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Behavioral Health Toolkit

for Primary Medical Providers

Foreword

Dear Primary Medical Provider:

The MDwise primary medical provider Behavioral Health Toolkit was designed to assist PMPs in their efforts to assess and treat behavioral health problems in the primary care setting, as well as to provide guidance regarding when to refer a MDwise member to a behavioral health provider.

The compiled materials were chosen to assist you in following the MDwise Clinical Care Guidelines which describe best practices. We also included materials designed to help you effectively and efficiently treat MDwise members with behavioral health needs.

Also included in the packet are materials that can be given to your members. Primary care physicians are in a unique position. Patients trust their family physician and may go to them for mental health concerns before they would consider approaching a counselor or psychiatrist. Physician's can help make their offices welcoming to those hesitant to discuss mental health concerns by doing the following:

- **Resources**–Include materials on mental health in waiting rooms.
- **Private area**–Have a private area to discuss mental health issues with or without children present.
- **More knowledgeable staff**–Evidence through discussions and materials that primary care staff are knowledgeable about mental health issues and resources.
- **Supportive, non-judgemental staff**–Show support to those with mental illness by engaging in active listening, using positive language, and providing prompts to discuss mental health concerns.
- **Screening tools, questionnaires, checklists**–Ask about and screen for developmental, emotional and behavioral issues during well-child visits to help normalize mental health issues. Families want screening as a part of routine clinical practice.

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Making a Referral to Behavioral Health Providers

When to Refer to a Behavioral Health Provider

Complex Behavioral & Emotional Issues

If a member:

- Has behavior or emotions that **pose a threat of harm** to the safety of self, a child or others (e.g. suicidal behavior, severe aggressive behavior, an eating disorder that is out of control, self-destructive behavior).
- Has had a significant **disruption in day-to day functioning** or loss of contact with reality.
- Has been recently **hospitalized** for treatment of a psychiatric illness.
- Has **complex diagnostic issues**.
- Has a mood disorder and would **benefit from CBT**.

Complex Social & Environmental Issues

If a member:

- Has a **caretaker with serious emotional issues** or a substance abuse problem, or there are other serious environmental issues such as a hostile divorce situation.
- Has a **history of abuse, neglect** and/ or removal from the home and has significant issues related to the abuse or neglect.
- Has a **significant change in emotions or behavior** for which there is no obvious precipitant e.g. sudden onset of school avoidance, a suicide attempt in a previously well functioning individual.

Complex Medical Issues

If a member:

- Has only a **partial response** to a course of medications or is being treated with more than one psychotropic medication.
- Has a family history that suggests treatment with psychotropic **medications may have an adverse effect** (e.g. prescribing stimulants to a child with a family history of schizophrenia or bipolar disorder, children under the age of 5 who require on-going use of a psychotropic medication).
- Has a **chronic medical condition** and behavior or emotions prevent the medical condition from being treated properly.
- Has had a course of treatment for 6 -8 weeks with **no meaningful improvement**.

Referral for Behavioral Health Services

Member Name: _____ **Date of Referral:** _____

Medicaid number: _____

Dear Colleague:

I am the primary medical provider for the above-named member, who has expressed concern about the issues checked below. A course of treatment ___has ___has not been started under my care.

Current concerns:

- ☐ Depressed symptoms
- ☐ Anxiety Symptoms
- ☐ ADHD Symptoms
- ☐ Eating Disorder
- ☐ Substance Use
- ☐ Behavior Problems
- ☐ Developmental Delays
- ☐ Head Injury
- ☐ Learning Problems
- ☐ Hallucinations/Delusions
- ☐ Mania
- ☐ Parenting
- ☐ Other _____

Current Medications:

Medication	Dose	Frequency	Length of time

☐ See attached list

Medical Problems:

☐ Diabetes ☐ Asthma ☐ Other _____

Attached lab results: ☐ CBC ☐ Thyroid Studies ☐ Chem. Profile ☐ EKG ☐ Lipid Profile ☐ Serum drug level

Diagnostic Tests:

_____

_____

Medical problem	Hospital	Date of admission

☐ **Recent Hospitalizations:**

_____

PMP Information: Name:
Address:
Phone:
Fax:

APPOO89 (11/11)

This form is also located on our website at:
MDwise.org/docs/providerbehavioralhealth/bh-referralform.pdf

Depression

Depression

MDwise Clinical Care Guidelines

Clinical Care Guidelines for:

Major Depression in Adults

OBJECTIVE

Guide the appropriate diagnosis and treatment of Major Depression in adults.

DIAGNOSIS & ASSESSMENT

DSM-5 DIAGNOSTIC CRITERIA

5 or more symptoms present during a 2 week period; (1) depressed mood or (2) loss of interest or pleasure and any three of the following:

- Significant weight loss or decrease in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or lack of energy
- Feelings of worthlessness or guilt
- Decreased concentration or indecisiveness
- Recurrent thoughts of death or suicide

Symptoms cause significant distress or impairment in functioning and not due to significant loss or change in life, absence of manic/hypomanic episodes.

The PHQ9 is recommended for screening and treatment monitoring.

RULE OUT/MONITOR CO-OCCURRING MEDICAL CONDITIONS

- Ensure that a general medical evaluation has been completed
- Evaluate functional impairment and quality of life

Assess for Suicidal Ideation/Crisis

- If the patient has a plan, the means or has recently attempted, hospitalize
- If the situation is unclear and the patient is being evaluated by a medical provider, refer to a behavioral health practitioner
- Evaluate level of impulsivity and if patient can commit to not harming himself; seek help if the ideation becomes overwhelming
- Refer to a psychiatrist or behavioral health professional if symptoms are severe, there are co-morbid conditions, there are significant psychosocial stressors, and/or substance abuse
- Assess level of self-care (nutrition, hydration, ADLs)
- Establish the least restrictive environment for treatment and evaluate frequently for any need to change the level of care

TREATMENT

MEDICATION MANAGEMENT

If symptoms are moderate to severe, evaluate for medication.

If medication is prescribed, patient should be seen within 1–4 weeks to assess and adjust.

At least 12 weeks continuous treatment in the acute phase.

At least one additional visit after the 4 week check in the next 4–8 weeks.

For effective continuation phase of treatment, monitor medication for the next 6 months. Visits may be less frequent.

To prevent relapse after symptom remission, stay on medication an additional 6–12 months.

Maintenance (greater than 9 months) for patients with a history of chronic symptoms, 3 or more episodes of depression, severe episodes, episodes beginning prior to age 20, or family history of bipolar disorder. Monitor at regular intervals and assess for re-emergence of symptoms. May require an additional 15–28 months on medication.

If discontinuing medication, taper slowly over several weeks and monitor for recurrence of symptoms.

Coordinate care with other clinicians involved in care.

Provide education to the family and patient.

PSYCHOTHERAPY

Cognitive behavioral therapy or individual interpersonal therapy–outpatient.

Therapy alone may be used for mild to moderate symptoms.

Frequency depends on the severity of the illness.

For moderate to severe symptoms, should be used in combination with medication.

Regular exercise and education regarding depression are recommended as adjuncts to treatment.

Severe symptoms, decline in functioning and/or suicidal ideation/intent may require a higher level of care.

If patient is discharged from inpatient hospitalization, patient needs to be seen in an outpatient setting, intensive outpatient setting or partial hospitalization by a behavioral health provider within 7 calendar days.

As depression symptoms remit, less frequent therapy sessions would be appropriate to maintain stability.

ECT is appropriate for severe depression that hasn't responded to numerous medications and/or therapy and who have significant functional impairment.

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MEDICATION THERAPY OPTIONS FOR DEPRESSION

Antidepressant medications are grouped into the following classes:

1. Tricyclic Antidepressants (TCAs)
2. Select Serotonin Reuptake Inhibitors (SSRIs)
3. Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)
4. Atypical Antidepressants
5. Monoamine Oxidase Inhibitors (MAOIs)
6. Norepinephrine Reuptake Inhibitor (NRI)
7. Dopamine Agonist (DA)

The effectiveness of antidepressant medications is generally comparable between classes and within classes of medications. Response rates typically range from 50% to 75% among all classes and agents. Antidepressants do differ in their potential to cause particular side effects such as adverse sexual effects, sedation, or weight gain. Because of this, the initial selection of an antidepressant medication regimen should strongly consider the tolerability, safety, and cost of the medication, as well as patient preference and history of prior medication treatment. Second-generation antidepressants, which include the SSRI, SNRI and Atypical Antidepressant classes are optimal and usually preferred for most patients over the older medications in the TCA and MAOI classes.

Antidepressant medication therapy is not a cure for depression. These drugs are effective in treating some of the symptoms of depression, but cannot change underlying contributions to depression in patients' lives. Studies have shown, and many experts believe, that antidepressant medications often work best in combination with psychotherapy lasting for several months. On their own, antidepressant medications are important, especially in treating patients who have difficulty, or are hesitant in, accessing a psychotherapy professional.

When initiating an antidepressant drug regimen, encourage the patient to be patient as it may take 4-8 weeks for the drug therapy to be fully effective. In addition, side effects may appear in the beginning, but most improve over time. Follow up visits are important to assess treatment response. Finally, consider changes in the drug regimen if significant improvement in symptoms does not occur after six weeks.

First Line Treatment: SSRI, TCA, SNRI, NRI, DA

Second Line Treatment: SSRI and a second anti-depressant; addition of atypical anti-psychotic

Therapeutic Class/ Brand Name	Dosage Forms	Recommended Starting Dose	FDA Maximum Daily Dose	Comments
Selective Serotonin Reuptake Inhibitors				
CELEXA® (generic) citalopram	10, 20, 40 mg tablet 10 mg/5ml solution	20mg once daily	40mg	Additive QTc prolongation 2-week washout period between MAOI and SSRI
LUVOX® (generic) fluvoxamine	25, 50, 100 mg tablet	100mg once daily	300mg	FDA indicated in OCD (off-label use for depression) 2-week washout period between MAOI and SSRI
LUVOX CR® (generic) fluvoxamine	100, 150 mg capsule	100mg once daily	300mg	
PAXIL/PAXIL CR® (generic) paroxetine	10, 20, 30, 40 mg tablet 12.5, 25, 37.5 mg ER tablet	20mg once daily (tablet) 25mg once daily (ER tablet)	60mg (tablet) 75mg (ER tablet)	Avoid use in pregnancy due to CV effects (all other SSRIs or TCA preferred in pregnancy) 2-week washout period between MAOI and SSRI
PROZAC® (generic) fluoxetine	10, 20 mg tablet 10, 20, 40 mg capsule 20mg/5ml solution	20mg once daily	80mg	Long half-life = self-tapering (all other antidepressants need to be tapered over several weeks) Activating; take in the morning 5-week wash-out period if switching from fluoxetine to MAOI 2-week washout from MAOI to SSRI
PROZAC WEEKLY® (generic) fluoxetine	90mg delayed release capsule	90mg once weekly	90mg weekly	

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Therapeutic Class/ Brand Name	Dosage Forms	Recommended Starting Dose	FDA Maximum Daily Dose	Comments
ZOLOFT® (generic) sertraline	25, 50, 100 mg tablet 20mg/ml concentrate	50mg once daily	200mg	First-choice for patients with comorbid CAD 2-week washout period between MAOI and SSRI
LEXAPRO® (generic) escitalopram	5, 10, 20 mg tablet 5mg/5ml solution	10mg once daily	20mg	Additive QTc prolongation 2-week washout period between MAOI and SSRI
VIIBRYD® Vilazodone	10, 20, 40 mg tablet	10mg once daily	Not Available	Take with food Less sexual side effects 2-week washout period between MAOI and SSRI
Serotonin and Norepinephrine Reuptake Inhibitors				
EFFEXOR/EFFEXOR XR® (generic) venlafaxine	25, 37.5, 50, 75, 100 mg tablet 37.5, 75, 150 225 mg ER tablet 37.5, 75, 150 mg ER capsule	25mg TID (tablet) 75mg once daily (ER tablet) 75mg once daily (ER capsule)	375mg (tablet) 225mg (ER tablet) 225mg (ER capsule)	Additive QTc prolongation Highest risk increasing BP, especially at doses > 150 mg/day (all SNRIs have dose-dependent risk) 7-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
FETZIMA® levomilnacipran	40, 80, 12 mg ER capsules	40 mg once daily	120 mg	Take capsule whole, do not crush/ chew 7-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
PRISTIQ® desvenlafaxine	50, 100 mg ER tablet	50mg once daily	Not Available. Doses up to 400mg/day have been used.	Additive QTc prolongation 7-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
CYMBALTA® duloxetine	20, 30, 60 mg capsule	20mg BID	60mg	Indicated for both depression and neuropathic/musculoskeletal pain 5 to 14-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
SAVELLA® Milnacipran	12.5, 25, 50, 100 mg tablet	12.5mg once daily	200mg	FDA indicated for fibromyalgia May cause hot flashes 5 to 14-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
Atypical Antidepressants				
WELLBUTRIN®/ WELLBUTRIN SR®, WELLBUTRIN XL® (generic) bupropion	75, 100 mg tablet 100, 150, 200 mg 12hr tablet 150, 300 mg 24hr tablet	75mg BID (tablet) 150mg once daily (12hr/24hr tab)	450mg (tablet) 400mg (12hr) 450mg (24hr)	Least likely to cause weight gain/ metabolic abnormalities Less likely to cause sexual side effects High risk of seizures ≥ 450 mg/day 2-week washout period between MAOI and bupropion
trazodone HCl (generic)	50, 100, 150, 300 mg tablet 150, 300 mg ER tablet	75mg BID (tablet) 150mg once daily (ER tablet)	400mg (tablet) 375mg (ER tablet)	Significant sedation and weight gain Risk of priapism 2-week washout period between MAOI and trazodone

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Therapeutic Class/ Brand Name	Dosage Forms	Recommended Starting Dose	FDA Maximum Daily Dose	Comments
REMERON®/REMERON SOLUTAB® (generic) mirtazapine	7.5, 15, 30, 45 mg tablet	15mg once daily	45mg	Significant sedation and weight gain 2-week washout period between MAOI and mirtazapine
nefazodone HCl (generic)	50, 100, 150, 200, 250 mg tablet	50mg BID	Not available. Doses up to 600mg have been used.	High risk of hepatotoxicity 2-week washout period between MAOI and nefazodone
BRINTELLIX® vortioxetine	5, 10, 20 mg tablets	10mg once daily	20 mg	21-day washout from vortioxetine to MAOI; 2-week washout from MAOI to vortioxetine

Disclaimer: Recommendation of treatment does not guarantee coverage of services.

REFERENCES

American Psychiatric Association (2010). Practice guideline for major depressive disorder in adults. American Journal of Psychiatry, 167 (suppl. 4), 1–52.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition TR (2013). American Psychiatric Association.

Gelenberg AJ, Freeman MP, Markowitz JC, et al. American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder third edition 2010. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf. Accessed February 19, 2018.

VHA/DOD (2000), Clinical practice guideline for the management of major depressive disorder in adults Version 2.0 (Contract number: V101 (93)P-1633, Washington, DC.

HEDIS 2014, Volume 2

Kaiser Permanente Care Management Institute. Diagnosis and Treatment of Depression in Adults: 2012 Clinical Practice Guideline. Oakland, CA: Kaiser Permanente Care Management Institute.

Approved by MAC: 12/10/08, 4/13/11, 2/8/12, 2/12/14, 4/6/16, 8/1/18 Revised: 1/25/11, 2/1/12, 1/17/14, 3/15/16 Reviewed: 03/2018 APP0146 (4/16)

Clinical Care Guidelines for:

Major Depression in Children and Adolescents

OBJECTIVE

To guide the appropriate diagnosis and treatment of Major Depression in children and adolescents.

