MCPAP

Massachusetts Child Psychiatry Access Program

Guidelines and Clinical Pearls

(Anxiety, Depression, ADHD, OCD, PTSD and ASD)

Revised Spring 2021

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)
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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: ▪ Any evidence of recent suicidal behavior ▪ Current active intent to engage in suicidal behavior ▪ Current significant planning for suicidal behavior ▪ Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified ▪ Evidence that youth or family will not or cannot access Emergency Psychiatric Service providers in times of worsening risk ▪ 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.

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 ▪ Initiation and close monitoring of medication treatment response and tolerance ▪ Weekly to bi-weekly check-ins with youth and/or family ▪ Monitor medication compliance and tolerance ▪ If youth experiencing side effects from medication, do not advance dose until side effect remits fully ▪ Re-assessment of depressive symptoms at 4 weeks using MFQ or PHQ-9 ▪ 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 ▪ Maintain active treatment plan (medication, psychotherapy) during this period ▪ Monitoring generally less involved or intensive assuming ongoing symptom improvement ▪ Monitor medication compliance and tolerance ▪ Ongoing collaboration with therapist if present ▪ Consult with MCPAP CAP as needed ▪ If symptoms and functioning improve for 6-12 months, reassess with MFQ/PHQ-9 ▪ 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 ▪ Informed consent with family: potential benefits of withdrawing treatment, potential risks of withdrawing treatment, plan to deal with problems or recurrence if needed ▪ Discuss medication strategies with family (consult with MCPAP CAP as needed) ▪ Active monitoring for several months during this phase ▪ 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 ▪ Ongoing collaboration with therapist if present ▪ 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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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: ▪ Any evidence of recent suicidal behavior ▪ Current active intent to engage in suicidal behavior ▪ Current significant planning for suicidal behavior ▪ Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified ▪ Evidence that youth or family will not or cannot access Emergency Psychiatric Service providers in times of worsening risk ▪ 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.

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 ▪ Initiation and close monitoring of medication treatment response and tolerance ▪ Monitor medication compliance and tolerance ▪ If youth is experiencing side effects from medication, do not advance dose until side effect remits fully ▪ Re-assessment of anxiety symptoms at 4, 8, and 12 weeks using GAD-7 or SCARED ▪ 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 ▪ Maintain active treatment plan (medication, psychotherapy) during this period ▪ Monitoring generally less involved or intensive assuming ongoing symptom improvement ▪ Monitor medication compliance and tolerance ▪ Ongoing collaboration with therapist if present ▪ Consult with MCPAP CAP as needed ▪ If symptoms and functioning improve for 6-12 months, reassess with GAD-7 or SCARED ▪ 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 ▪ Informed consent with family: potential benefits of withdrawing treatment, potential risks of withdrawing treatment, plan to deal with problems or recurrence if needed ▪ Discuss medication strategies with family (consult with MCPAP CAP as needed) ▪ Active monitoring for several months during this phase; re-evaluate need for resuming medication if assessment scales suggest episode relapse or recurrence ▪ Ongoing collaboration with therapist if present ▪ Consult with MCPAP CAP as needed

MCPAP ADHD Guidelines for PCPs

Massachusetts Child Psychiatry Access Program

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

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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: ▪ 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: ▪ 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 ▪ 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 ▪ 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.

MCPAP Obsessive Compulsive Disorder (OCD) Guidelines for PCPs

PCP Visit:

- Explore OCD concern, acute or gradual onset, prior history of anxiety, or family history of anxiety
- Obsession Assessment – history and details of unwanted ideas, thoughts, images, or urges that are explained and experienced as unpleasant or unwanted
- Compulsion Assessment – history of compulsions or rituals that the child feels he/she must do to get rid of upsetting feelings or prevent bad event from happening

Consider PANDAS/PANS Work-Up:

- Pre-pubertal, abrupt onset of OCD symptoms and/or tics
- Symptoms including: extreme anxiety/emotional lability or depression, aggression, rituals/compulsions, developmental regression, deterioration in school performance, sensory integration issues, sleep disturbance, enuresis/urinary frequency and/or arthralgias, restrictive eating
- Call MCPAP to review work-up, lab studies, and treatment recommendations

Focused Assessment including clinical interview (see *OCD Clinical Pearls*)

Child Yale-Brown Obsession Compulsion (CY-BOC): Ages 6-17, Symptom Inventory and Severity Scales

Subclinical/Mild (CY-BOC Score 0-15)

- Educate parent and child and create a family plan to reduce accommodations and avoidance behaviors (see *OCD Clinical Pearls*)
- Follow-up in 4-6 weeks; refer to Cognitive Behavioral Therapy (CBT) or Exposure Response Prevention Therapy (ERP), if persistent

Moderate (CY-BOC score 16-23) to Severe/Extreme (CY-BOC score >23)

- In addition to parent and child education and family plan, referral to individual therapy (CBT/ERP)
- Consideration of medication if severe or inadequate response to therapy

Adjunctive Medication Treatment for OCD with SSRI:
FDA-approved medication treatments: **Sertraline (>6), Fluvoxamine (>8),** and **Fluoxetine (>7)**
Consider MCPAP Consultation on medication for treatment for children age <6.

