PEDIATRIC MENTAL HEALTH INSTITUTE

Southwest Colorado Pediatric Mental Health Symposium

Digital Resource Guide

September 8-9, 2025

Children's Hospital Colorado

Affiliated with University of Colorado Anschutz Medical Campus

Welcome to the Southwest Colorado Pediatric Mental Health Symposium Digital Resource Guide! We're thrilled you're here and hope you find these resources helpful and insightful. Our team is here to support you every step of the way, so please don't hesitate to reach out if you have any questions about the information provided in this guide.

For general inquiries or if you need guidance navigating these resources, please feel free to contact:

Primary Contact: Natalie Hazemi

Email: Natalie.Hazemi@childrenscolorado.org

Secondary Contact: Michele Lueck

Email: Michele.Lueck@childrenscolorado.org

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Identifying Common Pediatric Mental Health Concerns in Community Settings

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Jessica Hawks, PhD
Child & Adolescent Psychologist
Francescon Family Endowed Chair for Mood Disorders
Chief of Psychology, Pediatric Mental Health Institute, Children's Hospital Colorado
Associate Professor, Division of Child & Adolescent Psychiatry, CU School of Medicine

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Disclosures

I have no financial disclosures with ineligible companies.

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Learning Objectives

1. Identify rationale for why pediatric mental health screenings should occur in community settings (e.g., schools, PCPs, hospitals, etc.).
2. Outline validated screening measures that can be used to identify mental health concerns in youth.
3. Describe action steps that can be taken in response to results of these screenings.

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Youth Mental Health Crisis

- 1 in 5 youth are living with a mental health disorder
- ***Less than 50%*** will ever receive the appropriate treatment

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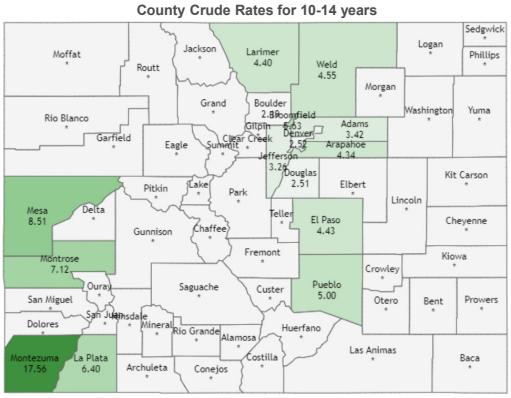
Colorado Youth Suicide Statistics

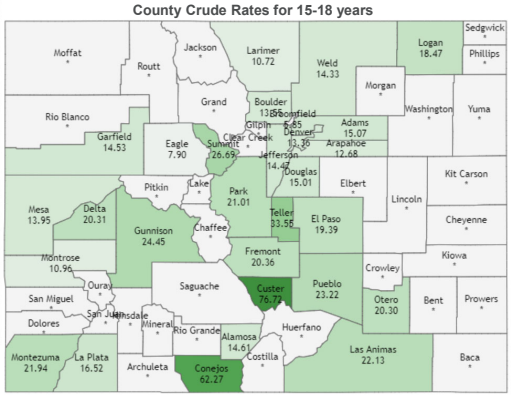
CDPHE Violent Death Reporting System Data, 2004-2023, 10-18 years old

Suicide is the leading cause of death among youth aged 10 to 18 years in Colorado

County Crude Rates for 10-14 years



County Crude Rates for 15-18 years



From 2018-2021

- **395** Colorado youth died by suicide
- **255** Colorado youth died by motor vehicle accidents

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https://cdphe.colorado.gov/colorado-suicide-statistics

Crude Rates per 100,000

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Suicide Improvement in 2024

- Youth suicide rate in CO dropped to lowest level since 2007
- 2020 (Peak): 12.91 deaths per 100,000 youth ages 10-18
- 2024: 5.85 deaths per 100,000 youth ages 10-18
  - Total of 39 suicide deaths – One youth suicide is too many, and the decrease is promising.
  - Still higher than the national average. Most recent data in 2022 was 5.3 deaths per 100,000.

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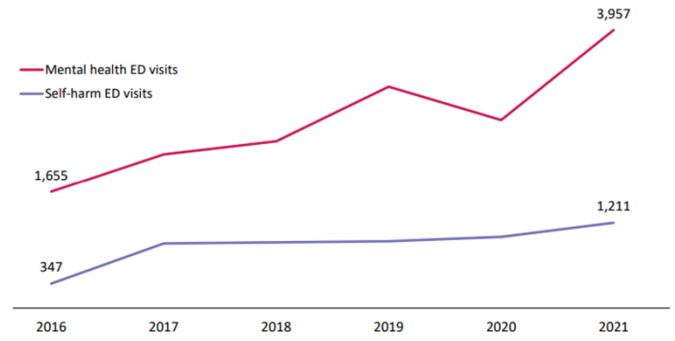
Impact on Emergency Departments

Count of Emergency Department visits related to mental health and/or self-harm among Colorado children, 2016-2021



Source: Center for Improving Value in Health Care

Positive Suicide Screening Rate	
15.22%	
Acuity	
# of Acute Positive	1,575 (3.18%)
# of Non-acute Positive	5,067 (10.23%)
# of Negative	42,357 (85.50%)
# of Psych Evaluation Already in Process	541 (1.09%)
Grand Total	49,540 (100.00%)

Source: Children's Hospital Colorado

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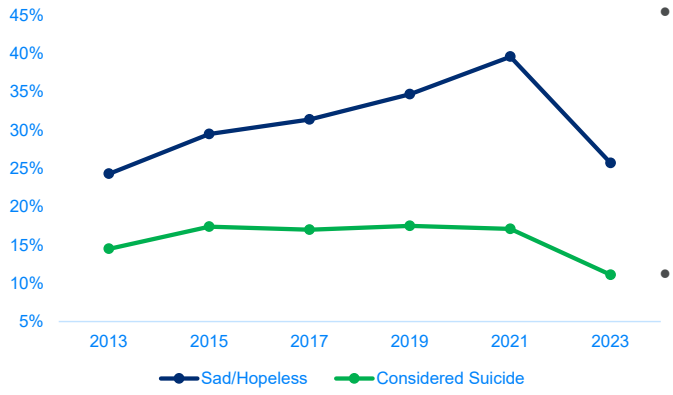
Youth Mental Health Trends



- Rates of mental health concerns have doubled
  - 2023 data suggests possible improvement for CO but should be interpreted with caution
- Youth are feeling more stressed every year
  - 45% of CO youth report their stress level is not manageable most days

Source: CO Healthy Kids Survey (2023)

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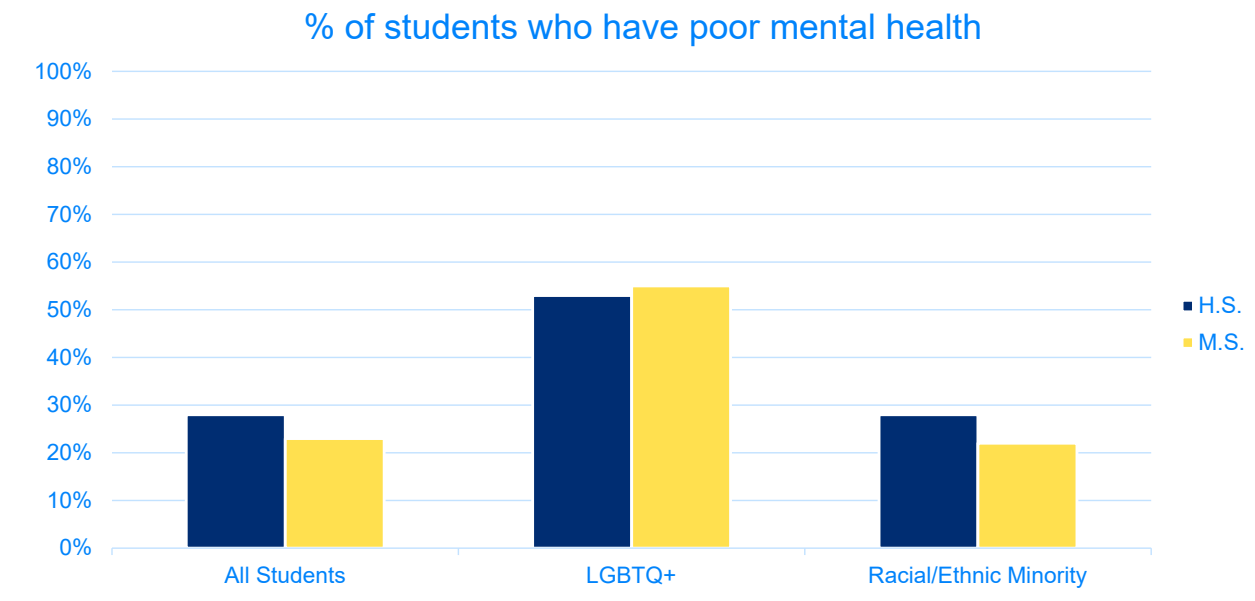

Source: CO Healthy Kids Survey (2023)

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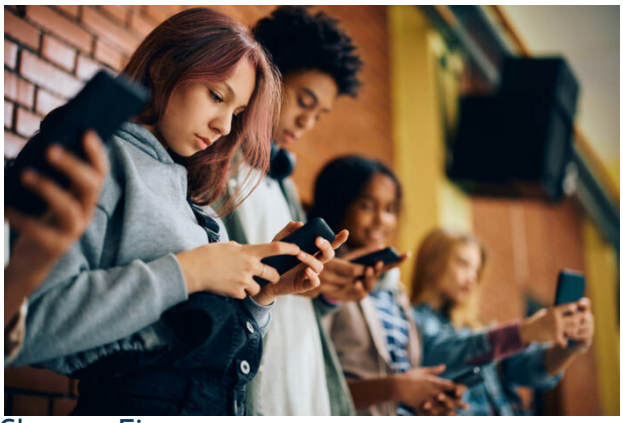
Factors Impacting Youth Mental Health

- Culture of Achievement
  - Overscheduling
  - Focus on outcomes vs efforts
- Social Media
  - "Social Media Phenomenon"
  - Online Bullying
  - Connected AND **Isolated**
- Chronic Stress for Youth and Families
  - Violence, School, Future, Politics, Climate Change, Finances



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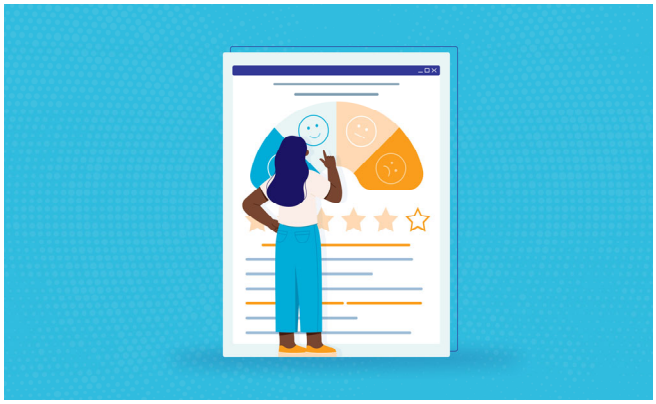
Why implement MH screenings?



