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Massachusetts Child Psychiatry Access Program

# Guidelines and Clinical Pearls

## (Anxiety, Depression, and ADHD)

Fall 2018

# MCPAP Depression Guidelines for PCPs

**PCP visit:**

- Screen for behavioral health problems
  - Pediatric Symptom Checklist-17 (cut-points: 15 total, 5 internalizing, individual depression items)
  - Patient Health Questionnaire, ages 12-13+ (cut-points: 3 [PHQ-2], 10 [PHQ-9])
- If screen is positive, conduct focused assessment
  - If concern for imminent danger, refer to hospital or crisis team for emergency psychiatric assessment
  - Consult with MCPAP CAP as needed

Focused assessment including clinical interview (see *Depression Clinical Pearls*) and symptom rating scales:
**Mood and Feelings Questionnaire – Long***:* ages 8-18 (cut-points: 27 parent, 29 youth) OR
**Patient Health Questionnaire – 9***:* ages 12-13+ (cut-points: 10 moderate, 20 severe)

**Sub-clinical to mild depression:**
Guided self-management with follow-up

**Moderate depression** (or self-management unsuccessful):
Refer for therapy; consider medication

**Severe depression:**
Refer to specialty care for therapy and medication management until stable

FDA-approved medications for depression:
**Fluoxetine: age 8+; Escitalopram: age 12+**

Evidence-based medication for depression:
**Sertraline**

- Start daily test dose for 1-2 weeks (e.g., fluoxetine 5mg < age 12 or fluoxetine 10mg age 12+; escitalopram 5mg age 12+; sertraline 12.5mg < age 12 or sertraline 25mg age 12+)
- If test dose tolerated, increase daily dose (e.g., fluoxetine 10mg < age 12 or fluoxetine 20mg age 12+; escitalopram 10mg age 12+; sertraline 25mg < age 12 or sertraline 50mg age 12+)
- Monitor weekly for agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency evaluation; consult with MCPAP CAP as needed

At 4 weeks, re-assess symptom severity with **MFQ or PHQ-9**

- If score > cut-point and impairment persists, consult MCPAP CAP for next steps
- If score < cut-point with mild to no impairment, remain at current dose for 6-12 months
- Monitor bi-monthly during the second four weeks and monthly thereafter for maintenance of remission, agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency evaluation; consult with MCPAP CAP as needed
- After 6-12 months of successful treatment, re-assess symptom severity with **MFQ or PHQ-9**
- If score < cut-point without impairment, then consider tapering antidepressant medication according to the following schedule: decrease daily dose by 25-50% every 2-4 weeks to starting dose, then discontinue medication; consult with MCPAP CAP as needed. Tapering should ideally occur during a time of relatively low stress. Maintenance of antidepressant medication may be considered beyond the 6- to 12-month period of successful treatment in cases of high severity/risk, recurrent pattern, and/or long duration of illness. Consider consulting with MCPAP CAP regarding decision to taper.
- Monitor with **MFQ or PHQ-9** for symptom recurrence for several months after discontinuation.

*HJ Walter, Department of Psychiatry, Boston Children's Hospital (adapted by MCPAP with permission)*
*Revised August 2018*
*Funding provided by the Massachusetts Department of Mental Health, Boston Children's Hospital, and Sidnev A. Swensrud Foundation*

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# Depression "Clinical Pearls" for Primary Care Providers

## I. CLINICAL HISTORY AND MEDICAL WORK-UP

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Assess current symptom severity, ideally using a standardized symptom rating scale | **Pearl:** Symptom severity will suggest appropriate level and type of treatment. |
| ☐ Assess current functioning in different areas (family, peers, school, community) | **Pearl:** Usually depression affects youth across most or all areas of their life; if the youth is functioning highly in some areas but is compromised in only one area; consider other explanations apart from mood disorder. |
| ☐ Assess for acute stressors, life events, or traumatic exposures which may be contributing to presentation | **Pearl:** Stressors or traumas can become important targets for intervention via psychoeducation; consider MCPAP consultation or specialty care. |
| ☐ Assess for prior episodes of treated or untreated depression or mania | **Pearl:** Multiple prior episodes of depression or mania increase the complexity of the presentation; consider MCPAP consultation or referral to specialty care. |
| ☐ Assess for presence of other psychiatric symptoms and/or substance use and abuse | **Pearl:** The presence of other psychiatric symptoms including ADHD and anxiety and/or active substance abuse or dependence may complicate assessment and treatment planning; consider MCPAP consultation or referral to specialty care. |
| ☐ Assess for current or previous non-suicidal and suicidal thinking and behavior (self-harm, suicide attempts) and previous suicidal crises | **Pearl:** Active suicidal planning, intent, or recent suicidal behavior increases safety risk; consider Psychiatric Crisis referral or MCPAP phone consultation. If there is a current active suicidal intent or plan, refer for immediate mental health assessment at a Crisis Center or equivalent. |
| ☐ Assess for current or previous episodes of mental health care and providers | **Pearl:** Prior history of specialized mental health care may indicate that the youth is presenting with complex or treatment-resistant depression; consider MCPAP consultation or referral to specialty care. Collaboration and information-sharing with current mental health providers is essential to quality care. |

