Pervasive Developmental Disorder.

C. Pathogenic care as evidenced by at least one of the following:

(1) Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection.

(2) Persistent disregard of the child's basic physical needs.

(3) Repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care).

D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Specify type:

Inhibited type: if Criterion A1 predominates in the clinical presentation.

Disinhibited type: if Criterion A2 predominates in the clinical presentation.

Proposed Criteria for DSM-5

RAD has been more systematically researched in the past 10 years compared to the 20 years after its original description in the DSM-III (APA, 1980). In a provocative paper Zeanah & Gleason (2010) provide insightful criticism of the DSM-IV-TR conceptualization of RAD and articulate a proposal to revise RAD criteria for inclusion in the DSM-5. They argue that: 1) limited research and small samples of children were originally used to formulate the 1980 RAD diagnostic nosology and the diagnostic criteria is confounded with non-organic failure to thrive and general trauma symptoms; 2) the RAD phenotype is insufficiently informed by developmental research on attachment; and 3) the RAD diagnosis uses vague descriptors. They conclude from the research that: 1) An alternate set of criteria (e.g., Research Diagnostic Criteria-Preschool Age (AACAP, 2003) and Diagnostic Classification: 0-3R (Zero to Three, 2005) show better validity [than DSM-IV-TR] across different populations and across different research teams; 2) the two subtypes of RAD described in DSM-IV-TR occur but are exceedingly rare and are reliably identifiable in populations of at risk children far more commonly than in low risk children; and 3) the evidence favors two distinct disorders rather than two subtypes of the same disorder. Using the composite of these research findings, Zeanah and Gleason (2010) have proposed revisions in the RAD criteria for DSM-5 that are based more on attachment behaviors than general social behaviors.

Proposed DSM-5 Criteria for Reactive Attachment Disorder of Infancy or Early Childhood (Zeanah & Gleason, 2010)

A. Pattern of markedly disturbed and developmentally inappropriate attachment behaviors, evident before 5 years of age, in which the child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection and nurturance. The disorder appears as a consistent pattern of inhibited, emotionally withdrawn behavior in which the child rarely or minimally directs attachment behaviors towards any adult caregivers, as manifest by both of the following:

1) Rarely or minimally seeks comfort when distressed.

2) Rarely or minimally responds to comfort offered when distressed.

B. Persistent social and emotional disturbance characterized by at least 2 of the following:

1) Relative lack of social and emotional responsiveness to others.

2) Limited positive affect.

3) Episodes of unexplained irritability, sadness, or fearfulness which are evident during nonthreatening interactions with adult caregivers.

C. Does not meet the criteria for Autistic Spectrum Disorder.

D. Pathogenic care as evidenced by at least one of the following:

1) Persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection (i.e., neglect).
2) Persistent disregard of the child’s basic physical needs.

3) Repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care).
4) Rearing in unusual settings such as institutions with high child/caregiver ratios that limit opportunities to form selective attachments.

E. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

F. The child has a developmental age of at least 9 months.

Considerations: Proposed Reactive Attachment Disorder

Note how the proposed changes in Criterion A are to focus more specifically on absent or aberrant attachment behaviors rather than on general social behaviors. Though some have suggested that social impairment (Green, 2003) or social communication (Minnis, et al., 2006) is the core of this disorder, it appears that the absence of a selective attachment necessarily impairs social functioning, and the social behaviors improve markedly once the child is in a more favorable environment (Zeanah & Smyke, 2005). More important, making attachment the core of the disorders is supported by the validity data which were derived from investigations of multiple samples of currently and formerly institutionalized children, children in foster care, and children in impoverished groups at risk for aberrant parenting behavior (e.g., Boris, Zeanah, Larrieu, Scheeringa, & Heller, 1998; Boris, Hinshaw-Fuseler, Smyke, Scheeringa, Heller & Zeanah, 2004; Zeanah, Scheeringa, Boris, Heller, Smyke, & Trapani, 2004).

Another significant change from DSM-IV-TR occurs in the inclusion of Criterion B, which describes the documented social and emotional disturbances in children with RAD. Separating these out from the A criterion restricts the diagnosis to those children who have both clear abnormalities in attachment behaviors and the absence of a preferred attachment figure (A) and social/emotional disturbances (B).

Criterion C is virtually identical to the DSM-IV-TR Criterion B.

Criterion D has been retained but revised. Practically, criterion D poses challenges for the clinician. Pathogenic care is not always disclosed and cannot always be clearly identified in clinical assessments or evaluations because young children cannot describe their own experiences and caregivers may not be forthcoming if they are implicated in pathogenic care. Retaining Criterion D precludes making the diagnosis of RAD in children whose maltreatment is not known to the clinician. On the other hand, there are no case reports of young children exhibiting the RAD phenotype without at least a reasonable inference of serious caregiving adversity.

The revisions are intended to describe in a bit more detail what is known about the types of care that seem to predispose symptoms of RAD. These categories remain less specific than is desirable, but this challenging area of investigation has yielded limited data.

Criterion E is unchanged from Criterion D in DSM-IV-TR.

Criterion F has been added to ensure that an attachment disorder is not diagnosed in children who are developmentally incapable of demonstrating a focused attachment. Stranger wariness and separation protest in addition to selective comfort seeking are behavioral indicators of selective attachment, typically emerging between 7 and 9 months of age. Criterion B ought to differentiate between children with RAD and typically developing children less than 9 months of age, but the inclusion of Criterion F provides additional insurance in cases with some ambiguity.

Proposed DSM-5 Criteria for Disinhibited Social Engagement Disorder
(Zeanah & Gleason, 2010)

A. A pattern of behavior in which the child actively approaches and interacts with unfamiliar adults by exhibiting at least 2 of the following:

1) Reduced or absent reticence to approach and interact with unfamiliar adults.

2) Overly familiar behavior (verbal or physical violation of culturally sanctioned social boundaries).

3) Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.

4) Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B. The behavior in A. is not limited to impulsivity as in ADHD but includes socially disinhibited behavior.

C. Pathogenic care as evidenced by at least one of the following:

1) Persistent failure to meet the child’s basic emotional needs for comfort, stimulation, and affection (i.e., neglect).

2) Persistent failure to provide for the child’s physical and psychological safety.

3) Persistent harsh punishment or other types of grossly inept parenting.

4) Repeated changes of primary caregiver that limit opportunities to form stable attachments (e.g., frequent changes in foster care).

5) Rearing in unusual settings that limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios).

D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

E. The child has a developmental age of at least nine months.

Considerations: Disinhibited Social Engagement Disorder

The indiscriminately social/disinhibited RAD phenotype is proposed to be a distinct disorder. The new name is intended to describe the core of the disorder, which is less about diffuse or disinhibited attachment behaviors and more about unmodulated and indiscriminate social behavior, especially initial approaches to and interaction with unfamiliar adults.

Criterion A focuses the disorder more on aberrant social behavior rather than on disordered attachment behavior.

Criterion B is new and presumed to be necessary from several lines of evidence suggesting co-occurrence of ADHD signs and the social impulsivity that characterizes the indiscriminately social/disinhibited phenotype. It appears that one may have ADHD with socially indiscriminate behavior, and one may have socially indiscriminate behavior without ADHD, but there are often moderately strong correlations between the two symptom profiles. Thus, rather than make ADHD a rule out for Disinhibited Social Engagement Disorder, it seems more useful to direct attention to its distinction from ADHD.

Pathogenic care is retained in Criterion C as in DSM-IV-TR for the important reason that children with adequate caregiving but with conditions such as Chromosome 7 deletion and Fetal Alcohol Syndrome may demonstrate phenotypically similar behavior to those with Disinhibited Social Engagement Disorder. It is described exactly as in RAD because there is no evidence to date that one or another of the types of pathogenic care are more or less likely to lead to RAD or to Disinhibited Social Engagement Disorder.

Criterion D is retained from DSM-IV-TR for the same reasons.

Criterion E is a replication of criterion F in the RAD subtype, and has been added to ensure that an attachment disorder is not diagnosed in children who are developmentally incapable of demonstrating a focused attachment.

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3. Attachment and Development: The Negative Consequences of Attachment Disturbances and Disorders

Serious disturbances of attachment occur most often in the context of early abuse, neglect, and deprivation. Although it is possible that some children will have significant attachment challenges for reasons not ostensibly consisting of abuse but still deprived of attachment opportunity (e.g., medically complicated infants with extensive hospitalizations) these examples are limited and have not been widely studied.

Disturbances of attachment were noted in the Strange Situation Procedure (SSP) while researchers were categorizing *organized* attachment into Secure and Insecure groups. In the SSP, anomalous attachment behaviors were noted in maltreated children that did not fit any of the previously established *organized* categories (Secure or Insecure). This provided a major impetus for the development of the criteria that now are used to identify *disorganized* attachment relationships (Main & Solomon, 1990). Children with disorganized attachment, as measured in the SSP, display clear psychiatric disturbance, however, it is assumed that they have histories of abuse, neglect or deprivation, thus complicating discernment of relative contributions of general trauma effects versus attachment trauma specific effects and gives rise to the question of whether such discernment is even practical or possible. Many children with disorganized attachment meet criteria for RAD and/or other co-morbid conditions more generally seen in children with complex early maltreatment trauma. Some experts argue that disorganized attachment, though problematic, is not the same as RAD (e.g., Zeanah & Gleason, 2010) while other experts argue that RAD actually represents an extreme form of disorganized attachment classification (e.g., Green, 2003) or that disorganized attachment ought to be considered an attachment disorder (van Izendoom & Bakersman-Kranenberg, 2002).

The following discussion regarding the impact of attachment disturbance on development reflects the literature that naturally combines children with diagnoses of RAD, and/or classifications of disorganized attachment, and/or complex effects of early maltreatment or deprivation. All of these categories represent children with attachment disturbances or disorders.

One well done study of infants/toddlers from the foster care system and infants/toddlers from an eastern European orphanage offers a clinical description of the common behavioral problems in maltreated and severely deprived infants and toddlers and is depicted in the table below (Zeanah & Smyke, 2005; table 9.1, p. 204):

Common Behavior Problems in Maltreated and Severely Deprived Infants and Toddlers[1]

Problem	Maltreated Children	Postinstitutionalized Children
Regulatory problems	• Extreme withdrawal • Severe temper tantrums • Easily frustrated • Poor attention	• Extreme withdrawal • Agitation • Constant activity • Easily frustrated • Stereotypies • Poor attention • Loudness/shouting • Temper tantrums
Developmental Problems	• Delayed speech/language • Fine-gross motor delays • Frequent mild cognitive delays	• Very poor speech/language • Fine/gross motor delays • Mild to significant cognitive delay • Autistic features that may persist

[2] Zeanah, C. H., & Smyke, A. T. (2005). *Building Attachment Relationships Following Maltreatment and Severe Deprivation*. In Berlin, Ziv, Amaya-Jackson, & Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention and policy* (pp. 195-216). New York: The Guilford Press.

Common Behavior Problems in Maltreated and Severely Deprived Infants and Toddlers (continued)[2]

Problem	Maltreated Children	Postinstitutionalized Children
Socioemotional problems	• Aggression • Indiscriminant behavior that usually resolves quickly • Difficulty forming attachment without adult's help	• Aggression • Indiscriminant behavior that may persist • Difficulty forming attachment without adult's help
Sleep Problems	• Difficulty going to sleep • Difficulty staying asleep	• Nightmares
Eating problems	• Overeating/stuffing	• Overeating/stuffing • Difficulty with complex textures • Marked food preferences (e.g., chocolate and bananas)
Toileting problems	• Incomplete toilet training • Soiling of clothing, home • Bedwetting • Difficult to toilet train	• Refusal to use toilet (in institution, children routinely required to sit on toilet up to 2 hours) • Sometimes quite difficult to toilet train

[2] Zeanah, C. H., & Smyke, A. T. (2005). *Building Attachment Relationships Following Maltreatment and Severe Deprivation*. In Berlin, Ziv, Amaya-Jackson, & Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention and policy* (pp. 195-216). New York: The Guilford Press.

As can be observed in the above table, young children are indeed adversely and measurably affected across all aspects of development by early and significant pathological care. It is clear that attachment disturbances and disorders occur in the context of psychological traumas so developmentally adverse that they block or interrupt the normal progression of development in periods when a child (usually in infancy and early childhood) is acquiring the fundamental psychological and biological foundations necessary for all subsequent development, including: (1) attention and learning; (2) memory; (3) emotion regulation; (4) personality formation and integration; and (5) relationships (Ford, 2009). The current literature based on both animal and human models (e.g., Teicher, 2002; de Bellis, 2001,2005; Shannon et al., 1998; Suomi,1996) notes that significant and ongoing psychological trauma in infancy/early childhood in which there is gross impairment in the caregiving system appears to cause adverse developmental effects, however, there are individual differences in the extent of impairment. There remains much to learn about the various risk and protective factors that affect ongoing development (e.g., intelligence level, genetics, duration/type of adversity, change to a healthy caregiving environment, and/or timing of interventions).

Research has shown positive effects of the early caregiving relationship on learning as well as negative effects from caregiving deprivation. In addition, studies have shown that environmental influences can have a direct effect on the developing brain. For example, prospective research has shown that early maternal support promotes larger hippocampal volumes in animals (e.g., Liu, et al., 1997; Meaney, 2001) and in children (Luby et al., 2012); the hippocampus is a key brain structure for memory and learning. The Bucharest Early Intervention Project (Nelson, Zeanah, Fox, Marshall, Smyke, & Guthrie, 2007) followed 136 children who had been orphaned and institutionalized at birth or shortly thereafter. The children were followed from under age 31 months through age 54 months and were randomly assigned to foster homes or to the institution. They were compared to other same-aged children who had never been institutionalized. Results showed that children reared in institutions showed greatly diminished intellectual performance relative to children reared in families of origin; the children randomly assigned to foster care experienced significant gains in cognitive function, and the younger a child was when placed in foster care, the better the outcome. The authors' finding that previously institutionalized children's cognitive development benefits most from foster care if placement occurs relatively early in a child's life suggests the possibility of a *sensitive period* for impacting learning and development in deprived children. Primate research also suggests the probability of sensitive periods for intervention following early caregiving deprivation (e.g., Suomi, 1996; Research Network on Early Experience and Brain Development, 2012).

In sum, current research indicates that early foundational brain development critically affects future learning and overall development. Extremely pathological caregiving affects the foundational architecture of the brain (e.g., neural circuitry structures). Psychological trauma and pathological attachment in the early developmental periods is likely to be complex in its effects, because it occurs in a one-time-only period of developmental growth (e.g., infancy/childhood) and/or developmental consolidation (adolescence). Learning across all domains (e.g., cognitive, emotional, social, physical) is predictably negatively affected; however, questions remain as to how much and when the brain can be altered through therapeutic efforts, and what individual variables both in the child and in the environment can most affect change.

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4. Differential Diagnosis and Comorbidity

As reviewed in section 2, the current RAD diagnosis in the DSM-IV-TR was developed with little empirical evidence or research support (Chaffin et al., 2006), was targeted at children who had been raised in institutions (including international orphanages and similar settings where children lacked a consistent caregiver), and occurs only rarely. However, most researchers agree that attachment disturbances occur on a continuum (Zeanah & Smyke, 2005) and that children raised in other circumstances, including by biological parents, can also have attachment issues. Further, children with other types of psychopathology may also have disturbances in their attachment relationships related to their symptomatology.

We are in the early stages of understanding attachment, but more research is being collected on the impact of maltreatment and inconsistent parenting as it applies to socio-emotional issues and attachment behaviors. Zeanah & Gleason's (2010) proposed changes to the RAD diagnosis for DSM-5 may provide more clarity on the variations of behaviors that stem from grossly pathogenic care (see section 2).

The DSM-IV-TR (2000) offers specific criteria for diagnosing a child with Reactive Attachment Disorder, but often children who have experienced "grossly pathogenic care" at an early age present with a host of other symptoms. Conceptually, these symptoms may be thought of as the result of chronic maltreatment and recurring traumatic stress, sometimes referred to as complex trauma or developmental trauma (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). There are multiple domains of impairment in complex trauma, including affective, somatic, behavioral, cognitive, relational, and self-attribution (van der Kolk, 2005). Children who have experienced chronic maltreatment may not only have attachment disruptions, but also poor emotion regulation, disruptive behaviors, neurocognitive impairments, and poor self-worth. Attachment is just one of several potential difficulties, so children with a history of grossly pathogenic care may or may not present with RAD, but may still present with significant developmental and behavioral problems. Similarly, even though these children have experienced chronic traumatic events, they may or may not meet criteria for a Posttraumatic Stress Disorder (PTSD) diagnosis. The complexity of their presentation often means they meet criteria for more than one disorder. Common co-occurring disorders include PTSD, Attention-Deficit/Hyperactivity Disorder (ADHD), disruptive behavior disorders, or mood disorders. Misleading information exists on the internet and elsewhere regarding "common" RAD symptoms that can include everything from bossiness to sleep disturbance to being accident prone (e.g., http://attachmenttherapy.com/childsymptom.htm). Clinicians should cautiously adhere to the DSM-IV-TR criteria as they exist at present and diagnose other conditions as warranted (Chaffin et al., 2006).

While children with early maltreatment often have multiple, overlapping symptoms, some conditions can be distinguished from RAD. The following table outlines specific rule out criteria from the DSM-IV-TR (2000):

Differential Diagnosis	Criteria	Can they co-occur?
Intellectual Disability (Mental Retardation)	Attachment problems due to intellectual deficiencies indicated by cognitive development at less than 9 months of age	Yes, if attachment problems go beyond cognitive limitations and both criteria are met
Autism Spectrum Disorder (Pervasive Developmental Disorders)	Behavioral manifestations mimicking attachment disturbances, e.g., communication impairment, stereotyped or repetitive behaviors	No; cannot diagnose RAD if criteria met for autism spectrum disorder

Differential Diagnosis	Criteria	Can they co-occur?
Social Phobia	Social inhibition apparent in unfamiliar settings but not with caregivers	Yes
ADHD	Generally impulsive behavior across settings, not just with unfamiliar adult caregivers	Yes
Conduct Disorder or Oppositional Defiant Disorder	Disruptive, defiant, or antisocial behaviors, which are not in RAD diagnostic criteria	Yes

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5. Assessment

The use of standardized measures in the diagnosis of impairments in the attachment relationship has been recommended as a best practice standard. However, the development and use of standardized instruments continues to lag. We can learn from other fields, in particular, the field of posttraumatic stress disorder (PTSD) for children which continues to work toward the development of measures for children.

There are several issues that contribute to the difficulties in the development of assessment instruments for attachment, including symptom crossover. That is, there is significant common ground between symptoms of attachment problems and other common childhood psychiatric disorders such as ADHD, oppositional defiant disorder, autism spectrum disorders, social phobia, and anxiety. Due to this sharing of behavioral symptoms, attachment issues may go unaddressed. In addition to symptom crossover with other more common diagnoses, there is considerable variability in the symptoms of children with attachment issues. These children may show both internalizing symptoms such as depressive and anxiety symptoms, and externalizing symptoms such as noncompliance, aggression, and anger. Children who have experienced extreme pathogenic care or unstable/inconsistent caregiving, such as those who have been adopted (internationally or domestically) and children who have been in state custody are at risk for co-occurring diagnoses such as PTSD, developmental disorders, and attachment problems. In addition, there is a lack of clarity about the presentation of attachment disorders over the age of five years and difficulty in distinguishing among aspects of attachment disorders, disorganized attachment or the more general consequences of maltreatment.

The American Academy of Child and Adolescent Psychiatry (AACAP) advises against giving a child a label of attachment disorder or a RAD diagnosis without a comprehensive evaluation. Their practice parameter states that the assessment of RAD requires evidence directly obtained from serial observations of the child interacting with his or her primary caregivers and history (as available) of the child’s patterns of attachment behavior with these caregivers. It also requires observations of the child’s behavior with unfamiliar adults and a comprehensive history of the child’s early caregiving environment including, for example, pediatricians, teachers, or caseworkers. AACAP recommends that initial evaluations be conducted by psychologists, psychiatrists, Licensed Clinical Social Workers or psychiatric nurses.

According to the AACAP Practice Parameter (2005), the question of whether attachment disorders can be reliably diagnosed in older children and adults has not been resolved. Attachment behaviors used for the diagnosis of RAD change markedly with development and defining analogous behaviors in older children is difficult. There are no substantially validated measures of attachment in middle childhood or early adolescence. Assessments of RAD past school age may not be possible at all, as by this time children have developed along individual lines to such an extent that early attachment experiences are only one factor among many that determine emotion and behavior.

There is as yet no universally accepted diagnostic protocol for RAD. O’Connor & Zeanah (2003) explore the critical behaviors that need to be assessed for making a diagnosis of attachment disorder and contextualize this issue within the problems inherent in the DSM classification itself. Most of the instruments currently available have been used primarily in research. For example, the Strange Situation Procedure (SSP) developed by Mary Ainsworth (1978) has been used widely in research for children up to 18 months of age, and there are adaptations of this procedure for children up through preschool and school ages such as the Preschool Assessment of Attachment (PAA) developed by Crittenden (1992) and the Main and Cassidy Attachment Classification System (1988). The SSP has been used mostly to classify various types of attachment styles; however, it has been adapted more recently to measure levels of attachment behaviors from no attachment to disorganized attachment, to insecure attachment to securely attached (Zeanah & Smyke, 2005). Observational methods, such as the Attachment Q-Set (AQS)(Waters, 1995), are available for infants and toddlers and a variety of narrative techniques using stem stories, puppets, or pictures have been developed and are being used in research for older children (Smeekens & Riksen-Walraven, 2009). The Child Attachment Interview (Target, 2003) which is a modification of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) is also available for older children. The AAI is considered the most valid measurement of the state of mind with respect to attachment in adolescents and adults and is a helpful measure to use with caregivers prior to attachment interventions. Finally, Smyke & Zeanah (1999) developed the Disturbances of Attachment Interview (DAI) which is a semi-structured interview used with the child's caregivers, accessing information about the symptoms of RAD and variants of attachment behavioral patterns. In summary, assessment choices are currently limited. O'Connor & Zeanah (2003) identify promising methods that focus on observations, clinical interviews, questionnaires, and social-cognitive/interview assessment with children. These authors emphasize how the assessment world is in its infancy and underscore that multiple methods are needed with a goal toward convergence among these sources of information. As the field clarifies the validity and usefulness of these instruments the march toward a clear standard of care for assessment of attachment disturbances may eventuate.

A child's pediatrician or PCP is often the first health professional to become concerned about a child's attachment relationship. As stated earlier, due to symptom crossover and the heterogeneity in childhood disorders, the behavioral profile may also vary due to age and the child's developmental status. Most typically a PCP might notice a disturbance in social interaction and emotional regulation. Infants up to about 24 months *may* present with symptoms of failure to thrive, display abnormal responsiveness to social and sensory stimuli, and show disturbances in their ability to seek and/or accept comfort or affection from familiar adults. Coupled with knowledge about a child's attachment and family history these types of symptoms should alert the PCP to seek mental health consultation. While RAD is likely to occur in relation to neglectful and abusive treatment, automatic diagnoses on this basis alone cannot be made, as children can form stable attachments and social relationships despite marked abuse and neglect. The PCP will want to initiate medical tests to distinguish an organic illness from the overlapping symptomatology. In spite of the challenges involved in adequately assessing the presence of RAD, clinicians will be called on to determine disturbances in the attachment relationship. These disturbances may result from maltreatment and trauma experienced in the early years as well as more subtle caregiving differences. Until a clinical protocol is available the mental health provider may want to consider the key points from the APSAC Attachment Task Force as guidelines:

1. Assess patterns of behavior over time.
2. Take into account cultural issues.
3. Sample behavior across situations and contexts.
   Consider behavior with different caregivers, familiar adults, and peers.
   Avoid basing diagnosis solely on problems with parent or primary caregiver.
4. Assessment should not rely on checklists alone.
5. Only those mental health professionals able to distinguish RAD from other childhood disorders should make this diagnosis.
6. If there are hoof sounds, think horses not zebras first, that is, consider common disorders before considering the rarer diagnoses.
7. Assessment for RAD is a family/relationship problem; it does not reside solely in the child.
8. Rule out other diagnoses (see # 5).
9. Diagnosis is not based on child's maltreatment history alone since resiliency is common.

In addition, the mental health provider may want to access other readily available assessment/screening tools that can be useful in conceptualizing a child's social, emotional, and attachment profile. These include:

- Temperament and Atypical Behavior Scales (TABS) (Neisworth, 1999)
- Infant Toddler Social Emotional Assessment (ITSEA) (Carter, et al, 2006)
- Brief Infant Toddler Social Emotional Assessment (BITSEA) (Carter, et al, 2006)
- Marschak Interaction Method (MIM) (Marschak, 1960)
- Achenbach Child Behavior Checklist (CBCL) (Achenbach& Rescorla, 2000)
- Parenting Stress Index (PSI), Fourth Edition (Abidin, 2012)
- Parent-Child Relationship Inventory (Gerard, 1994)
- Working Model of the Child Interview (Benoit, et al, 1997)
- The Parent Child Structured Play Interaction Procedure (Crowell, 1985, 1988)
- Adult Attachment Interview (for caregivers) - (George & Main, 1996)

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6. Prevention and Early Intervention

Preventing attachment disorders begins prior to the birth of the child and is mostly focused on holistic maternal health. It is important that all available information has been gathered related to the primary caregiver's/mother's psychosocial history. This is especially essential given the link between maternal sensitivity and attachment. The construct of maternal sensitivity (i.e. appropriate, timely, and consistent responses to children's signals and needs) is central to attachment theory. It is also central to gaining understanding and working with parents through intervention methods. (Lindhiem, Bernard, & Dozier, 2011).

Several preventive interventions in broad-based child development programs have shown promise for securing attachment in children and caregivers in high-risk population groups. For example, prenatal and infancy home visitation programs have been shown to achieve goals that can offset some of the risk factors that can lead to attachment difficulties (e.g., Olds, Eckenrode, Henderson, Kitzman, Powers, Cole, et al., 1997; Olds, 2005; Slade. Sadler. & Mayes, 2005). These programs typically focus on five domains of functioning including personal health, environmental health, maternal role development, maternal life-course development, and family and friend support. During home visits, nurses carry out three major activities including promoting adaptive change, helping to build supportive relationships with other family members and friends, and linkage with other services. There is importance placed on building parents' strengths and promoting parental competence and control over life.

Likewise, preventive intervention programs geared toward surrogate caregivers have also shown success. For example, the Attachment and Biobehavioral Catch-Up (ABC) model delivered in 10 sessions concentrates on teaching surrogate parents the essentials of fostering secure attachment with young foster children (Dozier, Lindheim & Ackerman, 2005) and the Bucharest Early Intervention Project geared toward working with surrogate caregivers in Romania showed substantial gain in children's' cognitive, general developmental status, and attachment status over several years (Zeanah & Smyke, 2005).

Other preventive intervention attempts have not been as successful in changing attachment classification, but still are promising in terms of enhanced parenting as a key mechanism underlying positive effects on children's cognitive and social development, for example, through the addition of the Parent-Child Communication Coaching Program (PCCCP) to the broader Early Head Start program (e.g., Love, et al. 2002); Spieker, Nelson, DeKlyen, & Stekel, 2005). Because this home-visiting program with high risk parents that begins in the stage of pregnancy and ends with the child's third birthday did not yield more attachment security than the control group, more research is needed to understand fully 'what works for whom'.

As will be detailed in section 7 (Treatment), recent research suggests that early interventions that have targeted sensitivity have been found to be more effective in enhancing security than other interventions targeting other issues (such as parental state of mind). Furthermore, interventions that started after the child was at least six months old have been more effective than those starting earlier. This may be due in part to children beginning to show attachment to specific caregivers during this time period (Dozier, & Bernard, 2009). A number of attachment based interventions highlight mothers' strengths (i.e., appropriate response) and weaknesses (i.e., missed opportunities to respond) by providing feedback. For example, the Circle of Security model, designed for early intervention, focuses on both the caregiver's internal working models of self and on the caregiving behavior (e.g., Cooper, Hoffman, Powell & Marvin, 2005).

Derived from attachment theory, the "Circle of Security" is a relationship-based intervention designed to change child behavior through changes in the parental behavior. The underlying premise is that the parent is a secure base from which young children can leave and explore their surroundings. Caregivers read and attend to child cues during exploration. Children then return to the safety and security of the caregiver base. The treatment plan is tailored to address the parent child dyad and to address the challenges that occur within that circle of exploration and safe return. The Circle of Security protocol consists of pre-intervention videotaped structured assessment. This is followed up by group based parent education and psychotherapy lasting about 20 weeks using videotaped intervention. The goals of this video review are to increase the sensitivity to the child's cues, increase self-other reflective capacity, and explore new representations and interaction patterns.

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7. *Treatment*

Traditional attachment theory holds that attachment develops in the context of a safe, secure relationship with a caregiver that is sensitive and responsive to the child's needs. It thus follows that successful attachment interventions are targeted at improving the quality of the caregiver-child relationship and their environment (Chaffin et al., 2006). The systematic study of attachment disorder is relatively new, and is plagued by the problem that, even when studied, strict criteria for attachment disorder have not been used. Studies have instead used a variety of observational interview measures to index a behavioral pattern based on early clinical description. (See O'Connor & Nilsen [2005] for commentary.) With these limitations in mind, several meta-analyses have identified common characteristics in successful interventions for children clinically described as attachment disturbed. One review found that interventions that increased parental sensitivity were most effective in increasing child attachment security (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2003). Successful interventions with infants were started after age six months, were shorter term, focused, and goal-directed, with an emphasis on increasing sensitive caregiver behaviors, rather than focusing on child pathology. Finally, these authors noted that interventions that were implemented in families in which the infants were considered to be at risk (due to prematurity, irritability, or international adoption) were more effective than interventions with at-risk parents. The authors concluded that it might be easier to prevent or change disorganized attachment when the parent is relatively well functioning and free of psychopathology (IJzendoorn, Bakermans-Kranenburg, & Juffer, 2005).

Systems of Care

Not only is parental involvement a key component, but Zeanah & Smyke (2005) emphasize the importance of working with multiple systems for children who are placed in foster care. Through their work in New Orleans and with the Bucharest Early Intervention Project (BIEP), they have found that facilitating a secure attachment between young children and foster parents improves attachment behaviors and reduces symptoms of Reactive Attachment Disorder. They accomplished this first by conducting thorough assessments with a team of providers trained in infant mental health. The assessment includes developmental and clinical evaluations, and observations of the child at home and in child care settings, with a careful appraisal of the relationship between the child and foster parent. The team works closely with the foster parents to make the environment safe and predictable, to help the child regulate his or her feelings, to respond effectively to distress, and to understand the child’s signals, in particular, any miscues the child may have developed in the context of a disrupted attachment with biological caregivers.

Best Practices Recommendations

Following are recommendations regarding treatment for attachment challenges taken directly from the American Professional Society on the Abuse of Children (APSAC) Attachment Task Force report (Chaffin, M., et al., 2006).

a. State-of-the-art, goal-directed, evidence-based approaches that fit the main presenting problem should be considered when selecting a first-line treatment. Where no evidence-based option exists or where evidence-based options have been exhausted, alternative treatments with sound theory foundations and broad clinical acceptance are appropriate. Before attempting novel or highly unconventional treatments with untested benefits, the potential for psychological or physical harm should be carefully weighed.
b. First-line services for children described as having attachment problems should be founded on the core principles suggested by attachment theory, including caregiver and environmental stability, child safety, patience, sensitivity, consistency, and nurturance. Shorter term, goal-directed, focused, behavioral interventions targeted at increasing parent sensitivity should be considered as a first-line treatment.
c. Treatment should involve parents and caregivers, including biological parents if reunification is an option. Fathers, and mothers, should be included if possible.

> Parents of children described as having attachment problems may benefit from ongoing support and education. Parents should not be instructed to engage in psychologically or physically coercive techniques for therapeutic purposes, including those associated with any of the known child deaths.

Evidence-Based Practices

In addition to broad recommendations for treating youth and families with attachment issues, there are specific treatment models that address many of the presenting problems seen in children with attachment issues. The table below outlines some appropriate evidence-based practices. It is worth highlighting that one consistent component across models is parenting practices and that caregiver participation is an essential component of treatment. Most emphasize parental attunement or sensitivity to the child's needs, and the treatment focuses on building that relationship through consistency, responsiveness, and predictability.

Intervention	**Developer / Reference**	**Age ranges**	**Target symptoms**	**Setting**
Attachment and Bio-behavioral Catch-up	Dozier, Lindhiem, & Ackerman, 2005	0-5	Child dysregulation Caregiver nurturance Caregiver parenting	Home (foster, adoptive, or biological)
Attachment, Self-Regulation, & Competency	Blaustein & Kinniburgh, 2010	2-21	Complex trauma Behavior problems	Outpatient Home Residential
Child Parent Psychotherapy	Lieberman & Van Horn, 2005	0-6	Child PTSD Child behavior Secure attachment Parent PTSD Parent mental health symptoms	Home Community setting

Intervention	**Developer / Reference**	**Age ranges**	**Target symptoms**	**Setting**
Circle of Security	Cooper, Hoffman, Powell, & Marvin, 2005	1-4	Child-caregiver interactions Child behavior Parenting stress	Outpatient
Incredible Years	Webster-Stratton, 1982	2-12	Parenting Child behaviors Parent bond with school Teacher classroom management	Outpatient Home School
Parent-Child Interaction Therapy	Hood & Eyberg, 2003	2-12	Parent-child interactions Child conduct behaviors Parental distress	Outpatient School
Real Life Heroes	Kagan, 2007	6-12 Adolescents (13-17) with developmental delays	Trauma symptoms Behavior problems Feeling secure with caregiver	Residential Outpatient Home

Caution Regarding Potentially Harmful Approaches

Some techniques that have been used to address attachment problems are known to be harmful and go against what is known about the relationship between sensitive care and the development of attachment. These techniques may re-traumatize an already traumatized child. In addition, six deaths in the U.S. have been reported in connection with one such technique known as “holding therapy” (O'Connor & Zeanah, 2003). To this point, the following recommendations are taken directly from the American Professional Society on the Abuse of Children (APSAC)

Attachment Task Force report (Chaffin, et al., 2006).

a. Treatment techniques or attachment parenting techniques involving physical coercion, psychologically or physically enforced holding, physical restraint, physical domination, provoked catharsis, ventilation of rage, age regression, humiliation, withholding or forcing food or water intake, prolonged social isolation, or assuming exaggerated levels of control and domination over a child are contraindicated because of risk of harm and absence of proven benefit and should not be used.
b. This recommendation should not be interpreted as pertaining to common and widely accepted treatment or behavior management approaches used within reason, such as time-out *, reward and punishment contingencies, occasional seclusion or physical restraint as necessary for physical safety, restriction of privileges, "grounding", offering physical comfort to a child, and so on. Prognostications that certain children are destined to become psychopaths or predators should never be made based on early childhood behavior. These beliefs create an atmosphere conducive to overreaction and harsh or abusive treatment. Professionals should speak out against these and similar unfounded conceptualizations of children who are maltreated.
c. Intervention models that portray young children in negative ways, including describing certain groups of young children as pervasively manipulative, cunning, or deceitful, are not conducive to good treatment and may promote abusive practices. In general, child maltreatment professionals should be skeptical of treatments that describe children in pejorative terms or that advocate aggressive techniques for breaking down children's defenses.
d. Children's expressions of distress during therapy always should be taken seriously. Some valid psychological treatments may involve transitory and controlled emotional distress. However, deliberately seeking to provoke intense emotional distress or dismissing children's protests of distress is contraindicated and should not be done.

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8. Other Interventions

Section 7 (Treatment) listed a number of Best Practice treatment suggestions specific to attachment challenges. In addition to these attachment-specific treatments, which always include the caregiver, children with attachment challenges, disruptions, and disorders often have needs for other interventions and services. These needs arise out of co-occurring developmental challenges deriving from early pathogenic care or from co-morbid conditions. Children with attachment challenges should be screened for co-existing developmental, health, and behavioral health challenges and should be appropriately referred as early in their development as possible for services such as:

- **Occupational Therapy** – often needed for challenges with sensory processing (i.e., coping with under-stimulation and over-stimulation), tasks of daily living (e.g., feeding, hygiene, tying shoes, managing buttons), educational tasks (e.g., mechanics of writing, staying seated comfortably), proprioceptive tasks (e.g., keeping balance).
- **Physical Therapy –** often needed to facilitate fine or gross motor skill development
- **Speech and Language Therapy** – often needed due to general delays
- **Therapeutic Preschool –** particularly helpful for social skills and emotion regulation
- **Social Skills groups** – often a central need for intervention
- **Special Education –often needed due to general delays**
- **Applied Behavioral Analysis** – this service is an intense, though short term behavior modification service that is typically provided across contexts such as school, home, and community (e.g., for self-injurious behaviors, aggression toward others, habilitative skills such as toileting)
- **Psychological/Psychoeducational Evaluation –** For young children, the evaluation may be called a “Developmental Evaluation”. Evaluations should aid planning for treatment needs as well as educational needs.
- **Trauma Specific Therapy –** indicated if a child is showing significant signs of trauma
- **Caregiver Psychoeducation –** Caregivers need information on attachment issues and any other diagnostic or developmental issues pertinent to their children
- **Medical /Genetic Screening and Subsequent Treatment –** children from pathogenic backgrounds often have undiagnosed and/or untreated medical conditions

In addition to services rendered by professionals as listed above, all children benefit from developmentally healthy activities that promote a solid sense of self and community. Sometimes the most therapeutic benefits come from helping a child discover his or her competencies and talents through normal activities such as:

- **Sports**—both formal (such as teams or tennis lessons) and informal (going to baseball games, playing catch out in the yard, swimming in the community pool or lake)
- **Music –** both formal (e.g., piano lesson, community choir) and informal (e.g., listening to music, singing with the family around a campfire)
- **Clubs –** (e.g., Scouts, chess club, art club, theater club, church mission groups, church youth groups)
- **Art –** both formal (e.g., art lessons) and informal (e.g., an “art studio” space in the home)

- **Serving others** – (e.g., community service such as feeding homeless, picking up litter, caring for pets)
- **Helping children develop interests -** (e.g., horseback riding, building with Legos, computer graphics, cooking)

9. *Helpful Resources*

Empirically Validated Treatments & Consensus Treatments

This refers to treatment programs that have evidence based support or programs which are based on principles and strategies that have been researched and are used to inform the intervention.

Blaustein, M.E. & Kinniburgh, K.M. (2010). *Treatment Traumatic Stress in Children and Adolescents: How to Foster Resilience through Attachment, Self-Regulation, and Competency*. New York: Guilford Press.

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Wesbster-Stratton, C. (1982). Teaching mothers through videotape modeling to change their children's behavior. *Journal of Pediatric Psychology, 7*(30), 279-294.

Resources for Practical Strategies for Parents

These books and resources may be informed by research but also may be more loosely tied to actual research.

Gray, D. (2002). *Attaching in adoption: Practical tools for today's parents.* Indianapolis, IN: Perspective Press, Inc.

Gray, D. (2007). *Nurturing in adoptions: Creating resilience after neglect and trauma*, Indianapolis, IN: Perspectives Press Inc.

Hughes, D. (2009). *Attachment focused parenting: Effective strategies to care for Children.* New York: W.W. Norton and Company.

Hughes, D. & Baylin, J. (2012). *Brain-based parenting: The neuroscience of caregiving for healthy attachment*. New York: W.W. Norton and Company.

Kagan, R. (2004). *Rebuilding attachments in traumatized children*. Binghamton, New York: The Haworth Press.

Purvis, K., Cross, D., & Sunshine, W. (2007). *The connected child: Bring hope and healing to your adoptive family*. New York: McGraw-Hill.

Maltreatment and Attachment Trauma

These resources address maltreated children specifically and are informed by research.

James, B. (1994). *Handbook for treatment of attachment-trauma in children.* New York: Free Press/Simon & Schuster.

Ziegler, D. (2000). *Raising children who refuse to be raised.* Phoenix, AZ: Acacia Publishing, Inc.

Concerns about Holding Therapy and Corrective Attachment Therapy

These resources either demonstrate the concerns regarding unproven approaches or caution the reader about such approaches.

Chaffin, M., Hanson, R., Saunders, B.E., Nichols, T., Barnett, D., Zeanah, C.H., … et al. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment, 11*, 76-89.

Friedrich, W. N. (Ed.) (2002). Holding therapy: Part I [Special issue]. *American Professional Society on the Abuse of Children (APSAC) Advisor, 14*(4).

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Assessing attachment in childhood

These resources provide guidance and information about assessment issues regarding RAD and disturbances in attachment.

Everett Waters website at SUNY Stony Brook. http://www.psychology.sunysb.edu/attachment/measures/measures_index.html.

Kerns, K.A., Tomich, P.L., Aspelmeier, J.E., & Contreras, J.M. (2000). Attachment-based assessments of parent-child relationships in middle childhood. *Developmental Psychology, 36*, 614-626.

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Trauma Focused Therapy

These resources provide details and materials for behavioral intervention. In most cases, specific training is recommended.

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: Guilford Press.

Deblinger, E., & Heflin, A. H. (1996). *Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach.* Thousand Oaks: Sage Publications, Inc.

Saunders, B., & Berliner, L. (2003). *Child physical and sexual abuse: Guidelines for treatment*. Washington, DC: Office of Victims of Crime. http://www.musc.edu/cvc/guide1.htm.

Resources for Practical Strategies for Parents

These books are designed to provide support for parents regarding a number of behavioral problems.

Barkley, R. (1997). *Defiant children.* New York: Guilford Press.

Barkley, R. (2000). *Taking charge of ADHD.* New York: Guilford Press.

Christopher, E.R., & Mortsweet, S.L. (2001). *Treatments that work with children: Empirically supported strategies for managing childhood problems.* Washington, DC: American Psychological Association.

Greene, R. W. (1998). *The explosive child.* New York: Harper Collins.

Other Helpful Resources

Berlin, L.J., Ziv, Y., Amaya-Jackson, L, &. Greenburg, M.T. (Eds.), *Enhancing early attachments: Theory, research, intervention, & policy* (pp. 195-216). New York: Guilford Press.

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Schore, A (2009). Attachment trauma and the developing right brain. In P. Dell & J. O'Neil (Eds.). *Dissociation and the dissociative disorders: DSM-V and beyond.* (pp. 107-141). New York: Routledge.

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TDMHSAS BEST PRACTICE GUIDELINES

Eating Disorders in Children and Adolescents

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1.) Introduction

Eating disorders are problematic to diagnose and effectively treat due to the complex and early presentations of symptoms, the need for interdisciplinary care and the morbidity rate of these disorders. Collaboration and coordination is vital between medical and behavioral health professionals in the treatment of Eating Disorders. Eating disorders (ED) are potentially life threatening, leading to premature death if untreated. The significantly high mortality rate is 12 times higher than any other cause of death in females aged 15 to 24 years old. Eating disorders represent the third most common chronic illness (after asthma and obesity) in adolescent females. Failure to detect an eating disorder at an early stage can result in an increase in severity, further weight loss and/or increases in behaviors.

Increases in the incidence and prevalence of eating disorders in children and adolescents, (a steady increase since 1950) especially in the last decade, have made it important that pediatricians, other providers and caregivers be familiar with the signs of eating disorders to detect its presence early and to manage the disorders appropriately. The prevalence of obesity has significantly increased with an unhealthy emphasis on dieting and weight loss (especially in suburban areas), concern with weight related issues in children of progressively younger ages, more incidences found in males and in countries not associated with these disorders in the past. There are also a large number of affected persons who experience the consequences of eating disorders without meeting the DSM-IV criteria for eating disorders. More than 50 percent of cases do not meet the DCM-IV criteria. The most common form of eating disorder is Eating Disorder Not Otherwise Specified (EDNOS). Several psychiatric issues are more prevalent in patients with eating disorders. Suicide attempts and completion are relatively common, especially with bingeing and/or purging behaviors. Eating disorders are becoming more common among elderly women in part due to maintenance of their illness into old age. A new study states that eating disorders are common in women over 50 years of age (four percent report binge eating, eight percent report purging, more than 70 percent diet to lose weight and 62 percent report their weight adversely affects their life). Attitudes that lay the groundwork for developing eating disorders occur as early as 4th or 5th grade, making prevention difficult (70 percent of 6th grade girls reported they first became concerned about their weight between age 9 and 11). Males continue to be less likely diagnosed with what is often considered a female disorder. Males are more likely to have muscle dysmorphia, a type of disorder that is characterized by an extreme concern with becoming more muscular. Some see themselves as smaller than they really are and want to gain weight or bulk up. These are more likely to use steroids or other drugs to increase muscle mass.

Those persons close to the individual with an eating disorder have opportunities to note behaviors and symptoms of the disorder. Parents, family, caregivers, school staff, and providers all have opportunities to detect the signs of an eating disorder. Some parents may deny the existence of a problem, if the child denies an eating disorder. Overpowering shame on the part of the parent or the child can lead to an even deeper cycle of denial and control. Many of these symptoms can seem to be normal adolescent behavior or easily explained by other causes. People struggling with eating disorders are very skilled at hiding or explaining their behaviors. People with an eating disorder may also appear to be a normal weight, making it harder to detect the symptoms. It is important to remain vigilant to signs and symptoms of disordered eating even if such is denied by the patient or caregiver. Three basic principles to use to prevent children from developing eating disorders:

1) accurate information
2) vigilance
3) immediate, aggressive, effective intervention

Knowledge of diagnostic criterion, medical complications, causes, warning signals, and risk factors is important for persons to know when dealing with this age group. Pediatricians and other providers are in the best situation to help detect and treat these disorders during routine care. Training initiatives for providers, including dentists, could help improve early identification and intervention for people with eating disorders. Routine screening for eating disorders by providers should be performed during all health visits and sports physicals.

2.) DSM-IV Definitions

307.1 Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85 percent of that expected; of failure to make expected weight gain during period of growth, leading to body weight less than 85 percent of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

Restricting Type: during the current episode of Anorexia Nervosa, the person that has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge eating of purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

307.51 Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation of unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting of the misuse of laxatives, diuretics, or enemas.

307.50 Eating Disorder Not Otherwise Specified

The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder. Examples include:

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but now swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa (see Appendix B in DSM-IV-TR for suggested research criteria).

3.) Impact on Learning

Impact of Eating Disorders on Learning

Eating disorders impact brain function, as discovered in brain research. Findings show that bulimic women had a weakened response in brain regions that are part of the reward circuitry. This response was related to the frequency of binge/purge episodes, setting off a vicious cycle of altered brain function. The more often an individual had binge/purge episodes, the less responsive the brain.

These findings directly implicate the brain reward system and related dopamine. Brain dopamine related reward circuitry, the pathways that modulate our desire to eat, may have a role in Bulimia Nervosa (BN). Bulimic behavior appears to directly affect brain reward function. It is uncertain whether such alterations return to normal with recovery or not. Brain dopamine could be a treatment target in BN using specific medication that targets those abnormalities.

Teens with eating disorders often struggle with many stressors which may negatively impact their education. The often obsessive nature of the disorder should not be overlooked. Many memory impairments exist as a result from eating disorders. Individuals with eating disorders appear to have memory impairments in executive functions, visual-spatial ability, divided and sustained attention, verbal functioning, learning, and memory.

Some impairments are due to nutritional deficiencies and various cognitive biases affecting cognitive ability and spatial memory when there is no steady supply of nutrients, such as glucose, fatty acids and vitamins, particularly B1 or Thiamine. The impact of under-nutrition can have detrimental effects on cognitive development in children, student behavior and performance. Students with under-nutrition may:

- Feel irritable
- Have less ability to concentrate and focus
- Less ability to listen and process information
- Feel nausea
- Have a headache
- Feel fatigue
- Have a lack of energy

These students are unable to perform as well as their nourished peers. Deficiencies in specific nutrients, such as iron, affect memory, the ability to concentrate, cause them to become less active, more apathetic, withdrawn and engage in fewer social interactions. Immune systems may be impaired, making students more vulnerable to illnesses and increased absenteeism.

Neurobiological differences have been found in individuals with eating disorders, such as verbal and visual memory, and information and emotional processing. Imbalances in certain serotonin receptor activity may cause impairment in working memory, attention, motivation and concentration. Specific memory biases include:

- directed-forgetting
- schema-related
- selective memory bias
- explicit memory including autobiographical memory deficits
- Implicit

Impaired social cognition found in people with eating disorders also include an inability to recognize, label, and respond to different emotional states, and are impaired in visual recognition tasks. (Bardick, et.al., 2004; Orfano, 2010; NEDA, 1999)

4.) Differential diagnosis

The differential diagnosis of diminished appetite or weight loss is broad and includes endocrinological, gastrointestinal, neurological, oncological, and psychological disorders. In addition, mood and anxiety disorders often affect eating behaviors. History and physical examination are usually sufficient to evaluate for many of these potentially confounding conditions. The clinician should also consider that an eating disorder may co-occur with other chronic conditions.

5.) Screening, assessment and/or evaluation

Central symptom domains (Anderson, Lundgren, Shapiro, & Palosky, 2004) which require assessment include:

- Body weight
- Binge eating and compensatory behavior
- Over concern with shape and weight
- Dietary restraint
- Body image disturbance
- Affective disturbance

Screening/Assessment Tools

1. **Eating Attitudes Test** (EAT) Garner & Garfinkel, 1979; later modified to EAT-26 by Garner, Olmstead, Bohr & Garfinkel, 1982
2. **Bulimia Test-Revised** (BULIT-R) Thelen, Farmer, Wonderlich, & Smith, 1991
3. **Eating Disorder Examination** (EDE) Z. Cooper & Fairburn, 1987
4. **The Interview for the Diagnosis of Eating Disorders – IV** (IDED-IV) Kutlesic, Williamson, Gleaves, Barbin, & Murphy-Eberenz, 1998
5. **Multifactorial Assessment of Eating Disorder Symptoms** (MAEDS) Anderson, Williamson, Duchmann, Gleaves, & Barbin, 1999
6. **Eating Disorders Inventory-2** (EDI-2) Garner, 1991
7. **Body Shape Questionnaire** (BSQ) P.J. Cooper, Taylor, Cooper, & Fairburn, 1987
8. **The Restraint Scale** (RS) Herman & Polivy, 1980
9. **Three Factor Eating Questionnaire Cognitive Restraint Scale,** (TFEQ-R) Stunkard & Messick, 1985
10. **Beck Depression Inventory-II** (BDI-II) Beck, Steer, & Brown, 1996
11. **Clinical Impairment Assessment** (CIA) Bohn, Doll, Cooper, O'Connor, Palmer, & Fairburn, *Behavioral Residential Therapy*, 2008 October, 46(10): 1105-1110.

The **SCOFF Questionnaire** has been found to be useful in primary care settings to screen for eating disorder. The questions are:

Do you make yourself **s**ick because you feel uncomfortably full?

- Do you have to worry that you have lost **c**ontrol over how much you eat?
- Have you recently lost more than **o**ne stone (14 pounds of 6.3 kg) in a 3-month period?
- Do you believe yourself to be **f**at when others say you are too thin?
- Would you sat that **f**ood dominates your life"

Two positive answers are highly predictive of either anorexia nervosa or bulimia nervosa. (Morgan, et.al., 1999) This study was validated with individuals 18 and older. For adolescents, failure to meet expected weight gains is also an early indicator of possible eating disorder.

6.) Prevention

Dieting behaviors and body image concerns are common in adolescence. In the context of increasing rates of obesity there has been increased focus on weight reduction, dieting and physical activity in the general community. Effective prevention of Eating Disorders may include more emphasis on nutrition and good health in general, less emphasis on thinness and body image.

Several factors may contribute to the onset of an eating disorder. Dieting is a primary trigger of the downward spiral into an eating disorder. Pathogenesis of eating disorders is multifactorial, with individual, family, cultural, and genetic/biochemical conditions all playing a role. Young people who diet moderately are 6 times more likely to develop an eating disorder; those who are severe dieters have an 18 fold risk. Behaviors related to food, health and body can become distorted, destructive and potentially fatal. Clinical depression is associated with development of eating disorders (stress hormones such as cortisol are elevated in people with eating disorders, and the neurotransmitter serotonin may not function correctly). Some factors that may contribute to the development of an eating disorder include:

- Family histories of eating disorders, major depression and anxiety or mood disorders, OCD
- Biochemical or genetic/biological reasons (genetic effects may be “activated” by puberty)
- Troubled family and personal relationships, history of physical or sexual abuse
- Difficulty expressing emotions or feeling
- History of being teased about size or weight
- Cultural norms or pressures that glorify thinness or the perfect body or value people by their appearance, Strict families with strong emphasis on appearance
- Excessive talk of diet and weight
- Involvement in professions or activities that emphasize thinness
- Media influences
- Clinical depression, anxiety, anger or loneliness
- Low self esteem
- Feelings of lack of control
- Strong need to please others

Individuals with eating disorders may present as:

- highly organized
- fully functional
- enthusiastic
- perfectionistic

- intelligent
- involved in a wide range of activities
- dieting

Children who are predisposed to eating disorders are usually:

- compliant, rule bound
- anxious, fearful of becoming fat
- obsessive
- perfectionistic, driven
- eager to please
- developing eating behaviors as a way to handle stress

7.) Early Identification / Intervention

Presenting complaints of poor appetite, failure to thrive, finicky eating, poor weight gain, excessive appetite, excessive weight gain, excess nutritional intake, and obesity are described as irregular feeding behaviors in the Diagnostic and Statistical Manual for Primary Care. Presenting complaints of dieting, losing weight, restricting food intake, disturbance in perception of body shape or size, and fear of getting fat are indicators of body image problems. Fasting, binge eating, uncontrolled eating, voluntary vomiting, laxative use, diuretic use, and compulsive exercising are also presentations that may be indicative of a developing eating disorder. These presentations may not fully meet the DSM-IV criteria and are likely to be included in a new category in DSM-5 (**Avoidant/Restrictive Food Intake Disorder)**.

A single general practitioner (GP) consultation for eating behavior or shape and weight concerns has been identified as a significant predictor for the subsequent emergence of an eating disorder (Yeo & Hughes, 2011).

The prognosis of eating disorders may be improved with early detection. There is evidence that short duration of illness, weight restoration, and long term follow up may contribute to better outcomes in younger adolescent patients (Steinhausen, 2009).

Because so many children do not fit all of the requirements for anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified, some practical diagnostic criteria for childhood onset anorexia are:

1.) determined food avoidance
2.) failure to maintain the steady weight gain expected for age, or actual weight loss
3.) over concern with weight and shape

Other common features include self-induced vomiting, laxative abuse, excessive exercising, distorted body image, and morbid preoccupation with energy intake.

Physical findings include dehydration, electrolyte imbalance, hypothermia, poor peripheral circulation, cardiac arrhythmias, hepatic steatosis, and ovarian and uterine regression.

8. Treatment

Team Approach

Treatment for eating disorders requires a team approach including psychotherapy, family intervention, nutritional intervention, and medical care which may include medications. This team approach involves three main phases: (1) restoring weight lost due to severe dieting and purging; (2) treating psychological disturbances such as distortion of body image, low self-esteem, family and interpersonal conflicts; (3) achieving long-term remission and rehabilitation, or full recovery. These phases are not intended to be sequential but occur simultaneously.

Treatment Steps

Restoring weight when there has been weight loss

- Weight loss may be severe enough for feeding to occur in inpatient setting.
- Restore weight with diet changes in outpatient setting
- Help caretakers/parents assist or support weight gain and maintenance
- Alteration of exercise patterns if needed
- For bulimia, establish a pattern of regular, non-binge meals
- Include nutritionist care to assist with weight maintenance
- Consider medications (SSRI's) after weight is restored to assist with weight maintenance
- Use of prescribed diet or behavioral contract

Nutritional therapy

- address weight distortions
- increase nutritional knowledge
- overcome control issues

Treating psychological disturbances

- Cognitive-behavioral therapy (CBT) to assist with distorted thoughts and behavioral patterns
- Family systems therapy to address maladaptive interactions/patterns which contribute to the eating disorder, tailored to family dynamics and developmental level of the adolescent CBT guided self-care (Treasure and Schmidt, 1997)
- CBT guided self-care (Treasure and Schmidt, 1997)
- Assess co-morbidity and need for treatment of any co-occurring disorder

Much of the literature regarding psychotherapy approaches have examined the efficacy of cognitive behavioral therapies and family therapy with mixed results. Published studies of the Maudsley model of family therapy have demonstrated good outcomes with Anorexia Nervosa (Lock, et al). Individual therapies are only recommended for patients with AN after weight restoration has been achieved, as formal psychotherapy is likely to be ineffective due the obsessionality and cognitive impairments associated with malnourishment. The treatment with the strongest evidence base for Bulimia is CBT which initially aims to normalize eating patterns and reduce binge/purge episodes.

Pharmacotherapy

a. No medications have been given approval by the US Food and Drug Administration (FDA) for the treatment of anorexia nervosa or eating disorder not otherwise specified.
b. Anxiety and mood disorders often co-occur with eating disorders and pharmacotherapy for co-morbid diagnoses may be warranted.
c. Fluoxetine has FDA approval for the treatment of bulimia nervosa and has been shown to be effective in reducing binge eating and purging behaviors. Though they do not have FDA indications, other medications including selective serotonin reuptake inhibitors (SSRI’s) and serotonin/norepinephrine reuptake inhibitors have been shown to decrease binge eating and purging behaviors.
d. Starvation and semi-starvation may lead to anxious and depressed mood. In addition, the efficacy of pharmacotherapy may be limited and side effects more pronounced in malnourished individuals. Therefore, nutritional rehabilitation should be a primary focus of treatment.
e. Hormonal supplementation has not been shown to be effective in increasing bone mineral density in adolescents/young adults with secondary amenorrhea. (Rosen, 2010)

Indications for inpatient care:

a) Physical signs and symptoms

  i) Precipitous weight loss, low body weight (< 75 percent of expected body weight), or weight loss despite outpatient treatment.

  ii) Vital sign instability (hypothermia, bradycardia, arrhythmia, low blood pressure)

  iii) Syncope or orthostatic intolerance

  iv) Serum electrolyte disturbance

  v) Uninterruptible vomiting

  vi) Hematemesis

b) Other

  i) Suicidal thoughts or behaviors

  ii) Food refusal

  iii) Inadequate response to outpatient treatment

Medical stabilization and nutritional rehabilitation are the most crucial determinants of short term and immediate term outcome. Long term follow up can help reduce progression and sequelae of the disease. Long term prognosis is more crucially determined by individual and family therapy, especially with younger children and adolescents. Family based treatment has been found to be more effective in supporting longer term remission. Pediatricians perform medical and nutritional management and coordination with mental health personnel, usually in an outpatient setting.

