PEDIATRIC PSYCHOTROPIC MEDICATION GUIDELINES:

OKLAHOMA'S EXPERT CONSENSUS OF BEST PRACTICE OF PSYCHIATRIC CARE OF OKLAHOMA'S YOUTH

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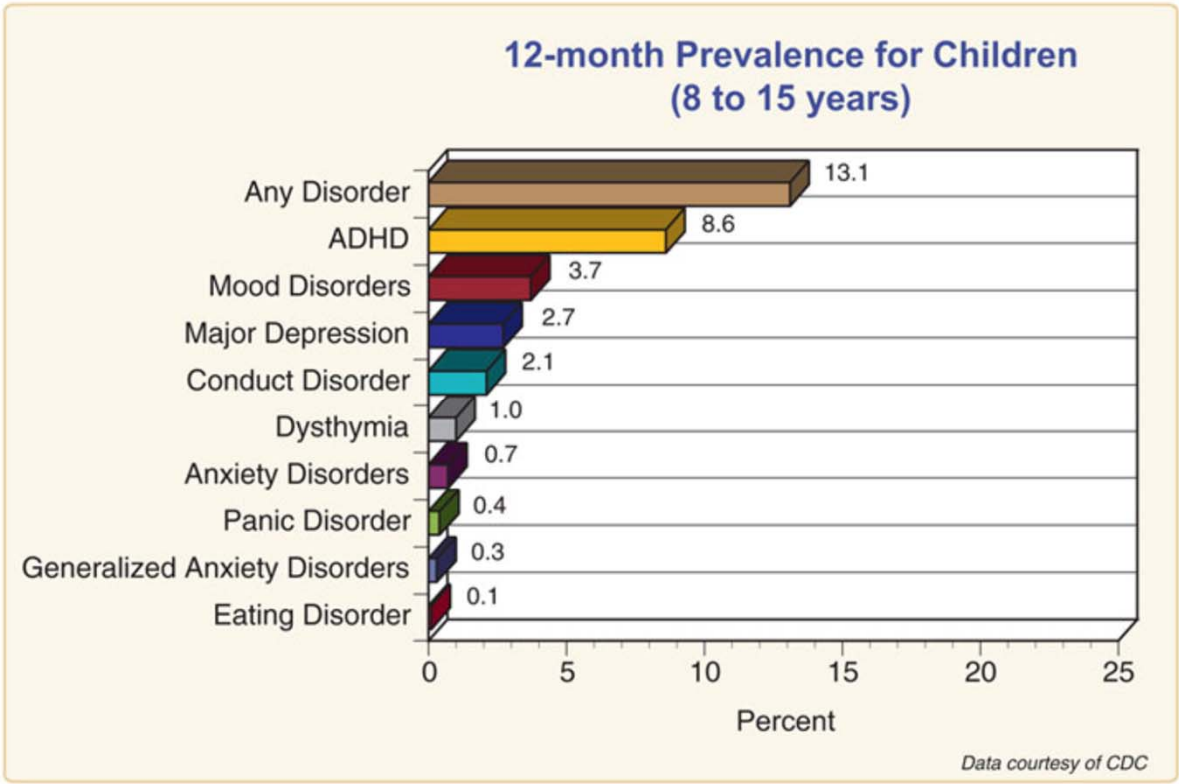
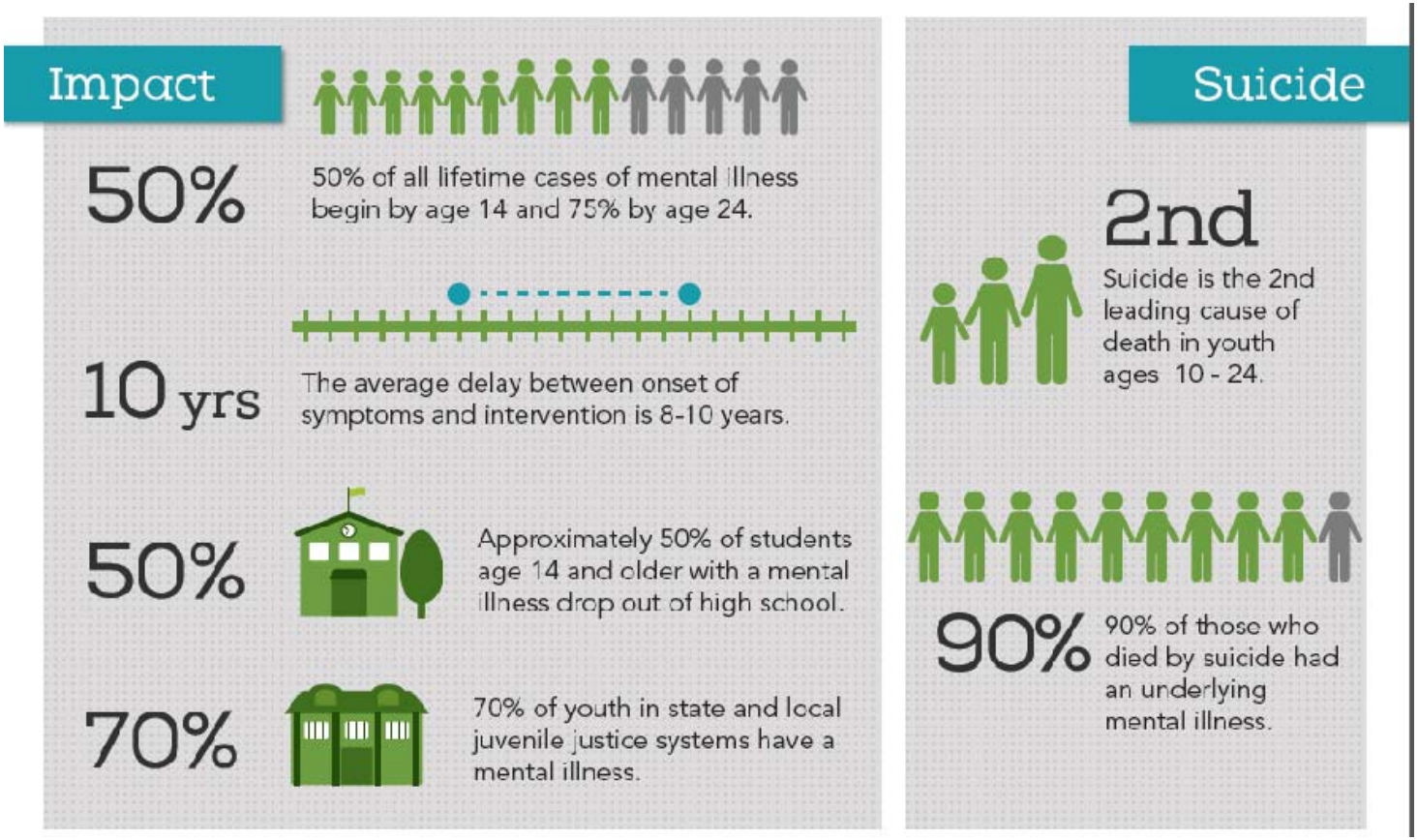
EPIDEMIOLOGY OF PEDIATRIC MENTAL HEALTH CONDITIONS