## II. MENTAL STATUS EXAMINATION

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ SIGECAPS assessment (Sleep changes, loss of Interest, Guilt, loss of Energy, reduced Concentration/Cognition, Appetite changes, Psychomotor changes, Suicidality) | **Pearl:** General assessment of depressive symptoms can identify targets of treatment, and change over time may indicate positive or negative effect of treatment efforts. |
| ☐ Suicidality: suicidal thoughts, degree of planning, degree of intent, sense of control, ability to communicate with others and reach out for help, reasons for living | **Pearl:** Reports of active suicidal planning, intent, or recent suicidal behavior increases safety risk; consider Psychiatric Crisis referral or MCPAP phone consultation. |
| ☐ Psychosis: hallucinations, delusions, abnormalities of thought processes or content | **Pearl:** Active symptoms of psychosis increase safety risk; consider Psychiatric Crisis referral for further assessment or MCPAP phone consultation. |

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## III. MEDICAL WORKUP

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Perform general standard medical assessment | **Pearl:** General medical assessment is part of good medical care for youth presenting with concerning mood symptoms. |
| ☐ Assessment of medical conditions that can present with depressive symptoms (i.e., thyroid abnormalities, chronic fatigue, chronic infections, etc.) | **Pearl:** Identification and intervention for general medical problems presenting with psychiatric symptoms may help with assessment and treatment planning; consider MCPAP phone consultation to discuss complex situations. |
| ☐ Assessment of medical treatments that can present with depressive symptoms as untoward reactions (i.e., steroid treatments, beta-blockers, anti-convulsants, etc.) | **Pearl:** Identification and intervention for medical treatments presenting with psychiatric symptoms may help with assessment and treatment planning; consider MCPAP phone consultation to discuss complex situations. |
| ☐ Assessment of medical conditions and concurrent medical treatments that may affect treatment planning | **Pearl:** Identify medical conditions that could impact antidepressant treatment (i.e., liver disease, renal problems) or medications with significant drug-drug interaction potential; consider MCPAP phone consultation for complicated situations. |

## IV. DIFFERENTIAL DIAGNOSIS

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Adjustment reactions to acute stressors (symptoms clearly correlated to recent and likely time-limited negative life event) | **Pearl:** Adjustment reactions rarely or ever require pharmacological intervention; consider general health education, health maintenance strategies, or referral for psychotherapy as first-line intervention. Consider MCPAP phone consultation for complex situations. |
| ☐ Bipolar disorders | **Pearl:** Bipolar disorders in youth can be complicated in terms of assessment; consider MCPAP phone or face-to-face consultation prior to initiating treatment if youth is presenting with signs of bipolar disorder. |
| ☐ Depressive disorder due to another medical condition | **Pearl:** First-line treatment would be intervention for the medical problem; consider interventions for depression as indicated. Consider MCPAP consultation in complex situations. |
| ☐ Substance/medication-induced depressive disorder | **Pearl:** First-line treatment would be removal of substance or medication causing symptoms; consider interventions for depression as indicated. Consider MCPAP consultation in complex situations. |
| ☐ Post-Traumatic Stress Disorder (PTSD) | **Pearl:** PTSD can present with prominent mood symptoms and emotional distress and also can co-occur with depression. Consider MCPAP phone or face-to-face consultation for diagnostic clarification in confusing situations. |
| ☐ Disruptive Mood Dysregulation Disorder (DMDD) | **Pearl:** DMDD can present with prominent irritability that may be difficult to distinguish from depressed mood with prominent irritability. Consider MCPAP phone or face-to-face consultation for diagnostic clarification in confusing situations. |

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## V. ASSESSMENT OF RISK

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Assess youth comprehensively for suicidal thinking or behavior as main short-term concern is risk of self-harm, suicidal behavior, or completed suicide | **Pearl:** Refer for immediate and emergent Crisis Assessment with Emergency Psychiatric Service providers in the following situations:<br>▪ Any evidence of recent suicidal behavior<br>▪ Current active intent to engage in suicidal behavior<br>▪ Current significant planning for suicidal behavior<br>▪ Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified<br>▪ Evidence that youth or family will not or cannot access Emergency Psychiatric Service providers in times of worsening risk<br>▪ Consider MCPAP phone consultation for complex or confusing situations. |