DIAGNOSIS & ASSESSMENT

DSM-5 Criteria

5 or more symptoms present during a 2 week period; (1) depressed or irritable, cranky mood (outside being frustrated) or (2) loss of interest or pleasure and any three of the following:

1. Significant weight loss or decrease in appetite (more than 5 percent of body weight in a month or failure to meet expected weight gains.)
2. Insomnia or hypersomnia
3. Psychomotor agitation or retardation
4. Fatigue or lack of energy
5. Feelings of worthlessness or guilt
6. Decreased concentration or indecisiveness
7. Recurrent thoughts of death or suicide

In addition to the above DSM-5 criteria, children and adolescents may also have some of the following symptoms:

- Persistent sad or irritable mood
- Frequent vague, non-specific physical complaints
- Frequent absences from school or poor performance in school
- Being bored
- Alcohol or substance abuse
- Increased irritability, anger or hostility
- Reckless behavior

Symptoms cause significant distress or impairment in functioning.

Depression Scales such as the Beck Depression Inventory, Children's Depression Inventory or the Reynolds Adolescent Depression Inventory can be used to establish severity, baseline functioning, and to monitor the progress of treatment.

Screening and Evaluation

Clinicians should screen all children for key depressive symptoms including sadness, irritability and a loss of pleasure in previously enjoyed activities. If these symptoms are present most of the time, affect psychosocial functioning and are not developmentally appropriate, refer for a full evaluation.

A thorough evaluation for depression should include determining the presence of other co-morbid psychiatric and medical disorders, interviews with the child and parents/caregivers, and if an adolescent, try to meet with him/her alone. Additionally, collect information from teachers, primary care physician, and other social service professionals.

- Assess for Suicidal Ideation/Crisis
    1. If the patient has a plan, the means or has recently attempted, hospitalize.
    2. If the situation is unclear, refer to a behavioral health practitioner.
    3. Evaluate level of impulsivity and if patient can commit to not harming himself; seek help if the ideation becomes overwhelming.
    4. Refer to a psychiatrist or behavioral health professional if symptoms are severe, there are co-morbid conditions, there are significant psychosocial stressors, and/or substance abuse.
- Assess for presence of on-going or past exposure to negative events such as abuse, neglect, family psychopathology, family dysfunction, and exposure to violence.
- If a child or adolescent is discharged from an inpatient hospitalization, s/he needs to be seen by an outpatient behavioral health clinician within 7 days of discharge.

TREATMENT

- Education, support, and case management appear to be sufficient for treatment of uncomplicated or brief depression.
- For children and adolescents who do not respond to the above or have more complicated depression, a trial of CBT and/or medication is indicated.
- Treatment with medication should always include acute and continuation phases. Some children may require maintenance treatment.
- May be seen more frequently during the first month and subsequent two months based on the needs of the child and the family.
- Each phase of treatment should include psychoeducation, supportive management, family and school involvement.
- Kennard, et. al. (2009) found that adolescents treated with a combination of an anti-depressant and CBT will remit earlier than those who receive either treatment alone and improvement is superior to that of both monotherapies.
- To consolidate the response to acute treatment and avoid relapse, treatment should always be continued for 6–12 months.
- Treatment should include the management of comorbid conditions.
- Progress in treatment should be monitored with rating scales such as the Beck Depression Inventory, Children's Depression Inventory or Reynolds Adolescent Depression Inventory.
- Abrupt discontinuation of anti-depressants is not recommended.

Disclaimer: Recommendation of treatment does not guarantee coverage of services.

REFERENCES

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition TR (2013) American Psychiatric Association.

Birmaher B, AACAP Work Group on Quality Issues. Practice Parameter for the assessment and treatment of children and adolescents with depressive disorders. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2007.

Kennard, Betsy D., et. al. (2009). Remission and Recovery Rates in the Treatment for Adolescents with Depression Study: Acute and Long-Term Outcomes. Journal of the American Academy of Child and Adolescent Psychiatry, vol. 48 (2): 186–195.

American Psychiatric Assoc. & American Academy of Child and Adolescent Psychiatry (2010) The Use of Medication in Treating Childhood and Adolescent Depression: Information for Physicians. ParentsMedGuide.org.

Approved by MAC: 6/9/10, 6/13/12, 2/12/14, 4/6/16 Revised: 3/27/12, 1/28/14, 3/15/16 Reviewed: 03/2018 APP0145 (4/16)

Depression

Practitioner Toolkit

Two Question Screen

A quick way of screening patients you think may be depressed requires asking patients these two questions:

During the past two months have you often been bothered by:

1. Little interest or pleasure in doing things?

   ☐ Yes ☐ No

2. Feeling down, depressed, or hopeless?

   ☐ Yes ☐ No

Scoring
If the patient's response to BOTH questions is "NO", the screen is negative.
If the patient responded "YES" to EITHER question, consider asking more detailed questions or using the PHQ-9 patient health questionnaire (next page).

Depression Management Toolkit:
https://www.lacare.org/sites/default/files/files/Depression%20Management%20Toolkit%202009%20macarthur_toolkit.pdf.

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 √s in the shaded section (including questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- If there are at least 5 √s in the shaded section (one of which corresponds to question #1 or #2)

Consider Other Depressive Disorder

- If there are 2–4 √s in the shaded section (one of which corresponds to question #1 or #2)

Note:

Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social occupational, or other important areas of functioning (question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitory severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete the questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up √s by column. For every √ : Several days = 1, More than half the days = 2, Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every √ Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1–4	Minimal depression
5–9	Mild depression
10–14	Moderate depression
15–19	Moderately severe depression
20–27	Severe depression

A2662B 10-04-2005

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems.
(use "√" to indicated your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Health care professional: for interpretation of TOTAL, please refer to accompanying score card.

add columns _____ + _____ + _____

TOTAL: _____

10. If you check off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Patient Health Questionnaire (Modified for Teens)

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: _____ Severity score: _____

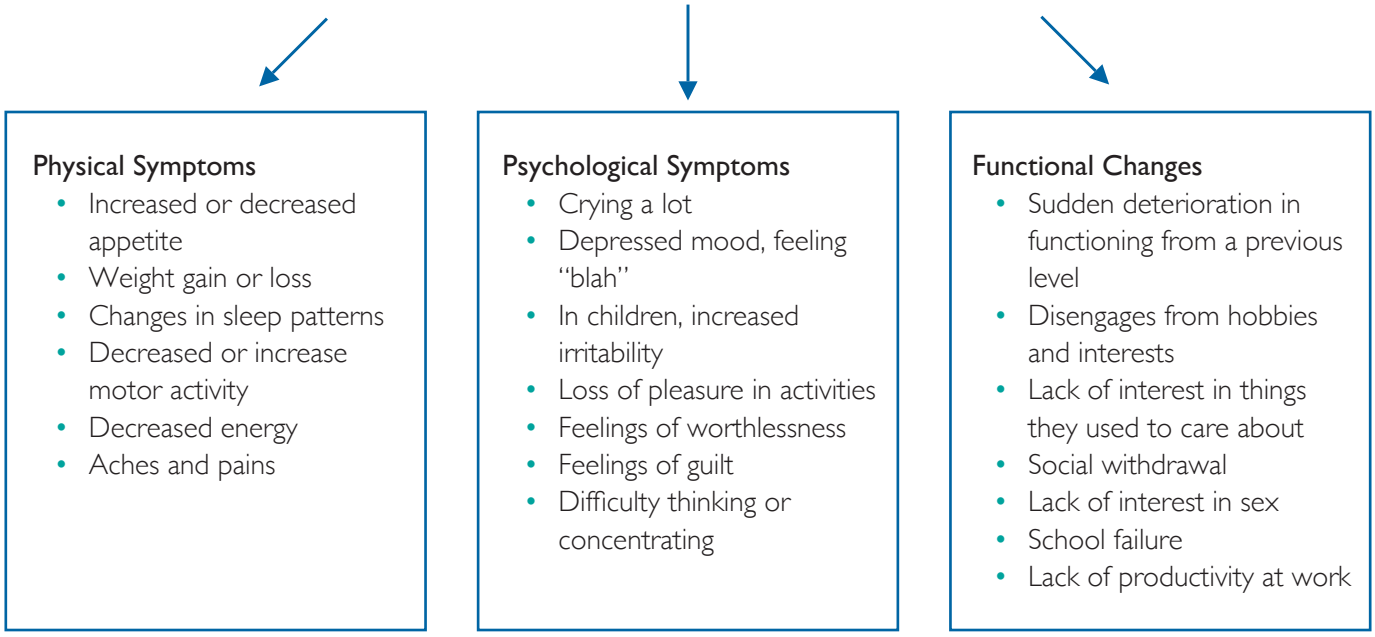
Using the PHQ-9 to Assess for Depression

Medication -Initial response (after 4 weeks of antidepressant)		
PHQ-9	**Treatment Response**	**Treatment Plan**
Drop of 5 points from baseline	Adequate	No treatment change needed. Follow-up in 4 weeks
Drop of 2–4 points	Possibly Adequate	May warrant an increase in antidepressant dose
Drop of 1 point or no change in or worsening symptoms	Inadequate	Increase dose; Augmentation; Switch; informal or formal psychiatric consultation; add psychological counseling
Side effect management		
Eyes sensitive to light	Wear sunglasses, hat or visor, avoid prolonged exposure	
Dryness of lips or mouth	Increase fluids, rinse mouth with water often, keep hard candy or sugarless gum handy	
Occasional stomach upset	Drink small amounts of clear soda water, eat dry saltines or toast.	
Occasional constipation	Increase water intake, increase physical exercise, eat green leafy vegetables or bran, drink lemon juice in water, occasional use of milk of magnesia or other mild laxative	
Tiredness	Take a brief rest during the day, consider switching medicine to evening	
Dryness of skin	Use mild shampoo and soap, use hand and body lotion after bathing, wear seasonal protective clothing	
Mild restlessness, muscle stiffness, or feeling slowed down	Exercise, take short walks, stretch muscles, relax to music	
Weight gain	Increase exercise, watch diet, reduce overeating	
Psychological Counseling-Initial Response (after 6 weeks)		
PHQ-9	**Treatment Response**	**Treatment Plan**
Drop of 5 points from baseline	Adequate	No treatment change needed. Follow up in 4 weeks.
Drop of 2–4 points	Possibly adequate	Probably no treatment change is needed. Share PHQ-9 with therapist
Drop of 1 point, no change, or an increase	Inadequate	Consider adding an antidepressant

Adapted from:
The McCarthur Initiative on Depression and Primary Care: Depression Management Toolkit. 2009, 3CM, LLC

Depression Flowchart

Symptoms: Does the patient have the symptoms and signs of depression?

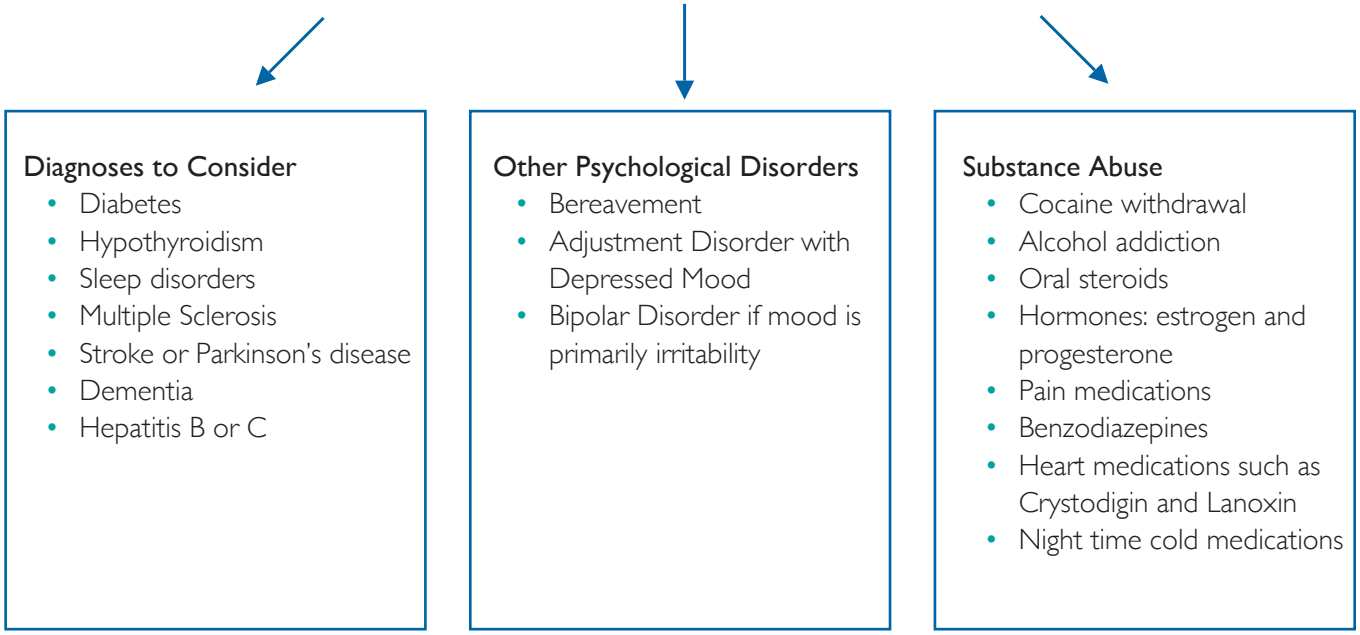


Physical Symptoms
- Increased or decreased appetite
- Weight gain or loss
- Changes in sleep patterns
- Decreased or increase motor activity
- Decreased energy
- Aches and pains

Psychological Symptoms
- Crying a lot
- Depressed mood, feeling "blah"
- In children, increased irritability
- Loss of pleasure in activities
- Feelings of worthlessness
- Feelings of guilt
- Difficulty thinking or concentrating

Functional Changes
- Sudden deterioration in functioning from a previous level
- Disengages from hobbies and interests
- Lack of interest in things they used to care about
- Social withdrawal
- Lack of interest in sex
- School failure
- Lack of productivity at work

Other diagnoses/co-morbidities to consider:



Diagnoses to Consider
- Diabetes
- Hypothyroidism
- Sleep disorders
- Multiple Sclerosis
- Stroke or Parkinson's disease
- Dementia
- Hepatitis B or C

Other Psychological Disorders
- Bereavement
- Adjustment Disorder with Depressed Mood
- Bipolar Disorder if mood is primarily irritability

Substance Abuse
- Cocaine withdrawal
- Alcohol addiction
- Oral steroids
- Hormones: estrogen and progesterone
- Pain medications
- Benzodiazepines
- Heart medications such as Crystodigin and Lanoxin
- Night time cold medications

Sources: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-TR (2000) American Psychiatric Association*
Ontario Guideline for the Management of Anxiety Disorders in Primary Care. 1st Edition, Fall (2000)

Depression

Member Materials

INcontrol

What is Depression?

Depression is a very common problem and can affect anyone. It is not just feeling "down in the dumps." It is actually a medical illness (just like diabetes or high blood pressure). Depression affects your thoughts, feelings, physical health, and behaviors. Everyone gets down in the dumps sometimes. People who have the illness of depression feel sad nearly every day for more than just a day at a time. Symptoms of depression include:

- Feeling sad, blue or "down in the dumps."
- Lack interest in things they used to like to do.
- Feel slowed down or they can feel uneasy.
- Have trouble sleeping or sleep too much.
- Have no energy or feel tired a lot.
- Losing or gaining weight.
- Trouble thinking, remembering, or making decisions.
- Feel worthless or guilty.
- Have thoughts about dying or think about suicide.

What can I do if I think I have depression?

Talk to your doctor. Depression Is very treatable. Your doctor can give you medicine or help you find a counselor to work with.