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TDMHSAS BEST PRACTICE GUIDELINES

Mood Disorders in Children and Adolescents

(NOTE: The new DSM-5 will split the Mood Disorders chapter into two sections: Depressive Disorders and Bipolar and Related Disorders [Bradley, n.d.].)

Workgroup Members: Cynthia Amos-Young, MD, United Healthcare Community Plan of Tennessee, Chairperson; and Susan McGuire, MD, Southeast Center of Excellence in Chattanooga.

Mood disorders include a range of moods from simple sadness to major manic excitement. Major Depressive Disorder (MDD) and Dysthymic Disorder (DD) are the most common mood disorders affecting children and adolescents, though Bipolar Disorder (BD) is on the rise (Kennedy, 2004; Merikangas, & Pato, 2009; Youngstrom, 2006). In fact, BD is emerging as the typical diagnosis in children under the age of 12 receiving psychiatric hospitalization (Youngstrom, 2006). Further, the increase in BD diagnoses in young people substantially outpaces diagnostic increases among adults. (Researchers are still cautious in their interpretation of this finding [NIMH, 2007]. Using the DSM-IV-TR, children and adolescents can be diagnosed with MDD, Dysthymia, Adjustment disorders, Depression Not Otherwise Specified (DNOS), and BD, hypomania, and cyclothymia. MDD and BD are less common before puberty, and typically emerge during adolescence (Kennedy, 2004; Fraser-Thill, n.d.). Some estimate that nearly 20 percent of youth experience a mood disorder prior to age 18 years (Kennedy, 2004).

A recent review reported that the incidence of the first onset of a major depressive episode (MDE) is lower in childhood compared to other age periods and higher in early adulthood as compared to adulthood; recurrence is lower during childhood than other age periods, which do not differ from each other; being female predicts first-incident MDD in childhood through adulthood, but is not associated with recurrence, and suicide attempt rates are significantly higher during adolescence than during either emerging adulthood or adulthood (Rohde, Lewinsohn, Klein, Seeley, & Gau, 2012). The prevalence of Dysthymic Disorder has been reported to be about 0.6-1.7 percent in children and 1.6-8.0 percent in adolescents (Turgay, 2005). SAMHSA's National Survey on Drug Use and Health (NSDUHs) based on 2009-2010 data indicates that 8.3 percent of Tennessee youth between 12-17 years of age experienced at least one MDE during the previous year (SAMHSA/NSDUH, 2012). Finally, early-onset depression often persists, recurs, and continues into adulthood, and may predict more serious mental illness in adult life (National Institute of Mental Health [NIMH], 2007).

Diagnosing Bipolar Disorder (BD) is rare and complex in children under age 10 due to the overlap with other childhood disorders (Carlson, 2012), particularly Attention Deficit Hyperactivity Disorder (ADHD) (Galanter & Leibenluft, 2008). Bipolar disorder occurs at about the same frequency for males and females (Kennedy, 2004). For both males and females, the highest rates of onset for pediatric bipolar disorder occur between the ages of 15 and 19 (Lansford, 2004). Approximately 10 percent to 25 percent of teens hospitalized for first psychotic episodes have a diagnosis of bipolar I disorder (Carlson, Naz, & Bromet, 2005).

DSM-IV-TR Criteria for Depressive Disorders

(NOTE: The new DSM-5 will split the Mood Disorders chapter into two sections: Depressive Disorders and Bipolar and Related Disorders [Bradley, n.d.].)

Prior to diagnosis of a specific mood disorder, criteria must be met for a mood episode. The mood episode might be a major depressive episode and/or a manic episode (DSM-IV-TR, 2000).

Major Depressive Episode

- At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; one or more of the symptoms is either 1) depressed/ irritable mood or 2) loss of interest or pleasure.
  - Depressed mood most of the day, nearly every day and based on self report or observations made by others. **Note: Youth may manifest an irritable mood**.
  - Markedly diminished interest or pleasure in almost all activities nearly every day for most of the day.
  - Significant weight loss (*when not on a diet*) or gain, or change in appetite nearly every day. **Note: Consider when the youth fails to make expected weight gains.**
  - Hypersomnia or insomnia nearly every day.
  - Psychomotor retardation or agitation nearly every day (as observed by others, not just subjective feelings of being slowed down or restlessness).
  - Loss of energy or fatigue nearly every day.
  - Feelings of inappropriate or excessive guilt (which may be delusional) or worthlessness nearly every day (not merely guilt or self-reproach about being sick).
  - Diminished ability to concentrate, think, or make decisions nearly every day (either as observed by others or by subjective account).
  - Recurrent thoughts of death (not just fear of dying), a suicide attempt/specific plan for committing suicide, or recurrent suicidal ideation minus a specific plan.
- Symptoms do not meet criteria for mixed episode.
- Symptoms create clinically significant distress/impairment in social, occupational, or other important areas of functioning.
- Symptoms not due to direct physiological effects of substance (e.g., drug abuse) or general medical condition.
- Symptoms not better accounted for by bereavement. They persist in excess of two months and are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Major Depressive Disorder (MDD) can be a single episode or recurrent. Recurrent requires at least two major depressive episodes, with an interval of at least two consecutive months in which criteria are not met for a major depressive episode.

Dysthymic Disorder

- Depressed Mood, most of the day, more days than not, for at least one year in pediatric populations, either by observation by others or by subjective account.
- Presence, while depressed, of at least two of the following:
  - Overeating/poor appetite.
  - Low energy/fatigue.
  - Low self-esteem.
  - Hypersomnia/insomnia.
  - Difficulty making decisions/poor concentration.
  - Feelings of hopelessness.
- The foregoing symptoms have not abated for longer than 2 months at a time during the one-year period.
- No major depressive episode during the first year, which signals that the disturbance is not better accounted for by MDD, either chronic or in partial remission.
- There has never been a manic, mixed, or hypomanic episode, and criteria for Cyclothymic disorder have never been met.
- Disturbance does not occur exclusively in the course of a Psychotic Disorder.
- Symptoms are not due to physiological effects of substance use or a general medical condition.
- Symptoms cause clinically significant impairment or distress in occupational, social, or other important areas of functioning (American Psychiatric Association, 2000).

Typical Differential Diagnosis –Pediatric Depressive Disorders

Anxiety disorders
Posttraumatic stress disorder
Adjustment disorders
Bereavement
Seasonal affective disorder
Premenstrual dysphoric disorder
Bipolar disorder

Medical disorders
Chronic fatigue syndrome
Personality disorders
Eating disorders
Disruptive disorders
Substance abuse disorders
Sexual identity and orientation issues

Comorbidity of MDD

- MDD shows substantial comorbidity with a lot of psychiatric disorders, especially anxiety, conduct, and eating disorders. In fact, the commonness of the comorbidity is generally regarded as the rule rather than the exception.
- Nearly six in 10 youth with MDD have at least two additional disorders. It has been shown that the presence of depression in young people increases the probability of another disorder 20-fold.
- For adolescents, the most common comorbidity with MDD includes anxiety, conduct, and substance use disorders.
    - Between one fourth to three fourths of cases had anxiety disorders;
    - From 21 percent to 50 percent had conduct disorders; and
    - Almost one fourth had substance abuse disorders.

Source: Essau & Chang, 2009.

In both clinic and community samples of children and adolescents, depression is associated with significant comorbidity (Angold, Costello, & Erkanli, 1999; Essau, Conradt, & Petermann, 2000). In the Oregon Adolescent Depression Project (OADP) (Lewinsohn et al., 1998), 43 percent of the adolescents with MDD also had a lifetime occurrence of another mental disorder.

For clinical samples of children and adolescents, the most common comorbid diagnosis with depression was an anxiety disorder, particularly GAD (55 percent), phobias (45 percent), and separation anxiety disorder (nine percent) (Birmaher et al., 1996; Simonoff, et al., 1997). Indeed, anxiety disorders may serve as a risk factor for depression (Garber & Weersing, 2011). A meta-analysis of studies of community samples of children and adolescents revealed that the odds ratios for comorbid disorders with MDD were 8.2 for anxiety disorders, 6.6 for conduct/oppositional defiant disorders, and 5.5 for ADHD (Angold et al., 1999).

Impairment in cognitive and social functioning in individuals with MDD may be intensified by comorbid conditions (Biederman, et al., 2008; Fergusson & Woodward, 2002; Rudolph & Clark, 2001). For example, depressed adolescents with ADHD have been found to be at increased risk for longer episode duration, a higher rate of suicidality, and a greater likelihood of needing psychiatric hospitalization (Biederman et al., 2008).

Symptoms/ Impairments in Pediatric Depression

Symptoms of depression in children and adolescents can vary in length and degree. Parents, caregivers, educators, and other significant persons in the lives of children should be aware of the following signs, symptoms, and associated impairment consistent with possible depression:

Signs and Symptoms

- Persistent sadness or hopelessness.
- Irritability, anger, and rage
- Changes in eating and/or sleeping habits.
- Withdrawal from friends and activities once enjoyed.
- Lack of enthusiasm, interest, or motivation
- Moving or talking very slowly; or very agitated, moving all the times.
- Difficulty making decisions, lack of concentration or forgetfulness.
- Low self-esteem or guilt.
- Thoughts or expressions of death or suicide

Impairment

- Hypersensitivity to criticism or rejection.
- Frequent physical complaints (e.g., headaches and stomachaches).
- Drug and/or alcohol abuse.
- Poor school work.
- School absences
- Problems with authority figures.
- Increase in difficulties getting along with others (Public School Parent's Network, 2003).

Although the presence of one of the above symptoms does not necessarily signal clinical depression, the presence of several symptoms occurring around the same time may be a cause for concern and suggest that further evaluations may be warranted (Cash, 2004).

Screening/Evaluation – Depression

Age appropriate assessment of depressive symptoms is a key initial step in the treatment process. Obtaining information from multiple informants and using a variety of assessment methods including clinical interviews, questionnaires, and behavioral observation will provide a more comprehensive evaluation needed to make accurate diagnoses and treatment plans. Even when information from multiple sources is available, getting report directly from the child or adolescent is essential; parents often are unaware of their child's inner experiences and therefore may be less accurate reporters about their child's subjective distress (Ferdinand, van der Ende, & Verhulst, 2004).

Depressive disorders in children and adolescents often are under-diagnosed and under-treated. Younger children (ages 6-7 for purposes of these guidelines) are less able to convey their internal mood state and may present with more somatic complaints (e.g., headaches and stomachaches. Recently, however, evidence of diagnosed depression in preschool-aged children has been reported (e.g., Luby, 2009).

Recognition and treatment of depression are especially important in primary care settings because for most children and adolescents, their primary care provider may be the only health professional seen within the course of a year. A study conducted in a primary care setting found that 20 percent of youth met criteria for a depressive disorder (Yates, Kramer & Garralda, 2004)

With this consideration, the recommended first step in diagnosing depression involves physicians ruling out medical conditions, medications, or their combination. Hence, the first step is a physical examination, and electrolytic and metabolic assessment. Physicians also may choose to screen youth for depression using the Children's Depression Inventory (CDI) for ages 7-17 (Bhatia & Bhatia, 2007) or the Center for Epidemiologic Studies Depression Scale Modified for Children (CES-DC) [NIMH, 2001]. (*A copy of CES-DC is found in Appendix C of this document*.) A score of 16 or above on the CDI long form or of 7 on the short form is clinically significant. On the CES-DC, total scores of 16-23 indicate mild depression, 24-30, moderate depression, and scores over 30 reflect more severe levels of depression (Roberts & Chen, 1995).

Positive scores on any screening instruments may signal the need for a more comprehensive evaluation by a Mental Health professional. Gathering information for a complete history of symptoms, conducting interviews with the young person, his/her parents or caregivers, exploration of family psychiatric history, and whenever possible, obtaining information from other informants such as teachers and social services workers likely will be useful during the assessment process. Questioning the young person about alcohol and drug use, and thoughts about death or suicide is critical. This assessment information and the young person's mental status examination [to evaluate any effects from the depression on speech, thought patterns, or memory (NIMH, 2001)], are critical to making a diagnosis and developing a treatment plan for the constellation of mood symptoms at that specific episode in the young person's life.

Treatment - Depression

Treatment Planning

Multimodal treatment plans may help with the high degree of comorbidity and the severity of the psychosocial and academic consequences associated with depression. It is important to develop a treatment plan that is appropriate for the developmental stage of the child or the adolescent while providing safe and effective treatment services in the least restrictive environment.

Acute Treatment

Factors to consider when selecting the initial treatment(s) include: Chronicity

- Severity and number of prior episodes
- Previous response to treatment
- Age of the child
- Compliance with treatment
- Child's and family's motivation for treatment
- Extent of psychopathology in the parent(s)

- Contextual issues

Family Education

Youth and their caregivers should be taught about the disorder and the treatment involved. Family education involves family members as informed partners in the treatment team. It helps for them to understand that depression is a treatable condition, and to identify patterns of behaviors and associated psychosocial concerns. Supportive involvement of family members may help the young person appreciate the importance of compliance with treatment.

Psychotherapy

Treatment must take into account the severity of depression, developmental stage, suicidality, and social and environmental factors (Clark, Jansen, & Cloy, 2012). The majority of the psychotherapy trials for depression in children and adolescents have evaluated the efficacy of various forms of cognitive-behavioral therapy (CBT), and some have used interpersonal therapy (IPT) or family therapy (Kaslow & Thomson, 1998). Both CBT and IPT are recommended treatments for young people with mild depression. These two psychotherapies further are appropriate adjuvant treatments to medication in young people with moderate to severe depression (Clark, Jansen, & Cloy, 2012).

***Cognitive-Behavioral Therapy** (CBT)* aims to help individuals identify and modify negative thought patterns, realistically evaluate the accuracy of their beliefs, and develop problem-solving and coping skills (Beck, Rush, Shaw, & Emory, 1979). There have been 14 randomized studies of some form of CBT with depressed youth: four in clinically referred samples, four in diagnosed community samples, and six in symptomatic but not diagnosed community samples.

CBT holds that cognitive distortions contribute to depression, and teaches youth to identify and counteract these negative beliefs. CBT is most efficacious with mild to moderate depression. Clinical studies have found high rates of relapse upon follow-up, however, suggesting the need for continuation treatment in individuals with more severe depression (NIMH, 2001). Research supports combination treatments for severe and recurrent depressive episodes (NIMH, 2007; Treatment for Adolescents with Depression [TADS] Team, 2004). CBT aims to promote self-esteem, coping skills, adaptive strategies, and improved peer and family relationships. The combination of CBT with antidepressant medications has been shown to be effective in reducing depression in adolescents (TADS Team, 2004).

IPT is a brief, time limited psychotherapy which assumes that the quality of interpersonal relationships can cause, maintain, or buffer against depression. Treatment with IPT involves three phases: initial, middle, and termination. The initial phase focuses on diagnosing the disorder, providing psychoeducation, exploring the youth’s significant relationships with peers and family members, and identifying the problem area that will be the focus of remaining treatment. In the middle phase, the therapist educates youth about the connection between his/her mood and problems that are occurring in relationships. The youth also learn ways that new communication and problem-solving skills can improve relationships, thereby leading to recovery from depression. The therapist focuses on identifying specific strategies to help the youth negotiate his/her interpersonal difficulties more successfully. Finally, the termination phase serves to clarify warning signs and symptoms of future depressive episodes, identify successful strategies from the middle phase, foster ways to generalize newly learned skills to future situations, emphasize mastery of new interpersonal skills, and discuss whether further treatment is warranted (EffectiveChildTherapy.com, n.d.).

Pharmacotherapy

The combination of pharmacotherapy (medications) and CBT are recommended for the treatment of MDD in youth, especially when depression is moderate to severe. Fluoxetine may be the initial drug of choice in this combination therapy (Tom-Revzon & Lee, 2006). A more specialized treatment with ***medications should be considered as first-line treatment for more difficult youth cases*** such as those with severe or psychotic symptoms, when psychotherapy is not appropriate or available, and youth with chronic or recurring episodes (NIMH, 2001). The use of specialized medications should involve Mental Health professionals as consultants or as primary caregivers as special care should be given to children and adolescents prescribed medicines with more chronic or complex symptom and family history. Some psychiatric medicines contain "***BLACK BOX***" warnings because they have been linked to increased suicidality in youth. Patients and parents should be educated about such risks and instructed to contact the physician and/or mental health professional if any suicidal ideation is experienced, particularly early in treatment or at any point such ideation occurs (American Psychiatric Association and American Academy of Child & Adolescent Psychiatry, 2005).

Table of Typically Prescribed Pediatric Medications – Depression

Benefits: Useful in treating depression. Most of the medications on the list are in the category of SSRI (Specific Serotonin Reuptake Inhibitors) that affect the neurotransmitter Serotonin.
Side Effects: Possible appetite changes, nausea, headache, sweating, insomnia and occasionally tiredness, sexual problems including desire.

MEDICATION NAME		**NOTES**
Brand Name	**Generic Name**	
1. Prozac / Serefam	Fluoxetine	***Fluoxetine is the only medication that carries FDA approval in the treatment of depression in children (NIMH, 2007).*** It has been approved in the treatment of pediatric patients as young as eight years of age. Keep the maximum dosage no higher than 20 mg/day (Texas Department of Family and Protective Services …, 2010).
2. Lexapro	Escitalopram	***Lexapro has been approved for use in adolescents (ages 12-17) with depression.*** Keep the maximum dosage no higher than 20 mg/day (Mayo Clinic, 2012; Texas Department of Family and Protective Services …, 2010).
3. Zoloft	Sertraline	***Not approved for use in pediatric patients with depression*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
4. Luvox	Fluvoxamine	***Not approved for use in pediatric patients with depression*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
5. Paxil/ Paxil CR	Paroxetine	***Not approved for use in pediatric patients with depression*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
6. Celexa	Citalopram	***Not approved for use in pediatric patients with depression*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
7.Effexor XR	Venlafaxine	***Not approved for use in pediatric patients with depression*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
8. Cymbalta	Duloxetine	***Not approved for use in pediatric patients with depression*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).
9. Pristiq	Desevenlafaxine	***Not approved for use in pediatric patients with depression*** (Texas Department of Family & Protective Services …, 2010). Use and dosage should be based on clinical need and determined by the prescriber (Mayo Clinic, 2012).

***NOTE**: There are black box warnings on all antidepressant medications, especially related to suicidal ideation. As a precaution, all patients receiving antidepressant therapy should be carefully monitored and closely observed for clinical worsening, suicidality, or unusual changes in behavior* (Texas Department of Family & Protective Services …, 2010).

Treatment Considerations and Duration

BEFORE beginning antidepressant therapy with young people, prescribers should ensure that a safety plan is in place. The safety plan is an agreement with the youth and his/her family that the patient will be kept safe and will contact a responsible adult if suicidal thoughts are too strong. Also included in this plan is assurance of that the treating prescriber or his/her proxy will be available 24 hours a day to manage emergencies.

Treatment duration is dependent upon the number of previous episodes of depression. At least six months of treatment is recommended in first episodes, with slow tapering of the drug over a six-to-eight week period to minimize risk of withdrawal syndrome. At least one year of treatment should be given for second episodes of depression. When there have been two or three episodes, treatment might last up to three years. More extensive treatment is recommended for pediatric patients with more than three previous episodes of depression, especially if the episodes are severe, involve suicidality, or have psychotic features.

Use the dosage at which symptom relief occurs as the dosage for maintenance. Family therapy and/or adjunctive psychotherapy can help consolidate gains. No optimal treatment duration for therapy has been established.

A child psychiatric consultation will be helpful for children with treatment-resistant depression or severe recurrent depression. Prescribers who are uncomfortable prescribing complex therapies should consider referral to a child psychiatrist, particularly if the patient has multiple comorbidities (Bhatia & Bhatia, 2007).

Prevention - Depression

Lifestyle strategies should be incorporated as much as possible on the front end as part of prevention as they are a part of treatment for depression. Such strategies include:

- Regular exercise
- A healthy, balanced diet
- Regular and sufficient sleep
- No alcohol, tobacco, or drugs
- Limit caffeine use
- Family education about the disorder (Bryson, 2005).

Youth with subclinical depressive symptoms are at high risk to develop clinical depression. When these symptoms persist after an episode of depression, continued treatment until full remission is recommended. For youth who have not had an episode of depressive symptoms of full duration or severity to be sufficient for clinical depression consideration, psychosocial interventions to reduce environmental and family stressors and CBT strategies appear to be efficacious to prevent the development of a full depressive disorder.

Children with depressive symptoms are at increased risk of having a first episode of MDD within a few years after onset of initial depressive symptoms. Thus, early intervention with mild to moderate depressive symptoms may decrease the likelihood of the onset of a full depressive episode. Early intervention with depressed youth also may reduce the chances of developing comorbid problems such as substance use disorders.

Bibliotherapy – Depression

The Children's Hospital & Regional Medical Center – Seattle (2004) lists the following three books about depression as resources for children to read:

- *Taking Depression to School*, Kathy Khalsa, 2002. A story in which a girl tells her classmates what life is like for her living with depression.
- *Tiger's Fall,* Molly Garrett Bang, 2001. A little girl becomes physically disabled as the result of an accident. She learns that her disability cannot limit her ability to make a difference.
- *Where's Your Smile*, *Crocodile*? Clair Freedman, 2001. A boy who visits with his friends from the jungle is the main character in this book. Through his visits, he learns important lessons about feelings and helping others.

Parents may gain knowledge and strength from the following books (Children's Hospital & Regional Medical Center – Seattle (2004):

- *The Childhood Depression Sourcebook*, Jeffery Miller, 1998. Provides useful insight and knowledge about why children get depressed, how to identify signs and symptoms, and where to find appropriate treatment.
- *The Depressed Child: Overcoming Teen Depression*, Mariam Kaufman, 2001. Guides parents/caregivers through the signs and symptoms of depression, what the illness is, and how it can be overcome.

Bipolar Disorder (BD)

(NOTE: The new DSM-5 will split the Mood Disorders chapter into two sections: Depressive Disorders and Bipolar and Related Disorders [Bradley, n.d.].)

Prior to diagnosis of BD, criteria must be met for a major depressive episode and a manic episode (DSM-IV-TR, 2000).

Manic Episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood that lasts at least a week.
- At least three of the following symptoms persist and have been present to a significant degree during the mood disturbance period (four symptoms, if mood is irritable).
    - Inflated self-esteem/grandiosity.
    - Decreased need for sleep.
    - More loquacious than usual or pressured to keep talking.
    - Flight of ideas or subjective experience that thoughts are racing.
    - Distractibility.

  - Increase in goal-directed activity, or psychomotor agitation.
  - Excessive involvement in pleasurable activities that have a high potential for painful consequences.
- Symptoms do not meet criteria for mixed episode.
- Mood disturbance is sufficiently severe to cause marked impairment in occupational functioning, usual social activities, or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- Symptoms not due to direct physiological effects of substance or general medical condition.

Manic or hypomanic episodes lend themselves to a diagnosis of Bipolar Disorder I or II, respectively. The manic episode should not be better accounted for Schizoaffective Disorder, and should not be superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (American Psychiatric Association, 2000). **(Note:** ***Manic-like episodes clearly caused by somatic antidepressant medication should be assessed without antidepressant treatment and may not meet the criteria for diagnosis of Bipolar I Disorder*** [American Psychiatric Association, 2000]).

A child with BD can express extreme, explosive anger that may be triggered when a parent/other authority figure attempts to set limits. The destruction that occurs is most likely intentional. Additionally, some youth with BD have an accompanying psychosis (Frank, 2006).

It is recommended that clinicians use the FIND strategy to determine the presence or absence of manic symptoms. FIND stands for frequency, intensity, number, and duration. For *frequency*, the symptoms must manifest most of the days during a week. *Intensity* means that the symptoms are so severe that at least one domain of functioning is significantly affected. If the manic symptoms are mild to moderate then at least two domains of functioning must be affected. *Number* means that the symptoms occur at least 3-4 times a day. Finally, *duration* relates to the length of time the symptoms occur. The standard is at least 4 hours a day, which do not have to be consecutive (Kowatch et al., 2005).

New DSM-5 Changes to Bipolar Classification

Besides becoming a separate section in the DSM-5 titled “Bipolar and Related Disorders” (Bradley, n.d.), a new disorder will be added to the section. Disruptive mood dysregulation disorder will be included to diagnose young people who show frequent episodes of behavior outbursts at least three times a week and persistent irritability for longer than a year (Gever, 2012; Grohol, 2012). Adding this diagnosis has the intent of addressing concerns about potential overdiagnosis and overtreatment of bipolar disorder in children and adolescents, hence reducing the number of young people that have a BD diagnosis.

Typical Differential Diagnosis for Pediatric Bipolar Disorder

Major depressive disorder
Disruptive disorders
Attention deficit hyperactivity disorders
Psychotic disorders
Personality disorders
Seasonal affective disorder
Adjustment disorders and bereavement
Premenstrual dysphoric disorder
Pervasive developmental disorder
Posttraumatic stress disorder
Anxiety disorders
Substance abuse disorders
Eating disorders
Medical disorders
Sexual identity and orientation issues

Youth with bipolar disorder are at extremely high risk for suicidal ideation, intent, plans, and attempts, during depressed or mixed episodes or when psychotic (Kowatch et al., 2005).

Comorbidity of Bipolar Disorder

Many young people with bipolar disorder are also diagnosed with attention deficit hyperactivity disorder (ADHD) (Frank, 2006; Lansford, 2004) or comorbid conduct disorder (Brown, 2002-2003). Differentiating among these various diagnoses often is difficult and controversial (Galanter & Leibenluft, 2008).

Screening/Evaluation – Bipolar Disorder

Bipolar is difficult to diagnose in children and early adolescents, in part because children lack the capacity to manifest many of the symptoms that show up in adults. Nevertheless, Geller (1998) identified five symptoms that will help in correctly diagnosing childhood bipolar disorder. They are grandiosity, flight of ideas or racing thoughts, decreased need for sleep, elation, and hypersexuality. In late adolescence, as many as 50 percent with bipolar disorder have been misdiagnosed as either conduct disorder or schizophrenia (Lansford, 2004).

Screening and evaluation for bipolar disorder in children and adolescents should involve procedures very similar to those used to identify depression. A thorough physical examination, metabolic and electrolytic evaluation and a diagnostic evaluation should be completed. At the very least, the youth and one parent should be interviewed, though both parents are preferable. The interview should be conducted by a specialized clinician that is knowledgeable about young people and mood disorders. Information should come from multiple sources, including teachers, coaches, afterschool care providers, peers, etc. Medical records also provide very useful information. The youth's medical history can help rule out physical conditions that may mimic bipolar symptoms. School input will be important during the initial evaluation and after treatment progresses (Kowatch et al., 2005).

During the evaluation, the clinician should establish a timeline that reflects the unfolding of the disorder and comorbid conditions over time. All "BAMO" (behavior, anxiety, mood, and other) symptoms should be included in the timeline. A fourth grade child, for example, could be asked whether any symptoms were present in 2nd or 3rd grade. If the clinician suspects illegal drug use, a drug screen should be ordered. If symptoms appear to have been triggered by a prescription drug use, a seven-to-ten-day "washout" period should be instituted. If symptoms persist following the washout period, a diagnosis of bipolar disorder should be considered. The evaluation should also include an assessment of suicidal thinking and/or attempts because suicidal behaviors are more common in persons with bipolar than in most any other pediatric psychiatric disorder (Kowatch et al., 2005).

Current symptom information is as important as gathering data about symptoms over time. Collecting family history information will help the clinician establish any genetic connection. Research has shown that children whose parents have the disorder are two to three times more likely to develop the disorder themselves (Kowatch et al., 2005).

Treatment – Bipolar Disorder

Psychosocial/Psychotherapeutic interventions

Psychotherapy can be an effective adjunctive treatment in depressed youth with or at risk for BD. Various psychotherapeutic approaches, including cognitive-behavioral therapy (CBT), dialectical-behavioral therapy (DBT) and family therapy, are beginning to be found to be efficacious in pediatric BD (Chang, 2009; The Balanced Mind Foundation, 2012).

In an open study of DBT in 10 adolescents with BD, depressive symptoms and suicidal ideations and behaviors decreased significantly over 1 year (Goldstein et al., 2007). DBT is particularly recommended when there is suicidal ideation or behaviors (Kowatch et al., 2005).

In a small controlled study of CBT for adolescents with BD, significant decreases in parent and child reported depressive symptoms were reported in the CBT condition. However, compared with BD youth who did not receive CBT, there were no differences in post-treatment depression scores by clinician assessment (Feeney et al., 2006). These individual therapy approaches show promise and should be considered when deciding about treatments alternatives for children with bipolar disorder.

A recent study of adolescents with BD found that family-focused therapy (FFT) was more effective than a series of psychoeducational sessions ("enhanced care" or EC) (Miklowitz, et al., 2008). Adolescents receiving FFT recovered faster from their baseline depressive symptoms and spent fewer weeks in depression than did those receiving EC. FFT was not more effective than EC in preventing relapse of depressive episodes. Thus, depression in the context of BD in youth may be particularly responsive to psychotherapeutic interventions, potentially more so than in pediatric patients with symptoms of mania.

Overall, common themes of these interventions are psychoeducation, behavioral and cognitive interventions, including reducing stress and improving coping strategies, and mood regulation techniques.

Psychosocial therapies such as CBT are generally recommended to treat the comorbid disorders that accompany the bipolar disorder. CBT or IPT often is used when the comorbid condition is depression, anxiety, or OCD. Family focused therapy (FFT) can be effective when substance use disorder is comorbid. Psychotherapy in the form of dialectic behavior therapy (DBT), if available, should be considered in the event of ongoing suicidality (Kowatch et al., 2005). A good treatment plan for bipolar disorder incorporates medication (pharmacotherapy), multifamily psychoeducational groups for the youth, family peer support for parents/caregivers, and accommodations at school in addition to psychotherapy (Lansford, 2004).

Treatment for Comorbidity

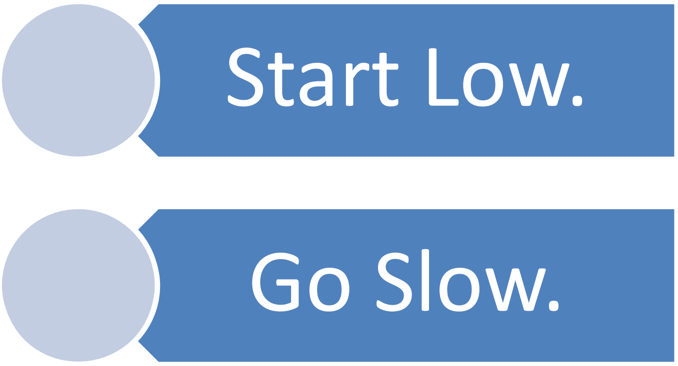
Most of the children with bipolar disorder additionally have at least one coexisting disorder (comorbid). Comorbid factors are frequently associated with non-response or poor response to treatment and should be explored whenever a youth does not respond to treatment (Kowatch et al, 2005). The symptoms of bipolar disorder should be stabilized in advance of treating the comorbid condition(s). Each comorbid condition should be treated sequentially, that is, one at a time, but only after the bipolar disorder has been adequately treated. Any medications should be introduced one at a time, whenever possible, so that benefits and side effects of each agent can be adequately monitored.

When a comorbid disorder is confirmed, the treatment plan must be modified to handle treatment of each disorder. It is likely that a number of combination trials of medications and psychotherapy will be necessary for successful outcomes. It is still important, however, that the bipolar symptoms be stabilized first (Kowatch et al., 2005).

Pharmacotherapy

Beginning with medications typically utilized in youth and/or those with FDA approval. noting that approval is associated with short-term treatment (FDA, 2007). A list of initial medications for consideration is shown below in the *Table of Typically Prescribed Medications – Bipolar Disorder*.

Monotherapy is an initial goal of pharmacotherapy; however, oftentimes at least two medications may be required for treatment of more severe or complex symptoms associated with Bipolar Disorder, especially when psychosis is one of the additional symptoms contributing to the complexity of the diagnosis. With young people and medication, it is recommended to:



Source: The Balanced Mind Foundation, 2012.

Table of Typically Prescribed Pediatric Medications for Bipolar Disorder*

Benefits: Useful in treating symptoms of bipolar disorder		
Side Effects: Possible excessive thirst, frequent urination, mild gastrointestinal discomfort, acne, weight gain, sedation and possible fine motor tremors (associated with list #4-8).		
MEDICATION NAME		**NOTES**
Brand Name	**Generic Name**	
1. Eskalith/ Lithobid	Lithium	***FDA approved for pediatric use in youth ages 12 and up.*** (NIMH, n.d.; Yan, 2007).
2. Risperdal	Risperidone	***FDA approved for use in pediatric patients ages 10 to 17*** (FDA, 2007; Yan, 2007).
3. Abilify	Aripiprazole	***FDA approved for use in pediatric patients ages 10 to 17*** (PsychCentral, 2008).
4. Zyprexa	Olanzapine	***FDA approved for use in pediatric patients ages 13 to 17*** (Pendulum.org, 2009; PsychCentral, 2009).
5. Seroquel	Quetiapine	***FDA approved for use in pediatric patients ages 10 to 17*** (PsychCentral, 2009).
6. Depakote	Valproic acid	***Not FDA approved for pediatric use*** (NAMI, 2010). Also has a "black box" warning for pancreatitis and liver failure (Wegmann, 2009).
7.Tegretol/Carbatrol	Carbamazepine	***Not FDA approved for pediatric use*** (Rutledge, n.d.).
8. Trileptal	Oxcarbazepine	***Not FDA approved for pediatric use***. Studies have not shown its use to be significantly superior to placebos in the treatment of bipolar in young people (Purse, 2010).
9. Lamictal	Lamotrigine	It is not known if this medication is effective or safe in children or adolescents younger than 18 years of age with mood disorders such as depression or bipolar disorder (FDA, 2012).

**At the time of this writing, there are no FDA-approved medications for the treatment of bipolar disorder under the age of 10 years.*

Treatment Duration:

Initial medication	At least four weeks	Up to six weeks if improvement noted in four weeks
Continuation therapy	At least six months	Longer if remission does not occur within six months
Maintenance therapy (1-3 years)	If youth has multiple or severe episodes of mood instability or suicidality	If youth is at high risk for recurrence

*****Content adapted from *Guide to Psychiatric Medications for Children and Adolescents* by Glenn Hirsch, M.D., at www.AboutOurKids.org and various US Food and Drug Administration (FDA) website on medication use with children and adolescents. However, content was primarily based on *Psychotropic Medication Utilization Parameters for Foster Children* (2010), as developed by the Texas Department of Family Protective Services and the University of Texas at Austin College of Pharmacy. Various FDA resources served as secondary sources.

Precautions – Bipolar Disorder

Effort to adequately diagnose bipolar disorder in youth whether as a child or adolescent is critical, but complex. It is important to note that using antidepressant medication to treat bipolar disorder may induce manic symptoms if antidepressant is used without a mood stabilizer. However, due to the progression of Bipolar Disorder the initial mood presentation may be depressive in nature, contributing to the diagnostic complexity of these cases. Collaboration between the pediatrician (oftentimes the original clinician to evaluate the symptoms) and the psychiatrist, especially Child and Adolescent Psychiatrist is an important step in the diagnosis and treatment of youth with Bipolar disorder. Physicians should educate families on the signs and symptoms of mania. The family is critical to the appropriate treatment of the youth and will assist with adherence to treatment. The family can report changes immediately to the physician resulting in appropriate treatment changes. (NIMH, 2001).

Prevention – Bipolar Disorder

Strategies that persons with bipolar disorder can use to prevent recurrences or reduce the existing symptoms include:

- Getting regular exercise.
- Eating a healthy diet.
- Getting adequate and regular sleep.
- Keeping to a regular schedule.
- Developing personal support systems, involving family and friends (Segal, de Benedictis, & Segal, 2007).

Bibliotherapy – Bipolar Disorder

There are several good books for children and adolescents with bipolar disorder. One of them focuses on siblings so they can learn about the disorder and how to best get along with their brother or sister.

- *The Storm in My Brain*. Child & Adolescent Bipolar Foundation (CABF), 2003. A booklet, created by young people with the disorder that speaks to other youth about how it feels to have a mood disorder.
- *Anger Mountain.* Hannah & Hebert, 2005. The book features an elementary school-age child who is dealing with significant anger issues. It gives youth hope, support, and strategies for coping with the disorder.
- *My Bipolar Roller Coaster Feelings Book & Workbook*. Hebert & Hannah, 2005. The book is written from the perspective of a young man who suffers from bipolar disorder. It is a great resource for other youth with the disorder, their family, friends, and significant others.
- *Turbo Max: A Story for Siblings of Bipolar Children.* Anglada, 2002. For siblings 8-12 years old. The boy's summer diary describes his journey with his sister's disorder, which culminates with his acceptance of her illness.
- *Matt the Moody Hermit Crab.* McGee, 2003. A young man undergoes onset, diagnosis, and treatment of bipolar disorder. It is designed for young people ages 8-12 (grades 4-7). ***Source****: Amazon.com, 2007.*

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TDMHSAS BEST PRACTICE GUIDELINES

Schizophrenia in Children and Adolescents

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Background: Pediatric schizophrenia is divided into two basic categories according to age of onset. When onset occurs before the age of 13, it is referred to as very-early-onset schizophrenia (VEOS). Depending on the source, VEOS may also be referred to as Childhood-Onset Schizophrenia, or COS; these terms are synonymous. When onset occurs after age 13, but before age 18, it is referred to as early-onset schizophrenia (EOS) [AACAP Schizophrenia CPG]. By comparison, the typical age of onset of schizophrenia in adults is the age range of 18 to 25.

Pediatric schizophrenia is rare, occurring in 1 in 40,000 individuals compared to Adult schizophrenia which occurs in 1 in 100 individuals. As one might imagine, the incidence in the EOS group increases as the adolescent approaches the age of 18 [NIMH, 2001]. In cases of VEOS in which developmental lags are present (e.g.-delays in motor and speech/language development), the course of the illness is more severe and the prognosis worse due to the involvement of important neurodevelopmental processes. The course and prognosis of illness can often be mitigated to a significant degree by early diagnosis and aggressive treatment, as is the case in adult onset schizophrenia.

DSM Criteria: DSM-IV-TR criteria for pediatric schizophrenia are identical to that for adult schizophrenia with one potential modification; the failure to meet expected interpersonal, academic, or occupational milestones may be present as opposed to exhibiting deterioration in functioning.

- At least two of the following must be present for a significant period of time during a one-month period:
  - Delusions.
  - Hallucinations.
  - Disorganized speech.
  - Grossly disorganized or catatonic behavior.
  - Negative symptoms (flattened affect, paucity of thought or speech).
- Only one symptom need be present if the delusions are bizarre, the hallucinations include a voice providing a running commentary on the person's behavior or thinking, or at least two voices are conversing with each other.
- In children and adolescents, there is a failure to achieve the expected level of interpersonal, academic, or occupational achievement.

- The disturbances must be present for a period of at least 6 months, which period must include one month (less if successfully treated) of active-phase symptoms described above, which may include residual or prodromal symptoms.
- Schizoaffective Disorder and Mood Disorder with Psychotic Features are ruled out.
- The disturbance is not due to the direct physiological effects of a substance or general medical condition.
- Where there is a history of Autistic or other Pervasive Developmental Disorder, delusions or hallucinations are also present for at least one month (less if successfully treated) [American Psychiatric Association, 2000].

Differential Diagnostic Considerations: Of all the differential diagnostic considerations listed below, one of the biggest challenges in the 3 to 7 year old age group is differentiating between autism or other pervasive developmental disorders (PDD) and VEOS. This is due to the similar failure to achieve language and socialization developmental milestones. In the VEOS group, hallucinations and delusions which persist over longer periods of time are present, whereas in autism or other PDDs, they do not persist if they are present at all. In the EOS group, it is differentiating between Bipolar Disorder and Schizophrenia.

The older the age of onset of Schizophrenia in adolescent presentations, the more the syndrome will appear similar to the onset in the adult population.

Bipolar Disorder
Schizoaffective Disorders
Other Psychotic Disorders
Pervasive Developmental Disorders
Organic Disorders
Delirium
Seizure
CNS Lesion
Neurodegenerative
Metabolic
Toxic Encephalopathy
Infectious Diseases

Developmental Language Disorders
Obsessive-Compulsive Disorder
Factitious Disorder
Substance Abuse/Substance Induced Psychosis
Personality Disorders:
    Paranoid
    Borderline
    Schizotypal
    Schizoid
Posttraumatic Stress Disorder
Other non-psychotic behavioral and/or disorders

Assessment: Schizophrenia tends to emerge gradually in children [NIMH, 2001]. Signs and symptoms to look for in VEOS include premorbid developmental impairments, such as language, motor and social deficits. These appear to be more frequent and more pronounced than for later-onset forms of Schizophrenia. Auditory hallucinations are the most frequent positive symptom, with visual and/or tactile hallucinations being extremely rare in the younger ages.

- Conduct a complete diagnostic assessment, which specifically should include the following elements:

  - Premorbid history (prenatal, developmental disturbances such as delays in motor and language development, interpersonal relationships such as the lack of friends, personality development, highest level of functioning).
  - History of present illness (DSM-IV-TR target symptoms; course of illness including onset, cyclical patterns, precipitating stressors; associated or compounding symptoms, especially mood disturbances, substance abuse, and organic factors).
  - Mental status examination.
  - Physical examination, including a thorough neurological assessment.
  - Laboratory evaluations, EEG, and neuroimaging techniques may be necessary to rule out other disorders.
  - Psychological and neuropsychological testing may be necessary to assess baseline cognitive deficits and to direct rehabilitative efforts.
  - Family history (environment, interactions, coping styles, resources, strengths; history of psychiatric and neurological conditions, and substance abuse).
  - School functioning.
  - Suspected skills deficits.
- Rule out other disorders and determine if it is necessary to place the child or adolescent in a more structured milieu, such as an inpatient unit, partial hospital or intensive outpatient program depending on diagnostic and assessment needs as well as to manage risk behavior or thoughts.
- Identify other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders, etc.).

Treatment:

Nonpharmacologic interventions include:

1) Periodic diagnostic reassessments to ensure accuracy of diagnosis.
2) Appropriate psychotherapy.
3) Psychoeducational services for the youth.
4) Psychoeducational services for the primary caregivers.
5) Social skills training geared to helping the individual to cope with their illness.
6) Case Management services for the youth and family (e.g. Coordinated Child and Family Therapy, or CCFT).
7) Supportive services for the family, such as Parental Peer Support offered by Tennessee Voices for Children.
8) Educational and vocational services (e.g.- special education and/or other accommodations may be required to help the child to succeed in the classroom)
9) Residential, partial hospitalization or intensive outpatient services when indicated.

Psychopharmacologic Therapy: See table titled *Psychotropic Medication Utilization Parameters* below [Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy. (December 2010). *Psychotropic medication utilization parameters for foster children*].

The use of antipsychotic agents requires the following:

1. Adequate informed consent from the parent, guardian, or youth.
2. Documentation of target symptoms.
3. Documentation of any required baseline and follow-up laboratory monitoring. This should include parameters indicative of the onset of metabolic syndrome such as Fasting Blood Sugar or hemoglobin 1Ac, Lipid profile, weight and BMI
4. Documentation of treatment response.
5. Documentation of pre-treatment abnormal movements, suspected side effects, and the monitoring for known side effects.
6. Adequate therapeutic trials, generally requiring that sufficient dosages are used, adherence is monitored and medications are used over a 4 to 6 weeks.
7. Long-term monitoring to reassess dosage, depending on the stage of illness.

Acute Phase

The choice of antipsychotic medication should be based on the agent's relative potency and spectrum of side effects, and on the history of medication response in the youth and his or her family members. Side effects occur with all antipsychotic medications, and may include acute extrapyramidal symptoms (EPS- such as dystonia, parkinsonism, akathisia), late-onset EPS (such as tardive dyskinesia, withdrawal dyskinesia, tardive dystonia), anticholinergic symptoms, neuroleptic malignant syndrome, cognitive impairment, sedation, orthostatic hypotension, weight gain, sexual dysfunction, hyperprolactinemia, decreased seizure threshold, increased hepatic metabolism, cholestatic jaundice, agranulocytosis, and activation or agitation. Many of these side effects are specific to particular antipsychotics and should be monitored when that antipsychotic is used.

When using antipsychotic medications, antiparkinsonian agents may be needed for the treatment of acute extrapyramidal side effects. Prophylactic use of antiparkinsonian agents should be considered when acute extrapyramidal symptoms are likely, such as when using high-potency neuroleptics, when treating new youth, or when treating paranoid youth for whom a dystonic reaction may significantly impair adherence.

For both prodromal and first-episode illness, start with an atypical antipsychotic drug that has FDA approval for children and/or adolescents. To date, only two antipsychotic medications meet this criterion: Risperdal and Abilify. Approved ages and maximum dosages can be found in the table titled *Psychotropic Medication Utilization Parameters* below. The second-choice medication should also fall in the atypical antipsychotic category. Thus, in the acute phase of the illness, the second-line drugs of choice might include: Olanzapine, Quetiapine, Ziprasidone, and Aripiprazole. To determine whether or not antipsychotic medication is effective, it must be used for at least four to six weeks at adequate dosages. If no effects are seen at that point, consideration should be given to changing to a different antipsychotic medication. Children and adolescents are likely to be more sensitive to the adverse effects of antipsychotic medications, and lower doses are as effective as higher doses with superior tolerability, and therefore adherence, in first episodes.

Inpatient treatment and other less restrictive milieu-based support options should be considered for observation and/or management of behavioral dyscontrol or other risk factors. The risk of relapse following recovery from a first psychotic episode is very high and significantly diminished by maintenance antipsychotic medication treatment. When the youth who has experienced only one episode of positive symptoms is symptom-free for 12 months, a gradual dose reduction over several months, with a trial period of no medication, may be considered. If the first episode was more severe and if the symptoms were slow to respond to treatment, a dosage reduction may be considered after 24 months. Incomplete response in some symptom areas, but with clear benefit in other areas, indicates a need for maintenance treatment for at least two to five years.

Stabilization Phase

Once the acute psychotic symptoms are stabilized, the youth may still have ongoing difficulties with confusion, disorganization, motivation, and possible dysphoria. Antipsychotic medication should be maintained through this phase to prevent acute exacerbations. The goal of therapy is to reintegrate the youth back to his or her home and school, if possible.

This period is generally considered to begin 4 to 12 weeks after the acute phase is controlled, at which time treatment should be continued for at least 6 to 12 months. Dosage reductions should be considered as indicated.

Residual or Remission Phase

The youth should be maintained on the lowest effective dose of antipsychotic medication. Once the youth is clinically stable, the dosages should be reassessed approximately every 6 months. Many youth will be chronically impaired and need to be maintained on long-term antipsychotic agents. The duration of treatment is indefinite when there have been multiple prior episodes or 2 episodes within 5 years.

When discontinuing these agents, they should be tapered, given the increased risk in children for withdrawal dyskinesia. The exception to this is when neuroleptic malignant syndrome occurs. Careful monitoring is needed during times in which the dosage is being changed to assess for symptoms of relapse. Longitudinal medication management is needed to monitor side effects, including tardive dyskinesia.

Relapse of Symptoms

The most common contributors to relapse are nonadherence to medications, substance use, and stressful life events. When a youth relapses, it should first be determined whether or not the youth was compliant with his or her antipsychotic medications. If not, resumption of the medication should occur.

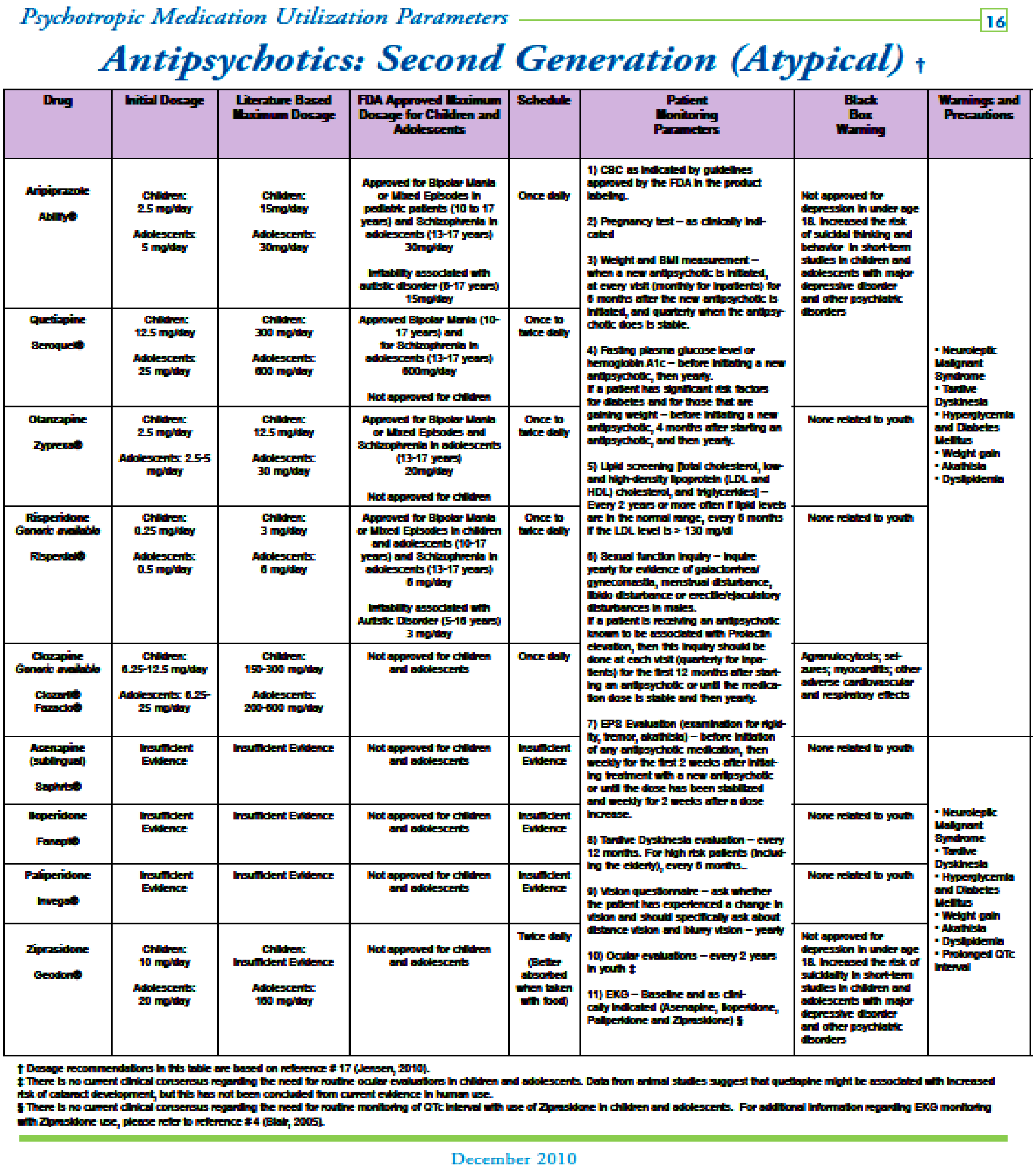
If the youth was compliant and had been previously responding and tolerating the agent, an increase in the medication dose may stabilize the psychotic symptoms (keeping in mind the standard dosage ranges).

The drugs of choice for nonadherent youth are the long-acting depot formulations Haloperidol Decanoate, Fluphenazine Decanoate, and Risperdal Consta because these formulations are only required to be readministered every two to four weeks, depending on the agent used. Invega Sustenna (paliperidone palmitate) is another potential depot formulation option, but there is very little experience in this population compared to the other depot formulations. As such, it should be considered only as last resort (other agents have failed or resulted in intolerable side effects). *Depot injections are not recommended for children younger than 12 years of age. They are recommended only for adolescents with a documented history of poor medication adherence and chronic psychotic symptoms.* Depot agents have inherent risks of long-term exposure to neuroleptic side effects. Further, their use has not been sufficiently studied in pediatric age groups.

Youth Who Do Not Respond to Antipsychotic Medications

Before it is decided that the youth is a non-responder, s/he must receive at least two adequate trials of different antipsychotic agents. Keep in mind that nonresponse, or poor response, to antipsychotic agents may reflect the presence of comorbid conditions. This should be a consideration when there has been a reduction in positive symptoms, but significant anxiety, depression, hostility, agitation, explosive outbursts, or mood instability, persist. In these circumstances, an adjunctive medication may be warranted. Although commonly used, there is often a dearth of randomized controlled trials that have systematically studied the use of adjunctive agents in children and adolescents.

Although Clozapine has been used successfully for adolescents with schizophrenia, there is little published data on its use in youth younger than sixteen years of age. If Clozapine is to be used, the prescriber **must** monitor closely for potential seizures, agranulocytosis (with the required periodic blood cell counts), weight gain, and glucose and lipid abnormalities. Clozapine is generally used only after trials of at least two other antipsychotic agents, one or both of which should have been a second-generation antipsychotic medication. [AACAP Schizophrenia CPG, 2001]



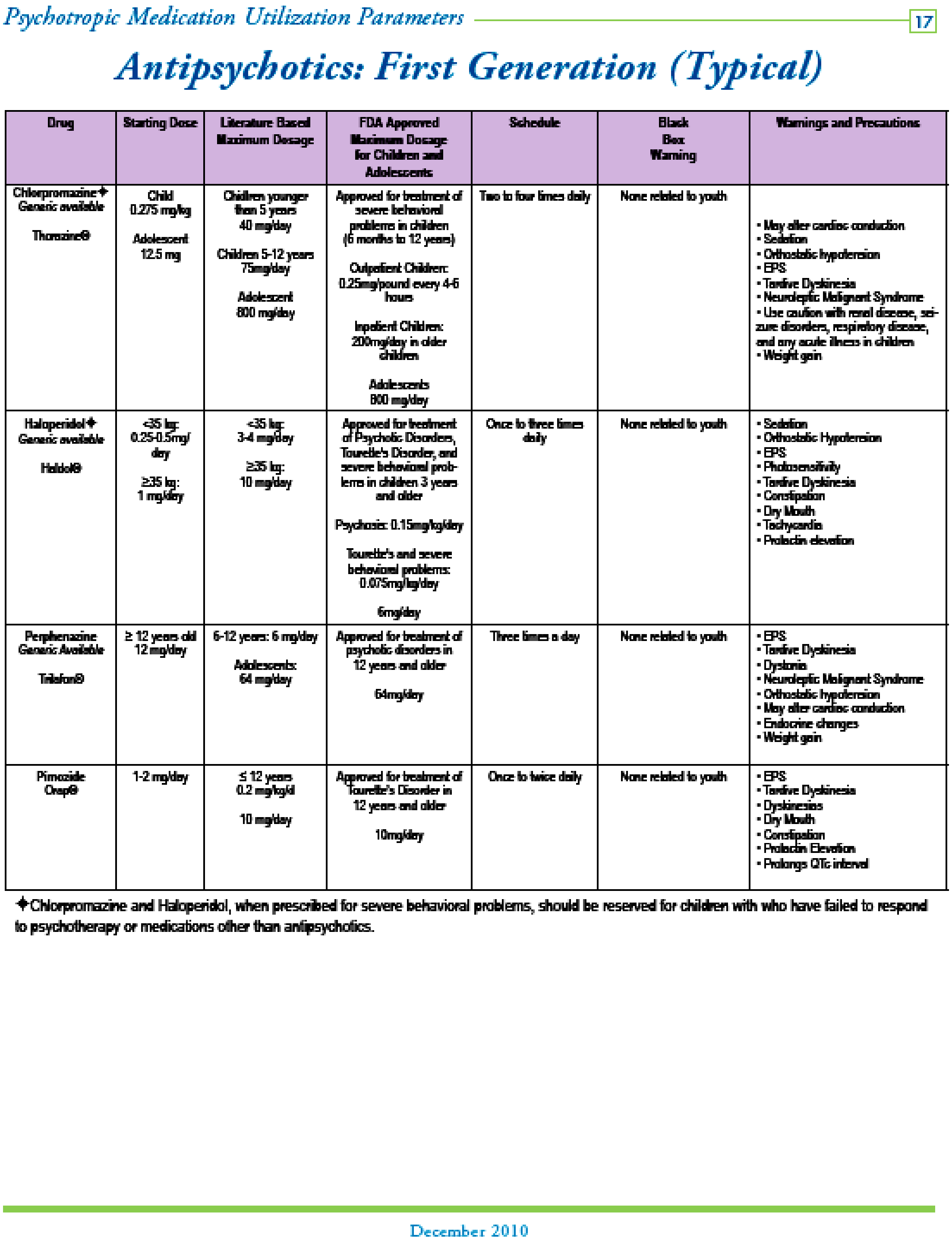
Psychotropic Medication Utilization Parameters 16

Antipsychotics: Second Generation (Atypical) †

Drug	Initial Dosage	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Patient Monitoring Parameters	Black Box Warning	Warnings and Precautions
Aripiprazole Abilify®	Children: 2.5 mg/day Adolescents: 5 mg/day	Children: 15mg/day Adolescents: 30mg/day	Approved for Bipolar Mania or Mixed Episodes in pediatric patients (10 to 17 years) and Schizophrenia in adolescents (13-17 years) 30mg/day Irritability associated with autistic disorder (6-17 years) 15mg/day	Once daily	1) CBC as indicated by guidelines approved by the FDA in the product labeling. 2) Pregnancy test – as clinically indicated 3) Weight and BMI measurement – when a new antipsychotic is initiated, at every visit (monthly for inpatients) for 6 months after the new antipsychotic is initiated, and quarterly when the antipsychotic does is stable. 4) Fasting plasma glucose level or hemoglobin A1c – before initiating a new antipsychotic, then yearly. If a patient has significant risk factors for diabetes and for those that are gaining weight – before initiating a new antipsychotic, 4 months after starting an antipsychotic, and then yearly. 5) Lipid screening [total cholesterol, low- and high-density lipoprotein (LDL and HDL) cholesterol, and triglycerides] – Every 2 years or more often if lipid levels are in the normal range, every 6 months if the LDL level is > 130 mg/dl 6) Sexual function inquiry – inquire yearly for evidence of galactorrhea/ gynecomastia, menstrual disturbance, libido disturbance or erectile/ejaculatory disturbances in males. If a patient is receiving an antipsychotic known to be associated with Prolactin elevation, then this inquiry should be done at each visit (quarterly for inpatients) for the first 12 months after starting an antipsychotic or until the medication dose is stable and then yearly. 7) EPS Evaluation (examination for rigidity, tremor, akathisia) – before initiation of any antipsychotic medication, then weekly for the first 2 weeks after initiating treatment with a new antipsychotic or until the dose has been stabilized and weekly for 2 weeks after a dose increase. 8) Tardive Dyskinesia evaluation – every 12 months. For high risk patients (including the elderly), every 6 months. 9) Vision questionnaire – ask whether the patient has experienced a change in vision and should specifically ask about distance vision and blurry vision – yearly 10) Ocular evaluations – every 2 years in youth ‡ 11) EKG – Baseline and as clinically indicated (Asenapine, Iloperidone, Paliperidone and Ziprasidone) §	Not approved for depression in under age 18. Increased the risk of suicidal thinking and behavior in short-term studies in children and adolescents with major depressive disorder and other psychiatric disorders	• Neuroleptic Malignant Syndrome • Tardive Dyskinesia • Hyperglycemia and Diabetes Mellitus • Weight gain • Akathisia • Dyslipidemia
Quetiapine Seroquel®	Children: 12.5 mg/day Adolescents: 25 mg/day	Children: 300 mg/day Adolescents: 600 mg/day	Approved Bipolar Mania (10-17 years) and for Schizophrenia in adolescents (13-17 years) 600mg/day Not approved for children	Once to twice daily			
Olanzapine Zyprexa®	Children: 2.5 mg/day Adolescents: 2.5-5 mg/day	Children: 12.5 mg/day Adolescents: 30 mg/day	Approved for Bipolar Mania or Mixed Episodes and Schizophrenia in adolescents (13-17 years) 20mg/day Not approved for children	Once to twice daily		None related to youth	
Risperidone Generic available Risperdal®	Children: 0.25 mg/day Adolescents: 0.5 mg/day	Children: 3 mg/day Adolescents: 6 mg/day	Approved for Bipolar Mania or Mixed Episodes in children and adolescents (10-17 years) and Schizophrenia in adolescents (13-17 years) 6 mg/day Irritability associated with Autistic Disorder (5-16 years) 3 mg/day	Once to twice daily		None related to youth	
Clozapine Generic available Clozaril® Fazaclo®	Children: 6.25-12.5 mg/day Adolescents: 6.25-25 mg/day	Children: 150-300 mg/day Adolescents: 200-600 mg/day	Not approved for children and adolescents	Once daily		Agranulocytosis; seizures; myocarditis; other adverse cardiovascular and respiratory effects	
Asenapine (sublingual) Saphris®	Insufficient Evidence	Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence		None related to youth	• Neuroleptic Malignant Syndrome • Tardive Dyskinesia • Hyperglycemia and Diabetes Mellitus • Weight gain • Akathisia • Dyslipidemia • Prolonged QTc interval
Iloperidone Fanapt®	Insufficient Evidence	Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence		None related to youth	
Paliperidone Invega®	Insufficient Evidence	Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence		None related to youth	
Ziprasidone Geodon®	Children: 10 mg/day Adolescents: 20 mg/day	Children: Insufficient Evidence Adolescents: 160 mg/day	Not approved for children and adolescents	Twice daily (Better absorbed when taken with food)		Not approved for depression in under age 18. Increased the risk of suicidality in short-term studies in children and adolescents with major depressive disorder and other psychiatric disorders	

† Dosage recommendations in this table are based on reference # 17 (Jensen, 2010).
‡ There is no current clinical consensus regarding the need for routine ocular evaluations in children and adolescents. Data from animal studies suggest that quetiapine might be associated with increased risk of cataract development, but this has not been concluded from current evidence in human use.
§ There is no current clinical consensus regarding the need for routine monitoring of QTc interval with use of Ziprasidone in children and adolescents. For additional information regarding EKG monitoring with Ziprasidone use, please refer to reference # 4 (Blair, 2005).