- 50% of lifetime mental health disorders will emerge by age 14
- Average delay of 8-10 years from onset of symptoms to accessing MH treatment
  - Universal screenings reduce access barriers
- Using validated screening measures to identify MH concerns = 70% accurately identified
  - Relying only on clinical judgment = 30% accurately identified

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Screening in Healthcare Settings

- Nearly 90% of youth who die by suicide had a healthcare appointment in the previous year
- American Academy of Pediatrics (AAP) recommends screening for Emotional/Social/Behavioral Concerns at every well-child visit
  - 1, 2, 4, & 6 months: Maternal Depression
  - Age 8+: Anxiety
  - Age 12+: Depression & Suicide
- Brief emotional/behavioral assessment with a standardized instrument is now a billable service in primary care (CPT 96127)

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY																															
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★
Hearing		●[8]	●[9]	→		★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	→			●[10]	→		●	→		●	→
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																															
Maternal Depression Screening[11]					●	●	●	●																							
Developmental Screening[12]								●			●		●																		
Autism Spectrum Disorder Screening[13]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●

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Screening in Schools

- Schools are the most common setting for youth to receive mental health services
- MTSS model = Universal screenings
  - Reduces stigma
  - Allows for earlier identification & connection to resources
  - Cost effective
- Importance of acting on the results of screenings
  - Can be an implementation barrier

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Anxiety

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Anxiety in Youth

- 1 in 3 youth will experience an anxiety disorder
- Contributing Factors/Risks
  - Culture of achievement
  - Increased stress
  - Parental accommodation
- Frequently presents as somatic complaints

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(Centers for Disease Control and Prevention, 2021)

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Diagnosis	Primary Symptoms	Important Considerations
Separation Anxiety Disorder	• Developmentally inappropriate fear/anxiety of separating from attachment figure • Anticipatory anxiety about separation; worry about loss/harm, event causing separation, refusal to go out, being alone, sleeping without caregiver; separation nightmares; physical complaints	• Rule-out medical condition • Rule out substance induced symptoms • Consider comorbidities/differential diagnoses (PTSD, OCD, depression, ASD, Eating Disorder, DBD) • Differentiate shy/introverted vs anxious (impairment) • Parental accommodation • Bullying/Social Media
Social Anxiety Disorder	• Fear/anxiety about social situation(s) where they could be exposed to possible scrutiny by peers	
Generalized Anxiety Disorder	• Excessive worry/anxiety about topics/events/activities • Difficult to control worry • Restless, easily fatigued, difficulty concentrating, irritable, muscle tension, or sleep disturbance	
Panic Disorder	• Recurrent unexpected panic attacks • Persistent worry about attacks, including significant change in behavior	
Specific Phobia	• Fear/anxiety about a specific object/situation	

https://www.aafp.org/pubs/afp/issues/2022/1200/anxiety-disorders-children-adolescents.html

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Assessment & Diagnosis

- Common Symptoms
  - Excessive worries and fears
  - Heightened physiological state
  - Behavioral avoidance
- Screeners
  - Generalized Anxiety Disorder-7 (GAD-7)
    - Ages 11-17; child only; 7 items,
  - Screen for Child Anxiety Related Emotional Disorders (SCARED)
    - Ages 8-18; child and/or parent; 41 items;
  - PROMIS-Anxiety
    - Ages 8-17 (self-report); Ages 5-17 (parent report); 4-8 items

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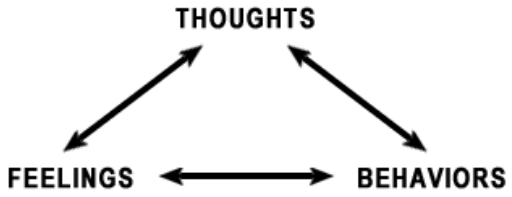
Response to Positive Screening

- Provide feedback to youth and/or caregiver in a timely fashion
- School excusal is not recommended
- Cognitive Behavioral Treatment
  - Exposures are critical ingredient
  - Parent involvement important



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Depression

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Depression in Youth

- 8-12% of kids will experience depression before age 13; 15-20% will experience depression before 18
  - Missed or misdiagnosed in 75% of youth
- Contributing Factors/Risks
  - Social isolation
  - Peer/family conflict
  - LGBTQ+
- Frequently presents as irritability

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(Centers for Disease Control and Prevention, 2021)

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Diagnosis	Primary Symptoms	Important Considerations
Major Depressive Disorder	• Persistent feeling of sadness, emptiness, hopelessness and/or anhedonia (at least 2 weeks) • Changes in appetite; weight loss/gain; psychomotor agitation/retardation; fatigue/loss of energy; feelings of worthlessness; excessive guilt; concentration difficulties; suicidal ideation	• Rule-out medical condition • Rule out substance induced symptoms • Consider comorbidities/differential diagnoses (PTSD, anxiety, ASD, eating Disorder, DBD) • Bullying/Social Media • Sleep
Persistent Depressive Disorder	• A depressed mood for most of the day, more days than not, for at least 1 year. • Changes in appetite; changes in sleep; low energy/fatigue, low self-esteem, poor concentration, hopelessness	
Disruptive Mood Dysregulation Disorder	• Severe, recurrent temper outbursts that are grossly out of proportion to situation (3+/week) • Persistently irritable/angry mood, most of the day, nearly every day	
Bipolar Disorder	• At least 1 manic episode (7 days – Bipolar I) or 1 hypomanic episode (4 days – Bipolar II)	

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Assessment & Diagnosis

- Common Symptoms
  - Sadness/tearfulness/***irritability***
  - Loss of interest/Low motivation
  - Changes to sleeping/eating patterns
  - Hopelessness/Worthlessness
  - Self-Harm/Suicidal Ideation (Ask Suicide Questionnaire)
- Screeners
  - Patient Health Questionnaire (PHQ-A)
    - Ages 11-17 (self-report); 9 items
  - PROMIS-Depression
    - Ages 8-17 (self-report); Ages 5-17 (parent report); 4-8 items
  - Revised Children's Anxiety and Depression Scale (RCADS)
    - Ages 8-18 (self and parent report); 47 items

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Response to Positive Screen

- Timely review of results, particularly questions regarding safety/suicidality
  - Further assess and triage
- Provide feedback to youth and/or caregiver in a timely fashion
- Cognitive Behavioral Therapy or Dialectical Behavioral Therapy
  - Behavioral activation is a critical ingredient
  - Parent involvement is important

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Behavioral Concerns

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Behavior Concerns

- Disruptive behaviors are the most common mental health concern
- Contributing Factors/Risks
  - Child "difficult temperament"
  - Authoritarian/Permissive Parenting
- Caregivers experience significant shame/perceived blame, which can create barriers to accessing treatment

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Diagnosis	Primary Symptoms	Important Considerations
Oppositional Defiant Disorder	• Often loses temper; touchy or easily annoyed; angry and resentful • Often argues with adults; actively defies/refuses to comply • Often deliberately annoys others; blames others for their mistakes • Spiteful or vindictive	• Rule-out medical condition • Rule out substance induced symptoms • Consider comorbidities/differential diagnoses (ADHD, OCD, depression, ASD, anxiety, trauma, learning disability) • Normative developmental considerations
Intermittent Explosive Disorder	• Fear/anxiety about social situation(s) where they could be exposed to possible scrutiny by peers	
Conduct Disorder	• Excessive worry/anxiety about topics/events/activities • Difficult to control worry • Restless, easily fatigued, difficulty concentrating, irritable, muscle tension, or sleep disturbance	

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Assessment & Diagnosis

- Common Symptoms
  - Noncompliance (keystone behavior)
  - Tantrums
  - Verbal/Physical Aggression

- Screeners
  - Eyberg Child Behavior Inventory (ECBI)
    - Ages 2-16; Parent report; 36 intensity/problem items
  - PROMIS-Anger
    - Ages 8-17 (self-report); Ages 5-17 (parent report); 6 items
  - Strengths & Difficulties Questionnaire (SDQ; broad-based)
    - Ages 11-17 (self-report); Ages 2-17 (parent report); 25 items
  - Vanderbilt (ADHD+)
    - Ages 6-12 (frequently used 6-17); 55 items

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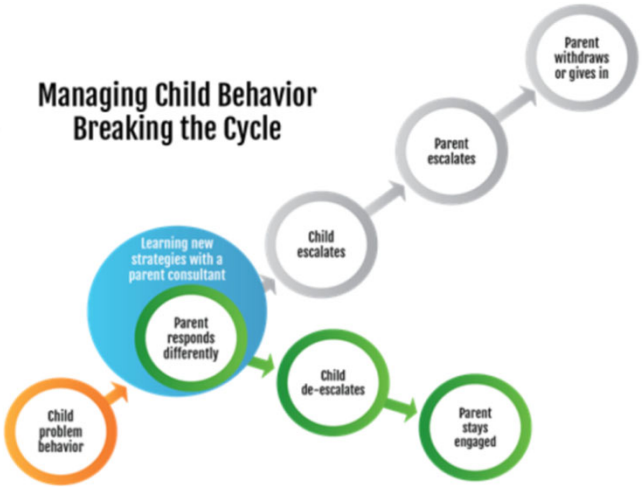
Response to Positive Screen

- Provide feedback to youth and/or caregiver in a timely fashion
  - Parent empowerment; avoid blaming

- Parent Management Training
  - Early intervention is best
  - CBT + PMT can be effective in older school-aged children



Mauricio, A. (2016, April). *Family-centered Parenting Programs in Juvenile Justice: Decreasing Recidivism One Family At a Time.* [PowerPoint Presentation]. Reach Institute. Arizona State University. https://cabhp.asu.edu/sites/default/files/session_24_family-centered_parenting_programs_anne_mauricio.pdf

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Questions?