Sertraline, Fluvoxamine, Fluoxetine

- Start test dose for 1 week (e.g., Sertraline 12.5mg, Fluvoxamine 25mg, Fluoxetine 5mg)
- If test dose tolerated, increase daily dose gradually (every 1-2 weeks) to target doses
  - **Sertraline** target 100 to 150mg – max dose 200mg – nighttime dosing if somnolence
  - **Fluvoxamine** target 100 to 150mg – max dose 200mg (ages 8-11), 300mg (adolescents); typical nighttime dosing, divided dosing recommended over 100mg
  - **Fluoxetine** target 20-30mg for children and 30-60mg for adolescents
- 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

Monitoring and Reassessment:

- Every 4 weeks until maintenance established - reassess with **CY-BOC** scale
- May titrate medication as tolerated towards max dosage (increments: Sertraline 12.5 mg, Fluvoxamine 25 mg, Fluoxetine 5 mg)
- Reinforce importance of CBT/ERP therapy as primary treatment (medication alone not established as effective treatment)
- Following one year of remission, consider gradual decrease every 4 weeks to initiation dose, then discontinue
- Monitor for potential exacerbation; if found, consider PANDAS

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Obsessive-Compulsive Disorder (OCD) Clinical Pearls for Primary Care Providers

I: Clinical History

Recommended Procedure	Clinical Pearls
☐ Assessment: OCD assessment – gather history of parental concerns and patient report. OCD inventories help identify the variety of obsessions and compulsions. ☐ Child Yale-Brown Obsession Compulsion (CY-BOC) ○ Subclinical (CY-BOC 0-15) ○ Moderate (CY-BOC 16-23) ○ Severe (CY-BOC >23) ☐ Consider screening for PANDAS particularly for those children presenting with sudden food refusal, separation anxiety, reported arthralgias, and secondary enuresis or encopresis.	**Pearl:** Frequently, OCD has a history of being undetected or hidden for several months to sometimes years before an exacerbation flare is severe or comes to the attention of the family. With rapid onset for a pre-pubertal child, consider PANDAS/PANS, which may go undetected because of the waxing and waning nature of the illness. CY-BOC has two parts; one is a symptom inventory and the other tracks severity.
☐ Family History: OCD and Anxiety disorders are common. ☐ Screen for family history of autoimmune disorders suggestive of possible PANDAS.	**Pearl:** Parents with OCD may need additional referral support to enhance their own treatment before they are able to effectively collaborate in their child's OCD care. Asking a child which parent has anxiety is usually revealing. Children with PANDAS frequently have family history of autoimmune disorders, particularly maternal thyroid disease.
☐ Assess parental behavioral efforts: inquire about how the parents have been managing behavior and provide guidance around parents who are overly accommodating or invalidating. ☐ The Family Accommodation Scale is a useful scale to assess parental and family accommodating.	**Pearl:** It is common for parents to be overly accommodating, especially if they have a history of anxiety symptoms. Under these circumstances, PCPs may provide guidance about typical age expectations and educate parents that reassurance seeking is often a core symptom of OCD. Parents should be advised to refrain from providing reassurance and be given a script for responding to reassurance seeking, e.g., "I'm not going to answer that question because we both know that you already know the answer, and it's better for us not to pay attention to these kinds of worries."
☐ Check for past psychiatric history, including a history of prior anxiety treatment or co-morbid psych history like ADHD or a learning disorder.	**Pearl:** Children with OCD frequently have other anxiety disorders like Separation Anxiety, Social Anxiety, or Specific Fears/Phobias.

II: Mental Status Examination

Recommended Procedure	Clinical Pearls
☐ Behavior observation; document any noted tics, hand or skin excoriation from excess washing, atypical hyperactivity, and restlessness or mood lability.	**Pearl:** Many children with OCD can manage their impulses in community or under observation. The presence of a comorbid tic, hyperactivity, and significant mood lability may suggest underlying PANDAS.

(continued)

Recommended Procedure	Clinical Pearls
☐ Observe parent-child/child-sibling interaction.	**Pearl:** Inquiring about family daily routines, especially morning or bedtime routines, may help gauge the degree of severity and family accommodations. For example, the parents might be engaged in ritualistic checking of closets or under the bed before bedtime every night.
☐ Interview the child.	**Pearl:** Utilizing a questionnaire/screening form can help provide the child with language to name his/her obsessions and compulsions.

III: Medical Workup

Recommended Procedure	Clinical Pearls
☐ Physical exam and Review of Systems	**Pearl:** You may find skin picking, excoriated hands from excessive washing, tics, missing scalp hair (trichotillomania), Somatic worries, or repeated medical reassurance seeking.
☐ Assessment of PANDAS/PANS ☐ Basic Lab Work - IgE Level, IgA, IgM, IgG (subclass 1, 2, 3, 4), CBC, ANA, Ferritin, B-12, Vitamin D ☐ Viral/Bacterial Testing - Strep throat culture, 48-hour culture or perianal culture; Antistreptolysin O (ASO); Anti-DNAse B; Streptozyme; Lyme Disease and co-infections; Mycoplasma Pneumoniae IgA and IgM; Pneumococcal Antibody Titers; Epstein Barr Virus Panel; Coxsackie A & B Titers; HHV-6 Titers	**Pearl:** Consider treatment for presumptive PANDAS/PANS. Refer to treatment recommendation and guidelines. Consult with MCPAP. www.pandasnetwork.org Advance Studies - Cunningham Panel* – autoimmune autoantibody levels: Dopamine D1 receptor, Dopamine D2L receptor, Lysoganglioside GM1, Tubulin, and CaM Kinase II. ○ Only 54 percent of children with strep showed a significant increase in ASO. ○ Only 45 percent showed an increase in anti–DNase B. ○ Only 63 percent showed an increase in either ASO and/or anti–DNase B. (Shet et. al (2003) study) Of new group A strep infections, 65% of new strep caused no symptoms yet were immunologically significant (Hysmith et. al (2017) study)
☐ Perform an assessment of medical conditions and concurrent medical treatments that may affect treatment planning.	**Pearl:** Use caution about over-reassurance or over-engaging in medical assessments that are meant to reassure rather than rule out a reasonable differential concern.