How is depression treated?

- Your doctor will make a treatment plan with you.
- Counseling has been shown to be helpful in treating depression.
- There are medicines your doctor can give you to help depression.
- The combination of counseling and medication has been shown to be most effective for majority of individuals with depression.

APM0037 (12/10)
HCCM0023 (3/15)
Revised 11/2018

What can I do to help myself with depression?

- Exercise helps! Take a short walk, work in the garden, take a bike ride.
- Spend time with friends or family who are supportive.
- Break tasks down into small parts and do a little bit each day even though you might not feel like it.
- Watch a funny movie. Try to find small things to laugh about or enjoy.
- Do something nice to help someone else.
- Try to talk back to negative thoughts you are having.
- Don't use alcohol or drugs.

Compiled from the following sources:
www.mentalhealthamerica.net/go/information/get-info
www.nimh.nih.gov/health/index.shtml

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My Depression Action Plan

I would rate my depression at the beginning of the week as:

Very depressed — Not depressed at all

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10_____

Be physically active: Start adding physical activity to your day. Don't overdo it. Start slowly. Examples: Take a walk, run/jog, ride a bike, dance, aerobics, swim, bowling, weight lifting, tennis, housework, gardening, play basketball or any sport, take the stairs, do yoga

My Goal: I will be physically active for _____ minutes each day.

Check any day you were active: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Do something you enjoy: We all have things to do like chores, going to school or work etc. Make time in your day to do something that you want to do for fun. Examples: See a funny movie, listen to music, draw, paint, plant flowers, play a game, read, sew, make something, cook, watch TV, play an instrument, talk to a friend, go to church or pray etc.

My Goal: I will schedule time to do something I enjoy _____ days this week.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Spend time with people who support you: When a person is depressed they often stay to themselves. It can help if you spend time with people who care about you. You can also do activities with school, a club, in your neighborhood, or with your church.

I feel supported by these people: _____.

My Goal: _____days this week I will:_____

_____.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Start solving a problem that seems really big to you by breaking it down into smaller steps. This is helpful to do if there is a problem you are avoiding or if you are having trouble making a decision.

PROBLEM: _____

Smaller Step 1: _____ **Completed: yes no**

Smaller Step 2: _____ **Completed: yes no**

Smaller Step 3: _____ **Completed: yes no**

Now my problem seems: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

Not very bad — As bad as a problem could be

I would rate my depression at the end of the week as:

Very depressed — Not depressed at all

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

Compiled from the following sources:

www.mentalhealthamerica.net/go/information/get-info

www.nimh.nih.gov/health/index.shtml

APM0037 (12/10)
HCCM0023 (3/15)

MDwise.org | 1.800.356.1204

INcontrol

What To Expect When You Go To Counseling

What will counseling be like?

Going to counseling is a lot like going to a regular doctor appointment. Most counselors work in offices that are a lot like a doctor's office. You will fill out information about yourself or your child just like you would at a doctor appointment.

People get ideas about counseling from what they see on TV. TV often shows a person lying on a couch talking to a "shrink." That is **not** what you should expect. You will talk to a counselor face to face and the counselor will treat you like you are a partner in making a plan to help your depression. Most counseling lasts around 8 to 20 visits.

What kind of things will I be asked to do?

You will talk with a counselor about what is going on in your life. If it is a child who is depressed, the counselor will talk to the child and the parents. Events in life or a person's reaction to these events can cause a person to become depressed. Hearing your story will help the counselor plan for how to help.

The counselor will ask the person with depression to talk about their thoughts and beliefs. People who have depression start to think negative thoughts. These thoughts affect how they feel. Your counselor will teach you to change what you are thinking about things in your life. When you change your thoughts, your feelings often change too. When both your thoughts and feelings change, the depression may get better.

The counselor will also ask you to talk about behavior. Some behaviors make depression worse. The counselor might ask you to change some of your habits. Habits are behaviors that you do on a regular basis. The counselor might ask a person with depression to eat healthier food, be more active, or change their sleep schedule. Some people feel happier when they learn to ask for help or speak up for themselves. Others may need to learn to relax and not worry so much. Some people get better from depression just by working with a counselor on these things. Counseling can help some people as much as medicine.

Children with depression can learn these things too. The counselor will ask parents to help the child remember to work on their treatment plan.

What kind of training do counselors have?

Counselors go to college for 6 years to learn to become counselors. All counselors must take a test after they have finished school. Passing the test shows that a counselor has learned what is needed to be a counselor. A counselor will work with you and with a doctor to make a plan to help you with depression.

What if counseling doesn't help me?

Tell your counselor if you are not feeling better. They might suggest that you see a doctor. The doctor can tell you if a medicine for depression will help. Your counselor will also ask if you are following your treatment plan for depression. You might need to adjust your plan or find a way to make it easier to follow.

What should I do if I have thoughts about suicide?

People who are depressed sometimes think about suicide. You should always tell someone If you have these thoughts! Your doctor or counselor will know how to help. Suicide is never the answer. There is always a way to feel better.

What if I don't feel comfortable talking with the counselor?

Tell the counselor how you feel. You and the counselor might find ways to work together after talking. Your counselor will want you to be honest with them. Counselors are all different just like people all are different. Don't give up! Find a counselor who is a good match for you and work with them until your depression is better. You can call MDwise Customer Service to help you find a counselor that is right for you. You can also talk to your doctor for suggestions.

Helpful tips for getting over depression:

- ☐ Be patient with yourself or your child. It takes time to recover from depression.
- ☐ Try to find things to do that make you feel happy or that make you feel good about yourself.
- ☐ Laugh…. even though it may seem hard! Watch something funny on TV or see a funny movie. Read the comic page in the newspaper. Ask someone to tell you a silly story.
- ☐ Try to avoid making important decisions in life when you are depressed. If you must make a big decision, ask someone you trust to help you.
- ☐ Refuse to believe negative thoughts that tell you to blame yourself or that you are a failure. Remind yourself that negative thinking is your depression talking. Work to talk back to the thoughts.
- ☐ Avoid drugs or alcohol. Both can make depression worse. They can also cause side effects if you are taking medicine.
- ☐ Spend time around family and friends. Ask for support.

Compiled from the following sources:
www.mentalhealthamerica.net/go/information/get-info
www.nimh.nih.gov/health/index.shtml

INcontrol

Frequently Asked Questions About Medicine for Depression

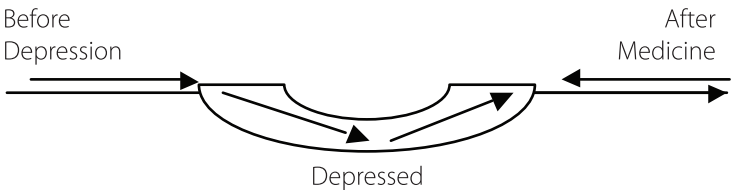
What kind of medicine helps depression?
Doctors use medicines called "antidepressants" to help people with depression. Antidepressant medicine helps the brain work right by making sure that a person has the right amount of chemicals in the brain.

Will I get better if I take medicine for depression?
Most people who take medicine for depression get better. When a person does not get better on antidepressant medicine it is time to talk to your doctor. Your doctor may want to try increasing the medicine or they may try a different medicine.

Is antidepressant medicine safe?
A person may have problems with any medicine. Antidepressant medicines are safe for most people to take. Ask your doctor if you have concerns about taking medicine for depression.

Will I have side effects?
Some people have mild problems like an upset stomach or headache when they first start taking antidepressant medicine. These problems usually go away after a couple of days. You should tell your doctor if you are having any of these problems. Your doctor will probably try a different antidepressant medicine if you continue to have problems.

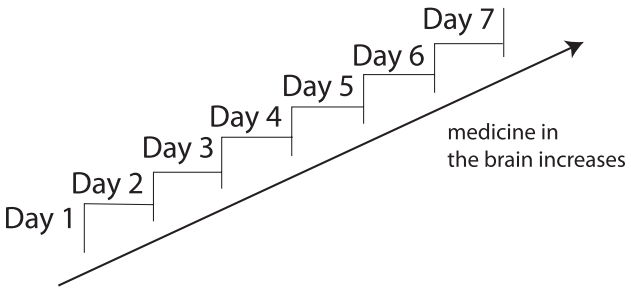
Will I get "high" or "hooked" on antidepressant medicine?
The answer to both is NO! Antidepressant medicine does not make a person feel "high." A person will feel like they felt before they became depressed when an antidepressant medicine begins to work. Depression makes a person feel like they are down in a deep hole. Medicine will help them feel like they are back to where they were before they became depressed. Also, a person does not get "hooked" on antidepressant medication medicine like you can to street drugs. Sometimes, when a person stops taking antidepressant medicine suddenly, they can feel strange or funny. If you want to stop taking antidepressant medicine, work with your doctor. Your doctor will give you a plan to help you stop your medicine gradually.



(over, please.)

How long does it take for antidepressant medicine to work?

It often takes 2 to 6 weeks before a person starts to feel better on an antidepressant medicine. Antidepressant medicine has to build up day by day over time in the brain. Once enough medicine has built up, the brain begins to work right. Your doctor may want to increase how much medicine you are taking if you do not feel better in 4 to 6 weeks. They might also try a different medicine. You may not notice that you are feeling better at first because the medicine works gradually. Your friends or family might notice positive changes in you before you do. Try to be patient. Getting better takes time.



It can help to rate how you are feeling every week on a scale. For example:

My mood this week has been:

1	2	3	4	5	6	7	8	9	10
Terrible The worst I could feel									**Great** The best I could feel

MDwise has a worksheet that you can use to keep track of your progress. Be sure to show your worksheet to your doctor or therapist.

How long will I have to take antidepressant medicine?

Doctors suggest that a person stay on antidepressant medicine for 4 to 9 months once you feel better. Every person is different though and some people need to stay on antidepressant medicine for longer. Staying on the antidepressant medicine even after you feel better can keep you from getting depressed again. Talk to your doctor about how long you will need to stay on antidepressant medicine.

What should I do if I forget to take my medicine?

If you forget to take your medicine you should not take a double dose the next day. Just take your medicine the next day the way you normally would.

Can I drink alcohol if I am taking antidepressant medicine?

Talk to your doctor before having drinks with alcohol. Alcohol can cause side effects in some people who take antidepressant medicine.

Compiled from the following sources:
www.mentalhealthamerica.net/go/information/get-info
www.nimh.nih.gov/health/index.shtml

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD

MDwise Clinical Care Guidelines

Clinical Care Guidelines for:

Attention Deficit Hyperactivity Disorder

OBJECTIVE

Guide the appropriate diagnosis and treatment of ADHD in the MDwise population as it is the second most common chronic condition in children and adolescents. This guideline is designed to assist the clinician by providing a framework for decision-making.

DIAGNOSIS & ASSESSMENT

DSM-5 DIAGNOSTIC CRITERIA

- Symptoms emerge up to age 12
- Symptoms are developmentally inappropriate
- Symptoms cause significant impairment in functioning in more than one setting
- 6 of 9 inattentive symptoms present indicate ADHD inattentive type; 5 symptoms for age 17 and older
- 6 of 9 impulsive-hyperactive symptoms indicate ADHD primarily impulsive-hyperactive type; 5 symptoms for age 17 and older
- 6 of 9 of a combination of inattentive and impulsive-hyperactive type indicate ADHD combined type; 5 symptoms for age 17 and older
- ADHD does persist into adulthood and impairment can continue at a level that requires treatment.
- Assess for co-morbid diagnoses such as oppositional defiant disorder, depression.

HISTORY

Obtain a thorough history to rule out:

- Sleep deprivation or a sleep disorder
- Medication side effects
- Depression as primary diagnosis
- Anxiety as primary diagnosis
- Any form of abuse
- Unstable family situations
- Other medical conditions that can mimic ADHD

And obtain a complete clinical picture of symptom presentation

If sufficient symptoms are endorsed during the interview, obtain behavior ratings from the home, school, or other environment the child spends time in to verify objectively that the child meets criteria. If additional psychological testing is needed due to inconclusive data from ratings scales, 2–4 hours of testing may be appropriate.

Applicable Rating Scales: Conners Scales, Vanderbilt

TREATMENT

MEDICATION MANAGEMENT

For ages 4–5, weigh risk of medication at an early age v. harm of delaying diagnosis and treatment.

Trial of stimulant medication titrated up as response dictates (until benefit or side effects occur). If one stimulant medication is not effective, another should be tried until benefit is achieved.

Child to be seen for a medication evaluation within 3 weeks of diagnosis and have 2 follow-up visits within the subsequent 9 months.

Monitor height, weight and side effects.

May re-administer behavior ratings to monitor response to medication.

THERAPY

For ages 4-5, refer for parent training and behavior therapy first; refer for medication if moderate to severe disturbance continues in spite of these interventions

Refer for education and behavior management therapy for the parents.

If an adult, refer for education and therapy to develop coping skills.

Coordinate behavior management with school personnel for children and adolescents.

If child or adult is discharged from inpatient hospitalization, child needs to be seen in an outpatient setting, intensive outpatient setting or partial hospitalization by a behavioral health provider within 7 calendar days.

**Treatment for ADHD must recognize it is a chronic condition that will need to be monitored over long periods in order to assist the person with ADHD in the ongoing management of this disorder.* The treatment plan may consist of medication and/or behavioral therapy.

MEDICATION THERAPY OPTIONS FOR TREATING ADD/ADHD

Stimulants are highly effective in the treatment of ADHD. Prescribers are free to choose any of the two stimulant types (methylphenidate or amphetamine) because evidence suggests the two are equally efficacious in the treatment of ADHD.

Immediate-release stimulant medications must be taken 2–3 times per day to control ADHD symptoms throughout the day. Long-acting forms may be used in initial treatment; there is no need to titrate to the appropriate dose on short-acting forms and then "transfer" patients to long-acting forms. Drug therapy regimens using long-acting forms should not be divided through the day, If the duration of action of a long-acting form is insufficient, either consider a different long-acting dosage form, or supplement the long-acting regimen with an immediate-release form to cover the duration need. If none of the agents bring satisfactory treatment of the patient with ADHD, the clinician should undertake a careful review of the diagnosis and then consider behavior therapy and/or the use of other medications for the treatment of ADHD.

The most common side effects for stimulants are appetite decrease, weight loss, insomnia, or headache. Less common side effects of stimulants include tics and emotional lability/irritability. It is prudent to monitor side effects that do not compromise the patient's health or cause discomfort that interferes with functioning because many side effects of stimulants are transient in nature and may resolve without treatment. Side effects with atomoxetine that occurred more often than those with placebo include gastrointestinal distress, sedation, and decreased appetite.