December 2010



Antipsychotics: First Generation (Typical)

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Black Box Warning	Warnings and Precautions
Chlorpromazine✦ Generic available Thorazine®	Child 0.275 mg/kg Adolescent 12.5 mg	Children younger than 5 years 40 mg/day Children 5-12 years 75mg/day Adolescent 800 mg/day	Approved for treatment of severe behavioral problems in children (6 months to 12 years) Outpatient Children: 0.25mg/pound every 4-6 hours Inpatient Children: 200mg/day in older children Adolescents 800 mg/day	Two to four times daily	None related to youth	• May alter cardiac conduction • Sedation • Orthostatic hypotension • EPS • Tardive Dyskinesia • Neuroleptic Malignant Syndrome • Use caution with renal disease, seizure disorders, respiratory disease, and any acute illness in children • Weight gain
Haloperidol✦ Generic available Haldol®	<35 kg: 0.25-0.5mg/day ≥35 kg: 1 mg/day	<35 kg: 3-4 mg/day ≥35 kg: 10 mg/day	Approved for treatment of Psychotic Disorders, Tourette's Disorder, and severe behavioral problems in children 3 years and older Psychosis: 0.15mg/kg/day Tourette's and severe behavioral problems: 0.075mg/kg/day 6mg/day	Once to three times daily	None related to youth	• Sedation • Orthostatic Hypotension • EPS • Photosensitivity • Tardive Dyskinesia • Constipation • Dry Mouth • Tachycardia • Prolactin elevation
Perphenazine Generic Available Trilafon®	≥ 12 years old 12 mg/day	6-12 years: 6 mg/day Adolescents: 64 mg/day	Approved for treatment of psychotic disorders in 12 years and older 64mg/day	Three times a day	None related to youth	• EPS • Tardive Dyskinesia • Dystonia • Neuroleptic Malignant Syndrome • Orthostatic hypotension • May alter cardiac conduction • Endocrine changes • Weight gain
Pimozide Orap®	1-2 mg/day	≤ 12 years 0.2 mg/kg/d 10 mg/day	Approved for treatment of Tourette's Disorder in 12 years and older 10mg/day	Once to twice daily	None related to youth	• EPS • Tardive Dyskinesia • Dyskinesias • Dry Mouth • Constipation • Prolactin Elevation • Prolongs QTc interval

✦Chlorpromazine and Haloperidol, when prescribed for severe behavioral problems, should be reserved for children with who have failed to respond to psychotherapy or medications other than antipsychotics.

Source: Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy. (December 2010). *Psychotropic medication utilization parameters for foster children.*

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TDMHSAS BEST PRACTICE GUIDELINES

Substance Use Disorders in Children and Adolescents

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Adolescence is a time of increased risk taking including experimentation with use of substances. Two national epidemiologic surveys provide data about the rates of substance use by youth across the United States. The National Survey on Drug Use and Health (SAMHSA, 2011) reports that rates of substance use in individuals aged 12-17 in the past month were 16 percent for alcohol, 10 percent for cigarettes, and 10 percent for illicit drugs. Marijuana is the illicit drug most frequently used by adolescents. The Monitoring the Future survey (Johnson, *et al*., 2011) reports data on 8th, 10th and 12th graders. Rates of lifetime alcohol use ranged from 37 percent in 8th graders to 72 percent in 12th graders. Lifetime use of illicit drugs was 20 percent for 8th graders and 44 percent for 12th graders. According to SAMHSA's 2009-2010 National Survey on Drug Use and Health (NSDUHs) data, six percent of Tennessee youth between the ages of 12 and 17 either abused or demonstrated dependence on alcohol or illicit drugs in the past year (SAMHSA/NSDUH, 2012).

The younger people are when they begin to experiment with substances, the more likely they are to abuse drugs in later life, an outcome that can be dangerous and even fatal (Virginia Commission on Youth, 2005). For each year of delay of onset of alcohol use, odds of developing an alcohol use disorder drops by 14 percent (Grant & Dawson, 1997). For persons who initiate drinking at or before age 14, the rate of later alcohol dependence is 15 percent compared to 3 percent for persons who have their first drink at age 21 or older (SAMHSA, 2011).

Problem substance use in youth often manifests as acute change in mood, cognition, and behavior. Behavioral changes may range from disinhibition with hyperactivity, agitation, and hypervigilance to lethargy or somnolence. Changes in cognition may include impaired concentration, changes in attention span, and severe disturbances in thinking such as delusions or hallucinations. Mood changes can range from depression to euphoria. The manifestations of substance use and intoxication vary with the type of substance used, the amount used during a given time period, the setting and context of use, and a host of characteristics of the individual such as experience with the substance, expectations of drug effect, and the presence or absence of other psychopathology.

A hallmark of Substance Use Disorder (SUD) in adolescents is impairment in psychosocial and academic functioning. Impairment can include family conflict or dysfunction, interpersonal conflict, and academic problems. School failure may be the first sign of a problem with alcohol or drugs. Associated characteristics include deviant and risk-taking behavior and co-occurring psychiatric disorders such as conduct disorder, attention deficit hyperactivity disorder (ADHD), and mood, anxiety, and learning disorders.

SUDs are defined in the DSM-IV as dependence on or abuse of specific classes of substances including (American Psychiatric Association, 2000; Rapoport & Ismond, 1996):

- Alcohol
- Nicotine.
- Amphetamines.
- Caffeine.
- Cannabis.
- Cocaine.
- Hallucinogens.
- Inhalants.
- Opiates.
- Phencyclidine.
- Sedatives, Hypnotics, or Anxiolytics.

Persons who use more than one substance in a problematic way are characterized as having polysubstance dependence. The course of SUDs in adolescents is variable. Adolescents with substance abuse often decrease or discontinue use in late adolescence or early adulthood, while those who meet criteria for substance dependence often have a more chronic and severe course of illness (AACAP, 2005).

Various individual, peer, family, and community risk and protective factors influence whether a given adolescent will develop a substance use disorder. Genetic predispositions to affective, cognitive, and behavioral dysregulation and other temperamental deviations contribute about half of the variance in development of SUD. Family and peer factors and the developmental issues of puberty may exacerbate risk. Early onset of disruptive behavior, mood, or anxiety disorders is associated with higher rates of SUDs. Common adolescent feelings of being invulnerable, issues of autonomy, and peer influences or peer pressure may also influence initiation and continued substance use (AACAP, 2005).

While estimates vary on the rate of comorbidity for adolescents who present with substance use issues, there is a clear association with the occurrence of Conduct Disorder, ADHD, traumatic experiences, and major mental illnesses such as depression and anxiety. A comprehensive diagnostic evaluation for mental health issues and family dysfunction is needed before an adequate treatment plan can be created.

DSM-IV-TR Criteria for Substance Use Disorders

*Substance Dependence**

- A maladaptive pattern of substance used that leads to clinically significant distress or impairment. It is manifested through at least three of the following behaviors and has occurred within the same 12-month period:
  1. Tolerance, as defined by:

    a. need for markedly increased amounts of the substance to achieve desired effect/intoxication; OR
    b. markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as evidenced by:
    a. the characteristic withdrawal syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged or that causes clinically significant impairment of distress in academic, social, or other important areas of functioning.
    b. similar or equivalent substance is taken to relieve or avoid symptoms of withdrawal.
3. Substance is taken in greater amounts or over a longer period of time that originally intended.
4. There exists persistent desire or unsuccessful efforts to cut down or regulate substance use.
5. An inordinate amount of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important academic, recreational, social or other activities are given up or reduced because of substance use.
7. Substance use continues despite knowledge that a persistent or recurring physical or psychological problem will erupt or become exacerbated by the substance.

<u>NOTE</u>: Criteria should specify with or without physiological dependence.

Substance Abuse*

- A maladaptive pattern of substance used that leads to clinically significant distress or impairment. It is manifested through at least one of the following behaviors and has occurred within the last 12 months:
    1. recurring substance use that results in a failure to fulfill major role obligations at school, home, or work (e.g., repeated absences or poor school performance related to substance use, suspensions or expulsions from school).
    2. repeated substance use in situations where it is physically dangerous to self and/or others (e.g., driving while under the influence of substances).
    3. recurring legal problems that stem from substance use (e.g., arrests for substance-related disorderly conduct).
    4. ongoing substance use despite having repeated interpersonal or social problems caused or made worse by the effects of the substance (e.g., physical fights, arguments with special friends or other significant others, including parents/caregivers) the behaviors exhibited under this class of substance have never met the criteria for Substance Dependence (American Psychiatric Association, 2000).

****The diagnostic categories substance dependence and substance abuse will be combined in the new DSM-5. Substance use disorder (SUD) in the DSM-5 will require two to three symptoms*** (Grohol, 2012).

<u>Differential Diagnosis</u>

The symptoms and behaviors associated with problem substance use may also indicate another underlying condition. Ruling out co-occurring mental disorders should be part of the routine screening process (Virginia Commission on Youth, 2005; Georgetown University, 2002*)*. Careful assessment for the following conditions is critical:

- Mood disorders
- Anxiety disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Oppositional Defiant Disorder
- Conduct Disorder
- Learning disorders
- Association with delinquent peers
- Troubled family relationships
- Abusive relationships/environments
- Parental/caregiver substance use

Comorbidity of Substance Use Disorders

- More than 50 percent of adolescents with substance abuse problems also have conduct problems (Virginia Commission on Youth, 2005).
- The coexistence of more than a single childhood psychiatric disorder greatly increases the risk for later substance use in adulthood (Center for Substance Abuse Treatment, 2008).

SUDs are commonly present with other psychiatric illness. Integrated treatment of both illnesses in combination is essential for the best outcomes. See the best practices section for co-occurring substance use and other psychiatric disorders for further information.

Screening/Evaluation

Mental health evaluation of any adolescent should include screening for use of alcohol, tobacco, and other drugs. The American Medical Association (AMA) also advocates for screening adolescents for alcohol and drug use during annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services or other office visits. Clinicians should begin by asking whether the child or adolescent has ever used any substance to alter the way they feel. If the youth does report use, the evaluator should identify the nature of the use pattern. Ask about age of first use, progression of use for specific substances, frequency and variability of use, in conjunction with the types of substances used to establish patterns of use. The questions, "What does [the drug] do *for* you?" and, "What does [the drug] do *to* you?" can give some sense of reasons why the teen uses and the associated perceived benefits as well as negative consequences.

The CRAFFT questions are particularly useful for screening for problematic use of alcohol or other drugs (Knight et. al., 2007). A positive response to any of these questions indicates a need for further evaluation.

The American Academy of Child and Adolescent Psychiatry (AACAP) published practice parameters in 2005 to address evaluation and treatment of SUDs. Each recommendation (including subsequent ones listed herein) falls within a category of endorsement: 1) **MS** – minimal standards; 2) **CG** – clinical guidelines; 3) **OP** – options; or 4) **NE** – not endorsed (AACAP, 2005). Within this section, recommendations are presented by number, with the category of endorsement in parentheses.

Recommendation 1 (**MS**) instructs *the clinician to observe appropriate levels of confidentiality during all phases of contact with youth, including screening and evaluation*. The clinician should openly inform the youth, usually an adolescent, about the conditions under which there may be limits to confidentiality. In addition, the clinician should clarify the types of information that cannot be shared without the youth's consent.

Recommendation 2 (MS) requires *screening of older youth to include questions about the use of alcohol or other drugs*. Youth exhibiting problems in one or more domains of adolescent functioning should be screened to determine the need for a comprehensive evaluation. Screening questions should gauge quantity and frequency of use, the presence of adverse consequences of use, and information about the young person's attitude toward use. A sample of screening instruments is presented in Table 1 below.

Table 1. Instruments That May Be Used to Screen for Substance Use in Adolescents*

Instrument	**Comments**
CRAFFT	6 items; brief screen for primary care professionals http://www.ceasar-boston.org/clinicians/crafft.php
The Drug Use Screening Inventory-Adolescents (DUSI-A)	159 items; documents the level of involvement with a variety of drugs and quantifies severity of consequences associated with drug use
Problem Oriented Screening Instrument for Teenagers (POSIT)	139 items; designed to identify problems and potential need for service in 10 functional areas, including substance use and abuse
Personal Experience Screening Questionnaire (PESQ)	40 items; screens for the need for further assessment of drug use disorders
Adolescent SASSI-A2	available at http://www.sassi.com/ or
	Global Appraisal of Individual Needs– Short Screener (GAIN-SS) available at http://www.gaincc.org/).

*Adapted from AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders, 2005.

Table 2. Instruments That May Be Used to Evaluate Substance Use in Adolescents*

Instrument	Comments
Adolescent Drug Abuse Diagnosis (ADAD)	Provides severity ratings on multiple domains of functioning
Adolescent Problem Severity Index (APSI)	Provides severity ratings on multiple domains of functioning
Teen Addiction Severity Index (T-ASI)	Provides severity ratings on multiple domains of functioning
Comprehensive Adolescent Severity Inventory for Adolescents (CASI-A)	Provides severity ratings on multiple domains of functioning
Global Appraisal of Individual Needs (GAIN)	Documents SUD and other psychiatric diagnoses; placement criteria; health, mental distress, and environment; and service utilization outcomes. A brief version allows for screening and an outcome version provides information about critical outcome variables.
Customary Drinking and Drug Use Record (CDDR)	Current and lifetime measures of 4 alcohol and other drug-related domains
Adolescent Diagnostic Interview (ADI)	Assesses symptoms associated with SUDs. Provides diagnoses, substance use history, and psychosocial functioning.

*Source: AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders, 2005.

If co-occurring disorders are suspected, ***Recommendation 13*** (**MS**) points out that *youth with SUDs should receive a thorough evaluation for comorbid psychiatric disorders* (AACAP, 2005). Because of the association of co-occurring disorders with SUD, the evaluation should include a comprehensive review of past and present psychopathology, which incorporates treatment history. Complete evaluations of adolescents should further include a detailed developmental history, social history, and medical history.

With regard to the diagnosis of SUDs, the primary goal of evaluation should be to ascertain whether the use of substances exists and, if so, does it meet the SUD criteria within the DSM-IV. Data collection should involve multiple sources in addition to the adolescent's self-report including parents or other caregivers, social service agencies, relevant educational information, and legal history including any drug or alcohol related offenses. Additionally, clinicians should take into consideration that dually-diagnosed patients may not present in the same way as substance users without a mental disorder. For example, dually-diagnosed children and adolescents may use lesser amounts of alcohol and/or drugs and experience different consequences from use. Therefore, it is recommended that clinicians conduct interviews and histories so that the presence of an SUD is not omitted, as might be the case using standard instruments alone (Virginia Commission on Youth, 2005).

Drug Testing

Repeated, random urine drug screens will assist in identifying adolescents who have substance use issues while receiving medical or psychiatric medication management. Practitioners should not assume that a negative test result confirms that an adolescent is not using substances.

Table 3. Urine toxicology*

Substance	Half-life (hr)	Detection after Last Use (days)
Amphetamines	10-15	1-2
Barbiturates	20-96	3-14
Benzodiazepines	20-90	2-9
Cocaine	0.8-6.0	0.2-4
Methaqualone	20-60	7-14
Opiates	2-4	1-2
Phencyclidine (PCP)	7-16	2-8
Cannabinoids (THC)	10-40	2-8 (acute) 14-42 (chronic)
Drugs not usually tested: LSD, psilocybin, MDMA, MDA, other designer drugs		

*Source: AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders, 2005.

Treatment

A diagnosis of SUD for adolescents should result in *specific treatment for substance use* (AACAP, 2005). In fact, research on treatment outcomes for adolescents concludes that treatment is better than no treatment, and longer treatment leads to more favorable outcomes. After treatment, positive outcomes are associated with being around non-using peers and involvement in a number of activities. The best outcomes are linked to treatment completion, low pretreatment use, and peer and parent social support and nonuse of substances. Treatment plans should incorporate modalities that target: 1) social ecology, as it relates to pro-social behaviors, peer relationships, and academic functioning; 2) improved problem solving and social skills, as well as relapse prevention; 3) motivation and engagement; 4) family involvement aimed at improving supervision, monitoring, and communication between youth and parents; 5) comorbid psychiatric disorders through psychosocial and/or medication treatments; and 6) adequate duration of treatment and aftercare.

Treatment should be provided in the least restrictive setting possible. Typical treatment settings for youth with SUD include:

- ***Inpatient treatment.*** Treatment at this level is generally limited to youth that demonstrate one of the following: severe psychiatric disorders (such as acute psychosis and/or dangerous behaviors); a history of treatment failure in less restrictive environments; or a risk of withdrawal. Alcohol and drug detoxification programs are typically included. In fact, going through detoxification is often a criterion for admission to other forms of treatment. This option is usually not available for patients with dual diagnosis who have severe mental illness.
- ***Residential treatment.*** Group homes and therapeutic communities are included here. While the environment is typically less restrictive than hospitalization, it still provides youth with intensive services and support.
- ***Partial hospitalization/day treatment.*** Youth remain in the community while receiving intensive treatment. They may further serve as a transition program for youth moving back into the community from a more restrictive setting.
- ***Outpatient treatment.*** Treatment is focused on the primary problem, commonly uses a single method, or a limited combination of the two. It is recommended for youth whose history, clinical status, and environment require a less intensive level of care.
- ***Community treatment.*** School-based counseling and self-help groups are included in this type of setting. Also considered are prosocial organizations and recreational opportunities that are made available to the youth. This type of treatment may be used either in conjunction with outpatient treatment, or as a transition from long-term treatment in more restrictive settings.

Recommendations based upon literature reviews of empirical studies, publications related to clinical experiences and SAMSHA's Report to Congress, include:

- Substance use and Co-occurring disorders in children and adolescents vary in severity, and require ***ongoing assessments,*** including random urine tests throughout treatment and careful psychopharmacological treatments to decrease abuse of substance for self-medication, as well as ***adjustments of treatment along a continuum of care***.
- Treatment must be ***developmentally*** appropriate which includes the recognition that ***confrontation may not be an appropriate method*** for adolescent populations. Because 12-Step AA/NA models were not designed to be developmentally appropriate for adolescents and do not appear as effective with this population, some authors recommend use of such groups only when the model and group appears to be a good match for the young client.
- ***Comprehensive approaches*** best ***integrate domains*** such as health, educational, legal, and recreational services using a ***variety of approaches*** including group, family and individual treatment modalities. *Cognitive treatment* such as identifying negative self-talk and distorted thoughts as well as *behavioral techniques* such as gradual exposure/ desensitization to traumatic memories are recommended for youth with substance abuse and PTSD. *Skill training*, such as stress management/ relaxation skills, problem-solving, drug refusal and safety skills and social skills, and *psychoeducation* should be included as well.

- Since a good ***therapeutic alliance*** is considered a crucial element, the ***active involvement of youth and family in the design of their program*** is recommended along with clear structure as well as flexibility to individualize treatment methods and goals.

In addition, recommendations for policies and training related to provision of treatment were as follows:

- Providers in all settings including primary care, mental health and substance abuse should ***consider co-occurring illness an expectation*** rather than an exception.
- ***No wrong door.*** Any door should be the right door to receive treatment for co-occurring disorders, understanding both disorders as "primary".
- ***Promoting awareness of different sites of care and the need for collaboration.***
- Treatment plans should be ***client-centered and individualized*** and families must be involved in treatment; recognition that there is ***no single correct intervention***.
- Prevention and treatment services must be ***culturally competent***, and appropriate for the diversity of age, sexual orientation and gender.

List of evidence based programs for treatment of SUD

The following treatment models have been approved as evidence-based programs for treatment of substance use disorder in the adolescent population by the Substance Abuse and Mental Health Services Administration, as cited on the National Registry of Evidence-Based Programs and Practices website:

- **Adolescent Community Reinforcement Approach (A-CRA)**

The Adolescent Community Reinforcement Approach (A-CRA) to alcohol and substance use treatment is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery.

- **Brief Strategic Family Therapy**

Brief Strategic Family Therapy (BSFT) is designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve pro-social behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school.

- **Chestnut Health Systems - Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model**

The Chestnut Health Systems-Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model is designed for youth between the ages of 12 and 18 who meet the American Society of Addiction Medicine's criteria for Level I or Level II treatment placement.

- **Family Behavior Therapy**

Family Behavior Therapy (FBT) is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance, and conduct problems in youth.

- **Family Support Network (FSN)**

Family Support Network (FSN) is an outpatient substance abuse treatment program targeting youth ages 10-18 years. FSN includes a family component along with a 12-session, adolescent-focused cognitive behavioral therapy--called Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT12)--and case management.

- **Moral Reconation Therapy**

Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth.

- **Multidimensional Family Therapy (MDFT)**

Multidimensional Family Therapy (MDFT) is a comprehensive and multisystemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency (National Registry of Evidence-based Programs and Practices, 2008).

- **Multisystemic Therapy (MST) for Juvenile Offenders**

Multisystemic Therapy (MST) for juvenile offenders addresses the multidimensional nature of behavior problems in troubled youth. Treatment focuses on those factors in each youth's social network that are contributing to his or her antisocial behavior.

- **Not On Tobacco (N-O-T)**

Not On Tobacco (N-O-T) is a school-based smoking cessation program designed for youth ages 14 to 19 who are daily smokers. N-O-T is based on social cognitive theory and incorporates training in self-management and stimulus control; social skills and social influence; stress management; relapse prevention; and techniques to manage nicotine withdrawal, weight, and family and peer pressure.

- **Parenting with Love and Limits (PLL)**

Parenting with Love and Limits (PLL) combines group therapy and family therapy to treat children and adolescents aged 10-18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation.

- **Phoenix House Academy**

Phoenix House Academy (formerly known as Phoenix Academy) is a therapeutic community (TC) model enhanced to meet the developmental needs of adolescents ages 13-17 with substance abuse and other co-occurring mental health and behavioral disorders.

- **Project ASSERT**

Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment) is a screening, brief intervention, and referral to treatment (SBIRT) model designed for use in health clinics or emergency departments (EDs).

- **Project SUCCESS**

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse.

- **Project Towards No Tobacco Use**

Project Towards No Tobacco Use (Project TNT) is a classroom-based curriculum that aims to prevent and reduce tobacco use, primarily among 6th- to 8th-grade students. The intervention was developed for a universal audience and has served students with a wide variety of risk factors.

- **Residential Student Assistance Program (RSAP)**

The Residential Student Assistance Program (RSAP) is designed to prevent and reduce alcohol and other drug (AOD) use among high-risk multi-problem youth ages 12 to 18 years who have been placed voluntarily or involuntarily in a residential child care facility (e.g., foster care facility, treatment center for adolescents with mental health problems, juvenile correctional facility).

- **Seeking Safety**

Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential).

- **The Seven Challenges**

The Seven Challenges is designed to treat adolescents with drug and other behavioral problems. Rather than using pre-structured sessions, counselors and clients identify the most important issues at the moment and discuss these issues while the counselor seamlessly integrates a set of concepts called the seven challenges into the conversation.

- **Teen Intervene**

Teen Intervene is an early intervention program targeting 12- to 19-year-olds who display the early stages of alcohol or drug use problems (e.g., using or possessing drugs during school) but do not use these substances daily or demonstrate substance dependence.

The following items are NOT on the Evidence-Based Registry for adolescents, but are widely endorsed either by profession or the State of Tennessee Department of Mental Health and Substance Abuse Services:

- **Dialectical Behavior Therapy**

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes.

- **Double Trouble in Recovery**

Double Trouble in Recovery (DTR) is a mutual aid, self-help program for adults ages 18-55 who have been dually diagnosed with mental illness and a substance use disorder. In a mutual aid program, people help each other address a common problem, usually in a group led by peer facilitators rather than by professional treatment or service providers.

- **Motivational Enhancement Therapy**

Motivational Enhancement Therapy (MET) is an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly non-confrontational manner.

- **Motivational Interviewing**

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. This method utilizes an interaction style that capitalizes on the readiness for change and helps the adolescent identify areas that need change and choices that are likely to result in undesired outcomes. MI research and tools can be accessed at http://www.motivationalinterview.net/.

- **Hazelden Adolescent Co-Occurring Series**

Hazelden Adolescent Co-Occurring Series utilizes an integrated therapies approach in conjunction with a family program and medication management. The therapy approach includes Motivational Enhancement Therapy, Cognitive-Behavioral Therapy and Twelve Step Facilitation.

- **Family-Based Education and Support**

Interventions that focus on addressing family functioning, relational concerns, primary caregiver problems, communication, supervision and parenting skills deficits have shown demonstrated efficacy in reducing substance use and disruptive behaviors.

Pharmacotherapy

The data supporting use of medication to treat substance use disorders in adolescents are limited. All medications carry some risk of adverse effects and many teens who abuse substances discontinue use without treatment as they get older. However, adolescents who exhibit severe problems with substance dependence should be evaluated by a child psychiatrist who is able to make recommendations about appropriate use of medications to treat the SUD as well as other co-occurring disorders. Medications are typically not indicated for substance abuse, but may play a role in treatment of severe substance dependence. For a review of the available literature to date, see Simkin & Grenoble, 2010. Results from this review are summarized here.

FDA approved medications are available to treat dependence on alcohol, opiates, and nicotine in adults. These medications have not been approved for adolescents, therefore all use of these medications in adolescents is *off-label use*. There are four main indications for use of medications in substance dependence: 1) detoxification, 2) aversive treatment, 3) craving reduction, and 4) substitution therapies. Substitution therapies include treatments that mimic some of the effects of the drug of abuse while decreasing the negative effects. Cutting edge research is now being conducted in adults on use of vaccines to prevent addiction in high risk populations (Volkow, 2007).

Alcohol:

Detoxification: Withdrawal from alcohol after the development of physiological dependence (tolerance and withdrawal) can be fatal and should be treated by a physician. Benzodiazepines are the first line pharmacological treatment for alcohol withdrawal. Benzodiazepines are approved for use in adults and decrease morbidity and mortality associated with alcohol withdrawal. No studies have been published addressing the safety or effectiveness of these medications in adolescents.

Aversive treatments: Disulfuram is a medication that interferes with the breakdown of alcohol resulting in the build-up of a toxic byproduct. Drinking alcohol while taking this medication results in negative consequences of flushing, nausea, vomiting, and headache. Disulfuram is approved for treatment of alcohol dependence in adults. A single randomized controlled trial of disulfuram in 49 adolescents showed promising results without adverse events. A case report has also been published of 2 adolescents--one maintained abstinence for 4 months, the other was not adherent with treatment.

Anti-craving agents: Acamprosate was approved for use in adults in 2004. On randomized controlled trial studied its use in 26 adolescents and found positive results with decreased alcohol use. This medication required three times daily dosing--a significant challenge for medication adherence. Naltrexone is a medication indicated for opiate dependence which is sometimes also used to reduce craving in alcohol dependence. Its use has not been studied in adolescents with alcohol dependence. Odansterone is a medication that works on the serotonin system. One open label trial has been published showing favorable results in adolescents.

Substitution therapies: There are no substitution therapies available for treatment of alcohol dependence.

Opiates:

Opiates include drugs like heroin and morphine as well as the prescription pain medications oxycodone, hydrocodone, among others. They are marketed under trade names such as Percocet, Lortab, Vicodin, and Oxycontin. These drugs may be used orally, or crushed and either snorted or injected. Intra-venous drug use presents additional health concerns including risk of infection and should be assessed by a physician.

Detoxification: Opiate withdrawal is extremely uncomfortable, but carries no risk of serious medical consequences. Medications used in opiate withdrawal are intended to decrease the negative consequences of withdrawal to encourage opiate dependent individuals to stop using. Clonidine is a medication which provides some relief for the symptoms of opiate withdrawal. This medication is frequently used in children and adolescents for other indications (such as ADHD) and is safe and tolerable.

Buprenorphine is a newer medication that acts as a partial antagonist at the mu-opioid receptor and has been studied in adolescent populations. Accumulating evidence suggests that it is safe and effective for treatment of opiate withdrawal. This medication has also been used as a substitution therapy, discussed below.

Aversive treatments: There are no aversive treatments for opiate dependence.

Anti-craving agents: Naltrexone was FDA approved for treatment of opiate addiction in adults in 1994. One open label trial and 2 case reports of its use in adolescents have shown positive results with improvement in clinical outcomes and no serious side effects.

Substitution therapies: Methadone was approved as treatment for opiate dependence in 1972. It was shown to have significant benefit in decreasing the morbidity and mortality associated with injection drug use. Over the past several decades, prescription opiate abuse has risen dramatically and tends to be the most commonly encountered opiate problem seen in adolescents. Subsequent FDA approval has been given for the following medications in the treatment of adults with opiate dependence: Levo α-acetyl methadol (LAAM) in 1993, sublingual buprenorphine (Subutex) and sublingual buprenorphine with naltrexone (Suboxone) in 2002. Several studies have found favorable results for substitution therapise in heroin-dependent teens. Strict federal regulations guide the prescription of these medications and require that anyone under the age of 18 have failed 2 courses of detoxification and maintenance treatment prior to trial of substitution therapy. Methadone treatment is recommended for the treatment of opiate dependence in pregnant teens to reduce the harm of repeated intoxication and withdrawal on the fetus.

Nicotine:

Detoxification: There are no treatments for nicotine detoxification.
Aversive treatments: There are no aversive treatments for nicotine dependence.
Anti-craving agents: The agents buproprion and varenicline have been FDA approved for treatment of nicotine dependence in adults. However, these medications now carry a black box warning that the use of these medications has been associated with serious mental health events, including changes in behavior, hostility, agitation, depressed mood, suicidality, and attempted suicide.

Substitution therapies: Nicotine patches, losenges, and gum are available substitution treatments for nicotine dependence in adults. Several randomized controlled studies have failed to show significant benefit of these medications in adolescents.
There are no approved medications for treatment of marijuana or cocaine dependence.

Prevention

Prevention works. The 2012 National Drug Control Strategy states that drug prevention “saves lives and cuts long-term costs.” The report also notes that drug abuse prevention is among the “highest drug policy priorities: of the current administration. Evidence-based programs must be incorporated into a range of settings including communities, schools, homes, workplaces, juvenile justice and child welfare services (National Drug Control Policy, 2012). In addition to community-based strategies, prevention focuses on individual and family interventions. Risk factors influence the onset of behaviors that may increase the likelihood of behaviors such as substance use. Protective factors may be family or personal characteristics, supports or other environmental situations that reduce risk. Risk and protective factors do not cause or cure substance abuse; however, prevention strategies typically target the reduction of risk and the increase of protective factors.

The Substance Abuse Mental Health Services Administration (SAMHSA) has endorsed a public health approach to prevention that engages whole communities in prevention initiatives. The public health approach endorses the creation of governmental and community-based infrastructures as well as capacity-building via committees, councils and boards directed and improving key health indicators (SAMHSA, 2012). This approach is operationalized in the SAMHSA Strategic Prevention Framework's planning process which guides states and communities in the development of prevention activities.

Tennessee utilizes the Strategic Prevention Framework as part of its statewide prevention programming. The five-step process 1) assesses needs of a population or specific community, 2) identifies resources and readiness to act on the identified issue; 3) builds capacity at the state and community level; 4) develops a strategic plan that articulates the vision of the community to address problems related to substance abuse; 5) implements evidence-based programs and practices and monitors implementation, evaluating for effectiveness and improvements related to the identified issues. Selecting and implementing evidence-based prevention programs is of particular importance in this process (Center for Substance Abuse Prevention, 2009).

Evidence based programs are those that meet one of the following criteria:

- The program is included in Federal registries of evidence-based practices. This may include the SAMHSA National Registry of Evidence-Based Programs and Practices, the Office of Juvenile Justice and Delinquency Programs Model Programs Guide, the Exemplary and Promising Safe or Disciplined and Drug-Free Schools Programs with the U.S. Department of Education
- The intervention is reported to have positive effects in peer-review journals
- There is documented effectiveness, supported by consensus judgment of informed experts.

Core components in programs proven to be effective in prevention or reducing substance abuse among adolescents include (Bandy & Moore, 2008; Terzian, Andrews & Moore, 2011):

- Multi-component programs in which a variety of approaches and outreach are utilized. These approaches include school, family, community, outside social activities and media campaigns to reach youth and impact substance use.
- Programs that address all forms of drug use in combination, such as initiation of alcohol, tobacco, marijuana and illicit drug use.
- Programs tailored to address substance use risk specific to a population. This may include programs that are gender-specific, have defined developmental or age assignments or are targeting a specific ethnic group.
- Peer teaching when combined with adult facilitation.
- Programs that emphasize drug resistance and reinforce anti-drug attitudes work.
- Support and strengthen family functioning
- Increase connections between students and schools
- Make communities safe and supportive
- Promote involvement in out-of-school programs
- Promote the development of sustained relationships with caring adults
- Provide children and youth opportunities to build social and emotional competence
- Provide children and youth with high quality education during early and middle childhood

Youth at risk for SUD often engage in a multiple risky behaviors. Strategies that address these multiple risky behaviors are more effective (Terzian, Andrews & Moore, 2011). The most effective prevention strategies encompass all domains of the youth's life, from the overarching culture of the community related to the acceptance of substance use, to the family support system and the youth's social engagement and self-image.

In Tennessee, several evidence-based programs have been initiated at the state, community and participant level. Most counties have anti-drug coalitions that provide community-level interventions and impact the development of local policies and laws. For example, Coalitions work closely with local beer boards to ensure area businesses are not selling to underage drinkers. Statewide, Checkpoint Tennessee has been identified as an effective substance abuse prevention program with the Office of Justice Programs. School systems across the state have implemented programs to suppress bullying and improve school climate. Locally, agencies have adopted and implemented evidence-based programs in the juvenile justice setting, in schools, at local community centers and after school programs and in a variety of settings in which children and adolescents congregate. Several programs incorporate family interventions as well as individual and group activities targeting multiple risk factors, and build on strengths and protective factors of each child and family system.

As recognized by SAMHSA, prevention works. Prevention also requires a multi-systemic, multi-level approach to address the needs of the children and youth of Tennessee and ensure that they are able to reach their full potential.

Early Intervention

Early Intervention is an approach that is specifically designed to explore and address problems or risk factors that appear to be related to substance use and to assist in recognizing the harmful consequences of substance use. Such services are intended to be a combination of prevention and treatment services for at-risk youth. Early intervention services are relevant for children and adolescents who do not yet meet diagnostic criteria for a substance use disorder as defined by DSM-IV criteria. Any adolescent whose substance use has progressed to the point of causing a pattern of impairment, even if that impairment is deemed to be mild, requires treatment services at a more intensive level of care. Early intervention for psychopathology in youths at risk of SUDs is critical to prevent early-onset substance use and SUDs. Interventions may include, but not be limited to, individual counseling, group counseling, family counseling, and educational experiences designed to help adolescents recognize problems, causes, changes that will promote health, and the skills to maintain those changes (American Society of Addiction Medicine, 2001).

According to ASAM Patient Placement Criteria-Second Edition Revised (PPC-2R), the length of time in service may vary depending on the following variables:
1) the individual's ability to comprehend the information being provided;
2) the individual's ability to apply the information to make behavioral changes;
3) the individual's ability to avoid problems related to substance use;
4) the appearance of new problems that may require treatment at another level of care.

Using ASAM PPC-2R, early intervention services would be considered Level 0.5 within a service matrix of 0.5- IV, thus demonstrating the lowest service level within the PPC-2. These services can be provided in any age-appropriate setting (e.g., schools, clinical offices, community centers, or an adolescent’s home). Support system considerations for early intervention programs should include capacity for referral services that may include but not be limited to:

- Additional substance related assessments
- Primary medical care
- Psychological services
- Psychiatric evaluation and medication management
- Ongoing treatment for substance abuse or dependence
- Community services (Self-Help Groups, Organized activities, CMHCs)
- Family support services

Professionals providing early intervention services need to be knowledgeable about adolescent development, the biopsychosocial dimensions of substance use and dependence, able to recognize mental health concerns and substance-related disorders, have experience working with and engaging adolescents and their families, and be skilled in providing drug and alcohol education, motivational counseling that incorporates the Transtheoretical Model of Change, and brief interventions (American Society of Addiction Medicine, Inc, 2001). The Transtheoretical Model of Change suggests that individuals move through the following stages in readiness for change and that interventions should be tailored to the particular stage: precontemplation, contemplation, determination, action, maintenance (Prochaska, DiClemente, & Norcross, 1992).

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TDMHSAS BEST PRACTICE GUIDELINES

Co-occurring Disorders: An Integrated Approach

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Introduction and Definitions

Co-occurring disorders (CODs) present significant concerns among adolescents and their families. Increasing attention has been paid to the prevalence and impact of co-occurring mental illness and addiction. In general, co-occurring disorders are associated with poorer treatment outcomes, increased utilization of emergency room services, repeat admissions to inpatient psychiatric hospitals, and higher rates of relapse and medical problems (Sterling et. al., 2011)

SAMHSA's 2002 report to Congress defines co-occurring disorders as:

> *"Individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other"* (p. 3).

For adolescents, it is noted that mental health conditions typically manifest prior to substance use disorders. While establishing a history and prior onset can serve to clarify the nature of a mental health disorder, it is less important to determine what came first than to address both conditions, simultaneously, and in an integrated manner. CODs often present as distinctive third disorders that are more than the "***sum***" of the individual disorders, and each of the disorders influences the other. This interaction ultimately affects the course of treatment and intervention, as well as the potential for relapse.

While it is important to address disorders in a co-occurring fashion, it is important to consider that early interventions with children and youth who have an identified mental disorder could prevent or change the course and development of a substance use disorder: Therefore prevention of substance use might be considered an important secondary outcome of interventions for early-onset mental disorders. (Glantz et al., 2008)

Alumbaugh (2008) states: “Different philosophies in mental health and substance abuse treatment have resulted in the development of parallel but not intersecting treatment systems with different funding streams, mandates and treatments.” Co-occurring disorders are at the nexus of this culture clash.”

The ***“no wrong door approach”*** is vital to treatment of co-occurring disorders, in which programs address both mental health and substance use, and an important way in which to overcome this “culture clash**.”** Integrating care further transcends the problems inherent in a fragmented treatment system. While this is sometimes approached through linkages to agencies and coordinated care, the ideal treatment system is one that integrates services.

As defined by SAMHSA’s Co-Occurring Center of Excellence brief, *Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders*, (SAMSHA, 2011) ***“no wrong door”*** denotes a system of care that is accessible from multiple entry points, integrates and addresses treatment for both mental illness and addiction, and collaborates with all entities involved with the adolescent and family.

> “Research results suggest that sequential treatment (treating one disorder first, then the other) and purely parallel treatment (treatment for both disorders provided by separate clinicians or teams who do not coordinate services) are not as effective as integrated treatment (Drake, O’Neal, & Wallach, 2008)”. Treatment approaches that treat a singular disorder without consideration of the impact of a co-occurring disorder(s) are less suited to the special needs of individuals with CODs .” (Rosenthal and Westreich, 1999; Sterling et. al., 2011).

“It is estimated that only two percent of the 5.6 million adults in the United States who are living with co-occurring substance use and mental health disorders actually receive evidence-based integrated care, due in large part to the lack of professional training on this approach. “ (van Hoof-Haines, 2012).” It is doubtful that the rate for children or youth is any higher. However, adolescents with co-occurring mental health and substance use issues who received psychiatric services are more likely to remain abstinent (especially if services were provided in co-located settings [mental health and substance abuse]) (Sterling and Weisner, 2005).

Adolescents with co-occurring disorders have greater rates of family, school, legal and social problems (Grella, et al, 2010; Rowe et al, 2004; & Libby et al, 2005). Therefore, approaches to prevention, screening and assessment, treatment and recovery will involve collaboration, including collaboration among the juvenile justice system, education, primary health care and human services. Services should also be family-centered and driven.

A standard array of treatment services should be available to address the appropriate level of care needed and include screening for COD, psychiatric evaluation, outpatient therapy and psychiatric evaluation, intensive outpatient programs and short-term residential treatment. Recovery services may include self-help groups, family education and support and other peer-led opportunities for adolescents to access social and emotional support.

Prevalence Rates

For a majority of adolescents referred to treatment for substance use disorders, a co-occurring mental illness also exists. Co-occurring disorders are an ***“expectation and not an exception.”*** (Minkoff and Ajilore, 1998).

- Twenty-one percent of US children ages 9 to 17 have a diagnosable mental disorder or addictive disorder with impairment (Kessler et al., 2005).

- Adolescents with SED (serious emotional disturbance) are five times more likely to have an alcohol dependence problem than those without SED (SAMSHA, 2000) .

- Forty-three percent of youth receiving mental health (MH) treatment services (CMHS, 2001) have a co-occurring disorder. Fifty percent of all lifetime cases of mental disorders are manifest by age 14; 90 percent with co-occurring disorders had one mental disorder prior to the onset of an SUD (Kessler et al., 2005).

- Individuals with a mental health disorder are at ***greater risk*** for a substance use /chemical dependency disorder, and individuals with a substance use problem are at ***greater risk*** for a mental health disorder. Van Hoof –Haines (2012) notes: that "the lifetime prevalence of individuals [all ages] with substance abuse or dependence in the general population is 16.7 percent; however, the prevalence is significantly higher among people who suffer from schizophrenia (47 percent), any mood disorder and obsessive/compulsive disorder (both 32 percent) and any anxiety disorder (23 percent)."

- In samples from SAMSHA treatment studies (CSAT 1997-2002), 62 percent of the male and 83 percent of female adolescents who received substance use treatment also had an emotional or behavioral disorder (SAMSHA, 2002). The co-occurring mental disorders most commonly noted were Conduct Disorder, Attention Deficit and Hyperactivity Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, and Post Traumatic Stress Disorder (SAMSHA, 2002).

- With early onset, there is greater risk for lifetime alcohol abuse or dependence (Dewittt, Adlaf, Offord & Ogborne, 2000). Also, individuals with co-occurring disorders use substances over longer periods. *Archives of General Psychiatry*. 2005 Jun; 62(6): 593-602. Kessler RC, Berglund PA, Demler O, Jin R, Walters, EE. Furthermore, individuals with co-occurring mental health and substance use disorders have poorer outcomes, including higher rates of relapse, suicide, homelessness, incarceration, hospitalization, and lower quality of life (Compton et al., 2003; Wright, Gournay, Glorney, & Thornicroft, 2000; Xie, McHugo, Helmstetter, & Drake, 2005; SAMSHA, 2011) and at least 50 percent of individuals who are homeless have co-occurring disorders (SAMHSA, 2011). This again highlights the importance of early intervention in changing the life-time course for individuals with co-occurring disorders.

- Individuals with co-occurring disorders have greater rates of family, school, legal social problems (Grella, et al., 2010; Rowe et al., 2004; & Libby et al., 2005).

- Youth involved in the juvenile justice system experience higher rates of mental illness and substance use disorders than the general population. Findings from the Northwest Juvenile Project noted that nearly two-thirds of males and three-fourths of females met the diagnostic criteria for one or more mental disorder. Youth diagnosed with a major mental illness had significantly greater chances of also having substance use disorders. The Office of Juvenile Justice and Delinquency Prevention publication, Psychiatric Disorders of Youth in Detention (April, 2006) noted that among adolescents with mental health conditions, substance use disorders and attention deficit disorder or disruptive behavior disorders were most common (OJJDP, April, 2006).

- Funk et al. (2003) report that 71 percent of adolescents in substance use treatment also have a history of trauma.

- Deykin & Buka (1997) report in a study of chemically dependent adolescents in treatment **a** lifetime prevalence rate for Post-Traumatic Stress Disorder (PTSD) of 29.6 percent.

- In an epidemiological study, researchers found a moderate overall co-occurrence of PTSD and substance abuse, with rates ranging from 13.5 percent to 29.7 percent (Kilpatrick, Ruggiero, Acierno, Saunders, Resnick, & Best, 2003). In this sample: — 29.7 percent of males and 24.4 percent of females who met diagnostic criteria for PTSD also met diagnostic criteria for either substance use or dependence disorders — 13.5 percent of males and 24.8 percent of females who met criteria for a substance use disorder also met diagnostic criteria for PTSD.

- Thirteen and a half percent of males and 24.8 percent of females who met criteria for SUD, also met PTSD criteria (Kilpatrick et al, 2003).

Guiding Principles

Based on prevalence rates, clinical practice guidelines for COD need to take into consideration the following guiding principles:

- COD is an ***expectation*** rather than an exception.

- Providers of Mental Health COD services need to take a "no wrong door approach." Assessment and treatment services need to be:

  - Integrated (SAMSHA, 2011a; 2011b).
  - Offer a full continuum of services from prevention, screening, through treatment and recovery.
  - Be family focused.

- Staff needs to be cross trained on assessment and treatment of COD. It is important that both addiction and mental health counselors are proficient in the screening, assessment and treatment of co-occurring disorders, including the unique presentation of CODs, as CODs really constitute a third disorder (van Hoof-Haines, 2012).

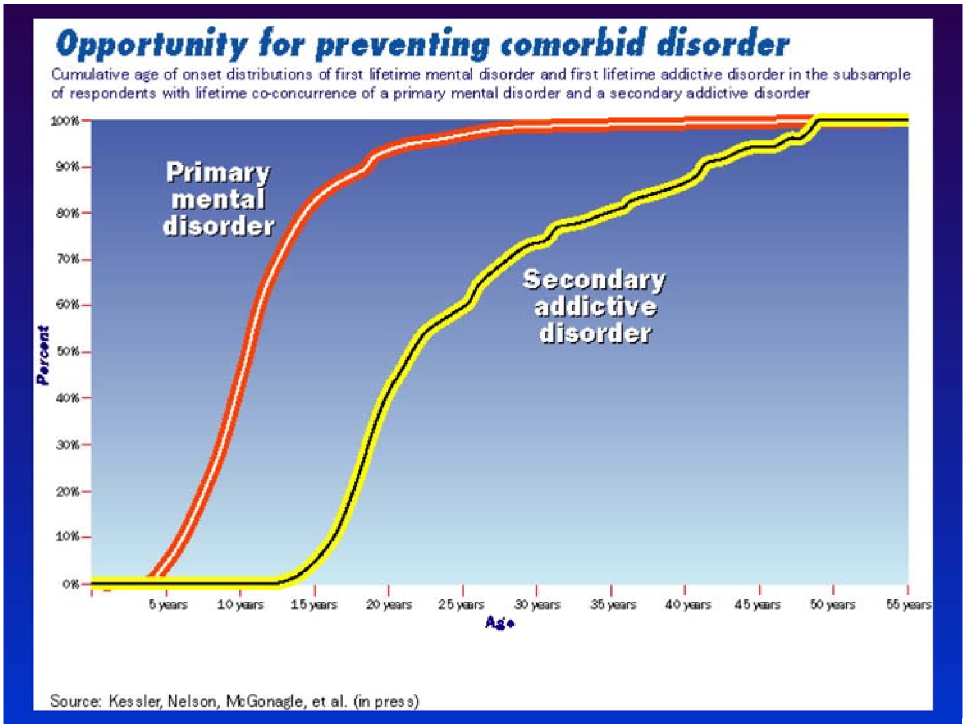
- Focus on multi-systemic and culturally-competent approaches that involve all environments and systems that impact a child/ adolescent including educational, family , medical (especially primary pediatric/adolescent care), and the justice system.

- The process for assessment and diagnosis will be evolving and needs to be ongoing.

- Trauma always needs to be a consideration due to high prevalence rate among COD populations; and therefore needs to be screened and addressed clinically.

- For the purposes of these guidelines, the focus will be on family based services.

- A developmental/prevention perspective: High prevalence rates emphasize the high rates of co-occurring disorders in a younger population, and the importance of prevention and early intervention in changing the life-time course for individuals with co-occurring disorders. COD affects the psychosocial and physical development of youth as drug abuse changes the brain chemistry of developing brains. (Degenhardt & Hall, 2006; 2006; Smit and P. Cuijpers,2004). Early interventions (and screenings) with children and youth who have an identified mental disorder may change or prevent the course and development of a substance abuse disorder. Ninety-percent with co-occurring disorders had one mental disorder prior to onset of SUD (Kessler et al 2005). The following graph cited in Alumbaugh (2008) clearly indicates a typical onset of a mental disorder prior to an SUD:



Opportunity for preventing comorbid disorder

Cumulative age of onset distributions of first lifetime mental disorder and first lifetime addictive disorder in the subsample of respondents with lifetime co-concurrence of a primary mental disorder and a secondary addictive disorder

Source: Kessler, Nelson, McGonagle, et al. (in press)

Note: Permission to use the above slide was obtained from Ronald Kessler, MD, first author.*

- Coordination of care is important, as is assisting adolescents in negotiating the transition to the adult service system of care.

- Best practices in the area of co-occurring services indicate a need for integrated approaches to treatment, including an integrated care of plan (SAMSHA, 2011a & 2011b) that addresses and incorporates all of the bio-psychosocial needs of the individual and family.

- Psychosocial factors may influence treatment such as socioeconomic issues that present barriers to accessing care.

Screening

The identification and use of appropriate screening and assessment tools for the co-occurring diagnoses is helpful in determining plans of care for co-occurring disorders.

According to Dr. Mary Jane Alumbaugh, PhD in her presentation on "Co-Occurring Disorders Best Practices and Adolescents, " Double Trouble- Early" (June 26, 2008, CiMH), "the process of screening, assessment, and treatment planning should be an integrated approach that addresses both substance abuse and mental health disorders, each in the context of the other and neither should be considered primary." (Myers, Brown, & Ott, 1995) She recommends that assessments for co-occurring disorders include:

- A comprehensive bio-psychosocial assessment
- An assessment for substance use disorder using a brief screening tool in ALL adolescents entering a behavioral health or healthcare system
- A follow-up with a comprehensive substance use disorder assessment for adolescents who present with a co-morbid substance abuse disorder
- An assessment for trauma/victimization

Screening Instruments:

The following screening protocols are recommended by Alumbaugh (2008) and others:

- Adolescent Alcohol Involvement Scale
- Adolescent Drug Involvement Scale(ADIS)
- Problem Oriented Screening Instrument for Teenagers (POSIT)
- Global Appraisal of Individual Needs Short Version—(GSS)
- CAGE-AID
- Modified Mini-Screen (MMS)

General Checklists:

- Achenbach YSR
- Revised Behavior Problem Checklist
- Youth Outcome Questionnaire YOQ
- Youth Outcome Questionnaire Self Report YOQ- SR

Substance Use Disorder Interviews:

- Adolescent Diagnostic Interview (ADI)

- Diagnostic Interview for Children and Adolescents (DICA)

Comprehensive Assessment Instruments:

- Comprehensive Adolescent Severity Inventory (CASI)
- The American Drug and Alcohol Survey (ADAS classroom use)
- Personal Experience Inventory (PEI)
- Substance Abuse Subtle Screening Inventory—SASSI

Trauma:

In addition, Coreena Hendrickson, (LCSW), Director, Substance Abuse Prevention and Treatment Services, Division of Adolescent Medicine, Children's Hospital, Los Angeles, CA, in her article, "Trauma and Co-Occurring Disorders among Youth," (2009, June) encourages the screening and assessment of trauma along with the screening of youth with co-occurring disorders due to the close association between the two. She says of diagnostic considerations that,

> "Ideally, careful assessment of traumatic stress and co-occurring disorders would be an integral part of the services provided by all agencies working with adolescents. In reality, although much progress has been made in the treatment of both substance abuse and traumatic stress, these fields remain primarily independent of each other and few service providers are skilled in assessing the multiple needs of youth with trauma and co-occurring disorders. Screening and assessment instruments for identifying trauma, mental health, and substance related problems of adolescents differ considerably in the kinds of psychological and behavioral characteristics that they evaluate. Most instruments focus on deficits and impairment, looking at symptoms and behavioral problems. An essential part of a complete assessment includes attention to the strengths of youths and the family or systems from which they have been referred"   (p. 36).

CSAT (2000) recommends that "Questions about trauma be brief and general, without evoking details that might precipitate stress." Hendrickson (2009) recommends the following validated instruments for Traumatic Stress and Substance Abuse*:

Global Appraisal of Individual Need (GAIN) is a series of clinician administered bio-psychosocial assessments designed to provide information useful for screenings, diagnosis, treatment, planning, and monitoring progress. Domains measured on the GAIN-Initial (GAIN-I) include substance use, physical health, risk behaviors, mental health, environment, legal and vocational. Several scales are derived from the GAIN-I, including substance problem, traumatic stress, and victimization indices. Dennis, M., White, M., Titus, J., and Unsicker, J. (2006) *Global Appraisal of Individual Needs* (GAIN): Administration guide for the GAIN and related measures (Version 5.4.0) Bloomington, IL: Chestnut Health Systems http://www.chestnut.org/LI/gain

- **Trauma Symptom Checklist for Children (TSCC)** is a self-rating measure used to evaluate both acute and chronic post-traumatic stress symptoms. John Briere, Ph.D. Psychological Assessment Services, http://www3.parinc.com/products/product.

- **University of California Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA PTSD RI for DSM‐IV)** is used to screen for exposure to traumatic events and DSM-IV PTSD symptoms. Three versions exist: a self report for school-age children, a self report for adolescents, and a parent report. An abbreviated version of the UCLA PTSD RI is also available. This nine-item scale provides a quick screen for PTSD symptoms. UCLA Trauma Psychiatry Service, 300 UCLA Medical Plaza, Ste. 2232, Los Angeles, CA 90095-6968, rpynoos@mednet.ucla.edu.

- In addition to the above screening instruments for trauma, a number of agencies in Tennessee, including the Tennessee Department of Children Services, include an adjustment to trauma module on the Child Assessment of Needs and Strengths (CANS) (PRAED, 2012), which is used extensively for developing plans for youth in state custody.

- **CRAFFT** is a six-item measurement tool that assesses adolescent substance use. The CRAFFT questions were developed by The Center for Adolescent Substance Use Research (CeASAR). The measure assesses reasons for drinking or other substance use, risky behavior associated with substance use, peer and family behavior surrounding substance use, as well as whether the adolescent has ever been in trouble as a result of his or her substance use. To obtain permission to make copies of the CRAFFT test, email info@CRAFFT.org. (2008) [*Listed in NTCSN's *Understanding the Links Between Adolescent Trauma and Substance Abuse*, 2008.]