## VI. TREATMENT PLANNING

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Present to family clinical impressions and recommendations regarding the need for treatment | **Pearl:** Consult with MCPAP by phone as needed regarding developing an appropriate treatment plan. |
| ☐ Using MCPAP guidelines, discuss treatment options with family and ascertain family preferences for treatment | **Pearl:** Family preferences regarding treatment choices can be taken into account along with many other factors in determining initial treatment plan in many situations; consider MCPAP phone or face-to-face consultation for complicated situations. |
| ☐ With medication treatment, discuss with parent/guardian/child potential benefits of treatment, potential side effects, alternatives to medication treatment, and prognosis with and without medication treatment; include discussion of “black box” warning regarding treatment-emergent suicidality associated with all anti-depressants for patients ages 25 and younger. Document this discussion in clinical record. Although only fluoxetine (ages 8 and older) and escitalopram (ages 12 and older) are FDA-approved for the treatment of depression, other SSRIs (especially sertraline) have proven safety and effectiveness in research studies. | **Pearl:** Consult with MCPAP CAP as needed regarding any concerns about informed consent as it applies to treatment planning. |
| ☐ Discuss plan for medication monitoring, dosage adjustment, and discontinuation | **Pearl:** Monitoring response to treatment, ideally with a standardized symptom rating scale, and adjusting medication dose as indicated may lead to an improved outcome; the plan for medication discontinuation after symptom remission should be discussed. |

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| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Utilize a practice tracking procedure to monitor patients diagnosed with depression in terms of after-care and clinical outcomes | **Pearl:** MCPAP is suggesting utilizing clinical "registry"-based procedures for monitoring patients in the practice with high-priority mental health conditions such as clinical depression. |
| ☐ MCPAP currently does NOT recommend the use of routine pharmacogenetic testing for initial medication selection strategies in primary care for youth with depression. | **Pearl:** Pharmacogenetic testing is considered experimental and is not incorporated at this time into any standard practice guidelines for youth with depression. There may be specialized situations where pharmacogenetic testing is appropriate in specialty care. Consider phone consultation with MCPAP CAP to discuss further as warranted. |

## VII. MEDICAL MONITORING

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Acute Treatment Phase (8-12 weeks) | **Pearl:** Goals - remission and/or reduction of symptoms, improvement in function<br>▪ Initiation and close monitoring of medication treatment response and tolerance<br>▪ Weekly to bi-weekly check-ins with youth and/or family<br>▪ Monitor medication compliance and tolerance<br>▪ If youth experiencing side effects from medication, do not advance dose until side effect remits fully<br>▪ Re-assessment of depressive symptoms at 4 weeks using MFQ or PHQ-9<br>▪ Follow guidelines and consult with MCPAP CAP as needed |
| ☐ Maintenance Phase (6-12 months) | **Pearl**: Goals - youth will continue to demonstrate reduction and/or remission of symptoms and improvement in function after positive acute treatment response<br>▪ Maintain active treatment plan (medication, psychotherapy) during this period<br>▪ Monitoring generally less involved or intensive assuming ongoing symptom improvement<br>▪ Monitor medication compliance and tolerance<br>▪ Ongoing collaboration with therapist if present<br>▪ Consult with MCPAP CAP as needed<br>▪ If symptoms and functioning improve for 6-12 months, reassess with MFQ/PHQ-9<br>▪ Discussion with MCPAP CAP of treatment discontinuation phase if response has been sustained for 6-12 months |
| ☐ Treatment Discontinuation Phase (3 to 6 months) | **Pearl**: Goals - safely and thoughtfully withdrawn treatment and monitor for symptom recurrence<br>▪ Informed consent with family: potential benefits of withdrawing treatment, potential risks of withdrawing treatment, plan to deal with problems or recurrence if needed<br>▪ Discuss medication strategies with family (consult with MCPAP CAP as needed)<br>▪ Active monitoring for several months during this phase<br>▪ Re-assessment of depressive symptoms at monthly to bi-monthly intervals using MFQ/PHQ-9 -> re-evaluate need for resuming medication if assessment scales suggest episode relapse or recurrence<br>▪ Ongoing collaboration with therapist if present<br>▪ Consult with MCPAP CAP as needed |

# MCPAP Anxiety Guidelines for PCPs

**PCP visit**:

- Screen for behavioral health problems
  - Pediatric Symptom Checklist-17 (cut-points: 15 total, 5 internalizing, individual anxiety item)
- If screen is positive, conduct focused assessment
  - If concern for imminent danger, refer to hospital or crisis team for emergency psychiatric assessment
  - Consult with MCPAP CAP as needed

Focused assessment including clinical interview (see *Anxiety Clinical Pearls*) and symptom rating scales:
**SCARED** (parent and child): ages 8-18 (cut-point: 25 parent and child) OR
**GAD-7**: ages 12+ (cut-points: 10 moderate, 15 severe)

**Sub-clinical to mild anxiety**: Guided self-management with follow-up

**Moderate anxiety** (or self-management unsuccessful): Refer for therapy (CBT preferred); consider medication

**Severe anxiety**: Refer to specialty care for therapy (CBT preferred) and medication management until stable

Evidence-based medications for anxiety: **Fluoxetine, Sertraline**

- Start daily test dose for 1-2 weeks (e.g., fluoxetine 5mg or sertraline 12.5mg)
- If test dose tolerated, increase daily dose (e.g., fluoxetine 10mg or sertraline 25mg)
- Monitor weekly for agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency evaluation; consult with MCPAP CAP as needed

Consider PRN meds for severe distress: Hydroxyzine: 12.5-25mg (age<12), 25-50mg (age 12+) q4h PRN not to exceed twice daily
Call MCPAP telephone consult to consider benzodiazepine for severe distress not responsive to above treatment.