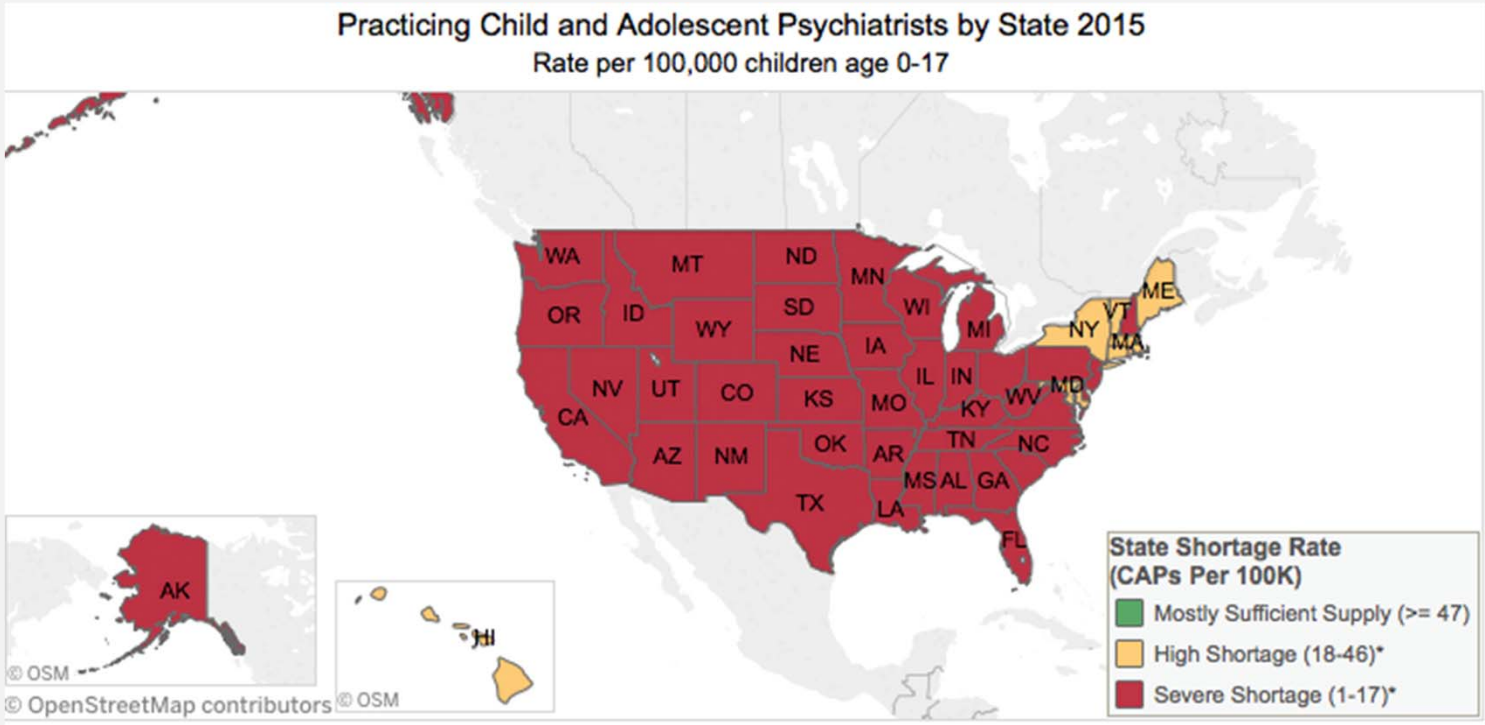


EPIDEMIOLOGY OF PEDIATRIC MENTAL HEALTH CONDITIONS

- **9.5-14.2%** of children birth to 5 have Social-Emotional problems interfering with functioning
- **21%** of children and adolescents in the U.S. meet diagnostic criteria for Mental Health disorder with impaired functioning



National Alliance of Mental Illness



https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx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OKLAHOMA PEDIATRIC PSYCHOTROPIC MEDICATION TASKFORCE

- Child and Adolescent Psychiatrists
  - Academics
  - Community
  - Private practice
  - Inpatient and Outpatient
- Pediatricians
- Pharmacists

OKLAHOMA PEDIATRIC PSYCHOTROPIC MEDICATION TASKFORCE

- **Aggression**
- **ADHD**
- **Anxiety**
- Autism Spectrum Disorders
- Bipolar Disorder
- **Depression**
- **DMDD**
- Eating Disorders
- Insomnia
- Nightmares
- OCD
- **ODD and CD**
- **PTSD**
- Schizophrenia and Related Disorders
- Substance Abuse
- Use of Complimentary and Alternative Treatments

OKLAHOMA PEDIATRIC PSYCHOTROPIC MEDICATION TASKFORCE

TREATMENT CONSIDERATIONS FOR YOUNG CHILDREN (0-5 YEARS OF AGE)