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Colorado LIFTS Fact Sheet

Linking Individuals and Families To Services

What is Colorado LIFTS?

Colorado LIFTS (Linking Individuals and Families To Services) is a new way to connect people in Colorado with a statewide, connected network of mental health, substance use, and crisis support and care navigation. It helps people get care—especially those who don't have insurance or don't have enough coverage.

Anyone in Colorado can utilize Colorado LIFTS care navigation to get connected to services, no matter where they live or if they have insurance.

250+ Behavioral Health Providers

Care Navigation for All People in Colorado

Community-Informed Through Regional Councils

Why This Matters

Easier Access for ALL People in Colorado

Fewer steps for individuals and families to get behavioral healthcare and faster access to care through real-time care navigation.

Streamlining a Fragmented System

Colorado LIFTS brings safety net behavioral health services into one network to ensure better coordination and support.

Regional Connections

Regional councils will help to ensure the Colorado LIFTS network reflects the unique needs of diverse communities across the state.

How to Access Colorado LIFTS

Call the care navigation line for your region, available Mon. - Fri., 8 a.m. - 5 p.m. To find the number, go to ownpath.co and enter your zip code.

Visit ownpath.co to search for BHA-licensed providers in your area.

Receive a screening from a behavioral health provider.

Colorado LIFTS is included in the OwnPath Care Directory.
OwnPath is an official website of the Colorado Behavioral Health Administration.

Colorado LIFTS
Linking Individuals and Families To Services

Frequently Asked Questions

Who can use Colorado LIFTS?
Anyone living in Colorado can use the LIFTS care navigation service. It's here to help people take the next step in caring for their mental health and well-being.

Can I talk to someone about how to get care?
Yes. Call your care navigation line Monday through Friday from 8 a.m. to 5 p.m. To find your care navigation number, visit **ownpath.co** and enter your zip code. A care navigator, powered through Colorado LIFTS, can help you understand your options and guide you to the right support.

Do I need to enroll to receive services?
No. You don't need to enroll or sign up to use Colorado LIFTS. It's not like Medicaid or private insurance.

If you're not sure what kind of coverage you have or what help you can get, call the care navigation line. They can explain your options and guide you to the right services.

Why is Colorado LIFTS better than the old system?
Colorado LIFTS makes it easier and faster to get help for mental health and substance use.

With LIFTS, people get real-time help and fewer steps to care. It's designed to make sure no one is left out because of money, language, or where they live.

Should I call Colorado LIFTS if I'm in immediate need of mental health support?
No. If you need immediate help, call or text **988** or chat online at **988colorado.com**. This free and confidential service is available 24/7.

What types of services are in the Colorado LIFTS network?
LIFTS providers offer help with:
- Mental health support
- Substance use treatment
- Crisis services

Find more resources and information at bha.colorado.gov/gethelp

Colorado LIFTS

Conectar a las personas y familias con los servicios

Hoja informativa

¿Qué es Colorado LIFTS?

Colorado LIFTS (Conectar a las personas y familias con los servicios, Linking Individuals and Families to Services) es una nueva forma de conectar a las personas en Colorado con una red estatal conectada de salud mental, consumo de sustancias y apoyo en situaciones de crisis y orientación para la atención médica. Ayuda a las personas a recibir atención, especialmente a las que no tienen seguro o no tienen suficiente cobertura.

Cualquier persona en Colorado puede utilizar la coordinación de la atención de Colorado LIFTS para ponerse en contacto con los servicios, sin importar dónde vivan o si tienen seguro.

Más de 250 proveedores de salud conductual

Coordinación de atención médica para todas las personas en Colorado

Informado por la comunidad a través de los consejos regionales

Por qué es importante

Acceso más fácil para TODAS las personas de Colorado
Menos pasos para las personas y las familias para recibir atención de salud conductual y un acceso más rápido a la atención a través de coordinación de la atención en tiempo real.

Optimización de un sistema fragmentado
Colorado LIFTS reúne los servicios de salud conductual de la red de seguridad en una sola red para garantizar una mejor coordinación y apoyo.

Enlaces regionales
Los consejos regionales contribuirán a garantizar que la red de Colorado LIFTS refleje las necesidades únicas de las diversos comunidades de todo el estado.

Cómo acceder a Colorado LIFTS

Llame a la línea de coordinación de la atención de su región, disponible de lunes a viernes, de 8 a. m. a 5 p. m. Para encontrar el número, vaya a ownpath.co e introduzca su código postal.

Visite ownpath.co para buscar proveedores con licencia de la BHA en su zona.

Reciba una evaluación por parte de un proveedor de salud conductual.

Colorado LIFTS está incluido en el Directorio OwnPath Care.
OwnPath es una página web oficial de la Administración de Salud del Comportamiento de Colorado

Colorado LIFTS

Conectar a las personas y familias con los servicios

Preguntas frecuentes

¿Quién puede usar Colorado LIFTS?
Cualquier persona que viva en Colorado puede utilizar el servicio de coordinación de la atención de LIFTS. Está aquí para ayudar a las personas a dar el siguiente paso en el cuidado de su salud mental y bienestar.

¿Puedo hablar con alguien sobre cómo recibir atención?
Sí. Llame a su línea de coordinación de la atención de lunes a viernes de 8 a. m. a 5 p. m. Para encontrar su número de coordinación de la atención, visite **ownpath.co** e introduzca su código postal. Un coordinador de atención, impulsado por Colorado LIFTS, puede ayudarle a entender sus opciones y guiarle hacia el apoyo adecuado.

¿Necesito inscribirme para recibir servicios?
No. No necesita inscribirse ni registrarse para utilizar Colorado LIFTS. No es como Medicaid o un seguro privado.

Si no está seguro de qué tipo de cobertura tiene o qué ayuda puede obtener, llame a la línea de coordinación de la atención médica. Ellos pueden explicar sus opciones y guiarle a los servicios adecuados.

¿Por qué Colorado LIFTS es mejor que el sistema anterior?
Colorado LIFTS facilita y agiliza la obtención de ayuda para la salud mental y el consumo de sustancias.

Con LIFTS, las personas reciben ayuda en tiempo real y menos pasos para recibir atención. Está diseñado para asegurarse de que nadie quede excluido debido al dinero, el idioma o el lugar donde vive.

¿Debo llamar a Colorado LIFTS si necesito ayuda inmediata en materia de salud mental?
No. Si necesita ayuda inmediata, llame o envíe un mensaje de texto al **988** o chatee en línea en **988colorado.com.** Este servicio gratuito y confidencial está disponible 24 horas al día, 7 días a la semana.

¿Qué tipos de servicios hay en la red de Colorado LIFTS?
Los proveedores de LIFTS ofrecen ayuda con:

- Apoyo a la salud mental
- Tratamiento por consumo de sustancias
- Servicios en casos de crisis

Encuentre más recursos e información en bha.colorado.gov/gethelp

Assessment and Treatment of Depression in Pediatric Primary Care

Cassidy McNitt, M.D.
Assistant Professor, Dept. of Psychiatry, University of Colorado School of Medicine

Associate Medical Director, Colorado Pediatric Consultation and Access Program (CoPPCAP), University of Colorado Department of Psychiatry

Child and Adolescent Psychiatrist, Consultative and Ambulatory Divisions, Pediatric Mental Health Institute, Children's Hospital Colorado

Financial Disclosure

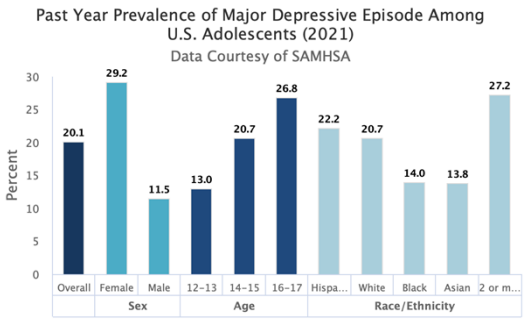
I have no relevant financial relationships with ineligible companies.

Objectives

- Discuss the prevalence and impacts of depression in children and adolescents
- Compare the clinical presentation of depression in children and adolescents to the presentation in adults
- Review the differential diagnosis for depression in children and adolescents
- Summarize non-pharmacologic and pharmacologic treatment options

Depression Among Youth in the US

- Per the 2021 National Survey on Drug Use and Health:
  - 5 million adolescents had at least on major depressive episode (20% of US adolescents)
  - 2-3x as likely in females as males
  - ~40% received treatment



Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report .