Well researched instruments for screening substance abuse and co-occurring disorders include:

- **Teen Addiction and Severity Index (T-ASI)** is a semi-structured interview that was developed to fill the need for a reliable, valid and standardized instrument for a periodic evaluation of adolescent substance abuse. The T-ASI uses a multidimensional approach of assessment as an age-appropriate modification of the Addiction Severity Index. It yields 70 ratings in seven domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status, and psychiatric status. Information about the T-ASI can be obtained from http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/70_T-ASI.pdf.

(**Note**: The T-SAI is utilized by providers of Tennessee Department of Mental Health and Substance Abuse Services providers.)

- Another instrument cited in several articles was the "***Michigan Assessment Screening Test for Alcohol and Drugs***" (MAST/AD). - Westermeyer, Joseph; Yargie, Ilhan; Thoras, Paul.

Screening in Primary/Pediatric Care Settings: *Providers in all settings including primary care, mental health and substance abuse should consider co-occurring illness to be an expectation rather than an exception. Screenings for substance use and mental disorders may also be performed by PCPs as part of EPSDT and other wellness visits. A typical screening instrument is the CRAFFT (info@CRAFFT.org. , 2008) PCPs may be able to include medical findings such as laboratory findings . Screenings as a component of a primary care visit can also indentify substance use problems that may be emerging and sub-threshold in terms of not meeting full diagnostic criteria; this is important since early intervention* *and prevention may change the course and development of SUDs. It is also important for behavioral health providers to develop relationships with PCPs for referrals.*

Diagnosis/Medication

The importance of assessment for possible behavioral disorders and/or substance abuse is crucial. While co-occurrence is expected, individuals with a behavioral condition or substance abuse are at greater risk for co-occurring conditions.

- Due to the higher risk of a co-occurring disorder when a substance use (SU) or mental health (MH) disorder already exists, it is important that behavioral health (BH) specialists be cross-trained in the assessment of substance abuse and mental disorders, as well as integrated approaches to treatment and recovery.
- Behavioral health professionals need to take a watchful approach in assessment regarding diagnosis, as a co-occurring condition scan emerge or abate over time. Substances can have the effect of interacting with, masking, exacerbating, mimicking, synergizing, or moderating a mental disorder. A period of recovery and/or abstinence can change the presentation; thus assessment and diagnostic considerations need to be ongoing as the presentation of symptoms can evolve over time.
- A careful history, if possible, should be collected to further determine if one problem (i.e adjustment problems) may have preceded the other. This may help to clarify and define the type of mental disorder, but even if this is established, the focus still needs to be upon dual or "co"-recovery (from both mental illness and SUD), including promotion of abstinence.
- There may be competing attitudes regarding the use of medication. Some traditionally oriented substance abuse programs for instance may frown on the use of medication and are slow to adopt psychopharmacological interventions for individuals with COD (Sterling et al, 2011) However, an integrated approach involves a multi-modal one that incorporates both therapy and , medication management, where indicated "The use of medication for either type of disorder does not imply that it is no longer necessary for the patient to focus on the importance of his/her own work in recovery from addiction. Consequently, utilizing medication to help treat addiction should always be considered as an ancillary tool to a full addiction recovery program." (Minkoff, 2005).

Psychopharmacological Treatment Strategies

A. General principles: In patients with psychotic presentations, with or without active substance dependence, initiation of treatment for psychosis is generally urgent. In patients with known active substance dependence and non-psychotic presentations, it is recommended to utilize the integrated longitudinal assessment process to determine the probability of a treatable mental health diagnosis before medication is initiated. It can be very difficult to make an accurate diagnosis and effectively monitor treatment without this first step. It is understood that all diagnoses are "presumptive" and subject to change as new information becomes available. If there is uncertainty about diagnosis after reasonable history taking, evidence for initial efforts to discontinue substance use may need to occur prior to initiation of psychopharmacology, in order to establish a framework for further diagnostic evaluation. However, for high risk patients, with or without psychosis, developing a treatment relationship is a priority, and there should not be an arbitrary length of time required before treatment initiation takes place, nor should absolute diagnostic certainty be required. Individuals with reasonable probability of a treatable disorder can be treated

Psychotropic medications, particularly for anxiety and mood disorders, should be clearly directed to the treatment of known or probable psychiatric disorders, not to medicate feelings. It is important to communicate to patients with addiction that successful treatment of a comorbid anxiety or mood disorder with medication is not intended to remove normal painful feelings (such as normal anxiety or depressed feelings). The medication is meant to help the patient feel his or her painful feelings accurately, and to facilitate the process of developing healthy capacities to cope with those feelings without using substances. If psychotropic medications are used for mental illness in individuals with addiction, or if medication is used in the treatment of the addiction itself, the following precepts may be helpful to communicate to the patient:

Addicts in early recovery have great difficulty regulating medication; fixed dose regimes, not PRN's, are recommended in the treatment of mood and anxiety disorders.

Just as in individuals with single disorders, and perhaps more so, it is important to engage patients with co-occurring disorders as much as possible in understanding the nature of the illness or illnesses for which they are being treated, and to participating in partnership with prescribers in determining the best course of treatment. For this reason, most established medication algorithms (e.g. TMAP) and practice guidelines recommend that medication education and peer support regarding understanding the risks and benefits of medication use are incorporated into standard treatment practice. This is certainly true for individuals with co-occurring disorders, for whom information provided by peers may be particularly helpful in making good choices and decisions regarding both taking medication and reduction or elimination of substance use.

B. Diagnosis specific psychopharmacological treatment for mental illness

1. Psychotic Disorders: Use the best psychotropic agent available for the condition. Improving psychotic or negative symptoms may promote substance recovery. This includes treatment of substance-induced psychoses, as well as psychosis associated with conventional psychiatric disorders.

    a. Atypical neuroleptics: Consider olanzapine, risperidone, quetiapine, aripiprazole, ziprasidone or clozapine. In addition, it is well documented that clozapine has a direct effect on reducing substance use in this population, beyond any improvement in psychotic symptoms, and therefore may be specifically indicated for selected patients.
    b. Typical neuroleptics: Consider use in adjunct to the atypicals, especially in situations of acute agitation, unresolved psychosis, and acute decompensation
    c. Many individuals with cod will benefit from depot antipsychotic medications. Both typical and atypical neuroleptics (e.g., risperidone) are available in depot form. There have not been specific studies about the utilization of depot risperidone in individuals with co-occurring substance use disorder, but there is no apparent contraindication to its use.

2. Major Depression: The relative safety profile of SSRI’s (and to a somewhat lesser extend SNRI’s such as venlafaxine), other newer generation antidepressants and possibly buproprion (though higher seizure risk must be considered) make their use reasonable (risk-benefit assessment) in the treatment

of individuals with CODs. SSRI's have been demonstrated to be associated with lower alcohol use in a subset of alcohol dependent patients, with or without depression. The use of tricyclic antidepressants (TCAs) and MAO inhibitors (MAOIs) can be more difficult and possibly more dangerous in the COD population if there is a risk of active substance use.

3. Bipolar Disorder: Use the best mood stabilizer or combination of mood stabilizers that match the needs of the patient. Be aware that rapid cycling and mixed states may be more common, hence consider valproate, oxycarbamazepine, carbamazepine or olanzapine (and other atypicals), in patients who may have these variants.

4. ADHD: Initial treatment recommendations, in early sobriety, have included buproprion. Recently, atomoxetine has been available, and may be a reasonable first choice, though there have not been specific studies in co-occurring populations. In both adolescents and adults, there is clear evidence that if stimulant medications are necessary to stabilize ADHD, then these medications can be used safely, once addiction is adequately stabilized and/or the patient is properly monitored, and will be associated with better outcomes for both ADHD and substance use disorder.

5. Anxiety disorders: Consider SSRIs, venlafaxine, buspirone, clonidine and possibly mood stabilizers such as valproate, carbamazepine, oxycarbamazepine, gabapentin, and topiramate, as well as atypical neuroleptics. There is evidence of effectiveness of topiramate for nightmares and flashbacks associated with PTSD.

For patients with known substance dependence (active or remitted), the continuation of prescriptions for of benzodiazepines, addictive pain medications, or non- specific sedative/hypnotics is not recommended, with or without comorbid psychiatric disorder. On the other hand, medications with addiction potential should not be withheld for carefully selected patients with well-established abstinence who demonstrate specific beneficial responses to them without signs of misuse, merely because of a history of addiction. However, consideration of continuing prescription of potentially addictive medications for individuals with diagnosed substance dependence, is an indication for both (a) careful discussion of risks and benefits with the patient (and, where indicated, the family) and (b) documentation of expert consultation or peer review.

Sleep disturbances are common in mental illness as well as substance use disorders in early recovery. Use of non-addictive sedating medications (e.g., trazodone) may be used with a careful risk benefit assessment.

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Minkoff, K. (2005). Comprehensive continuous integrated system of care (CCISC): Psychopharmacology practice guidelines for individuals with co-occurring psychiatric and substance use disorders (COD). Boston: Harvard Medical School.

Treatment/Interventions

Identification of possible best practices while not meeting evidenced based practices (SAMSHA criteria) is promising. Treatment approaches include *Double Trouble and Recovery*, (peer support) and programs

from Hazelden, an intensive outpatient program. Also included are evidence based components such as cognitive behavioral therapy (CBT) and contingency management that are
In incorporated into treatment programs.

In a 2005 report produced by the University of Kansas, School of Social Welfare entitled, *Best Practices in Children's Mental Health*, recommendations for substance use and co-occurring treatment were cited. Those recommendations, based upon literature reviews of empirical studies, publications related to clinical experiences and SAMSHA's Report to Congress, included the following:

- Co-occurring disorders in children and adolescents vary in severity, and require *ongoing assessments,* including random urine tests throughout treatment and careful psychopharmacological treatments to decrease abuse of substance for self-medication, as well as *adjustments of treatment along a continuum of care*.

- Treatment must be *developmentally* appropriate, which includes the recognition that *confrontation may not be an appropriate method* for adolescent populations or for populations that may be more psychologically vulnerable and less likely to handle the stress of more traditional approaches to treatment. For instance the concept of "*powerlessness*" may be difficult for an individual dealing with trauma or living with schizophrenia. Because 12-Step AA/NA models were not designed for adolescents and do not appear as effective with this population, some authors recommend use of such groups only when the model and group appear to be a good match for the young client, or the model has been adapted for a particular population

- *Comprehensive approaches* best *integrate domains* such as health, educational, legal, and recreational services using a *variety of approaches* including group, family and individual treatment modalities.

- *Cognitive treatment* such as identifying negative self-talk and distorted thoughts as well as *behavioral techniques* such as gradual exposure/desensitization to traumatic memories are recommended for youth with substance abuse and PTSD. *Skill training*, such as stress management/relaxation, problem-solving, drug refusal, safety, social, and *psycho-education* should be included as well.

- Interventions may need to be timed and sequenced; e.g. an individual may need to establish a period of recovery and stability before addressing issues such as trauma. Trauma presents a unique challenge: adolescents may be denied entry into programs that can address their substance abuse issues until their emotional distrees is addressed, or into mental health programs until they have gained abstinence. The more appropriate course is to gauge the youth's readiness to address clinical issues, including factors such as the relative threat to safety, health and immediate well being (NCTSN, 2008)

- Since a good *therapeutic alliance* is considered a crucial element, the *active involvement of youth and family in the design of their program* and recovery is recommended, along with clear structure and flexibility to individualize treatment methods and goals.

- Treatment needs to include relapse prevention strategies.

- *A "no wrong door" perspective allows a*ny door to be the right door to receive treatment for co-occurring disorders, while understanding both disorders as "primary". Agencies vary in their capacities: do they offer a full continuum of care, emphasize recovery, integrated treatment plans? Do they have providers who are cross-trained and who offer integrated approaches? Integration of services is a key to successful outcomes. More programs are emerging that serve individuals with co-occurring disorders. To enable this process there are now assessment tools available to assess the degree of integration of mental health and substance abuse services. SAMSHA offers the following toolkits: ***Dual Diagnosis Capability in Mental Health Treatment*** *(DDCMHT)* ***Toolkit Version 4.0*** *(SAMSHA 2011a) and* ***Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit.*** TDMHSAS is recommending program evaluations using the toolkit as a means to assess an agency's program COD capabilities.

- Treatment plans should be *client-centered, individualized* and include family involvement in treatment. There is *no single correct intervention*. Strengths of the individual and family also need to be identified, including personal goals and life plans for recovery. Best practices in the area of co-occurring services indicate a need for integrated approaches to treatment, including an integrated care of plan that addresses and incorporates all of the bio-psychosocial needs of the individual and family (SAMSHA, 2011a & 2011b).

- Prevention and treatment services must be *culturally competent*, and appropriate for the diversity of age, sexual orientation and gender.

- PCP screening may identify patterns of abuse in early stages that do not rise above the threshold diagnostic criteria for specific disorders (Sterling et al, 2011). However individuals with less severity level of severity may benefit from brief interventions that may prevent more severe problems (Sterling et al, 2011), such as Screening, Brief Intervention, and Referral to Treatment [SBIRT] (SAMSHA, 2012) that can be delivered in primary care settings.

- Community-based case management may assist adolescents with CODs in making the transition to the adult care system.

Family Systems Approaches: Family therapy is strongly recommended in combination with any individual or group treatment and seems to have the highest proficiency for success. The recommended guiding principles of treatment, according to Holly (2007) are:

- Building a strong relationship and motivating clients to attend treatment;
- Creating a treatment plan that centers on client-generated goals;
- Applying empirically supported treatments, focused on interventions specific to the client's diagnostic presentation;
- Using culturally and developmentally sensitive content;
- Focusing on client strengths, with an emphasis on impulse control, communication, problem solving, and regulation of affect;

- Designing goals and objectives focus on change that is sustainable over the long term;
- Monitoring motivation, substance use and medication compliance, if utilized;
- Increasing intensity if the intended response is not achieved;
- Using relapse prevention strategies;
- Fostering peer group influences; and
- Conducting psychoeducation for parents. (Holly, H. 2007)

According to Mueser, Torrey, Lynde, Singer, and Drake (2003), family engagement in treating COD's is beneficial in that they offer the possibility of increasing the person's self-efficacy, can encourage treatment compliance, and help facilitate needed support systems. Fals-Stewart and O'Farrell (2003) suggest that family involvement can improve over all coping skills for clients, and with family psycho-educational efforts, reduce unintentional enabling. Engaging the family as part of any treatment model according to Fals-Stewart and O'Farrell can have a positive influence on relapse prevention and adherence to treatment goals.

Evidenced-based practices: The following treatment models have been approved as evidence-based programs for treatment of substance use disorder in the adolescent population by the Substance Abuse and Mental Health Services Administration (SAMHSA) as cited on the National Registry of Evidence-Based Programs and Practices website (SAMHSA, 2010):

- **Adolescent Community Reinforcement Approach (A-CRA)** - The Adolescent Community Reinforcement Approach (A-CRA) to alcohol and substance use treatment is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery.

- **Brief Strategic Family Therapy (BSFT)** is designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve pro-social behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school.

- **The Chestnut Health Systems-Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model** is designed for youth between the ages of 12 and 18 who meet the American Society of Addiction Medicine's criteria for Level I or Level II treatment placement.

- **Family Behavior Therapy (FBT)** is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth, as well as common co-occurring problem behaviors, such as depression, family discord, school or work attendance, and conduct problems in youth.

- **Family Support Network (FSN)** is an outpatient substance abuse treatment program targeting youth ages 10-18 years. FSN includes a family component along with a 12-session, adolescent-focused cognitive behavioral therapy--called **Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT12)** and case management.

- **Moral Reconation Therapy (MRT)** is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth.

- **Multidimensional Family Therapy (MDFT)** is a comprehensive and multi-systemic family - based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency.

- **Multisystemic Therapy (MST) for Juvenile Offenders** addresses the multidimensional nature of behavior problems in troubled youth. Treatment focuses on those factors in each youth's social network that are contributing to his or her antisocial behavior.

- **Not On Tobacco (N-O-T)** is a school-based smoking cessation program designed for youth ages 14 to 19 who are daily smokers. N-O-T is based on social cognitive theory and incorporates training in self-management and stimulus control; social skills and social influence; stress management; relapse prevention; and techniques to manage nicotine withdrawal, weight, family and peer pressure.

- **Parenting with Love and Limits (PLL)** combines group therapy and family therapy to treat children and adolescents aged 10-18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation.

- **Phoenix House Academy** (formerly known as Phoenix Academy) is a therapeutic community (TC) model enhanced to meet the developmental needs of adolescents ages 13-17 with substance abuse and other co-occurring mental health and behavioral disorders.

- **Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment)** is a **screening, brief intervention, and referral to treatment (SBIRT)** model designed for use in health clinics or emergency departments (EDs).

- **Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students)** is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse.

- **Project Towards No Tobacco Use (Project TNT)** is a classroom-based curriculum that aims to prevent and reduce tobacco use, primarily among 6th to 8th grade students. The intervention was developed for a universal audience and has served students with a wide variety of risk factors.

- The **Residential Student Assistance Program (RSAP)** is designed to prevent and reduce alcohol and other drug (AOD) use among high risk multi-problem youth ages 12 to 18 years who have been placed voluntarily or involuntarily in a residential child care facility (e.g., foster care facility, treatment center for adolescents with mental health problems, juvenile correctional facility).

- **Seeking Safety** is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: in group or individual formats, male or female clients, and a variety of settings (e.g., outpatient, inpatient, residential).

- **The Seven Challenges** is designed to treat adolescents with drug and other behavioral problems. Rather than using pre-structured sessions, counselors and clients identify the most important issues at the moment and discuss these issues while the counselor seamlessly integrates a set of concepts called the seven challenges into the conversation.

- **Teen Intervene** is an early intervention program targeting 12 to 19 year olds who display the early stages of alcohol or drug use problems (e.g., using or possessing drugs during school) but do not use these substances daily or demonstrate substance dependence.

The following items are NOT on the Evidence Based Registry for adolescents, but either widely endorsed by professionals or the State of Tennessee Department of Mental Health and Substance Abuse Services:

- **Dialectical Behavior Therapy (DBT)** is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes.

- **Double Trouble in Recovery (DTR)** is a mutual aid, self-help program for adults aged 18 to 55 who have been dually diagnosed with mental illness and a substance use disorder. In a mutual aid program, people help each other address a common problem, usually in a group led by peer facilitators rather than by professional treatment or service providers.

- **Motivational Enhancement Therapy (MET)** is an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly non-confrontational manner.

- **Motivational Interviewing (MI)** is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal.

- **Hazelden Adolescent Co-Occurring Series** utilizes an integrated therapies approach in conjunction with a family program and medication management. The therapy approach includes Motivational Enhancement Therapy, Cognitive-Behavioral Therapy and Twelve Step Facilitation.

Other Interventions: A systems approach may focus on working with a family unit or providing services in the natural environments of child/adolescents. Examples of promising and innovative approaches include:

- **Case management services:** Family-focused case management services have proven effective with adults with co-occurring disorders and their children. "**Parent participants experienced reduced mental health–related stigma and stress, improved parenting skills and social support networks, and had relatively few psychiatric hospitalizations. Families were supported by providing children enhanced access to services for cognitive and/or developmental delays and through the facilitation of many lasting reunifications"** (Finnel & Vogel, 2012).

- **School and community-based programs:** Recent findings suggested that medications for SED could yield favorable treatment results for youth receiving alcohol treatment in school settings, community-based intervention programs, clinic treatment, partial day treatment, day treatment, and short-term inpatient treatment (SAMSHA, 2000).

The examples of innovative treatment programs for adolescents with substance use problems include recovery programs that occur in an individual's natural environment such as school-based student assistance programs (True North, 2012).

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Areas of Special Concern in Behavioral Health Services for Children and Adolescents

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TDMHSAS BEST PRACTICE GUIDELINES

Intellectual Disability and Comorbid Psychiatric Disorders
In Persons Under 22 Years of Age

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Introduction

Psychiatric disorders are frequently comorbid with Intellectual Disability (ID). Prevalence estimates of psychiatric disorders in Intellectual Disability range from 30 percent to 70 percent Virtually all categories of psychiatric disorders have been reported. Often, particularly in those with more severe intellectual disability, specific psychiatric diagnoses cannot be made yet, behavioral symptoms significantly compromise optimal daily functioning by interfering with adaptive, communication, social, learning, recreational and/or motor activities.

Key Principles in Children with ID

There are several key principles that should guide the care of children/adolescents with Intellectual Disability (ID) and comorbid psychiatric disorders or challenging behaviors.

- Children/adolescents with ID can have the full range of psychiatric disorders seen in the general population. Indeed, there is a 3-5 fold greater prevalence of psychiatric disorders in individuals with ID.
- Children's behavior must be seen in a developmental context. The child's behavior/attention/interactions may be inappropriate for his/her chronological age but entirely appropriate for his/her developmental age.
- Psychiatric disorders may be under-diagnosed because
  i) professionals feel challenging behaviors are part of the child's cognitive delay or disorder and warrant no further investigation;
  ii) the child's communicative or cognitive skills interfere with symptom reporting;
  iii) caregivers are not familiar with the range of symptoms or behaviors of the individual;
  iv) disorders such as depression may present differently in children, including those with ID, than in adults.
- Communicate the working diagnosis with the family or caregivers. The psychiatric diagnoses in people with intellectual disabilities tend to accumulate and travel with them for years, so help them sort through which diagnoses are active, and which ones are not.
- Many children/adolescents with ID may not clearly fit DSM diagnostic criteria. In this case, systematic but empiric approaches to "target" symptom management are necessary.

- Comorbid medical disorders often present as behavioral change. Attention to possible conditions such as gastresophageal reflux, dental pain, infections, medication side-effect, seizures, constipation and other disorders is important. Treatment of the comorbid disorder(s) may alleviate the behavioral symptoms.
- Stress may lead to behavior symptoms. Removing the source of stress may do much to diminish challenging behaviors.
- The appropriateness and effectiveness of behavioral therapies varies with the child's developmental age.
- Pharmacological intervention is only one component of a therapeutic package which may also include a wide range of psychotherapies, environmental changes and other contextual interventions.
- Children/adolescents (and adults) with ID may experience greater side effects from psychotropic medications than those without ID. A basic strategy of "Start low, go slow" is warranted (lower starting doses, increase more slowly.)
- Closer monitoring for treatment effect and side effect in children/adolescents with ID is required, compared to adults without ID. Rates of response are often poorer and side effects more frequent than in individuals without ID.
- Relatively little psychotropic medication research has been done in children/adolescents with ID. Studies are predominately open trials, case reports or controlled trials with small samples. Risperidone is an exception.
- Studies of long-term benefits or side effects are not available.

Assessment and Diagnosis

The psychiatric diagnostic evaluation of persons who have ID is in principle the same as for persons who do not have ID. Diagnostic approaches are modified, depending on the child's cognitive level and communication skills. For persons who have mild ID and good verbal skills, the approach does not differ much from diagnosing persons with typical cognitive skills. The poorer the communication skills, the more one has to depend on information provided by caregivers familiar with the child and on direct behavioral observations.

Psychiatric and behavioral assessment and diagnosis of persons with ID includes:

- Comprehensive assessment of ID.
- Comprehensive history and physical examination, child and caregiver interviews, medical record review, completion of relevant laboratory tests and psychological testing, behavioral inventories and diagnostic formulation.

Criteria for Diagnosis of ID (Based on DSM-IV-TR and AAIDD criteria)

Criteria	Definition	
Significantly subaverage general intellectual functioning	IQ approximately 70 or below	
Accompanying significant limitations in measured adaptive functioning in at least two areas:	Communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety	
Age of onset	Must be evident before 18 years of age	
Levels of severity (DSM-IV-TR)	Mild	IQ 50-55 to approximately 70
	Moderate	IQ 35-40 to 50-55
	Severe	IQ 20-25 to 35-40
	Profound	IQ below 25
Levels of supports needed (AAIDD)	Intermittent, Limited, Extensive or Pervasive	
Be cautious in interpreting low IQ in the presence of a psychiatric disorder	Low IQ must precede and not be a direct result of psychiatric disorder or behavior symptoms	

Assessment of individuals with ID and behavioral problems and/or suspected psychiatric disorders includes:

Comprehensive History from Parent/Caregiver

- Presenting symptoms/behaviors.
- Assessment of functioning, including communication.
- Treatment history.
- Prior medications responses.
- Prior behavioral interventions.
- Placements and supports.
- Family/household dynamics.
- Past evaluations.

Interview (where appropriate) and Observation of Child/Adolescent

- Ample time should be allotted for the child interview. Sufficient time may be needed to put the child at ease.
- The interview should be adapted to the child's communication skills.
- Clear and developmentally appropriate language should be used.
- Reassurance and support should be provided.
- Leading questions should be avoided.

- The interviewer should attempt to ensure the child understands all questions and communications.
- Mental status may be assessed from observation and context of conversation/interaction, rather than by formal mental status examination.
- Nonverbal expression and activity should be considered, possibly as communication.

Medical Review

- Developmental history.
- Past medical history, including medical diagnoses and treatments.
- Family history
- Social history, including living context.
- Educational history
- Physical examination
- Neurodevelopmental examination

Laboratory Studies

Laboratory and radiologic studies should be guided by history and examination and may include chromosomal analysis or chromosomal microarray, fragile-X by DNA analysis, amino acid and organic acid studies, and other appropriate tests for inborn errors of metabolism. If there is concern for underlying metabolic disorder, a pediatric genetics and/or child neurology consultation should be obtained. If there is concern about seizure disorder, structural brain abnormality or progressive neurological disorder, a child neurology consultation should be obtained.

Psychological Testing

Intellectual Disability must be assessed using standardized, full scale measures of intelligence. Acceptable instruments include the Wechsler Adult Intelligence Scale, 4th Ed. (WAIS-IV), Wechsler Intelligence Scale for Children, 4th Ed. (WISC-IV), Kaufman Assessment Battery for Children, 2nd ed. (K-ABC-II) and the Stanford-Binet Scales, 5th Ed. Brief forms of these are not acceptable for the purposes of diagnosis. A diagnosis of ID should never be made solely on the basis of an IQ score. Evaluation of adaptive behavior is also required. Frequently used measures of adaptive behavior include Adaptive Behavior Assessment System, 2nd Ed. (ABAS-II), Scales of Independent Behavior-Revised (SIB-R) and the Vineland Adaptive Behavior Scales, 2nd Ed (Vineland-II).

Psychological tests can provide additional support for the diagnosis of a psychiatric disorder. Rating and self report scales such as the Child Behavior Checklist (CBCL), Beck Depression Inventory (BDI), the Structured Clinical Interview (SCID), and the Behavior Assessment System for Children, 2nd Ed. (BASC-2) are highly reliable tools. Most instruments include guidelines for use with various populations and reading levels.

Evaluation of Stressors

Complete evaluation and individualized treatment requires attention to possible stressors that may be triggering or exacerbating the presenting problem in someone with ID. The stressors listed below may be more likely to occur in persons with ID, and cause difficulties for those who have reduced coping skills. Helping the individual, family, and caregivers deal with or eliminate stressors may sometimes be the primary target of treatment and often facilitates other treatment interventions.

Type of Stressor	Examples
Change	New school, job or residence
Interpersonal	Loss of family member, friend, job; taunting, teasing, bullying, other social exploitation
Environmental	Crowding, noise, lack of stimulation, lack of privacy, work or school-related stress
Parenting or Social Support	Lack of support from others; disruptive visits or contacts; neglect, hostility, physical or sexual abuse; sibling issues; domestic violence; parent/caretaker stress
Illness/Disability	Chronic or recurrent illness, serous acute illness, sensory deficits, seizures, recurrent constipation, GERD, occult fracture or musculoskeletal injury, occult pain, medication side effects; changing disability such as declining mobility, dysphagia
Frustration	Communication problems, lack of choice, awareness of disability
Trauma	Persons with ID have higher rates of victimization

Diagnosis and Identification of "Target" Symptoms

Children and adolescents with ID are vulnerable to the same major psychiatric conditions as people without intellectual disabilities. It is essential to gather information about possible comorbid conditions and environmental factors which may be contributing to the target symptoms as children and adolescents with ID are likely to have difficulties presenting their own history.

Keep in mind that similar to typical children, children with ID rarely self refer. They are brought by family or caregivers who are usually concerned about particular behaviors.

Consider whether the target symptoms are due to developmental delay, symptoms consistent with a specific developmental disorder, symptoms of a medical condition or signs of psychopathology requiring a psychiatric diagnosis.

As the level of ID becomes more severe, it is increasingly difficult to make specific DSM-IV-TR diagnoses (other than autistic disorder) reliably. [Autistic disorder is a common comorbid condition in people with ID, and the reader is referred to the chapter on Autism Spectrum Disorders in these guidelines.]

The psychopharmacologic and/or behavioral treatments of children and adolescents with intellectual disabilities and suspected Psychiatric Disorders should be based on the most specific DSM-IV-TR diagnosis possible. If the treatment does not work to resolve the presenting problem, consider that the diagnosis may not be correct and that additional information not present at the outset may lead to a new diagnosis.

When there is not a psychiatric syndrome such as a mood disorder or, more rarely, a psychotic disorder, then a tentative nonspecific DSM-IV-TR diagnosis can be made. The clinician may need to focus on one or more behavioral symptoms as the target(s) of treatment in the absence of a firm diagnosis.

The following are some of the more common problems that may be targets of behavioral or psychopharmacologic treatment in the context of a DSM-IV-TR diagnosis or on their own if the clinician is unable to make a more specific diagnosis:

- Self-injurious behavior.
- Physical aggression toward people or destruction of property.
- Impulsivity/hyperactivity .
- Suicidal ideation/behavior.
- Sexually aggressive behavior.
- Sexual self-exposure/public masturbation.
- Social withdrawal.
- Excessive dependency.
- Noncompliance/oppositional behavior.
- Obsessive thoughts and obsessive compulsive behaviors.

Patient and Caregiver Interview

The child or adolescent may present with limited communication skills or may be shy to disclose relevant history. Information from parents and caregivers should always be sought in order to develop a more complete assessment, especially in those instances where the child or adolescent lacks adequate communication skills. Keep in mind that 90 percent of people with ID are in the mild categories and, especially for adolescents, may be able to present very pertinent parts of their history. They should be interviewed alone at some point, if possible. Attempts should be made to collect both anecdotal subjective information and more objective data, such as adaptive functioning, daily record keeping, or graphical data.

Treatment

General

Habilitation of persons with ID is based on the principles of normalization and community-based care, with additional supports as needed. Federal legislation, for example, the Individuals with Disabilities Education Act (IDEA), entitles children and adolescents with disabilities to a full range of diagnostic, educational and support services from birth to age 21. Specialized treatments are also provided if necessary for children and adolescents with additional severe visual and auditory impairment or motor disabilities.

The parents of children and adolescents with ID are entitled by these laws to receive support services and to be active participants in treatment planning. Some parents and older children are not fully aware of their rights to obtain services. The clinician has an important role in such instances to educate and, if needed, to refer to a "patient advocate" or "educational advocate."[2]

In recent practice, children and adolescents are educated in special classes in regular school or in inclusionary programs (in age appropriate regular classes, with additional supports as needed). In the United States, children with ID are now rarely if ever placed in residential institutions and seldom in separate schools.

Habilitation and treatment include:

- Specific treatment of the underlying condition, if known, to prevent or to minimize brain insults that result in ID (e.g., shunting in the case of hydrocephalus).
- Early intervention, education, and ancillary therapies (such as physical, occupational, speech and/or language therapies, *and behavior therapies*), family support, and other services, as needed.
- Treatment of comorbid physical conditions, such as hypothyroidism, congenital cataracts or heart defects in children with Down syndrome or treatment of seizures in persons with tuberous sclerosis.
- Treatment of comorbid mental disorders, including psychosocial interventions and pharmacotherapy.

Psychiatric

The psychiatric treatment of persons with ID and a comorbid mental disorder is generally the same as for persons without ID. However, persons with ID and a comorbid psychiatric disorder may have features that warrant special consideration; for example some persons with ID may be more sensitive to the disinhibiting effects of sedative/hypnotic agents and this needs to be taken into account in choosing a medication.

Psychotropic medication should be integrated as part of a comprehensive treatment plan that includes, appropriate behavior planning, behavior monitoring, and communication between the prescribing physician, therapists, and others providing supports, habilitative services, and medical treatment.

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[2] In Tennessee, Support Training for Exceptional Parents (STEP) is the statewide family-to-family program providing free information, advocacy training, and support services to parents of children eligible to receive special education or related services. STEP can be reached at (800)-280-STEP.

Treatment including psychotropic medications should be based on the most specific DSM-IV TR diagnosis possible. When only a tentative non-specific DSM-IV TR diagnosis can be made, the clinician may need to focus on one or more behavioral symptoms as the target of treatment. There should be an effort, over time, to adjust medication doses to document ongoing need or the minimum dose at which a medication remains effective. The prescribing clinician may want to collaborate with a Board Certified Behavior Analyst regarding behavior analysis and treatment.

Psychotropic medication decisions need to be made with due consideration for potential problems of polypharmacy, and otherwise for negative impact on the individual's functioning and overall quality of life. Every effort should be made to avoid unnecessary compromise of cognitive, communicative, social, adaptive or motor function. Risk vs. benefit needs to be considered and continually reassessed, and justification for duration of treatment needs to be established periodically during the course of treatment.

Behavioral Emergencies

- Individuals will be evaluated for any contraindication for restraint or emergency medication.
- Possible medical causes for an acute behavioral exacerbation must be considered (e.g., other illness, injury, medication side effects).
- Reassessment of the diagnosis and the plan of treatment and support are indicated when there is an emergent behavioral episode.
- Restraint of any kind, where permitted, is used only when efforts at redirection or de-escalation have failed and the individual poses an imminent risk of harm to self or others.
- Emergency medications, where permitted, are given only after appropriate diagnostic assessment and other alternatives have been attempted or are contraindicated.

Psychotherapeutic Interventions

Psychotherapy can be effective for persons with ID toward realization of a variety of goals such as:
- Mitigation of stressors.
- Improved coping skills.
- Improved communication of feelings, problems, etc.
- Improved problem solving skills.
- Improved social and interpersonal skills.
- Reduction/elimination of maladaptive behaviors.
- Increase of adaptive behaviors.
- Understanding of disability and illness.
- Increased self-esteem.

Modality and Technique

Types of psychotherapy for persons with ID and a comorbid mental disorder may include:

- Individual.
- Applied behavior analysis (ABA).
- Group.
- Family therapy.

As with all psychiatric care, the approach to treatment of persons with ID and a comorbid mental disorder is generally the same as for the general population. Techniques typically utilized with persons with mental disorders can be considered potential interventions for persons who are dually diagnosed, with adaptations made as necessary, based on the needs and strengths of the individual. The approach to therapy may need to be more concrete, repetitive, and/or directive, and may need to incorporate visual and auditory aids. Role play can be effective, and behavioral techniques, such as positive reinforcement are very important.

Treatment should be appropriate for the individual's cognitive and communicative skills. Generally, the lower the cognitive and adaptive functioning of the child, the more extensive the needed modifications in technique. Some techniques are rarely appropriate for persons who function at the lower levels of ID.

Applied behavior analysis (ABA) is a widely used strategy for addressing behavior problems among patients with disorders such as ID, other developmental disabilities, and traumatic brain injury. It considers antecedents (environmental factors that appear to trigger unwanted behavior), the behaviors themselves, and consequences that either increase or decrease future occurrences of that behavior. A treatment program using a behavioral technique known as operant conditioning is then carried out to address the specific challenging behavior, such as self-injurious behavior.

The principles of ABA include:
- Indirect Assessment, such as interviewing family/caregivers; use of behavior rating scales.
- Direct observation of behavior.
- Functional analysis, i.e., a formal evaluation of the effects of specific environmental variables upon the behavior.
- Ongoing assessment of treatment effects by repeated direct observations of behavior, coupled with repeated behavioral assessments.

Residential Treatment Programs

Treatment of children and adolescents with Intellectual Disability should always be in the least restrictive environment possible. Residential treatment programs that serve children and adolescents with ID should only be considered if they are experienced in serving children with ID and children are protected in the setting. Children and adolescents with ID are easily victimized and need enhanced supervision and support. In groups they may need fewer distractions (e.g.small group size), a more psychoeducational rather than process therapy approach, developmentally appropriate language and adequate time to practice/rehearse.

Treatment Follow-up

It is essential to assess treatment effectiveness. Treatment goals as well as “target” symptoms must be established by the clinicians, family caregivers and where appropriate, the child.. Interdisciplinary collaboration of professionals and caregivers is essential. Follow-up includes repeated recipient interview/observation and obtaining comprehensive interim information. The risks vs. benefits of a treatment must be reevaluated on an ongoing basis throughout the course of treatment. When psychotropic medications are prescribed for the individual with ID and a comorbid mental disorder, the treating professionals should establish a plan to monitor for potential side effects as well as for continued efficacy and need for continued use of the medication. If the child or adolescent is not experiencing improvement, the accuracy and completeness of the diagnosis should be reviewed, as well as the consistency of implementation of treatment by the caregivers.

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TDMHSAS BEST PRACTICE GUIDELINES

Children with Sexual Behavior Problems

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Nationally, increasingly younger children are coming to the attention of schools, courts, and social service agencies for sexual behavior problems. While Tennessee law, state policy and mental health practice originally geared for adult offenders have been modified in part for minors who commit sexual offenses, they do not differentiate between the behavior of older minors and children 12 and under that are experiencing sexual behavioral problems. However, research has shown that the assessment and treatment needs of children ages 12 and under who have sexual behavior problems are different from the assessment and treatment needs of adolescents who offend sexually. These differences must be taken into account when working with this population of children. It is also important to note that problematic sexual behaviors are only a small part of a child's behavior and should not overshadow the view of the whole child.

The co-occurrence of victimization, trauma, and inappropriate sexual behavior by young children accounts for an undeniably high number of cases of children 12 and under who have sexual behavior problems. However, not all children who are sexually abused develop sexual behavior problems, and not all children who exhibit inappropriate sexual behavior are victims of childhood sexual abuse. Therefore, inappropriate sexual behavior is not in and of itself "diagnostic" for a history of abuse or sexual trauma.

I. Definition of Children with Sexual Behavior Problems (CSBP)

Child sexual behavior problems are a set of functioning behaviors that fall outside acceptable societal norms. It is not a diagnostic category. Generally CSBP are defined as children 12 and younger who initiate behaviors involving sexual body parts that are developmentally inappropriate or potentially harmful. The intention and/or motivation of the behaviors may or may not be related to sexual gratification. These behaviors can be related to other factors such as curiosity, anxiety, imitation, attention seeking and/or self-calming. Sexual behaviors can be self-focused or involve other children (Chaffin, M., Berliner, L., Block, R., Johnson, T. C., Friedrich, W. N., Louis, D. G., et al., 2006).

II. Healthy vs. Problematic Sexual Behavior in Children

When considering sexual behavior in children under the age or 12 it is essential to distinguish between behavior that is healthy and that which is considered problematic. Elements to consider include:

- Healthy sexual play and exploration occurs spontaneously, intermittently, is mutual and non-coercive, not causing emotional distress.
- Children engage in healthy sexual behavior because it is pleasant and they are curious. Sexual exploration is part of social development and information gathering about issues such as gender roles and behaviors, how bodies look alike and are different.
- Healthy sexual behavior is not a preoccupation. It generally comes out of a place of curiosity and exploration.
- Healthy sexual behavior does not usually involve advanced sexual behavior, such as intercourse or oral sex.
- When making distinctions between healthy and problematic sexual behavior it is important to be sensitive to developmental stage and cultural norms.
- Other factors to consider when distinguishing between healthy and problematic behavior include:

    - Frequency – problematic sexual behavior occurs more frequently and is likely to interfere with normal childhood activities.
    - Whether the child responds to correction by an adult. Generally, children engaging in sexual behavior within the healthy range are responsive to redirection by adults. It is important to note that children with developmental disabilities may respond less quickly and therefore require additional redirection. When caught, children engaging in healthy sexual behavior may show embarrassment, but usually not more negative emotions such as shame or anxiety.
    - Age/developmental difference of children.
    - Use of force (self/others), intimidation or coercion.
    - Presence of emotional distress.
    - Interference with social development.

Healthy Sexual Behavior	**Problematic Sexual Behavior**
• Comes from a place of curiosity • Behavior is spontaneous and mutual • Behavior involves positive affect • Behavior is responsive to redirection • Involves children in similar age/developmental range • Low Frequency	• Behavior seems to be a preoccupation • Engaging in advanced sexual behavior or knowledge • Behavior seems planned/targeted or is coercive • Behavior is emotionally distressing • Behavior is unresponsive to redirection • Inappropriate age/developmental range between children • Behavior is frequent or obsessive • Behavior interferes with social development • Behavior disrupts functioning

For most children with sexual behavior problems, it is not necessary to conduct extensive, broad range assessments across many sessions. It is important to determine at the very beginning whether the referral for an assessment of sexual behavior is appropriate. Evaluators can make this determination at the time of the referral by requesting collateral data to support existence of inappropriate sexual behavior and by helping the referring party to clarify referral questions.

In gathering information for the assessment, focus should be on the following:

- <u>Context, Social Ecology and Family</u>: Assess the context of the behavior in question as well as family and environmental issues that may be impacting the child. In cases where children are in temporary living situations, the assessment should also focus on environmental needs in the permanent setting.

- <u>Broad Psychological and Behavioral Status</u>: Non-sexual problems including internalizing problems, externalizing problems, developmental issues and adverse environments often exist in children with sexual behavior problems. It is necessary to assess for these issues so that behaviors and presenting problems can be prioritized.

- <u>Sexual Behavior and Contributing Factors</u>: Attempt to identify circumstances under which sexual behavior problems (SBP) seem to occur by obtaining a clear behavioral description of the sexual behaviors in a chronological sequence. Some children might engage in SBP when under stress, when depressed or frightened, when angry, or when reminded about past abuse. Others may engage in the behavior in response to environmental triggers or when there is opportunity.

Relevant information summarized above can be gathered using the following components:

- Review of background and collateral materials. This can include past psychological evaluations and school evaluations.
- Behavioral and psychosocial history as reported by caregiver. This may include:

    - Developmental History;
    - Family History: special attention paid to early development of relationships and environmental context, use of authority/discipline in the home, role of coercion and sexuality in family, manner of expressing affection and personal boundaries, parental history of psychological functioning and past trauma, and how supportive will family be in terms of treatment;
    - Social History – peer relations, social skills;
    - Psychiatric/Treatment History;
    - School History/Intellectual Functioning; and
    - Medical History – includes any current medications, significant medical conditions.

- Child interview - focus on information gathering, including the child’s understanding of the negative sexual behavior and laying the groundwork for addressing the SBP. The focus is not to get an admission and the interview should not include pressure the child to disclose.
- Administration of any of the following measures:

  - The Child Sexual Behavior Inventory (CSBI) measures the frequency of both common and atypical behaviors, self-focused and other-focused behaviors, sexual knowledge and level of sexual interest
  - The Child Sexual Behavior Checklist (CSBCL- 2nd revision) lists 150 behaviors related to sex and sexuality in children, asks about environmental factors, gathers details about sexual behavior and lists 26 problematic characteristics of child sexual behavior.
  - The Weekly Behavior Report (WBR) tracks week-to-week changes in general and sexual behavior among young children.
  - Measures of behavior and emotional symptoms, such as Child Behavior Checklists (CBCL), Behavior Assessment System for Children (BASC), and Trauma Symptom Checklist for Children (TSCC).

Key differences between a psychosexual evaluation completed for an adolescent and an assessment for a child with sexual behavior problems:

- There are typical components of a psychosexual that are not included in a child's assessment, such as sexual history and certain risk measures.
- Standard recommendations such as no contact with children 12 and under are not appropriate in assessments for children.
- Children 12 and under should *never* be labeled as perpetrators or offenders in an assessment.
- Polygraphs or techniques designed to elicit a confession should never be used.
- It should be noted that "level of risk" is not considered a factor in CSBP in the same way it is with adolescent and adult sexual offenders. CSBP are not considered sexual offenders, regardless of whether they have been involved with the legal system or not. Thus, "risk to reoffend" is not a consideration. Increasing structure and supervision in the home and addressing associated child and family treatment needs decreases the "risk" that is present for continued sexual acting out.

Evaluation Recommendations for Children with Sexual Behavior Problems:

- Recommendations should avoid broad statements; rather recommendations should focus on the individual child and family.
- Recommendations should be individualized based on the family circumstances and the age/developmental level of the child.
- Family issues to address should include needed services and supports for family members.
- Recommendations should address issues that are triggers for inappropriate sexual behavior, as well as issues related to boundary needs.
- Recommendations should address the existence of co-occurring conditions or other factors present in the child or family that require treatment attention.
- Specific recommendations related to safety in the home and community for the targeted child as well as any other children in the home should be included. This can include recommendations regarding the development of safety plans and factors that should be addressed in a safety plan, including supervision needs. Factors to consider in development of a safety plan include:

  - Level of awareness of the youth and family regarding the SBPs;
    - Level of understanding on the part of the youth and family that the sexual behavior is problematic;

- Level of understanding regarding the impact of behavior on others on part of child and family;
- Specific recommendations for the school to ensure safety of the child and other children;
- Plan for responding to subsequent incidents of inappropriate sexual behavior; and
- Specific behavior management strategies to reinforce appropriate behavior and reduce negative behaviors.

Areas of caution related to the assessment of CSBP:

- Interviewers should be sensitive to developmental issues and past trauma when interviewing children. The atmosphere should be supportive and pressure to reveal information *should not be applied*. Interviewers should expect children to be reluctant to reveal the truth and details about events may be upsetting to the child.
- *It is important to note that admission of engagement in the sexual behavior, or lack thereof, is not a factor that is related to risk.*
- Adult and adolescent assessment tools are inappropriate for children and should not be used
- While children who exhibit sexual behavior problems might have a history of sexual abuse, evidence suggests that there are other pathways to sexual behavior problems. Therefore, while it is appropriate to question whether or not the child has been sexually abused, it is inappropriate to assume that SBP definitively indicates past sexual abuse.
- Assessment of a child's sexual behavior problems *should not be considered valid beyond one year* from the time that the evaluation was conducted. Developmental factors, environment, and status change over time. Therefore, assessment recommendations that are specific to SBP should not be considered later in the child's life. The assessment should give more weight to recent events and issues.
- Restrictions addressed in safety plans should not last forever. After a period of time that is designated on the safety plan, if no inappropriate sexual behaviors occur the safety plan should be revisited and the child should be allowed more freedom and restrictions relaxed. The goal of a safety plan to is to provide support around resolving the problem behavior, not punishment.

IV. Factors that may contribute to sexual behavior problems

The family environment is key in assessing and treating child sexual behavior. The following factors, including familial, social and economic, have been identified as being related to child sexual behavior problems and thus they should be considered when assessing a child's needs:

- History of physical and/or emotional abuse, neglect, exposure to domestic violence, and disruptions in care (i.e., placement in foster care, incarcerated caretakers, caretaker with mental or severe physical illness that impact care);
- Exposure to sexually explicit media (i.e., TV, magazines, web) and sexual violence;
- Living in a highly sexualized environment (i.e., parental arguments about sex, sexual language, exposure to adult sexuality) or homes with poor boundaries and little privacy (i.e., no locks on bathrooms or family members don't knock, bodies are inspected or discussed (over age 6), children are expected to kiss or hug people they don't like, exposure to nudity);
- Children are expected to meet an emotional need of a parent: in role of substitute partner to include sleeping in the same bed or hearing about the parent's problems;
- Children live in places where sex is paired with aggression;

- Children are hormonally or physically different from other children;
- Limitations or disruptions in the quality of caregiver relationship related to engagement and attachment;
- Adult capacity to supervise and opportunities for inappropriate behavior;
- Positive and negative role models and peers;
- Types of discipline and structure;
- Cultural factors;
- Resiliency;
- Poverty;
- Single parents with little education;
- Excessive stressful life events; and
- Sexual victimization within the extended family.

Additionally, it is important to note that while children who have been sexually abused do engage in higher frequency of sexual behaviors than children who have not been sexually abused, children who have no history of sexual abuse also engage in problematic sexual behavior. Child sexual behavior problems can occur as part of an overall pattern of disruptive behavior, in addition to being isolated or specialized.

V. Evidence Based Treatment

SBP Outcomes Research

Several studies have emerged examining a variety of interventions and treatment modalities, including individual, group, family, and play therapies, some of which target SBP directly and others indirectly. Emerging evidence-based treatments designed to primarily target SBP are largely group interventions that use cognitive behavioral therapy (CBT) and are time-limited (Chaffin et al., 2006). Following is a summary of significant findings related to treatment of CSBP's:

- More structured programs demonstrate improved SBP in comparison to less structured interventions. For example, compared to a play therapy group (Bonner, Walker, & Berliner, 1999), children randomly assigned to a CBT group demonstrated fewer sex offense arrests at 10-year follow-up (Carpentier, Silovsky, & Chaffin, 2006). Additional studies looking at CBT format interventions found improvements with this population. (Pithers, Gray, Busconi, & Houchens, 1998).

- Interventions with preschool children are especially effective, as demonstrated by Silovsky and colleagues (2007) who successfully treated children ages 3-7 and their caregivers in a group program. Interventions targeted at preschool-age children resulted in the biggest changes, perhaps because parent practice elements like behavior management are better implemented at that age.

- Interventions that target traumatic stress with SBP as a secondary symptom have also demonstrated improvements in children with SBP. Comparisons of Sexual Abuse Specific (SAS) Cognitive Behavior Therapy (CBT) with Nondirective Supportive Therapy (Cohen & Mannarino 1998, 1996) have consistently demonstrated more improvements of SBP's in the

SAS CBT groups. Trauma-Focused CBT has also improved SBP relative to supportive therapy (Deblinger, Stauffer, & Steer, 2001).

- St. Amand and colleagues (2008) conducted a meta-analysis of 11 treatment outcome studies evaluating 18 specific interventions for SBP in young children. They limited their review to studies of children between ages 3 and 12 and to short-term outcomes, given the dearth of long-term outcome studies. Several characteristics of treatment were examined, including specific practice elements rather than whole treatment models (e.g., cognitive coping vs. TF-CBT); treatment type (CBT, play therapy); treatment modality (individual, group, family); and therapist approach (directiveness, limit setting, and use of modeling/practice). The analysis indicated that overall, the degree of change in SBPs following treatment is .46, a medium effect size statistically but a substantial amount clinically, indicating that treatment does work with a heterogeneous group of children (St. Amand et. al, 2008).

- Treatment modality (individual vs. group) is less important than specific practice elements (St. Amand et al., 2008).

Recommended Practice Elements

Parent Components

Family/Caregiver involvement in treatment is key. This includes biological parents, foster care or kinship care parents, and any other current or potential future caregivers. In some cases, it will be appropriate for therapists to work directly with surrogate caregivers, such as day care staff or teachers, depending on where the SBP occurs. Research has identified specific elements to be included in successful interventions (Chaffin et al., 2008). Parent/caregiver components include:

1. Developing and implementing a safety plan, which includes:
    a. A supervision and monitoring plan
    b. Communicating the plan with other adults in the child's life
    c. Modifying the plan over time as needed
2. Education about healthy sexual development and how it differs from SBP
3. Developing privacy and sexual behavior rules for the child
4. Education about factors that contribute to and maintain SBP
5. Sex education and how to discuss with children
6. Parenting strategies to improve the relationship with the child
7. Supporting child's use of self-control strategies
8. Modeling appropriate physical affection and building relationship
9. Guiding the child toward positive peer groups

Child components

The following child components of successful intervention have been identified:

1. Recognition of the inappropriateness of the sexual behavior and apologizing for that behavior. This is **not** the same as an admission of past behaviors as a requisite for treatment.

2. Education and practice of boundaries and rules about sexual behavior
3. Age-appropriate sex education
4. Coping skills and self-control strategies
5. Sex abuse prevention and safety skills
6. Improving social skills

Relapse prevention, abuse cycles, and other practice elements that are derived from adult and adolescent sex offender treatment protocols are **not** recommended for children with sexual behavior problems.

Co-Occurring Conditions and Developmental Level

Co-occurring conditions are very high among children who are physically and sexually abused, so it not surprising that children with SBP, who often may be victims of abuse, have other conditions that require treatment.

- Treatments that target traumatic stress symptoms such as Post Traumatic Stress Disorder (PTSD) are also effective at reducing SBP (Cohen, Deblinger, Mannarino, & Steer, 2004; St. Amand et al., 2008). Which intervention to use as the primary treatment is a clinical decision that will depend on the highest priority issue. A trauma-focused intervention may be indicated for children with severe PTSD symptoms, but if the child does not present with significant internalizing behavior, then an SBP-focused intervention may be more appropriate.

- A more behaviorally-focused intervention may be more appropriate for children with significant externalizing or disruptive behaviors. Because many of the evidence-based interventions for use with children include similar elements as those that are effective with SBP, namely CBT and behavioral strategies, treatments can be integrated successfully.

Another issue to consider in any treatment for children is the child’s developmental stage and level of cognitive and emotional functioning.

- Younger children and those with developmental delays are much less likely to be able to cognitively process certain concepts and are less emotionally mature. For these children, more concrete behavioral strategies that focus on simple rules and behavior plans are indicated. Role playing, practicing, and reinforcing appropriate behaviors are effective strategies.

- Young children with SBP are more impulsive than compulsive. Therefore traditional adult offender strategies, such as changing cognitive distortions, improving cognitive coping skills, or learning about the abuse cycle, are not likely to be effective.

VI. Reporting Inappropriate Sexual Behaviors in Children 12 and Under

There are multiple factors to consider when making a report regarding sexual behavior problems with children. Reporting is most appropriate where both of the following conditions are true:

- Behavior that has involved significant harm or exploitation. Where the sexual behavior has caused significant distress or harm; OR a child has used physical and/or emotional coercion (can include bribes and/or threats) to gain the compliance or reduce the resistance of another child; OR where the age or developmental difference between the children indicated substantial inequality; **AND**

- Serious or persistent behavior. The sexual behaviors are of an advanced nature such as oral-genital contact or penetration, penile-anal contact or penetration, penile-vaginal contact or penetration, digital contact or penetration of the rectum or vagina; OR other sexual behavior of a less advanced nature that persist despite efforts to correct them or admonitions to stop.

If there are reasonable suspicions that the child may have experienced prior or ongoing maltreatment, or where parents or caregivers are neglecting to provide sufficient supervision or care, reporting requirements may be triggered.

Typical or normative sexual play and exploration between children, as outlined earlier, does not merit a report to law enforcement or child welfare authorities. Even SBP that may warrant consulting a professional may not always merit a report to the authorities (Chaffin, et al, 2006).

The law in Tennessee requires anyone who suspects abuse to report it to the Department of Children's Services or local law enforcement. More specifically:

- Professionals who work with children in organizations that are responsible for the care of children (i.e. child care center's or programs, schools or educational enrichment type settings, mental &/or behavioral health providers, clinics, hospitals and residential care faculties) as defined in statue 71-3-501 and 37-5-501

-Or-

- Relatives, neighbors or community members who have concerns about possible child abuse, which a referent may suspect with a child who presents SBP, they are responsible to report their concerns of possible abuse to: Juvenile Court, Department of Children's Service, Sheriff in the county where the child resides, or Chief law enforcement officer in the county where the child resides; as outlined in statue 37-1-605.

VII. Supervision and Monitoring

It is important to develop, implement and communicate supervision and monitoring plans for children with sexual behavior problems across systems.

- Most children with SBPs can remain in their home or foster home with other children without problematic sexual behavior. However, children who continue to exhibit highly intrusive or aggressive sexual behavior despite treatment and close supervision should not live with other young children until this behavior is resolved.
- Most children can attend public schools and participate in school activates without jeopardizing the safety of other students. Children with serious, aggressive sexual behaviors may need a more restrictive educational environment.
- A behavioral plan to decrease the child's problematic sexual behaviors should be developed with full participation of the caregivers and the child. The plan requires full participation of both and must be clear regarding acceptable behaviors.

- Depending on the level and type of sexual behavior problems, the child may need to be supervised while with other children; not sleep in the same room with another child; not sleep in the same bed with other children or adults at any time; not be left to care for other children, even for a short time; all bathroom activities should be done separately from other children and adults; adults and children should not walk around without clothes on; caregivers should not have sexual intercourse when the child is in the home; and if a child who has previously engaged in sexually inappropriate behavior is living in a home with other children the other children should be told. Motion detectors and buzzers can be used if needed to alert caregivers of the child leaving the bedroom at night.
- The home environment must provide a healthy sexual environment and encourage healthy boundaries by developing healthy rules.
- Some children with sexual behavior problems will require notification of the school and after care providers. All professionals working with the child should be in monthly communication to assure that there is a coordinated treatment plan on which all team members agree.
- All decisions and goals should be made with the child, whenever possible.
- If the child with SBP's remains at home, it is strongly advised to have an open CPS case with authority. When parents and children have to go to therapy without the authoritative incentive of CPS or probation, attendance may be sporadic or nonexistent.
- Some children with SBP's are put on probation. If the child is on probation the terms of the probation should be understood by all of the members of the treatment team.

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TDMHSAS BEST PRACTICE GUIDELINES

Adolescents Who Have Engaged In Sexually Abusive Behavior

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The guidelines presented here are to assist in the evaluation and treatment of adolescents who have engaged in sexually abusive behavior. The goal of these guidelines is to improve the care of adolescents who have engaged in sexually abusive behavior, which in turn increases community safety and decreases the victimization of others.

These guidelines are primarily intended for males who have engaged in sexually abusive behavior. Though some may apply to females there is insufficient research to develop guidelines for females who have engaged in sexually abusive behavior. Caution should also be taken in directly applying these to youth with significant developmental disabilities.

The document was written as “considerations” rather than “policy,” to avoid the unintended consequences of a policy too slavishly adhered to. It is intended for use in various areas of DCS: child protective services, juvenile justice, and foster care. It is also intended to be useful to courts and treatment providers.