IV: Differential Diagnosis

Recommended Procedure	Clinical Pearls
☐ Normal Development; brief obsessions lasting weeks to months can be developmentally appropriate. A child can have normal obsessive interests like repeatedly watching a favorite movie or lining up toys and collectables.	**Pearl:** Additional inputs from teachers or other care-givers can assist if there is uncertainty about normal vs more-excessive obsessions.
☐ Oppositional Defiant Disorder includes undoing defenses, lining up, or over possessiveness.	**Pearl:** With ODD, there is a more chronic history of argumentativeness and over-attention to fairness. With OCD, there is more often pleading and acting out to accommodate their anxiety.

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Recommended Procedure	Clinical Pearls
☐ Autism Spectrum Disorder	**Pearl:** Perseveration and restricted interest range overlap with OCD. ASD has high co-morbid OCD association where OCD symptoms tend to be in the “Symmetry” subgroup.
☐ Attention Deficit Disorder	**Pearl:** ADHD frequently is comorbid in children with OCD. Further assessment with Connor’s or Vanderbilt scales from parents and teachers may be needed.

V. Assessment of Risk

Recommended Procedure	Clinical Pearls
☐ Safety Assessment; assess youth for suicidal thinking or self-harm behavior.	**Pearl:** Refer for Crisis Assessment with Emergency Psychiatric Services providers in the following situations. ○ Any evidence of recent suicidal behavior ○ Suicidal or self-harm behavior ○ Any suicidal ideation, especially if there are significant suicidal plans ○ Any degree of lack of cooperation in assessment from youth or family ○ Evidence that youth or family will not or cannot access Emergency Psychiatric Services providers in times of worsening risk Consider MCPAP phone consultation.

VI: Treatment Planning

Recommended Procedure	Clinical Pearls
☐ Note mild concerns like excessive hand washing or germ/emetophobia that are not interfering with school and family function.	**Pearl:** Provide psychoeducation and information for the patient, family, and caregivers regarding the need for gentle redirection. Consider parental self-guided treatment and support. Refer to www.iocdf.org and books like "Talking Back to OCD" by Dr. John March.
☐ Note moderate concerns like two or more OCD symptom categories and more severity that is impacting family, school, or social function.	**Pearl:** Refer to Individual therapy with CBT and ERP treatment capacity. Better therapy engages the family to align with the patient to treat the OCD.
☐ Note severe concerns like child distress and significant impact with school, activities, and family functions.	**Pearl:** In addition to referral to therapy, medication treatment initiation is recommended. Also, consider symptomatic treatment for challenges like acute anxiety or insomnia. For children with PANDAS, initiation of a two-week course of antibiotics and NSAIDS may be warranted. Consult with MCPAP for further guidance.

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VII: Medical Monitoring

Recommended Procedure	Clinical Pearls
☐ The goal of the Initiation Phase is to monitor tolerance and side effects. Review SSRI suicidal ideation risk and develop a safety plan. Follow guidelines.	**Pearl:** Start low and go slow. If the youth experiences side effects, do not advance medication until side effects remit. Reassessment at 2-4 weeks, 8 weeks, and 12 weeks.
☐ Establish optimal dosing by gradually increasing to recommend treatment doses, which are typically at the higher dosing range.	**Pearl:** Support the patient and family with the slower time to treatment benefit. Medication treatment is largely incomplete. Maintain perspective that medication treatment is an adjunct to CBT/ERP therapy. Consider alternative SSRI medication trial following 12 to 16 week trial on highest tolerated dose.
☐ Termination; consider a gradual decrease of SSRI medication following 6 months of OCD remission.	**Pearl:** Go slowly, titrating the dose by small increments, no more frequently than every 4 to 8 weeks.

Resources:

Talking Back to Your OCD by John March:
https://www.amazon.com/dp/1593853556/ref=cm_sw_r_em_api_i_c_yadKCbWDNJ9KV

ADAA: https://adaa.org/obsessive-compulsive-disorder.

Here is the OCD best practices page, which has information about treatment (including meds):
https://adaa.org/resources-professionals/practice-guidelines-ocd

OCD Foundation: https://iocdf.org/

Blog written by one of the McLean Anxiety Mastery Program clinicians ("Helping a Child with OCD"):
https://www.health.harvard.edu/blog/helping-a-child-with-obsessive-compulsive-disorder-2018110115154

The Family Accommodation Scale:
(http://supp.apa.org/psycarticles/supplemental/pas0000165/z1t002152914so1PDF.pdf)

PANDAS Physician Network: http://PANDASppn.org

Thienemann, M. et al, “Clinical Management of Pediatric Acute Onset Neuropsychiatric Syndrome,” http://doi.org/10.1089/cao.2016.0145 , 1 Sep. 2017.

Pediatric OCD Treatment Study (POTS) JAMA. 2004 Oct. 27;292(16):1969-76.