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Depression Among Colorado Youth

- Per the 2023 Health Kids Colorado Survey:
  - 26% of high schoolers reported feeling persistently sad or hopeless in the past year
  - 11% of high schoolers seriously considered suicide in the past year
  - 6% of high schoolers attempted suicide in the past year
- Suicide is a leading cause of death for youth 10 – 24 years old

https://cdphe.colorado.gov/healthy-kids-colorado-survey-information/2023-healthy-kids-colorado-survey-results

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Diagnostic Criteria

- 5 or more symptoms in a 2-week period
  - Sleep disturbance
  - Interest
  - Guilt
  - Energy
  - Concentration
  - Appetite
  - Psychomotor activity
  - Suicidal thoughts
- Must represent a change from normal baseline

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Other Diagnostic Considerations

- Irritability
- Somatic complaints
- Behavioral changes
  - Decreased school performance
  - Social withdrawal
- Teens often individuating from parents and sharing less

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Typical vs Atypical Adolescent Behavior

Typical	Cause for Concern
Increased Parent-Adolescent Conflict	Aggression; Self-injury or Suicidal Thoughts
Drug and Alcohol Experimentation/Knowledge	Substance Abuse, Using Substances to Manage Emotions
Increased Risk Taking and Sensation Seeking	Excessive Risk Taking and Recklessness
Increased Stress at School due to Workload or Transitions	Lack of Connection to School or Peers, Truancy, Decline in Perf.
Increased Focus on Body Image	Drastic Change in Appearance
Self-Consciousness	Excessive Restrictive Eating, Binging, Purging
Lying to Avoid Getting into Trouble	Not Knowing Friends, Activities, How They Spend Their Time
Many Hours of Screen Time Each Day	No Communication; Strange Thoughts or Unusual Behaviors

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Differential Diagnosis

- Medical Diagnoses
- Trauma and Abuse
- Substance Use
- Family or Environmental Stressors
- Anxiety Disorders
- Bipolar Disorder

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Bipolar Disorder

- Many bipolar illnesses begin with 1 or more depressive episodes
- More likely in those who have:
  - Early onset depression
  - Family hx of mania
  - Psychotic symptoms
  - Episodic mood lability
  - Subthreshold hypomania
  - ADHD +/- fluctuating mood
- Mood Disorder Questionnaire-Adolescent Version (MDQ-A)
- Children's Affective Lability Scale (CALS)
  - 8+ years old
  - 20 questions

Jasper KH, et al, Prospective Evaluation of the Pharmacologic Management of Youth at Clinical and Genetic High Risk for Bipolar Disorder, Poster presented March 24, 2021

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Comorbidity in Children and Adolescents with Depression

- Comorbidity is the rule, not the exception!
  - 40 – 90% of youth with depression, are diagnosed with another psychiatric disorder
  - Up to 50% have 2+ additional diagnoses
- Most common comorbid diagnoses:
  - Anxiety disorders
  - Disruptive disorders
  - ADHD
  - Substance use disorders

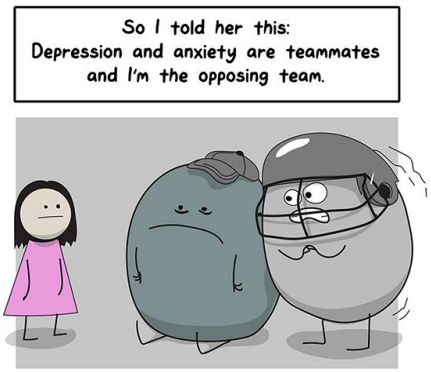

image credit Nick Seluk, theawkwardyeti.com

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Assessing for Depression in Youth

- Interview child or teen
  - Subjective information on mood, thoughts, and experience of symptoms
  - Separate from parent
  - Screen for substance use, traumatic experiences, familial/environmental stressors
- Interview parent or guardian
  - changes in behavior, relationships, and functioning
- Collateral from outside sources (teachers, mentors, school counselors, etc.)
- Labs and additional medical work up as indicated

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Screening Tools for Depression

- PHQ-9 (Modified)
  - "A" normed for ages 12-18
  - Score of 11: sensitivity 89.5% and specificity 77.5%
  - Mild: 5-10, Moderate: 11-14, Moderately Severe: 15-19, Severe>20
  - Free, Some EHR's have built in
- Short Mood & Feelings Questionnaire (SMFQ)
  - Children & Teens 6-17 yo
  - For score 12 & >: sensitivity 84.2% and specificity 68.2%
  - Child & Parent report in combo, greatest efficacy to predict depression
  - Combined scores (parent + child) > 10 concern for depression
  - Individual: child > 7, parent > 4

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Treatment of Depression

- **Should always include psychoeducation, supportive treatment, and family and school involvement**
  - Supportive treatment = active listening, problem solving, restoration of hope, coping skills
- **Mild**
  - Supportive treatment is equally efficacious to interpersonal therapy (IPT) or cognitive behavioral therapy (CBT)
  - Expect 4-6 weeks to improvement
- **Moderate**
  - May respond to therapy (CBT or IPT) alone
  - Consider medication if unable or unwilling to engage in psychotherapy/not responsive to therapy
- **Severe**
  - Therapy + Medication likely necessary

Birmaher et al, J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY, 46:11, NOVEMBER 2007

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Therapy and Medication Most Effective

- **Treatment for Adolescents with Depression Study (TADS)**
  - Evaluated effectiveness of CBT alone, fluoxetine alone, or combination treatment for adolescents with depression
  - Results
    - Fluoxetine accelerated response to treatment
    - Suicidal ideation decreased with treatment, but less so with fluoxetine alone
    - **Combination therapy led to most rapid treatment response**
- **Treatment of Resistant Depression in Adolescents Study (TORDIA)**
  - Evaluated effectiveness of medication switch (either to a different SSRI or a SNRI) or medication switch plus CBT in adolescents with SSRI-resistant depression
  - Results
    - Patients with earlier clinical response more likely to remit
    - **Medication switch plus CBT led to higher rate of clinical response**
    - A switch to a different SSRI was just as efficacious as a switch to an SNRI

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Evidence Based Therapies for Depression in Youth

- Cognitive Behavioral Therapy (CBT)
  - a form of psychotherapy that focuses on challenging unhelpful thoughts and behaviors developing coping strategies to improve mood
- Interpersonal Therapy (IPT)
  - brief, attachment-focused psychotherapy that centers on improving relationships with family and friends and improving problem-solving skills
- Dialectal Behavioral Therapy (DBT)
  - a structured, skills-based psychotherapy modality focusing on improving mindfulness skills, emotional regulation, distress tolerance, and interpersonal skills
- Few studies have assessed benefit of family or psychodynamic therapies in treating depression in youth

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When Do You Consider Medication?

- Psychotherapy unavailable or ineffective
- Symptoms significant or severe
- Patient and family prefer drug treatment
- Greater chance of compliance with medication

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Pharmacologic Treatments for Depression in Youth

- SSRIs
  - **First-line medications for treatment of depression in children and adolescents**
  - Only escitalopram (> 12 years old) and fluoxetine (> 8 years old) FDA approved for treatment of depression in children
  - Zoloft and Celexa have 1 positive RCT for use for depression in adolescents but no FDA approval
- SNRIs
  - Limited RCT data regarding use of venlafaxine or duloxetine for treatment of depression in children and adolescents, though some studies show benefit
- Bupropion
  - Limited RTC regarding use in children and adolescents for treatment of depression, though some studies have shown benefit

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Common Treatment Side Effects in Children and Adolescents

- Side effects from SSRIs are similar in children and adults
  - GI symptoms
  - Sleep changes (insomnia vs sedation, vivid dreams, nightmares)
  - Restlessness
  - Diaphoresis
  - Headaches
  - Akathisia
  - Changes in appetite
- **3-8% of youths, particularly younger children, may experience increased irritability, agitation, impulsivity, silliness, and behavioral activation**

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Activation vs Bipolar Switching

- **Activation**
  - Increase in activity level seen soon after a dose change
  - Dose dependent, can reduce or discontinue
  - Likely not indicative of long-term risk for bipolar disorder
  - Distinct, paradoxical, reversible with dose adjustment
- **Bipolar Switching**
  - Changes in mood, behavior, and impulse control
  - Rarer and more concerning for Bipolar Disorder
  - Not easily reversible
  - Patients cannot be prescribed antidepressants if concern for bipolar switching

Walkup, J, Labellarte M. J Child Adol Psychopharmacol. 2001;11(1): 1-4.

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SSRI Black Box Warning

- In 2004, FDA required a black box warning be added to labels of antidepressants stating they are associated with an increased risk of suicidal thinking and behavior in adolescents
- In 2007, warning was expanded to included young adults up to 24 years old
- Recommendation based on analysis from Columbia University and the FDA to evaluate effects of 9 antidepressants used in 24 RCTs on suicidality
  - RR for suicidal ideation 1.74
  - RR for suicide attempts 1.9
  - For SSRIs specifically, RR was 1.66
  - There were no completed suicides among 2000 youth in all reviewed studies
  - Patients on antidepressants reported suicidal thoughts or suicidal behaviors more frequently than those not on antidepressants (4% vs 2%)

PROZAC®
FLUOXETINE CAPSULES, USP
FLUOXETINE ORAL SOLUTION, USP
FLUOXETINE DELAYED-RELEASE CAPSULES, USP

WARNING

Suicidality and Antidepressant Drugs — Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Prozac or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Prozac is approved for use in pediatric patients with MDD and obsessive compulsive disorder (OCD). (*See* WARNINGS, Clinical Worsening and Suicide Risk, PRECAUTIONS, Information for Patients, *and* PRECAUTIONS, Pediatric Use.)

How Do We Discuss the Black Box Warning with Patients and Families?

- The risk of suicidal thoughts or behaviors is relatively low
  - No completed suicides in any of the reviewed studies
  - Increased risk attributed to use of medications was relatively modest (increase from 2% to 4%)
- Suicidal thoughts and behaviors are a risk associated with untreated depression
- There is clear benefit with use of antidepressant medication
  - Suicide rates declined following increase in use of SSRIs
  - Studies have shown use of SSRIs contributes to a decrease suicidality

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Starting Medications for Depression in Youth

- Choosing a medication
  - SSRIs are first-line, usually fluoxetine due to numerous studies showing safety and efficacy
  - Consider side-effect profile, positive family response to a medication, patient and family preference
- Starting and titrating medications
  - Start low, go slow
  - Increase to target dose over 1-4 weeks
  - Wait 4-6 weeks at target dose to assess benefit
  - Patients may not respond for up to 12 weeks

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Managing Medications for Depression in Youth

- If minimal to no response after 8 weeks at effective dose, consider switching to a different medication (usually different SSRI)
- Once remission is achieved, continue therapy for 6 – 12 months to minimize risk of relapse
  - Consider longer therapy continuation periods in patients with history of prior depressive episodes or more severe episodes
  - Consider discontinuing over summer in children and teens to avoid impacts on school functioning
- If discontinuing medications, taper to avoid withdrawal syndromes

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Brief Interventions for Depression in Primary Care

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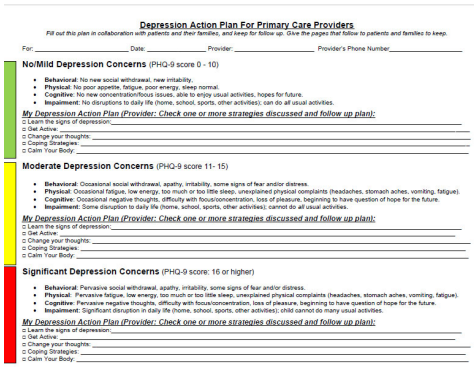
What about: A Depression Action Plan for Primary Care?