I. Special Considerations for Informed Consent

Overall provisions of informed consent common to all mental health services apply also to adolescents who have engaged in sexually abusive behavior. For these adolescents, however, several additional considerations come into play:

Evaluation and treatment of adolescents who have engaged in sexually abusive behavior typically involve multiple systems, and depend on close coordination of these systems. Therefore, the limits of confidentiality and the importance of sharing information with professionals in other systems (court, probation, DCS) should be discussed as part of informed consent.

For adolescents who have engaged in sexually abusive behavior, evaluation and treatment may not be voluntary. The discussion of possible benefits, risks, and adverse effects of evaluation or treatment should also include the potential legal consequences of consenting or not consenting to evaluation or treatment.

II. Definition of Adolescents Who Have Engaged in Sexually Abusive Behavior

The current revision of the guidelines utilizes the term "youth who have engaged in sexually abusive behavior" instead of adolescent sex offender which was used in the previous guidelines. This change, which is consistent with national trends, avoids labeling, clarifies that the youth has engaged in the behavior while negating a preconceived notion that he/she will continue the behavior and encompasses youth who are not involved in the legal system or adjudicated for an offense. Many youth who have engaged in sexually abusive behavior may not have adjudications or be involved in the legal system, but may be involved in a social services system (Prentky, Li, Righthand, Cavanaugh & Lee, 2010). In Tennessee youth who have engaged in sexually abusive behavior may also be addressed in a variety of ways including legal involvement, social services involvement, or other linkage to services.

Adolescents, for purposes of these guidelines, are defined as youth ages 13 through 17 years. Youth 12 and under who have engaged in problematic and/or abusive sexual behavior are considered children with sexual behavior problems and differ significantly from adolescents who have engaged in sexually abusive behavior and have very different treatment needs (Chaffin et al., 2008). Please refer the TDMHSAS Guidelines for CSBP for further information.

Defining adolescents who have engaged in sexually abusive behavior does not lend itself to use of the DSM-IV-TR. While some youth may have co-morbid psychiatric disorders, few will meet criteria for "Paraphilias" and many of the paraphilias require the youth to be 16 years of age and older. In addition, the current recommendations by the DSM-5 paraphilia work group would raise the age requirement to 18. More importantly, a "Paraphilia" diagnosis provides little information that assists in determining risk or treatment needs.

Some favor defining adolescents who have engaged in sexually abusive behavior by legal criteria, however, given that legal statues can differ, for our purposes, it is more beneficial to use a clinical definition. The clinical definition includes the following factors (Murphy, Haynes, & Page, 1992): (1) age difference of at least four to five years between the victim and the offender; (2) use of verbal or physical force or a weapon; (3) power differences between the offender and victim (older sibling made responsible for younger siblings); (4) developmental differences between the victim and the offender (e.g., taking advantage of a peer with developmental disabilities); (5) differences in emotional stability (e.g., taking advantage of a peer with clear emotional disturbance); (6) engaging in such behaviors as exposing, voyeurism, and obscene phone calls to unsuspecting persons.

III. Prevalence

The actual incidence or prevalence of sexually abusive behavior by adolescents is difficult to determine. There are a number of estimates based on different data sources including criminal justice reports, victim surveys, and surveys of the general population. Criminal justice records suggest that adolescents are frequently identified for committing sexual offenses. In 2009, approximately 15,400 youth were seen in juvenile courts in the U. S. for a sexual offense

(Puzzanchera & Kang, 2012) and data from the FBI's Unified Crime Report indicated that about 17 percent of arrest for rapes or other sexual offenses were under age 18 (Puzzanchera, Adams, & Kang, 2007). Finkelhor, Ormrod, and Chaffin (2009) analyzed data from the 2004 National Incident Based Reporting System. The NIBRS is designed to replace the FBI crime reports and provides more case detail and covers a wider number of criminal offenses. They found that 25.8 percent of all sex offenses known to the police were committed by persons under age 18 and 35.6 percent of those offenses against juvenile victims were under 18. It should be noted that the 2004 NIBRS did not have complete coverage of all jurisdictions in the United States and therefore cannot be considered a representative sample of police data.

The National Incident Study of Missing, Abducted, Runaway and Thrownaway Children (NSMART-2) used telephone interviewing methods to collect information on a national probability sample of households (Finkelhor, Hammer, & Sedlak, 2008). Information on victimization was obtained through proxy interviews with caretakers of children under age 17 and through direct interviews with the victims themselves for children aged 10 to 17). Results indicated that 25 percent of the sexual victims indicated that the offender was under 18, with only 30 percent of these victims reporting these to the police.

There have also been attempts to determine the prevalence of sexual abuse among adolescents by studying representative nonclinical populations (Ageton, 1983; Borowski, Hogan, & Ireland, 1997; Casey, Beadnell, & Lindhorst, 2009). These studies suggest prevalence rates of between 2.4 percent and 5.6 percent. However, the behaviors being measured may not be similar to the populations seen in clinical programs and the screening questions used may not have captured the full range of sexually abusive behavior.

Existing data for Tennessee suggest a similar pattern. In 2009, DCS data indicates that there were 2,588 indicated perpetrators of child sexual abuse in the state of which 717 were youth between the ages of 13 and 17, representing approximately 28 percent for indicated cases. Juvenile Court data for 2008 indicated that there were 603 referrals to Juvenile Court for a sexual offense and 261 adjudications for a sexual offense. In 2011, based on the TN Incident Based reporting system, (available from the TBI website) there were 5,920 reports of sexual offenses by individuals identified as age 13 and over and 890 or 15 percent of these were ages 13-17.

IV. Adolescents Who Have Engaged In Sexually Abusive Behavior: What We Know

Data suggest that adolescents are responsible for a significant number of sexual offenses. While historically adolescents were viewed in similar ways as adult offenders, research has shown that they are not the same as adult offenders and, in fact, there are significant differences. Unfortunately, despite research to the contrary, adolescents have been subjected to adult sanctions (consequences) such as community notification and registration and viewed as needing long term treatment in restrictive environments.

Adolescence is a time of continued development and change with research showing that brain development continues into early adulthood (Steinberg, 2012). One example of the impact of brain development is the decrease in sensation seeking and impulsivity as the adolescent moves into adulthood. Adolescents also have less entrenched deviant sexual arousal patterns and less entrenched antisocial attitudes than adult sex offenders. Adolescents who have engaged in sexually abusive behavior also appear to have more often experienced trauma than adult offenders. In addition, adolescents are much more influenced by family and interventions that involve the youth's family and social environment are an important aspect of treatment.

It is also appears that adolescents have lower recidivism rates as compared to adult offenders. Two large meta-analyses have shown that sexual re-offense rates are between 7 percent -12 percent (Caldwell, 2010; Reitzel & Carbonell, 2006). Adolescents also appear to be much more responsive to interventions.

In addition to research distinguishing adolescents who have engaged in sexually abusive behavior from adult sex offenders, research has also demonstrated that this group of youth is quite heterogeneous. These youth may vary on a number of factors including: cognitive and learning skills, social competence, family functioning, personal victimization, co-morbid diagnosis and delinquency. Family and environmental strengths and assets as well as individual strengths and assets may differ as may the youth's ability and willingness to engage in interventions. The youth's risk to reoffend, both sexually and non-sexually, will vary which impacts treatment and supervision.

Hunter (2006) based on his and colleagues' research describes three developmental pathways for youth who have engaged in sexually abusive behavior. This includes: 1) an Adolescent-Onset Paraphilic group which is at most risk for repeat sex offending without intervention; but only represents a very small proportion of adolescents who have engaged in sexually abusive behavior, 2) a Life Style Persistent pathway in which youth are more at risk for general offending, but are less at risk for continued sexual offending, and 3) an Adolescent-Onset Non-Paraphilic group whose offending is transitory. This may represent the most frequent group of youth who have engaged in sexually abusive behavior.

V. Core Foundations

The research findings previously highlighted, and other current research, suggest that adolescents who have engaged in sexually abusive behavior are a very heterogeneous group with only a small number at risk for future sexual offending. Effective interventions with this population require recognition of this heterogeneity and adherence to the risk-need-responsivity principles.

Risk-Need-Responsivity

Risk-need-responsivity principles encompass the heterogeneity of the youth by guiding decisions based on the individual youth. Risk looks at the factors within the youth and his/her environment that is associated with delinquent and/or sexual reoffending behaviors. The intensity of interventions and level of supervision are based on the youth's level of risk. Need refers to risk factors that can be changed and if changed reduce the risk for future delinquent and/or sex offending behavior. This principle ensures that what is being targeted in treatment is related to risk factors associated with recidivism specific to the individual youth. Factors not related to recidivism, but relevant for the youth, are also addressed to ensure the overall well being of the youth. The responsivity principle directs attention to factors within the individual or his/her environment that affect his/her response to interventions and applies effective methods that maximize the youth's ability to learn from rehabilitative interventions.

Treatment does not look the same for all youth and varies according to the risk and need needs of the youth. Assessment is key to identifying risk and need including identifying those youth at most risk for reoffending sexually. Intensive interventions are reserved for the higher risk group as intensive interventions with lower risk youth may actually increase their risk (Lowenkamp, Makarios, Latessa, Lemke, & Smith, 2010). Some youth who are at lower risk will need only limited interventions. Higher risk youth receiving higher intensity interventions potentially may need a more secure treatment setting than those who present at a lower level of risk. Lower risk youth should be treated in less restrictive environments to avoid being exposed to higher risk, more deviant peers and treatment should be more limited in length. In regard to treatment focus, for some youth interventions may focus on general delinquency/conduct disorder related issues with a more limited focus on sexually abusive behavior while for other youth there may be more of a focus on the sexually abusive behavior. The assessment provides information to guide decisions related to management of the youth including level of supervision, intensity of services and structure needed as well as guiding the treatment focus for the youth.

As noted the need principle looks at risk factors related to recidivism that can change. While further research is needed related to specific factors related to adolescents' risk of continuing to engage in sexually abusive behavior, the field has moved forward in this area and we do have a foundation of knowledge regarding factors that relate to risk and certain factors that do not relate to risk. There is clear research and literature regarding factors that relate to general delinquent offending which should also be addressed in assessments and treatment.

Factors that relate to risk include both those that are not changeable, which we call static risk factors, and those that are dynamic risk factors, which are changeable.

The current research literature focuses on factors related to sexual reoffending as well as factors related to general (non-sexual) recidivism. These factors are delineated in the table below.

Sex Offending Specific		
Static Risk Factors **(factors that cannot change)**	**Dynamic Risk Factors** **(factors that can change)**	**Factors Not Likely Related to Reoffending**
▪ Prior charge for sex offenses ▪ Multiple victims ▪ Stranger victims ▪ Prior treatment failure ▪ Prior history of general criminal behavior ▪ Male victims	▪ Deviant sexual interest ▪ Sexual preoccupation/obsession ▪ Attitudes supportive of offending ▪ Social isolation ▪ Difficulties establishing peer relationships ▪ Difficulties managing emotions ▪ Family dysfunction	▪ Denial ▪ Clinician rated motivation at intake ▪ Victim empathy ▪ General psychological problems

Factors Related to General Delinquent Reoffending
▪ Prior legally charged offenses ▪ Family functioning ▪ (including family supervision and discipline practices) ▪ School achievement and behavior ▪ Negative peer relationships ▪ Substance use and abuse ▪ Use of recreation time ▪ Antisocial/pro-criminal attitudes ▪ Certain behavior and personality traits such as aggression, poor frustration tolerance, impulsivity, defiance of authority ▪ Out of home placements

General delinquency research also provides us with information about protective factors. Protective factors are factors that may moderate the effects of risk and can be viewed as strengths. The protective factors can be built on through our interventions and treatment planning for the youth.

Protective Factors-General Delinquency

- Positive Family Functioning
    - Adequate Supervision
    - Consistent and Fair Discipline
    - Non-Abusive/Non-Violent
- Availability of Supportive Adult
- Emotional Maturity
- Commitment to School
- Positive Peer Social Group
- Involvement in Positive Community Activities
- Interest in Hobbies/Sports
- Pro-Social/Non-Criminal Attitudes

Several of the protective factors identified in the juvenile delinquency literature mirror factors now being identified in the resiliency research as being related to healthy adolescent development. The similar factors include positive family functioning, positive peer social group and availability of support adult.

Responsivity factors inform how we adjust our interventions and approaches. As noted, these are factors that impact the youth's response to treatment. Unfortunately these factors and their potential impact are often overlooked. Treatment efforts are enhanced when responsivity factors are taken into consideration in our work with adolescents who have engaged in sexually abusive behavior. The responsivity principle also focuses on the use of effective methods that will change the youth and family's behavior and attitude. (is this sentence needed?) Effective methods include cognitive behavioral treatment and skills based approaches. The interventions need to be tailored to the learning style, motivation, abilities and strengths of the youth and take into consideration responsivity factors for the youth and family.

Examples of Responsivity Factors:

- Motivation and Readiness
- Cognitive Abilities
- Learning Style and/or Learning Problems
- Emotional /Psychological Difficulties
- Personality Characteristics
    - Anxiety, Self-esteem
- Religious Beliefs
- Bio-Social factors
    - Age, Gender, Ethnic/Culture

VI. Assessment

Introduction

In Tennessee, there are a variety of labels or terms for the specialized assessment of adolescents who have engaged in sexually abusive behaviors. Regardless of the label, the purpose of the evaluation remains the same. The evaluation addresses the risk, need and responsivity principals relevant to the individual youth. The evaluation:

- Addresses the youth's risk to engage in sexually abusive behaviors and/or general delinquent behavior
- Identifies treatment needs that if addressed can reduce risk
- Provides information to assist in decisions regarding:
  - disposition
  - level of supervision
  - intensity of treatment services
  - placement
- Identifies strengths and assets of the youth and family
- Identifies factors that may impact the youth's response to treatment

Overview of Use

The evaluator has the responsibility of ensuring that this type of evaluation is conducted with appropriate cases. At times, referral sources may not be clear about what the evaluation entails and/or what warrants an appropriate referral. In these situations, the evaluator can provide an explanation of the evaluation and review situations in which it is appropriate. This type of specialized evaluation is limited to use with youth who:

- Have a child protective services finding of having perpetrated the abuse or
- Have been adjudicated in court on a sex related offense or
- There has been a direct observation of illegal sexual behavior/sexually abusive behavior by a reliable source or
- Admit to having engaged in sexually abusive behavior/illegal sexual behavior.

Unfortunately, at times the specialized evaluation may be misused. It should be recognized that evaluations of this type:

- Should not be conducted or used to determine if a youth engaged in the alleged sexually abusive behavior or not; this is a misuse of the assessment process. The Department of Children's Services Child Protective Services and/or law enforcement are the investigative agencies in Tennessee.
- Should not be used to state whether a youth fits or does not fit the profile of a sexually abusive youth. There is no specific profile and no research to support such statements.
- Evaluations are most appropriately conducted post-adjudication to inform disposition. Pre-adjudication evaluations raise concerns about self-incrimination and statements of risk prior to adjudication may unduly influence court finding regarding guilt.

Overview of Content

Assessments should be developmentally appropriate and provide information related to risk, need and responsivity as well as strengths specific to the individual youth and his/her family. Adolescents who have engaged in sexually abusive behavior are a diverse, heterogeneous group with varying circumstances and situations that can impact the referral question and/or purpose of the evaluation which in turn can influence the scope and nature of the evaluation. The youth's individual circumstances and situation can also influence the content of the evaluation.

- In general a youth with more intrusive, higher frequency or lengthier history of problematic sexual behavior would warrant a more thorough exploration of the core areas. (See p. 291.)
- Cases in which decisions with potentially negative impact, such as removal from the community, are being considered also call for a more comprehensive approach.
- Significant mental health issues or developmental disabilities may warrant a more comprehensive evaluation.

Being aware of the referral question and the purpose of the evaluation allows the evaluator to determine the comprehensiveness of the evaluation. Evaluations may be requested to:

- assist in treatment planning
- inform placement
- inform supervision decisions
- inform disposition after a youth has been adjudicated on a sex offense.

The assessment should consist of what is necessary to answer the referral question and address the purpose of the evaluation. At a minimum the assessment involves:

- Face to face detailed clinical interview with the youth
- Face to face detailed clinical interview with the youth's parental unit
- Review of information related to the sexually abusive behavior
- Collecting of information from other sources including:
    - Social Services
    - Police
    - Court
    - Family
    - Mental Health Agencies

- Review of relevant records
    - Juvenile Court
    - Past evaluations and assessments
    - Past treatment records or information related to treatment
    - Relevant educational records, including grades, behavior, special education needs

There are several areas to be considered in the assessment process. These are not limited to the youth, but encompass other relevant components also. ***Core areas*** to be addressed in the assessment include:

- Issues specific to sexually abusive behavior(s)
- Issues specific to delinquent behavior, if present
- Psychosexual history
- Current situation and circumstances
- Mental status
- Youth's functioning and factors across all life areas (home, school/employment, community, social)
- Family characteristics and functioning
- Strengths and protective factors
- Interventions or immediate steps that can be taken to modify assessed risk (are the following bullets a bit too detailed?)
  - Youth's risk is impacted by lack of parental supervision and stable living environment.
    - Are there any relatives or friends who are appropriate and willing to provide a placement for the youth?
  - Youth's risk is impacted by significant behavioral health issues such as untreated ADHD
    - Can appropriate treatment immediately help relieve these symptoms?

Assessing Risk and Need

There are evidence-informed, structured risk assessment tools that have been developed to assess the risk and needs of adolescents who have engaged in sexually abusive behavior. Research related to risk and need assessment of these youth continues to evolve and professionals conducting evaluations stay current of the research literature. There are limitations to the current risk assessment tools. While recent research (Viljoen, Mordell, & Beneteau, 2012; Worling, Bookalam, & Litteljohn, 2012) provides preliminary support that existing instruments predict recidivism with better-than-chance accuracy, there is still a great deal of variability between studies and none of the currently available tools are an actuarial tool on which we can definitively base predictions of recidivism.

The most commonly used risk and need assessment tools are the ERASOR 2.0 and JSOAP-II. Risk and need assessment is a component of the evaluation and evaluators should be trained on the instruments. In general evaluators should remember that:

  - The risk assessment tool is to be utilized to help facilitate the assessment of the relevant areas and to provide increased accuracy over unstructured clinical assessments. The tools assess static and dynamic factors currently identified in the research which evaluator use to make evidenced based judgments.
  - Statements about percentages of risk to reoffend are not appropriate. At this time there is inadequate data to tie a specific score or risk level to a percentage risk to reoffend.
- Evaluations that outline the factors and situations that place the youth at risk and provide information about protective factors, strengths and assets are more beneficial in informing decisions for effective management and treatment planning.

- Evaluators should use caution if using terms such as “low,” “medium” and “high” risk; there is no agreed upon definition of these terms which can easily lead to misinterpretation and the “level” can unintentionally label the youth.
- Risk assessments need to be periodically updated to ensure that they are reflecting the youth’s current level of risk; updates are recommended every 6 months.

Qualifications of Evaluator

Assessment of adolescents who have engaged in sexually abusive behavior is not the same as conducting a general evaluation. Specific to these evaluations, the evaluator needs to:

- Be knowledgeable about sexually abusive youth and adolescent development. Sexually abusive behavior is differentiated from developmentally normative behaviors and it is important to be aware of both normative sexual development and general adolescent development.
- Be comfortable in conducting an interview that includes discussion of sex**u**al behavior.
- Evaluators need to have participated in training on assessment and relevant risk assessment tools.

Summary

The specialized evaluation is grounded ine risk, need, responsivity principles, taking into account the youth’s social, family and environmental context while incorporating relevant risk assessment findings to formulate an individualized plan for youth who have engaged in sexually abusive behavior. Adolescence is a period of rapid change, the youth’s circumstances are dynamic and in addition interventions related to risk can further impact the situation. The youth’s risk and needs are not stagnant and assessments should be updated every six months or when risk-relevant changes occur. Initial assessments should not be considered final assessments as changes associated with risk (maturity, school, friends, treatment progress, etc.) do occur over time.

VII. Interventions and Treatment

Given the current data on adolescent offenders and general delinquent offenders, treatment is most likely to be effective if it is skills based and cognitive behavioral in nature focusing on dynamic risk factors delivered in an appropriate therapeutic style, and involves systems impacting the youth outside of the treatment situation. Socio-ecological models of intervention recognize the importance of family and environment and their impact on adolescents. The youth’s environment, including school, peer selection, use of leisure time, is an important component of a comprehensive approach to rehabilitation. If interventions only focus on the youth, they will be less effective.

Treatment Related Research

There is support in the literature that treatment and interventions can be effective with adolescents who have engaged in sexually abusive behavior. A 20 year follow-up study (Worling, Litteljohn, & Bookalam, 2010) showed a 9 percent recidivism rate for a treated group and 21 percent recidivism rate for a non-treated group. There is also a meta-analysis which suggests youth receiving treatment have lower recidivism rates than youth who do not receive treatment (Reitzel & Carbonell, 2006). In addition, there have been randomized controlled trials of a social-ecological approach (Multi-Systemic Therapy) which supports treatment effectiveness in this population (Borduin, Henggeler, Blaske, & Stein, 1990; Borduin, Schaffer, & Heiblum, 2008; Letourneau et al., 2009).

There is also a large literature on intervening with youth engaging in general delinquent behavior that supports that programs that follow the risk/need/responsivity principals have better outcomes (Lipsey, Howell, Kelly, Chapman, & Carver, 2010; Vieira, Skilling, & Peterson-Badali, 2009). As noted earlier, adolescents who have engaged in sexually abusive behavior are much more likely to engage in non-sexual re-offenses than sexual re-offenses. This is important to remember in our interventions and treatment efforts.

Importance of the Therapeutic Relationship

There is strong support for the importance of therapeutic relationship variables (Karver, Handelsman, Fields, & Bickman, 2006) in the treatment of youth and families. Research and clinical practice with adult sex offender (Marshall, 2005) and adolescents (Smallbone, Crissman, & Rayment-McHugh, 2009) also supports the importance of the therapeutic relationship variables. Treatment will be most effective when the adolescent and family are treated with respect and where hope is present. Treatment will be least effective when harsh, confrontational treatment styles are employed. Treatment will be more effective if there is a focus on developing approach goals rather than being limited to the narrow focus of what should be avoided. Approach goals are defined as striving for more positive achievements and prosocial behaviors that are incompatible with sex offending (Mann, Webster, Schofield, & Marshall, 2004).

Treating the Whole Youth

It is important to treat those factors most relevant to reoffending. However, it is clearly recognized that many youth who engage in sexually abusive behavior, especially those at higher risk, have a number of other issues including significant general behavioral problems, co-morbid psychiatric issues, family dysfunction, and trauma. While these issues may not be directly related to reoffending, they should be addressed due to the impact on the youth and potential interference of the youth reaching their maximum potential and leading a healthy, fulfilled life.

Treatment as Part of a Broader Social-Ecological Approach

Youth who engage in sexually abusive behavior are impacted by a number of systems and providers need to recognize the impact these systems can have on the youth, both positive and negative.

- Families are an important part of the lives of all youth and this is also true on youth who engage in sexually abusive behavior. Families of adolescents who engage in sexually abusive families vary on a number of characteristic some with significant family dysfunction, some that function well. They vary on parenting skills. In all cases, where appropriate, families should be part of the treatment process. In cases in which abuse, neglect or other significant issues preclude direct involvement, the youth may well still feel a connection to the family and this should not be dismissed. In such cases intervention should strive to involve other potential adult support systems.
- Many youth experience problems in school, have poor peer selection and make poor use of leisure time, all factors that can increase at least risk for general offending. Working with these systems should be part of treatment. In cases where there are multiple problems, the addition of in-home services that actually work with community resources can be an important component of comprehensive management.
- Youth who engage in sexually abusive behavior are many times involved with the juvenile justice system and/or the social services system. Family Service Workers or court workers play an important role in the youth's life and should be seen as part of the treatment team. It is important that those providing therapeutic service develop relationships with these workers.

Treatment Targets

Assessment should guide the selection of the treatment needs since not all youth present with the same dynamic risk factors and treatment will need to be individualized. However, currently the following are thought to be the most relevant dynamic risk factors to address in the treatment of adolescents who have engaged in sexually abusive behavior:

- Attitudes and justifications supportive of offending
- Emotional Management
- Social Competence/Relationship Skills
- Healthy Sexuality
- Ability to establish peer relationships
- General self-management skills
- Family Education/Functioning
- Sexual Deviation or Sexual Preoccupation (if applicable)
- Development of Positive Life Goals
- Individualized Issues as Needed

Treatment Modalities

Various treatment modalities are used with adolescents who have engaged in sexually abusive behavior. While early clinical literature suggested that group therapy was the preferred modality, there is little evidence supporting one modality as superior to others. Therefore, the choice of modalities should be based on the youth's and family's needs.

Family Therapy

Family involvement is a crucial component of work with these youth. Caregiver(s) experience a variety of emotions and reactions to learning that their child has engaged in sexually abusive behavior. They may be resistant or hesitant about treatment and the treatment provider's role is to meet them where they are in the process. The caregivers' understanding of the problem, learning about managing risk and support of the adolescent contributes to the youth's success.

While specifics are tailored to the individual family, there are some basic components of family therapy. These include:

- Builds on family strengths
- Addresses dysfunctional family interactions and familial-based risk factors that contribute to the youth's sexual abusive behavior
- Reinforces and promotes healthy communication, interactions and parenting skills.
- Provides education regarding adolescents who have engaged in sexually abusive behavior and issues specific to their youth.

Group Therapy

- Group therapy provides a modality to address a variety of risk factors.
- Group therapy can be specifically beneficial in targeting interpersonal-based risk factors such as
  - power and control interactions,
  - social isolation,
  - communication,
  - passive and aggressive patterns of interactions and
  - other interpersonal, social issues.

Skills Focused Group Therapy

- Provides skills building focused interventions such as anger management, conflict resolution, problem solving, decision making, etc.

Individual Therapy

- Individual therapy is used to address specific individual issues, comorbid conditions, and special needs.
- Individual therapy can also be utilized to reinforce and prepare for work in the group therapy setting.
- Individual therapy can also include skills building focused interventions.
- Individual therapy is also utilized to address risk factors related to reoffending.

Reconciliation/Reunification

Adolescents who have engaged in sexually abusive behavior will potentially be reuniting with their families where the victim also lives and/or where there are other vulnerable children. This most often occurs when the victim is a sibling or close extended family member of the youth. Reconciliation/reunification related work may be incorporated into several treatment modalities. The reconciliation/reunification process takes time and provides the victim, abusive youth and family opportunity to work through issues related to the abusive behavior while creating a safer and more secure family environment with an increased opportunity for success and growth. In many cases reconciliation and/or reunification is appropriate and can promote healing within the family. The core focus of reconciliation/reunification is the best interest and well being of the victim.

There are several aspects to be considered prior to initiating the reconciliation/reunification process including safety, both physical and emotional, supervision and readiness of the victim, the abusive youth and the family. It is helpful to think about the reunification process in steps, with adequate time in between steps to assess application of safety guidelines and the impact on the victim, youth and family. It is recommended that reconciliation/reunification take place in the context of therapy, which provides a safe and structured environment to explore difficult feelings and supports healthier relationships built on safety. This also allows the family to have the treatment providers' support during the process and transition period in which the youth may be returning to live with or be in regular contact with the victim. The Joint Task Force on Children's Justice and Child Sexual Abuse has developed considerations for reunification and these have been adopted by the Department of Children's Services; please refer to Appendix A.

Medication therapy

- Medication therapy such as SSRI's may be helpful for addressing sexual preoccupation in some youth. However, medication should be used as part of a comprehensive program.

Treatment Sequencing

An important part of treatment is how treatment is sequenced. Early approaches to this population focused on the sexually abusive behavior very early in the treatment process. However, clinical experience suggests that many times this early focus only increases the youth's and family's resistance and can actually extend treatment. Although each youth is different and may need more or less time in each phase of treatment, the phases described below provide at least one road map through treatment.

Phases

It is important to note that safety rules and guidelines to prevent sexually abusive behavior are in place throughout phases of treatment. It is the direct focus on the sexually abusive behavior that occurs later in the treatment process.

- Engagement and Motivation: The first steps to treatment is engaging the youth and family in the treatment process and trying to increase motivation. This phase will use techniques from motivational interviewing and will collaboratively work with the youth and family to establish some agreeable treatment goals. In general this phase does not focus on the sex abusive behaviors directly.

- Treatment Interfering Behaviors/General Treatment Skills: For higher risk youth many will display significant disruptive behavior and or significant co-morbid psychiatric disorders. Until some of these are resolved, it will be difficult for the youth to focus on sexually abusive issues, although it should be recognized that many of these behavioral issues such as poor emotional management are also related to risk for sexual reoffending. Therefore the goals of this phase are to stabilize significant psychiatric disorders and to focus on managing disruptive behaviors. This includes such interventions as anger management, impulse control, etc. For youth who show less disruptive behavior this phase is to learn basic skills which will be applied throughout treatments such as healthy decision making, problem solving recognizing the link between situations-thoughts-behaviors and developing basic cognitive restructuring skills. Most of this can be done by addressing general behavioral issues rather than sexually abusive behavior per se.

- Problem Identification: In this phase one begins exploring the sexually abusive behavior with the goal of identifying the factors related to the youth's sexually abusive behavior. One begins reviewing the history of sexually abusive behaviors to identify factors that may increase future risk for reoffending and attitudes that may support sexually abusive behavior. It is important to recognize that not all youth will have the same risk factors, that there is not a set cycle of abuse and that for some youth the sexually abusive behavior is not planned and is more a result of poor decision making and may not have a specific trigger.

- Skill Development: Once the dynamic risk factor for the youth has been identified then the focus is on developing the skills to cope with the dynamic factors and to be able to challenge any attitudes that support offending.

- Aftercare: For youth in residential or congregate care settings an important component is appropriate follow-up care to assist in generalizing what has been learned in treatment to a more natural environment. Some youth will need fairly extensive treatment that continues to focus on sexually abusive behavior while others may need treatment that focuses more on general adolescent issues and transition issues and some may only need treatment that monitors risk and reinforces change.

APPENDIX A: Considerations in the Reunification of Sexually Abusive Youth With The Families Where the Victims (or other vulnerable children) Reside

(From The Joint Task Force on Children's Justice and Child Sexual Abuse)

The following criteria are recommended guidelines for reunification of Sexually Abusive Youth (persons age 13 and over) back into the home where the victim resides. Each item in the criteria represents an element that should be considered and weighed carefully in a professional staffing that includes the DCS case manager, treatment professionals, and service providers working with the individuals and family and with consideration of any court orders which may be in place. There is no magic formula or combination of factors that will guarantee a successful reunification. The consideration of each issue in concert with other professionals may help to identify gains in the treatment process thus far and potential pitfalls in the reunification effort.

I. The Sexually Abusive Youth (**SAY**) has undergone an adequate risk/needs assessment to explore issues, behaviors, and conditions related to the sexually abusive behavior. This assessment may have, but not necessarily will have, been conducted as part of a "psychosexual evaluation."

II. The Adolescent has participated in a treatment program in which issues related to reoffending have been addressed. This covers a variety of issues which MAY include the following:

a. Sexual Deviance
b. Ability to establish and maintain peer relationships
c. Anger management
d. Thinking errors and attitudes that support reoffending behavior
e. Impulse control
f. Concomitant psychiatric/psychological issues
g. Other issues as appropriate

III. There is an adequate Relapse/Safety Plan that is "do-able" (it is within the realm of possibility that these persons could "reasonably" live within the confines of this plan). The plan should account for issues that may include:

a. Work schedules of parents or persons overseeing the children
b. Schedules of children in the home
c. Physical proximity of possible victim's bedroom from SAY's bedroom
d. Physical layout of the home and how that layout lends itself to monitoring activity within the home
e. Issues of personal space, securing boundaries and privacy of individuals in the home (e.g. doors on bathrooms)
f. Established rules for expected behavior and how misbehavior will be dealt with
g. Any court orders which may be in place.

IV. There must be an established plan for gradually increasing visitation between the SAY and the victim. This visitation would ***typically*** begin with initiation of contact in a therapeutic setting (clarification), progressing to short visits in a neutral setting, to short visits in the home that gradually increase over time. Family members or other people external to the family may supervise the visits. Visitation may unfold differently in each case situation but the steps of the visitation plan for each case should be clearly established in concert with therapists for all parties prior to initiation of the plan. The plan should include steps to evaluate the impact of visits on the victim at each stage of the progression.

V. Victim Re-assessment – In considering the reunification, there should be statements from a therapist who can speak to the impact of the reunification on the victim, the victim's understanding of the reunification and how it will affect the victim's life and lifestyle, and the victim's knowledge and understanding of all of the provisions of the safety plan.

VI. There should be an assessment of parents'/caretakers' willingness to enact the safety plan. One would expect these persons were actively involved in developing this plan; that they show an understanding of the plan; and illustrate a commitment to implement the plan. The assessment would likely address parents'/caretakers' comprehension of how this plan will impact their lifestyles.

VII. Availability of Follow-up Services. The reports should indicate that some type of supportive services are available to the SAY, the victim, and family as they strive to live by the safety plan for AS LONG AS THEY NEED THESE SERVICES. These services may include:

a. treatment/therapy services for individuals and for the family,
b. home based crisis intervention type services to intervene in crisis or particularly challenging situations
c. services to meet basic needs such as child care or economic needs
d. advocacy to help in navigating other systems (schools?) and connecting with other community resources

Background

The Treatment Committee of the Joint Task Force on Children's Justice and Child Sexual Abuse and has been working for several years to develop recommendations for improving the system's effectiveness in dealing with Sexually Abusive Youth (**SAY**, formerly referred to as Adolescent Sex Offenders). These are individuals age 13 and older who have committed a sexual crime or who have perpetrated sexual abuse on another child. These youth are involved with the system in various ways:

- They may have been prosecuted and adjudicated through the juvenile justice system.
- They may have come to the attention of DCS through an abuse report (CPS).
- They may be in the Foster Care system for various reasons, either related or unrelated to their sexually abusive behavior.

The problems of **SAY** present in many different contexts and involve different components of the child welfare and juvenile justice system. Consequently, the Treatment Committee had some trouble getting its arms around the problem. We decided early on to narrow our efforts down to one particular group of **SAY**, namely those facing possible reunification with families where victims or other vulnerable children reside.

A major system problem in dealing with **SAY** is that professionals within the system (judges, juvenile court staff, DCS workers, therapists, and others) have widely varying levels of knowledge and sophistication regarding **SAY**. At one end of the spectrum is a naiveté that assumes if a **SAY** has had treatment of any kind, his/her offending issues must have been addressed. Professionals at this end of the spectrum do not have the knowledge to judge appropriate treatments or treatment providers for these youth. The "Considerations" were developed in part to aid this group in identifying whether effective treatment has taken place by identifying some elements that are likely to be present.

At the other end of the spectrum is a division of opinion among therapists treating **SAY** about best practices and what constitutes appropriate treatment. While there is general agreement that treatment should have some "offender-specific" components, there is not agreement on what these components should be, and research data do not support the efficacy of a single model. Research also points to considerable heterogeneity among **SAY**, such that there should not be a "one size fits all" approach. The "Considerations" address this problem by listing elements that **may** be present without specifying that all **must** be present.

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TDMHSAS BEST PRACTICE GUIDELINES

Children and Adolescents Who Identify as Lesbian, Gay, Bisexual, Transsexual, Transgendered and Gender Nonconforming, or Questioning

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I. Introduction-

It can be challenging for adults to acknowledge the sexuality of children and adolescents in general, much less feel comfortable with considering this issue in youth with a minority sexual or gender orientation. It can be equally challenging for young people to self identify to their families or others for fear of rejection and/or serious negative reactions (Ryan, 2009).

Despite the fact that many popular television shows feature LGBTQ characters or that there are a number of celebrity marriages involving this group, LGBTQ youth still find the going extremely rough. Children and/or adolescents that self identify as LGBTQ often struggle about whether to tell their parents, teachers, friends—anyone—about these thoughts and feelings. Because they might be viewed as being different by their peers, particularly during the adolescent years, many of these youth become targets of harassment and bullying (Lyness & Izenberg, 2010).

A fair proportion of LGBTQ youth are in foster care. The Lambda Legal Defense and Education Fund estimates that between five and ten percent of young people in foster care self identify as LGBTQ. However, this figure is most likely an underreporting since many LGBTQ youth fail to disclose and/or actively hide their sexual orientation. Some of these youth have been rejected and/or abused by their families because of their sexual orientation. Others have been victims of discrimination, harassment, and even physical violence perpetrated by foster parents, peers/siblings, even group care staff. Many choose to run away from their placement to live on the streets where they feel safer (Dworsky, 2013).

Self identification as LGBTQ may be extremely stressful and/or painful for young people that lack supportive friends and family, live in smaller towns, or come from more traditional families. These youth experience so much pain that they are reported to have one of the highest rates of suicide attempts, as well as other health problems, especially related to substance abuse. Their risk is increased because they perceive the world they live in as hostile and unaccepting. Not having support, real or perceived, can cause LGBTQ youth to feel very isolated and have low self esteem and/or poor self image (Lyness & Izenberg, 2010).

The goals of this practice guideline are to assist clinicians in becoming more comfortable recognizing and addressing the emotional and developmental needs of this population, to provide evidence-based treatment principles, and to provide a list of references for self-education that include definitions of the most current terminology used in this field and practice guidelines/reports developed by the American Academy of Child and Adolescent Psychiatry (AACAP), the American Psychiatric Association, and the American Psychological Association. Until the early 1990's, there were limited resources for youth who identified as LBGTQ or their families (Ryan, 2009). Resources in these guidelines should provide a helpful starting place.

II. Practice Principles (From AACAP Practice Parameter on Gay, Lesbian or Bisexual Sexual Orientation, Gender-Nonconformity, and Gender Discordance in Children and Adolescents/2012).

Please refer to the AACAP Practice Parameter for a thorough review of this topic.

Principle 1. ***A comprehensive diagnostic evaluation should include an age-appropriate assessment of psychosexual development for all youths.***

Principle 2. ***The need for confidentiality in the clinical alliance is a special consideration in the assessment of sexual and gender minority youth.***

Principle 3. ***Family dynamics pertinent to sexual orientation, gender nonconformity, and gender identity should be explored in the context of the cultural values of the youth, family and community.***

Principle 4. ***Clinicians should inquire about circumstances commonly encountered by youth with sexual and gender minority status that confer increased psychiatric risk.***

- *Bullying.*
- *Suicide.*
- *High-Risk Behaviors.*
- *Substance Abuse.*
- *HIV/AIDS and Other Sexually Transmitted Illnesses.*

Principle 5. ***Clinicians should aim to foster healthy psychosexual development in sexual and gender minority youth and protect the individual's full capacity for integrated identity formation and adaptive functioning.***

Principle 6. ***Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful.***

Principle 7. ***Clinicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.***

Principle 8. ***Clinicians should be prepared to consult and act as a liaison with schools, community agencies, and other health care providers, advocating for the unique needs of sexual and gender minority youth and their families.***

Principle 9. ***Mental health professionals should be aware of community and professional resources relevant to sexual and gender minority youth.***

III. The Family Acceptance Project: Resources for Providers

Research conducted by the Family Acceptance Project (FAP) suggests that few providers who work with youth who identify as LGBTQ ask about how this decision affects the young person's relationships with their parents, foster parents, caregivers, and/or other adults. (FAP is a community research, intervention, education, and policy initiative started in 2002 to study how family acceptance and rejection affect the mental health, health, and wellbeing of these youth.) Instead the data show that providers tend to make the assumption that families are not supportive. Thus, FAP contends that providers do not consider families as a potential resource for helping youth that identify as LGBTQ (Ryan, 2009).

As a result, FAP is developing a new family model for working with young people who identify as LGBTQ, which engages families as allies to promote support for their children. The materials will be available online in English, Spanish, and Chinese. FAP has also developed a six-question tool (FAPrisk) that providers can use to quickly assess the level of family rejection and related health risks in youth who have self-identified as LGBTQ. The tool can be used by a variety of behavioral health providers, including pediatricians, nurses, social workers, school counselors, and mental health professionals. In addition to accurately identifying high levels of family rejection, the tool will aid in the identification of related risk for suicide, depression, substance abuse problems, and risk for HIV and STDs in the youth. The FAPrisk will give providers a way to start the conversation about family relationships and quickly help in identifying families in need of education and support. Information on FAP and/or the risk assessment tool can be obtained from fap@sfsu.edu and http://familyproject.sfsu.edu (Ryan, 2009).

FAP further offers strategies for providers who work with LGBTQ children, youth, and families. Among the strategies are the following:

- Locate community and online resources for LGBTQ youth and families to teach parents and caregivers how to assist and support their young person. Parents and caregivers need access to positive family role models to help learn new ways to care for and support their LGBTQ youth, including gender-nonconforming children.
- Provide supportive counseling, as needed, and connect youth with LGBTQ community programs and resources.
- Use the FAP screener to identify the level of family rejection and related health risks in LGBTQ youth. Refer and follow up with families, as needed, to provide education and family counseling.
- Help families identify supportive behaviors that will provide protection against risk and promote their youth's well-being (Ryan, 2009).

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TDMHSAS BEST PRACTICE GUIDELINES

Children and Adolescents with Mental Health and Physical Disorders

Initial Discussions on Addressing Growing Concerns

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Introduction

Persons with major mental disorders lose 25 to 30 years of potential life in comparison with the general population, primarily due to premature cardiovascular mortality (Bartels & Desilets, 2012). For instance, clients diagnosed with a serious mental illness (SMI) who are receiving services from public mental health agencies in eight US states were found to have lower life expectancies of 13 to more than 30 years compared to the general population (depending on the year and state) (Canada, 2010; Chang et al., 2011). Further it has been shown that persons with SMI who are in outpatient care are more likely to have comorbid medical conditions than persons in the general population. The odds of diabetes, lung diseases, and liver problems are particularly elevated (Colton & Manderscheid, 2006). Further complicating this decline in life expectancy is the finding that individuals with severe mental illness are also less likely to receive (or seek) medical care such as for cardiovascular issues (Davis et al., 2007). This is complicated by issues with their being able to manage chronic conditions, and access to appropriate care. This discrepancy in medical care exists despite literature that physical health risk assessments and assertive evidence-based intervention by primary and secondary medical services have been implemented and have resulted in improvements (De Hert et al., 2011). For instance, diabetes monitoring for individuals with schizophrenia may lead to proper treatment and control of blood sugar yet among patients with co-occurring schizophrenia and metabolic disorders, the non-treatment rate for diabetes is approximately 32 percent (Druss et al., 2002).

Health-related morbidity is not only impacting the adult mentally ill population, but is seen among individuals under 21 years of age, despite the fact that adolescence and early stage of adulthood may be very important developmental eras in which to intervene to change the trajectory and course of an individual's health status, especially if they are living with comorbid conditions (mental illness and chronic health problems). Adolescents face many healthcare challenges, especially if they are living with mental health issues. Families with teenage children may struggle with the youth's illness, which can be complicated by having a comorbid mental health diagnosis. Dealing with added stress brought on by mental illness may make management of the adolescent's physical more difficult. Even though, wellness visits are often important in order to maintain one's health and prevent health problems. The majority of this population does not seek care from their primary care physicians (PCPs) unless an acute illness or injury has occurred. Extensive outreach and education (to both families and individuals) is necessary to encourage this age group to seek out health care. Establishing consistent quality healthcare during these earlier stages of life can make a difference. A particular focus needs to be upon helping individuals make the transition from the child/youth-serving healthcare systems (including behavioral health) to systems that serve adults (including the use of case management and care coordination, peer support, and psychoeducational programs focusing on wellness as well as mental health) (Khatri, Raynor, Bishop, & Saporito, 2011).

Physical health and mental health are inextricably linked (healthypeople.com, n.d.). For example, a young child who is overweight may be teased about his/her weight and, as a corollary, withdraw socially and become depressed and/or reluctant to play with others or exercise. These "withdrawal" behaviors then further contribute to the child's poorer physical health and mental health. Issues such as pointed out in this example have long-term implications on the ability of children and adolescents to fulfill their potential as well as consequences for the health, labor, education, and criminal justice systems of our society (APA, n.d.). Moreover, physical illness has been observed as one of the primary risk factors to predict onset and persistence of behavior and mental disorders in young people, based on a large, three-year follow-up study of child health in the United Kingdom (Merikangas, Nakamura, & Kessler, 2009).

As stated in a review article in 2007, "By routinely performing physical health monitoring, referrals, and/or treatment for patients with schizophrenia and other forms of severe mental illness, mental health care providers can take a lead role in transforming the current system of fragmented mental and physical health services into a system focused on early intervention, wellness, and recovery" (Sernyak, 2007, Abstract).

To accomplish this behavioral health professionals are encouraged to embrace physical health screening tools such as the monitoring for metabolic syndrome when a person is treated with a second generation antipsychotic (Kroenke, Spitzer, & Williams, 2001; 2003) and primary care providers are similarly needing to screen for mental health issues or substance abuse through the ongoing use of established instruments such as the PHQ-9 or the PHQ-2 (Nasrallah et al., 2006; Newcomer, 2007).

Obesity and Fitness

While multiple health-related topics could be included in this review, it is felt that the most prevalent conditions impacting persons with serious mental illness (such as diabetes and increased risk of cardiac disease) could be best addressed through the implementation of an assertive program of fitness and improved nutrition.

Individuals with SMI have a higher incidence of obesity and thus are at higher risk factors for cardiovascular disease, diabetes, and reduced life expectancy. As a result, practitioners are encouraged to utilize evidence-based health promotion consisting of combined physical fitness and nutrition programs should be an integral component of mental health services seeking to provide overall wellness and recovery for persons with SMI. Curriculum-based and lengthier programs have been shown to be the most effective in reducing weight, improving physical fitness, and improving psychological symptoms and overall health. (See the SAMHSA-HRSA Center for Integrated Health Solutions overview by Health Promotion Programs for People with Serious Mental Illness prepared by the Dartmouth Health Promotion Research Team, January 2012.) One such program is the "Whole Health

Action Management" Program (WHAM) developed in 2012 by SAMHSA (www.integration.samhsa.gov).

As stated in their training materials, the WHAM program engages peer support to help people develop whole health self-management. The program design combines the powerful benefits of peer-based (recovery-oriented) support with an eight-week curriculum aimed at letting each participant establish and start to attain their own goals as they relate to coping with stress, improving their health, connecting with others for support, and health risk screening and decision making.

Poor nutrition and its contribution to obesity) is a growing issue among children and adolescents. The rate of obesity in the US is 27.1 percent overall, and 16.9 percent for youth. These rates are higher in TN with overall obesity being 32.8 percent of all individuals (the third worst state in the US) and 13 percent of youth in TN (CDC Behavioral Risk Factor Surveillance System "BRFSS" data 2009). There are significant implications to being overweight as a young person ages. It has been suggested that rapid infant weight gain will often lead to excessive weight gain by age four. Overweight toddlers are five times as likely to be overweight as adolescents. Overweight adolescents have a 70 percent risk of becoming overweight adults. 60 percent of overweight children aged 5-10 years already have one or more risk factors for heart disease and/or diabetes. (as reported by Rick Canada, the Director of Nutrition, Physical Activity, and Obesity for TN's Department of Health). Individuals are reported to be obese when they have a BMI of 30 or higher. Youth are defined as obese when their height and weight are above the 95 percent and as being overweight when their height and weight are above the 85 percent.

In addition to those obesity-related health consequences seen in adults, there are also significant psychosocial risks for children and adolescents who are obese, including poor self-esteem, negative self-concept, and negative mood (Sernyak, 2007).

It is has been demonstrated that behavioral counseling as a part of a multi-component pediatric weight management program results in significant reduction in weight status and adiposity in youth. Furthermore, family participation is believed to be more of an imperative for youth between the ages of six and 12 years, while more conditional with fair or limited results for older youth (Spear et al., 2007).

It has been recommended that treatment be along a step or staged approach for weight management (Sokal, 2004; Young & Foster, 2000). It should be noted, however, that there is more evidence supporting the components of stages rather than the staged-approach itself. The notion of stages is simply a means of conveying the importance of matching treatment with the presentation of patients and their families.

Stages typically include (See Khatri et al., 2011.):

Stage I: Prevention

This should be started once a child's BMI is greater than 85th percentile and once the child is at least two years of age. This step is not necessary if a child reaches 12 years of age and has a BMI greater than the 99th percentile. At that level a more intensive treatment stage should be started, depending upon the motivation of the patient and family. Treatment, including prevention, should be matched to the motivational level of the patient and family with their active involvement in setting goals. Targets should address:

- consumption of healthier foods and limits on high sugar content foods;
- provision of adequate physical activity (and limits on sedentary activities such as limiting screen time to two hours per day, no television in bedrooms, and no television viewing if the child is two years of age (consistent evidence);
- Family focused interventions such as not skipping breakfast, limiting eating out, and eating meals together as a family at least five or six times a week (all have mixed evidence).

Frequency of follow-up depends upon motivation toward change and the next stage of treatment should be considered if there is not significant improvement in three to six months.

Stage II: Structured Weight Management

This level of intervention centers on closer follow-up with patients and families, with more of a focus on behavioral monitoring and reinforcement of achieving treatment goals. There is also more attention given to developing a structured dietary plan. This plan should stress minimizing energy dense foods and the provision of more consistent, structured meals and snacks (three meals and two snacks per day) (evidence is suggestive). Attention should also be directed at reinforcing consistent and frequent activity while minimizing sedentary behavior. There could also be discussion/review of cues for eating and attitudes and beliefs in regards to eating behaviors with the intent of improving eating habits.

Stage III: Comprehensive Multidisciplinary Intervention

This stage of intervention centers on increasing the intensity of behavioral strategies with more focus on the family and the behaviorist working with a provider. There would certainly be more frequent contact with even more focus on structure and consistency with dietary and activity goals. This may even include calorie goals.

Stage IV: Tertiary Care Intervention

If it is determined that the patient continues to fail treatment and there are significant health concerns, they may benefit from a referral to a pediatric tertiary weight management center that has access to a multidisciplinary team with expertise in childhood obesity and that utilizes a designed protocol.

Recommendations

Future reviewers of evidence-based approaches to integrate behavioral health and physical health services are encouraged to address:

- Approaches that mental health professionals can adopt to enhance physical health monitoring and early intervention into prevalent disorders found among persons with severe mental illness. These might include addressing the concurrent medical and mental health needs of persons with diabetes, asthma, and cardiac disease ;

- Disorder-specific programming that both mental health professionals and medical providers can involve their patients in when it is found that they are impacted by concurrent psychiatric and medical illnesses. Specific areas of focus should include:

  - Diabetes
  - Cardiovascular disease (including myocardial infarction and stroke)
  - Cancer
  - Asthma

- Educational programs to enhance physical health services for those with mental illness (as well as similar programming for improving the mental health treatment of persons with concurrent medical issues).

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Children and Adolescents in Child Welfare

The unique behavioral and emotional needs of children in foster care long been recognized by the child welfare community in the United States (Leathers, McMeel, Prabhughate, & Atkins, 2009). Many of the children who come to the attention of the child welfare system have encountered abuse and/or neglect as well as separation from a parent. They come from high-risk home environments characterized by instability, poverty, and/or parents/caregivers with poor psychological well-being, which results in poor wellbeing for the child (Kortenkamp & Ehrle, 2002; Mental health issues in the child welfare system, 2003.). Moreover, many of these young people have experienced significant trauma. If the children are placed in custody, there is trauma associated with separation from their families and movement within the foster care system itself which typically compounds the original trauma. Thus, these children are extremely vulnerable and at very high risk for mental health and/or substance abuse problems (Child and Family Services Division, n.d.).

Behavioral and/or emotional problems of children in child welfare are generally significant. A survey of mental health needs using the National Survey of Child and Adolescent Well-Being (NSCAW) indicated that almost 50 percent of children in the two to 14-year-old age range have ***clinically significant*** behavioral and/or emotional problems (Child and Family Services Division, n.d.; Leathers et al., 2009). For the schoolage group, many are not involved with extracurricular activities and have low school engagement. A significant number also deal with problems concerning health insurance coverage, receipt of health care, or health status. Many of these children live with parents or caregivers that have poor mental health. More than one in four lives with parents or caregivers that might be described as highly aggravated. For children younger than six years of age, fewer than one fourth live with parents/caregivers who will take them on outings such as to the park, grocery store, etc. and only a little more than 25 percent have parents/caregivers who read to them more than twice a week (Kortenkamp & Ehrle, 2002). Nevertheless, some researchers contend that the mental health issues of many children and adolescents in the child welfare system often go unmet and/or inappropriately met with the wrong treatments (The Reach Institute, n.d.)

In Tennessee, there were 7,643 in custodial placement by the end of fiscal year (FY) 2011. An overwhelming majority of these children (90 percent) were newly admitted during the fiscal year. More than three fourths were classified as dependent/neglect rather than as delinquent or unruly. Per the Tennessee Code Annotated (TCA 37-1-102), a “dependent/neglected” child is a child:

a) Who is without a parent, legal custodian or guardian;
b) Whose guardian, parent or person with whom the child lives, by reason of mental incapacity, immorality, cruelty or depravity is unfit to properly care for such child;
c) Who is under unlawful or improper supervision, custody, care, or restraint by any person, agency, association, institution, corporation, society or other organization or who is unlawfully kept out of school;
d) Whose guardian, parent or custodian refuses or neglects to provide necessary medical, institutional, surgical or hospital care for such child;

e) Who, because of lack of proper supervision, is found in any place the existence of which is in violation of law;
f) Who is in such condition of suffering or want or is under such improper control or guardianship as to endanger or injure the health or morals of such child or others;
g) Who is suffering from neglect or abuse;
h) Who has been in the care and control of one or more agency or person not related to such child by marriage or blood for a continuous period of six months or longer in the absence of a court order or power of attorney, and such person or agency has not initiated judicial proceedings seeking either adoption of the child or legal custody;
i) Who is or has been allowed, encouraged or permitted to engage in obscene or prostitution or pornographic posing, filming, photographing, or similar activity and whose guardian, parent or other custodian refuses or neglects to protect such child from further such activity; or
j) Who has willfully been left in the sole physical care and sole financial care of a related caregiver for not less than 18 consecutive months by the child's parent, parents or legal custodian to the related caregiver, and the child will suffer substantial harm if removed from the continuous care of such relative (TCCY, 2011).

The average length of stay for children exiting DCS custody during FY 2011 is provided in the table below:

TFACTS is a “live” system that receives continuous updates; therefore results may vary based on when data are collected. **Responsible Region**	**Adjudication**	**Median Length of Stay in Months for Children Exiting Care in FY 2010-2011**	**Median Length of Stay in Months for Children Remaining in Care on June 30, 2011**
Statewide	Delinquent	8.9	6.7
	Dependent/Neglect	9.7	8.9
	Unruly	9.0	5.4
	All Adjudications	9.3	8.3

Source: DCS Annual Report: July 1, 2010-June 30, 2011

The average length of stay in custody is about nine months.

Provisions of mental health treatment primarily in residential settings for children in child welfare are on the decline. The new trend shows effective treatment models for children in foster care settings. Research supporting effective clinic-based models and service-intervention models continues to proliferate. Thus increased communication between child welfare and mental health service systems about mental health services is much needed and warranted (Leathers, 2009).

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Psychosocial versus Pharmacological Treatments

A controversy continues to exist around the use of psychosical versus pharmacological treatments with children and/or adolescents. ***Psychosocial treatments*** provide guidance, support, and education to persons with mental illness, as well as their families. It typically includes psychotherapy (talk therapy), play therapy (for younger children), and/or social and vocational training (NAMI, 2012). Psychosocial treatments should be given consideration as first-line treatments for children and adolescents. They take longer for improvements to be noticed, but have solid grounding in empirical support as stand-alone treatments and are safer than their pharmacological counterparts (American Psychological Association [APA], 2006). However, it may be more difficult to get insurance to cover payment for psychosocial services. ***Pharmacological treatments*** are another way of referring to medications.

Psychosocial Treatments

Psychosocial treatments come in a variety of packages. Some of the most commonly used treatments for children and adolescents include the following:

- **Behavioral therapy** – Using tools like reward charts to help increase positive behaviors and reduce negative, acting-out behaviors.
- **Cognitive behavioral therapy** – An intervention designed to correct the pattern of negative thoughts that interefere with the child's ability to relate to people.
- **Play therapy** – Primarily used with younger children, it can help heal past trauma and facilitate the child's return to normal functioning.
- **Child-parent psychotherapy** – This intervention focuses on working directly with the child and the parent to deal with relationship issues. It can further help the child increase healthy ways of functioning and interacting. Parents are taught to be more reflective and how to develop a deeper understaning of their child and the role they play in their child's life. Parents are also taught how to interact with their child, thus promoting a healthy and secure attachment process as well as a healthy growth and development trajectory. Often parent coaching is a component of this therapy.
- **Dialectical behavioral therapy** (DBT) – Used mostly with adolescents, it teaches skills such as emotional regulation and distress tolerance, helping the struggling adolescent to integrate these new skills in their daily interactions (Solchany, 2011).

Researchers investigating the overall effect of psychosocial treatments on early disruptive behavior problems found support for their use as a first-line treatment with very young children. Using meta analysis involving 36 controlled trials, the researchers observed a sustained, large effect on early disruptive behavior problems, with the greatest effects linked to behavioral treatments. The average age of the children included in the analyzed studies was 4.7 years (Comer, Chow, Chan, Cooper-Vince, & Wilson, 2012).

Regardless of the difficulty in helping parents, educators, and other caregivers understand the value of psychosocial treatments, the working group on psychotropic medications of the American Psychological Association (APA) recommends that, in most cases, psychosocial interventions should be the intervention considered first for children and adolescents. Clearly these interventions are safer than pharmacological medications (APA, 2006). However, when pharmacological treatments are necessary, their use should be carefully chosen, monitored, and tapered off as soon as possible (Tweed, Barkin, Cook, & Freeman, 2012).

The American Academy of Pediatrics (AAP) has developed a concise, single-page report of evidence-based psychosocial interventions for children and adolescents. This report was designed to guide persons who work with children and adolescents, including clinicians, educators, youth, and families, in developing appropriate plans using psychosocial interventions. It was created using the PracticeWise Evidence-Based Services (PWEBS) Database (www.practicewise.com). The report can be found at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/CRPsychosocialInterventions.pdf. Check the AAP web site, www.aap.org/mentalhealth for updates and/or the most current version.