MCPAP Guideline for Primary Care: Evaluating and Managing Traumatic Stress Disorders

Suggested Screening Question:

- **For parents/guardians:** *"Has anything really scary or upsetting ever happened to your child or anyone else in your family?"*
- **For kids age 7-17:** *"Has anything really scary or upsetting happened to you or your family?"*

If **Yes**

Continue interviewing, gather details, and assess for imminent safety concerns:

- If concern for recent or current abuse/neglect ➔ File 51A
- If concern for imminent danger to self or others ➔ Refer to ER or crisis team for emergency assessment

Use the **Child and Adolescent Trauma Screen (CATS)** to assess for adverse childhood events/trauma and PTSD symptoms.

- CATS is available as a caregiver report for ages 3-6 and caregiver report for ages 7-17.
- CATs has youth report form for ages 7-17.

CATS Ages 3-6 Score < 12 CATS Ages 17-17 Score < 15 Normal

- Provide support and empathy
- Build relationship and rapport with patient and family
- Encourage healthy coping, including parent-child quality time**,** sleep hygiene, bedtime routines and rituals, and self-soothing skills (deep breathing and progressive muscle relaxation)

CATS Ages 3-6 Score 12-14 CATS Ages 7-17 Score 15-20 Moderate Trauma-Related Stress

- Assess for co-occurring depression and/or anxiety *(see relevant MCPAP guideline)*
- Monitor closely for suicidal ideation or self-injurious behavior
- Provide education on trauma and encourage healthy coping
- Consider referral for trauma-focused therapy *(see box below)*
- Schedule follow up visit in 4-6 weeks to ensure symptoms resolving

CATS Ages 3-6 Score 15+ CATS Ages 7-17 Score 21+ Probable PTSD

- Assess for co-occurring depression and/or anxiety *(see relevant MCPAP guideline)*
- Monitor closely for suicidal ideation or self-injurious behavior
- Provide education on trauma
- Refer for trauma-focused, evidence-based therapy *(see box below)*
- Consider indications for prescribing psychiatric medication *(see box below)*
- Convey hope for recovery
- Schedule follow up visit in 4-6 weeks ensure connection to specialty care

Trauma-Focused, Evidence-Based Therapies (EBTs):

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) – ages 3-21, focuses on building skills for emotional and behavioral regulation, strengthening relationships, and processing traumatic events
  - To find a provider of trauma focused care, call the state Child Trauma Training Center (855-Link-Kid) or visit https://www.umassmed.edu/cttc/cttc-services/link-kid.
- Child-Parent Psychotherapy (CPP) – ages 0-5, focus on strengthening parent-child attachment
- Parent-Child Interaction Therapy (PCIT), ages 2-7, therapist coaches parent in the moment to change parent child interactional patterns
- Attachment Regulation and Competency (ARC) – ages 2-21, provides a framework for working with children and adolescents who have experienced multiple or prolonged traumas

For more information on different types of trauma therapy, please visit https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions.

See reverse side for medication considerations.

We understand that the assessment and treatment of PTSD is complex. Do not hesitate to call MCPAP discuss specific cases with child psychiatrist on call.

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MCPAP Guideline for Primary Care: Evaluating and Managing Traumatic Stress Disorders

Indications for psychiatric medication in children with PTSD and related conditions:

- The patient has comorbid depression and/or anxiety requiring medication treatment (see appropriate MCPAP guideline).
- Symptoms are causing significant distress or functional impairment despite an adequate trial of an evidence-based psychotherapy for PTSD.
- Symptom severity is limiting engagement in psychotherapy for PTSD.

Medications used in the treatment of PTSD:*

- Medications are selected to target the symptom causing the most distress or functional impairment.
    - For **trouble falling asleep** not responsive to sleep hygiene:
        - Melatonin 3-6 mg QHS
        - Clonidine 0.05mg x1 week and then 0.1 mg QHS
    - For **severe nightmares** not responsive to behavioral interventions:
        - In consultation with the MCPAP CAP on call, consider a trial of prazosin starting at 1 mg QHS.
        - Do not mix prazosin (alpha 1 antagonist) with guanfacine or Tenex (alpha 2 agonists); the combination may cause hypotension.
    - For **hyper-arousal symptoms** (CATS 7-17 symptom questions 15-20, CATS 3-6 symptom questions 12-16), including anger/irritability:
        - Consider an alpha agonist trial such as clonidine or guanfacine at the same dosing as used for hyperactivity in ADHD.
    - For **negative alterations of cognition** (CATS 7-17 symptom questions 8-14, CATs 3-6 symptom questions 8-11), including symptoms of depression and anxiety:
        - Consider an SSRI trial with dosing recommended in the depression and anxiety algorithms.
        - Monitor closely for development or worsening of suicidal ideation.
        - We recommend weekly follow up for the first four weeks of treatment, if possible.
    - Consider slow taper off of medication a when positive response has been sustained for 6-12 months.
        - Less likely in situations with multiple and complex traumas and high levels of stress

**Please note that all of the above medications are supported by published evidence, but not FDA-approved. For any off label prescribing, please consider calling MCPAP for consultation.*

Additional referrals to consider:

- If acute safety concerns → Mobile Crisis Intervention (MCI) or ER evaluation
- If severe symptoms limit functioning, including school refusal, but family is managing at home → Partial Hospital Program (PHP) referral
- If severe symptoms limit functioning, including school refusal, and family is unable to manage at home → Community-Based Acute Treatment (CBAT)/inpatient admission (usually requires an MCI or ER evaluation)

We understand that the assessment and treatment of PTSD is complex. Do not hesitate to call MCPAP discuss specific cases with child psychiatrist on call.