At 4 weeks, re-assess symptom severity with **SCARED or GAD-7**

- If score > cut-point and impairment persists, increase daily dose (e.g., fluoxetine 20mg or sertraline 50mg); monitor bi-monthly for agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency psychiatric assessment; consult with MCPAP CAP as needed

At 8 weeks, re-assess symptom severity with **SCARED or GAD-7**

- If score > cut-point and impairment persists, increase daily dose (e.g., fluoxetine 30mg or sertraline 75mg); monitor bi-monthly for agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency psychiatric assessment; consult with MCPAP CAP as needed

NOTE: If distress/impairment are severe, can increase fluoxetine by 10mg every 2 weeks to 40mg and sertraline by 25mg every 2 weeks to 100mg, obtaining follow-up **SCARED or GAD-7** at 4 and 8 weeks

- At 12 weeks, re-assess symptom severity with **SCARED or GAD-7**
- If score > cut-point and impairment persists, consult with MCPAP CAP for next steps
- If score < cut-point with mild to no impairment, remain at current dose for 6-12 months
- Monitor monthly for maintenance of remission, agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency psychiatric assessment; consult with MCPAP CAP as needed
- After 6-12 months of successful treatment, re-assess symptom severity with **SCARED or GAD-7**
- If score < cut-point without impairment, then consider tapering medication according to the following schedule: decrease daily dose by 25-50% every 2-4 weeks to starting dose, then discontinue medication; consult with MCPAP CAP as needed. Tapering should ideally occur during a time of relatively low stress. Maintenance of medication may be considered beyond the 6- to 12-month period of successful treatment in cases of high severity/risk, recurrent pattern, and/or long duration of illness. Consider consulting with MCPAP CAP regarding decision to taper.
- Monitor with **SCARED or GAD-7** for several months after discontinuation for symptom recurrence

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*Revised August 2018*
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# Anxiety "Clinical Pearls" for Primary Care Providers

## I. CLINICAL HISTORY AND MEDICAL WORK-UP

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Assess current symptom severity, ideally using a standardized symptom rating scale | **Pearl:** Symptom severity will suggest appropriate level and type of treatment. |
| ☐ Assess avoidant behavior | **Pearl:** Avoidance of activities and circumstances that provoke anxiety often are the most disabling aspects of anxiety disorders for children and adolescents, at times contributing to developmental delays. Avoidant behaviors become habitual and may be reinforced by family members and teachers. Avoidant behaviors may result in patients with severe anxiety disorders to be "free" of subjective feelings of anxiety. In addition to psychotherapy referral, primary care providers should educate patients and families regarding the importance of exposure in order to address this aspect of the disorder. |
| ☐ Assess for acute and chronic stressors which may be contributing to presentation | **Pearl:** Stressors may trigger the onset of an anxiety disorder or exacerbate the course of one. Therapy referral is helpful to support effective coping. |
| ☐ Assess chronicity of symptoms | **Pearl:** Anxiety disorders tend to be recurrent and persistent. There is some evidence that psychotherapy is more durably effective than medication treatment and should be included in the treatment plan in order to mitigate risk of recurrence. |
| ☐ Assess for current or previous non-suicidal or suicidal thinking and behavior (self-harm, suicide attempts) and previous suicidal crises | **Pearl:** Anxiety disorders can be associated with suicidal ideation with or without comorbid depression. |
| ☐ Assess for multiple anxiety disorders | **Pearl:** Patients commonly meet criteria for more than one anxiety disorder. The accurate identification of the type(s) of anxiety disorder is pertinent to the psychotherapy treatment plan, less so for the medication treatment plan. |
| ☐ Assess for the presence of other psychiatric symptoms and/or substance use and abuse | **Pearl:** The most common co-occurring psychiatric diagnoses include ADHD, Depression, and Substance Use Disorders. These issues should be assessed and treated concurrently. |

## II. MENTAL STATUS EXAMINATION

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Common mental status findings | **Pearl:** Clinicians may observe difficulties with separation, selective mutism, behavioral inhibition, or especially in younger children, over-arousal and hyperactivity. Mental status exam may be entirely normal. Children usually have poor insight into anxiety symptoms and may actively try to minimize or obscure symptoms. |
| ☐ Suicidality ideation: suicidal thoughts, degree of planning, degree of intent, sense of control, ability to communicate with others and reach out for help, reasons for living | **Pearl:** Reports of active suicidal planning or intent or recent suicidal behavior increase safety risk; consider Psychiatric Crisis referral or MCPAP phone consultation. |