Therapeutic Class/ Brand Name	Dosage Forms	Recommended Starting Dose	FDA Maximum Daily Dose	Comments
Amphetamine Preparations				
Short Acting				Disadvantage: BID-TID dosing
ADDERALL (generic) Amphetamine-dextroamphetamine	5, 7.5, 10, 12.5, 15, 20, 30 mg tablet	3–5 yr: 2.5mg qD; ≥6 yr: 5mg qD-BID	40mg	
EVEKEO (generic) amphetamine	5, 10 mg tablets	3–5 yr: 2.5mg qD; ≥6 yr: 5mg qD-BID		
DEXEDRINE/ DEXTROSTAT (generic) dextroamphetamine	5, 10 mg tablet 5mg/5ml solution (PROCENTRA)	3–5 yr: 2.5mg qD 6 yr: 5mg qD-BID		
methamphetamine (generic) DESOXYN	5mg tablet	≥6 yr: 5mg qD-BID		
Long Acting				Advantage: Convenience/Compliance Disadvantage: Loss of evening appetite and sleep
DEXEDRINE SPANSULE (generic) dextroamphetamine	5, 10, 15, mg capsule	≥6 yr: 5-10mg qD-BID	40mg	
ZENZEDI (generic) dextroamphetamine	2.5, 5, 7.5, 10, 15, 20, 30 mg tablet	≥6 yr: 5-10mg qD-BID		
ADDERALL XR (generic) Amphetamine-dextroamphetamine	5, 10, 15, 20, 25, 30 mg capsule	≥6 yr: 10mg qD	30mg	Capsule may be opened and sprinkled on food.
VYVANSE lisdexamfetamine	20, 30, 40, 50, 60, 70 mg capsule	≥6 yr: 30mg qD	70mg	
Methylphenidate Preparations				
Short Acting				
FOCALIN (generic) dexmethylphenidate	2.5, 5, 10 mg tablet	≥6 yr: 2.5mg BID	20mg	
RITALIN/METHYLIN (generic) methylphenidate	5, 10, 20 mg tablet 5mg/5ml, 10mg/5ml solution	≥6 yr: 5mg BID	60mg	

Therapeutic Class/ Brand Name	Dosage Forms	Recommended Starting Dose	FDA Maximum Daily Dose	Comments
Methylphenidate Preparations (continued)				
Intermediate Acting				
METADATE ER (generic) methylphenidate ER	20mg tablet	20mg qAM	60mg	Duration of action is approximately 8 hours.
METHYLIN ER (generic) methylphenidate ER	10, 20 mg tablet	10mg qAM	60mg	Duration of action is approximately 8 hours.
RITALIN SR (generic) methylphenidate ER	20mg tablet	20mg qAM	60mg	Duration of action is approximately 8 hours.
METADATE CD (generic) methylphenidate CD	10, 20, 30, 40, 50, 60 mg capsule	20mg qAM	60mg	Comprised of 30% of dose in immediate-release form and 70% in sustained release form.
RITALIN LA (generic) methylphenidate LA	10, 20, 30, 40 mg capsule	20mg qAM	60mg	Comprised of 50% of dose in immediate-release form and 50% in delay-released form.
Long Acting				
CONCERTA (generic) methylphenidate extended release	18, 27, 36, 54 mg tablet	18–36mg qD	72mg	Initial release of dose from outer coating within 1 hour and remainder released at controlled rate over a total of 6–10 hours.
APTENSIO XR (generic) methylphenidate	10, 15, 20, 30, 40, 50, 60 mg ER capsule	10 mg QD	60 mg	
DAYTRANA Methylphenidate transdermal	10, 15, 20, 30 mg patches	10mg topical qD	30mg	Patch designed for 9 hours of use
FOCALIN XR dexmethylphenidate	5, 10, 15, 20, 25, 30, 35, 40 mg capsule	≥6 yr: 5mg qD ≥18 yr: 10mg qD	≥6 yr: 30mg ≥18 yr: 40mg	
QUILLIVANT XR methylphenidate	25 mg/ml solution	20 mg QD	60mg	
Selective Norepinephrine Reuptake Inhibitor				
STRATTERA atomoxetine	10, 18, 25, 40, 60, 80, 100 mg capsule	≤70 kg weight: 0.5mg/kg/day, titrating after a minimum of 3 days to a target daily dose not to exceed 1.2 mg/kg/day >70kg weight: 40mg qD, titrating after a minimum of 3 days to a target dose of 40mg BID or 80mg qD.		Consider if active substance abuse or severe side effects. Give qAM or divided doses BID.

Disclaimer: Recommendation of treatment does not guarantee coverage of services.

REFERENCES

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition TR (2013) American Psychiatric Association.

American Academy of Pediatrics, Clinical Practice Guidelines (2011)

American Academy of Child and Adolescent Psychiatry, Practice Parameter for the Use of Stimulant Medication (2002)

NIMH, A 14 month Randomized, Clinical Trial (1999)

NIMH Treatment Study Follow-Up: 24 month outcomes (2004)

RA Barkley & KR Murphy (2006) Attention Deficit Hyperactivity Disorder: A Clinical Workbook (3rd ed). New York: Guilford Publications

Journal of American Academy of Child and Adolescent Psychiatry, 46:7 (2007)

Pliszka S. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 2007;46:894-921.

Approved by the Medical Advisory Council on 12/10/08, 4/13/11, 2/8/12, 2/12/14, 4/6/16, 8/1/2018 Revised: 1/25/11, 2/1/12, 1/28/14, 3/15/16 Reviewed 3/2018
AP0147 (4/16)

ADHD

Practitioner Toolkit

Vanderbilt ADHD Diagnostic Parent Rating Scale

Child's Name:_____ Today's Date: _____
Date of Birth: _____ Age: _____ Grade: _____

Circle the number on the scale that corresponds to how you would rate your child's behavior.
0 = Never 1 = Occasionally 2 = Often 3 = Very Often

1.	Does not pay attention to details or makes careless mistakes, for example homework	0	1	2	3
2.	Has difficulty attending to what needs to be done	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through when given directions and fails to finish things	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7.	Loses things needed for tasks or activities (assignments, pencils, books)	0	1	2	3
8.	Is easily distracted by noises or other things	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat when he is suppose to stay in his seat	0	1	2	3
12.	Runs about or climbs too much when he is suppose to stay seated	0	1	2	3
13.	Has difficulty playing or starting quiet games	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his/her turn	0	1	2	3
18.	Interrupts or bothers others when they are talking or playing games	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively disobeys or refuses to follow an adults' requests or rules	0	1	2	3
22.	Bothers people on purpose	0	1	2	3
23.	Blames others for his or her mistakes or misbehaviors	0	1	2	3
24.	Is touchy or easily annoyed by others	0	1	2	3
25.	Is angry or bitter	0	1	2	3
26.	Is hateful and wants to get even	0	1	2	3
27.	Bullies, threatens, or scares others	0	1	2	3
28.	Starts physical fights	0	1	2	3

Vanderbilt ADHD Diagnostic Parent Rating Scale (continued)

Child's Name: _____

29.	Lies to get out of trouble or to avoid jobs (i.e., "cons" others)	0	1	2	3
30.	Skips school without permission	0	1	2	3
31.	Is physically unkind to people	0	1	2	3
32.	Has stolen things that have value	0	1	2	3
33.	Destroys others' property on purpose	0	1	2	3
34.	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35.	Is physically mean to animals	0	1	2	3
36.	Has set fires on purpose to cause damage	0	1	2	3
37.	Has broken into someone else's home, business, or car	0	1	2	3
38.	Has stayed out at night without permission	0	1	2	3
39.	Has run away from home overnight	0	1	2	3
40.	Has forced someone into sexual activity	0	1	2	3
41.	Is fearful, nervous, or worried	0	1	2	3
42.	Is afraid to try new things for fear of making mistakes	0	1	2	3
43.	Feels useless or inferior	0	1	2	3
44.	Blames self for problems, feels at fault	0	1	2	3
45.	Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46.	Is sad or unhappy	0	1	2	3
47.	Feels different and easily embarrassed	0	1	2	3

How is your child doing?

		Problem		Average	Above Average	
1.	Rate how your child is doing in school overall	1	2	3	4	5
	a. How is your child doing in reading?	1	2	3	4	5
	b. How is your child doing in writing?	1	2	3	4	5
	c. How is your child doing in math?	1	2	3	4	5
2.	How does your child get along with you?	1	2	3	4	5
3.	How does your child get along with brothers and sisters?	1	2	3	4	5
4.	How does your child get along with others his/her own age?	1	2	3	4	5
5.	How does your child do in activities such as games or team play?	1	2	3	4	5

Vanderbilt ADHD Diagnostic Parent Rating Scale (continued)

Scoring Instructions for the ADTRS

- **Predominately inattentive subtype** requires 6 or 9 behaviors, (scores of 2 or 3 are positive) on items 1 through 9, and a performance problem (scores of 1 or 2) in any of the items on the performance section.
- **Predominately hyperactive/Impulsive subtype** requires 6 or 9 behaviors (scores of 2 or 3 are positive) on items 10 through 18 and a problem (scores of 1 or 2) in any of the items on the performance section.
- **The Combined Subtype** requires the above criteria on both inattention and hyperactivity/impulsivity.
- **Oppositional-defiant disorder** is screened by 4 of 8 behaviors, (scores of 2 or 3 are positive) (19 through 26)
- **Conduct disorder** is screened by 3 of 15 behaviors, (scores of 2 or 3 are positive) (27 through 40).
- **Anxiety or depression** are screened by behaviors 41 through 47, scores of 3 of 7 are required, (scores of 2 or 3 are positive).

Vanderbilt ADHD Diagnostic Teacher Rating Scale

INSTRUCTIONS AND SCORING

Behaviors are counted if they are scored 2 (often) or 3 (very often).

Inattention	Requires six or more counted behaviors from questions 1–9 for indication of the predominantly inattentive subtype.
Hyperactivity/impulsivity	Requires six or more counted behaviors from questions 10–18 for indication of the predominantly hyperactive/impulsive subtype.
Combined subtype	Requires six or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.
Oppositional defiant and conduct disorders	Requires three or more counted behaviors from questions 19–28.
Anxiety or depression symptoms	Requires three or more counted behaviors from questions 29–35.

The performance section is scored as indicating some impairment if a child scores 1 or 2 on at least one item.

FOR MORE INFORMATION CONTACT

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The scale is available at http://peds.mc.vanderbilt.edu/VCHWEB_1/rating~1.html.

REFERENCE FOR THE SCALE'S PSYCHOMETRIC PROPERTIES

Wolraich ML, Feurer ID, Hannah JN, et al. 1998. Obtaining systematic teacher reports of disruptive behavior disorders utilizing DSM-IV. *Journal of Abnormal Child Psychology* 26(2):141–152.

Vanderbilt ADHD Diagnostic Teacher Rating Scale (conintued)

Name: _____ Grade: _____

Date of Birth: _____ Teacher: _____ School: _____

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

1.	Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2.	Has difficulty sustaining attention to tasks or activities	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustaining mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by extraneous stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12.	Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks excessively	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting in line	0	1	2	3
18.	Interrupts or intrudes on others (e.g., butts into conversations or games)	0	1	2	3
19.	Loses temper	0	1	2	3

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

20. Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (i.e., "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems, feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

PERFORMANCE

	Problematic		Average	Above Average	
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavioral Performance					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

ADHD

Member Materials

INcontrol

What is ADHD?

Attention Deficit/Hyperactivity Disorder (ADHD) is a disorder that has both behavioral and emotional symptoms. It is also sometimes called Attention Deficit Disorder (ADD). It is usually first seen in children and the problems may continue all through their life.

Children who have ADHD might:

- Have trouble paying attention.
- Do things without thinking first.
- Be very active and seem like they are always moving or talking.
- Daydream a lot.
- Forget to do things they are supposed to do.
- Have trouble taking turns.
- Seem like they don't listen.
- Interrupt when other people are talking.
- Refuse to do homework.
- Refuse to do chores.
- Leave the table at family meals.
- Have trouble sitting through a church service.
- Dart out into the street.
- Argue with parents, teachers, and friends.
- Regularly say "I forgot."

A child with ADHD will have problem behaviors in more than one setting (at school, at home, at grandmas and at church). Two different children with ADHD may seem very different from each other. It depends on which combination of symptoms they have.

Who can diagnose ADHD?

A medical doctor must decide if your child has ADHD. This could be your child's primary care doctor or a doctor who specializes in ADHD (a psychiatrist or neurologist).

If you take your child to a psychiatrist, they may have you and your child meet with a therapist first to gather important information.

How will the doctor decide if my child has ADHD?

There is not a single test to diagnose ADHD. Your doctor must follow several steps to decide if your child has ADHD.

A doctor will follow these steps to diagnose ADHD:

- **Medical checkup:** A doctor will ask questions about your child's health. They might do a medical checkup to make sure that your child is well. Some physical health problems (sleep difficulties, problems with hearing, allergies etc.) can cause children to have these behaviors too.
- **Ask for history:** A doctor will ask you questions about your child's behavior. You may be asked to tell about times when your child has had these problems.
- **Rating scales:** A doctor will ask you to fill out a checklist of ADHD symptoms. The checklist helps the doctor see how many symptoms of ADHD your child has and how often they happen. You may also be asked to give your child's teacher a checklist to fill out.

Where can I learn more about ADHD?

- Children and Adults with Attention Deficit Hyperactivity Disorder (CHADD)
  www.CHADD.org
- Visit the MDwise website at:
  MDwise.org

Compiled from the following sources:
www.mentalhealthamerica.net/go/information/get-info
www.nimh.nih.gov/health/index.shtml

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What does treatment for ADHD involve?

ADHD (Attention Deficit Hyperactivity Disorder) is a chronic or long lasting condition. Families must manage the treatment of ADHD on an ongoing basis. In most cases, treatment for ADHD includes the following:

1. **A long-term management plan.** This will have:
   - **Goals** (better grades in school, improved social skills, can sit still longer)
   - **Follow-up activities** (e.g., medication, making changes that affect behavior at school and at home, talking to the staff at school, helping with homework)
   - **Monitoring** (checking the child's progress with the target outcomes)
2. **Medication.** Medications have been found to be one of the best ways to help ADHD symptoms. It can be scary to decide to give your child medicine for ADHD. There are many stories in the media that say bad things about these medicines. Talk to your child's doctor. They can help you understand how medicine helps ADHD and which type of medicine is best for your child.
3. **Behavior Therapy.** This focuses on making changes in the child's school setting and home to help improve behavior.
4. **Parent Training.** Training can give parents specific ideas on how to help with ADHD behaviors in a positive way.
5. **Education.** Everyone in the school needs to understand what ADHD is and what can be done to help. Parents can learn more about ADHD from their child's doctor or therapist. There are also support groups that can help you.
6. **Teamwork.** Treatment works best when doctors, parents, teachers, caregivers, and the child work together. It may take some time to develop your child's treatment plan. Medicine alone may not fully treat the ADHD-type behaviors. Most school-aged children with ADHD do best when their treatment plan includes both medications and behavior therapy.

Is there a cure for ADHD?

There is no proven cure for ADHD at this time. The cause of ADHD is also unknown at this time. We do know that ADHD is **not caused** by bad parenting!

Research is going on to learn more about the role of the brain in ADHD and the best ways to treat the disorder. Many good treatment options are available. The outlook for children who receive treatment for ADHD is encouraging.

Will my child out grow ADHD?

Unfortunately, no. Sometimes children seem less active as they get older. They will still have other signs of ADHD, however. It is **very important** for your child to continue to take medicine. It is just as important to go to therapy. When your child gets better, you might think that treatment is over. Remember, ADHD is a long lasting condition. Going to see your child's therapist is like getting a behavior "tune up." This "tune up" helps keep old problems from showing up again!

As a parent, you are an important part of the ADHD team!

Compiled from the following sources:

www.nimh.nih.gov/health/index.shtml

https://psychcentral.com/lib/adhd-behavioral-interventions-for-the-home/

INcontrol

Why is my child having trouble in school?

It is very common for children with ADHD to have problems with school work and grades. These problems can occur for many reasons:

- Children with ADHD find it hard to sit still all day and focus on work.
- Children with ADHD have trouble with being organized and staying on schedule.
- Children with ADHD may have trouble with self control – they may get into trouble a lot.
- Some children with ADHD may learn quickly, but forget what they have learned by the next day.
- Some children with ADHD learn more slowly and need a lot of repetition.
- Many children with ADHD may also have a Learning Disability (LD). A child with LD is often very smart, but learning certain subjects may be very hard for them (math, reading, spelling etc.).

What can a parent do to help?