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Post-Traumatic Stress Disorder (PTSD) 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, including therapist if already in treatment	**Pearl:** PTSD can develop in response to experiencing a traumatic event, witnessing a traumatic event, or being indirectly exposed to details of a traumatic event (vicarious trauma).
☐ Assess for PTSD symptom clusters: **Re-experiencing** (nightmares, intrusive thoughts/memories, flashbacks) **Avoidance** (internal or external reminders) **Hyperarousal** (hypervigilence, increased startle, anger/irritability, risk taking, concentration difficulties, sleep disturbance) **Negative alterations in mood and cognitions** include negative thoughts about oneself, other people, and/or the world; can overlap with depressive and anxious symptoms	**Pearl:** The Child and Adolescent Trauma Screen (CATS) caregiver or youth self-report measure screens for traumatic events and also PTSD symptoms. On the CATS caregiver report for ages 3-6, questions 1-5 screen for re-experiencing symptoms, 6-7 for avoidance symptoms, 8-11 for negative cognitions, and 12-16 for hyperarousal symptoms. On the CATS caregiver and youth self-report for ages 7-17, questions 1-5 screen for re-experiencing symptoms, 6-7 for avoidance symptoms, 8-14 for negative cognitions, and 15-20 for hyperarousal symptoms.
☐ Assess for single vs. multiple traumas	**Pearl:** A high number of small-scale traumas in the context of chronic toxic stress may be more complicated to treat than a single discreet trauma in context of many supports.
☐ Assess timing of the trauma	**Pearl:** Symptoms in the month after a traumatic event are classified as acute stress reactions and are common. **Pearl:** PTSD symptoms persisting three months after a trauma are unlikely to remit without treatment.
☐ Assess level of psychosocial stress	**Pearl:** Chronic and severe stress can cause psychological difficulties even in absence of abuse/neglect/violence.
☐ Assess for co-morbid depression and/or anxiety	**Pearl:** Depression and anxiety are common co-morbid conditions with PTSD – consider MCPAP consultation or referral to specialty care.
☐ Assess for prior episodes of treated or untreated mania/hypomania	**Pearl:** Prior episodes of mania or hypomania will likely alter treatment planning- consider MCPAP consultation or referral to specialty care.
☐ Assess for presence of substance use and abuse	**Pearl:** Active substance abuse or dependence may complicate assessment and treatment planning – consider MCPAP consultation or referral to more-specialized care.
☐ Assess for history of non-suicidal and suicidal thinking and behavior (self-harm, suicide attempts) and previous suicidal crises	**Pearl:** History of active suicidal planning or intent or recent suicidal behavior increases safety risk – consider Psychiatric Crisis referral or urgent MCPAP phone consultation.
☐ Assess for family history of trauma	**Pearl:** Trauma can have an intergenerational legacy.
☐ Assess for current abuse/neglect	**Pearl:** Safety must be ensured before psychological treatment can be effective. If there are concerns re: current or recent abuse, file a 51A.

(continued)

II: Mental Status Examination

Recommended Procedure	Clinical Pearls
☐ Assess affect (dysregulated, flooded, constricted, withdrawn, dissociated)	**Pearl:** Children who have experienced trauma may have repetitive play or reenact the trauma through their play.
☐ 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 or intent or recent suicidal behavior increases safety risk – consider Psychiatric Crisis referral or urgent MCPAP phone consultation.
☐ Psychosis: hallucinations, delusions, abnormalities of thought processes or content	**Pearl:** Hallucinations due to PTSD are typically brief experiences related to the trauma and in the context of intact reality testing. Consider MCPAP phone consultation. If there are abnormalities in the thought process or behavior, we recommend Psychiatric Crisis referral for further assessment.

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 psychiatric symptoms.
☐ Assessment of medical conditions that can present with depressive or anxious symptoms (i.e., thyroid abnormalities, cardiac arrhythmias, 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:** Identification of medical conditions that could impact medication treatment (i.e., liver disease, cardiac or renal problems) or medications with significant drug-drug interaction potential – consider MCPAP phone consultation for complicated situations.

IV: Differential Diagnosis

Recommended Procedure	Clinical Pearls
☐ Acute Stress Disorder	**Pearl:** Clinically significant symptoms in the month following a trauma are more common than PTSD as symptoms tend to fade with time.
☐ PTSD	**Pearl:** Clinically significant symptoms that persist beyond one month after the trauma. Symptoms that persist past three months are unlikely to remit without treatment.
☐ Anxiety Disorder	**Pearl:** If a stressful but not traumatic life event is causing a lot of emotional distress, assess for underlying anxiety disorder. **Pearl:** Anxiety disorders are risk factors for PTSD. They are also frequently comorbid with PTSD.

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Recommended Procedure	Clinical Pearls
☐ Depression	**Pearl:** Depressive disorders are risk factors for PTSD. They are also frequently comorbid with PTSD.
☐ Bipolar Disorder	**Pearl:** The hyperarousal symptoms of PTSD, especially irritability and anger, can be confused with bipolar disorder.
☐ ADHD	**Pearl:** Difficulty concentrating is a symptom of both PTSD and ADHD. The hyperarousal symptoms of PTSD may also present as hyperactivity, especially in young children. In patients with history of trauma, assess for ADHD if difficulties concentrating remain after PTSD has been treated.