Depression Action Plan For Primary Care Providers

Fill out this plan in collaboration with patients and their families, and keep for follow up. Give the pages that follow to patients and families to keep.

For: _____ Date: _____ Provider: _____ Provider's Phone Number: _____

No/Mild Depression Concerns (PHQ-9 score 0 - 10)

- **Behavioral:** No new social withdrawal, new irritability.
- **Physical:** No poor appetite, fatigue, poor energy, sleep normal.
- **Cognitive:** No new concentration/focus issues, able to enjoy usual activities, hopes for future.
- **Impairment:** No disruptions to daily life (home, school, sports, other activities); can do all usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of depression: _____
□ Get Active: _____
□ Change your thoughts: _____
□ Coping Strategies: _____
□ Calm Your Body: _____

Moderate Depression Concerns (PHQ-9 score 11- 15)

- **Behavioral:** Occasional social withdrawal, apathy, irritability, some signs of fear and/or distress.
- **Physical:** Occasional fatigue, low energy, too much or too little sleep, unexplained physical complaints (headaches, stomach aches, vomiting, fatigue).
- **Cognitive:** Occasional negative thoughts, difficulty with focus/concentration, loss of pleasure, beginning to have question of hope for the future.
- **Impairment:** Some disruption to daily life (home, school, sports, other activities); cannot do all usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

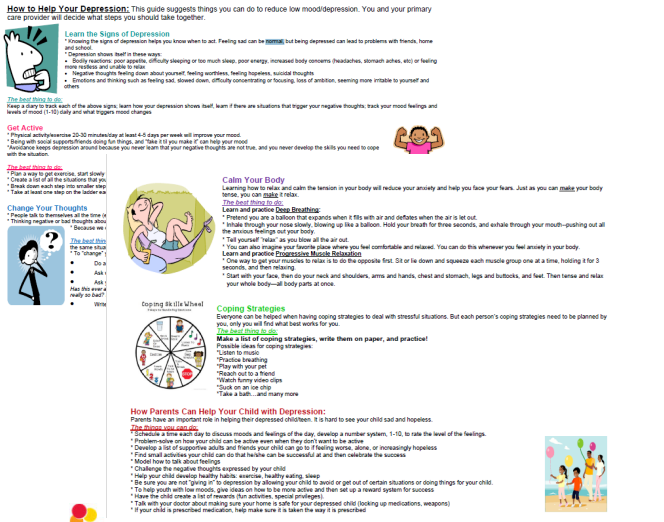
□ Learn the signs of depression: _____
□ Get Active: _____
□ Change your thoughts: _____
□ Coping Strategies: _____
□ Calm Your Body: _____

Significant Depression Concerns (PHQ-9 score: 16 or higher)

- **Behavioral:** Pervasive social withdrawal, apathy, irritability, some signs of fear and/or distress.
- **Physical:** Pervasive fatigue, low energy, too much or too little sleep, unexplained physical complaints (headaches, stomach aches, vomiting, fatigue).
- **Cognitive:** Pervasive negative thoughts, difficulty with focus/concentration, loss of pleasure, beginning to have question of hope for the future.
- **Impairment:** Significant disruption in daily life (home, school, sports, other activities); child cannot do many usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of depression: _____
□ Get Active: _____
□ Change your thoughts: _____
□ Coping Strategies: _____
□ Calm Your Body: _____



How to Help Your Depression: This guide suggests things you can do to reduce low mood/depression. You and your primary care provider will decide what steps you should take together.

Learn the Signs of Depression

* Knowing the signs of depression helps you know when to act. Feeling sad can be normal but being depressed can lead to problems with friends, home and school.
* Depression shows itself in these ways:
  - Bodily reactions: poor appetite, difficulty sleeping or too much sleep, poor energy, increased body concerns (headaches, stomach aches, etc) or feeling more restless and unable to relax
  - Negative thoughts feeling down about yourself, feeling worthless, feeling hopeless, suicidal thoughts
  - Emotions and thinking such as feeling sad, slowed down, difficulty concentrating or focusing, loss of ambition, seeming more irritable to yourself and others

The best thing to do:
Keep a diary to track each of the above signs, learn how your depression shows itself, learn if there are situations that trigger your negative thoughts; track your mood feelings and levels of mood (1-10) daily and what triggers mood changes

Get Active

* Physical activity/exercise 20-30 minutes/day at least 4-5 days per week will improve your mood
* Being with social supports/friends doing fun things, and "fake it til you make it" can help your mood

"Avoidance keeps depression around because you never learn that your negative thoughts are not true, and you never develop the skills you need to cope with the situation.

The best thing to do:
* Plan a way to get exercise, start slowly
* Create a list of all the situations that yo
* Break down each step into smaller step
* Take at least one step on the ladder ea

Change Your Thoughts

* People talk to themselves all the time (
* Thinking negative or bad thoughts abou
  Because we

The best thing
Do some situa
* To "change",
  - Do
  - Ask
  - Ask

Has this ever a
really so bad?
- Write

Calm Your Body

Learning how to relax and calm the tension in your body will reduce your anxiety and help you face your fears. Just as you can make your body tense, you can make it relax.

The best thing to do:
Learn and practice Deep Breathing:
* Pretend you are a balloon that expands when it fills with air and deflates when the air is let out.
* Inhale through your nose slowly, blowing up like a balloon. Hold your breath for three seconds, and exhale through your mouth--pushing out all the anxious feelings out your body.
* Tell yourself "relax" as you blow all the air out.
* You can also imagine your favorite place where you feel comfortable and relaxed. You can do this whenever you feel anxiety in your body.

Learn and practice Progressive Muscle Relaxation
* One way to get your muscles to relax is to do the opposite first. Sit or lie down and squeeze each muscle group one at a time, holding it for 3 seconds, and then relaxing.
* Start with your face, then do your neck and shoulders, arms and hands, chest and stomach, legs and buttocks, and feet. Then tense and relax your whole body—all body parts at once.

Coping Strategies

Coping Skills Wheel

Everyone can be helped when having coping strategies to deal with stressful situations. But each person's coping strategies need to be planned by you, only you will find what best works for you.

The best thing to do:
Make a list of coping strategies, write them on paper, and practice!
Possible ideas for coping strategies:
*Listen to music
*Practice breathing
*Play with your pet
*Reach out to a friend
*Watch funny video clips
*Suck on an ice chip
*Take a bath…and many more

How Parents Can Help Your Child with Depression:

Parents have an important role in helping their depressed child/teen. It is hard to see your child sad and hopeless.

The things you can do:
* Schedule a time each day to discuss moods and feelings of the day, develop a number system, 1-10, to rate the level of the feelings.
* Problem-solve on how your child can be active even when they don't want to be active
* Develop a list of supportive adults and friends your child can go to if feeling worse, alone, or increasingly hopeless
* Find small activities your child can do that he/she can be successful at and then celebrate the success
* Model how to talk about feelings
* Challenge the negative thoughts expressed by your child
* Help your child develop healthy habits: exercise, healthy eating, sleep
* Be sure you are not "giving in" to depression by allowing your child to avoid or get out of certain situations or doing things for your child.
* To help youth with low moods, give ideas on how to be more active and then set up a reward system for success
* Have the child create a list of rewards (fun activities, special privileges)
* Talk with your doctor about making sure your home is safe for your depressed child (locking up medications, weapons)
* If your child is prescribed medication, help make sure it is taken the way it is prescribed

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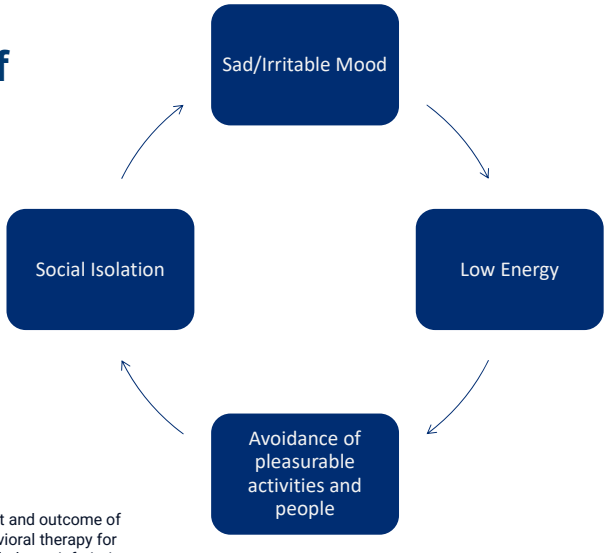
CBT Model of Depression



Richards DA, Ekers D, McMillan D, et al. Cost and outcome of behavioral activation versus cognitive behavioral therapy for depression (COBRA): a randomized, controlled, non-inferiority trial. *Lancet*. 2016;388(10047):871–880