Alternative treatments such as yoga are being explored as modalities that lead to the improvement of mental health in young people, especially adolescents. Yoga practices incorporate the mental and the physical, heling to develop self awareness and grounding, calm the nervous sytem, and build balance, flexibility and strength. A few studies involving control groups have demonstrated yoga's benefits on positive self regard, perceptions of wellbeing, and emotional regulation skills. Yoga has further been identified as a technique for treating trauma issues experienced by youth. Since 2003, the Trauma Center at Justice Resource Institute (Massachusetts) has adapted a form of yoga for traumatized youth that are housed in residential treatment settings. Street Yoga, an organization that has expanded its boundaries from Portland, Oregon, to New York, San Diego, and Seattle, uses yoga classes to help youth build assertiveness and strength with a sense of safety. Instructors who teach the classes must go through special training (Marino, 2012).

Pharmacological Treatments

Pharmacologic medications can be beneficial adjuncts to behavioral treatments. In fact, AACAP does not recommend solely using medications with children and adolescents.

Prior to prescribing medication for pediatric patients, it is recommended that the medical professional interview the young person so that a thorough diagnostic evaluation can be made. It is possible that some evaluations may include physical examinations, laboratory tests, electrocardiograms (EKGs), electroencephalograms (EEGs), other medical tests, and/or consultations with other medical specialists (AACAP, 2004; Stambaugh, Leslie, Ringeisen, Smith, & Hodgkin, 2012).

General Principles Regarding the Use of Psychotropic Medications with Youth

- There must be a DSM psychiatric diagnosis ***BEFORE*** psychotropic medications are prescribed.

- The medical record must contain clearly defined target symptoms and treatment goals for the use of psychotropic medications at the time of or before beginning treatment with a psychotropic medication.
    - Target symptoms and treatment goals should be assessed at each clinic visit with the child and caregiver.
    - Recognized clinical rating scales or other measures should be used to quantify the response of the youth's target symptoms to treatment and the progress made toward treatment goals, whenever possible.
- Clinicians should carefully consider potential side effects, including those that are uncommon but potentially severe, and evaluate the overall benefit-to-risk ratio of pharmacotherapy in their decision-making about prescribing a psychotropic medication in a specific young person.
- Informed consent should be obtained from all appropriate parties ***BEFORE*** beginning psychotropic medication, except in cases of extreme emergency.
- The presence or absence of medication side effects should be documented in the medical record at each visit while the youth is taking psychotropic medication.
- Additional factors that should be monitored and documented include height, weight, and blood pressure or other laboratory findings.
- Put youngsters on monotherapy regimens for a given disorder ***BEFORE*** starting polypharmacy regimens.
- Start doses as low as possible, titrating carefully as needed.
- Change only one medication at a time, unless clinically contraindicated by documentation in the medical record. (***Note: Starting a new medication and beginning the dose taper of a current medication is considered one medication change***).
- As needed (prn) prescriptions should be discouraged. ***IF USED***, the situation indicating need of administration as well as the maximum number of prn doses per day and/or week should be clearly indicated. Frequency of administrations should be carefully monitored to keep prn medications from becoming regularly scheduled medications.
- Follow-up should be appropriate for the severity of the youth's condition and adequate to monitor response to treatment, including symptoms, function, behavior, and potential side effects.
- For depressed children and adolescents, carefully evaluate and monitor the potential for emergent suicidality.
- Whenever possible, the prescribing clinician should be a child psychiatrist. Referral to or consultation with a child psychiatrist (or general psychiatrist with significant experience in treating children) should definitely occur if the child's clinical status does not show meaningful improvement within the timeframe appropriate for the clinical response and medication regimen being used.
- Conduct further assessments ***BEFORE*** adding more psychotropic medications to a regimen. At minimum, the child should be assessed for adequate medication adherence, accuracy of the diagnosis, the occurrence of comorbid disorders (including substance abuse and general medical disorders), and the influence of psychosocial stressors.
- If a medication is being used in a child because of the presence of a primary target symptom of aggression associated with a DSM nonpsychotic diagnosis (e.g., conduct disorder, oppositional defiant disorder), and the behavioral disturbance has been in remission for six months, serious consideration should be given to slow tapering and discontinuation of the medication. If the medication is continued in this situation, its necessity should be evaluated and documented every six months, at minimum.

- Care should be clearly documented in the child's medical record. Documentation should include history; mental status assessment; physical findings (when relevant); impressions; adequate laboratory monitoring specific to the drug(s) prescribed at intervals required and potential known risks; medication response; presence or absence of side effects; treatment plan; and intended use of prescribed medications (Stambaugh et al., 2012; Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, 2010).

It is extremely important that medications be dispensed properly, not just when the patient is a child or adolescent, but for all patients, young and old. Clinicians should make every effort to adhere to the five rights of medication administration, as displayed in the table below.

Five Rights of Medication Administration*
The **RIGHT** patient
Receives the **RIGHT** drug
In the **RIGHT** dose
By the **RIGHT** route
At the **RIGHT** time.

*Source: *George Washington University, Center for Health and Health Care in Schools, School of Public Health & Health Services* (2007).

Criteria Indicating Need for Further Review of Clinical Status When Psychotropic Medications Are Prescribed

The criteria that follow were adapted from *Psychotropic Medication Utilization Parameters for Foster Children* (Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, 2010). While the parameters indicate the need for further review, they do ***NOT*** necessarily indicate that treatment is inappropriate.

1) Absence of a thorough assessment of DSM diagnosis in the child's medical record.
2) At least five psychotropic medications are prescribed concomitantly.
3) When the following have been prescribed:
    a) Two or more concurrent antidepressants
    b) Two or more concomitant antipsychotic medications
    c) Two or more concurrent stimulant medications[1]
    d) Three or more concomitant mood stabilizer medications

(***NOTE. Polypharmacy is defined as the use of two or more medications for the same indication, i.e., specific mental disorder.)***

4) The prescribed psychotropic medications are inconsistent with appropriate care for the youth's diagnosed mental disorder or with documented target symptoms typically associated with a therapeutic response to the medication that has been prescribed.
5) A psychotropic polypharmacy regimen for a given mental disorder is prescribed ***BEFORE*** utilizing monotherapy.
6) The psychotropic medication dose exceeds what is usual and customary.
7) Psychotropic medications are prescribed for very young children, including children receiving the following medications with an age of:
    a) Antidepressants: Child younger than four years of age
    b) Antipsychotics: Child below the age of four years
    c) Stimulants: Child under three years of age
8) Medication is prescribed by a primary care provider (PCP) for a diagnosis ***OTHER*** than the following, ***UNLESS*** recommended by a psychiatrist consultant or the PCP has documented previous specialty training in the diagnosis:
    a) Attention Deficit Hyperactive Disorder (ADHD)
    b) Uncomplicated anxiety disorders
    c) Uncomplicated depression

[1] The prescription of a long-acting stimulant and an immediate-release stimulant of the same chemical entity (e.g., methylphenidate) does *NOT* constitute concomitant prescribing.

The *Psychotropic Medication Utilization Parameters for Foster Children* document (2010) further contains medication charts for the following:

- Stimulants (for treatment of ADHD)
- Other ADHD treatments
- Antidepressants, SSRIs
- Antidepressants, SNRIs
- Antipsychotics: Second Generation (atypical)
- Antipsychotics: First Generation (typical)
- Mood stabilizers.

Each chart displays the name of the drug, initial dosage, literature based maximum dosage, FDA-approved maximum dosage for children and adolescents, schedule, black box warning, and warnings and precautions. The parameters can be downloaded from http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf.

For children in state custody in Tennessee, all psychotropic medication requests for children age five and under must be approved by a psychiatrist in DCS's central office. Moreover, consultation with DCS's Chief Medical Officer is additionally required for certain requests such as the prescribing of four or more psychotropic medications or two of the same class of medications (DCS, personal communication, January 18, 2013).

How Often Should Children and Adolescents Taking Pharmacologic Medications Be Monitored

It is important that children and adolescents on psychotropic medications be carefully monitored, ***especially if they are taking antidepressants***. The FDA recommends the following monitoring schedule (***shown below***) when antidepressants are involved. An equivalent or similar schedule might be followed when children or adolescents have been prescribed other types of medications.

Monitoring Schedule	***Treatment Phase***
Weekly	First month of treatment
Bi-weekly	Second month of treatment
Follow-up	After 12 weeks of treatment
As recommended	Following 12 weeks of treatment

Source: *Mayo Clinic, 2007*

Further monitoring capabilities are in place for children in Tennessee's child welfare system. DCS has an established database that allows appropriate staff to review prescribing patterns of children in DCS custody (DCS, personal communication, January 18, 2013).

Overuse of Antipsychotics

Research continues to point to increased prescribing of antipsychotic medication for children and adolescents. Using data from the National Ambulatory Medical Care Survey (NAMCS), researchers examined office visits resulting in a prescription of antipsychotic medication. Between 1993-1998 and 2005-2009, they found that office visits to doctors with a prescription of antipsychotic medications per 100 persons grew from 0.24 to 1.83 for children and from 0.78 to 3.76 for adolescents. (Children were defined as 0-13 years of age and adolescents were ages 14-20 years.) A diagnosis of disruptive behavior disorder (DBD) accounted for 63 percent of the child antipsychotic visits and 34 percent of the visits by adolescents in 2005-2009. The fastest rate of increase in use of antipsychotics was apparent when children and adolescents visited non-psychiatric physicians, many of whom were primary care doctors (Antipsychotic use, 2012), a finding that is troubling and indicative of the need for these guidelines.

Overprescribing of psychotropic medications has become a growing concern for children and adolescents in foster care as well. A 2008 General Accounting Office report based on Medicaid claims found that 21-39 percent of children in foster care received a prescription for psychotropic medication, compared to five to10 percent of youth not in foster care. Moreover, they observed that as many as 41 percent of youth that took psychotropic medications received three or more medications within the same month. When considering type of placement, youth living in nonrelative foster parent care, residential treatment centers, or group homes had the highest rates of psychotropic medication use (almost 30 percent). The most common age group receiving psychotropic medications was the six-to-11-year olds (nearly 20 percent). About four percent of children ages five and younger were taking one or more psychotropic medications (Stambaugh et al., 2012).

A guide has been developed by the Children's Bureau to empower youth and help them understand and make healthy choices about psychotropic medications (Children's Bureau, 2012). Written expressly for youth education and information, the guide can be obtained from http://www.nrcyd.ou.edu/publication-db/documents/psychmedyouthguide.pdf.

Special Psychotropic Prescribing Considerations for Preschool Children

Guidelines for using psychotropic medications with preschool children were crafted and published by the Preschool Psychopharmacology Working Group (PPWG). Those guidelines emphasize the consideration of multiple different factors, such as the assessment and diagnostic methods used to evaluate the child's psychiatric problems, when deciding about prescribing psychotropics to preschoolers. The guidelines also contain information to help with treatment decisions for anxiety disorder, attention deficit hyperactivity disorder, bipolar disorder, disruptive behavioral disorder, major depressive disorder, obsessive compulsive disorder, persasive developmental disorders, post traumatic stress disorder, and primary sleep disorders. It should be noted that more emphasis is placed on treating children of preschool age with psychosocial interventions for up to 12 weeks before starting any pharmacological treatment. Assessment of the mental health needs and functioning of the child's parent is addressed along with training parents in how to use evidence-based behavioral management strategies (Gleason, 2007, as cited in Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, 2010).

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Medication Safety

There are several issues surrounding medication safety for children and adolescents. One obvious issue relates to how medications, including vitamins, are stored in homes or facilities where children reside and/or visit. A less talked about, but equally important, issue is the difficulty that parents and/or other caregivers have in accurately measuring medication dosages for young children, in particular ("Errors put infants", 2011).

Storage Considerations

Often homes with young children do not do a good job of safely storing medications (Asti, Jones, & Bridge, 2012). This lack of attention to proper medication storage leaves the door open for children, especially young children, to inappropriately access medications, the result of which could be a call to the poison center, a trip to the emergency room, or worse. Baker & Mickalide (2012) say that the number of children seen in emergency departments (ED) on a daily basis can fill nearly four school buses.

- 95 percent of ED visits involving children younger than five years of age are associated with unsupervised accidental intake of medications.
- For two-year-olds, one in 150 go to the ED due to unintentional medication overdose.
- Calls to poison control centers indicate that sedatives, analgesics, and antihistamines are the primary culprits in 50 percent of all poison-related deaths among young children (Baker & Mickalide, 2012).

A group of researchers in Ohio conducted a pilot study to explore medication storage patterns and the presence of expired medications in the home using direct observation (Asti, Jones, & Bridge, 2012). Children in the homes ranged in age from two to six years. "Unsafe storage" meant that either medications were stored at less than five feet, i.e., adult "eye' level, or that when stored at less than five feet, the medications were not in a locked container/entity. This study differed from previous studies on storage patterns in that storage was directly observed in the home and not based on self report. Though the sample size was small (N = 24 families) and selected based on availability rather than using random selection, the results offer useful information on how medications in homes with children are really stored.

- Most medications tend to be stored in the kitchen, with the bathroom being the second most common storage location.
- Slightly more than 20 percent of medications were stored in an unsafe manner.

- Only seven percent of medications were stored in a locked container, a finding much lower than observed in previous research. However, the findings are based on direct observation compared to self report (Asti, Jones, & Bridge, 2012).

Storage Solutions

Store medications in locked receptacles. This is a recommendation of the American Academy of Pediatrics (AAP). Childproof caps and packages are not as effective in keeping medications out of the reach of children as locked containers. Many children can open the "childproofed" medications better than adults. Thus, "childproofed" medications still leave children at high risk of unintentional poisoning and/or death (Baker & Mickalide, 2012; Asti, Jones, & Bridge, 2012). Storing medications in locked containers will reduce that risk.

Store medications in locations that are not easily accessible by children. In this context, children include the parent's own children, children for whom a caregiver is responsible, and/or any child that is visiting the home and/or facility. Every reasonable effort should be made to store medications 'up and away', out of sight of children. The Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA) have several resources to assist providers, parents, caregivers, and youth in adhering to proper storage of medications.

- Tips for Safe Medicine Storage can be retrieved from http://www.upandaway.org/pdf/Travel_Tips.pdf. This is a one-page document that can serve as a reminder on appropriate medicine storage when traveling.

- Under no circumstances should you refer to medications as candy (Baker & Mickalide, 2012).

- An "Up and Away" coloring book for younger children is available through the PROTECT initiative in partnership with CDC. The coloring book can be downloaded at http://www.upandaway.org/pdf/Up_and_Away_Downloadable_Coloring_Pages_508.pdf.

Older youth, parents, caregivers, providers, or anyone serious about medication safety for children should take the following pledge.

- **I pledge to:**

  - Pick a place high up and out of sight that my child cannot reach where I can safely store my medicines and vitamins.
  - Always put every medicine and vitamin away every time I use it, including those I use every day.
  - Always re-lock the safety cap on a medicine bottle.
  - If the medicine has a locking cap that turns, I will twist it until I hear the click.
  - Teach my children about medicine safety.
  - Tell guests, friends and family about medicine safety and ask when they visit my home to keep their medicines up and away and out of sight.
  - Program my Poison Help center's number in my phone: 800.222.1222 (upandaway.org, 2012).

- Two online videos are available through the FDA at http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-CounterMedicines/ucm204457.htm. The videos are titled "Medicines in My Home: The Over-the-Counter Drug Facts Label" and "Lock It Up: Medicine Safety in Your Home".

Expiration Considerations

Keeping medicines longer than their expiration date also lead to bad outcomes for children and adolescents. Research has shown that many homes where children reside and/or visit keep at least one medication that has reached its expiration date. Medications with expired dates tend to lose their potency and may cause harm due to a breakdown of the chemicals. Actually, without laboratory test, the extent of deterioration in expired medications is unknown.

The pilot research study of researchers from Ohio showed the following about expired medications as found in observed homes:

- Close to 30 percent of all medications—prescription and over-the-counter (OTC)—were past their expiration date.
- On average, there were nine expired medications per home.
- One "outlier" home had 31 expired medications (Asti, Jones, & Bridge, 2012).

Expiration Date Solution

Dispose of medications that are no longer needed and/or have not been used (Asti, Jones, & Bridge, 2012). Medications that have past their expiration date meet these criteria. If the child or adolescent takes expired medication, he/she may not be receiving the required dosage, which sometimes can be as harmful as receiving too much medication. It is also possible that the chemical structure of the expired medication has changed, which would make it extremely difficult to assess its interaction with other medicines or foods.

Dosing Considerations

Lack of parent/caregiver knowledge about selecting and dispensing medications for young people, especially those under five years of age, has been identified as a potential medication safety hazard. Researchers in Australia found that dosing errors and inappropriate use of medicines, including OTC medications, led to a dramatic upswing in the number of calls to poison centers and visits to emergency rooms involving youth. Doses for children are typically small so the risk of making an error in measurement is greatly increased. In 2008, 48 percent of more than 100,000 calls to poison centers were concerned with accidental overdoses in children. Fifteen percent of those children had to be hospitalized. More than 85 percent of the calls involved children younger than five years of age, with nearly 80 percent of the incidents involving children younger than three years old ("Widespread parental misuse", 2010).

It is especially important that parents and/or caregivers that give young children prescription painkillers take extra care in making sure they give just the right dose. There is some concern that, without taking into consideration the age, gender, and weight of the child, the pharmacy dosage could be too high. University of South Carolina researchers found evidence of an overdose amount, with greater incidence of overdose amounts for the younger children ("Errors put infants", 2011).

Dosage Solution

Domestic spoons should never be used to dispense medications to children. There are significant differences in the capacity of spoons, with some holding up to three times as much as others. This differential in capacity could result in too little or too much medication for the child (Falagas, Vouloumanou, Plessa, Peppas, & Rafailidis, 2010;"Using domestic spoons", 2010).

Providers should strive for accurate prescribing and pharmacists should aim for accurate dispensing. Prescribers must consider factors such as body-weight, body-surface, gender, age of the child, or some combination when preparing the prescription. Pharmacists should ensure that the prescription is appropriately and accurately filled. To accomplish this, contact with the prescriber may be necessary ("Errors put infants", 2011).

How Psychiatric Medications Are Determined as Safe for Use with Children and Adolescents

Until recently, most psychotropic medications prescribed for youth were "off label". This means that the appropriate scientific studies have not yet been conducted with children and adolescents. Off-labeling, however, is typical and consistent with general clinical practice involving pediatric populations (APA & AACAP, n.d.). Dr. Phillip Janicak (2007) says that the lack of regulation essentially mandates that clinicians should follow a consistent standard of care. His recommendations for a standard of care for off-label prescribing include:

- Tell the patient or his/her representatives why the off-label medication is their best option BEFORE prescribing it.
- Inform the patient and/or his/her representatives about other treatment options, and do NOT proceed with off-label prescribing until you have the consent of the patient or his/her representatives.
- Document the process and note that a discussion has taken place with the patient and/or his/her representatives regarding the off-label prescribing.
- Stay vigilant for any unexpected adverse events, particularly in the early stages of treatment (Janicak, 2007).

The U.S. Food and Drug Administration (FDA) currently requires that researchers include young people in studies for approval of medications for their population (APA&AACAP, n.d.; healthyplace.com, 2001). The process often begins when psychiatrists describe their successes in single cases. If the outcome is positive, the next step is the ***gold standard***, a double blind, placebo controlled study. In this design, neither physicians nor patients know if the patient is receiving the active medication or a placebo (a look-alike for the drug under study). The final test is to be able to repeat the double blind study in other settings and to obtain similar positive outcomes (Klee, 2001).

The FDA's role is to determine whether research sponsored by pharmaceutical companies indicates that a medication is safe and effective for the indications in which it has been studied. The agency has the additional responsibility of ensuring that information on the approved product labeling is accurate. As a result, the FDA limits the manufacturer's marketing to the information contained in the approved labeling. ***The FDA does not, however, limit the manner in which psychiatrists and other prescribing professionals prescribe an approved drug***. Prescribing professionals should continue to use the available evidence, expert opinion, and their own clinical experience in decisions related to what is the best medication for each individual patient (Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, 2010).

"Black Box" Warnings

The FDA required makers of all antidepressant medications to update the existing warning on the product labeling for antidepressants and include additional warnings about increased risks of suicidal behavior and thinking in young adults (ages 18-24) during initial treatment. Initial treatment was defined as the first one to two months (FDA, 2007a).

Moreover, the FDA (2007b) revised its Medication Guide that deals with the risk of suicidal actions and thoughts in antidepressant medicines. The Guide was designed to answer the question: What is the most important information to know about antidepressant medicines, depression and/or other serious mental illnesses, and suicidal actions or thoughts? **First and foremost**, though, the Guide tells the reader to talk to his/her or a family member's healthcare provider.

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TDMHSAS BEST PRACTICE GUIDELINES

Obtaining Informed Consent for Children and Adolescents

Informed Consent

There are considerations that must be taken into account involving every encounter with children and adolescents. First and foremost is the issue of informed consent. Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

No person with mental illness or serious emotional disturbance, hospitalized or admitted, whether voluntarily or involuntarily, or ordered to participate in nonresidential treatment or service under Title 33 of the Tennessee Code Annotated (TCA) shall, solely by reason of the hospitalization, admission, or order, be denied the right to give informed consent to treatment, unless the service recipient has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity or the denial is authorized by state or federal statute [TCA § 33-3-102(a)]. The Rules of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) define "informed consent" as "consent voluntarily given in writing after sufficient explanation and disclosure of the subject matter involved to enable the person whose consent is sought to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. Informed consent for psychotropic medication can be obtained from a person who is capable of understanding after adequate explanation a medication's expected benefits, possible risks and side effect, the advantage and risk or alternative treatments, and the prognosis if medication is not given" [Rule 0940-1-1-.02(i); January 1999, Revised]. Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient if he or she has the capacity to give it. In the Tennessee Healthcare Decisions Act, capacity refers to the individual's ability to understand the significant risks, benefits, and alternatives to the healthcare, including mental healthcare, being proposed as well as the individual's ability to make and communicate decisions about such health care [TCA §§ 68-11-1802 *et seq*.]. No person shall make decisions for a service recipient on the basis of a claim to be the service recipient's conservator, legal guardian, guardian ad litem, caregiver under TCA Title 34, Chapter 6, Part 3, or to be acting under a durable power of attorney for health care under TCA Title 34, Chapter 6, Part 2 that specifically includes powers related to decisions about mental healthcare, until the person has presented written evidence of the person's status [TCA § 33-3-102(b)].

Fundamental principles of informed consent for youth in state custody

For children in state custody to receive appropriate behavioral health services, DCS facilitates the informed consent process by involving the parent/guardian/older youth or by providing the consent as appropriate.

DCS procedures involving children in custody state that every individual has a right to:

1. Control what is right for his/her bodily integrity.

2. Receive information regarding prescribed treatments, services, or tests, including risks and benefits of the prescribed treatments, services, or tests.
3. Obtain information in sufficient detail to be able to make an informed decision regarding consent or refusal of the treatments, services, or tests.
4. Have the behavioral healthcare provider make available written and/or oral explanation of any and all prescribed treatments, services, or tests in language the individual fully understands, and that typically includes the following:

    a. Diagnosis for which the treatments, services, and/or tests are prescribed;
    b. Nature of the treatments, services, and/or tests/procedures;
    c. Both brand and generic names of medications, dosages, and frequencies of administration, when applicable;
    d. Expected recovery schedule for procedures;
    e. Any expected benefits;
    f. Known side effects and risks;
    g. Whether alternatives are available; and
    h. Prognosis if prescribed treatments, services, and/or tests are not utilized (DCS, 2011).

Capacity to give informed consent

Legally all parents in Tennessee have decision-making power over their own minor children. Guardianship is the term used to describe the legal relationship (ARC, 2011). Tennessee, however, recognizes the 'mature minor exception' to permission for behavioral health treatment, which defines the age of consent to mental health treatment and/or services as 16 years of age. A "minor child" is defined at TCA §33-1-101 as a person under 18 years of age, but TCA §33-8-202 that states if a child with serious emotional disturbance or mental illness is 16 years of age or older, the child has the same rights as an adult with respect to, among other things, confidential information. Further TCA §33-3-104 lists a service recipient 16 years of age and over as one of the persons authorized to consent to disclosure of confidential information (TDMHSAS Policies and procedures, 2011). Thus, adolescents 16 years of age and older in Tennessee are presumed to have the maturity to consent to medical care, including mental health care, and can sign their own consents for treatments, services, and/or tests (DCS, 2011).

Since young people in DCS custody may provide their own consents for mental health treatment, additional consent from the parent, legal guardian or legal custodian is not needed. Yet some mental health providers, at their discretion, may choose not to treat 16-year-old youths without parental involvement. In those situations and the 16-year-old youth does not want his/her parents involved, another mental health treatment provider should be sought (DCS, 2011). Detailed policy and procedures related to informed consent requirements for children in state custody, and capacity in particular, can be found in DCS's Administrative Policies and Procedures: 20.24.

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Screening, Assessment, and Evaluation

Classifying mental or behavioral health needs for children and adolescents is not simple because definitions differ across systems. Schools use one classification of needs, mental health agencies use another, and social service organizations may use slightly different categories for mental health needs of youth. Moreover, there is no single, uniform profile, or description, for young people with mental health issues. Further, children and adolescents with mental health problems may present with more than one mental health need concurrently which will likely result in additional challenges in their transition to adulthood (Podmostko, 2007).

Youth mental health needs may manifest in childhood or adolescence, though most first occur and are diagnosed during the teen years. Some studies have shown that about 75 percent of young adults with mental health diagnoses were first diagnosed with a mental health disorder during adolescence. The most commonly diagnosed disorders for young people are anxiety, depression, and maladaptive behaviors (Podmostko, 2007).

A number of behaviors have been identified as possible signs of mental illness in young people. The National Alliance for the Mentally Ill (NAMI) includes the following behaviors:

- school failure, truancy, frequent expulsion from school;
- crying persistently;
- fatigue or lethargy;
- grouchiness or irritability;
- over-reactions to failures or disappointments;
- isolation from family and friends;
- difficulties sleeping;
- encounters with the juvenile justice system;
- accident-prone, reckless behavior;
- risky behaviors such as sexual activity or alcohol and drug abuse;
- agitation or hyperactivity;
- separation anxiety;
- panic attacks;
- social phobias;
- sudden weight loss or lack of hygiene;
- repetitive, ritualistic behaviors (counting, writing/rewriting, hand-washing);
- obsessive doubts, thoughts, or fears;
- changes in speech (brevity, incoherence, rapidity);
- changes in behavior (rocking, pacing, disorganization, grimacing);
- paranoia,delusions, or hallucinations;
- no motivation;
- flat affect; and
- low self-esteem that may be masked by a 'tough' demeanor (Burland, 2003).

One or two of the above behaviors alone are not enough to indicate possible mental health needs for youth, but combinations of these behaviors along with relational problems with family members or peers or problems at school may indicate a need for further evaluation (Podmostko, 2007).

Many young people who develop mental health problems as adolescents often go undiagnosed and/or unidentified. School records, assessment results, behaviors, and/or interview responses may suggest previously undiagnosed or unidentified mental health problems in young people. Among the problems may be, but not limited to, inconsistent academic performance, limited vocabulary, and low literacy levels. A screening process may be necessary to determine if further diagnostic assessment, conducted by a trained mental health professional, should be provided (Podmostko, 2007).

Mental Health Screens vs. Evaluations

Screen	Evaluation
Brief process or instrument that provides preliminary information on behaviors, risk factors, or other issues that may indicate the presence of a mental health need.	In-depth evaluation for diagnosing a mental health need and its severity, often requiring a combination of assessment instruments, interviews, record reviews, and observations.
Can take as little as 8-10 minutes to administer and 5-10 minutes to score.	Can take days or weeks to collect information and interpret the results.
Can be administered by properly trained youth service workers/staff.	Must be administered by highly trained professionals such as psychiatrists, psychologists, or others with graduate-level training in the mental health discipline.
Used to help in decision making regarding the need of referral for a mental health evaluation.	Used to determine if a disability is present and the level of its severity.

Source: Podmostko, 2007.

Podmostko (2007) is insistent that screening programs be assessed regularly to determine (1) the extent to which young people and their families follow through with referrals, (2) the results of mental health assessments and diagnoses, and (3) the relationship between the screens used (and the type of referrals that are made), as well as the success of youth in school, whether college-bound or vocational.

Children and adolescents with serious behavioral and emotional problems will undergo comprehensive psychiatric evaluation. These evaluations typically span several hours, requiring one or more office visits for the youth and his/her family. Among the information gathered for the comprehensive evaluation are:

- A description of presenting problems and symptoms
- Health, illness and treatment status (both physical and psychiatric), including current medications
- Parent and family health and psychiatric histories
- Developmental milestones
- School history and friendships
- Family relationships
- Youth interview
- Parent/caregiver interview

- Laboratory work such as blood tests, x-rays, or special assessments (for example, psychological, educational, speech and language evaluation), if necessary (American Academy of Child & Adolescent Psychiatry [AACAP], 2005).

Following the comprehensive evaluation, the clinician, ideally a child and adolescent psychiatrist, should develop a formulation that describes the youth's problems and explains them in family-friendly language. The formulation should combine biological, psychological and social components of the problem with developmental needs, history and assets of the young person and his/her family (AACAP, 2005).

Standardized and/or structured instruments serve as the best evaluation tools. Such tools can be used to help measure the youth's mental health symptoms and/or any progress s/he makes following interventions. Please keep the following caveats in mind when using screening tools or rating scales:

- A diagnosis is NOT produced merely because the clinician uses instruments.
- A particular "score" on an instrument does not guarantee that the youth has a particular disorder.
- Diagnoses should only be made by trained clinicians after they conduct thorough evaluations.

Any symptoms suggestive of suicidal or harmful behaviors necessitate immediate attention by the trained clinician (Massachusetts General Hospital, School Psychiatry Program & MADI Resource Center, 2010). The Massachusetts General Hospital (2010) website displays a list of screening tools and rating scales that are appropriate for use with young people. Instruments screen for symptoms of the following disorders: anxiety; social anxiety; obsessive-compulsive; depression; bipolar/mania; suicide risk; attention deficit hyperactivity; pervasive developmental disorder/autism; Asperger's; nonverbal learning disabilities; and disruptive behaviors. Clinicians can use the site to identify specific information about the instrument including what subscales are measured, to whom the measure can be administered, the number of items, the age levels for which the tool is appropriate, and the length of time it takes to complete the screener, and whether the instrument is available online. The website is located at http://www2.massgeneral.org/schoolpsychiatry/checklists_table.asp.

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TDMHSAS BEST PRACTICE GUIDELINES

Cultural Competence

Providers of mental health services must acknowledge that culture counts. For the patient, culture will influence how s/he communicates and manifests his/her symptoms. It might also affect whether the patient will even seek out mental health services. For the clinician, culture will play an important role in diagnosis, treatment, and service delivery. It is estimated that population growth for youth of color will far exceed that of Caucasian youth. During the 20-year period between 1995 and 2015, the population growth for Caucasian youth is expected to hover around three percent, compared to 17 percent for Hispanic youth; 19 percent for African American youth; and 74 percent for Asian American youth (Nguyen, Huang, Arganza, & Liao, 2007). Of particular importance are the issues to which clinicians must be attuned in order to provide effective and efficient service to racial and ethnic minorities.

Any discussion of the services that youth receive would be incomplete without highlighting that issues of cultural competence and institutional racism are rife in this field. Youth of color, especially African Americans, are more likely to receive harsher treatment when involved in school discipline proceedings, child welfare cases, or the juvenile justice system. Tunneling, then, is not only a function of a youth's problem, but is also influenced by conscious and unconscious biases on the part of government agencies (Ross & Miller, 2005, p. 5, cited in Podmostko, 2007).

- **African Americans**: Research showed that errors in diagnosis are made more often for African Americans than for Caucasians with certain disorders, like schizophrenia and mood disorders. In addition, it is less likely that African Americans will receive clinical care that adheres to evidence-based practice in accordance with professional treatment guidelines, when compared to Caucasians (DHHS, 2001).

- **American Indians and Alaska Natives**: Limited research exists on these subgroups, though appropriateness and outcome issues are critical for planning treatment and prevention programs. Nevertheless, it should be noted that these subgroups prefer traditional healing methods as treatment options. Besides getting out of the "office" setting, clinicians should be willing to incorporate into treatment traditional healing and spiritual activities and customs that are likely part of the client's belief system and that of his/her family (Barnett & Bivings, 2003; DHHS, 2001).

- **Asian Americans and Pacific Islanders**: Limited research abounds for these subgroups as well. However, patients from these subgroups may benefit from lower dosages of certain drugs than typically prescribed for whites because of differences in their rates of drug metabolism. Whenever possible, try to match these patients with therapists of the same culture. The end result would likely be higher rates of mental health service utilization (Africa & Carrasco, 2011; DHHS, 2001). Efforts should also be made not to "lump" these subgroups together as "one". Their languages and dialects are quite diverse (in excess of 100) and typically resources are not available in sufficient diversity to accommodate this subgroup (Africa & Carrasco, 2011).

- **Latino Americans**: As with many other subgroups, research is limited; yet, the data suggests that this subgroup can experience favorable outcomes, given mental health treatment (DHHS, 2001). Clinicians who present as distant or cold in the therapeutic relationship will experience high attrition rates from their Latino clients. Self-disclosure is also a requirement for a successful therapeutic relationship (Barnett & Bivings, 2003). Like African Americans, Latinos, too, are less likely to receive evidence-based clinical care in accordance with professional treatment guidelines (DHHS, 2001).

Culture must always weigh into the mental health service delivery equation. Mental health professionals should use one or more of the following strategies in their efforts to provide the highest quality of care to every child and family, regardless of race, ethnicity, cultural background, English proficiency or literacy.

- Provide interpreter services. Recommended practices for working with interpreters can be found at the website of the National Association of School Psychologists (NASP). The practices are designed to be applicable during interviews or assessment sessions. They also assume that the interpreter has a high level of proficiency in English and the second language, as well as adequate training working in the setting. (See Lopez, 2002). A PDF containing the practices can be downloaded from the following link: http://www.nasponline.org/resources/culturalcompetence/recommend.pdf.
- Recruit and retain minority staff.
- Provide training to increase cultural awareness, knowledge, and skills. When is the last time your staff attended cultural competence training? When is the last time you attended training in cultural competence?
- Coordinate with traditional healers. Healing practices figure prominently in the lives of Native Americans and Alaskan natives (DHHS, 2001).
- Use community health workers
- Incorporate culture-specific attitudes and values into health promotion tools
- Include family and community members in health care decision making
- Locate clinics in geographic areas that are easily accessible for certain populations
- Expand hours of operation
- Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials

Fourteen culturally and linguistically appropriate services (CLAS) standards in health care, organized by themes, have been developed and issued by the Department of Health and Human Services, Office of Minority Health. Actual standards can be found http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 (DHHS Office of Minority Health, 2007). ***CLAS mandates (Standards 4, 5, 6, and 7) are current Federal requirements for all recipients of Federal funds***. The CLAS mandates focus on: 1) offering and providing language assistance services without cost and in a timely manner; 2) providing verbal and written notices of rights to receive language assistance services in the service recipient's preferred language; 3) assuring the competence of language assistance services; and 4) making available easily understood materials including visuals in languages of the commonly encountered/represented groups in the service area. In addition, the American Psychological Association (APA) publishes *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*. These guidelines provide a sociocultural framework to better aid the mental health professional in considering culture in his/her interactions with diverse populations and, additionally, offer suggestions on how to interface with various groups (APA, 1990). They can be obtained from http://www.apa.org/pi/oema/resources/policy/provider-guidelines.aspx. Georgetown University's

Center for Child and Human Development (n.d.) maintains a National Center for Cultural Competence website that houses a plethora of resources and tools, including publications and promising practices. The material is available in both English and Spanish, and can be accessed from the following link: http://www11.georgetown.edu/research/gucchd/nccc/.

Cultural competence is more than ethnicity, race, or language issues and the specialized training required of providers of mental health services in Tennessee encompasses the broadness of the topic. Network providers that render behavioral health services for Managed Care Organizations (MCOs) must provide specialized training in cultural competence and diversity to all staff, licensed as well as staff for whom a license is not required. Cultural competence training may emphasize eye contact, health values, help-seeking behaviors, work ethics, spiritual values, attitudes regarding treatment of mental illness and substance abuse, language, dress, traditions, notions of modesty, concepts of status, and/or issues of personal boundaries and privacy. Staff training should occur within the first 90 days of employment initially, a requirement that can be met either through training or assessment of competency. Thereafter, this specialized training should be documented annually (TDMHSAS and Bureau of TennCare, 2010).

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TDMHSAS BEST PRACTICE GUIDELINES

Bibliotherapy

A section on bibliotherapy may be included in the main body of text for some disorders. Bibliotherapy involves the use of books to help children and adolescents and/or their parents/caregivers better cope with various mental disorders. The books and/or other audio or visual aids are designed to:

- give information.
- provide insight.
- stimulate conversation about problems.
- communicate new attitudes and values.
- create awareness that other children and adolescents have similar problems.
- offer realistic solutions to problems (Hayati, 2003).

Perhaps the most significant benefit of bibliotherapy for youth is the way it helps them realize that they are not alone. Other young people may suffer from the same mental disorder. Some disorders have more resources than others. In some cases, parents/caregivers are the target audience.

Bibliotherapy is useful only if people are ready to receive and read the available material. It serves solely as an adjunct to therapy and should not replace therapeutic interventions, including medications. In the current time, bibliotherapy more likely includes material presented in interactive and/or digital formats, such as web-based videos. Regardless the medium, the purpose of these materials remains consistent with those delineated by Hayati (2003).

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TDMHSAS Programs Serving Children and Adolescents and/or Their Families

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TDMHSAS BEST PRACTICE PROGRAMS

Substance Abuse Treatment Services for Adolescents

The Division of Substance Abuse Services (DSAS) funds two ***Adolescent Outpatient*** programs. These are nonresidential services provided a minimum of once a week and may include group therapy as well as individual therapy. There are nine ***Adolescent Day/Evening Treatment*** program*s* funded. The services provided include group and individual as well as family therapy.

Substance Abuse Prevention Services

DSAS funds the ***Tennessee Prevention Network***, a statewide prevention program that provides evidence based primary prevention services to high risk individuals. DSAS also funds the ***Comprehensive Alcohol, Tobacco, and other Drug Prevention Services for Youth,*** a prevention program consisting of structured, intensive group sessions targeting youth who may be at risk for developing alcohol, tobacco, or other drug (ATOD) use and abuse problems. The ***School Based Liaisons for At-Risk Youth*** program provides face-to-face consultation with classroom teachers to assist them in structuring the classroom to enhance the learning environment for children with Serious Emotional Disturbance (SED), behavior problems, or Substance Use and Abuse Disorders (SUAD). ***Nurses for Newborns*** is an in-home visitation service provided to at-risk mothers and babies to reduce the use and misuse of tobacco, alcohol, and other substances and to increase the early identification and management of maternal depression.

Building Strong Families in Rural Tennessee (BSF)

Building Strong Families in Rural Tennessee (BSF) is a grant project designed to continue addressing the complex needs of *children (ages 0-18) who are in or at-risk of out-of-home placement due to parent/caretaker methamphetamine or other substance abuse*. It operates through TDMHSAS as lead agency in partnership with the Tennessee's Department of Children's Services; Administrative Office of the Courts; Centerstone of Tennessee; and Centerstone Research Institute. BSF continues to implement a trauma-informed, culturally competent continuum of outreach, treatment, education/counseling, and supportive services for children and families utilizing all components of an evidence-based, high fidelity Intensive Family Preservation Services (IFPS) model.

For FFY 2013 and 2014, BSF will serve an additional 80 families total in eight rural Tennessee counties: *Bedford*, *Cannon, Coffee, Franklin, Grundy, Lincoln, Moore,* and *Warren*. The project supports at-risk families by providing services that reduce the need for out-of-home placement and promote child safety, permanency, and wellbeing. Through a collaborative effort of agencies and organizations, integrated services and enhanced continuity of care will continue providing families with interventions that build skills and capacities contributing to healthy, well functioning families. BSF further provides linkages with social/community support services, including substance abuse treatment programs/recovery supports. BSF In-home Specialists are available 24/7 to provide crisis intervention and intensive services to keep children out of harm's way. BSF collaborative councils, representing all project partners, local service agencies, government agencies and funding stream representatives, individuals in recovery, parents/caretakers, and other community stakeholders, will continue to work toward sustainability of the project.

BSF has been funded since FFY 2007 *through the United States Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant # 90CU0051.*

Early Childhood Services

The ***Child Care Consultation*** program provides mental health training and technical assistance services through a series of four training workshops*:* 1) Social-Emotional Development in Young Children; 2) Classroom Strategies for Promoting the Social-Emotional Competencies of Young Children**.** ***Project B.A.S.I.C. (Better Attitudes and Skills in Children)*** is a school-based, mental health prevention and early intervention service that focuses on the promotion of mental health in children in the earliest school grades plus the identification, assessment, and referral of children with Serious Emotional Disturbances (SED). ***Renewal House*** provides early intervention and prevention services to children at risk of serious emotional disturbances or substance abuse, who reside at Renewal House with their parent. The ***Regional Intervention Program (RIP)*** is an internationally recognized parent implemented program in which parents learn to work directly with their own children. Experienced RIP parents provide training and support to newly enrolled families. RIP is designed for the early treatment of children up to age 6 years who have moderate to severe behavior disorders. This is a parent-implemented program supported by a small professional and paraprofessional staff. Parents serve as primary teachers and behavior change agents for their own child as well as daily operators of the overall program.

Education, Training and Anti-Stigma Efforts

The Office of Children and Youth oversees the *Child and Family Education Program*, based on the With Hope in Mind program, providing free classes for caregivers about brain biology and specific brain disorders such as Attention Deficit Disorder (ADD)/Hyperactivity Disorder (ADHD) and learn coping skills, such as communication, self-care, problem management, advocacy, and organization and record keeping. *Erase the Stigma (IC HOPE)* is a mental health awareness curriculum for youth to promote understanding of mental illness and to reduce the stigma associated with mental illness. *Violence and Bullying Prevention* is a violence prevention and resiliency enhancement program designed for youth in grades four through eight.

Family Support Services

DMHSAS funds a variety of programs and supportive services for families of children with mental health needs. The ***Emotional Fitness Centers program*** is a faith-based initiative in Memphis and Shelby County that provides funding for Peer Advocate Liaisons (PALS) in churches in underserved African-American communities to assist parishioners in identifying behavioral health needs and helping to successfully navigate the behavioral health system with the goal of increasing utilization of mental health and substance abuse services. OCY also oversees the ***Family Support and Advocacy Program***, which funds Tennessee Voices for Children's Statewide Family Support Network, a comprehensive family advocacy, outreach, support, and referral service provided statewide. This service also provides information and training to lay and professional groups. The ***Office of Consumer Affairs (OCA) Ombudsman Program*** offers direct assistance to individuals who are experiencing problems accessing mental health services and supports through Consumer Advocates. OCY oversees the ***Family Support Specialist (FSS) Certification***, which provides state certification for individuals who provide direct caregiver-to-caregiver support services to families of children and youth with emotional, behavioral, or co-occurring disorders. The ***Building Strong Families in Rural Tennessee (BSF)*** extension grant and new ***Therapeutic Intervention, Education & Skills*** (***TIES***) grant provide intensive in-home services (using high fidelity Intensive Family Preservation Services) to families of children, ages birth to eighteen, who are currently in or at-risk of out-of-home placement as a result of a parent's or caregiver's substance use in select counties in rural and urban Middle Tennessee. ***The Tennessee Integrated Court Screening and Referral Project,*** a collaboration between the Office of Forensic and Juvenile Court Services and the Administrative Office of the Courts (see Forensic Services, below), includes placing certified Family Support Providers in four juvenile courts to assist youth in legal trouble and their families in gaining access to mental health, substance abuse and family services.

Forensic Services

The Office of Forensic and Juvenile Court Services provides comprehensive mental health evaluations on forensic issues ordered by juvenile courts on youth alleged to be delinquent, and is collaborating with the Administrative Office of the Courts, Vanderbilt University COE, TCCY, DCS and TVC on a federal grant to train Youth Service Officers to complete mental health and substance abuse screening for youth in juvenile courts.

Housing and Homeless Services

The *Homeless Outreach Project* identifies children and youth with SED and their families who are homeless or at risk of homelessness and provides short-term services that links them to more permanent housing as well as mainstream case management, mental health treatment and/or other social services or removes the threat of homelessness.

Mobile Crisis Services

Mobile Crisis is a community-based service that offers twenty-four hours per day, seven days per week toll-free telephone triage and intervention as needed, face-to-face services including prevention, triage, intervention, community screenings by a mandatory prescreening agent, evaluation and referral for additional services and treatment, stabilization of symptoms, mobile services to wherever the crisis is occurring in the community whenever possible and follow-up services for a behavioral health illness, a crisis situation, or a perception of a crisis situation for children and youth under the age of 18 years old.

Respite Services

Planned Respite provides respite consultants in eight regional sites across the state who provide direct respite for caregivers by taking the child out for respite outings. They also train parents in how to access or develop ongoing respite resources, including knowledge of techniques for better managing their child's behaviors. The *Respite Voucher Program* provides respite vouchers in each of the seven mental health planning regions for families whose children have SED or developmental disabilities.

Suicide Prevention Services

Project Tennessee (fka Jason Foundation) is an intensive two-hour curriculum that provides education for teachers, students and parents about the signs of suicide and gives them the tools and resources needed to identify at-risk youth. *Mental Health 101 (MH 101)* is an educational program for youth in middle and high schools in 18 eastern and middle Tennessee counties. The *TeenScreen* program is a national, evidence-based mental health and suicide risk-screening program for youth. The purpose of the program is to ensure that all parents are offered the opportunity for their teens to receive a voluntary mental health check-up at their school. *Tennessee Lives Count (TLC) Project* is a statewide youth early prevention and intervention program to reduce suicides and suicide attempts for youth and young adults ages ten to twenty four years through statewide Gatekeeper training. The *Tennessee Suicide Prevention Network (TSPN)* is a statewide coalition of agencies, advocates and individuals who oversee the implementation of strategies to eliminate/reduce the incidence of suicide across the life span, to reduce the stigma of seeking help for mental health disorders, and to educate communities throughout the state about suicide intervention and prevention strategies.

System of Care Initiatives

The ***system of care model*** is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance (SED) and their families. ***Systems of Care (SOC)*** engage families and youth in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life. The Office of Children and Youth oversees four federally funded ***System of Care*** initiatives in eight counties across the state. DMHSAS is also responsible for partnering with the Council on Children's Mental Health (CCMH) to develop a strategic plan for statewide System of Care expansion.

Therapeutic Intervention, Education and Skills (TIES)

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) was awarded a new grant from *the United States Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant # 90CU0069* to address the complex needs of children (age 0-17) who are in or at-risk of out-of-home placement due to parent/caretaker substance abuse. TDMHSAS partnered with the Tennessee Department of Children's Services (TDCS); Centerstone of Tennessee; and Centerstone Research Institute (CRI) to establish and implement an evidence-based, trauma-informed, culturally competent continuum of outreach, treatments, education/ counseling, and supportive services for children and families utilizing all components of a high fidelity Intensive Family Preservation Services (IFPS) program in conjunction with *Seeking Safety*, as appropriate, for participants with a history of trauma. ***TIES*** will serve at least 300 ethnically/culturally diverse families over a five-year period in seven to eight Middle Tennessee counties. Rural and urban counties will be targeted. The project will bridge a significant gap in locally available family treatment services.

TIES will integrate project staff into existing behavioral health teams in the target area, ensuring integrated services and enhancing continuity of care for participating families. Using a high fidelity IFPS model, with *Seeking Safety* as appropriate, ***TIES*** will support at-risk families by providing services that reduce the need for out-of-home placement and promote child safety, permanency, and well-being. Through a collaborative effort of agencies and organizations, families will be provided with interventions that build skills and capacities contributing to healthy, well functioning families. ***TIES*** will provide in-home counseling, basic skills education, psychosocial education, and linkages with social/community services. Program staff will link parents/caretakers with substance abuse treatment programs/recovery supports and ensure access to needed services. ***TIES*** Therapists will be available 24/7 to provide crisis intervention and intensive services to keep children out of harm's way. In addition, ***TIES*** will establish a Steering Committee with representation from all grant partners as well as local service agencies, government agency and funding stream representatives, individuals in recovery, parents/caretakers, and other community stakeholders that will work to ensure sustainability of the project. ***TIES*** will evaluate project strategies and models and conduct comprehensive project performance measurement, including documentation of fidelity, process, outcomes, cost effectiveness, and follow-up data, and will develop and disseminate a thoroughly documented service model for replication across the state and nation.

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APPENDICES

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APPENDIX A

Council on Children’s Mental Health

Appendix A
Interagency Systems of Care for Children's Mental Health
(Council on Children's Mental Health)

Workgroup Members*:* **Dustin Keller, LPC-MHSP, Tennessee Commission on Children and Youth (TCCY) – Chairperson; Susan Steckel, LMSW, TDMHSAS – Co-Chairperson; Lindsay Myers, MA, Helen Ross McNabb Center; Michelle Covington, MA, Centerstone of Tennessee; Jeff Gray, LPC-MHSP, Pathways; Katherine Williams, BSW, MA, Centerstone of Tennessee; and Dana Casey, LAPSW, Amerigroup Real Solutions.** ***(*This group reviewed the section in the 2007 guidelines and updated where necessary.)***

All children function within multiple systems, usually including their families, schools, communities, and primary health care. Children experiencing emotional and behavioral problems require services from additional systems such as mental health, substance abuse, special education, intellectual and developmental disabilities, child welfare, or juvenile justice. Care is optimal when systems are organized to coordinate and integrate these services. Coordination of services is essential for all children involved with more than one system, but is even more important for the children and adolescents with multiple agency involvement, whose care has historically been uncoordinated and fragmented. The community-based System of Care (SOC) philosophy is designed to address these needs. It emphasizes an individualized and flexible approach striving to coordinate and integrate care and provide services in the child's home and community whenever possible.

This practice parameter was written to reflect these paradigms and approaches inherent SOC philosophy. It serves as an overarching set of principles and practices that are broadly applicable to community-based practice. It is not intended to duplicate other practice parameters on assessment and treatment, and will therefore emphasize aspects of clinical practice particularly important in SOC. It is also not intended to duplicate parameters on specific areas of community-based practice, such as treatment of specific populations of children in the community (e.g., children in foster care), or mental health services in specific settings (e.g., school-based consultation; mental health in juvenile justice settings). Instead, it focuses on practices recommended across all populations and settings.

This parameter addresses community mental health care in SOC at three levels: (1) independently practicing child and adolescent psychiatrists and other mental health clinicians who apply SOC principles; (2) mental health care delivered in community settings such as community mental health agencies, school-based mental health programs or other educational settings (e.g., Head Start programs), juvenile justice facilities, child welfare settings (e.g., therapeutic foster homes), or primary health settings; and (3) mental health care delivered in an organized "system of care" containing structural elements supporting integration and coordination of services, flexible funding, and wraparound planning processes. These organized systems of care facilitate individualized services such as intensive home- or community-based interventions. Community-based practice may also include administrative consultation to local and state health and social service organizations.

Recommendations

Recommendation 1. Clinical assessment and treatment approaches should be guided by an understanding of the ecological context of the child and family, incorporating information from community systems (formal and informal) with which they are involved.

The child and adolescent psychiatric assessment as applied in a clinic or office practice focuses on the child, his/her nuclear family, and his/her functioning at home, in school, and with peers. The assessment yields a diagnosis and target symptoms and behaviors to be addressed by the treating clinician. Assessment should be expanded for children with serious emotional and behavioral disorders served in community systems of care, who may already be involved with multiple agencies and treatment settings. Their families typically face multiple stressors and may encounter barriers in accessing treatment. The assessment process should incorporate a broad social ecological framework, taking into account a multiplicity of environmental and systems factors (Henggeler et al., 2001; Pumariega & Winters, 2003b; Woolston et al., 1998).

The social ecological perspective conceptualizes human development as a reciprocal interchange between the individual and “nested concentric structures” mutually influencing one another (Bronfenbrenner, 1979). The individual is embedded within interconnected systems, including the family system (and the extended family) and the extrafamilial systems, such as school, work, peers, and primary health care, and the larger community and cultural institutions that are part of the child and family’s life experience, such as religious institutions. Systemic issues (e.g., legal, social, or financial) impacting care are also part of the child’s ecological system.

Ecologically targeted interventions may include addressing barriers to care (e.g., home-based services or transportation to appointments) or accessing strengths and resources in the child’s natural environment that can promote positive change. For example, identification of a helpful adult who is already present in the child’s natural environment and might become a formal mentor or provide part-time employment can be a potent intervention. Since children are involved in many systems, it is also essential that adequate time be allotted in the evaluative process to gather ancillary data and communicate with other providers, in addition to having adequate time to interview the child and family.

Recommendation 2. The clinician should develop collaborative relationships with families, emphasizing partnerships at both the case planning and system planning level.

One of the most important contributions in the past two decades of system reform has been the growth of the family and movements that focus on users of services. In systems of care, families are included as partners in all levels of the system, including leadership roles in system design. Family advocacy organizations have taken a leadership role in mental health advocacy, system planning, quality improvement, program evaluation, parent education, and development of parent mentoring programs (Friesen and Stephens, 1998). The development of partnerships with families has been associated with a shift from conceptualizing the family as the source of (or significant contributor to) the child’s pathology, to collaborating with parents, other family members, and parent advocates as partners in treatment. The parents' knowledge of their child, family, and culture is seen as equal in importance to the clinicians' knowledge of child development and psychopathology.

Recognition and support of the child and family's strengths allows for development of effective child and family teams in which parents can assume the natural functions of case management and self-advocacy. The family drives the team process by defining the desired outcomes and selecting individuals to add to the team. The team's function is to help identify how best to support the needs of the child and family. The child and family team should promote a climate of collaboration, respect, and trust. Family-centered approaches have been recognized as improving the quality of care and contributing to increased satisfaction of the service recipient (Friesen and Stephens, 1998). An example was a parent with several special-needs children who was spending her entire week at appointments recommended by multiple providers who had never communicated with one another. On noting repeated missed appointments, one of the clinicians suggested convening a child and family team meeting. At the meeting, the parent's accomplishments in caring for her children were acknowledged. She was able to share the burden of this situation and felt supported in her requests that the number of appointments be reduced.

Recommendation 3. Mental health interventions should be actively coordinated with services by other providers, including primary care providers, and, whenever possible, integrated with interventions provided by other social agencies.

Mental health is one of six components in systems of care for children, in addition to primary health care, education (including Early Intervention services and special education), child welfare, juvenile justice, and developmental disabilities. In addition, in most communities, chemical dependency and substance abuse services reside in a separate agency. Most children are involved with more than one provider or agency, most often primary health care and regular education, and issues of coordination begin to apply even at this level. Children with complex needs are generally served by multiple agencies and without active coordination of care; these children are at risk of receiving fragmented care that fails to address their overall needs.

Service coordination and integration can occur at the case, program, and larger system level. The clinician should actively promote coordination and integration of services at each of these levels. At the case level the clinician is most effective when collaborating with other providers to make strategic use of available services and ensure that care is coordinated. For example, the clinician can collaborate with the Early Intervention specialist to advocate for child welfare-funded respite services to help the parents keep the child in the home. The clinician may also advocate for mental health services to be integrated into the classroom setting for a particular child. The clinician can facilitate consistency of communication across providers by attending child and family team meetings, either in person or by video/teleconferencing, providing information about diagnosis and treatment options to the team, and serving as a liaison to the child's primary care provider.

At the system level, the clinician can promote integration and collaboration by advocating for interagency structures and agreements, which may include sitting on an interagency collaborative council. Facilitating collaboration within an agency is also important. Such activities are enhanced by familiarity with the philosophies, mandates, and financial and organizational structures of the different child-serving agencies. These characteristics impact the agency's ability to collaborate at the clinical and system level. Availability to provide mental health consultation to primary care providers is another critical element in promoting collaboration and integration of care.

There is growing evidence for effectiveness of integrated mental health services delivered in settings such as schools, juvenile justice settings, and early childhood programs such as Head Start (Porter et al., 2003; Heffron et al., 2003). Clinicians may advocate for service integration and be available to consult in these settings. Not infrequently, it is difficult to get funding for these activities. In such cases, clinicians may actively advocate for and explore opportunities for funding interagency activity as a way to increase the effectiveness of their role. Child and adolescent psychiatrists can be important consultants in these settings for diagnostic and treatment purposes. It may be necessary to join with other professionals in the community to establish the importance of child and adolescent psychiatry's role in these activities.

Increased service integration presents both opportunities and challenges in the area of patient information and confidentiality. Information sharing across service providers in the case of a multiagency-involved youth is essential to effective service coordination. Organized systems of care have the potential to create informational databases that can be readily accessed in crisis situations. However, increased information sharing requires a heightened sensitivity that these are privileged documents, and the clinician should participate in safeguarding them against potential misuse. The clinician must also comply with state confidentiality requirements (which may vary across states) and the federal Health Insurance Portability and Accountability Act (HIPAA).

Recommendation 4. Services should be culturally competent and should address the needs of underserved, culturally diverse, at-risk populations.

More than 40 percent of all children and youth in the United States are from diverse, non-European racial and ethnic backgrounds, and this figure is expected to rise to more than 50 percent by the year 2030. Children and youth from non-European backgrounds and their families face many disadvantages, including socioeconomic and educational disparities, language barriers, social discrimination, and lesser opportunities. Their cultures are distinctly different from those of European origins, with different beliefs, values, normative expectations for development and adaptive behaviors, parenting practices, relationship and family patterns, symptomatic expressions of distress, and explanations of mental illness (Pumariega, 2003). Because of these differences, culturally diverse children and their families have many specific mental health needs relevant to assessment, treatment approaches and modalities, and support services. Unfortunately, the failure to meet such needs has contributed to increasing mental health disparities in these already vulnerable populations. Studies support the presence of significant racial and ethnic disparities in a number of areas relating to children's mental health, including access to community-based services, accurate diagnostic assessment, access to evidence-based interventions, increasing rates of various forms of psychopathology in some populations, and significantly higher rates of out-of-home placements and institutionalization (particularly in child welfare and juvenile justice) (U.S. Department of Health and Human Services, 2001; Pumariega, 2003). In addition, there is evidence of subtle differences in the metabolism of psychopharmacological agents in diverse populations, related to both genetic and environmental (e.g., dietary) factors (U.S. Department of Health and Human Services, 1999).