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## III. MEDICAL WORKUP

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Perform general standard medical assessment | **Pearl:** General medical assessment is part of good medical care for youth presenting with concerning anxiety symptoms |
| ☐ Assessment of medical conditions that can present with anxiety symptoms (i.e., thyroid abnormalities, cardiac arrhythmias) | **Pearl:** Identification and intervention for general medical problems presenting with psychiatric symptoms may help with assessment and treatment planning; consider MCPAP phone consultation to discuss complex situations. |
| ☐ Assessment of medical treatments that can present with anxiety symptoms as untoward reactions (i.e., steroid treatments, anti-convulsants, pseudephedrine, etc.) | **Pearl:** Identification and intervention for medical treatments presenting with psychiatric symptoms may help with assessment and treatment planning; consider MCPAP phone consultation to discuss complex situations. |
| ☐ Assessment of medical conditions and concurrent medical treatments that may affect treatment planning | **Pearl:** Identification of medical conditions that could impact antidepressant treatment (i.e., liver disease, renal problems) or medications with significant drug-drug interaction potential; consider MCPAP phone consultation for complicated situations. |

## IV. DIFFERENTIAL DIAGNOSIS

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Adjustment reactions to acute stressors (symptoms clearly correlated to recent and likely time-limited negative life event) | **Pearl:** Adjustment reactions rarely require pharmacological intervention; consider general health education, health maintenance strategies, or referral for psychotherapy as first-line intervention. Consider MCPAP phone consultation for complex situations. |
| ☐ Consider bullying | **Pearl:** Children who are victims of bullying may present with avoidance and anxiety symptoms, which represent acute or recurrent adjustment reactions to bullying. Also consider that patients with anxiety disorders may be targets of bullying behavior, therefore the experience of bullying doesn't exclude the possibility of an anxiety disorder. |
| ☐ Bipolar disorders | **Pearl:** Bipolar disorders in youth can be complicated in terms of assessment; consider MCPAP phone or face-to-face consultation prior to initiating treatment if the youth is presenting with signs of bipolar disorder. |
| ☐ Anxiety disorder due to another medical condition | **Pearl:** First-line treatment would be intervention for the medical problem; consider interventions for anxiety as indicated. Consider MCPAP consultation in complex situations. |
| ☐ Substance use disorder | **Pearl:** Patients with anxiety disorders may self-medicate with substances and present with subjective anxiety associated with cravings and withdrawal. Careful assessment of the onset and course of the anxiety symptoms can help with differential diagnosis. In the case of dual diagnosis, it is necessary to treat both the anxiety disorder (avoiding benzodiazepines) and the substance use disorder concurrently. |
| ☐ Autism spectrum disorder | **Pearl:** Patients with autism frequently have significant anxiety symptoms, which may be attributed to the core symptoms of autism. Consider consulting with MCPAP for help in clarifying diagnosis and addressing these symptoms. |

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## V. ASSESSMENT OF RISK

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Assess youth comprehensively for suicidal thinking or behavior as main, short-term concern is risk of self-harm, suicidal behavior, or completed suicide | **Pearl:** Refer for immediate and emergent Crisis Assessment with Emergency Psychiatric Service providers in the following situations:<br>▪ Any evidence of recent suicidal behavior<br>▪ Current active intent to engage in suicidal behavior<br>▪ Current significant planning for suicidal behavior<br>▪ Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified<br>▪ Evidence that youth or family will not or cannot access Emergency Psychiatric Service providers in times of worsening risk<br>▪ Consider MCPAP phone consultation for complex or confusing situations |

## VI. TREATMENT PLANNING

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Present to family clinical impressions and recommendations regarding the need for treatment | **Pearl:** Consult with MCPAP by phone as needed regarding developing an appropriate treatment plan. |
| ☐ Using MCPAP guidelines, discuss treatment options with family and ascertain family preferences for treatment | **Pearl:** Family preferences regarding treatment choices can be taken into account along with many other factors in determining initial treatment plan in many situations; consider MCPAP phone or face-to-face consultation for complicated situations. |
| ☐ With medication treatment, utilize standard informed consent procedures discussing potential benefits of treatment, potential side effects, alternatives to medication treatment, and prognosis with and without medication treatment; include discussion of “black box” warning regarding treatment-emergent suicidality associated with all anti-depressants for patients ages 25 and younger. Document this discussion in clinical record. Although only duloxetine is FDA-approved for the treatment of anxiety in children and adolescents older than age 7, the SSRIs (especially sertraline and fluoxetine) generally are preferred despite lacking FDA approval due to their greater tolerability along with proven effectiveness in research studies. | **Pearl:** Consult with MCPAP CAP as needed regarding any concerns about informed consent as it applies to treatment planning. |
| ☐ Discuss plan for medication monitoring, dosage adjustment, and discontinuation | **Pearl:** Monitoring response to treatment, ideally with a standardized symptom rating scale and adjusting medication dose as indicated may lead to an improved outcome; the plan for medication discontinuation after symptom remission should be discussed. |

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| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ MCPAP currently does NOT recommend the use of routine pharmacogenetic testing for initial medication selection strategies in primary care for youth with anxiety. | **Pearl:** Pharmacogenetic testing is considered experimental and is not incorporated at this time into any standard practice guidelines for youth with depression. There may be specialized situations where pharmacogenetic testing is appropriate in specialty care. Consider phone consultation with MCPAP CAP to discuss further as warranted. |