- Attachment Disorders
- Anxiety Disorders
- Attention Deficit Hyperactivity Disorders
- Bipolar Disorder
- Depression
- Disruptive Behavior Disorders
- Obsessive Compulsive Disorder
- Post-Traumatic Stress Disorder

GENERAL PRINCIPLES OF PRESCRIBING MEDICATIONS

- Before initiating pharmacotherapy, a psychiatric evaluation Is completed which should include a medical work up when indicated and collateral information (therapist, school, etc.).
- Best efforts should be made to obtain all past medical history for outpatient and inpatient treatment. Specific questions about trauma and safety should be part of every assessment.
- The prescriber develops an interdisciplinary, psychosocial and psychopharmacological treatment plan based on the best available evidence. This should include feedback about the diagnosis.
- For the majority of psychiatric diagnosis behavioral therapy (including caregiver participation) is indicated as first line treatment.

GENERAL PRINCIPLES OF PRESCRIBING MEDICATIONS

- The prescriber develops a plan to monitor the patient and the treatment plan. This plan should include treatment response and side effects.
- Rating scales for disorders should be used as screeners and to ensure treatment response.
- Typically monitoring of mental health concerns should occur every week to 2 weeks at first, then monthly as symptoms stabilize to less frequent visits (e.g. every 3-6 months).
- Complete and document the assent of the child and consent of the parents before initiating medication treatment and during any changes in treatment.
- The assent and consent discussion focuses on the risks and benefits of the proposed and alternative treatments.

GENERAL PRINCIPLES OF PRESCRIBING MEDICATIONS

- Implement medication trials using an adequate dose and for an adequate duration of treatment.
- Document the side effects, treatment duration and treatment outcome.
- Document what constitutes a treatment failure (e.g. adequate trial to maximum dose without response; side effects intolerable although mild treatment response).
- The prescriber needs a clear rationale for using medication combinations. If multiple medications are indicated only one medication change should be made at a time; unless clinically indicated.
- Other than cross tapering*, there is no evidence to support the use of two medications from the same class being used simultaneously and should be avoided.

GENERAL PRINCIPLES OF PRESCRIBING MEDICATIONS

- Discontinuing Medication in Children Requires a Specific Plan, which should include ongoing monitoring of return of symptoms. Depending on the diagnosis (e.g. depression, anxiety, ADHD) a discussion of when a medication would potentially be discontinued should be discussed (e.g. after 6 months-year anxiety symptom free).

AGGRESSION:
CLINICAL PEARLS

- Aggression can be a symptom of many psychiatric disorders and appropriate assessment should be conducted prior to treating the "symptom of aggression"
- A thorough assessment must be completed to determine an etiology of the symptom of aggression. A thorough assessment includes gathering a detailed history of the child including symptom onset, illness course and intervention outcomes.
- Trauma history must be included and correlated with symptomatology in collaboration with a responsible adult who knows the child well.
- If medication is prescribed strictly for managing aggression not associated with mood or psychotic symptoms (ie: CD, ODD, IED) and there has been 6 months of symptom remission, consider a slow taper and discontinue medication

AGGRESSION: TREATMENT APPROACH

- **Stage 1**: Complete diagnostic assessment as referenced in the clinical pearls.
  - Use MOAS scale to establish baseline.
  - Refer to higher level of care if life threatening behavior is present.
  - Provide supportive educational material to the family.
- **Stage 2:** Treat the primary diagnosis and any co-morbid conditions.
  - Continue monitoring progress with standardized scale (MOAS)
  - Begin therapeutic intervention correlated to patient age, cognitive ability, and nature of the etiology of aggression: Applied Behavioral Analysis (ABA), Cognitive Behavioral Therapy (CBT), Family Therapy, Multi-systemic Therapy, Parent-Child Interaction Therapy (PCIT), Parent Management Training (PMT)
-

AGGRESSION: TREATMENT APPROACH CONT.