- Tell your child's teacher and school team that the doctor has diagnosed your child with ADHD. The school nurse may be helpful in making sure your child gets their medicine.
- Be friendly and positive at the school. Tell them you want to help and want to work with the school to help your child.
- Make a plan with the teacher to keep track of how your child is doing. This is sometimes called a "daily report card" system.
- Ask to spend time in your child's classroom to see how your child behaves. The teacher may be very happy to have you there.
- Thank your child's teacher for the help he/she gives your child. The teacher is doing extra work to help you and your child.

- Learn all you can about ADHD. Become an expert on your child's needs.
- Be your child's advocate. An advocate is someone who asks for help on behalf of a child. An advocate keeps asking even if at first they are told "no." They keep on asking for help because they know what their child needs.
- Help your child stay organized. Ask to see your child's assignment sheet or school planner every day. Help them organize their backpack and notebooks. A well organized notebook can help a lot. Remove all graded papers and put unfinished work in a folder. An ADHD child's back pack can quickly become a mess.
- Take care of yourself too! The job "parent" can be very challenging – especially if your child has ADHD. Ask family and friends to help you when you feel tired. Join a parent support group for ADHD.

Compiled from the following sources:
www.CHADD.org/for-parents/education/

INcontrol

ADHD Homework Tips

Getting homework done is a common problem for children with ADHD. For success, a parent will need to **BE ACTIVELY INVOLVED! Here is a list of helpful hints!**

- Set up a regular place and time for your child to do their homework.
- Make homework time early enough so that the child's medicine is still working.
- Remove things that take attention away from homework (TV, objects, pets) Sometimes children with ADHD study better with music in the background. Choose music with no words, like classical music.
- Divide homework into smaller parts. Have only one part in front of them at a time. Children with ADHD will say, "I'll never be able to do all of this!" If they only see one section of the work at a time, the child may not feel defeated before they even get started.
- Help them get started. Read the directions together and answer a couple of questions together. Stay and watch them answer a question on their own. Then, let them work on their own. You will need to stay near by or check on them to see if they are still working.
- Use a kitchen timer. Set a kitchen timer for 10 to 15 minutes and ask your child to work without stopping until the timer rings. When the timer rings, let them take a very short break to have a drink or snack. Then repeat setting the timer for 10 to 15 more minutes.
- Help children who rush through homework to slow down. Again, set a kitchen timer for 10 to 15 minutes. Tell your child to use all of the time on the clock to make sure they use their best hand writing or to find their best answer.
- Help your child study for tests. Have your child look over what they are being tested on. Then ask the child questions about what they have studied. Pretend like you are playing a TV game show. Children with ADHD often do better studying when it seems like they are playing. For younger children, use flash cards to practice math skills or spelling words. Children can make their own cards on pieces of paper.
- Help children complete bigger projects. Read the teachers project description. Help your child divide the project into smaller sections. Write the smaller sections on a calendar or in the child's assignment notebook. Complete the smaller sections like they are regular homework.
- Make sure that your child puts homework they have finished in their backpack. Children with ADHD are often forgetful.

Compiled from the following sources:
psychcentra.com/lib/adhd-behavioral-interventions-for-the-home

Strategies for ADHD Symptoms

Inattention

- **Use a timer –** Set a timer for 15 minutes or less to help them focus. Say "try to get as many Math problems done as you can in 3 minutes. On your mark, get set, go!" (not a good idea for children who are very nervous).
- **Make any task into a game –** To clean up a bedroom or play area, do a "5 minute pick up". Ask the child to pick up anything out of place and sort things into piles. After 5 minutes, return items to areas where they belong.
- **Break large tasks into small parts.**
- **Give countdowns when it's time to stop a fun activity –** Say "you have 5 more minutes to play your game. In a few minutes, say "you have 2 more minutes to play." Helps to avoid meltdowns.

Organization

- **Use color coding to organize –** For example, items that have to do with Math are blue (dividers, book cover, folders etc.), English is red and so on.
- **Use clear plastic containers.**
- **Use open containers –** With no lids, items can be easily dropped in.
- **Group like things together.**
- **Put storage where they'll use it –** if they usually undress at the end of the bed, put the hamper at the end of the bed.
- **Make routines.**

Hyperactivity/Impulsivity

- **Involve child in structured activities –** Individual activities may be best i.e. gymnastics, karate, cross country, wrestling, swimming, piano lessons, painting, etc.
- **Quiet activities before bed –** Avoid TV and computer which may be too stimulating. Encourage reading, quiet music, drawing to wind down.
- **Play games at home that require calm behavior –** Pick up sticks, Concentration, Jenga, Operation, Mother May I?, Simon Says, Card games, etc.

School

- **Keep them on track –** Help your child in setting up their assignment notebook (see organization for ideas).
- **Parents must assist with setting up school binder –** monitor daily.
- **Monitor grades –** Teach older children to "average" their grades. Missing assignments do make a difference.
- **Develop a partnership with the teacher –** Ask for a 504 plan or testing if learning is a problem.
- **Organize belongings at night –** Lay out clothes, put their back pack by the door, sign permission slips, etc. Mornings can be chaotic.
- **Call the homework hotline** or find a study buddy to call.

Teens and ADHD

Remember, the teen brain is different than a child's brain. Teens are making their way into the world and need to be treated differently than children. Be flexible with them and work with the teen in creating their schedule and boundaries. One example would be creating a contract that outlines expectations the teen agrees to follow. You and your teen sign the contract.

Source:
Teenagers with ADD: A Parent's Guide, Chris A. Zeigler Dendy, Woodbine House, 1995.:
https://psychcentral.com/lib/adhd-behavioral-interventions-for-the-home/

Daily/Weekly Academic Report

Student Name:____

Date: / / Class Period: Subject:

(+) = yes; (-) = no	M	T	W	T	F
Homework turned in					
On-task					
Has needed materials					

Unfinished assignments? _____ yes _____no
Test grades C or better? _____ yes _____no

Comments:

Teacher Signature: ________________________________

Date: / / Class Period: Subject:

(+) = yes; (-) = no	M	T	W	T	F
Homework turned in					
On-task					
Has needed materials					

Unfinished assignments? _____ yes _____no
Test grades C or better? _____ yes _____no

Comments:

Teacher Signature: ________________________________

Date: / / Class Period: Subject:

(+) = yes; (-) = no	M	T	W	T	F
Homework turned in					
On-task					
Has needed materials					

Unfinished assignments? _____ yes _____no
Test grades C or better? _____ yes _____no

Comments:

Teacher Signature: ________________________________

Date: / / Class Period: Subject:

(+) = yes; (-) = no	M	T	W	T	F
Homework turned in					
On-task					
Has needed materials					

Unfinished assignments? _____ yes _____no
Test grades C or better? _____ yes _____no

Comments:

Teacher Signature: ________________________________

Date: / / Class Period: Subject:

(+) = yes; (-) = no	M	T	W	T	F
Homework turned in					
On-task					
Has needed materials					

Unfinished assignments? _____ yes _____no
Test grades C or better? _____ yes _____no

Comments:

Teacher Signature: ________________________________

Date: / / Class Period: Subject:

(+) = yes; (-) = no	M	T	W	T	F
Homework turned in					
On-task					
Has needed materials					

Unfinished assignments? _____ yes _____no
Test grades C or better? _____ yes _____no

Comments:

Teacher Signature: ________________________________

Adapted from:
Teenagers with ADD: A Parent's Guide by Chris A. Zeigler Dendy, M.S. 1995.

APM0081 (11/18)

Famous People with ADHD

Here's a list of famous people with ADHD. People on the list who lived a long time ago weren't officially diagnosed with ADHD, but their written history suggests they might have had ADHD. Enjoy the list. You are in good company!

Will Smith…actor, singer **Jim Carrey**…comedian, actor **Paris Hilton**...actress **James Carvel**…political analyst **Ansel Adams**…photographer **Pete Rose**…Major League Baseball player **Glenn Beck**…conservative TV and radio personality **Michael Phelps**…Olympic swimmer **Howie Mandell**…comedian, actor **David Neeleman**…founder of Jet Blue Airways **Paul Orfalea**… founder of Kinko's **John F. Kennedy**…U.S. President **Jamie Oliver**…British celebrity chef **Whoopi Goldburg**…comedian, actress **Justin Timberlake**…singer, actor **Terry Bradshaw**…former Pittsburgh Steelers quarterback **Karina Smirnoff**…Ukranian professional dancer on *Dancing with the Stars* **Sir Richard Branson**…British founder of Virgin Airlines **Erin Brockovich-Ellis**…legal clerk and activist **Ty Pennington**…TV personality **Scott Eyre**…Major League Baseball player **Frank Lloyd Wright**…architect **Bruce Jenner**…Olympic athlete **Michelle Rodriguez**…actress **Solange Knowles**…singer (Beyonce's little sister) **Charles Schwab**…financial expert **Greg Louganis**… Olympic swimmer **Dustin Hoffman**…actor **Walt Disney**…founder of Disney Productions **Robin Williams**…comedian, actor **Steve Jobs**…founder of Apple Computers **Woody Harrelson**…actor **Prince Charles**…future King of England **John Denver**…musician **Dwight D. Eisenhower**… U.S. President, military general **Nelson Rockefeller**…U.S. Vice President **Beethoven**…German composer **Lewis Carroll**…British author of *Alice in Wonderland* **Henry Ford**…automobile innovator **John Lennon**…British musician, member of The Beatles **George Bernard Shaw**…Irish author **Pablo Picasso**…Spanish Cubist artist **Jackie Stewart**…Scottish race car driver **Anna Eleanor Roosevelt**… U.S. First Lady **Steven Spielberg**… filmmaker **Babe Ruth**… Major League Baseball player **General William C. Westmoreland**…military general **Orville and Wilber Wright**… airplane developers **Stevie Wonder**…musician **Henry David Thoreau**…author, poet **Sir Issac Newton**…English scientist, mathematician **Dustin Hoffman**…actor **Cher**…actress, singer **Alexander Graham Bell**…telephone inventor **Wolfgang Amadeus Mozart**…German child prodigy composer **Galileo**…Italian astronomer **and the list goes on and on …**

Source: Grohol, J. (2010). Famous People with ADHD. Psych Central. http://psychcentral.com/lib/2010/famous-people-with-adhd/

Autism Spectrum Disorder

Autism Spectrum Disorder

MDwise Clinical Care Guidelines

Clinical Care Guidelines for:

Autism Spectrum Disorder

OBJECTIVE

Guide the appropriate diagnosis and treatment of Autism Spectrum Disorder (ASD) in children and adolescents. ASD is characterized by delays in socialization and communication skills and is a neurodevelopmental disorder.

DIAGNOSIS & ASSESSMENT

DSM-5 DIAGNOSTIC CRITERIA

- Parents may notice symptoms in early infancy, although the typical age of onset is prior to age three.
- Symptoms of disorders on the higher functioning end of the spectrum may emerge later.
- Symptoms may include difficulty with understanding and expressing language, problems relating to peers and objects, unusual focus on toys or objects, repetitive body movements or repetitive behavior, and sensory sensitivity.
- Symptoms cause significant impairment in functioning in more than one setting. The following areas are affected:
  A. Social communication and interaction
  B. Repetitive patterns of behavior, interests or activities

Early intervention is critical in obtaining appropriate support and services for this population.

PROCEDURES

Diagnosis of a Autism Spectrum Disorder requires a multi-disciplinary evaluation. This will include:

- Screening with PMP
- Obtaining a thorough history that includes:
  - Language development; occurrence of repetitive movement; problems relating to others, objects, and/or environment; sensitivity to sensory input (loud noises, lights); difficulty adjusting to changes in routine; and unusual focus on an object (toys, obsessive talk about a particular subject of interest)
- Diagnosis of ASD is done by a qualified health professional as outlined by Indiana Code and the IHCP guidelines. Only a specialist can diagnose ASD and other health conditions should be ruled out before an ASD diagnosis. The diagnosis should be based on the DSM-5 criteria but be specific to the member being assessed.
- Diagnosis of ASD will include diagnostic tools as well as screening tools. It is important that both are completed for a diagnosis of ASD. There are several types of screening tools and diagnostic tools utilized.

Refer to one of the below specialists to support treatment and establish levels of functioning for treatment.

- Psychologist
- Speech Therapist
- Occupational Therapist

TREATMENT

MEDICATION MANAGEMENT

A trial of medication may be appropriate based on the severity of symptoms and level of impairment in functioning.

May re-administer behavior ratings to monitor response to medication.

If on atypical anti-psychotic medication, monitor blood glucose levels, weight and diet.

Risperdone has the most substantive amount of clinical evidence for children and adolescents. There is a paucity of evidence on the other atypical anti-psychotics for use with children and adolescents.

THERAPY

Applied Behavior Analysis, Speech/Language and Occupational Therapy.

Family and individual therapy.

Special education programs and support services through the school system.

Support services for parents, community-based resources, respite services and evaluation and training with a behavioral specialist who works with Autism Spectrum Disorders.

If child is discharged from inpatient hospitalization, child needs to be seen in an outpatient setting, intensive outpatient setting or partial hospitalization by a behavioral health provider within 7 calendar days.

** Early treatment for ASD must recognize it is a chronic condition that will need to be monitored over long periods in order to assist the person with ASD in the on-going management of this disorder. Multi-disciplinary therapies are more effective over the course of the disorder than one form of therapy alone.*

Disclaimer: Recommendation of treatment does not guarantee coverage of services.

REFERENCES

American Academy of Child and Adolescent Psychiatry (2011). Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents. 2014: https://www.jaacap.org/article/S0890-8567(13)00819-8/pdf

American Diabetes Association, American Psychiatric Association, Association of Clinical Endocrinologists, North American Association for the Study of Obesity: Consensus Development Conference on Anti-Psychotic Drugs and Obesity and Diabetes. Diabetes Care (2004) vol 27, 596-601.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition–TR (2013) American Psychiatric Association.

National Autism Center (2009) National Standards Project. www.nationalautismcenter.org.

Approved by the Medical Advisory Council on 6/11/14 Revised: 4/22/14
APP0159 (6/14) Reviewed 02/2020
HHW-HIPP0721 (2/22) Reviewed 02/2022

Autism Spectrum Disorder

Practitioner Toolkit

Modified Checklist for Autism Toddlers (M-CHAT)*

Diana L. Robins, M.A., Deborah Fein, Ph.D., Marianne L. Barton, Ph.D., & James A. Green, Ph.D.
University of Connecticut
The full text may be obtained through the Journal of Autism and Developmental Disorders, April 2001

PLEASE NOTE: The M-CHAT was not designed to be scored by the person taking it. In the validation sample, the authors of the M-CHAT scored all checklists. If parents are concerned, they should contact their child's physician.

Abstract

Autism, a severe disorder of development, is difficult to detect in very young children. However, children who receive early intervention have improved long-term prognoses. The Modified – Checklist for Autism in Toddlers (M–CHAT), consisting of 23 yes/no items, was used to screen 1076 children. Thirty of 44 children given a diagnostic/developmental evaluation were diagnosed with a disorder on the autism spectrum. Nine items pertaining to social relatedness and communication were found to have the best discriminability between children diagnosed with and without autism/PDD. Cutoff scores were created for the best items and the total checklist. Results indicate that the M-CHAT is a promising instrument for the early detection of autism.

Background

The M-CHAT is an expanded American version of the original CHAT from the U.K. The M-CHAT has 23 questions using the original nine from the CHAT as its basis. Its goal is to improve the sensitivity of the CHAT and position it better for an American audience. The M-CHAT has been steadily expanding its radius of usage in the state of Connecticut and surrounding New England states. Its authors are still collecting data on the initial study, awaiting final outcomes for sensitivity and specificity after the subjects return for their 3.5 year well-child visit by 2003. The authors have applied for funding of an expanded study on 33,000 children. The M-CHAT tests for autism spectrum disorders against normally developing children.