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:** Referral for immediate and emergent Crisis Assessment with Emergency Psychiatric Service providers in the following situations: • Any evidence of recent suicidal behavior • Current active intent to engage in suicidal behavior • Current significant planning for suicidal behavior • Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified • Evidence that youth or family will not or cannot access Emergency Psychiatric Service providers in times of worsening risk • Consider urgent MCPAP phone consultation for complex or confusing situations

VI: Treatment Planning

Recommended Procedure	Clinical Pearls
☐ Using MCPAP algorithm, discuss recommended treatment plan with family	**Pearl:** Psychosocial interventions (therapy and family support) are very important. No medications are FDA-approved for PTSD in children and teens, and our evidence base regarding these medications is quite limited.
☐ Psychotherapy is the first line treatment for PTSD.	**Pearl:** Most good therapy for PTSD includes caregiver involvement, skills for coping/relaxation, challenging negative cognitive distortions related to the trauma, and building a trauma narrative and competent sense of identity.
☐ Ascertain from 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, utilize standard informed consent procedures discussing potential benefits of treatment, potential side effects, and that treatment is off-label as no medications have FDA approval for treatment of PTSD in children and adolescent	**Pearl:** Consult with MCPAP CAP as needed regarding any concerns about informed consent as it applies to treatment planning.

(continued)

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 PTSD.	**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)	**Goals:** • Remission and/or reduction of symptoms, improvement in function • Initiation and close monitoring of medication treatment response and tolerance • Weekly to bi-weekly check-ins with youth and/or family • Monitor medication compliance and tolerance • If youth experiencing side effects from medication, do not advance dose until side effect remits fully • Re-assessment of symptoms at four weeks using CATS symptom monitoring form or PTSD screening form • Note that there is a six-question follow up version of the CATS that may be utilized for monitoring • Follow algorithm and consult with MCPAP CAP on call as needed
☐ Maintenance Phase (6-12 months)	**Goals:** • Youth will continue to demonstrate reduction and/or remission of symptoms and improvement in function after positive acute treatment response • Maintain active treatment plan (medication, psychotherapy) during this period • Monitoring generally less-involved or intensive assuming ongoing symptom improvement • Monitor medication compliance and tolerance • Ongoing collaboration with therapist if present • Consult with MCPAP CAP as needed • If symptoms and functioning improve for 6-12 months, reassess with CATS • Discussion of treatment discontinuation if positive response has been sustained for 6-12 months. This is less likely in situations with multiple and complex traumas and high levels of ongoing psychosocial stress.
☐ Treatment Discontinuation Phase (3 to 6 months)	**Goals:** • Safely and thoughtfully withdrawn treatment and monitor for symptom recurrence • Informed consent with family: potential benefits of withdrawing treatment, potential risks of withdrawing treatment, plan to deal with problems or recurrence if needed • Discuss medication strategies with family (consult with MCPAP CAP as needed) • Active monitoring for several months during this phase • Ongoing collaboration with therapist if present • Consult with MCPAP CAP as needed

Management of Psychiatric Symptoms in Children and Adolescents with Autism Spectrum Disorder (ASD): Guidelines for PCPs

PCP Visit:

- Patient with known ASD diagnosis presenting with challenging symptoms or behaviors causing distress and/or impeding developmental progress
- Evaluate functioning at home, at school, and with peers
- Screen for comorbid psychiatric disorders, including ADHD, anxiety, and depression

Focused Assessment including clinical interview (see *Autism Clinical Pearls*)
Evaluate for comorbid psychiatric disorders, including screen for irritability, aggression, and self-harm

1. **Refer for appropriate services:**
   - ABA
   - Social skills groups
   - Social pragmatics
   - Sensory processing/OT
   - Parent guidance
   - Early intervention for younger children
   - Evaluation for IEP in school

2. **If screening indicates the presence of comorbid psychiatric disorders:**
   - Review the pertinent clinical guidelines for each disorder and treat as instructed.
   - With ASD, medication management is always best tolerated if medication dosing is started at the lowest possible dose and titrated slowly.

3. **For patients demonstrating irritability, aggression, self-harm:**
   - Screen for and treat any comorbid psychiatric conditions or symptoms (anxiety, ADHD), as some may cause worsening irritability.
   - **Rule out medical conditions that may contribute, especially if there is a sudden onset of behavioral issues.**
   - If irritability persists, or aggression/self-harm is severe, consider medication management.

Medications used in the treatment of Autism Spectrum Disorders*

- Medications are used to target symptoms causing functional impairment in ASD.
- There are no medications currently available that treat social impairment in ASD.
  - For symptoms of **impulsivity and/or hyperactivity:**
    - Stimulant medications
    - Alpha agonists (clonidine or guanfacine)
    - Use the same dosing as in ADHD (refer to MCPAP ADHD Guidelines if needed).
  - For symptoms of **irritability and aggression**
    - Behavioral interventions are first line
    - Mild to moderate irritability can be treated with alpha agonists (clonidine or guanfacine).
    - Severe irritability can be treated with atypical antipsychotics (see next page).
  - For symptoms of **anxiety and/or repetitive behaviors**
    - There is no clear evidence for specific medications to treat these symptoms.
    - Consider MCPAP consultation for assistance.
  - For **sleep disturbance** not responsive to sleep hygiene
    - Melatonin 1-6mg nightly
    - Clonidine 0.05mg nightly to start; can increase to 0.1mg if needed

**Please note that all of the above medications are supported by published evidence, but not FDA-approved. For any off label prescribing, please consider calling MCPAP for consultation.*

See reverse side for additional medication considerations.