Children's mental health services should be provided within the cultural competence model. This model indicates the need to address the special mental health needs of diverse populations through both clinician-related factors (such as acquiring knowledge, skills, and attitudes that enable them to serve populations different from their own) and system factors (such as reviewing and changing policies and practices that present barriers to diverse populations, staff training around cultural competence, and the recruitment of diverse staff and clinicians for planning service pathways and delivering care). This model also calls for the use of natural strengths and resources in diverse communities and cultures that are protective and support children and families dealing with emotional disturbance. It also includes the adoption of evidence-based culturally specific therapeutic modalities (such as use of native healers or cultural mediators), ethnopsychopharmacology practices, and the appropriate use of language interpreters (Pumariega, 2003).

The cultural competence model has been operationalized in consensus health and mental health cultural competence standards, such as the CMHS standards (CMHS, 1999), the Office of Minority Health (2001) Cultural and Linguistic Standards, and state-specific standards such as the state of California Cultural Competence Standards (1997). These standards address cultural adaptations and modifications in clinical processes (such as assessment, treatment planning, case management, and linguistic support) and system processes (such as staff training and development, access protocols, governance of service systems, quality assurance and improvement, and information management). There is beginning evidence that adopting such practices results in improved access to services and retention in treatment (Pumariega et al., in press).

Recommendation 5. To achieve individualization of care for children with significant mental health needs, clinicians may use a wraparound planning process

Wraparound is an integrated planning process that knits together services from all involved providers to address the strengths and needs of the child and family. It is an essential tool in the system-of-care model. The wraparound process should be guided by a comprehensive clinical assessment specifically addressing diagnostic and treatment issues (Solnit et al., 1997). The wraparound process as formally defined is most effectively applied in an organized system of care in which the focus of service planning is the child and family team with an assigned facilitator, and in which providers are encouraged to devote time to attending interagency meetings.

Even in less developed or organized systems, however, elements and principles of the wraparound process can be incorporated. For example, use of a strength-based orientation and discussion of needs rather than problems promotes more active engagement of families in service planning activities. Team members can think strategically about how to use system resources most effectively to meet the individual child and family’s needs. The complementary contributions of various team members can work synergistically to promote better outcomes.

Interventions should be designed to reinforce strengths of the child and family. For example, a youth at risk for substance abuse might receive funding for prosocial activities such as lessons in horseback riding or a health club membership to decrease the risk of association with substance-using peers. Strength-based approaches may include nontraditional therapies such as skills training or mentored work experiences that remediate or offset deficits. For example, a youth might be given a mentored job experience in a family restaurant where the restaurant owners’ adult son can coach him on developing more positive social behaviors. These interventions generally are not included in traditional categorical mental health funding and may require flexible funds that are not assigned to specific service types.

Through providing a balance of formal services and natural supports, wraparound plans can build a level of service intensity rivaling that of inpatient or residential settings, without removing a child from the home. A number of studies of the wraparound process in different communities with diverse populations of at-risk children and families have reported positive outcomes in terms of reduction of externalizing behavioral problems, level of function, reduction in out-of-home placement, improved family management skills and function, and service recipient/family satisfaction (Burchard et al., 2002; Kamradt and Meyers, 1999). The wraparound process is best suited for children and their families with complex mental health and related needs who have not benefited from traditional services.

Recommendation 6. Treatment planning in systems of care should incorporate effective interventions supported by the available evidence base.

Wraparound as a process alone may not be effective if the specific interventions themselves are not effective or if the skills and training of clinicians providing care are not adequate. Therefore, interventions with the strongest evidence base should be prioritized in clinical and systems planning. Evidence-based interventions such as cognitive-behavioral and other therapies for specific disorders should be incorporated (McClellan and Werry, 2003; AACAP, 2007), as well as evidence-based community-based interventions (Burns and Hoagwood, 2002).

One of the most evidence-based community-based interventions is multisystemic therapy (MST), an intensive, home-based wraparound model that combines a variety of individual and family interventions within a systemic context. MST has been evaluated with youth at risk of detention/incarceration and at risk of psychiatric or substance abuse hospitalization, with significant results in reducing out-of-home placement, reducing externalizing problem behaviors, reducing rates of recidivism, and lowering costs of treatment (Henggeler et al., 2001; Henggeler et al., 2003). Surgeon General Reports on mental health (1999) and on youth violence (2001), in addition to the President's New Freedom Commission, point to research evidence supporting the effectiveness of a number of other community-based interventions for children and youth such as intensive case management, therapeutic foster care, partial hospitalization, and intensive in-home interventions. Other community-based interventions that show promise include school-based interventions, mentoring programs, family education and support, crisis mobile outreach teams, culturally appropriate family support services, and time-limited hospitalization with coordinated community services (U.S. Department of Health and Human Services, 1999; Burns and Hoagwood, 2002; Rogers, 2003).

Recommendation 7. An interdisciplinary approach should be nurtured in systems of care programs, with all treatment being delivered in such a context. This includes both clear definitions of disciplinary roles and contributions as well as flexibility in these when necessary for the best outcomes for children and families.

a) Child and Adolescent Psychiatrists: Child and adolescent psychiatrist may function in multiple roles in a system of care, including assessment, triage, direct service provision (psychosocial therapies as well as pharmacotherapy), consultation to other service providers, quality improvement, program design and evaluation, and advocacy.

Child and adolescent psychiatrists have broad training in child development, biopsychosocial psychiatric assessment, psychosocial and pharmacological treatment modalities, risk assessment and crisis intervention, and systems/organizational processes. Consequently, there are many possible roles in systems of care in which these skills can contribute to the quality of care delivered. Potential roles for child and adolescent psychiatrists include not only direct service provision (e.g., biopsychosocial assessments, triage, level or intensity of care determinations, and provision of ongoing treatment), but also agency- or system-enhancing activities (e.g., facilitating team building and interagency collaboration, participation in wraparound child and family teams, staff training, program development, medical leadership, and involvement in quality improvement and outcomes monitoring).

Often dilemmas arise around agencies' need for physicians to prescribe medications for a large population of children, at times attenuating opportunities for other roles that are equally important to the provision of quality care (e.g., consultation to primary therapists, collaboration with teams, and contributing to program development and evaluation). It is important in such situations for physicians to explore mechanisms to broaden their involvement and add additional value to the agency processes. Examples might include training and consultation to other clinicians to improve intake and triage operations, supervising other medical professionals to expand the medical resource, assisting the agency or program in selecting the most appropriate evidence-based interventions for the population, and using telemedicine or videoconferencing to increase opportunities for participation in team processes. Physicians should advocate for funding for attending interdisciplinary meetings, especially for children with complex psychiatric and medical issues. This may include advocating with insurance companies.

The child and adolescent psychiatrist may be a consultant, staff psychiatrist, or medical director in a variety of agencies, including governmental, private not-for-profit, public health, university, etc. It is important for the physician to advocate to be included in clinical and system planning meetings as part of the role when negotiating a position in a mental health or other child-serving agency. The role of the child and adolescent psychiatrist also includes advocacy at the community level through involvement in planning groups, professional advocacy organizations, publications or other contact with the media, and political advocacy.

b) Child psychologists
c) Master's level therapists
d) General psychiatrists
e) Nurse Practitioners
f) Primary care physicians
g) Bachelors' level clinicians

Recommendation 8. Pharmacotherapy should be performed by a physician or medical practitioner who is integrated in the interdisciplinary process and has completed a biopsychosocial assessment, including interviewing the child and his/her parent or caregiver and reviewing relevant ancillary data.

Growing awareness of the potential benefits of pharmacotherapy for children and adolescents has led to increased emphasis on the psychopharmacological role of the child and adolescent psychiatrist in community systems of care. This role is an important one, especially as newer and potentially more effective pharmacological agents continue to emerge. However, the biopsychosocial knowledge and skills of the child and adolescent psychiatrist are used most effectively as an integral part of the ongoing assessment and treatment planning process. Ongoing management may be provided by the child and adolescent psychiatrist, or the child and adolescent psychiatrist may function as a consultant. Systems of care should promote the full integration of prescribing practitioners into interdisciplinary teams and integrate pharmacological therapies into children's wraparound plans. This should include systematic assessment of target symptoms, behaviors, function, and adverse effects by the whole team (including both synergistic and interfering side effects and such issues as optimal administration and dosing schedules). The team should also participate in the assessment of the efficacy of medications and interactions between pharmacotherapy and other treatment modalities and strength-based activities. Pharmacotherapy in systems of care should focus on functional improvement as well as on symptomatic relief. It should also include collaboration and psychiatric consultation around medication management with other prescribing medical professionals (Pumariega & Fallon, 2003).

It is important that practitioners of pharmacotherapy not practice in isolation from the rest of the treatment team and treatment planning process. Practicing in isolation runs counter to system-of-care principles and does not support coordination and integration of care. Constraints are frequently placed on the implementation of appropriate standards of practice, such as access to comprehensive psychiatric evaluation and adequate frequency and duration of medication management follow-up. Additionally, prescribing physicians may not have access to the inherent resources of system-of-care programs to inform pharmacological decision-making (such as multiple informants to evaluate the child's symptom patterns and function in different contexts, and child and family education and support for treatment adherence). Lack of adequate contact of the children and families with the prescribing physician or medical practitioner often leads to children and families feeling uninformed, disempowered, and mistrustful of pharmacological therapies (Pumariega & Fallon, 2003).

Prescribing physicians in systems of care should promote clinical standards for effective pharmacological therapy, including the use of evidence-based systematic assessment and symptom-rating tools and the use of evidence-based pharmacological interventions. They should become actively involved in quality assurance and improvement around pharmacological decision-making, practices, and therapies. They should also promote and implement training in psychopharmacotherapy for nonmedical mental health professionals and other child-serving professionals and staff in the system of care so as to better support the practice of psychopharmacotherapy and diminish stigma and distortion around this modality.

Prescribing physicians should promote the active involvement of children and families in pharmacological decision-making. This should be promoted through the physician's offering education about psychiatric disorders and pharmacotherapy, engagement around treatment selection, effective consent procedures that address perceived power differential and stigma, and engagement in the evaluation of efficacy and side effects so as to promote adherence. Informed consent must be obtained, ideally by the physician, but when this is not feasible at a minimum the physician should oversee the process and be available to answer questions of the parents or legal guardian. Attention should be given to cultural factors in pharmacotherapy, including consideration of ethnobiological factors, culturally appropriate decision-making and consent processes, and addressing issues of stigma and fears about the misuse of medications.

Recommendation 9. The clinician should be familiar with the organizational context of the agency or system in which he/she is working in order to advocate effectively for adequacy of resources and practices to meet the needs of children and families served.

The organizational culture and structure of a system of care or its component agencies largely influences and shapes the service delivery processes within the system of care, and the quality and effectiveness of such processes. These contextual factors determine the governance, funding mechanisms, resource allocation, accountability, communication, and quality assurance and improvement processes within such systems. Clinicians in systems of care should become familiar with agency and system administrative structures, mandates or contracted responsibilities, policies and procedures, and organizational culture. They should be able to evaluate the impact of system structure and function on clinical care processes and outcomes. They should also be familiar with quality assurance and improvement processes, including the evaluation of clinical and system outcomes and satisfaction of service recipients.

Clinicians should become involved in administrative and organizational processes as a means of advocacy for improved access and quality of care. As more emphasis is placed on fiscal and resource management during times of limited funding, there is an even greater need for effective advocacy for adequate resources to ensure necessary services for children and families as well as the maintenance of quality of care (Winters et al., 2003). Additionally, clinicians should be familiar with evidence-based community-based interventions and treatment modalities and advocate for their adoption within systems-of-care agencies and programs (Rogers, 2003).

Clinicians should participate in quality assurance and improvement processes and the evaluation of agency and systems outcomes (Friesen and Winters, 2003). As agencies and systems become larger and more complex, there is a danger of their becoming more impersonal and removed from the perspectives of clinicians as well as becoming less responsive to the children and families they serve and their local communities. Clinicians should advocate for local governance and accountability for agencies and systems of care as a means of balancing local community interests with corporate or governmental interests. They should also advocate for service recipient and family participation in governance and accountability processes (Vander Stoep et al., 2001).

Recommendation 10. The clinician and family share accountability for treatment success. The system of care should be accountable for clinical outcomes and actively involved in quality improvement efforts.

With increased societal demand for fiscal accountability, interest has grown in measuring outcomes for evaluation of individual mental health services and program effectiveness. Clinicians and health care administrators have also recognized that process is not by itself an adequate indicator of quality of care, and therefore clinical outcomes need to be measured. However, different stakeholders define desirable outcomes differently. Community systems of care for children or youth with serious emotional and behavioral disorders have many stakeholders, including the child, family, school, mental health or other service agency, primary health care provider, funding agency, etc. Local, state, and federal funding agencies are likely to prioritize cost and service utilization outcomes, whereas families are more likely to prioritize functional outcomes such as ability to function at home and at school and reduced family burden of illness (Friesen and Winters, 2003). Outcomes therefore need to be multidimensional. Several models have been presented as ways of conceptualizing different domains of outcomes that might be measured. Hoagwood et al. (1996) delineate five outcome domains: symptoms and diagnoses, functioning (i.e., the capacity to function within developmentally appropriate role expectations), service-recipient perspectives (e.g., satisfaction with care, family strain), environments (i.e., the stability of the child's environment), and systems (e.g., change in utilization of services, restrictiveness of services, overall cost).

The system-of-care model entails accountability of the system for outcomes, also recognizing that functional outcomes may be as important to families as symptomatic improvement. Traditional services (and clinical research) have most often addressed symptomatic improvement and underemphasized functional issues more salient for day-to-day family life. In community systems of care, children and families who do not believe they are benefiting from services may either drop out or not comply with treatment recommendations. In the past, poor outcomes were blamed on family resistance or noncompliance, and such families were dropped from treatment. In these circumstances the clinician should identify what needs to be done differently to meet the needs of the child and family. A child or family dropping out of service should trigger review of the treatment plan rather than discharge from care. Different strategies may include offering home-based services or offering more culturally competent services. Setting different target goals for treatment or shifting the focus to functional issues that are more important to the child's parents may be required.

It is incumbent on the system (and clinicians working within it) to collaborate with families in deciding what the desired outcomes should be and share accountability with them for those outcomes. Families and service recipients have taken a more active role in some systems of care in developing outcome measures and approaches to program evaluation (Vander Stoep et al., 2001). These measures may convey information that is more meaningful to families. To be valid, system- and child/family-level outcomes should be derived from the planning process (Rosenblatt et al., 1998) and must be measurable and collected systematically. Clinicians share with the agency and system of care responsibility to evaluate the effectiveness of services and programs through quality improvement processes and formal evaluation procedures. Use of evidence-based interventions is likely to result in better outcomes. The recent review of evidence-based practice in child and adolescent mental health services by Hoagwood et al. (2001) makes the point that interventions found to be efficacious in rigorous laboratory conditions may not be transportable to community settings. Thus, interventions need to be tested in community systems of care using research designs adapted to community practice settings. Selection of evidence-based, outcomes-driven treatment approaches will be increasingly important as the stewardship of public funds comes under greater scrutiny.

Recommendation 11. Services should be delivered in the most normative and least restrictive setting that is clinically appropriate. Children should have access to a continuum of care with assignment of level or intensity of care determined by clinically informed decision-making.

It is a widely held clinical and societal value that children and adolescents are best served in the most normative setting possible, to provide them with the experience of living in a family and being a productive member of a community. Data on the efficacy of restrictive levels of care (e.g., hospital, residential treatment) have been mixed (U.S. Department of Health and Human Services, 1999). Yet youth with serious emotional and behavioral disorders are frequently at risk for placement in restrictive levels of care, separating them from their families and communities. Too often residential and hospital services are used because of unavailability of adequate community-based outpatient services. There are promising community-based interventions (e.g., MST, day treatment, therapeutic foster care, and intensive wraparound services) that may stabilize at-risk youth and allow them to remain in the community.

Redefining “level of care” as “intensity of services” encourages use of individualized services such as in-home supports or therapeutic mentoring, as opposed to placement in a “bricks and mortar” program. Other ways to achieve intensive community-based services include increasing levels of service coordination, team collaboration, and cross-agency involvement. Children should have access to a full continuum of services, with level or intensity of care determined by clinically informed decision-making rather than arbitrary protocols or benefit limitations. Assignment of level of care or service intensity may be facilitated by use of functional and level-of-care assessment methods, e.g., Child and Adolescent Functional Assessment Scale (Hodges, 1994), Child and Adolescent Service Intensity Instrument (AACAP, 2004), or Child and Adolescent Needs and Strengths-Mental Health (Lyons et al., 1999).

There are some situations, however, in which these restrictive placements are necessary and should be available, such as acute suicidality or psychosis, violent behavior, or serious sex offending disorders requiring safety and containment (AACAP Policy Statement, 1989).

Recommendation 12. Families and youth served by community systems of care should be empowered not only to actively participate in their own service planning and implementation, but also to assume critical roles in the governance of such systems and in service delivery.

Roles for families and youth in treatment planning

There is a growing recognition that family members and the youths themselves are critical members of their own treatment teams. Family members hold true expertise on their own children and have a primary decision making role in treatment planning. As Burns, Hoagwood, and Mrazek have pointed out, “It is becoming increasingly clear that family engagement is a key component not only of participation in care, but also in the effective implementation of it.”(Burns, Hoagwood, and Mrazek, 1999).

The Federation of Families and the Center for Mental Health Services has adopted the following definition of Family-Driven Care:

> *Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This Includes:*
>
> - *choosing supports, services, and providers;*
> - *setting goals;*
> - *designing and implementing programs;*
> - *monitoring outcomes; and*
> - *determining the effectiveness of all efforts to promote the mental health and well-being of children and youth.*

Families should be respected as experts on their own children and enlisted as partners in the care of their children. Family involvement during all phases of service delivery, including participation on the service planning/ treatment team is required in order to have individualized services for youth (Wood, 2004).

There is a substantial amount of literature supporting parent involvement in service delivery. Increased parent involvement has been associated with treatment benefits including increased parental investment in their child's treatment and outcomes, improved parent self-esteem, more positive role modeling for children, greater parent-professional collaboration, an expanded array of interventions and available supports, reduced lengths of stays in treatment environments, shorter stays in residential treatment services, and positive program feedback and satisfaction from parents (Worthington, Hernandez, Friedman, Uzzell, 2001).

Within the system of care environment, the Child and Family Team concept has emerged as a model service planning/ treatment team. The Child and Family Team include the family, the relevant professionals, providers, agencies, and any individual significant to and supportive of the family. The family often has a trained advocate who has learned to navigate the system also involved with the planning and the team meetings. The parent advocate is also a parent of a child with a serious emotional disturbance. The Child and Family Team accept the family as the primary decision maker and involve the youth whenever age and developmentally appropriate. The team bases its planning on the strengths based assessment of the child and family and relies on the child and family to set their goals, identify their needs, as well as their criteria for success. Services address the needs of the entire family, promote the connections between family and community, are flexible and accessible to families, and provide opportunities for learning and skill building. Families are given the chance to solve their own problems.

Families have emerged as effective monitors of their own child's success as well as effective interviewers, data collectors and evaluators (Osher, deFur, Nava, Spencer, Toth-Dennis, 1998).

Roles of families and youth in organizational governance

Families and youth bring valuable and insightful experiences to organizational governance and policy development. Their experiences are critical to system design, operation and evaluation. Family members and youth as policy makers can describe to agency administrators and providers how policy decisions affect their every day lives. The families and youths can describe their criteria for success and the importance of specific outcomes in programs and services. At the very heart of self-governance, is the right of individuals to be a part of the decision making when the policies and decisions affect their lives. Family members are important members of Child-Serving Agencies Advisory and governance councils, Mental Health Boards, Managed Care Councils, Children's Cabinets, Quality Assurance Committees, Council on Children's Mental Health and Consumer and Family Satisfaction Committees.

Roles of families and youth as providers and researchers

Families and youth have learned how to effectively provide quality mental health services including filling roles such as service coordinators/case managers, facilitators, interviewers, data collectors, data analysts, monitors, trainers, skill builders, advocacy, support group facilitators, peer-to-peer mentors, and researchers. Family members bring not only professional skills but also family experience and commitment to their roles. Families and youth have been instrumental in assisting researchers in understanding the needs of families, the criteria they have for success, what outcomes are important to families, and how to ask the questions critical in gathering the data as well as interpreting the findings and outcomes.

Role of advocacy organizations

Advocacy organizations have provided strong leadership in the children's mental health field, addressed the needs of youth and their families, ensured their rights, ensured that children received needed services, provided needed information and engaged in advocacy regarding family voice and involvement, research, early intervention and prevention, family support, education, community based services, and the importance of coordinated, integrated systems of care.

National organizations such as the Federation of Families for Children's Mental Health, the National Alliance for the Mentally Ill and the National Mental Health Association have ensured that children's mental health remains a highly visible, national priority. The Federation of Families for Children's Mental Health and the Center for Mental Health Services has supported the development of statewide family support networks run by family organizations in every state. Family organizations have provided education and training for youth, families and providers, advocated for interagency coordination and collaboration, provided peer-to-peer mentoring, support groups, youth groups, and individual advocacy. The family run organizations have been instrumental in increasing family involvement in their own treatment planning, increasing parent/professional collaboration, and in increasing effective family friendly policy development at the local, regional, state and national levels.

Recommendation 13. Significant attention should be paid to transitions between levels of care, services, agencies, or systems to ensure that care is appropriate, emphasizing continuity of care.

Youth with serious emotional and behavioral disorders in community systems of care are likely to receive services from multiple agencies and require different levels of care at different times. Consequently, they are likely to have many transitions, including shifting between treatment settings, responsible agencies, and service systems related to age. At such times, gaps in treatment, breaks in continuity of care, and inadequate service coordination are likely to arise. Examples of such transitions include youth turning 18 and transitioning from the child mental health system to the adult system, children or youth transitioning from the hospital or residential treatment to the community, children transitioning from day treatment to outpatient care, youth leaving juvenile justice correctional institutions, and young children transitioning from Early Intervention or early special education to school age.

The system of care should provide sufficient support for level of care intensity to be able to deliver each needed level of care (see Table 4). These levels of care should be comprised of different continuum of care components (see Table 2), augmented by whatever flexible wrap-around services are necessary to maintain the child the closest to their community but within the necessary level of care intensity.

There is a need for programmatic and financial support during these transitions. For example, in transitioning from residential treatment back to outpatient services, there may be a break in services before a new clinician is assigned. In such cases, the residential treatment center should provide services and care coordination during the transition period and be proactive prior to discharge in setting up the outpatient plan. Another example is a youth entering a juvenile justice setting who may be losing needed mental health services and important clinical information unless there is adequate communication and opportunity for mental health treatment in that setting. It is also important to involve the school in the planning process before a youth leaves a treatment center. In all cases the parents and youth should be involved in decision-making around these transitions in care.

The system of care should prioritize continuity of care whenever possible if the intervention is working, including situations in which funding considerations may mandate a switch of providers. This is especially true for primary health care providers in which continuous relationships have health benefits. During transitions, continuity should be maintained through communication and information transmission, ongoing coordination of care, and continuing a particularly effective service during the transition period. For example, some systems will allow a child to continue seeing a longstanding individual therapist periodically during placement in residential treatment to avoid an interruption in that relationship.

Recommendation 14. Systems of care should incorporate prevention strategies in clinical practice and system design.

Prevention is a core concept in the system-of-care philosophy. The integration of mental health services into schools, child welfare, and juvenile justice settings provides early intervention opportunities for children and youth with early symptoms of mental health disorders. A specific area for prevention whose importance is being increasingly recognized is the early childhood population. Since many agencies are involved with young children, the system-of-care model is very suitable for this age group. Surprisingly, systems of care have not been extended to the 0-5 age group until recently (Knitzer, 1998). There are substantial data demonstrating benefits of early intervention on later development (Shonkoff and Phillips, 2000). Examples of successful preventive approaches include nurse home visiting (Olds et al., 1998), referral of a young child to Early Intervention services, advocacy for stable placement (Goldstein et al., 1996), supporting prenatal care, provision of mental health services to parents (Lieberman and Zeanah, 1995), and early mental health services for children at risk for psychiatric disturbance (Webster-Stratton et al., 2004).

Systems of care bear responsibility to assign some of their resources to prevention efforts. These may include such activities as providing mental health consultation to Head Start, Early Intervention, and other childcare settings; providing mental health services to adults whose children are at risk of out-of-home placement; and providing consultation to primary care settings. For mental health agencies to provide services to children who do not yet meet the full criteria for a mental health diagnosis, the state and local funding agencies need to adopt alternative eligibility criteria for services or have contractual agreements with other child-serving agencies that obviate the need for formal diagnosis. For young children who are already showing some early symptoms of disorder, use of the more age-appropriate Diagnostic System for Zero to Three (DC:0-3) (Zero to Three, 1994) is more likely to identify conditions making them eligible for services.

Clinicians can incorporate prevention efforts in their clinical practice through helping to identify vulnerable or at-risk young children (as well as older children and adolescents) that might benefit from preventive services. Examples of vulnerable populations include children experiencing violence or other trauma and children showing signs of depression or other mental health problems in the school setting. Clinical preventive efforts include addressing parent mental health issues and working closely with other providers such as primary care practitioners, child care providers, schools, and community health nurses. Clinicians should advocate in their system of care for appropriate resources to be assigned to prevention, including accommodations to allow eligibility for young at-risk children and enhanced interagency cooperation among the different child-serving agencies. Child and adolescent psychiatrists can play a role in educating professionals from other systems who may be in a position to engage in early identification and referral.

Scientific Data and Clinical Consensus

Best practice guidelines are strategies for patient management, developed to assist clinicians in psychiatric decision-making. These best practices Tennessee Best Practice Guidelines for Child Behavioral Health are based on evaluation of the scientific literature and relevant clinical consensus, and describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These guidelines are not intended to define the standard of care; nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his/her family, the diagnostic and treatment options available, and available resources.

Table 1: Key Components of Community-Based SOC's

Interdisciplinary teams
Child & Family Teams
Case management
Wrap-around approach to services
Family and youth advocacy
Flexible services and dollars
Array of community-based services
Evidence-based interventions
Use of natural community supports to enhance strengths
Focus on function over diagnosis

Table 2: Continuum of Child Mental Health Services

Crisis/observation beds
Intensive outpatient care
Respite services
Home-based services
Acute residential treatment
Outpatient clinic/services
School-based services
Therapeutic homes
Partial hospital/day programs
Therapeutic group homes
Mobile emergency services
Acute inpatient care
Outpatient crisis stabilization
Residential treatment
Rehabilitative services

Table 3: Evidence-Based Community-Based Interventions

Intensive Case Management
Wraparound Services
Therapeutic Foster Care
Multi-systemic Therapy
Partial hospitalization
Mobile Crisis Services
Mentor services
Family psychoeducation

Over 100 studies demonstrate improvement in: Externalizing, internalizing, family function, reduced restrictive services (inpatient, residential, emergency room visits, etc.)

Table 4: Levels of Care in Systems of Care (from CASII)

Level 0: Basic Services	This is a basic package of prevention and health maintenance services that are assumed to be available to all people in the community
Level 1: Recovery Maintenance and Health Management	This level of service is usually reserved for those stepping down from higher levels of care that need minimal system involvement to maintain their current level of function or need brief intervention to return to their previous level of functioning. Examples of this level of service are: children or adolescents who only need ongoing medication services for a chronic condition or brief crisis counseling.

Table 4: Levels of Care in Systems of Care (from CASII continued)

Level 2: Outpatient Services	This level of care most closely resembles traditional once a week visits.
Level 3: Intensive Outpatient Services	This level of service can range from a couple visits per week up to a few hours for three days per week and may include multiple services (e.g., big brother, church services, mental health services) necessitating coordination (case management).
Level 4: Intensive Integrated Service Without 24-Hour Medical Monitoring	This level of care best describes the increased intensity of services necessary for the "multi-system, multi-problem" child or adolescent requiring more extensive collaboration between the increased number of providers and agencies. A more elaborate Wraparound plan is also required, using an increased number of formal supports. Additional supports may include respite, homemaking services or paid mentors. In more traditional systems, this level of service is often provided in a day treatment or partial hospitalization setting. Active case management is essential at this level of care.
Level 5: Non-Secure, 24-Hour, Medically Monitored Services	Traditionally, this level of care has provided a safe residence and has including group home, foster care or a residential facility, but can also be provided by a tightly knit array of Wraparound services in the community.
Level 6: Secure, 24-Hours, Medically Managed Services	Most commonly, these services are provided in inpatient psychiatric settings or highly programmed residential facilities. If security needs can be met through the wraparound process, then this level of intensity of service could also be provided in a community setting. Case management remains essential to make sure that the time each child spends at this level of care is held to the minimum required for optimal care and that the transition to lower levels of care are smooth.

Brief History

National

Community child mental health has a long tradition dating back to the Child Guidance movement of the early 1900s. Despite a resurgence of interest in community mental health beginning with the Community Mental Health Centers Act of 1964, community-based services for children failed to materialize (Lourie, 2003). In 1969 the Joint Commission on Children's Mental Health (1969) found that too many children were receiving grossly inadequate and inappropriate mental health services. A study published by the Children's Defense Fund, *Unclaimed Children* (Knitzer, 1982), further documented that children with serious mental and emotional disorders were receiving care that was fragmented, uncoordinated, and largely ineffective, often in institutions far from their homes. These findings led to the establishment in 1984 of the Child and Adolescent Service System Program (CASSP) under the auspices of the National Institute of Mental Health.

CASSP promoted the development of service delivery through a system-of-care approach, defined as a comprehensive spectrum of mental health and other services and supports organized into a coordinated network to meet the diverse and changing needs of children and adolescents with severe emotional disorders and their families (Stroul and Friedman, 1986). CASSP outlined core values and guiding principles for a system of care that have served as a template for child community mental health system development across the nation. The major emphases of the CASSP principles are (1) individualized care that is tailored to the individual needs and preferences of the child and family, (2) family inclusion at every level of the clinical process and system development, (3) collaboration between different child-serving agencies and integration of services across agencies, (4) provision of culturally competent services, and (5) serving youth in their communities, or the least restrictive setting that meets their clinical needs. Community-based supports (e.g., respite, crisis shelter care, mentoring) are added to enable highly disturbed youth to remain with their families.

The SOC model for children's mental health required a change in service design and delivery. Several early demonstration projects were initiated to develop systems of care, including those in Ventura County in California (Attkisson et al., 1997) and Vermont (Bruns et al., 1995) and the continuum of care established by the Department of Defense CHAMPUS program at Fort Bragg, North Carolina. From 1990-1995 the Robert Wood Johnson Mental Health Services Program for Youth funded seven national demonstration programs. More recently, the Center for Mental Health Services (CMHS) Comprehensive Community Mental Health Services for Children and Their Families Program has funded more than 80 demonstration projects in diverse communities throughout the nation to implement systems of care. The goals of these programs have been to implement CASSP values, reduce out-of-home placements, reduce service fragmentation, and promote earlier mental health intervention to reduce functional morbidity. The goal of maintaining children in their communities has more recently been reinforced by rising mental health care costs, with the resulting priority of reducing utilization of highly restrictive and expensive services.

Although in the Fort Bragg study a randomly assigned system-of-care group showed clinical and functional outcomes similar to those of the traditional services group (Bickman et al., 1997), other system-of-care research has been more encouraging. A longitudinal study of the Vermont system of care concluded that the model was cost-effective and resulted in reduced rates of out-of-home placement (Santarcangelo et al., 1998). Outcomes of systems of care in three California counties were compared with those in three counties that had more traditional services. More positive outcomes were found in the system-of-care counties in the form of cost savings from reduced group home and foster care expenditures (Attkisson et al., 1997). Rosenblatt (1998) reviewed results of 20 community-based system-of-care studies, concluding that there were improvements in most domains assessed, including clinical status, cost, and use of restrictive placements. The system-of-care model appears to be beneficial for youth with severe emotional and behavioral disorders who are served in multiple systems and are at risk of being placed in restrictive settings.

Whereas child and adolescent psychiatry occupied a central role in the early community-oriented child guidance centers, later there was a shift to individual psychodynamic psychotherapy. Child and adolescent psychiatry has more recently reengaged itself as a discipline in community systems of care, providing an opportunity for a broader scope of child psychiatric practice. The current challenge facing child and adolescent psychiatry is to integrate its developing clinical and scientific knowledge and skills base into those systems and to integrate CASSP system-of-care values into the practice of child and adolescent psychiatry (Pumariega et al, 2003).

In 2003, the *President's New Freedom Commission on Mental Health* issued its report on transforming mental health care in America, reinforcing such SOC principles as family and youth partnerships, cultural and linguistic competence, individualized services, and early intervention. The report also introduced the application of a public health approach to children's systems of care. Also during this time, the federal Children's Bureau funded nine states and local communities to build systems of care for children, youth, and families involved in the child welfare system. The bureau has continued to fund state and local communities in building or expanding systems of care for children with severe persistent mental illness. Five years later, the bureau funded regional technical assistance centers to work intensively with states to reform child welfare systems through the application of SOC concepts.

Over time, system of care efforts have broadened to encompass not only children with serious emotional disorders, as originally envisioned by CASSP, but also other populations of children, youth, and families involved, or at risk for involvement, in multiple systems. The system of care concept has been increasingly embraced, not only by the children's mental health field, initiating the movement, but also by other systems, such as child welfare and adolescent substance abuse treatment, with national support from federal agencies and foundations.

State

The Tennessee Department of Mental Health and Substance Abuse Services has had substantial experience with development and implementation of federally funded System of Care grants including securing the required federal match of cash and in-kind resources, using the SOC core values and guiding principles to guide the initiative. Tennessee's experiences are summarized in the table below. Federally funded System of Care grants are typically awarded for a six-year grant cycle with the possibility of a seventh year no-cost extension if funding allows. The first full year of the grant cycle is considered a planning year for the Initiative to organize, hire and train staff, develop the local governance structure, etc. Typically sites do not begin serving children until well into the second year of funding. The federal expectation and understanding of the importance of system and sustainability planning and development for the demonstration sites also has relevance to the Council on Children's Mental Health efforts for System of Care across Tennessee (discussed in the next section).

SAMHSA-funded SOC grants require children and families served with federal dollars to meet the following eligibility criteria: 1) child/youth at-risk of placement to a higher level of care such as inpatient hospitalization, residential placement, or state custody; 2) child/youth with serious emotional disturbance (SED); 3) child/youth who have multiple system involvement; 4) caregivers willing to participate in child's service delivery team; and 5) child/youth lives within defined geographic areas served by the grant (i.e. specific county). Families are usually at or near the federal poverty level. The initiatives are structured to be replicated and sustainable with outcomes measured by SOC national and local evaluations. A common staffing model for Tennessee's SOC initiatives is also present in each system where a child and family are served by a community liaison/mental health specialist and a family support provider. Typically, the family support provider is a parent or caregiver of a child with a mental health disorder who has successfully navigated multiple child-serving systems (i.e. mental health, child welfare, juvenile justice) and has been trained and/or certified as a Family Support Specialist by TDMHSAS.

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
NASHVILLE CONNECTION Funding over 7 Years: $6.3M Federal $4.2 Match Provided**	Initiated: 1999 Ended: 2007	323	• Davidson County residents; • Children with SED age 5-18; • Global Assessment Function (GAF) of ≤ 50; • Multi-agency involvement; • Imminent risk of state custody or psychiatric hospitalization; • Most (69%) at or near poverty level; • One third w/ 4 or more family risk factors; • 40% of children w/ 2 diagnoses and 15% w/ 3 or more diagnoses; • 30% had previous psychiatric hospitalizations; • 50% of caregivers had mental illness or dual diagnosis.	• 97% of children remained in the community; • All demonstrated clinical improvement over time; • Decreased school absenteeism; • Decreased residential care and hospitalization; • Increased service coordination; • Improved grades; • Decreased suspensions; • When grant ended: (1) sustained and expanded MH-School Liaisons to rural East, Middle and West Tennessee through DMHSAS partnership with DOE; (2) sustained a piloted family support SOC-based program, "Family Connection" through DCS funding, local and state grants and single case agreements with MCOs.

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.

** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
Mule Town Family Network (now known as South Central System of Care (SCSC)) Funding Over 6 Years: $6.7M Federal $6.7M Match Required**	Initiated: 2005 Anticipated End Date: 2012	Target: 440 Served to Date: 414	• Maury County residents (under SCSC is now expanded to 12 counties that make up South Central DCS Region); • Birth-21 years of age; • SED diagnosis (includes but not limited to ADHD, OCD, bipolar, depression); • Multi-agency involvement; • 72% below poverty and 10% at or near poverty; • 44% have IEP; • 49% have witnessed domestic violence; • 66% have lived with someone who was depressed; • 13% have attempted suicide; • 70% of caregivers report a family history of depression; • 62% of caregivers report a family history of substance abuse.	• Increased stability of living arrangements; • Decreased school suspensions; • Decreased delinquent behaviors; • Improvement in measures relating to anxiety, depression, internalized and externalized behavior problems; • Reduced overall caregiver strain; • Increased behavioral and emotional strengths; • Over 95% of families reported positive experience on access to services, participation in treatment, cultural sensitivity, and satisfaction with services at both 6 and 12 month follow up.

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.

** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
Just Care Family Network Funding Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 10/2008 Anticipated End Date: 2014	Target: 450 Served to Date: 95 youth , 140 family members	• Shelby County residents; • 5-19 years old at time of enrollment; • Emotional, behavioral or mental health disorder present; • Multi-agency involvement; • At risk of placement outside home; • Caregiver/parent willing to maintain child in home, school and community.	• Increased natural supports for enrolled youth and families • Increased creation of and compliance with IEPs/504s • Decreased school suspensions • Decreased delinquent behaviors • Increased compliance with mental health treatment recommendations Projected outcomes in addition to improved Functional and Clinical Outcomes noted above: • Family Support Provider/Mental Health Consultant working as a team integral to SOC success in Shelby County • Youth That Care Youth Council and Parents That Care Support Group now established as vehicles for youth and family members to serve as community leaders & advocates for promoting awareness of and need to destigmatize mental health issues • Formal referral and collaborative care relationship with DCS, Juvenile Court and school system • Creation of county-wide child and family serving system that utilizes the wraparound approach to service delivery

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.

** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
K-Town Youth Empowerment Network Funding Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 9/2009 Anticipated End Date: 2015	Target: 400 Served to Date: 95	• Knox County residents; • Youth age 14-21; • Emotional, behavioral or mental health disorder present; • Multi-agency involvement; • At risk of placement to a higher level of care (inpatient hospitalization, residential treatment, or state's custody); • Caregiver/parent willing to maintain child in home, school and community OR youth willing to participate in WRAP services to remain independently in the community.	PROJECTED Outcomes in addition to improved Clinical Outcomes^: • Youth In Action Council established as community leaders and peer advocates; • Improved functioning in the home, school, and community; • Successful transition into adulthood, per individual youth's definition.
Early Connections Network: Fulfilling the Promise Funding Request Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 10/2010 Anticipated End Date: 2016	Target: 400 Enrollment Opens July 2012	• Residents of Cheatham, Dickson, Montgomery, Robertson, and Sumner Counties; • Young children ages 0-5 and their families; • Emotional, behavioral or mental health disorder present or at risk of being developed; • A parent or caregiver willing to participate in the wraparound process to maintain the child at home, at school or childcare and in the community.	PROJECTED Outcomes in addition to improved Clinical Outcomes^: • Improved functioning in the home, pre-school, child care and community settings; • Expanded early childhood training of local community service providers • Increased number of early childhood specialists

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.

** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

Council on Children's Mental Health

In 2008, Public Chapter 1062 (codified at T.C.A. 37-3-110 – 37-3-115) established the Council on Children's Mental Health (CCMH) to design a plan for a statewide system of mental health care for children. The principles for systems of care were promulgated in Title 33, the Mental Health and Developmental Disabilities law, in 2000. However, children's mental health issues span across departmental lines at the state and local levels. The significance of P.C. 1062 is its recognition that attaining children's mental health goes beyond administrative and service boundaries of any one department or agency.

The statue currently requires Council to develop a plan for a statewide system of care where children's mental health services is child-centered, family-driven, and culturally and linguistically competent, and provides a coordinated system of care for children's mental health needs in the state. The Council is to be co-chaired by the Commissioner of the Department of Mental Health and Substance Abuse Services and the Executive Director of the Tennessee Commission on Children and Youth. Council Members must include but are not limited to:

- Commissioners or designees of the Department of Children's Services, Finance and Administration, Health, Human Services, Education, TennCare Bureau, Intellectual and Developmental Disabilities, Mental Health and Substance Abuse Services (representatives familiar with children and youth services and alcohol and drug abuse services);
- Commission on Children and Youth Chairman or designee;
- Member of Governor's staff;
- Senator;
- Representative;
- Comptroller of the Treasury representative;
- Four parents of children who have received mental health services;
- Two persons under 24 years of age who are receiving or have received mental health services;
- Three representatives of Community Services Agencies;
- Two representatives of a statewide agency that advocates for children's mental health needs;
- Two representatives of providers of children's mental health services; and
- Three juvenile court judges, one from each grand division.

The plan should also include a core set of services and supports that appropriately and effectively address the mental health needs of children and families. The Council must develop a financial resource map and cost analysis of all federal and state funded programs for children's mental health, updated on an annual basis, to guide and support the plan. Other duties include stimulating more effective use of resources, assisting in developing interagency agreements, determining whether programs are evidence-based, research-based and theory-based and submitting those findings.

The Council is currently designing this prescribed plan by meeting every other month and relying on the help of various workgroups. Additional information or to become involved with the Council's work visit: http://www.tn.gov/tccy/ccmh-home.shtml.

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APPENDIX B

Screening Tools and Assessment Resources

TDMHSAS BEST PRACTICE GUIDELINES

Screening Tools and Assessment Resources

Because it is imperative that clinicians obtain the correct diagnosis, tools have been included to assist clinicians in making the right diagnosis the first time. ***Actual copies of "no-cost" screening tools are found in this section. These tools can be copied and used by clinicians so long as there is no charge to pediatric patients and their families***. Selected screening tools and scales are included by permission of the developer/author. They are included solely for guidance and diagnostic assistance. ***Their inclusion should not be perceived as an endorsement***. While these screening instruments can assist clinicians in determining whether further referral and/or evaluation is warranted, links to a wealth of screening tools and rating scales, some for which permission could not be obtained because they are proprietary, are additionally provided in this section. Typically behavioral health screening tools for very young children fall in the proprietary category.

Ages and Stages Questionnaire (ASQ) Screening Test

The Ages and Stages Questionnaire (ASQ) screening tool can be used with children as young as four months old through five years of age. Parents or any individuals that spend time with the child on a regular basis, such as grandparents, aunts, uncles, caregivers, or foster parents, are asked to complete 30 items. Administration of the ASQ screener takes between 10-20 minutes. If completed accurately, the ASQ can identify developmental delays, including emotional or social problems in young children. There is some question about ease of administration for parents who may be less educated. All total, there are 19 age-based forms. Similar to other quality screening tools, the ASQ has several language versions, including Spanish, Korean, and French. There is a cost associated with this screening test (CEBC4CW, 2009c).

Child/Adolescent Psychiatry Screen (CAPS)

The Child/Adolescent Psychiatry Screen (CAPS) includes symptoms representative of 18 disorders associated with children and youth. It can serve as an initial indicator of areas needing further investigation. Comprised of 85 items, CAPS is recommended for use with parents/families that have children ranging in age between 3-21 years. ***It is only a preliminary screening tool***. This means that a particular "score" will not confirm that a child has a particular disorder. A youth might have symptoms like those indicated by this tool, but s/he may not have any "disorder." Trained clinicians should make the diagnoses following comprehensive and thorough assessments. ***Any symptoms that point to suicidal or harmful behaviors warrant immediate attention by clinicians***.

CAPS takes approximately 15-20 minutes to complete. Hard copy of CAPS is available in this section. The prescreener can also be downloaded from http://www2.massgeneral.org/schoolpsychiatry/childadolescentpscychiatryscreencaps.pdf. (The PDF version may be a better resource from which to make copies.) *CAPS will not help the clinician monitor the effects of treatment(s)*.

***<u>Kiddie-Sads-Present and Lifetime Version</u>* (K-SADS-PL)**

The Kiddie-Sads-Present and Lifetime Version, better known as K-SADS-PL, is a semi-structured interview designed to assess past and current psychopathology in children and adolescents 7-18 years of age. Among the primary diagnoses assessed with the K-SADS-PL are major depression, ADHD, tourette's disorder, PTSD, anxiety, and schizophrenia. It is available in several languages other than English, including European Spanish and Mexican Spanish. The tool can be used freely in clinical settings of not-for-profit entities and/or when its use is included as part of an IRB-approved research protocol. A PDF version can be downloaded from http://www.psychiatry.pitt.edu/research/tools-research/ksads-pl. Unfortunately, its clinical use is limited by the required time of administration, which can range from 90-120 minutes (Kaufman & Schweder, 2003).

***<u>Mood and Feelings Questionnaire</u>* (MFQ)**

Developed by Angold and Costello in 1987, the Mood and Feelings Questionnaire (MFQ) is comprised of a series of descriptive phrases about how the youth has been acting or feeling recently. Codings are indicative of whether the phrase described the youth most of the time, sometimes, or not at all in the past two weeks. There are long and short versions (33 items and 13 items, respectively) for both the youth and the parent. The youth versions can be given to young people ages 13-18, requiring no more than 10 minutes of administration time. Download of the MFQ is free but a form must be completed to obtain passwords for these PDF files. ***<u>A written request must be made to administer the MFQ to clients. The request should be addressed to Anita Chalmers, Box 3454 DUMC, Durham, NC 27710</u>***. Contact information and relevant citations can be gleaned at http://devepi.mc.duke.edu/mfq.html.

***<u>Pediatric Symptom Checklist</u>* (PSC)**

The PSC is a screening tool designed to inform clinicians early about difficulties in functioning that may indicate current or potential psychosocial problems of 6-16 year olds, though use has been extended downward to three years of age and upward to 18 year olds. It contains 35 items and should be completed by parents or guardians. ***<u>This screening tool may be particularly useful because there are both English and Spanish versions, among many other language versions including Haitian-Creole, Chinese, Dutch, French, Italian, Somali, and German</u>***. The PSC language versions can be gleaned from http://www.massgeneral.org/psychiatry/services/psc_forms.aspx. Positive screens (i.e., scores indicative of further assessment) comprise scores greater than 27 for young people ages 6-18 and scores of at least 24 for children in the four-to-five-year-old age range.

At most, the PSC takes 10 minutes to complete. Because the PSC is a screener, it cannot be used to make formal diagnoses or measure treatment interventions. Nevertheless, it is useful in psychosocial screening during Early Periodic Screening, Diagnosis, and Treatment (EPSDT) in states such as Tennessee, Arizona, and Massachusetts (Massachusetts General Hospital, Psychiatry, n.d.a). Moreover, there exists an urgency for providers of pediatric care to screen for behavioral health issues during well child visits using reliable, validated measures such as the PSC and other instruments mentioned in this section (Cappelli, et al., 2012; Hawkins-Walsh & Stone, 2004). Additional versions of the PSC are available in the form of the PSC-17 and the PSC-Y.

The PSC-17 contains only 17 questions and was designed for behavioral health screening of children between the ages of 4-18 years by primary care professionals. ***It can be administered in less than three minutes***. Research has shown that the PSC-17 performs as well as other screening instruments in identifying externalizing disorders, depression, and ADHD, but with less sensitivity in the identification of anxiety (CEBC4CW, 2009a). A total cut score of 15 has been recommended for the PSC-17. However, the original 35-item tool provides the greatest accuracy and remains the instrument of choice unless time pressures dictate the use of the briefest possible screen (Massachuetts General Hospital/School Psychiatry, n.d.b). The PSC-17 is available in a variety of languages, all of which can be viewed and downloaded at http://www.massgeneral.org/psychiatry/services/psc_forms.aspx.

The PSC-Y was designed as a youth self-report version of the PSC, which is completed by the parent. Young people ages 11 years and older can take the PSC-Y. A positive screen on the PSC-Y is a score of 30 or higher (brightfutures.org, n.d.). As with the full-version and PSC-17, the PSC-Y is available in several languages. Language appropriate versions are located at http://www.massgeneral.org/psychiatry/services/psc_forms.aspx. All versions of the PSC are available without charge but proprietary or for-profit use is prohibited.

Hard copies of various versions of the PSC are located in this section and online access is available as well. The English version can be found at http://www.massgeneral.org/psychiatry/assets/PSC-35.pdf or http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf, with the Spanish version available at http://www.massgeneral.org/psychiatry/assets/PSC_Spanish_1.pdf. The ***TENNderCARE website also includes access to this tool for providers under the Pediatric Symptom Checklist link*:** http://www.tn.gov/tenncare/tenndercare/psceng.pdf.

Sometimes youth themselves make the best reporters of their issues, especially when mood disorders like depression and anxiety are involved. In those instances, administer the youth self-report versions of the PSC. The PSC English Youth Self Report version is available at http://www.massgeneral.org/psychiatry/assets/PSCY-35_English.PDF or http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf. The Spanish version of the PSC Youth Self Report can be obtained at http://www.massgeneral.org/psychiatry/assets/PSC_Y_Youth_Self_Report_Spanish.pdf. A number of youth versions in various other languages can be found at http://www.massgeneral.org/psychiatry/services/psc_forms.aspx. The youth version of the PSC may also be referenced as Y-PSC.

Self-Report for Childhood Anxiety Related Emotional Disorders (SCARED)

Another anxiety screening tool in this section is the SCARED. It was designed as a screener for children and adolescents at least 8 years of age. There are child and parent versions of the SCARED. Both versions contain 41 items that measure five areas: general anxiety, physical symptoms of anxiety, school phobia, separation anxiety, and social phobia. Each screen takes about 5 minutes to complete and is additionally available online. The child version is available at http://psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Child%20with%20scoring.pdf. The parent version can be found at http://psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Parent.pdf.

***Swanson, Nolan and Pelham Teacher and Parent Rating Scale* (SNAP-IV)**

The SNAP-IV is a 90-item tool, originally devised to screen for attention deficit hyperactivity disorder (ADHD), but can yield more general information. It takes 10 minutes to complete and provides symptomatology for children 6-18 years of age. The SNAP should be completed by parents or other caregivers, as well as teachers. Besides symptoms associated with attention disorders, the SNAP-IV assesses symptoms linked with Conduct Disorder, Dysthymic Disorder, Generalized Anxiety Disorder, Intermittent Explosive Disorder, Major Depressive Episode, Manic Episode, Narcolepsy, Obsessive-Compulsive Disorder, Stereotypic Movement Disorder, and Tourette's Disorder. The tool and scoring instructions are provided in this section. It is also available at http://www.adhd.net/snap-iv-form.pdf. Scoring instructions for the SNAP-IV can also be found at http://www.adhd.net/snap-iv-instructions.pdf.

Vanderbilt ADHD Diagnostic Rating Scales

The Vanderbilt ADHD Diagnostic Rating Scales should be used as initial assessment tools with children ages 6-12. They include descriptions of symptoms and impairment in academic and behavioral performance. The scales are not intended for diagnosis, but are widely used to provide information about symptom presence and severity, and performance in the classroom, home, and social settings. The 55-item scale should be completed by parents and the 43-item scale should be completed by the child's teacher. Either scale can be completed in 10 minutes.

Both scales are included in this section. The parent version is also available online at http://www.collab4kids.org/images/uploads/Vanderbilt%20ADHD%20Diagnostic%20Parent%20Scoring%20&%20Instructions.pdf. Scoring information is included. n be found at http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/adhd.pdf, along with scoring instructions.

***Modified Checklist for Autism in Toddlers* (M-CHAT)**

Because children with autism that receive early intervention have improved long-term prognoses, the M-CHAT was developed as a screening tool. It consists of 23 yes/no questions and can be completed by clinicians and/or parents and guardians. (Parents should take their completed forms to the clinician for scoring and interpretation.) The M-CHAT is an expanded American version of the CHAT that was originally developed in the United Kingdom. Red flags arise when two or more critical items are failed on the checklist or when any three consecutive items are failed. It is typically recommended that this screen be administered at the 18-month checkup (Robins, Fein, Barton, & Green, 2001).

In addition to inclusion in this section, the author notes that the M-CHAT is available free of charge at www.mchatscreen.com (D. Robins, personal communication, February 19, 2013). This link includes instructions for use and scoring, as well as the tool. The author strongly recommends the use of the M-CHAT Follow-up Interview for screened positive cases. The follow-up interview is included in this section, and can also be obtained from www.mchatscreen.com (D. Robins, personal communication, February 19, 2013). The website link will further be a way to check for updates.

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

The Center for Epidemiological Studies (CES) Depression Scale (CES-D) for adults was adapted for use with children and adolescents in the form of the CES-DC. Like its adult counterpart, the CES-DC is comprised of 20 items and takes less than 15 minutes to complete. It has been recommended for use with persons 7-17 years of age. Although it is included in this section, the CES-DC can also be obtained from http://www.depressedchild.org/Tests/Depression%20Test.htm. Another online version of the document is provided through the brightfutures.org website of Georgetown University.

Strengths and Difficulties Questionnaire ***(SDQ)***

The Strengths and Difficulties Questionnaire (SDQ) is a 25-item behavioral screen tool for children ages 3-16 years of age. It is designed for completion by parents, teachers, or the youth themselves if they are ages 12-16 and have adequate level of literacy and understanding. Parent, teacher, and youth versions of the SDQ contain the same 25 items*. (**NOTE*: The version for three and four year olds contains only 22 items that are identical on the other scale versions. Two items on oppositionality are substituted for items on antisocial behavior and an item on reflectiveness is softened.) The items are divided into give scales measuring emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior. There are also follow-up versions if the clinician is intested in psychiatric caseness or determinatns of service use. Further, there are versions in many different languages. Administration time is reportedly around five minutes (CEBC4CW, 2009b).

PDF versions of the SDQ and scoring instructions are available online at http://sdqinfo.org. They can be downloaded for free at the website. The website contains the most recent verion of the SDQ, as well as all translations. Norms, relevant articles, and validity information are also accessible from the website.

Parent Version of the Young Mania Rating Scale ***(P-YMRS)***

The P-YMRS is a revision of the original YMRS. Designed specifically for the pediatric population (children ages 5-17), the P-YMRS contains 11 items. Parents are asked about their youth’s present state. The tool should help clinicians determine when children should be referred for further evaluation. In addition, it should help them assess the extent to which the youth’s symptoms are responding to treatment (Massachusetts General Hospital/School Psychiatry, n.d.d; The Balanced Mind, 2010).

Scores range from 0-60. Anything above 13 suggests a potential case of mania or hypomania. Scores above 21 were indicative of probable cases in pediatric research studies. In general, higher scores should raise “red flags” for the clinician. The P-YMRS will take between 15-30 minutes to administer (The Balanced Mind Foundation, 2010). Hard copy is presented in this section, but the tool can also be accessed online as a PDF from http://www.thebalancedmind.org/sites/default/files/ymrsparent.pdf or as a Word document from http://www.thebalancedmind.org/learn/library/parent-version-of-the-young-mania-rating-scale-word-doc-version. Permission to include this tool was granted in 2007 by the first author, Barbara Gracious.

CRAFFT

The CRAFFT is a brief screening tool for adolescent substance abuse and has been recommended by the American Academy of Pediatrics' Committee on Substance Abuse (CeASAR, n.d.). Designed for young people ages 11-21 years of age, the CRAFFT consists of three preliminary questions, followed by six easy-to-remember items (TeenScreen,. The tool's title is a mnemonic acronym for the issues addressed by the six questions. The letters in the title represent the keyword in each of the six questions: C = Car; R = Relax; A = Alone; F = Forget; F = Family/Friends; and T = Trouble. Youth should respond "YES" or "NO". At least two "YES" responses to the six questions signal a significant problem (CeASAR, n.d.). Health and/or mental health professionals should administer the screening test.

Contained in this section, the CRAFFT screening test is also available online from the Center for Adolescent Substance Abuse Research(CeASAR) at http://www.ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf. The tool is available as cards too, which can be requested from http://www.ceasar.org/about/CRAFFT%20Card%20Request%20Form.pdf. The CRAFFT has been translated into a considerable number of languages and PDFs of these versions can be obtained from the CeASAR website. A self-administered version, to be administered by the teen, can be accessed from http://www.ceasar.org/CRAFFT/pdf/CRAFFT_SA_English.pdf.

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Child/Adolescent Psychiatry Screen (CAPS)

How to Use the Child/Adolescent Psychiatry Screen (CAPS)

If you suspect your child has a mental health condition and are not sure what symptoms are most troublesome, the Child/Adolescent Psychiatry Screen can provide an initial indicator of areas for further investigation.

This is only a preliminary screening tool. Do not assume that a particular "score" means a child has a particular disorder; many people have symptoms like those described in this screening tool, but do not have a "disorder." Diagnoses should be made only by a trained clinician after a thorough assessment. Symptoms suggestive of suicidal or harmful behaviors warrant immediate attention by a trained clinician.