M-CHAT Scoring Instructions

A child fails the checklist when 2 or more critical items are failed OR when any three items are failed. Yes/no answers convert to pass/fail responses. Below are listed the failed responses for each item on the M-CHAT. Bold capitalized items are CRITICAL items. Not all children who fail the checklist will meet criteria for a diagnosis on the autism spectrum. However, children who fail the checklist should be evaluated in more depth by the physician or referred for a developmental evaluation with a specialist.

1. No	6. No	11. Yes	16. No	21. No
2. NO	**7. NO**	12. No	17. No	22. Yes
3. No	8. No	**13. NO**	18. Yes	23. No
4. No	**9. NO**	**14. NO**	19. No	
5. No	10. No	**15. NO**	20. Yes	

Instructions and Permissions for Use of the M-CHAT

The Modified Checklist for Autism in Toddlers (M-CHAT; Robins, Fein, & Barton, 1999) is available for free download for clinical, research, and educational purposes. There are two authorized websites: the MCHAT and supplemental materials can be downloaded from **www.firstsigns.org** or from Dr. Robins' website, at **http://www2.gsu.edu/~psydlr/DianaLRobins/Official_M-CHAT_Website.html**

Users should be aware that the M-CHAT continues to be studied, and may be revised in the future. Any revisions will be posted to the two websites noted above.

Furthermore, the M-CHAT is a copyrighted instrument, and use of the M-CHAT must follow these guidelines:

(1) Reprints/reproductions of the M-CHAT must include the copyright at the bottom (© 1999 Robins, Fein, & Barton). No modifications can be made to items or instructions without permission from the authors.

(2) The M-CHAT must be used in its entirety. There is no evidence that using a subset of items will be valid.

(3) Parties interested in reproducing the M-CHAT in print (e.g., a book or journal article) or electronically (e.g., as part of digital medical records or software packages) must contact Diana Robins to request permission (drobins@gsu.edu).

Instructions for Use

The M-CHAT is validated for screening toddlers between 16 and 30 months of age, to assess risk for autism spectrum disorders (ASD). The M-CHAT can be administered and scored as part of a well-child check-up, and also can be used by specialists or other professionals to assess risk for ASD. The primary goal of the M-CHAT was to maximize sensitivity, meaning to detect as many cases of ASD as possible. Therefore, there is a high false positive rate, meaning that not all children who score at risk for ASD will be diagnosed with ASD. To address this, we have developed a structured follow-up interview for use in conjunction with the M-CHAT; it is available at the two websites listed above. Users should be aware that even with the follow-up questions, a significant number of the children who fail the M-CHAT will not be diagnosed with an ASD; however, these children are at risk for other developmental disorders or delays, and therefore, evaluation is warranted for any child who fails the screening.

The M-CHAT can be scored in less than two minutes. Scoring instructions can be downloaded from **http://www2.gsu.edu/~psydlr/DianaLRobins/Official_M-CHAT_Website.html** or **www.firstsigns.org**. We also have developed a scoring template, which is available on these websites; when printed on an overhead transparency and laid over the completed M-CHAT, it facilitates scoring. Please note that minor differences in printers may cause your scoring template not to line up exactly with the printed M-CHAT.

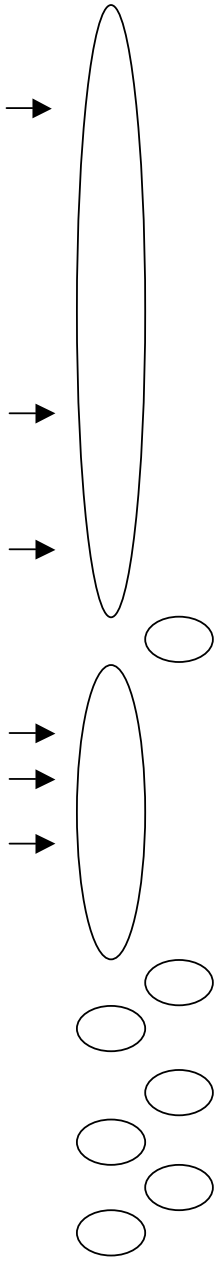
Children who fail more than 3 items total or 2 critical items (particularly if these scores remain elevated after the follow-up interview) should be referred for diagnostic evaluation by a specialist trained to evaluate ASD in very young children. In addition, children for whom there are physician, parent, or other professional's concerns about ASD should be referred for evaluation, given that it is unlikely for any screening instrument to have 100% sensitivity.

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes	No
2.	Does your child take an interest in other children?	Yes	No
3.	Does your child like climbing on things, such as up stairs?	Yes	No
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes	No
5.	Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Yes	No
6.	Does your child ever use his/her index finger to point, to ask for something?	Yes	No
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Yes	No
8.	Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?	Yes	No
9.	Does your child ever bring objects over to you (parent) to show you something?	Yes	No
10.	Does your child look you in the eye for more than a second or two?	Yes	No
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes	No
12.	Does your child smile in response to your face or your smile?	Yes	No
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes	No
14.	Does your child respond to his/her name when you call?	Yes	No
15.	If you point at a toy across the room, does your child look at it?	Yes	No
16.	Does your child walk?	Yes	No
17.	Does your child look at things you are looking at?	Yes	No
18.	Does your child make unusual finger movements near his/her face?	Yes	No
19.	Does your child try to attract your attention to his/her own activity?	Yes	No
20.	Have you ever wondered if your child is deaf?	Yes	No
21.	Does your child understand what people say?	Yes	No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes	No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes	No

M-CHAT Scoring Template



If 2 or more Critical Items (denoted by →) are failed, *OR* 3 or more items total are failed, child FAILS the M-CHAT and a follow-up interview should be administered for failed items only. Otherwise, child PASSES the M-CHAT

Autism Spectrum Disorder

Member Materials

INcontrol

What is Autism Spectrum Disorder (ASD)?

You have just been told by your doctor that your child has or may have Autism Spectrum Disorder (ASD).

...it feels like your whole world has come to an end.

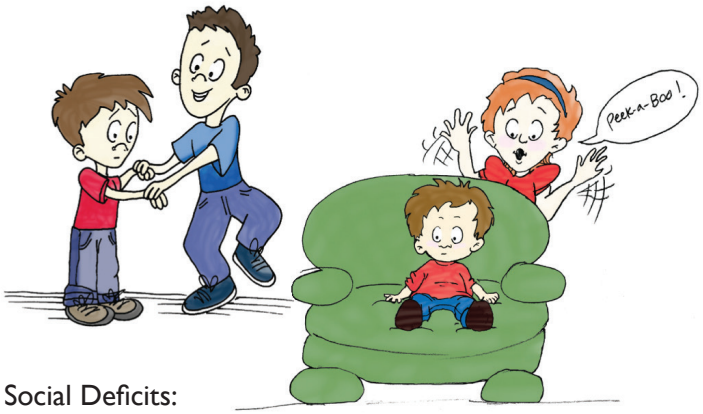
...all the dreams and hopes you have for your child seem shattered.

This is exactly how many parents feel. It is a natural reaction to such devastating news.

BUT you are NOT alone. Your physician wants to help.

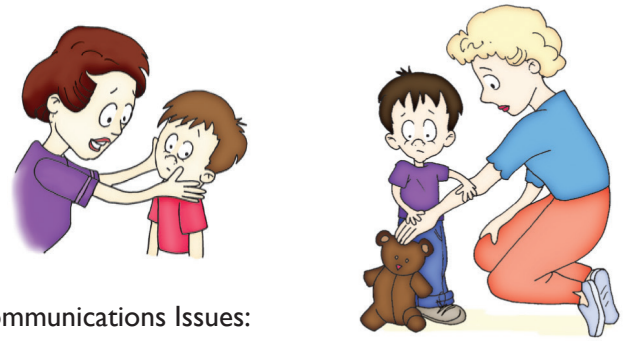
At one time autism was considered rare and hopeless, but this is no longer true. Many children with autism, especially with early intervention, make considerable improvements and may even mainstream into regular classrooms.

Your physician will provide you with resources and referrals that can profoundly affect your child's outcome for the better.



Social Deficits:

May show no interest in
Peek-a-boo or other interactive games.



Communications Issues:

May not communicate typically by verbalizing or pointing; instead they may "hand-lead" to the desired object.
May have decreased eye-contact.

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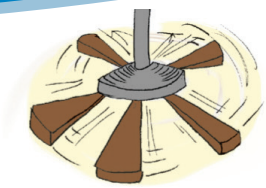
Revised 11/2018



Bizarre / Repetitive Behaviors:

Such as staring at ceiling fans for hours, spinning, rocking, flapping and flicking their fingers.

Sensory Issues:

May have difficulty with clothing, noise, music, lights, smells, bathing, and any new situation.

Self-Injurious Behaviors:

May have biting, head-banging, ripping at skin and hair.

Gastro-Intestinal Problems:

Some children may have Gastro-Intestinal Problems such as diarrhea, constipation, bloody stool, undigested food in stool, frequent vomiting, and food sensitivities.

Motor Issues:

May be unable to pick up small objects, appear clumsy, have balance and coordination difficulties.

Autism is a "catch-all" word that is applied to a group of symptoms, some of which are shown above. These occur in varying degrees depending on the individual child.

Source: Help Autism Now, at www.helpautismnow.com

INcontrol

If You Think Your Child Has Autism Spectrum Disorder (ASD), There is Help

Signs of Autism Spectrum Disorder (ASD)

- Little or no speech.
- Odd speech.
- Avoids being with others, likes to be alone.
- Plays with things in an odd way: spinning, staring at lights or fans, lines things up over and over.

If your child has these or any other unusual behaviors:

- Talk to your doctor. Ask for tests to rule out other problems such as hearing loss or seizures.
- Make an appointment with a developmental pediatrician or other doctor who can help with autism. Your doctor can help you find one.
- Call First Steps if your child is under 3, at 1-800-441-7837, or e-mail **FirstStepsWeb@fssa.in.gov** for early intervention.
- Call Head Start if your child is over 3, at 317-233-6837 in the Indianapolis area, or go to **www.in.gov/fssa/dfr** for more information.
- Talk to your child's teacher if he or she is in school. The school can help find out if your child's behavior may be Autism Spectrum Disorder (ASD).

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For help being a parent:

- Autism Society Indiana
  317-695-0252
  www.autismsocietyofindiana.org

- About Special Kids
  800-964-4746
  www.aboutspecialkids.org

- Indiana Institute on Disability and Community
  Indiana Resource Center for Autism
  812-855-6508
  www.iidc.indiana.edu

- **www.in.gov/medicaid/members**
  For help with medical care

Source: Help Autism Now, at www.helpautismnow.com

Autism Spectrum Disorder (ASD): A Parent's Guide

Your physician may decide your child could benefit from referrals to the following types of doctors:

- Developmental pediatrician/Specialist
- Early intervention
- Hearing test
- Speech therapy evaluation
- Occupational therapy evaluation
- Physical therapy evaluation
- Gastro-intestinal specialist

Other resources

- Local support groups
- Family counseling

www.oregonautism.com

CDC Autism Information Center
www.cdc.gov/ncbddd/autism/index.html

National Institute of Health Autism Website
www.nichd.nih.gov/autism/

Source: Help Autism Now, at www.helpautismnow.com

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Planning for Good Visits to the Doctor

What you and your doctor can do to help the visit go smoother:

Prepare the exam room

Nurse/Medical Assistant can check in advance with the parent regarding room accommodations. These may include:

- Quiet room
- Room without a window
- No bright lights
- No music

If necessary remove all objects that could potentially be used as missiles or weapons.

Minimize waiting time if possible

Consider:

Scheduling the child as the first appointment of the day (ten minutes earlier will prevent the child from seeing other people when he arrives).

Potential advantages:

Minimizes risk of:

1. Child "melt-down".
2. Disruption for other families in the Waiting Room.
3. Embarrassment for the parent.
4. Damage to the actual Waiting Room.

If possible register the child in advance by telephone.

Be alert for your own safety

Some children with autism may not understand that you are there to help them, instead they may see you as a threat. They can be calm at one moment and erupt the next and may:

- Head-butt
- Bite
- Kick
- Spit
- Punch
- Pull hair

Respect the child's personal space (it may be much larger than usual).

Source: Help Autism Now, at www.helpautismnow.com

Altered Pain Response for Autism Spectrum Disorder (ASD)

Children with Autism Spectrum Disorder (ASD) often have altered reactions to pain. They may also show behaviors where they are hurting themselves.

Altered Pain Responses

Diminished/Absent Pain Responses or Heightened Pain Responses

Head-banging

Self-biting with no apparent pain

Ripping and scratching at skin

Pulling out handfuls of hair

Source: Help Autism Now, at www.helpautismnow.com

Early Intervention Services

Studies have shown that early intensive educational interventions result in improved outcomes for the child and family. Initial strategies may include teaching the child to notice what is going on in their environment, to be able to pay attention, to imitate behavior, and later progressing to communication skills, etc.

Refer the family to Early Intervention (EI) evaluation if any developmental delay is suspected. Depending on the child's needs, EI may include Speech, Occupational and/or Physical Therapy.

Source: Help Autism Now, at www.helpautismnow.com

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Sleep Disturbances in Autism Spectrum Disorder (ASD)

Sleep disturbances

Children may go days without any apparent need to sleep. They may not seem to notice a difference between day and night. They also may have difficulty going to sleep and staying asleep. It is possible they may only sleep for brief periods of an hour or two maximum.

Source: Help Autism Now, at www.helpautismnow.com

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Impact on Families with Autism Spectrum Disorder (ASD)

The impact of Autism Spectrum Disorder (ASD) can be huge for a family. Your doctor can refer you to services such as:

Sibling Workshops
Family Support Groups
Respite Services

With a child with Autism Spectrum Disorder (ASD), routine everyday activities may be impossible.

Stress on marriage and siblings can be tremendous. Referral to family/siblings counseling and local support groups may be appropriate.

Source: Help Autism Now, at www.helpautismnow.com

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Websites Parents May Find Helpful

American Academy of Pediatrics
www.aap.org/healthtopics/autism.cfm
Autism-specific news, resources.

Arc of the United States
www.thearc.org
Network to improve systems of supports and services; connect families; inspire communities, influence public policy. Advocates for rights, full participation of all persons with intellectual and developmental disabilities.

Autism and PDD Support Network
www.autism-pdd.net/resources-by-state.html
Comprehensive state-by-state guide to local Early Intervention (birth–5 yrs.), state agencies, and resources.

AutismInfo.com
www.autisminfo.com
Extensive list of "A to Z" autism resources; daily updates, studies, and news articles.

Autism Key
www.autismkey.com
News, videos, information, resources. Autism Message Boards; find other local parents and support.
www.autismkey.com/autism_directory.htm
Resource list of organizations, foundations, and treatment centers.

AutismLink ListServ
http://lists.autismlink.com/lists/
Online news service covering autism-related news including biomedical, research, education, advocacy, etc. Sign up for areas of interest nationally or regionally.

AutisticLiving.com
www.autisticliving.com
Comprehensive web site developed by parents for parents. "The goal of AutisticLiving.com is to allow parents to spend more time living instead of researching, which in turn will give their autistic child a better life." Topics include: news articles, behavioral therapy information, dietary information, doctor directory, events, forum discussion, links, etc.

Autism Research Center, Cambridge University, England
www.autismresearchcenter.com
Mission of ARC is to understand the biomedical causes of autism spectrum conditions, and develop new and validated methods for assessment and intervention. The ARC fosters collaboration between scientists in Cambridge University and outside. Dr. Simon Baron-Cohen, Co-Director, is developer of CHAT screening tool and author of numerous books and research papers.