We understand that the assessment and treatment of ASD is complex. Do not hesitate to call MCPAP to discuss specific cases with an on-call child psychiatrist.

C. Vaudreuil, Department of Psychiatry, Massachusetts General Hospital
Revised March 2021
Funding provided by the Massachusetts Department of Mental Health

MCPAP Autism Spectrum Disorder (ASD) Guidelines for PCPs

Medications used in the treatment of Autism Spectrum Disorders, Continued*

Medication management for severe irritability, aggression, and self-injurious behaviors in ASD:
FDA-approved medication treatments: **Risperidone (5+) and Aripiprazole (6+)**

Risperidone, Aripiprazole:
Prior to starting medication, get baseline labs: HbA1c, fasting lipid panel, and fasting glucose. Record vitals, height, weight, and BMI. If there is a personal or family history of cardiac abnormalities, obtain an EKG.

- Start a test dose for 1 week (e.g., Risperidone 0.25mg daily, Aripiprazole 2mg daily).
- If the test dose is tolerated, increase the daily dose gradually (every 7 days) to target dose.
  - **Risperidone** target 0.5mg/day for children < 20kg and 1mg/day for children > 20kg
    - Max daily dose: <20kg 1mg/day, >20kg 3 mg/day
    - Higher doses may be appropriate on a case-by-case basis. Call MCPAP for further guidance.
  - **Aripiprazole** target 5mg/day, max daily dose 15mg/day
    - If medication causes sedation, consider a nighttime dosing or split dosing.
- Monitor for worsening agitation or sedation; consult with MCPAP CAP as needed.

Monitoring and Reassessment:

- Obtain height, weight, BMI, and vital signs at regular intervals.
- Labs should be repeated as clinically indicated, or every six months.
- Monitor for movement disorders (tardive dyskinesia) every 6 months using the Abnormal Involuntary Movement Scale (AIMS).
- Follow up with EKG if obtained initially, or if there are any cardiovascular side effects, to evaluate for QTc prolongation.
- If weight gain or abnormal lab values develop, consider switching to a more weight-neutral agent (aripiprazole is more weight-neutral than risperidone) and/or add metformin.

**Please note that all of the above medications are supported by published evidence, but not FDA-approved. For any off-label prescribing, please consider calling MCPAP for consultation.*

We understand that the assessment and treatment of ASD is complex. Do not hesitate to call MCPAP to discuss specific cases with an on-call child psychiatrist.

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Revised March 2021
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Management of Psychiatric Symptoms in Children with Autism Spectrum Disorder (ASD) 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 ☐ Collaborate with and gather collateral information from school	**Pearl:** Find more about Autism screening on the CDC website: https://www.cdc.gov/ncbddd/autism/hcp-screening.html American Academy of Child and Adolescent Psychiatry Autism Practice Parameters: https://www.jaacap.org/article/S0890-8567(13)00819-8/pdf
☐ Assess current functioning in different areas (family, peers, school, community)	**Pearl:** Persons with autism may have developmental problems in multiple areas of functioning, including cognitive functioning, social, communication, imagination, and adaptive skills.
☐ Assess social functioning in different areas (family, peers, school, community)	**Pearl:** Social interactions will be impaired across multiple domains; however, they may be most notable with same-aged peers. Some children with ASD are much better interacting with younger children and/or adults. Difficulties in social competence will be in excess of what should be expected despite any intellectual impairments.
☐ Assess for developmental progress and history of early milestone delays	**Pearl:** Deficits in the development of expressive language are one of the most frequent sources of initial concern for parents in children who will be later diagnosed with ASD. If there is a history of language delay - consider a 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-morbidities.
☐ Assess for history of clinically significant trauma experiences	**Pearl:** History of current or remote trauma or neglect may increase complexity of assessment and treatment planning. Consider a MCPAP consultation or referral to specialty care.
☐ Assess for typical day from waking, meals, afterschool, and bedtime transition	**Pearl:** Get parental guidance around specific parenting challenges, and begin to provide a framework for the parent to think about enhancing daily structure.
☐ Assess for current or previous parental behavioral efforts	**Pearl:** Target parental guidance, the 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.
☐ Assess sleep	**Pearl:** Assess sleep onset, sleep quality, and independent sleep. Provide guidance about recommended sleep amounts based on age.
☐ Assess screen time use	**Pearl:** Understanding screen time amount and use, and utilize AAP Tools and the AAP Family Media Plan. www.healthychildren.org/English/media/Pages/default.aspx

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II: Mental Status Examination

Recommended Procedure	Clinical Pearls
☐ Behavior observation – assessment of level and type of interaction with clinician	**Pearl:** Observe the patient's ability to make eye contact, respond appropriately to questions, and engage in play. Note repetitive behaviors, flattened affect, and difficulty with back-and-forth conversation.
☐ Parent – child and child – sibling interaction observation	**Pearl:** Does the child respond to parents and siblings appropriately? Does the child make eye contact with family without being reminded?
☐ Interview with child	**Pearl:** Games or drawing tasks help with establishing a rapport with the child. Assess if the child can engage in back-and-forth play, and note if the child draws the examiner's attention to appropriate things.
☐ Interview with teen	**Pearl:** Inquire about interests, friends, activities, and academics.
☐ Interview with parents	**Pearl:** Children with ASD might tell you they have friends but may not understand that they do not have "typical" social relationships. It will be important to discuss with the parent privately to get the parent's honest opinion about the child's relationships.