Pediatric Mental Health Institute

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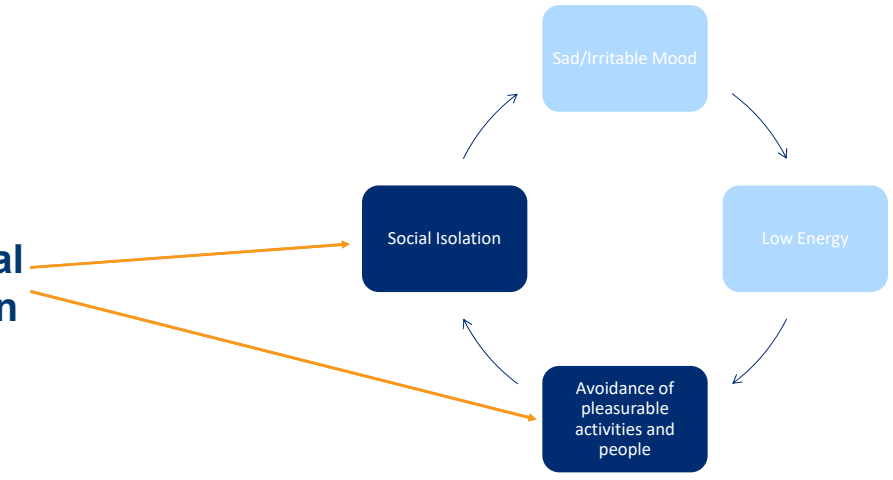
Behavioral Activation



Richards et al., 2016

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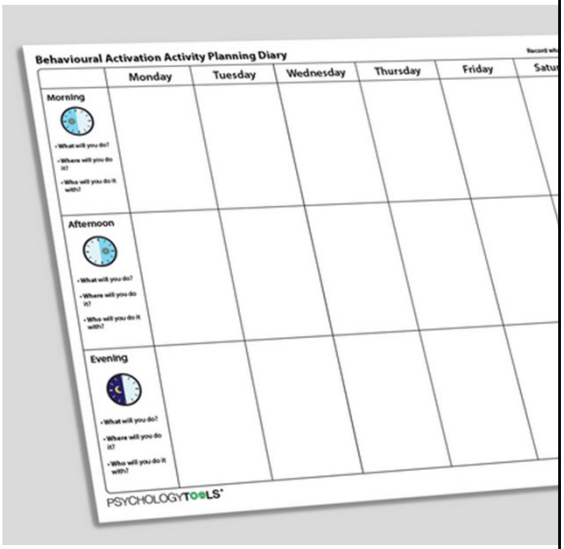
Activity Scheduling

Planning and engaging in positive activities to improve mood and increase a sense of accomplishment.

1. Identify individual & family enjoyable activities.
   - Brainstorm a list or use a curated list.
2. Set realistic & achievable goals.
3. Schedule it – like a doctor's appointment.
   - Intervenes with mood-dependent behavior.
4. Create a routine over time.
5. Monitor & adjust based on testing it out/feedback.
6. Include social activities with peers/family.
   - *FAMILY RULE = must keep it pleasant
   - Young children – daily 5-10minutes of play
7. Celebrate successes.



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A "dopamine menu"

♥Pleasant activities that take
- 5-10 minutes
- 45+ minutes

♥Activities to add to other tasks.

♥Indulgences

♥Extra special things

@Amy • Happy Olive Studio

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Parent Tips While Navigating Depression

1. Try to understand your child's depression and how it affects behavior at home and at school.

2. Support your child's efforts to try new strategies without over pressuring.

3. Increase positive / pleasant interactions and reduce negative / aversive interaction.

Praise wins.
If it's annoying... ignore it.

Thank You

BIOS
11/03

CHILDREN'S AFFECTIVE LABILITY SCALE (CALS)
Child Form for children 8 years and older

DIRECTIONS: Fill in the circle on the scale below each question that best describes your mood.

1. I suddenly start to cry for little or no apparent reason.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

2. It is hard to tell what will set me off into a temper or a fit.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

3. I suddenly become tense or anxious.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

4. I have bursts of being overly affectionate for little reason, hugging or kissing more than people than I would expect.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

5. I suddenly lose interest in what I am doing.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

6. It is hard to tell what mood I will be in (how I will feel; happy, sad, excited, mad).

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

7. I suddenly lose my temper (yell, curse, or throw something) when others would not expect it.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

8. I have bursts or increased talking.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

9. I have short periods when I feel shaky or my heart is pounding, or I have difficulty breathing (not due to asthma or another medical problem).

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

ID: | | | | |

10. It is hard to tell what will set me off crying.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

11. I have bursts of silliness for little or no apparent reason.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

12. I do an activity and then suddenly stop because I am tired.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

13. You never know when I am going to blow up.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

14. I have periods of time when I talk about the same thing over and over.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

15. I suddenly start to laugh about something that most people do not think is funny.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

16. I suddenly appear sad, depressed, and down in the dumps for no apparent reason.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

17. I have bursts of being nervous or fidgety.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

18. I have bursts of crabbiness or irritability.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

19. I suddenly act overly familiar with people I barely know.

Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

20. I appear very angry (yell, curse) in response to a simple request.

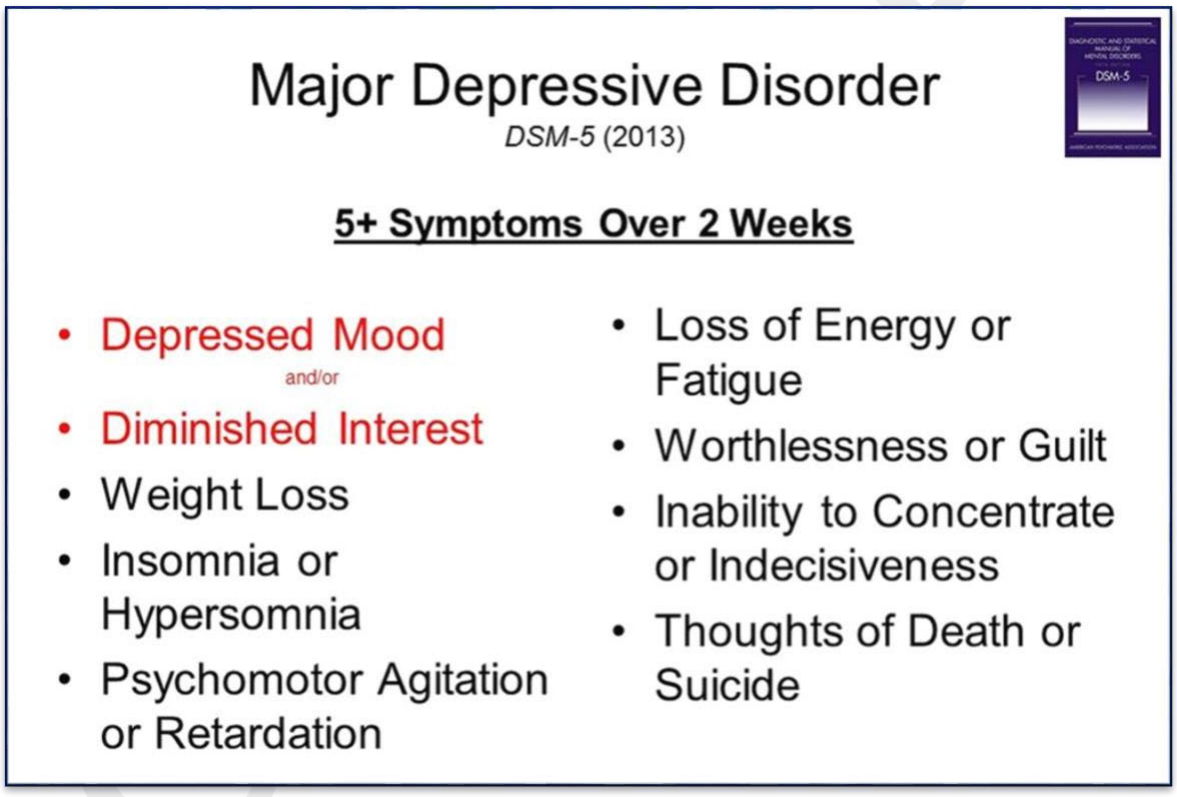
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day
○	○	○	○	○

Year: ☐☐ **ID:** ☐☐☐☐ **DATE:** ☐☐ / ☐☐ / ☐☐☐☐

DEPRESSION

• Major Depressive Disorder •

3.2% of children aged 3-17 years (approximately 1.9 million) have diagnosed depression. Diagnoses of depression are more common with increased age.



Screening

CoPPCAP recommends pediatric providers consider rating scales to identify depression symptoms, track response to intervention 1-2 weeks after starting medication, to guide dose changes, and routinely every 6 months even when stable medication dose is achieved to monitor symptoms. Additionally, when tracking response to treatment intervention, consider use of the same screening form used at baseline prior to diagnosis.

AUTHORS:
McNitt, Cassidy, MD, Ryan Asherin, PhD, & Sandra Fritsch, MD

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
Depression	Edinburgh Postnatal Depression Scale 18+ years Adult Report	EPDS ⇒ English ⇒ Spanish	The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child.
Depression	Patient Health Questionnaire - 9A (modified for teens) 13 – 18 years Self Report	PHQ-9A ⇒ English	The PHQ-9 is the nine item depression scale of the patient health questionnaire.* It is one of the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM 5.
Depression	Patient Health Questionnaire - 9A 12+ years Self Report	PHQ-9 ⇒ English ⇒ Spanish	The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day).
Depression	Short Mood and Feelings Questionnaire 6 – 18 years Caregiver Report Self-Report	SMFQ ⇒ English ⇒ Spanish	The Short Mood and Feelings Questionnaire (SMFQ-short), child version, is an 13 item subscale from a longer 33-item questionnaire (the original MFQ). This instrument should be used an indicator of depressive symptoms and not as a diagnostic tool and therefore does not indicate whether a child or adolescent has a particular disorder. Diagnoses of mental disorder should only be made by a trained clinician after a thorough evaluation.
Depression	Center for Epidemiological Studies Depression Scale for Children 6 – 17 years Self-Report	CES-DC ⇒ English ⇒ Spanish	The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20 item self-report questionnaire for young people between the ages of 6 and 17. It asks young people to rate how many depressive symptoms they have experienced in the last week.
Depression	Quick Inventory of Depressive Symptomatology – Adolescent – (17 Item) – Clinician Rated 12 – 18 years Clinician Report	QIDS-A17-C ⇒ English ⇒ Spanish	The QIDS-A17-C is a 17-item clinician-reported depression measure, where a score of 6–10 indicates mild depression; 10–15, moderate depression; 16–20, severe depression; and ≥21, very severe depression

Diagnosis of Major Depressive Disorder

According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), five or more of the symptoms listed below must be present during the same 2-week time period that represents changes in functioning. At least one symptom is either a depressed mood or loss of interest.