Autism Research Institute
www.autism.com
Non-profit founded in 1967 by Dr. Bernard Rimland, Ph.D. to conduct and foster scientific research designed to improve the methods of diagnosing, treating, and preventing autism and disseminates findings to parents and others seeking help. The ARI data bank, the world's largest, contains over 40,000 detailed case histories of children with autism from more than 60 countries. Dr. Stephen M. Edelson, Ph.D. is the current director of ARI.

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Online resource includes a database covering more than two decades of responses from over 25,000 parents on the behavioral effects of biological interventions. Articles available in Spanish, French, Italian, Russian, and Portuguese.

Autism Research Unit, University of Sunderland, UK
http://osiris.sunderland.ac.uk/autism/aru.htm
Provides a basis for research into the cause of autism and an accessible store of traditional and current research on autism. Produces a booklet guide for parents/ clinicians with current research and treatment suggestions.

Autism Resources
www.autism-resources.com
Extensive book list and international resource links. Translates into 16 languages: Arabic, Chinese, Danish, Dutch, Finnish, French, German, Greek, Hebrew, Hungarian, Italian, Japanese, Korean, Portuguese, Spanish, and Swedish.

Autism Society of America
www.autism-society.org
"Improving the lives of all affected by autism. ASA is the leading voice and resource of the entire autism community in education, advocacy, services, research and support. ASA, a chapter-and member-based organization, is committed to meaningful participation and self-determination in all aspects of life....with a successful network of chapters, members, supporters and organizations."

Autism Society Canada
www.autismsocietycanada.ca
Information, resources, research, treatment, education, events, conferences, links. Available in French.

Autism Speaks
www.autismspeaks.org
Autism Speaks is committed to raising public awareness about autism and its effects on individuals, families, and society, and to giving hope to all who deal with the hardships of this disorder. Autism Speaks raises funds to facilitate effective treatment and research, and is dedicated to uncovering the biology of autism and developing effective biomedical treatments through research funding.

Autism Today
www.autismtoday.com
Creative, interactive, one-stop shop to navigate the maze of autism-related information. Over 2,500 pages, is the largest autism resource online and resource distributors in the world. Bookstore, conferences, online access to experts, etc. Translates into Chinese, French, German, Italian, Japanese, Korean, and Spanish.

Autismweb.com
www.autismweb.com
General information including: Early Warning signs, What's Autism?, Interventions, books, conferences, teaching methods, message board, etc.

CDC Autism Information Center
www.cdc.gov/ncbddd/autism/index.htm
Screening/diagnosis, treatment/therapy, resources, news, research, state and congressional activities, educational materials.

Children's Disabilities Information
www.childrensdisabilities.info
General disability information with autism-specific resources including: books, articles, links, etc.

Dan Marino Childnett
www.childnett.tv
A first-of-its-kind internet web channel dedicated to autism and other neurological disorders.

Dan Marino Foundation
www.danmarinofoundation.com
Non-profit organization founded in 1992 by Claire and Dan Marino, to support programs which provide integrated intervention services for children with special needs: medical, emotional and/or behavioral.

Doug Flutie, Jr. Foundation
www.dougflutiejrfoundation.org
Grants for families, events, resources, education, and advocacy.

First Signs
www.firstsigns.org
Resource for parents and professionals regarding normal/typical developmental milestones. Useful baseline information for parent to discuss with physician if they have developmental concerns about their child.

Help Autism Now Society
www.helpautismnow.com
Physician resources include user-friendly, objective materials to enable physicians to more quickly recognize and screen for autism, handbook with over 100 illustrations depicting the "behavioral symptoms" of autism, 4 minute tutorial video of CHAT screening tool. Online social stories: "Going to See the Doctor" and "Going to Have Blood Drawn" can help prepare children with autism for these events. Online readable book for siblings written through an 8-year-old sibling's eyes, *Autism: Living with My Brother Tiger.*

Ladders
www.ladders.org
Learning and Developmental Disabilities Evaluation and Rehabilitation Services. Mass. General Hospital for Children, Boston MA. Interdisciplinary program designed to provide services in the evaluation and treatment of children and adults with autism, pervasive developmental disorder and related disorders.

MedLinePlus
www.nlm.nih.gov/medlineplus/autism.html
Links to news, NIH; diagnosis/symptoms, treatment, research, organizations, Available in Spanish.

National Autistic Society, UK
www.nas.org.uk
Based in UK but provides useful info for US residents. Telephone hotline, free parent-to-parent telephone service, support, schools, news, and events.

NICHCY, National Dissemination Center for Children with Disabilities
www.nichcy.org/pubs/factshe/fs1txt.htm
Autism facts, resources, organizations. Spanish translation.
www.nichcy.org/states.htm
State agencies and organizations, parent groups in each state.

NIH Autism Website
www.nichd.nih.gov/autism
Most current information about NICHD research projects, publications, news releases, and other activities related to autism. Publications available in Spanish.

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NIMH, National Institute of Mental Health

www.nimh.nih.gov/healthinformation/autismmenu.cfm

Signs/symptoms, treatment, fact sheets, news, links to research.

Northwest Autism Foundation

www.autismnwaf.org

Non-profit organization provides education and information for parents and professionals in the northwestern US. Publishes a useful NW Resource Directory available at no charge.

Pubmed

www.ncbi.nlm.nih.gov/pubmed

Free, immediate, internet access to the most up-to-date and previously published medical studies from numerous US and international medical journals. Can access by subject, author, or title of study. Abstracts often available electronically at no charge.

Schafer Autism Report

www.sarnet.org

Online newsletter of all major news sources, websites, and latest research for important and practical new developments regarding autism. Studies often available for viewing in advance of publication. Subscription fee.

Syracuse University Autism Web links

http://web.syr.edu/~rjkopp/data/autlinkinfo.html

Site provides over 100 links to diverse website resources.

WEBSITES IN OTHER LANGUAGES/ INTERNATIONAL RESOURCES

Inclusion of websites is for informational purposes only and does not indicate an endorsement of their contents.

Action for Autism

www.autism-india.org/worldorgs.html

Worldwide links to autism organizations, resources in almost 100 different countries.

Autism Canada

www.autismcanada.org

Autism Canada Foundation is a registered Canadian charity focused on engaging, education, empowering and uniting people to find the cause and the cure for Autism. Autism Canada supports a 'multi-disciplinary' approach to treating individuals on the autism spectrum combining biomedical and educational treatments. Online resources include: signs/symptoms, treatment options, research, news, library, conferences, events, links to organizations and service providers.

Autism Resources

www.autism-resources.com/links/nonenglish.html

Extensive book list and international resource links. Available in Arabic, Chinese, Danish, Dutch, Finnish, French, German, Greek, Hebrew, Hungarian, Italian, Japanese, Korean, Portuguese, Spanish, and Swedish.

Autism Research Institute

www.autism.com

Comprehensive online resource includes a database covering more than two decades of responses from over 25,000 parents on the behavioral effects of biological interventions. Articles available in Spanish, French, Italian, Russian, and Portuguese.

Autism Society Canada

www.autismsocietycanada.ca

Information, resources, research, treatment, education, events, conferences, links. Available in French.

Autism Today

www.autismtoday.com

Creative, interactive, one-stop shop to navigate the maze of autism-related information. Over 2,500 pages, is the largest autism resource online and resource distributors in the world. Bookstore, conferences online access to experts, etc. Translates into Chinese, French, German, Italian, Japanese, Korean, and Spanish.

Future Horizons
www.autismoespanol.com
Extensive resource for publishing and books relating to the autism spectrum; books and tapes available online. Website in Spanish.

National Autistic Society, UK
www.nas.org.uk
Based in UK, but provides useful information for US residents. Telephone hotline, and free parent-to-parent telephone service, support, schools, news, and events.

NICHCY, National Dissemination Center for Children with Disabilities
www.nichcy.org/pubs/factshe/fs1txt.htm
Autism facts, resources, organizations. Available in Spanish.

NIH Autism Website
www.nichd.nih.gov/autism
Most current information about NICHD research projects, publications, news releases, and other activities related to autism. Available in Spanish.

MAGAZINES

The Autism Asperger's Digest
www.futurehorizons-autism.com
Features articles and material from around the world; covers the latest people, products, research, news and viewpoints emerging in the autism field. Full-length excerpts from ground-breaking new books on autism, original articles from top specialists, etc.

The Autism Perspective, TAP
www.theautismperspective.org
Provides balanced information on the myriad of therapies and treatments for the vast and complicated realm of autism.

The Autism Spectrum Quarterly
www.ASQuarterly.com
ASQ is a "megajournal," combining the readability and interest of a high-level magazine with the substance and depth of a professional journal. Features research and commentary aimed at helping parents, teachers, and clinicians to translate research into practice.

Spectrum
www.spectrumpublications.com
For parents of children with autism and developmental disabilities. Wide variety of topics, including educational, biomedical and research. Contains autism-specific news articles and interviews with autism experts and mainstream celebrities affiliated with autism.

AUTISM ONLINE STORES

Autismshop.com
www.autismshop.com
Store with wide selection of products that focus specifically on autism products including books, videos, games, visuals, timers, picture exchange schedules, etc.

Baby Bumble Bee
www.babybumblebee.com/l_landings/Autism_PDD.cfm
Originally developed for typical children however parents of children with autism have found the real-life video format helpful for language development, etc. Video Series includes: Verbs and Nouns, Numbers, Alphabet, Phonics, Colors and Opposites.

Bright Start Therapeutics/ The Adaptive Child
www.bright-start.com
Wide selection adaptive therapy products focus on movement, positioning, sensorimotor, exercise, aquatics and play, including special needs strollers, toys, clothing, learning tools and other adaptive equipment.

Do To Learn
www.dotolearn.com
Early educational materials, many specifically geared toward "visual learners", including flash cards and schedules. Many free educational products available. Suitable for parents and educators.

Future Horizons
www.futurehorizons-autism.com
Extensive selection of books, conferences, and other valuable information on Autism (ASD), Asperger's Syndrome, Pervasive Developmental Disorders (PDD).

Model Me Kids
www.modelmekids.com
Educational video series demonstrates social skills by modeling peer behavior in different scenarios, e.g. school, playdates, birthday parties, playgrounds, library.

Source: Help Autism Now, at www.helpautismnow.com

Anxiety Disorders

Anxiety Disorders

MDwise Clinical Care Guidelines

Behavioral Health Clinical Practice Guidelines for:

Anxiety, Obsessive-Compulsive and Related Disorders in Children and Adults

OBJECTIVE

To guide the appropriate diagnosis and treatment of Anxiety Disorders in Children and Adults.

DIAGNOSIS & ASSESSMENT

MEETS DSM-5 DIAGNOSTIC CRITERIA FOR

- Panic Disorder
- Social Anxiety Disorder
- Specific Phobia
- Generalized Anxiety Disorder
- Obsessive Compulsive Disorder
- Hoarding Disorder
- Trichotillomania
- Excoriation Disorder

Scales such as the Beck Anxiety Inventory, the Multidimensional Anxiety Scale for Chlidren, the Y-BOCS and CY-BOCS are useful for obtaining baseline data on severity and can be used for monitoring progress. MDwise.org for rating scale links.

ASSESSMENT

- Any substance induced condition such as excess caffeine intake (coffee, sodas, chocolate), nicotine or other substance that increases anxiety
- Any underlying medical condition
- If rating scales indicate significant anxiety, conduct a formal evaluation to determine which anxiety disorder is present
- Determine presence of any co-morbid diagnoses such as depression or ADHD
- Full medical, developmental, school history, psychiatric history

TREATMENT

MEDICATION MANAGEMENT

SSRIs/SNRIs for stabilization.

Optimize dosage and duration of first line agent.

If inadequate response, switch to alternate first-line agent.

If partial response, adding another agent may be preferred over switching.

Benzodiazepines are appropriate for short term use for severe impairment; may be used in combination with SSRIs/SNRIs.

Beta Blockers (such as Inderal) may be used.

Treat co-morbid diagnoses.

THERAPY

Cognitive behavioral therapy is well accepted by patients and has been well researched.

There are different forms of cognitive behavioral therapy that have been developed for the various disorders.

Can be used in combination with medication management or alone.

CBT is first line treatment for mild-moderate cases when possible.

CBT and SSRIs are evidenced based treatments for children.

Involve parent in treatment if patient is a child or adolescent.

If patient is discharged from inpatient hospitalization, patient needs to be seen in an outpatient setting, intensive outpatient setting or partial hospitalization by a behavioral health provider within 7 calendar days.

Address co-morbid diagnoses.

Treatment reccomendations does not guarantee coverage or services.

REFERENCES

Barlow, David H. & Cruske, Michelle, G. (2006) Mastery of Your Anxiety and Panic-4th ed. Oxford University Press.
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013). American Psychiatric Association.
NIMH (2008) Study Identifies Three Effective Treatments for Childhood Anxiety Disorders. Website.
NIMH (2008) Treatment of Anxiety Disorders. Website.
Rosenbaum, JF; Labbate, LA; Arana, GW; Hyman,SE; Fava, M (2005) Handbook of Psychiatric Drug Therapy. Lippincott Williams & Wilkins.
Journal of the American Academy of Child and Adolescent Psychiarty (2007), 46(2): 267-283.
Journal of the American Academy of Child and Adolescent Psychiatry (2012), 51(1):98-113.
Koran, LM; Simpson, HB (2013) Guideline Watch: Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder. American Psychiatric Association.

Approved by the Medical Advisory Council on 12/10/2008 Revised: 2/14/11, 7/19/13, 6/23/15 Approved by MAC: 4/13/11, 8/14/13, 8/12/15 Reviewed: 8/2016

APP02014 (8/15) Reviewed 3/2018

Anxiety Disorders

Practitioner Toolkit

Hamilton Anxiety Rating Scale (HAM-A)

Reference: Hamilton M.The assessment of anxiety states by rating. Br J Med Psychol 1959; 32:50–55.

Rating Clinician-rated

Administration time 10–15 minutes

Main purpose To assess the severity of symptoms of anxiety

Population Adults, adolescents and children

Commentary

The HAM-A was one of the first rating scales developed to measure the severity of anxiety symptoms, and is still widely used today in both clinical and research settings. The scale consists of 14 items, each defined by a series of symptoms, and measures both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). Although the HAM-A remains widely used as an outcome measure in clinical trials, it has been criticized for its sometimes poor ability to discriminate between anxiolytic and antidepressant effects, and somatic anxiety versus somatic side effects. The HAM-A does not provide any standardized probe questions. Despite this, the reported levels of interrater reliability for the scale appear to be acceptable.

Scoring

Each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity and 25–30 moderate to severe.

Versions

The scale has been translated into: Cantonese for China, French and Spanish. An IVR version of the scale is available from Healthcare Technology Systems.

Additional references

Maier W, Buller R, Philipp M, Heuser I. The Hamilton Anxiety Scale: reliability, validity and sensitivity tochange in anxiety and depressive disorders. J Affect Disord 1988;14(1):61–8.

Borkovec T and Costello E. Efficacy of applied relaxation and cognitive behavioral therapy in the treatment of generalized anxiety disorder. J Clin Consult Psychol 1993; 61(4):611–19

Address for correspondence

The HAM-A is in the public domain.

Hamilton Anxiety Rating Scale (HAM-A) (continued)

Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present, 1 =Mild, 2= Moderate, 3 =Severe, 4= Very severe.