III: Medical Workup

Recommended Procedure	Clinical Pearls
☐ Perform general standard medical assessment	**Pearl:** General medical assessment is part of good medical care for youth. Notable physical features that may be observed in ASD are: head circumference > 97th percentile and mild hypotonia. Be sure to check height and weight.
☐ Review the developmental history	**Pearl:** Pay particular attention to social-emotional and language milestones, early communicative behaviors (pointing, use of eye contact, response to name), play skills (preoccupation with parts of toys, inappropriate use of toys), difficulties with transitions, repetitiveness, ritualized or stereotypical behaviors, sensory issues, and any regression.
☐ Review pregnancy and birth history, if available	**Pearl:** Fetal alcohol syndrome can present with symptoms of ASD.
☐ Assessment of medical conditions that can present with symptoms of ASD (learning disabilities, hearing impairment, vision impairment, speech delay)	**Pearl:** Neuropsychological testing can be utilized to explore the possibility of learning disabilities, either privately or through school.
☐ Assessment for other psychiatric conditions that can present with symptoms of ASD (social anxiety, depression, psychosis)	**Pearl:** Onset of symptoms may help distinguish ASD from other psychiatric conditions. ASD should be present from a very young age. Other psychiatric conditions often develop later.
☐ Assessment of medical conditions and concurrent medical treatments that may affect treatment planning	**Pearl:** Twenty percent of children with ASD also have epilepsy. Children with ASD may be more susceptible to GI disturbance and sleep issues.
☐ Assessment of whether any genetic disorders may be present	**Pearl:** Evaluate for dysmorphic features. ASD can be comorbid with Fragile X and Tuberous Sclerosis, Angelman syndrome, or Smith-Lemli-Opitz syndrome among others.

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IV: Differential Diagnosis and Co-Morbidities

Recommended Procedure	Clinical Pearls
☐ Anxiety disorders - i.e., social anxiety, generalized anxiety	**Pearl:** Anxiety is commonly comorbid with ASD. Children with ASD can have rigidity and difficulty with change/transitions, as well as sensory issues, all of which can cause anxiety. Children with more mild ASD may be aware that they are socially awkward, which can cause social anxiety.
☐ Learning disorders/intellectual disability	**Pearl:** Learning disorders and intellectual disabilities are very common. Encourage a school assessment. Parents may need additional school support, IEP.
☐ Depression	**Pearl:** Depression can be comorbid with ASD. Normal early social development with social withdrawal later in life might signal depression as opposed to ASD.
☐ Early psychosis	**Pearl:** Early onset and prodromal psychosis for teens may present with troubles with cognitive function, thought blocking, loss of initiative, and social isolation. This would be a change from baseline, as opposed to ASD, which should be present in a very young child.
☐ ADHD	**Pearl:** ASD is commonly comorbid with ADHD. Utilize regular ADHD screening (Vanderbilt forms from home and school, history taking).
☐ Reactive attachment disorder or severe early deprivation	**Pearl:** These can present like ASD. Consider them in children with a history of trauma or neglect.
☐ Rett disorder	**Pearl:** Development is normal initially, with the onset of sx between 5-48 months, in F > M, head growth deceleration, and severe intellectual disability.
☐ Social communication disorder	**Pearl:** Social communication disorder is distinguished from ASD by the absence of restricted, repetitive patterns of behavior, interests, or activities.
☐ Obsessive compulsive disorder	**Pearl:** Individuals with OCD typically find their thoughts and behaviors distressing, while those with ASD do not. Children with OCD usually have normal social and communication skills.
☐ Oppositional defiant disorder	**Pearl:** Due to rigidity, people with ASD can become emotionally dysregulated when things don't go as they anticipated. Sometimes this can be hard for caregivers to understand as they may not have even known what the child was expecting.

V: Treatment Planning

Recommended Procedure	Clinical Pearls
☐ Review child's strengths and weaknesses and develop goals for treatment	**Pearl:** Goals may include: improve social functioning and play skills, improve communications skills, improve adaptive skills, decrease nonfunctional (repetitive) or negative behaviors, and promote academic functioning.
☐ Referrals	**Pearl:** Consider early intervention for younger children; ST, OT, and/or PT as appropriate.
☐ School	**Pearl:** The child will need evaluation for an IEP and social, emotional, and academic supports in school as appropriate.

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Recommended Procedure	Clinical Pearls
☐ Therapy	**Pearl:** Applied Behavior Analysis (ABA) is recommended for children with ASD. Children may also benefit from social skills groups. Parents may benefit from parent guidance to manage difficult behaviors.
☐ Psychiatric treatment	**Pearl:** There are no medication interventions currently approved for ASD. However, patients may benefit from treatment of psychiatric comorbidities or may require medication intervention if they are displaying aggression or self harm.
☐ Sleep	**Pearl:** Many children with ASD have sleep disturbance. Maximize sleep hygiene. Consider a referral to sleep medicine to rule out sleep apnea or other sleep disorders.