- **Stage 3:** Consider a low dose of level A evidence drugs for treating aggression symptoms not responding to earlier stages of treatment:
  - SGAs: risperidone, aripiprazole
  - FGAs: haloperidol, chlorpromazine
  - Mood stabilizers: lithium
- **Stage 4:** If symptoms are not improved, consider replacing level A drug with low dose of level B evidence drug:
  - SGAs: quetiapine, olanzapine, ziprasidone
  - Mood stabilizers: valproic acid
  - Alpha-2-agonist: clonidine, guanfacine

AGGRESSION:
TREATMENT APPROACH CONT.

- **Stage 5:** If symptoms are not improved, consider replacing/augmenting with level C evidence drugs:
  - SGAs: paliperidone
  - Mood stabilizers: carbamazepine
  - Beta-blocker: propranolol
- **Stage 6:** If symptoms are not improved, consider augmenting/replacing with level D evidence drugs:
  - SGAs: lurasidone, asenapine

ANXIETY DISORDERS: CLINICAL PEARLS

- Anxiety disorders are the most common psychiatric disorder in children and adolescents, affecting between 15-20% of youth
- Anxiety in youth may present as crying, irritability, angry outbursts, oppositionality or disobedience
- First-line treatment is Psychotherapy (mild-moderate) and/or Psychotropic medications (if severe or unresponsive to therapy)
- One anxiety disorder is highly comorbid with other anxiety disorders.
- Additional psychiatric disorders frequently develop by late adolescents or early adulthood such as depression and substance use disorders.
- Parental anxiety can be a contributing factor to anxiety in youth; and if youth anxiety is not improving treating of parental/caregiver anxiety may be indicated

ANXIETY DISORDERS: TREATMENT APPROACH

- Stage 1A: Screening: early intervention and prevention offers a proactive method for alleviating symptoms and may improve long term functioning
- Stage 1B: Differential diagnosis (DSM-5 criteria)
  - Other psychiatric disorders, physical condition, and medication induced anxiety should be ruled out as some have similar symptoms
    - Psychiatric disorders with similar symptoms include ADHD, pervasive developmental disorders (especially Asperger's), learning disabilities, bipolar disorder, depression and psychotic disorders.
    - Physical conditions which may mimic anxiety include hyperthyroidism, caffeinism, migraines, asthma, seizure disorders, and lead intoxication
    - Medications that may induce anxiety symptoms include anti-asthmatics, steroids, SSRIs, sympathomimetics, antipsychotics.
- Stage 1C: Assess Severity and Impairment to guide treatment options

ANXIETY DISORDERS: TREATMENT APPROACH CONT.

- Stage 2A: Parent and child education about anxiety disorders
- Stage 2B: Mild to Moderate Severity and Impairment
  - First line treatment should be psychotherapy
  - Second line treatment should be considered if inadequate relief of symptoms has not occurred after adequate trial of psychotherapy
    - Selective Serotonin Reuptake Inhibitors (SSRIs)* (fluoxetine and sertraline)[2]
      - Start at low dose and if there is no significant improvement after 4 weeks of therapy increase dose

*** Black Box Warning regarding children and adolescents have an increased risk of suicidal ideations at therapy initiation and patients should be monitored closely**

ANXIETY DISORDERS: TREATMENT APPROACH CONT.

- Stage 2C: Moderate to Severe Severity and Impairment
  - Combination CBT and psychotropic medication
  - Psychotropic medications
    - First line is an SSRI (fluoxetine and sertraline)[2]
    - Second line is a different SSRI
      - In order to avoid polypharmacy slowly titrate down dose of 1st SSRI while titrating up 2nd SSRI
    - Third line is a Serotonin Norepinephrine Reuptake Inhibitor (SNRI)
      - Third line due to increased risk of more severe Adverse Events (AEs) such as weight loss, nausea, dizziness, palpitations, or oropharyngeal pain

      - *Tricyclics are no longer recommended due to the cardiac monitoring requirements and a greater risk for overdose. May consider if other therapies are not working.*
      - *Benzodiazepines have shown no benefits in clinical trials*
      - *Buspirone has shown small benefits in adults, but no evidence in children*