1 Anxious mood 0 1 2 3 4
Worries, anticipation of the worst, fearful anticipation, irritability.

2 Tension 0 1 2 3 4
Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.

3 Fears 0 1 2 3 4
Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.

4 Insomnia 0 1 2 3 4
Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.

5 Intellectual 0 1 2 3 4
Difficulty in concentration, poor memory.

6 Depressed mood 0 1 2 3 4
Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.

7 Somatic (muscular) 0 1 2 3 4
Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.

8 Somatic (sensory) 0 1 2 3 4
Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.

9 Cardiovascular symptoms 0 1 2 3 4
Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.

10 Respiratory symptoms 0 1 2 3 4
Pressure or constriction in chest, choking feelings, sighing, dyspnea.

11 Gastrointestinal symptoms 0 1 2 3 4
Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.

12 Genitourinary symptoms 0 1 2 3 4
Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.

13 Autonomic symptoms 0 1 2 3 4
Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.

14 Behavior at interview 0 1 2 3 4
Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.

Anxiety Flowchart

Step 1: Does the patient have the symptoms and signs of anxiety?

Physical Symptoms
- Palpitations
- Sweating
- "Butterflies" in the stomach
- Shortness of breath
- Nausea/Diarrhea
- "Light headed"
- Tremulous

Psychological Symptoms
- Fear, anxiety, tension, worry, indecision
- Apprehension, startlles easily
- Irritability
- Restlessness, poor concentration
- Insomnia

Functional Changes
- Sudden loss of function/ chronic limitations
- Self medicating (e.g., alcohol)
- Avoidance, housebound
- Poor relationships
- High utilization of medical resources

Step 2: Consider and treat other causes of anxiety or co-morbidities

Diagnosis To Consider
- Hyperthyroidism
- Temporal lobe epilepsy
- Endocrine dysfunction
- Pheochromocytoma
- Caffeine abuse
- Other stimulants
- Cardiac illness

Depression
- Considerable overlap in symptoms
- Consider isolated depression symptoms such as anhedonia and weight changes
- Assess severity and suicidal ideation

Substance Abuse
- Identify if abusing alcohol and/or drugs
- Identify dependence and/ or harmful/hazardous use
- Educate regarding relationships between substance abuse and anxiety
- Initiate treatment plan (ARF phone number for anxiety substance abuse program)

Anxiety Disorders

Member Materials

INcontrol

What is Anxiety?

Everyone has anxiety. Having anxiety means feeling worried or nervous. Anxiety is a normal reaction to stressful things that happen in life. Having some anxiety can be a good thing. Anxiety gives us extra energy and focus. Changes happen in our brains and bodies that make us feel more energized and more alert. Extra energy and focus can help us take action to make changes that help with stress.

The reaction in our brains and bodies is something that happens naturally to help keep us safe in dangerous situations. You might have heard this called "the fight or flight response". In dangerous situations our bodies prepare us to get ready to fight or get ready to run … literally for our lives! You can imagine how in early times this helped people survive. People often were in life threatening situations hundreds of years ago. Most of us today though do not have things that threaten our lives on a daily basis.

Anxiety becomes a problem when our brains and bodies act like our life is in danger in everyday stressful situations. The reaction is much stronger than it needs to be because most stresses don't threaten our lives. When a person reacts to stress like it is life-threatening most of the time, they may have an anxiety disorder.

There are several different kinds of anxiety disorders. Some of the symptoms people may have include:

- Having constant worries about all kinds of different things.
- Having problems sleeping.
- Getting stomachaches or headaches.
- Feeling tightness in their muscles.
- Feeling numbness or a sense that they are out of their bodies.
- Feeling like things around them aren't real.
- Feeling like they are unable to speak or remember things.
- Feeling panic like they can't breathe or are going to die.

To help when these feelings happen, people with anxiety disorder may:

- Avoid situations or people that seem frightening.
- Repeat certain behaviors or thoughts over and over as a way of stopping bad things from happening.
- Refuse to go to public places or be around a lot of people.

Doctors may say that a person has an anxiety disorder if the anxiety:

- Seem stronger than it should be for the situation.
- Lasts for a long time after a frightening thing happens.
- Interferes with school, work or family relations.
- Makes a person feel sick all of the time.

What can I do if I think I might have an anxiety disorder?

Talk to your doctor. Anxiety is very treatable. Your doctor can give you medicine or help you find a counselor to work with.

How is anxiety treated?

- Your doctor will make a treatment plan with you.
- Counseling has been shown to be helpful in treating anxiety.
- There are medicines your doctor can give you to help with anxiety.

What can I do to help myself with anxiety?

- Take slow, deep breaths.
- Use calm "self talk." Tell yourself to breathe and calm down.
- Ask yourself questions about how likely it is that a bad thing will happen.
- Ask yourself if a situation will really matter that much 6 months from now.
- Try and replace worried thoughts with thoughts that are less scary.
- Remind yourself that you cannot die from feelings of panic.
- Exercise.

Compiled from the following sources:
National Anxiety Foundation:
http://www.nationalanxietyfoundation.org/naf.html
NIMH:
https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

INcontrol

Changing Worried Thoughts

Directions: Under the first column, write down what happened when you started to feel worried. Next, write down your main fear or what you worried would happen. In the next column, write down other less scary thoughts that talk back to your worries. In the last column, rate how likely you think it is that you first worried thought will come true. 0% means there is no chance that the thought will happen and 100% means it will definitely happen. See below for examples.

Changing Worried Thoughts Examples

EVENT	WORRIED THOUGHT	TALKING BACK THOUGHTS	CHANCES THE WORRY WILL COME TRUE 0–100%
I failed my math test.	I'm going to fail this class and will have to repeat it. My parents are going to kill me. I'll be grounded for a year.	While it's not great that I failed this test, there are 3 more tests that I can do better on so I probably won't fail. My parents may be disappointed in me, but I know they won't kill me. I'll tell them what my plan is for studying for the next test.	10%
I was invited to my friend's house who lives on the other side of town. I'll have to drive across a bridge to get there.	I'm not going to be able to go to my friends because I can't go across the bridge. I'll have a panic attack and wreck the car before I get there.	I need to remember that bridges are very sturdy and well built. The chances of the bridge falling down are very small especially if you think of all of the cars that cross the bridge. Why would the bridge fall down at the very moment that I'm about to cross it. That seems sort of silly. I'll just try to remember that the worst that will happen is that I might feel a little nervous.	5%
I have to give a report in front of my class.	I'm sure that I will get so scared that I'll mess the whole thing up and then everyone will laugh at me. I might even faint or throw up in front of the class.	Most people get a little nervous when they talk in front of other people so they will understand if I seem a little nervous. No one that I'm talking to knows as much about this as I do, since I have studied up on the subject. I will practice ahead of time in front of my family to help me be more confident. The worst that will happen is that I'll feel nervous which won't kill me.	50%

EVENT	WORRIED THOUGHT	TALKING BACK THOUGHTS	CHANCES THE WORRY WILL COME TRUE 0–100%

EVENT	WORRIED THOUGHT	TALKING BACK THOUGHTS	CHANCES THE WORRY WILL COME TRUE 0–100%

EVENT	WORRIED THOUGHT	TALKING BACK THOUGHTS	CHANCES THE WORRY WILL COME TRUE 0–100%

Compiled from the following sources:

Burns, D. D. (1980). Feeling Good: The New Mood Therapy (preface by Aaron T. Beck). New York: Wm. Morrow and Co (hardbound); New American Library, 1981 (paperback). Revised and updated, 1999.

http://www.get.gg/freedownloads2.htm

Post-Traumatic Stress Disorder (PTSD)

Post Traumatic Stress Disorder (PTSD)

MDwise Clinical Care Guidelines

Guidelines for:

Post-Traumatic Stress Disorder in Adults

OBJECTIVE

To guide the appropriate diagnosis and treatment of post-traumatic stress disorder (PTSD) in adults.

DIAGNOSIS & ASSESSMENT

- Meets DSM-5 diagnostic criteria
- Complete a thorough diagnostic evaluation that may include structured interviews such as the CAPS-S (www.ptsd.va.gov/professional/assessment/adult-int/caps.asp)
- Evaluate for comorbid diagnoses such as depression and substance use disorders that may include brief self-report scales such as the PHQ-9 or CAGE
- Complete a functional assessment and determine the availability of basic care resources
- Include medical history and current conditions

TREATMENT

MEDICATION MANAGEMENT

- SSRIs and SNRIs first line treatment
- Mirtazapine or Prazosin for sleep issues and nightmares, TCAs have some benefit

PSYCHOTHERAPY

- Trauma-focused therapies: CBT, EMDR and prolonged exposure
- Stress inoculation therapy is an alternative to trauma-focused therapies
- Augment with stress reduction and relaxation techniques
- May need psychosocial rehabilitation services such as self-care, independent living, marriage and family skills training or social skills training

Disclaimer: Recommendation of treatment does not guarantee coverage of services.

REFERENCES

Diagnostic and Statistical Manual of Mental Disorders 5th Edition (2013). American Psychiatric Association.

VA/DoD Clinical Practice Guideline (2017) Management of Post-Traumatic Stress Disorder.

Guideline Watch (March 2009) Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder. American Psychiatric Association.

Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder (2004) American Psychiatric Association.

Approved by MAC: 12/10/2014 Reviewed: 03/2018 APP0180 (12/14)

Guidelines for:

Post-Traumatic Stress Disorder in Children and Adolescents

OBJECTIVE

To guide the appropriate diagnosis and treatment of post-traumatic stress disorder (PTSD) in children and adolescents.

DIAGNOSIS & ASSESSMENT

- Meets DSM-5 diagnostic criteria
- In children older than six, some symptoms may manifest in their play, through behavioral re-enactment or flashbacks and memories
- In children younger than six, DSM-5 criteria are different than for children older than six and for adolescents
- Most common symptoms: re-experiencing the trauma, avoidance of reminders of the trauma, sleep problems, emotional numbing, increased arousal, hypervigilance and regression
- Completion of a thorough diagnostic interview such as the CAPS-CA (www.ptsd.va.gov/professional/assessment/adult-int/caps.asp) to confirm the diagnosis and establish a treatment plan
- Comorbid diagnoses and other disorders that mimic PTSD should be addressed
- Useful psychological tests include: Children's PTSD Inventory, Child PTSD Symptom Scale, Trauma Symptom Checklist for Children and Screen for Child Anxiety Related Disorders

TREATMENT

- Trauma-focused psychotherapies should be considered first-line treatments. These include cognitive behavioral therapy (CBT), trauma-focused CBT, relaxation techniques and play therapy.
- Parent/caretaker support and education should be included.
- In children who have persistent symptoms despite CBT or who need additional help with control of symptoms, SSRIs may be considered. Medication should not be used in the absence of psychotherapy for childhood PTSD. Less is known about the benefits of other types of medications.

Disclaimer: Recommendation of treatment does not guarantee coverage of services.

REFERENCES

Diagnostic and Statistical Manual of Mental Disorders 5th Edition (2013). American Psychiatric Association.

Practice Parameter for the Assessment and Treatment of Children and Adolescents with Post-Traumatic Stress Disorder. Journal of the American Academy of Child and Adolescent Psychiatry (2010) 49(4).

Lubit, RH, et al (2014) Post-Traumatic Stress Disorder in Children. Medscape.

https://www.ptsd.va.gov/professional/treatment/children/ptsd_in_children_and_adolescents_overview_for_professionals.asp

Approved by MAC: 12/10/2014 Reviewed: 10/4/16, 03/2018 APP0179 (12/14)

Post-Traumatic Stress Disorder (PTSD)

Practitioner Toolkit

Provider Resources

Trauma Resources

SAMHSA-HRSA Center for Integrated Health Services (CIHS)
www.integration.samhsa.gov/clinical-practice/trauma#RESOURCES

The Anna Institute
www.theannainstitute.org

The National Child Traumatic Stress Network
www.nctsn.org

U.S Department of Veteran Affairs PTSD: National Center for PTSD
www.ptsd.va.gov

Trauma Toolbox for Primary Care
https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx

Screening Tools

Primary Care PTSD Screen (PC-PTSD)
www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf

U.S Department of Veteran Affairs PTSD: National Center for PTSD
www.ptsd.va.gov

Post-Traumatic Stress Disorder Self-Test
www.ptsd.ne.gov/pdfs/ptsd.pdf

Mental Health America: Mental Health Screening Tools
www.mentalhealthamerica.net/mental-health-screen

Post-Traumatic Stress Disorder (PTSD)

Member Materials

Member Resources

Trauma Resources

The Anna Institute
www.theannainstitute.org

The National Child Traumatic Stress Network
www.nctsn.org

U.S Department of Veteran Affairs PTSD: National Center for PTSD
www.ptsd.va.gov

Mental Health America
www.mentalhealthamerica.net

Screening Tools

Post-Traumatic Stress Disorder Self-Test
https://adaa.org/screening-posttraumatic-stress-disorder-ptsd

Mental Health America: Mental Health Screening Tools
www.mentalhealthamerica.net/mental-health-screen

Additional Resources

Behavioral Health Rating Scales Website Links

Depression Screening Tools

Patient Health Questionnaire	integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf
Child/Adolescent–Patient Health Questionnaire	ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/upload/PHQ-A-Severity-Measure-for-Depression.pdf
Hamilton Depression Rating Scale	assessmentpsychology.com/HAM-D.pdf
Suicide Behaviors Questionnaire-Revised	cqaimh.org/stable/pdf/tool_sbq-r.pdf
PHQ-9 Modified PHQ-9 (Teens)	integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf ppn.mh.ohio.gov/portals/0/pdf/PHQ-9%20Modified%20for%20Teens.pdf

ADHD Screening Tools

Vanderbilt ADHD Diagnostic Teacher Rating Scale	aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/vanderbilt_adhd_diagnostic_rating_scale.pdf
Vanderbilt ADHD Parent Rating Scale	dss.mo.gov/mhd/cs/psych/pdf/adhd_scoring_parent.pdf
Swanson, Nolan, and Pelham Questionnaire (SNAP)	attentionpoint.com/x_upload/media/images/snap_description_with_questions-1.pdf
Adult ADHD Self-Rating Scale vs.1.1	add.org/wp-content/uploads/2015/03/adhd-questionnaire-ASRS111.pdf

Anxiety Disorder Screening Tools

Hamilton Anxiety Rating Scale	dcf.psychiatry.ufl.edu/files/2011/05/HAMILTON-ANXIETY.pdf
Children's Yale-Brown Obsessive-Compulsive Scale	iocdf.org/wp-content/uploads/2016/04/05-CYBOCS-complete.pdf
Spence Children's Anxiety Scale	scaswebsite.com/

Multi-symptom Child Rating Scale

Pediatric Symptom Checklist (depression, anxiety, behavior sx.)	brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf

Autism

Modified Checklist for Autism in Toddlers	m-chat.org/en-us/page/take-m-chat-test/online

Substance Abuse

Conjoint Screening Questionnaires for Alcohol and other Drug Abuse	www.cqaimh.org/pdf/STABLE_toolkit.pdf
Alcohol Use Disorders ID Test	whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

Bipolar Disorder Screening Tools

The Mood Disorder Questionnaire	cqaimh.org/pdf/tool_mdq.pdf
Altman Self-Rating Mania Scale	cqaimh.org/stable/pdf/tool_asrm.pdf

Other

Sheehan Disability Scale	cqaimh.org/stable/pdf/tool_lof_sds.pdf
Rosenberg Self-Esteem Scale	socy.umd.edu/quick-links/using-rosenberg-self-esteem-scale
PTSD Checklist-Civilian Version (PCL-C)	ptsd.va.gov/professional/assessment/documents/PCL-5_Standard.pdf

Helpful Websites

MDwise Wellness Tools
MDwise.org/hoosierhealthwise/wellnesstools.html

MDwise Disease Management Tools
MDwise.org/dm

Anxiety Disorders Association of America
adaa.org

Anxiety Network International
anxietynetwork.com

National Institute of Mental Health
nimh.nih.gov/health/index.shtml

Mental Health America
nmha.org

PsychCentral
psychcentral.com

International OCD Foundation
ocfoundation.org

HelpGuide.org: A Trusted Non-Profit Resource
helpguide.org

National Association on Mental Illness
nami.org