## VII: MEDICAL MONITORING

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Acute Treatment Phase (8-12 weeks) | **Pearl**: Goals - remission and/or reduction of symptoms, improvement in function<br>▪ Initiation and close monitoring of medication treatment response and tolerance<br>▪ Monitor medication compliance and tolerance<br>▪ If youth is experiencing side effects from medication, do not advance dose until side effect remits fully<br>▪ Re-assessment of anxiety symptoms at 4, 8, and 12 weeks using GAD-7 or SCARED<br>▪ Follow guidelines and consult with MCPAP CAP as needed |
| ☐ Maintenance Phase (6-12 months) | **Pearl**: Goals - youth will continue to demonstrate reduction and/or remission of symptoms and improvement in function after positive acute treatment response<br>▪ Maintain active treatment plan (medication, psychotherapy) during this period<br>▪ Monitoring generally less involved or intensive assuming ongoing symptom improvement<br>▪ Monitor medication compliance and tolerance<br>▪ Ongoing collaboration with therapist if present<br>▪ Consult with MCPAP CAP as needed<br>▪ If symptoms and functioning improve for 6-12 months, reassess with GAD-7 or SCARED<br>▪ Discussion with MCPAP CAP of treatment discontinuation phase if response has been sustained for 6-12 months |
| ☐ Treatment Discontinuation Phase (3 to 6 months) | **Pearl**: Goals - safely and thoughtfully withdrawn treatment and monitor for symptom recurrence<br>▪ Informed consent with family: potential benefits of withdrawing treatment, potential risks of withdrawing treatment, plan to deal with problems or recurrence if needed<br>▪ Discuss medication strategies with family (consult with MCPAP CAP as needed)<br>▪ Active monitoring for several months during this phase; re-evaluate need for resuming medication if assessment scales suggest episode relapse or recurrence<br>▪ Ongoing collaboration with therapist if present<br>▪ Consult with MCPAP CAP as needed |

# MCPAP ADHD Guidelines for PCPs

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**PCP Visit:**

- Screen for behavioral health problems
  - Pediatric Symptom Checklist-17 (cut-points: 15 total, 7 attention, 7 behavior, individual attention, and behavior items)
- If screen is positive, conduct focused assessment
  - If concern for imminent danger, refer to hospital or crisis team for emergency psychiatric assessment
  - Consult with MCPAP CAP as needed

Focused assessment including clinical interview (see *ADHD Clinical Pearls*) and symptom rating scales for (both parent and teacher):

**Parent: Vanderbilt – Initial (age <13)**; ADHD cut-points: 6+ "often" or "very often" on items 1-9 (inattentive) and/or 10-18 (hyperactive/impulsive); ODD cut-points: 4+ "often" or "very often" on items 19-26

**Teacher: Vanderbilt – Initial (age <13);** ADHD cut-points: 6+ "often" or "very often" on items 1-9 (inattentive) and/or 10-18 (hyperactive/impulsive); behavior cut-points: 3+ "often" or "very often" on items 19-28

**SNAP-IV 26 Parent and Teacher (age <18);** ADHD cut-points: 13+ for items 1-9 (inattentive) and/or 13+ for items 10-18 (hyperactive/impulsive); ODD cut-point: 8+ for items 19-26

**Sub-clinical to mild ADHD or behavior problem:** Guided self-management with follow-up

**Moderate ADHD** (or self-management unsuccessful): Consider medication; **Moderate ADHD with moderate behavior problem** (or self-management unsuccessful)**:** Consider medication and refer to therapy

**Severe ADHD with high-risk behavior problem or other co-morbidity:** Refer to specialty care for therapy and medication management until stable

FDA-approved medications for ADHD (age 6+): (Consider MCPAP consultation on medication treatment for children age <6)

**Methylphenidate**

e.g., **Oros methylphenidate extended release –** starting dose: 18mg; therapeutic dosage range: 18-54mg; duration of action: ≤12 hrs

e.g., **Dexmethylphenidate extended release –** starting dose: 5mg; therapeutic dosage range: 5-30mg; duration of action: ≤12 hrs

**Amphetamine**

e.g., **Amphetamine/dextroamphetamine mixed salts extended release –** starting dose: 5mg; therapeutic dosage range: 5-30mg; duration of action: ≤12 hrs

e.g., **Lisdexamfetamine –** starting dose: 20mg; therapeutic dosage range: 20-70mg; duration of action: ≤12 hrs

Baseline medical assessment: personal/family cardiovascular history; height, weight, pulse, blood pressure; substance use disorder history

After 2-3 weeks on starting dose, obtain **Vanderbilt Parent and Teacher Follow-Up or SNAP-IV** to assess response

If inattention and/or hyperactive/impulsive scores > cut-points and impairment persists, increase dose to next step (in 18mg increments for Oros methylphenidate, 10mg increments for lisdexamfetamine and 5mg increments for other medications)

After each dosage increase, obtain **Vanderbilt Parent and Teacher Follow-Up or SNAP-IV** to assess response before further dosage increase