- Depressed mood most of the day, nearly every day, as indicated in the subjective report or in observation made by others
- Markedly diminished interest in pleasure in all, or almost all, activities most of the day and nearly every day
- Significant weight loss when not dieting or weight gain, for example, more than 5 percent of body weight in a month or changes in appetite nearly every day
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness nearly every day
- Recurrent thoughts of death

The ICD-10 classification of Mental and Behavioral Disorders developed in part by the American Psychiatric Association classifies depression by code. In typical, mild, moderate, or severe depressive episodes the patient suffers from lowering of mood, reduction of energy and decrease in activities. Their capacity for enjoyment, interest, and concentration is reduced and is marked by tiredness after even a minimum of effort is common. Sleep patterns are usually disturbed and appetite diminished along with reduced self-confidence and self-esteem. Final code selection should use specifiers based on severity (mild, moderate, severe) and status. Depending on the number and severity of the symptoms, a depressive episode may be specified as mild, moderate, or severe.

For **mild** depressive episodes two or three symptoms from the list above are usually present.

For **moderate** depressive episodes four or more of the symptoms noted above are usually present and the patient is likely to have great difficulty in continuing with ordinary activities.

For a classification of **in remission** the patient has had two or more depressive episodes in the past but has been free from depressive symptoms for several months. This category can still be used if the patient is receiving treatment to reduce the risk of further episodes. It will be based on the provider's clinical determination and documentation.

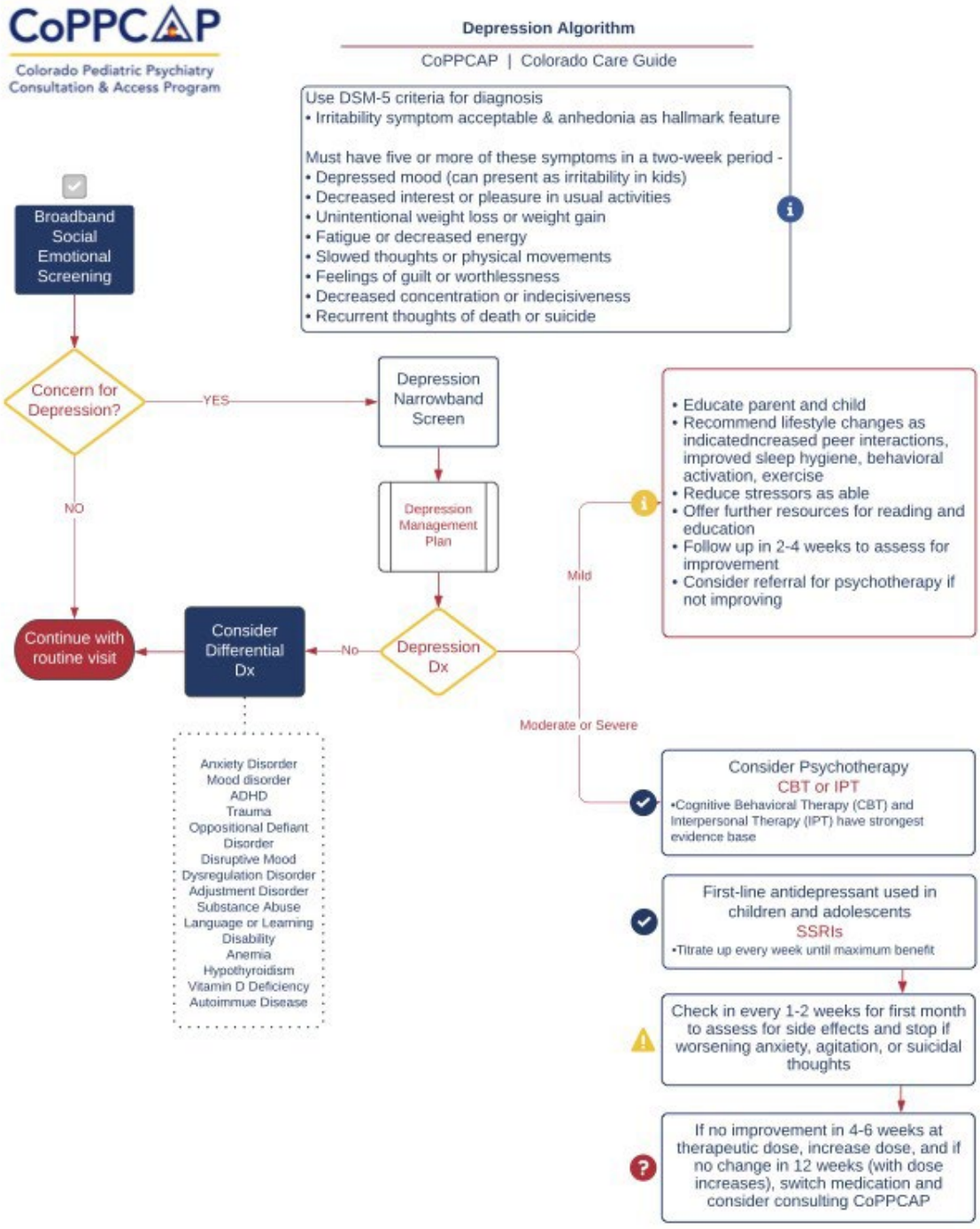
Coding for Major Depressive Disorder, single episode

- F32.0 Major depressive disorder, single episode, mild
- F32.1 Major depressive disorder, single episode, moderate
- F32.2 Major depressive disorder, single episode, severe without psychotic features
- F32.3 Major depressive disorder, single episode, severe with psychotic features
- F32.4 Major depressive disorder, single episode, in partial remission
- F32.5 Major depressive disorder, single episode, in full remission
- F33Major depressive disorder, recurrent

Coding for Major Depressive Disorder, recurrent

A recurrent depressive disorder is characterized by repeated episodes of depression without any history of independent episodes of mood elevation and increased energy or mania. There has been at least one previous episode lasting a minimum of two weeks and separated by the current episode of at least two months. At no time in the past has there been any hypomanic or manic episodes.

- F33.0 Major depressive disorder, recurrent, mild
- F33.1 Major depressive disorder, recurrent, moderate
- F33.2 Major depressive disorder, recurrent, severe without psychotic features
- F33.3 Major depressive disorder, recurrent, severe with psychotic features
- F33.4Major depressive disorder, recurrent, in remission
- F33.40 Major depressive disorder, recurrent, in remission, unspecified
- F33.41 Major depressive disorder, recurrent, in partial remission
- F33.42 Major depressive disorder, recurrent, in full remission



click the algorithm above to enlarge

Options for Treatment: Psychotherapy

- Psychotherapy alone can be effective for mild to moderate depression. More severe depression is likely to require treatment with medication.
- If depression is not improving after six to twelve weeks of therapy, adding a medication should be considered.
- Consider regulatory functioning with sleep, diet, and exercise
- The two types of therapy shown to be most effective in treating depression in children and adolescents are **cognitive behavioral therapy (CBT)** and **interpersonal therapy (IPT)**
    - CBT is based on the idea that thoughts, feelings, and behaviors impact one another. Negative thoughts are believed to contribute to negative behaviors and depressed mood, which can contribute to more negative thoughts. CBT works by targeting patients' thoughts and behaviors to improve mood. Key components of CBT including increasing positive activities (behavioral activation), identifying and challenging negative thoughts (cognitive restructuring), and improving coping and problem-solving skills.
    - IPT is based on the idea that interpersonal problems can contribute to depressed mood. The goal of treatment is to address interpersonal problems that may be contributing to depressed mood by identifying problem areas in relationships and improving problem-solving and communication skills to build social supports.
- Other non-pharmacologic treatments that may be helpful in treating depression include:
    - DBT (dialectical behavioral therapy) – DBT is a manualized therapy originally developed for adults and more recently adapted for adolescents. DBT focuses on teaching mindfulness skills, emotional regulation, distress tolerance, and interpersonal effectiveness and has been shown to be effective in treating moderate to severe depression and self-harm and suicidal behaviors.
    - Family-based treatments, particularly attachment-based family therapy, which is a manualized treatment that focuses on promoting family connections and building on family strengths while also working to improve a child's success outside the home.
    - Promoting general wellness including encouraging exercise, which has shown to be effective by itself in reducing depression, engagement in prosocial activities, good sleep hygiene, and healthy eating

Options for Treatment: Pharmacotherapy

- Medications are indicated for more severe depression or in depression that has not been responsive to psychotherapy alone
- Approximately 55-65% of children and adolescents will respond to an initial antidepressant trial
- SSRIs are typically the first-line pharmacologic treatment in children and adolescents
- Fluoxetine (Prozac) and Escitalopram (Lexapro) are the only FDA approved medications for use for depression in children and adolescents, though other antidepressant medications have been FDA approved for other indications and in common use for depression
- The most common side effects of SSRIs are gastrointestinal symptoms, headaches, agitation, sleep changes, irritability, motor restlessness (need to constantly move), and behavioral activation. These side effects are most likely to occur in the first 1-2 weeks after starting the medication, or when making dosage increases.
- Concerning side effects of SSRIs include serotonin syndrome and increased suicidal thoughts.
    - When discussing antidepressant medications with families, always provide education about the FDA black box warning for increased suicidal thoughts when used in children and adolescents. This warning is based upon a 2004 review 24 clinical trials of children and adolescents who had been prescribed antidepressants. No suicides occurred in any of these studies, but 4 out of 100 children taking antidepressants reported suicidal thoughts or behaviors while 2 out of 100 children not on medication reported suicidal thoughts or behaviors. As a result, the FDA applied the black box warning for increased suicidal thoughts to all antidepressant medications.
- Frequent check ins are recommended during the first month to monitor for development of side effects or suicidal thoughts. Medication should be stopped if patient develops intolerable side effects or suicidal thoughts during this period.
    - Consider phone calls directly or via support staff to monitor mood and functioning weekly when first starting medication
- SSRIs can be titrated weekly, as tolerated, to a therapeutic dose (see depression medication chart below)
- Patients may have to take SSRIs for 4-6 weeks at an effective dose before experiencing any reduction in depression symptoms