ATTENTION DEFICIT HYPERACTIVITY DISORDER: CLINICAL PEARLS

- Recent meta-analysis calculated a pooled worldwide ADHD prevalence of 7.2% among children and is considered the most common neurobehavioral disorder in childhood.
- Children and adolescents presenting with behavioral symptoms concerning for ADHD should be screened for trauma. If concerns for traumatic stress exists, evidence-based therapy to address the trauma should occur.
- It is also important to rule out additional causative factors including but not limited to: Seizure, Elevated Lead levels, Vision, Hearing, Thyroid, Hepatic, Substance abuse
- Learning and language problems are common comorbid conditions with ADHD.
- To make a diagnosis of ADHD, the clinician should determine that *DSM-5* criteria have been met, including documentation of symptoms and impairment in more than 1 major setting (ie, social, academic, or occupational), with information obtained primarily from reports from parents or guardians, teachers, other school personnel, and mental health clinicians who are involved in the child or adolescent's care.
- If diagnosis is unclear referral for psychological testing may be indicated prior to initiating medications.
- Uncomplicated ADHD should be able to be diagnosed and treated in the patient-centered medical home.

ATTENTION DEFICIT HYPERACTIVITY DISORDER: TREATMENT

- Age 0 – 5 years: behavioral therapy, add MPH if insufficient response
- Age 6 – 11: FDA-approved medication with behavioral therapy
- Age 12 – 17: FDA-approved medication; add behavioral therapy if insufficient response
- **Insufficient response:** Rule out lack of adherence at every stage

ATTENTION DEFICIT HYPERACTIVITY DISORDER: TREATMENT CONT.

Treatment Approach: Pharmacotherapy			
	No contributory comorbidities	**Hypertension**	**Anxiety, tics, active substance abuse**
Stage 1	MPH or AMP (titration weekly to effect, or max recommended dose)	α-2 (age 6-17 only, titration every 3-4 weeks to effect, or max recommended dose)	ATX (age 6-17 only, titration every 2-4 weeks to effect, or max recommended dose)
Stage 2	MPH or AMP (not used in Stage 1)	α-2 (not used in Stage 1) or ATX	α-2 (if substance abuse) or MPH, or AMP (monitor comorbidity, titrate off ATX)
Stage 3	MPH or AMP (not used in Stage 1 or 2)	MPH or AMP +/- α-2 (monitor HTN, titrate off ATX)	α-2 (not used in Stage 2) or MPH or AMP (not used in Stage 2) (monitor comorbidity)
Stage 4	MPH or AMP + α-2 or α-2 alone, or ATX alone	MPH or AMP (not used in Stage 3) +/- α-2 (monitor HTN)	MPH or AMP (not used in Stage 3, monitor comorbidity)
Stage 5	Refer to mental health specialist		
*MPH: methylphenidate AMP: amphetamine α-2 agonists: ER/IR guanfacine, ER/IR clonidine ATX: atomoxetine			

DEPRESSION:
CLINICAL PEARLS

- Approximately 2% of children and at least 4% of adolescents suffer from depression at any given time; by the end of high school, 1 in 5 will have had at least 1 episode of depression.
- First line treatment for mild depression is psychotherapy and an addition of a Selective Serotonin Reuptake Inhibitors (SSRIs)], for moderate to severe depression not-responsive to therapy.
- If abuse is suspected, ensuring the safety of the patient is the first priority of treatment.
  - OK DHS Child Abuse and Neglect Hotline: 1-800-522-3511
- Depression is closely associated with suicidal thoughts and behavior; thus, it is imperative to evaluate these symptoms at the initial and subsequent assessments.
  - **National Suicide Prevention Lifeline: 1-800-273-TALK (8255)**
  - Removing access to firearms and other lethal means in an important part of suicide prevention (*refer to Section 15:Adolescent Suicide for more details*)
- Comorbid diagnoses (anxiety, disruptive disorders, ADHD, substance use disorder) are common; depression increases the risk of the development of non-mood psychiatric problems (e.g., conduct disorder, substance abuse disorders). This should be a hyperlink within the document to the adolescent suicide.