If scores > cut-points and impairment persists, continue to up-titrate dose stepwise every 2-3 weeks to maximum therapeutic dose as tolerated

If scores > cut-points at maximum therapeutic dose, consult MCPAP CAP for next steps

If scores < cut-point with mild to no impairment, remain at current dose for remainder of school year

Monitor at least every 3-4 months for maintenance of remission, side effects, and anthropometrics/vitals; consult with MCPAP CAP as needed

Consider off medication on weekends, holidays, vacation days

Consider discontinuation each school year; monitor with **Vanderbilt Parent and Teacher Initial or SNAP-IV** for symptom recurrence for several months after discontinuation

*HJ Walter, Department of Psychiatry, Boston Children's Hospital (adapted by MCPAP with permission)*

*Revised August 2018*

*Funding provided by the Massachusetts Department of Mental Health, Boston Children's Hospital, & Sidney A. Swensrud Foundation*

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# ADHD "Clinical Pearls" for Primary Care Providers

## I. CLINICAL HISTORY

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Multi-informant assessment: gather history from youth, parent/guardian, others who know youth well as indicated | **Pearl:** Disruptive behavior screening forms (i.e., Vanderbilt) should be completed and reviewed prior to clinical visit. Notes and school reports cards can have helpful information (review behavioral comment section). |
| ☐ Collaborate with and gather collateral information from school | |
| ☐ Assess current functioning in different areas (family, peers, school, community) | **Pearl:** Usually ADHD affects youth across areas of their life; if youth is functioning highly in some areas but is compromised in one area, consider other explanations apart from ADHD |
| ☐ Assess for acute stressors of life events/trauma which may be contributing to presentation | **Pearl:** Stressors can become important targets for intervention via psychoeducation or psychotherapy. Understanding acting out as child communication of distress can be help parents re-structure their interventions. |
| ☐ Assess for history of clinically significant trauma experiences | **Pearl:** History of current or remote trauma may increase complexity of assessment and treatment planning; consider MCPAP consultation or referral to specialty care. |
| ☐ Assess for developmental progress and history of early milestone delays | **Pearl:** Prior history of language delay; consider speech and hearing assessment |
| ☐ Assess for delay in learning progress concerns | **Pearl:** Educational assessment and assessment of learning disorders through the school or psychological testing can clarify possible co-morbidity. |
| ☐ Assess for presence of substance use and abuse | **Pearl:** History of active substance abuse or dependence may complicate assessment and treatment planning; consider MCPAP consultation or referral to more specialized care. |
| ☐ Assess for typical day from waking, meals, afterschool, bedtime transition | **Pearl:** Provide parental guidance around specific parenting challenges, and begin to provide a framework for parent to think about enhancing structure. |
| ☐ Assess for current or previous parental behavioral efforts | **Pearl:** Target parental guidance, role of positive parenting and encouragement, empowering parenting vs discipline |
| ☐ Assess for current or previous mental health providers | **Pearl:** Collaboration and information sharing with current mental health providers is essential to quality care. |
| ☐ Assessing sleep | **Pearl:** Assess sleep onset, quality, independent sleep. Provide guidance about recommended sleep amount based on age. |
| ☐ Assessing screen time use | **Pearl:** Understand screen time amount and use, utilize AAP Tools, AAP Family Media Plan www.healthychildren.org/English/media/Pages/default.aspx |
| ☐ Review longitudinal history (age of onset of symptoms, duration, evolution of symptoms across development) | **Pearl:** ADHD symptoms ordinarily begin in early childhood. Hyperactivity usually wanes in adolescence. For late onset presentations, in the absence of retrospective parental verification of early onset symptoms, consider alternative explanations and consider MCPAP consultation. |

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Assess for psychiatric co-morbidity | **Pearl:** Anxiety and Depression symptoms can include loss of attention and decrease in sustained concentration. Oppositional Defiant Disorder, DMDD, and Bipolar Disorder are characterized by emotional dysregulation and symptoms of inattention, impulsivity, and disruptive behavior. If co-morbidity is suspected or identified medication treatment is likely complex and MCPAP guidance is recommended to assist with further assessment and treatment planning. |

## II. MENTAL STATUS EXAMINATION

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Behavior observation – assessment of level of energy, distractibility, attention | **Pearl:** Observation of the patient in the waiting room and the impression of front desk staff can be valuable adjuncts to assessment as some children will be very shy and reserved in the office. |
| ☐ Parent-child/child-sibling interaction observation | **Pearl:** Children with ADHD may be assigned the "problem child role" in the family and held disproportionately responsible for conflicts in family. |
| ☐ Interview with child | **Pearl:** Games or drawing tasks help with establishing a report with the child and assessing fine motor skills. |
| ☐ Interview with teen | **Pearl:** Inquire about ADHD symptom experience and ask about how long a teen can read; retention and comprehension is helpful to understand inattention. |