1. **Answer all items in the checklist**, using the appropriate column to indicate the frequency of each symptom.
2. **Examine the columns to determine if certain clusters of items have more "Moderate" or "Severe" responses.** Don't panic: having a high (or low) number of moderate or severe responses in any section does NOT mean that your child has this disorder. It just means that these symptoms should be discussed with a trained clinician familiar with these disorders so that you can make sense of these symptoms (and determine the best course of action to address them).
3. **Symptoms have been arranged in the following sections/clusters to help identify areas for discussion with a trained clinician:**

Items 1-7	Anxiety
Item 8	Panic Disorder
Item 9	Phobia
Item 10-11	Obsessive-Compulsive Disorder (OCD)
Item 12	Post-Traumatic Stress (PTSD)
Item 13	Generalized Anxiety Disorder
Item 14	Enuresis (bed-wetting) / Encopresis (fecal soiling)
Items 15-16	Tics (vocal and/or motor)
Items 17-31	Attention Deficit/Hyperactivity Disorder (ADD/ADHD)
Items 32-38	Mania/Bipolar Disorder
Items 39-46	Depression
Items 47-49	Substance Abuse / Dependence
Items 50-53	Anorexia / Bulimia
Items 54-64	Antisocial Disorder
Items 65-70	Oppositional Defiant (ODD) Disorder
Items 71-72	Hallucinations or Delusions
Items 73-74	Learning Disability
Items 75-85	Autistic Spectrum (including Asperger's)

4. **Use the results for a focused conversation with your child's primary care clinician, mental health clinician, or with school staff about options to improve your child's mental health.** If particular sections receive mostly moderate and severe answers, show and describe these to your clinician. At that time, it may be useful to show and describe the "Past" column, since some symptoms tend to predict certain other symptoms or clarify other factors to consider.

5. **Consider obtaining additional screening tools and rating scales for more detailed assessment.** Many of these are described and/or accessible from http://www2.massgeneral.org/schoolpsychiatry/schoolpsychiatry_screeningtools.asp**.**

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Child/Adolescent Psychiatry Screen (CAPS)

Child's Name:______________________________________ Date of Birth :_________________ Male _____ Female _____

Form Completed By:_________________________________ Relationship to Child:___________________________________

For each item below, check the one category that best describes your child ***during the past 6 months.***

None = the child never or very rarely exhibits this behavior. **Mild** = the child exhibits this behavior approximately once per week, and few others notice or complain about this behavior. **Moderate** = the child exhibits this behavior at least three times per week, and others notice or comment on this behavior. **Severe** = the child exhibits this behavior almost daily, and multiple others complain about this behavior.

Past = the child used to have significant problems with this behavior, ***but not during the past 6 months.***

	None	**Mild**	**Moderate**	**Severe**	***Past***
1. Has difficulty separating from parents* (* = or major caregiver/guardian)					
2. Worries excessively about losing or harm occurring to parents					
3. Worries about being separated from parent* (getting lost or kidnapped)					
4. Resists going to school or elsewhere because of fears of separation					
5. Resists being alone or without parents					
6. Has difficulty going to sleep without parent nearby					
7. Physical complaints (headache, stomach ache, nausea) when anticipating separation					
8. Has discrete periods of intense fear that peak within 10 minutes					
9. Has excessive, unreasonable fear of a specific object or situation					
10. Has recurrent thoughts that cause marked distress (e.g., fears germs)					
11. Driven to perform repetitive behaviors (e.g., handwashing, doing things 3 times)					
12. Has recurrent, distressing recollections of past difficult or painful events					
13. Worries excessively about multiple things (e.g., school, family, health, etc.)					
14. Goes to the bathroom at inappropriate times or places					
15. Makes noises, and is often unaware of them					
16. Makes repetitive, sudden, nonrhythmic movements					
17. Fails to pay close attention to details or makes careless mistakes					
18. Has difficulty sustaining attention during play or school activities					
19. Does not seem to listen when spoken to directly					
20. Does not follow through on instructions; fails to finish schoolwork/chores					

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Child/Adolescent Psychiatry Screen (CAPS) - continued

	None	**Mild**	**Moderate**	**Severe**	***Past***
21. Has difficulty organizing tasks and activities					
22. Loses things necessary for tasks are activities (toys, pencils, etc.)					
23. Is easily distracted easily by irrelevant stimuli					
24. Is forgetful in daily activities					
25. Is fidgety or squirms in seat					
26. Has difficulty remaining seated					
27. Runs or climbs excessively; is restless					
28. Talks excessively					
29. Blurts out answers before questions have been completed					
30. Has difficulty waiting turn					
31. Interrupts or intrude on others					
32. Episodes of unusually elevated or irritable mood					
33. During this episode, grandiosity or markedly inflated self-esteem (Superhero)					
34. During this episode, is more talkative than usual/seems pressured to keep talking					
35. During this episode, races from thought to thought					
36. During this episode, is very distractible					
37. During this episode, excessively involved in things (too religious, hypersexual)					
38. During this episode, dangerous involvement in pleasurable activity (spending, sex)					
39. Depressed or irritable mood most of the day, most days for at least 1 week					
40. Loss of interest in previously enjoyable activities					
41. Notable change in appetite (not when dieting or trying to gain weight)					
42. Difficulty falling or staying asleep, or sleeping excessively through the day					
43. Others notice child is sluggish or agitated most of the time					
44. Loss of energy nearly every day					
45. Feelings of worthlessness or inappropriate guilt nearly every day					
46. Thinks about dying or wouldn't care if died					
47. Smokes cigarettes, drinks alcohol, OR abuses drugs (Circle all that apply)					
48. Has bad things happen when under the influence of substances					

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Child/Adolescent Psychiatry Screen (CAPS) - continued

	None	**Mild**	**Moderate**	**Severe**	***Past***
49. Has made unsuccessful efforts to stop using a substance	_____	_____	_____	_____	____
50. Is excessively worried about gaining weight, even though underweight	_____	_____	_____	_____	____
51. If female, has stopped having menstrual cycles (after regularly having)	_____	_____	_____	_____	____
52. Thinks he/she is fat, even though not overweight (pulls skin and claims is fat, etc.)	_____	_____	_____	_____	____
53. Engages in binging and purging (eats excessively, then vomits or uses laxatives)	_____	_____	_____	_____	____
54. Bullies, threatens, or intimidates others	_____	_____	_____	_____	____
55. Initiates physical fights	_____	_____	_____	_____	____
56. Uses weapons that could harm others	_____	_____	_____	_____	____
57. Has been physically cruel to animals	_____	_____	_____	_____	____
58. Has shoplifted or stolen items	_____	_____	_____	_____	____
59. Has deliberately set fires	_____	_____	_____	_____	____
60. Has deliberately destroyed others’ property	_____	_____	_____	_____	____
61. Lies to obtain goods or to avoid obligations	_____	_____	_____	_____	____
62. Stays out at night despite parental prohibitions	_____	_____	_____	_____	____
63. Has run away from home overnight on at least two occasions	_____	_____	_____	_____	____
64. Is truant from school	_____	_____	_____	_____	____
65. Loses temper	_____	_____	_____	_____	____
66. Actively defies or refuses to comply with adult rules	_____	_____	_____	_____	____
67. Deliberately annoys others	_____	_____	_____	_____	____
68. Blames others for his/her mistakes or misbehavior	_____	_____	_____	_____	____
69. Easily annoyed by others	_____	_____	_____	_____	____
70. Is spiteful or vindictive	_____	_____	_____	_____	____
71. Has unusual thoughts that others cannot understand or believe	_____	_____	_____	_____	____
72. Hears voices speaking to him/her that others don’t hear	_____	_____	_____	_____	____
73. Does poorly at sports or games requiring physical coordination skills	_____	_____	_____	_____	____
74. Has difficulty at school with: reading, writing, math, spelling (Circle all that apply)	_____	_____	_____	_____	____
75. Had delayed speech or has limited language now	_____	_____	_____	_____	____
76. Avoids eye contact during conversations	_____	_____	_____	_____	____

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Child/Adolescent Psychiatry Screen (CAPS) - continued

	None	**Mild**	**Moderate**	**Severe**	***Past***
77. Does not follow when others point to objects	_____	_____	_____	_____	____
78. Shows little interest in others; emotionally out of sync with others	_____	_____	_____	_____	____
79. Difficulty starting, stopping conversation; continues talking after others lose interest	_____	_____	_____	_____	____
80. Uses unusual phrases, possibly over and over (speaks Disney or movie lines)	_____	_____	_____	_____	____
81. Does not engage in make-believe play; plays more alone than with others	_____	_____	_____	_____	____
82. Unusual preoccupations with objects or unusual routines (lines up 100's of cars, etc.)	_____	_____	_____	_____	____
83. Difficulty with transitions; may be inflexible about adhering to routines or rules	_____	_____	_____	_____	____
84. Shows unusual physical mannerisms (hand-flapping, shrieks, objects in mouth, etc.)	_____	_____	_____	_____	____
85. Unusual preoccupations (schedules, own alphabet, weather reports, etc.)	_____	_____	_____	_____	____

Thank you for answering each of these items. Please list any other symptoms that concern you:

____

____

____

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Pediatric Symptom Checklist (PSC),
PSC-Y, and PSC-17 – English and Spanish Versions

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child. ***Please mark under the heading that best describes your child***:

		Never (0)	**Sometimes (1)**	**Often (2)**
1. Complains of aches and pains	1	___	___	___
2. Spends more time alone	2	___	___	___
3. Tires easily, has little energy	3	___	___	___
4. Fidgety, unable to sit still	4	___	___	___
5. Has trouble with teacher	5	___	___	___
6. Less interested in school	6	___	___	___
7. Acts as if driven by a motor	7	___	___	___
8. Daydreams too much	8	___	___	___
9. Distracted easily	9	___	___	___
10. Is afraid of new situations	10	___	___	___
11. Feels sad, unhappy	11	___	___	___
12. Is irritable, angry	12	___	___	___
13. Feels hopeless	13	___	___	___
14. Has trouble concentrating	14	___	___	___
15. Less interested in friends	15	___	___	___
16. Fights with other children	16	___	___	___
17. Absent from school	17	___	___	___
18. School grades dropping	18	___	___	___
19. Is down on him or herself	19	___	___	___
20. Visits the doctor with doctor finding nothing wrong	20	___	___	___
21. Has trouble sleeping	21	___	___	___
22. Worries a lot	22	___	___	___
23. Wants to be with you more than before	23	___	___	___
24. Feels he or she is bad	24	___	___	___
25. Takes unnecessary risks	25	___	___	___
26. Gets hurt frequently	26	___	___	___
27. Seems to be having less fun	27	___	___	___
28. Acts younger than children his or her age	28	___	___	___

		Never (0)	Sometimes (1)	Often (2)
29. Does not listen to rules	29	___	___	___
30. Does not show feelings	30	___	___	___
31. Does not understand other people’s feelings	31	___	___	___
32. Teases others	32	___	___	___
33. Blames others for his or her troubles	33	___	___	___
34. Takes things that do not belong to him or her	34	___	___	___
35. Refuses to share	35	___	___	___

Total Score ______

Does your child have any emotional or behavioral problems for which she or he needs help?	( ) N	( ) Y
Are there any services that you would like your child to receive for these problems?	( ) N	( ) Y

If yes, what services? ________________________________

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Completado por: (por avor circule uno)
Padres / Pariente / Guardián / Paciente
(Parent / Relative / Gaurdian / Self)

LISTA DE SÍNTOMAS PEDIÁTRICOS **PEDIATRIC SYMPTOM CHECKLIST (PSC)**

Indique cual síntoma mejor describe a su hijo: Please mark under the heading that best describes your child:	**NUNCA** Never **(0)**	**A VECES** Sometimes **(1)**	**SEGUIDO** Often **(2)**
1. Se queja de dolores y malestares (Complains of aches and pains)			
2. Pasa mucho tiempo solo (Spends more time alone)			
3. Se cansa fácilmente, tiene poca energía (Tires easily, has little energy)			
4. Es inquieto (Fidgety, unable to sit still)			
5. Tiene problemas con maestros (Has trouble with teacher)			
6. Menos interesado(a) en la escuela (Less interested in school)			
7. Es muy activo(a), tiene mucha energía (Acts as if driven by a motor)			
8. Es muy soñador(a) (Daydreams too much)			
9. Se distrae fácilmente (Distracted easily)			
10. Temeroso(a) de nuevas situaciónes (Is afraid of new situations)			
11. Se siente triste, infeliz (Feels sad, unhappy)			
12. Es irritable, enojón (Is irritable, angry)			
13. Se siente sin esperanzas (Feels hopeless)			
14. Tiene problemas para concentrarse (Has trouble concentrating)			
15. Está menos interesado(a) en sus amistades (Less interested in friends)			
16. Pelea con otros niños(as) (Fights with other children)			
17. Se ausenta de la escuela (Absent from school)			
18. Sus notas escolares están bajando (School grades dropping)			
19. Se critica a si mismo(a) (Is down on him or herself)			
20. Visita al doctor y el doctor no le encuentra nada malo (Visits the doctor with doctor finding nothing			
21. Tiene problemas para dormir (Has trouble sleeping)			
22. Se preocupa mucho (Worries a lot)			
23. Quiere estar con usted más que antes (Wants to be with you more than before)			
24. Se siente que él/ella es malo(a) (Feels he or she is bad)			
25. Toma riezgos innecesarios (Takes unnecessary risks)			
26. Se lastima facilmente/frecuentemente (Gets hurt frequently)			
27. Parece divertise menos (Seems to be having less fun)			
28. Actúa más chico que niños de su propia edad (Acts younger than children his or her age)			
29. No obedece reglas (Does not listen to rules)			
30. No demuestra sus sentimientos (Does not show feelings)			
31. No comprende los sentimientos de otros (Does not understand other people's feelings)			
32. Molesta a otros (Teases others)			
33. Culpa a otros por sus problemas (Blames other for his or her troubles)			
34. Toma cosas que no le pertenecen (Takes things that do not belong to him or her)			
35. Se rehusa a compartir (Refuses to share)			
Total Score _____			

36. ¿Su hijo tiene algun problema emocional, o de comportamiento, para el cual necesita ayuda? No Sí
Does your child have any emotional or behavioral problems for which she/he needs help?

37. De momento, ¿su hijo se está consultando con un profesional de salud mental? No Sí
Is your child currently seeing a mental health counselor?

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Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never (0)	**Sometimes (1)**	**Often (2)**
1. Complain of aches and pains	1			
2. Spend more time alone	2			
3. Tire easily, little energy	3			
4. Fidgety, unable to sit still	4			
5. Have trouble with teacher	5			
6. Less interested in school	6			
7. Act as if driven by a motor	7			
8. Daydream too much	8			
9. Distract easily	9			
10. Are afraid of new situations	10			
11. Feel sad, unhappy	11			
12. Are irritable, angry	12			
13. Feel hopeless	13			
14. Have trouble concentrating	14			
15. Less interested in friends	15			
16. Fight with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Down on yourself	19			
20. Visit doctor with doctor finding nothing wrong	20			
21. Have trouble sleeping	21			
22. Worry a lot	22			
23. Want to be with parent more than before	23			
24. Feel that you are bad	24			
25. Take unnecessary risks	25			
26. Get hurt frequently	26			
27. Seem to be having less fun	27			
28. Act younger than children your age	28			
29. Do not listen to rules	29			
30. Do not show feelings	30			
31. Do not understand other people’s feelings	31			
32. Tease others	32			
33. Blame others for your troubles	33			
34. Take things that do not belong to you	34			
35. Refuse to share	35			

Total score ________

CUESTIONARIO (PSC-Y)

La salud fisica y emocional van juntas. Usted pueda ayudar al doctor/a a obtener el mejor servicio posible, contestando unas pocas preguntas acerca de usted. La informacion que nos de es parte de la visita de hov.

Indique cual síntoma mejor describe a su niño/a:

		NUNCA (0)	**A VECES (1)**	**SEGUIDO (2)**
1. Se queja de dolores y malestares	1			
2. Pasa mucho tiempo solo(a)	2			
3. Se cansa fácilmente, poca energiá	3			
4. Es inquieto(a)	4			
5. Problemas con un maestro(a)	5			
6. Menos interesado en la escuela	6			
7. Es incansable	7			
8. Es Imuy sonador	8			
9. Se distrae facilmente	9			
10. Temeroso(a) a nuevas situaciónes	10			
11. Se siete triste, infeliz	11			
12. Es irritable, enojon	12			
13. Se siente sin esperanzas	13			
14. Tiene problemas para concentrandose	14			
15. Menos interesado(a) en amigos(as)	15			
16. Pelea con otros niños(as)	16			
17. Falta a la escuela a menudo	17			
18. Estan bejando sus calificaciones	18			
19. Se critica a si mismo(a)	19			
20. Va al doctor y no encuentren nada	20			
21. Tiene problemas para dormir	21			
22. Se preocupa mucho	22			
23. Extranas a tus padres	23			
24. Cree que eres malo(a)	24			
25. Se pone en peligro sin necesidad	25			
26. Se lastima facilmente	26			
27. Parece divertise menos	27			
28. Actua como un nino a su edad	28			
29. No obedece reglas	29			
30. No demuestra sus sentimientos	30			
31. No comprende el sentir de otros	31			
32. Molesta a otros	32			
33. Culpa a otros de sus problemas	33			
34. Toma cosas que no le pertenecen	34			
35. Se rehusa a compartir	35			

Total score ________

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Pediatric Symptom Checklist 17 (PSC-17)

Child's Name: ______________________________________ Date of Birth: ____________________

Filled out by: ______________________________________ Today's Date: ____________________

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child. **Please mark under the heading that best describes your child:**

		Never	Sometimes	Often
◆	**Fidgety, unable to sit still**	0	**1**	**2**
■	**Feels sad, unhappy**	0	**1**	**2**
◆	**Daydreams too much**	0	**1**	**2**
●	**Refuses to share**	0	**1**	**2**
●	**Does not understand other people's feelings**	0	**1**	**2**
■	**Feels hopeless**	0	**1**	**2**
◆	**Has trouble concentrating**	0	**1**	**2**
●	**Fights with other children**	0	**1**	**2**
■	**Is down on him or herself**	0	**1**	**2**
●	**Blames others for his or her troubles**	0	**1**	**2**
■	**Seems to have less fun**	0	**1**	**2**
●	**Does not listen to rules**	0	**1**	**2**
◆	**Acts as if driven by a motor**	0	**1**	**2**
●	**Teases others**	0	**1**	**2**
■	**Worries a lot**	0	**1**	**2**
●	**Takes things that do not belong to him or her**	0	**1**	**2**
◆	**Distracted easily**	0	**1**	**2**

Total ◆ ____________ **Total** ● ________

Total ■ ____________

◆ + ● + ■ = ___

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FECHA DE HOY ___________________

COMPLETADO POR ______________

ListadeSíntomas Pediátricos(PediatricSymptom Checklist –PSC)

La salud física y emocional son importantes para cada niño. Los padres son los primeros que notan un problema de la conducta emocional o del aprendizaje de su hijo(a). Ud. puede ayudar a su hijo(a) a obtener el mejor cuidado de su doctor por medio de contestar estas preguntas. Favor de indicar cual frase describe a su hijo(a).

Indique cual síntoma mejor describe a su hijo/a:

			NUNCA (0)	ALGUNAS VECES (1)	FRECUENTEMENTE (2)
1.	Se siente triste, infeliz ------------------	1.			
2.	Se siente sin esperanzas------------------	2.			
3.	Se siente mal de sí mismo(a)------------	3.			
4.	Se preocupa mucho-----------------------	4.			
5.	Parece divertirse menos -----------------	5.			
6.	Es inquieto(a), incapaz de sentarse	6.			
7.	Sueña despierto demasiado--------------	7.			
8.	Se distrae fácilmente---------------------	8.			
9	Tiene problemas para concentrarse----	9			
10.	Es muy activo(a), tiene mucha	10			
11.	Pelea con otros niños---------------------	11			
12.	No obedece las reglas -------------------	12			
13.	No comprende los sentimientos de	13			
14.	Molesta o se burla de otros -------------	14			
15.	Culpa a otros por sus problemas -------	15			
16.	Se niega a compartir ---------------------	16			
17.	Toma cosas que no le pertenecen ------	17			

Total ___________

¿Tiene su hijo(a) algeprinted with permission of Michael Jellinek, MD, & J. Michael M ayuda?------------ ☐ No ☐ Si

M.S. Jellinek and J.M. Murphy, Massachusetts General Hospital
Spanish PSC Gouverneur Revision 2-7-03

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Screen for Child Anxiety Related Disorders (SCARED)
Child Version

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Name: ____ Date: ________________________

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

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

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu. Reprinted with permission from B. Birmaher, MD., May 2007.

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–1236.

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

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

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu. Reprinted with permission from B. Birmaher, MD., May 2007.

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–1236.

SCARED SCORING, Child Version:

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

TOTAL =

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

PN =

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

GD =

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

SP =

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

SC =

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

SH =

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

The child version of the *SCARED* is available at no cost at http://psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Child%20with%20scoring.pdf. (Reprinted with permission from B. Birmaher, MD., May 2007.)

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Fangzi Liao developed the scorable template.

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version

Screen for Child Anxiety Related Disorders (SCARED)
Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: ____ Date: _____________________________

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

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

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd., David Brent, MD, and Sandra McKenzie, PhD., Western Psychiatric Institute and Clinic, University of Pittsburgh. (10/95). E-mail: birmaherb@msx.upmc.edu. Reprinted with permission from B. Birmaher, MD., May 2007.

Screen for Child Anxiety Related Disorders (SCARED)

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

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

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SCARED SCORING, Parent Version:

SCORING:

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

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

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

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

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Swanson, Nolan and Pelham Teacher and Parent Rating Scale (Snap-IV)

The SNAP-IV Teacher and Parent Rating Scale

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

Name: ____ Gender: ________ Age: ________ Grade: ________

Ethnicity (circle one which best applies): African-American Asian Caucasian Hispanic Other ________________________

Completed by: _______________________________ Type of Class: ________________ Class size: ________________

For each item, check the column which best describes this child:	***Not At All***	***Just A Little***	***Quite A Bit***	***Very Much***
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks	_____	_____	_____	_____
2. Often has difficulty sustaining attention in tasks or play activities	_____	_____	_____	_____
3. Often does not seem to listen when spoken to directly	_____	_____	_____	_____
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties	_____	_____	_____	_____
5. Often has difficulty organizing tasks and activities	_____	_____	_____	_____
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort	_____	_____	_____	_____
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)	_____	_____	_____	_____
8. Often is distracted by extraneous stimuli	_____	_____	_____	_____
9. Often is forgetful in daily activities	_____	_____	_____	_____
10. Often has difficulty maintaining alertness, orienting to requests, or executing directions	_____	_____	_____	_____
11. Often fidgets with hands or feet or squirms in seat	_____	_____	_____	_____
12. Often leaves seat in classroom or in other situations in which remaining seated is expected	_____	_____	_____	_____
13. Often runs about or climbs excessively in situations in which it is inappropriate	_____	_____	_____	_____
14. Often has difficulty playing or engaging in leisure activities quietly	_____	_____	_____	_____
15. Often is "on the go" or often acts as if "driven by a motor"	_____	_____	_____	_____
16. Often talks excessively	_____	_____	_____	_____
17. Often blurts out answers before questions have been completed	_____	_____	_____	_____
18. Often has difficulty awaiting turn	_____	_____	_____	_____
19. Often interrupts or intrudes on others (e.g., butts into conversations/games)	_____	_____	_____	_____
20. Often has difficulty sitting still, being quiet, or inhibiting impulses in the classroom or at home	_____	_____	_____	_____

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The SNAP-IV Teacher and Parent Rating Scale (continued)

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

For each item, check the column which best describes this child:	***Not At All***	***Just A Little***	***Quite A Bit***	***Very Much***
21. Often loses temper				
22. Often argues with adults				
23. Often actively defies or refuses adult requests or rules				
24. Often deliberately does things that annoy other people				
25. Often blames others for his or her mistakes or misbehavior				
26. Often touchy or easily annoyed by others				
27 Often is angry and resentful				
28. Often is spiteful or vindictive				
29. Often is quarrelsome				
30. Often is negative, defiant, disobedient, or hostile toward authority figures				
31. Often makes noises (e.g., humming or odd sounds)				
32. Often is excitable, impulsive				
33. Often cries easily				
34. Often is uncooperative				
35. Often acts “smart”				
36. Often is restless or overactive				
37. Often disturbs other children				
38. Often changes mood quickly and drastically				
39. Often easily frustrated if demand are not met immediately				
40. Often teases other children and interferes with their activities				
41. Often is aggressive to other children (e.g., picks fights or bullies)				
42. Often is destructive with property of others (e.g., vandalism)				
43. Often is deceitful (e.g., steals, lies, forges, copies the work of others, or “cons” others)				
44. Often and seriously violates rules (e.g., is truant, runs away, or completely ignores class rules)				

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The SNAP-IV Teacher and Parent Rating Scale (continued)

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

Check the column which best describes this child:	***Not At All***	***Just A Little***	***Quite A Bit***	***Very Much***
45. Has persistent pattern of violating the basic rights of others or major societal norms	_____	_____	_____	_____
46. Has episodes of failure to resist aggressive impulses (to assault others or to destroy property)	_____	_____	_____	_____
47. Has motor or verbal tics (sudden, rapid, recurrent, nonrhythmic motor or verbal activity)	_____	_____	_____	_____
48. Has repetitive motor behavior (e.g., hand waving, body rocking, or picking at skin)	_____	_____	_____	_____
49. Has obsessions (persistent and intrusive inappropriate ideas, thoughts, or impulses)	_____	_____	_____	_____
50. Has compulsions (repetitive behaviors or mental acts to reduce anxiety or distress)	_____	_____	_____	_____
51. Often is restless or seems keyed up or on edge	_____	_____	_____	_____
52. Often is easily fatigued	_____	_____	_____	_____
53. Often has difficulty concentrating (mind goes blank)	_____	_____	_____	_____
54. Often is irritable	_____	_____	_____	_____
55. Often has muscle tension	_____	_____	_____	_____
56. Often has excessive anxiety and worry (e.g., apprehensive expectation)	_____	_____	_____	_____
57. Often has daytime sleepiness (unintended sleeping in inappropriate situations)	_____	_____	_____	_____
58. Often has excessive emotionality and attention-seeking behavior	_____	_____	_____	_____
59. Often has need for undue admiration, grandiose behavior, or lack of empathy	_____	_____	_____	_____
60. Often has instability in relationships with others, reactive mood, and impulsivity	_____	_____	_____	_____
61 Sometimes for at least a week has inflated self esteem or grandiosity	_____	_____	_____	_____
62. Sometimes for at least a week is more talkative than usual or seems pressured to keep talking	_____	_____	_____	_____
63. Sometimes for at least a week has flight of ideas or says that thoughts are racing	_____	_____	_____	_____
64. Sometimes for at least a week has elevated, expansive or euphoric mood	_____	_____	_____	_____
65. Sometimes for at least a week is excessively involved in pleasurable but risky activities	_____	_____	_____	_____
66. Sometimes for at least 2 weeks has depressed mood (sad, hopeless, discouraged)	_____	_____	_____	_____
67. Sometimes for at least 2 weeks has irritable or cranky mood (not just when frustrated)	_____	_____	_____	_____
68. Sometimes for at least 2 weeks has markedly diminished interest or pleasure in most activities	_____	_____	_____	_____
69. Sometimes for at least 2 weeks has psychomotor agitation (even more active than usual)	_____	_____	_____	_____
70. Sometimes for at least 2 weeks has psychomotor retardation (slowed down in most activities)	_____	_____	_____	_____

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The SNAP-IV Teacher and Parent Rating Scale (continued)

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

Check the column which best describes this child:	***Not At All***	***Just A Little***	***Quite A Bit***	***Very Much***
71. Sometimes for at least 2 weeks is fatigued or has loss of energy	_____	_____	_____	_____
72. Sometimes for at least 2 weeks has feelings of worthlessness or excessive, inappropriate guilt	_____	_____	_____	_____
73. Sometimes for at least 2 weeks has diminished ability to think or concentrate	_____	_____	_____	_____
74. Chronic low self-esteem most of the time for at least a year	_____	_____	_____	_____
75. Chronic poor concentration or difficulty making decisions most of the time for at least a year	_____	_____	_____	_____
76. Chronic feelings of hopelessness most of the time for at least a year	_____	_____	_____	_____
77. Currently is hypervigilant (overly watchful or alert) or has exaggerated startle response	_____	_____	_____	_____
78. Currently is irritable, has anger outbursts, or has difficulty concentrating	_____	_____	_____	_____
79. Currently has an emotional (e.g., nervous, worried, hopeless, tearful) response to stress	_____	_____	_____	_____
80. Currently has a behavioral (e.g., fighting, vandalism, truancy) response to stress	_____	_____	_____	_____
81. Has difficulty getting started on classroom assignments	_____	_____	_____	_____
82. Has difficulty staying on task for an entire classroom period	_____	_____	_____	_____
83. Has problems in completion of work on classroom assignments	_____	_____	_____	_____
84. Has problems in accuracy or neatness of written work in the classroom	_____	_____	_____	_____
85. Has difficulty attending to a group classroom activity or discussion	_____	_____	_____	_____
86. Has difficulty making transitions to the next topic or classroom period	_____	_____	_____	_____
87. Has problems in interactions with peers in the classroom	_____	_____	_____	_____
88. Has problems in interactions with staff (teacher or aide)	_____	_____	_____	_____
89. Has difficulty remaining quiet according to classroom rules	_____	_____	_____	_____
90. Has difficulty staying seated according to classroom rules	_____	_____	_____	_____

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The SNAP-IV Teacher and Parent Rating Scale

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

Scoring Instructions for the SNAP-IV

The SNAP-IV Rating Scale is a revision of the Swanson, Nolan and Pelham (SNAP) Questionnaire (Swanson et al, 1983). The items from the DSM-IV (1994) criteria for Attention-Deficit/Hyperactivity Disorder (ADHD) are included for the two subsets of symptoms: inattention (items #1-#9) and hyperactivity/impulsivity (items #11-#19). Also, items are included from the DSM-IV criteria for Oppositional Defiant Disorder (items #21-#28) since it often is present in children with ADHD. Items have been added to summarize the Inattention domain (#10) and the Hyperactivity/Impulsivity domain (#20) of ADHD. Two other items were added: an item from DSM-III-R (#29) that was not included in the DSM-IV list for ODD, and an item to summarize the ODD domain (#30).

In addition to the DSM-IV items for ADHD and ODD, the SNAP-IV contains items from the Conners Index Questionnaire (Conners, 1968) and the IOWA Conners Questionnaire (Loney and Milich, 1985). The IOWA was developed using divergent validity to separate items which measure inattention/overactivity (I/O — items #4, #8, #11, #31, #32) from those items which measure aggression/defiance (A/D — items #21, #23, #29, #34, #35). The Conners Index (items #4, #8, #11, #21, #32, #33, #36, #37, #38, #39) was developed by selecting the items which loaded highest on the multiple factors of the Conners Questionnaire, and thus represents a general index of childhood problems.

The SNAP-IV is based on a 0 to 3 rating scale: Not at All = 0, Just A Little = 1, Quite A Bit = 2, and Very Much = 3. Subscale scores on the SNAP-IV are calculated by summing the scores on the items in the subset and dividing by the number of items in the subset. The score for any subset is expressed as the Average Rating-Per-Item, as shown for ratings on the ADHD-Inattentive (ADHD-I) subset:

	Not At All	Just A Little	Quite A Bit	Very Much	Item Score
1. Makes careless mistakes	____	____	__X_	____	2
2. Can't pay attention	____	____	____	__X_	3
3. Doesn't listen	____	____	____	__X_	3
4. Fails to finish work	____	____	__X_	____	2
5. Disorganized	____	__X_	____	____	1
6. Can't concentrate	____	____	____	__X_	3
7. Loses things	____	__X_	____	____	1
8. Distractible	____	____	____	__X_	3
9. Forgetful	__X_	____	____	_____	0

ADHD-In Total = 18, Average = 18/9 = 2.0

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The SNAP-IV Teacher and Parent Rating Scale

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

Scoring Instructions for the SNAP-IV (continued)

A scoring template for the DSM-IV subtypes of ADHD (In and H/Im), for ODD; for the dimensions of the CLAM (I/O and A/D); and for the Conners Index are presented below:

ADHD-In	ADHD-H/Im	ODD	I/O	A/D	Conners Index
# 1 _____	#11 _____	#21 _____	# 4 _____	#21 _____	# 4 _____
# 2 _____	#12 _____	#22 _____	# 8 _____	#23 _____	# 8 _____
# 3 _____	#13 _____	#23 _____	#11 _____	#29 _____	#11 _____
# 4 _____	#14 _____	#24 _____	#31 _____	#34 _____	#21 _____
# 5 _____	#15 _____	#25 _____	#32 _____	#35 _____	#32 _____
# 6 _____	#16 _____	#26 _____			#33 _____
# 7 _____	#17 _____	#27 _____			#36 _____
# 8 _____	#18 _____	#28 _____			#37 _____
# 9 _____	#19 _____				#38 _____
					#39 _____

Total In = _____	H/Im = _____	ODD = _____	I/O = _____	A/D = _____	CI = _____
Average = _____	= _____	= _____	= _____	= _____	= _____

C = _____

= _____

		Teacher	***Parent***
Tentative 5% Cutoffs:	ADHD-In	2.56	1.78
	ADHD-H/Im	1.78	1.44
	ADHD-C	2.00	1.67
	ODD	1.38	1.88

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Scoring Instructions for the SNAP-IV (continued)

The items on page 2 of the SNAP-IV Rating Scale are from other DSM-IV disorders which may overlap with or masquerade as symptoms of ADHD. In some cases, these may be comorbid disorders, but in other cases the presence of one or more of these disorders may be sufficient to exclude a diagnosis of ADHD. The SNAP-IV is not designed to be used in the formal process of diagnosing these non-ADHD disorders, but if symptoms on page 2 of the SNAP-IV receive a high ("Quite A Bit" or "Very Much") rating, then an assessment of the implicated non-ADHD disorders may be warranted.

The DSM-IV Manual should be consulted to follow-up with an evaluation of these non-ADHD disorders. The DSM Codes and the page numbers in the DSM Manual are specified below to help in the assessment of possible conditions which may exclude or qualify a diagnosis of ADHD. A referral to a psychiatrist or a clinical psychologist may be required.

#41-#45 Conduct Disorder	**(DSM 312.8, p. 85)**
#46 Intermittent Explosive Disorder	**(DSM 312.34, p. 609)**
#47 Tourette's Disorder	**(DSM 307.23, p. 103)**
#48 Stereotypic Movement Disorder	**(DSM 307.3, p. 121)**
#49-#50 Obsessive-Compulsive Disorder	**(DSM 300.3, p. 417)**
#51-#56 Generalized Anxiety Disorder	**(DSM 300.02, p. 432)**
#57 Narcolepsy	**(DSM 347, p. 562)**
#58 Histrionic Personality Disorder	**(DSM 301.50, p. 655)**
#59 Narcissistic Personality Disorder	**(DSM 301.81, p. 658)**
#60 Borderline Personality Disorder	**(DSM 301.83, p. 650)**
#61-#65 Manic Episode	**(DSM 296.00, p. 328)**
#66-#73 Major Depressive Episode	**(DSM 296.2, p. 320)**
#74-#76 Dysthymic Disorder	**(DSM 300.4, p. 345)**
#77-#78 Posttraumatic Stress Disorder	**(DSM 309.81, p. 424)**
#79-#80 Adjustment Disorder	**(DSM 309, p. 623)**

Finally, the SNAP-IV includes the 10 items of the Swanson, Kotkin, Agler, Mylnn, and Pelham (SKAMP) Rating Scale. These items are classroom manifestations of inattention, hyperactivity, and impulsivity (i.e., getting started, staying on task, interactions with others, completing work, and shifting activities). The SKAMP may be used to estimate severity of impairment in the classroom.

It is important to note that many disorders may produce impairment in the classroom setting, not just ADHD. Therefore, this rating scale is presented last so the possible exclusion conditions (on page 2 of the SNAP-IV) will be considered in addition to the inclusion criteria for ADHD (on page 1 of the SNAP-IV). Both should be considered before interpreting the SKAMP measure of classroom impairment or attributing high ratings on the SKAMP to ADHD.

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Scoring Instructions for the SNAP-IV (continued)

ACADEMIC	DEPORTMENT
#81 _____	#87 _____
#82 _____	#88 _____
#83 _____	#89 _____
#84 _____	#90 _____
#85 _____	
#86 _____	
Total = _____	= _____
Avg. = _____	= _____

Orienting (#81,#86) = _____	Attention to Other (#87,#88) = _____
Maintaining (#82,#83) = _____	Attention to Rules (#89,#90) = _____
Directing (#84,#85) = _____	

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Vanderbilt ADHD Diagnostic Parent Rating Scale

VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE
Page 1 of 3

Child's Name: ______________________________ **Today's Date:** ____________

Date of Birth: ______________________________ **Age:** ________ **Grade:** _______

Circle the number on the scale that corresponds to how you would rate your child's behavior.

0 = Never 1 = Occasionally 2 = Often 3 = Very Often

1.	Does not pay attention to details or makes careless mistakes, for example homework	0	1	2	3
2.	Has difficulty attending to what needs to be done	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through when given directions and fails to finish things	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7.	Loses things needed for tasks or activities (assignments, pencils, books)	0	1	2	3
8.	Is easily distracted by noises or other things	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat when he is suppose to stay in his seat	0	1	2	3
12.	Runs about or climbs too much when he is suppose to stay seated	0	1	2	3
13.	Has difficulty playing or starting quiet games	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his/her turn	0	1	2	3
18.	Interrupts or bothers others when they are talking or playing games	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively disobeys or refuses to follow an adults' requests or rules	0	1	2	3
22.	Bothers people on purpose	0	1	2	3
23.	Blames others for his or her mistakes or misbehaviors	0	1	2	3
24.	Is touchy or easily annoyed by others	0	1	2	3
25.	Is angry or bitter	0	1	2	3
26.	Is hateful and wants to get even	0	1	2	3
27.	Bullies, threatens, or scares others	0	1	2	3
28.	Starts physical fights	0	1	2	3

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VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE *(continued)*
Page 2 of 3

Child's Name: ______________________

	0 = Never	**1 = Occasionally**	**2 = Often**	**3 = Very Often**
29. Lies to get out of trouble or to avoid jobs (i.e., "cons" others)	0	1	2	3
30. Skips school without permission	0	1	2	3
31. Is physically unkind to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3
33. Destroys others' property on purpose	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically mean to animals	0	1	2	3
36. Has set fires on purpose to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, nervous, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels useless or inferior	0	1	2	3
44. Blames self for problems, feels at fault	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46. Is sad or unhappy	0	1	2	3
47. Feels different and easily embarrassed	0	1	2	3

How is your child doing?

	Problem		**Average**		**Above Average**
1. Rate how your child is doing in school overall	**1**	**2**	**3**	**4**	**5**
a. How is your child doing in reading?	**1**	**2**	**3**	**4**	**5**
b. How is your child doing in writing?	**1**	**2**	**3**	**4**	**5**
c. How is your child doing in math?	**1**	**2**	**3**	**4**	**5**
2. How does your child get along with you?	**1**	**2**	**3**	**4**	**5**
3. How does your child get along with brothers and sisters?	**1**	**2**	**3**	**4**	**5**
4. How does your child get along with others his/her own age?	**1**	**2**	**3**	**4**	**5**
5. How does your child do in activities such as games or team play?	**1**	**2**	**3**	**4**	**5**

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VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE (continued)
Page 3 of 3

<u>Scoring Instructions for the ADTRS</u>

***Predominately inattentive subtype** requires 6 or 9 behaviors, (scores of 2 or 3 are positive) on items 1 through 9, and a performance problem (scores of 1 or 2) in any of the items on the performance section.

***Predominately hyperactive/Impulsive subtype** requires 6 or 9 behaviors (scores of 2 or 3 are positive) on items 10 through 18 and a problem (scores of 1 or 2) in any of the items on the performance section.

***The Combined Subtype** requires the above criteria on both inattention and hyperactivity/impulsivity.

***Oppositional-defiant disorder** is screened by 4 of 8 behaviors, (scores of 2 or 3 are positive) (19 through 26)

***Conduct disorder** is screened by 3 of 15 behaviors, (scores of 2 or 3 are positive) (27 through 40).

***Anxiety or depression** are screened by behaviors 41 through 47, scores of 3 of 7 are required, (scores of 2 or 3 are positive).

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Vanderbilt ADHD Diagnostic Teacher Rating Scale

Vanderbilt ADHD Diagnostic Teacher Rating Scale
INSTRUCTIONS AND SCORING

Behaviors are counted if they are scored 2 (often) or 3 (very often).

Inattention	Requires six or more counted behaviors from questions 1–9 for indication of the predominantly inattentive subtype.
Hyperactivity/ impulsivity	Requires six or more counted behaviors from questions 10–18 for indication of the predominantly hyperactive/impulsive subtype.
Combined subtype	Requires six or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.
Oppositional defiant and conduct disorders	Requires three or more counted behaviors from questions 19–28.
Anxiety or depression symptoms	Requires three or more counted behaviors from questions 29–35.

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

FOR MORE INFORMATION CONTACT

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REFERENCE FOR THE SCALE'S PSYCHOMETRIC PROPERTIES

Wolraich, M.L., Feurer, I.D., Hannah, J.N., et al. (1998). Obtaining systematic teacher reports of disruptive behavior disorders utilizing DSM-IV. *Journal of Abnormal Child Psychology* *26*(2):141–152.

The scale is available at http://peds.mc. vanderbilt.edu/VCHWEB_1/rating~1.html.

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Name: ____ **Grade:** __________

Date of Birth: ________ **Teacher:** __________________ **School:** _______________

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

1.	Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2.	**Has difficulty sustaining attention to tasks or activities**	**0**	**1**	**2**	**3**
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	**Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)**	**0**	**1**	**2**	**3**
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	**Avoids, dislikes, or is reluctant to engage in tasks that require sustaining mental effort**	**0**	**1**	**2**	**3**
7.	Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8.	**Is easily distracted by extraneous stimuli**	**0**	**1**	**2**	**3**
9.	Is forgetful in daily activities	0	1	2	3
10.	**Fidgets with hands or feet or squirms in seat**	**0**	**1**	**2**	**3**
11.	Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12.	**Runs about or climbs excessively in situations in which remaining seated is expected**	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	**Is "on the go" or often acts as if "driven by a motor"**	**0**	**1**	**2**	**3**
15.	Talks excessively	0	1	2	3
16.	**Blurts out answers before questions have been completed**	**0**	**1**	**2**	**3**
17.	Has difficulty waiting in line	0	1	2	3
18.	**Interrupts or intrudes on others (e.g., butts into conversations or games)**	**0**	**1**	**2**	**3**
19.	Loses temper	0	1	2	3

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Vanderbilt ADHD Diagnostic Teacher Rating Scale (continued)

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

20.	**Actively defies or refuses to comply with adults' requests or rules**	**0**	**1**	**2**	**3**
21.	Is angry or resentful	0	1	2	3
22.	**Is spiteful and vindictive**	**0**	**1**	**2**	**3**
23.	Bullies, threatens, or intimidates others	0	1	2	3
24.	**Initiates physical fights**	**0**	**1**	**2**	**3**
25.	Lies to obtain goods for favors or to avoid obligations (i.e., "cons" others	0	1	2	3
26.	**Is physically cruel to people**	**0**	**1**	**2**	**3**
27.	Has stolen items of nontrivial value	0	1	2	3
28.	**Deliberately destroys others' property**	**0**	**1**	**2**	**3**
29.	Is fearful, anxious, or worriet	0	1	2	3
30.	**Is self-conscious or easily embarrassed**	**0**	**1**	**2**	**3**
31.	Is afraid to try new things for fear of making mistakes	0	1	2	3
32.	**Feels worthless or inferior**	**0**	**1**	**2**	**3**
33.	Blames self for problems, feels guilty	0	1	2	3
34.	**Feels lonely, unwanted, or unloved; complains that "no one loves him/her"**	**0**	**1**	**2**	**3**
35.	Is sad, unhappy, or depressed	0	1	2	3

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PERFORMANCE

	Problematic		Average		Above Average
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavioral Performance					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

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Modified Checklist for Autism in Toddlers (M-CHAT)

M-CHAT

Please fill out the following about your child's usual behavior, and try to answer every question. If the behavior is rare (you've only seen it once or twice), please answer as if your child does *not* do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes	No
2.	Does your child take an interest in other children?	Yes	No
3.	Does your child like climbing on things, such as up stairs?	Yes	No
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes	No
5.	Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Yes	No
6.	Does your child ever use his/her index finger to point, to ask for something?	Yes	No
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Yes	No
8.	Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?	Yes	No
9.	Does your child ever bring objects over to you (parent) to show you something?	Yes	No
10.	Does your child look you in the eye for more than a second or two?	Yes	No
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes	No
12.	Does your child smile in response to your face or your smile?	Yes	No
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes	No
14.	Does your child respond to his/her name when you call?	Yes	No
15.	If you point at a toy across the room, does your child look at it?	Yes	No
16.	Does your child walk?	Yes	No
17.	Does your child look at things you are looking at?	Yes	No
18.	Does your child make unusual finger movements near his/her face?	Yes	No
19.	Does your child try to attract your attention to his/her own activity?	Yes	No
20.	Have you ever wondered if your child is deaf?	Yes	No
21.	Does your child understand what people say?	Yes	No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes	No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes	No

Refer to: Robins, D., Fein, D., Barton, M, & Green, J. (2001). The modified checklist for autism in toddlers: An initial study investigating the early detection of autism and pervasive developmental disorders. *Journal of Autism and Developmental Disorders*, *35*(2), 131-144.

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Instructions and Permissions for Use of the M-CHAT

The Modified Checklist for Autism in Toddlers (M-CHAT; Robins, Fein, & Barton, 1999) is available for free download for clinical, research, and educational purposes. There are two authorized websites: the M- CHAT and supplemental materials can be downloaded from Dr. Robins' website at http://www.mchatscreen.com.

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Users should be aware that the M-CHAT continues to be studied and may be revised in the future. Any revisions will be posted to the two websites noted above.

Furthermore, the M-CHAT is a copyrighted instrument, and use of the M-CHAT must follow these guidelines:

(1) Reprints/reproductions of the M-CHAT must include the copyright at the bottom ©1999 Robins, Fein, & Barton). No modifications can be made to items, instructions, or item order without permission from the authors.

(2) The M-CHAT must be used in its entirety. There is no evidence that using a subset of items will be valid.

(3) Parties interested in reproducing the M-CHAT in print (e.g., a book or journal article) or electronically for use by others (e.g., as part of digital medical record or other software packages) must contact Diana Robins to request permission (**drobins@gsu.edu**).

(4) If you are part of a medical practice, and you want to incorporate the M-CHAT into your own practice's electronic medical record (EMR), you are welcome to do so. However, if you ever want to distribute your EMR page outside of your practice, please contact Diana Robins to request permission.

Instructions for Use

The M-CHAT is validated for screening toddlers between 16 and 30 months of age, to assess risk for autism spectrum disorders (ASD). The M-CHAT can be administered and scored as part of a well-child check-up, and also can be used by specialists or other professionals to assess risk for ASD. The primary goal of the M-CHAT was to maximize sensitivity, meaning to detect as many cases of ASD as possible. Therefore, there is a high false positive rate, meaning that not all children who score at risk for ASD will be diagnosed with ASD. To address this, we have developed a structured follow-up interview for use in conjunction with the M-CHAT; it is available at the two websites listed above. Users should be aware that even with the follow-up questions, a significant number of the children who fail the M-CHAT will not be diagnosed with an ASD; however, these children are at risk for other developmental disorders or delays, and therefore, evaluation is warranted for any child who fails the screening.

The M-CHAT can be scored in less than two minutes. Scoring instructions can be downloaded from **http://www.mchatscreen.com**. We also have developed a scoring template, which is available on these websites; when printed on an overhead transparency and laid over the completed M-CHAT, it facilitates scoring. Please note that minor differences in printers may cause your scoring template not to line up exactly with the printed M-CHAT.

Children who fail three or more items total or two or more critical items (particularly if these scores remain elevated after the M-CHAT Follow-up Interview) should be referred for diagnostic evaluation by a specialist trained to evaluate ASD in very young children. In addition, children for whom there are physician, parent, or other professional's concerns about ASD should be referred for evaluation, given that it is unlikely for any screening instrument to have 100% sensitivity. The author strongly recommends using the M-CHAT Follow-up Interview for screen positive cases. The follow-up interview with instructions can be accessed from www.mchatscreen.com.

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

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

Scoring Instructions

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20-item self-report depression tool with possible scores ranging from 0 to 60. It was adapted from the adult depression scale, the CES-D. Responses to each item are scored as follows, excluding the exceptions identified below:

0 = “Not At All”

1 = “A Little”

2 = “Some”

3 = “A Lot”

Exceptions to the above scoring rule are items 4, 8, 12, and 16. These items are phrased positively and thus are scored in the reverse manner:

3 = “Not At All”

2 = “A Little”

1 = “Some”

0 = “A Lot”

The CES-DC is listed as a screening tool for depression in youth in the second edition of the *Guide to Clinical Preventive Services*. This guide can be obtained from the Agency of Healthcare Research and Quality (AHRQ) website directly or through the U.S. Department of Health and Human Services website.

Higher CES-DC scores reflect increasing levels of depression. A study by Weissman, Orvaschel, & Padian (1980) as well as the *Guide to Clinical Preventive Services* (Chapter 49), designate the ***cutoff score of 15 as suggestive of depressive symptoms in children and adolescents***. This means that scores greater than 15 might indicate significant levels of depressive symptoms and that a more comprehensive assessment is warranted. (Further assessment is also warranted for children or adolescents who exhibit depressive symptoms but who do not screen positive.)

*Research efforts identify this tool as a product of the National Institute of Mental Health (NIMH). All NIMH documents are in the public domain and may be provided free of charge.

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

INSTRUCTIONS

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

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

DURING THE PAST WEEK	**Not At All**	**A Little**	**Some**	**A Lot**
6. I felt down and unhappy.	____	____	____	____
7. I felt like I was too tired to do things.	____	____	____	____
8. I felt like something good was going to happen.	____	____	____	____
10. I felt scared.	____	____	____	____

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

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

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

Number ____________________

Score ______________________

*Research efforts identify this tool as a product of the National Institute of Mental Health (NIMH). All NIMH documents are in the public domain and may be provided free of charge.

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Parent Version of the Young Mania Rating Scale (P-YMRS)

Child Name: ____________________

Date: ____________________

YMRS - PARENT VERSION

Directions: Please read each question below and circle the answer number which most closely describes your child.

1. Mood - ***Is your child's mood higher (better) than usual?***

0. No
1. Mildly or possibly increased
2. Definite elevation- more optimistic, self-confident; cheerful; appropriate to their conversation
3. Elevated but inappropriate to content; joking, mildly silly
4. Euphoric; inappropriate laughter; singing/making noises; very silly

2. Motor Activity/Energy - ***Does your child's energy level or motor activity appear to be greater than usual?***

0. No
1. Mildly or possibly increased
2. More animated; increased gesturing
3. Energy is excessive; hyperactive at times; restless but can be calmed
4. Very excited; continuous hyperactivity; cannot be calmed

3. Sexual Interest - ***Is your child showing more than usual interest in sexual matters?***

0. No
1. Mildly or possibly increased
2. Definite increase when the topic arises
3. Talks spontaneously about sexual matters; gives more detail than usual; more interested in girls/boys than usual
4. Has shown open sexual behavior- touching others or self inappropriately

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Name: ____________________
Date: _____________________

YMRS-Parent Continued… (Page 2)

4. Sleep - ***Has your child's sleep decreased lately?***

0. No
1. Sleeping less than normal amount by up to one hour
2. Sleeping less than normal amount by more than one hour
3. Need for sleep appears decreased; less than four hours
4. Denies need for sleep; has stayed up one night or more

5. Irritability - ***Has your child appeared irritable?***

0. No more than usual
2. More grouchy or crabby
4. Irritable openly several times throughout the day; recent episodes of anger with family, at school, or with friends
6. Frequently irritable to point of being rude or withdrawn
8. Hostile and uncooperative about all the time

6. Speech (rate and amount) - ***Is your child talking more quickly or more than usual?***

0. No change
2. Seems more talkative
4. Talking faster or more to say at times
6. Talking more or faster to point he/she is difficult to interrupt
8. Continuous speech; unable to interrupt

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Name: ______________________
Date: ________________________

YMRS-Parent Continued… (Page 3)

7. **Thoughts -** ***Has your child shown changes in his/her thought patterns?***

0. No
1. Thinking faster; some decrease in concentration; talking "around the issue"
2. Distractible; loses track of the point; changes topics frequently; thoughts racing
3. Difficult to follow; goes from one idea to the next; topics do not relate; makes rhymes or repeats words
4. Not understandable; he/she doesn't seem to make any sense

8. **Content -** ***Is your child talking about different things than usual?***

0. No
2. He/she has new interests and is making more plans
4. Making special projects; more religious or interested in God
6. Thinks more of him/herself; believes he/she has special powers; believes he/she is receiving special messages
8. Is hearing unreal noises/voices; detects odors no one else smells; feels unusual sensations; has unreal beliefs

9. **Disruptive-Aggressive Behavior -** ***Has your child been more disruptive or aggressive?***

0. No; he/she is cooperative
2. Sarcastic; loud; defensive
4. More demanding; making threats
6. Has threatened a family member or teacher; shouting; knocking over possessions/ furniture or hitting a wall
8. Has attacked family member, teacher, or peer; destroyed property; cannot be spoken to without violence

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Name: ______________________

Date: _______________________

YMRS-Parent Continued… (Page 4)

10. Appearance - ***Has your child's interest in his/her appearance changed recently?***

0. No
1. A little less or more interest in grooming than usual
2. Doesn't care about washing or changing clothes, or is changing clothes more than three time a day
3. Very messy; needs to be supervised to finish dressing; applying makeup in overly-done or poor fashion
4. Refuses to dress appropriately; wearing bizarre styles

11. Insight - ***Does your child think he/she needs help at this time?***

0. Yes; admits difficulties and wants treatment
1. Believes there might be something wrong
2. Admits to change in behavior but denies he/she needs help
3. Admits behavior might have changed but denies need for help
4. Denies there have been any changes in his/her behavior/thinking

Signature of Parent / Guardian: ____

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CRAFFT

The CRAFFT Screening Interview

It is suggested that the clinician start with: **"I'm going to ask you a few questions that I ask all my patients. Please be honest."** (Then ask the following opening questions.)

Part A

- **During the PAST 12 MONTHS, did you:**
  - **1**. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.) YES NO
  - **2**. Smoke any marijuana or hashish? YES NO
  - **3**. Use anything else to get high? ("anything else" includes over the counter and prescription drugs, illegal drugs, and things that you sniff or "huff") YES NO

If the adolescent answers "**YES**" to any of the opening questions, ***administer all six questions in Part B below***. If the adolescent answers "**NO**" to any of the opening questions, ***administer only the first of the six questions in Part B below***.

Part B

	Yes	No
1. **C** - Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	___	___
2. **R** - Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	___	___
3. **A** - Do you ever use alcohol/drugs while you are by yourself, **ALONE**?	___	___
4. **F** - Do you ever **FORGET** things you did while using alcohol or drugs?	___	___
5. **F** - Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	___	___
6. **T** - Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	___	___

CRAFFT cards can be requested from http://www.ceasar.org/about/CRAFFT%20Card%20Request%20Form.pdf. For more information, visit http://www.ceasar.org/CRAFFT/index.php.

Self Administration and Scoring of the CRAFFT

A self-administered version of the CRAFFT is available at **http://www.ceasar.org/CRAFFT/pdf/CRAFFT_SA_English.pdf.** Both the screener (on the previous page and the self-administered version should be scored using the same criteria. ***It should be noted that Part A items and responses determine which of the Part B items should be administered.***

Responses to Part B items are used as the primary screening results. Scoring follows the pattern below:

- ***Each "YES" response should receive a score of 1.***
- ***Two or more "YES" responses are indicative of a positive screen and suggest the probability of a significant problem involving substances.***

Any score of at least 2 indicates a need for additional assessment.

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Other Diagnostic Resources

Other Diagnostic Resources

Peabody Treatment Progress Battery (PTPB)(2nd edition)

This version of the Peabody Treatment Progress Battery (PTPB) was made available in 2010. It was developed by Vanderbilt's Center for Evaluation and Program Improvement (CEPI) and designed to provide feedback on the effects of treatment for youth ages 11-18. The youth can be serviced in a variety of settings, including in-home treatment, foster care, and outpatient care. The PTPB is merely one component of the Contextualized Feedback Systems, also developed by the CEPI. The battery includes 11 measures of key clinical processes and mental health outcomes. The tool is psychometrically sound and easy to administer. The PTPB is written at the 4th grade reading level and takes less than 10 minutes to administer each week. Both English and Spanish versions are available, with plans to extend the battery to younger children and adult populations, as well as in other languages.

Resources, including instructions for use are available free of charge at http://peabody.vanderbilt.edu/research/center-evaluation-program-improvement-cepi/reg/ptpb_2nd_ed_downloads.php. A completed registration form and consent to the license agreement are still required and must be completed prior to use. After submission, you will receive an email that provides a link to the manual. It is further possible to use the battery on a computerized, automated, or web-based system. A supplemental license agreement regarding computerized use must be completed first. You can even submit your own instruments for possible inclusion in the PTPB.

Diagnostic Classification of Mental Health and Developmental Disorders of infancy and Early Childhood, Revised (DC:0-3R)

The *DC: 0-3R* is a developmentally based system for diagnosing mental health and developmental disorders in children three and under. Designed for mental health clinicians, counselors, physicians, nurses, early interventionists, early childhood administrators/teachers, and researchers, it is an indispensable guide to evaluation and treatment planning for infants and toddlers. The *DC: 0-3R* can help clinicians:

- Recognize mental health and development challenges in young children.
- Understand how relationships and environmental factors contribute to mental health and development disorders.
- Use diagnostic criteria effectively for classification and intervention.
- Work more effectively with parents and other professionals to develop effective treatment plans.

In addition, the DC:0-3R enhances the ability of mental health professionals in preventing, diagnosing, and treating problems in the earliest years as it identifies and describes disorders not addressed in other classification systems. The resource further points the way to effective intervention approaches. Other information on the DC:0-3R can be found at http://www.zerotothree.org/child-development/early-childhood-mental-health/diagnostic-classification-of-mental-health-and-developmental-disorders-of-infancy-and-early-childhood-revised.html. The DC:0-3R must be purchased, as should following recommended forms:

- Functional Rating Scale for Emotional and Social Functioning Capacities
- Parent-Infant Relationship Global Assessment Scale (PIR-GAS)
- Psychosocial & Environmental Stressor Checklist
- Relationship Problems Checklist (RPCL)

All DC:0-3R materials are proprietary and can be purchased through the ZERO TO THREE eSTORE, http://main.zerotothree.org/site/PageServer?pagename=ter_est_home.

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