DEPRESSION:
TREATMENT

- **Stage 1:** Diagnostic assessment (DSM-5 criteria With concurrent therapy in place, mild to moderate depression can be diagnosed and treated in the medical home.
- **Stage 1A**: Several psychiatric and medical disorders may co-occur or mimic MDD (e.g. hypothyroidism, mononucleosis, side effects to medications.
- **Stage 2:** For patients with mild or brief depression: supportive therapy (education, support, and case management related to stressors in the family and school)
- **Stage 2A:** Monitor for response to supportive therapy (4-6 weeks) with rating scale
  - If improving, continue treatment

DEPRESSION:
TREATMENT CONT.

- **Stage 3:** For patients who do not respond to supportive psychotherapy or who have moderate to severe depression (including chronic or recurrent depression, psychosocial impairment, suicidality, agitation, and psychosis): specific types of psychotherapy and/or antidepressants
  - Cognitive-behavioral therapy (CBT) or interpersonal therapy (IBT)
  - Selective Serotonin Reuptake Inhibitors (SSRIs): fluoxetine is FDA approved in ages 8 and older; escitalopram is FDA approved in ages 12 and older (Jill to get a list)
  - **Black Box Warning: Antidepressants can increase the risk of suicidal thinking and behavior in children, adolescents, and young adults with MDD. Patients of all ages should be closely monitored for clinical worsening and emergence of suicidal thoughts and behaviors.**
  - Despite the above Black Box Warning, SSRIs are first line pharmacotherapy for pediatric/adolescent depression. It is important to note that depression is closely associated with suicidal thoughts and behavior, and untreated depression increases the risk of suicide.

DEPRESSION: TREATMENT CONT.

- **Stage 3A:** Monitor for treatment response (4-6 weeks) with rating scale; also monitor for suicidal thoughts and behaviors
  - If improving, continue treatment
  - If tolerating treatment but incomplete response, consider increasing SSRI dose (or consider adding SSRI or psychotherapy, if not already on combination of SSRI + psychotherapy)
  - If not tolerating treatment/side effects, stop treatment/SSRI and consider alternative treatments (alternative SSRI and/or psychotherapy)
  - If no or minimal response after at least 8 weeks of treatment (including dose optimization) with 2 different SSRIs, consider consultation with mental health specialist (and referral, if appropriate)
    - OHCA psychiatric consultation hotline: 1-405-522-7597
    - OHCA referral for behavioral health services: 1-800-652-2010
    - Pediatric Behavioral and Emotional Health ECHO (include Link)

DISRUPTIVE MOOD DYSREGULATION DISORDER: CLINICAL PEARLS

- DMDD is a relatively new diagnosis with limited evidence to support pharmacological treatment of core symptoms.
- Core symptoms include temper outbursts that occur at frequent intervals that are not considered developmentally appropriate.
- Important to rule out other diagnosis that have supported evidence-based treatments (e.g. ADHD, Depression, Anxiety, ODD, etc.) If co-morbid diagnosis exist treatment should include addressing those as well.
- First line treatment should include therapeutic support .
- Medication use if often guided by post-hoc studies on disruptive behavior disorders

DISRUPTIVE MOOD DYSREGULATION DISORDER: TREATMENT APPROACH

- **Stage 1**: Behavioral Therapy focusing on targeted behaviors. Current supported therapies include Delayed Goal Attainment; Cognitive Behavioral Therapy, Play Therapy or Interpretation Bias Training, Dialectical Behavioral Therapy adapted for Children
- **Stage 1A**: Monitor for treatment response with rating scale (if improving continue therapy, if not improving f/u with therapist)
- **Stage 2**: If symptoms of aggression persist consider the aggression guidelines
- **Stage 3**: Consider use of methylphenidate if concerns with impulsivity/hyperactivity and DMDD symptoms (caution with co-morbid trauma-reactive symptoms)
- **Stage 4**: If symptoms are severe and not responsive to stimulant medication, stop stimulate medications and include a trial of second-generation antipsychotic (e.g. risperidone or aripiprazole)