## III. MEDICAL WORKUP

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Perform general standard medical assessment | **Pearl:** General medical assessment is part of good medical care for youth; soft signs like mild incoordination and poor fine motor skills are noted to be associated. |
| ☐ Assessment of medical conditions that can present with ADHD symptoms (i.e., Lead poisoning, environmental allergies, hyperthyroid) | **Pearl:** Identification and intervention for general medical problems are part of good care. |
| ☐ Assessment of medical treatments that can present with inattention symptoms as untoward reactions (i.e., Antihistamines, steroids) | **Pearl:** Identification and intervention for medical treatments presenting with psychiatric symptoms may help with assessment and treatment planning; consider MCPAP phone consultation to discuss complex situations. |
| ☐ Assessment of medical conditions and concurrent medical treatments that may affect treatment planning | **Pearl:** Identification of medical conditions that could impact stimulant treatment (i.e., malnutrition, anorexia nervosa, cardiac conditions) or medications with significant drug-drug interaction potential; consider MCPAP phone consultation for complicated situations. |

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## IV. DIFFERENTIAL DIAGNOSIS

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Adjustment reactions to acute stressors (symptoms clearly correlated to recent and likely time-limited negative life event) | **Pearl:** Adjustment reactions rarely or ever require pharmacological intervention; consider general health education, health maintenance strategies, or referral for psychotherapy as first-line intervention. Consider MCPAP phone consultation for complex situations. |
| ☐ Bipolar Disorders | **Pearl:** Bipolar disorders in youth can be complicated in terms of assessment; consider MCPAP phone or face-to-face consultation prior to initiating treatment if the youth is presenting with signs of bipolar disorder such as grandiosity or fluctuating energy level. |
| ☐ Disruptive Mood Dysregulation Disorder (DMDD) | **Pearl:** Patients with chronic irritability, negativity, and explosive behavior should be considered for DMDD; consider MCPAP consultation. |
| ☐ Autism Spectrum Disorder (ASD) | **Pearl:** Patients with ASD may present with hyperactivity and/or inattention, which may represent either comorbid ADHD or may be related to core symptoms of ASD; consider MCPAP consultation. |

## V. TREATMENT PLANNING

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Present to family results of diagnostic evaluation and recommendations regarding the need for treatment | **Pearl:** Consult with MCPAP phone consultation as needed regarding developing an appropriate treatment plan. |
| ☐ Using MCPAP algorithm, discuss with family recommended treatment plan | **Pearl:** Family preferences regarding treatment choices can be taken into account along with many other factors in determining initial treatment plan in many situations; consider MCPAP phone or face-to-face consultation for complicated situations. |
| ☐ Ascertain family preferences regarding treatment plan | **Pearl:** Family preferences regarding treatment choices can be taken into account along with many other factors in determining initial treatment plan in many situations; consider MCPAP phone consultation or face-to-face consultation for complicated situations. |
| ☐ With medication treatment | **Pearl:** Consult with MCPAP CAP as needed regarding any concerns about informed consent as it applies to treatment planning. |
| ☐ MCPAP currently does NOT recommend the use of routine pharmacogenetic testing for initial medication selection strategies in primary care for youth with ADHD. | **Pearl:** Pharmacogenetic testing is considered experimental and is not incorporated at this time into any standard practice guidelines for youth with ADHD. There may be specialized situations where pharmacogenetic testing is appropriate in specialty care. Consider phone consultation with MCPAP CAP to discuss further as warranted. |

## VI. MEDICAL MONITORING

| Recommended Procedure | Clinical Pearls |
|---|---|
| ☐ Initiation:<br>▪ Goal is to find optimal treatment dose and help family develop a workable treatment schedule while monitoring and problem-solving side effect challenges | **Pearl:** Initial follow up in two weeks to review side effect and treatment dosing. Continue with two-week follow-up until an effective dose is established without the overburden of side effect challenges. Problem solve with parents around medication timing. |

| Recommended Procedure | Clinical Pearls |
| --- | --- |
| ☐ Maintenance:<br>▪ Providing ongoing monitoring and parental guidance especially for social skills, discipline, enrichment, supervision, and academic progress | **Pearl:** Follow up every three months (quarter). Monitor weight and growth. Address seasonal and school schedule changes; adjust dosing and medication timing as needed. Provide parental anticipatory guidance. Consider referral to social skills programs or Individual Therapy if adjustment challenges go beyond the scope of parental guidance. |
| ☐ Cardiac Assessment<br>▪ Physical exam, cardiac exam, vital signs, and review of patient and family cardiac history | **Pearl:** Findings on exam or family or patient history of dizziness, syncopal episodes, palpitations, prior cardiac surgery/intervention, or arrhythmias warrant further cardiology assessment and clearance. Routine EKG is not necessary for initiation or monitoring of stimulant medication. |
| ☐ Discontinuation<br>▪ Teens and parents at times will want to consider discontinuation. Some children will mature out of ADHD; it is sufficient to discontinue medication treatment. | **Pearl:** Provide psychoeducation around the risks of treatment discontinuation and increase in risk behavior. Take a collaborative, experiment approach with termination. Consider more flexible dosing schedules. Explore concerns and consider alternative ADHD treatments which may be better fit. |