OPPOSITIONAL DEFIANT DISORDER AND CONDUCT DISORDER: CLINICAL PEARLS

- ODD and CD can appear to be on a spectrum of disruptive behavior disorders
- First line treatment should include a culturally-sensitive family- based therapy
- Conduct Disorder with callous and unemotional traits holds a worse prognosis.
- Co-Morbidity with ADHD, Anxiety, Substance Use, Depression, and trauma-related symptoms are common. If indicated pharmacological treatment should focus on co-morbid diagnosis if therapy is not effective.
- Medications are typically reserved for severe disruptive and aggressive behavior.

OPPOSITIONAL DEFIANT DISORDER AND CONDUCT DISORDER: TREATMENT APPROACH

- **Stage 1**: Family-based therapy (e.g. Parent Child Interaction Therapy for O.D.D., Multisystemic therapy, functional family therapy for CD) is considered first line including school and other systems when indicated. *
- **Stage 1A**: Monitor for treatment response with rating scale (if improving continue therapy, if not improving f/u with therapist)
- **Stage 2**: If symptoms persist or co-morbid anxiety/depression/ADHD ensure adequate treatment for co-morbid disorders
- **Stage 3**: Monitor for treatment response if not improving and/or aggression is sever consider protocol for managing aggressive behaviors.

*Boot Camps, scared-straight scenarios are not recommended.

PTSD AND TRAUMA RELATED DISORDERS: CLINICAL PEARLS

- Exposure to trauma is common, by the end of adolescents more than ½ of young people will have been exposed to a traumatic event; screening for trauma/stressors when behavioral/emotional problems emerge is imperative to accurate diagnosis.
- First line treatment is a trauma-focused therapy (e.g. Trauma Focused Cognitive Behavioral Therapy, Eye-Movement Desensitization and Reprocessing Therapy)[10]
- Screening for abuse and trauma should occur in a developmentally appropriate fashion which includes interviewing the child/adolescent alone
- If abuse is suspected the DHS hotline should be called 1-800-522-3511
- Co-Morbidity with ADHD, Anxiety, Substance Use, Depression and others is common. If co-morbid diagnosis is not improving with treatment, a trauma-focused treatment should be implemented.[14]

PTSD AND TRAUMA RELATED DISORDERS: TREATMENT APPROACH

- **Stage 1**: Trauma Focused Therapy Including Parent/Guardian (Trauma-Focused Cognitive Behavioral Therapy, Seeking Safety, Cognitive Behavioral Interventions for Trauma in Schools, Eye-Movement Desensitization and Reprocessing Therapy)
- **Stage 1A**: Monitor for treatment response with rating scale (if improving continue therapy, if not improving f/u with therapist)
- **Stage 2a With Co-Morbid Anxiety or Depression**: If symptoms persist or co-morbid anxiety/depression consider starting SSRI [10](e.g. citalopram[11]) 4-6 weeks for treatment response in combination with trauma-focused therapy

PTSD AND TRAUMA RELATED DISORDERS: TREATMENT APPROACH CONT.

- **Stage 2b with Co-Morbid Hypervigilant Response/Hyperarousal** : Monitor for treatment response if not improving consider Clonidine[3]/Guanfacine[4] (4-6 weeks for treatment response) in conjunction with a trauma focused therapy
- **Stage 3**: If symptoms persist, are severe and are more consistent with hypervigilance and paranoia, and are not helped with SSRI and/or Alpha Agonist there is very limited data to support the use of Atypical Antipsychotic (Quetiapine[12], Risperidone[8]) although studies are small.

NEXT STEPS

- Spring 2020 Completion and Distribution of Guidelines
- TOMS Conference
- Oklahoma Children's Behavioral Health Conference
- Updates occurring every 2 years

QUESTIONS

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QUESTIONS