  - If no benefit after 4-6 weeks, increase dose. If no benefit after 12 weeks, switch to a different medication.
- Patients should continue medication for 6-12 months following resolution of symptoms
- When discontinuing antidepressant medications, taper slowly to minimize side effects (going down by the lowest titration increment every 1-2 weeks)

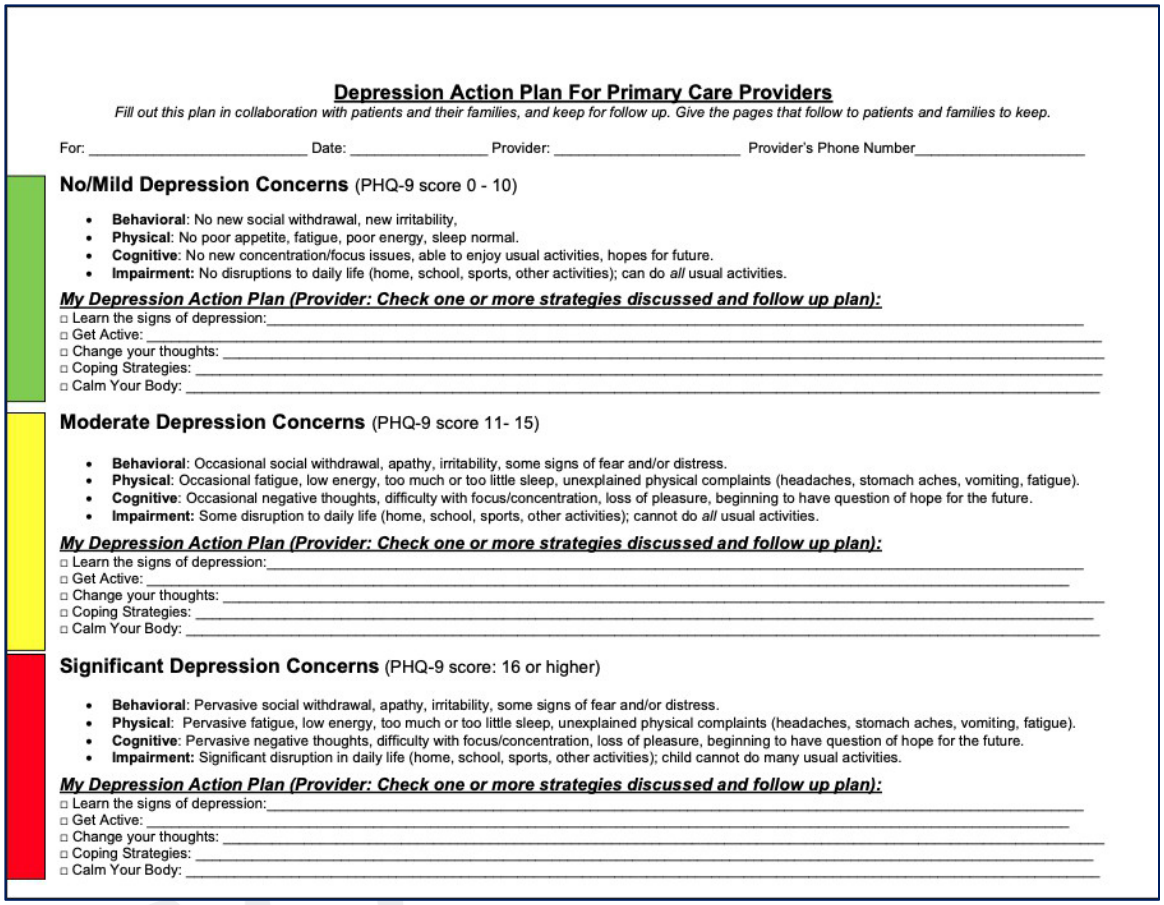
Depression Medications

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI'S)						
Drug Name	Dose Form	Usual Starting Dose	Increase Increment	RCT Evidence in Kids	FDA approved in kids?	Things to know
Citalopram (Celexa)	Tablet: 10/20/40mg Suspension: 10mg/5ml	10 mg daily	10 – 20 mg (40 mg max daily dose)	Yes	No	Risk for QT prolongation at doses above 40 mg
Escitalopram (Lexapro)	Tablet: 5/10/20mg Suspension: 1mg/1ml	5 mg daily	5 - 10 mg (20 mg max daily dose)	Yes	Yes (for 12 years and up)	**Second line,** lower risk for GI side effects and med interactions
Fluoxetine (Prozac)	Tablet: 10/20/40/60mg Suspension: 20mg/5ml	10 mg daily	10 – 20 mg (60 mg max daily dose)	Yes	Yes (for 8 years and up)	**First line**, long half-life
Fluxoxamine (Luvox)	Tablet: 25/50/100mg	25mg daily	50 – 200 mg			
Paroxetine (Paxil)	Tablet: 10/20/30/40mg Tablet CR: 12.5/25/37.5mg Suspension: 10mg/5ml		10 – 50 mg			
Sertraline (Zoloft)	25, 50, 100 mg 20 mg/mL	25 mg daily	25 – 50 mg (200 mg max daily dose)	Yes	No (FDA approved for use in kids with anxiety)	**Second line,** prone to GI side effects
NON-SSRI ANTIDEPRESSANTS						
Drug Name	Dose Form	Usual Starting Dose	Increase Increment	RCT Evidence in Kids	FDA approved in kids?	Things to know
Bupropion, Bupropion SR (Wellbutrin)	IR form: 75/100mg	37.5 – 75 mg daily	75 – 100 mg (typically BID or TID dosing, max dose 450	No	No	Can be activating. Avoid in eating disorders due to risk of

	SR form: 100/150/200mg XL form: 150/300/450mg	150 mg daily	mg daily for IR or 400 mg daily for ER) 150 mg (450 mg max daily dose)			lowering seizure threshold. Can have some benefit for ADHD symptoms
Desvenlafaxine (Pristiq)	Tablet ER 24 hour: 25/50/100mg	25 – 50 mg daily	50 – 100 mg daily			
Duloxetine (Cymbalta)	Tablet: 20/30/40/60mg	20mg daily	40 – 60 mg daily			
Mirtazapine (Remeron)	7.5, 15, 30, 45 mg	7.5 mg daily	7.5 – 15 mg (45 mg max daily dose)	No	No	Sedating, stimulates appetite
Trazodone (Desyrel)	Tablet: 50/100/150/300mg	25 – 50 mg daily	100 – 150 mg daily			
Venlafaxine (Effexor)	IR form: 25/37.5/50/75/100mg ER form: 37.5/75/150/225mg	37.5 mg daily	37.5 – 75 mg (225 mg max daily dose)	No	No	Risk for withdrawal syndrome due to short half-life

Depression Management Plan

CoPPCAP developed a Depression Management Plan for use in Primary Care settings to help provide psychoeducation & actionable items providers, caregivers, and patients can take after depression screening.



Depression Action Plan For Primary Care Providers

Fill out this plan in collaboration with patients and their families, and keep for follow up. Give the pages that follow to patients and families to keep.

For: _____ Date: _____ Provider: _____ Provider's Phone Number_____

No/Mild Depression Concerns (PHQ-9 score 0 - 10)

- **Behavioral**: No new social withdrawal, new irritability,
- **Physical**: No poor appetite, fatigue, poor energy, sleep normal.
- **Cognitive**: No new concentration/focus issues, able to enjoy usual activities, hopes for future.
- **Impairment:** No disruptions to daily life (home, school, sports, other activities); can do *all* usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of depression:_____
□ Get Active: _____
□ Change your thoughts: _____
□ Coping Strategies: _____
□ Calm Your Body: _____

Moderate Depression Concerns (PHQ-9 score 11- 15)

- **Behavioral**: Occasional social withdrawal, apathy, irritability, some signs of fear and/or distress.
- **Physical**: Occasional fatigue, low energy, too much or too little sleep, unexplained physical complaints (headaches, stomach aches, vomiting, fatigue).
- **Cognitive**: Occasional negative thoughts, difficulty with focus/concentration, loss of pleasure, beginning to have question of hope for the future.
- **Impairment:** Some disruption to daily life (home, school, sports, other activities); cannot do *all* usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of depression:_____
□ Get Active: _____
□ Change your thoughts: _____
□ Coping Strategies: _____
□ Calm Your Body: _____

Significant Depression Concerns (PHQ-9 score: 16 or higher)

- **Behavioral**: Pervasive social withdrawal, apathy, irritability, some signs of fear and/or distress.
- **Physical**: Pervasive fatigue, low energy, too much or too little sleep, unexplained physical complaints (headaches, stomach aches, vomiting, fatigue).
- **Cognitive**: Pervasive negative thoughts, difficulty with focus/concentration, loss of pleasure, beginning to have question of hope for the future.
- **Impairment:** Significant disruption in daily life (home, school, sports, other activities); child cannot do many usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of depression:_____
□ Get Active: _____
□ Change your thoughts: _____
□ Coping Strategies: _____
□ Calm Your Body: _____

click the image above to access the full Depression Management Plan

Safety Assessment and Planning in Depressed Adolescents

- **Ask.** Providers and families should regularly ask about suicidal thoughts and behaviors.
- **Restrict means.** Providers should ask all families of depressed adolescents about access to potentially harmful items including firearms, other weapons, medications (prescription and over the counter), sharps objects like knives and razors, and items that could be used for strangulation like ropes and belts and recommend removing these items from the home or locking them up.
- **Monitor for risky or suicidal behaviors.** Watch for behaviors such as:
    - Expressing hopelessness
    - Expressing suicidal or self-harm thoughts
    - Behaving in an unusually impulsive or risky manner
    - Researching means of harming one's self
    - For young children, using death as a theme in play
    - Giving away possessions
    - Talking about being a burden to others
- **Watch for substance use.** Using substances including alcohol and drugs can make it more likely that a person with suicidal thoughts acts on those thoughts, so parents so closely monitor for substance use and remove any substances from their home.
- **Develop a crisis plan or safety plan.** Develop a plan with adolescents and their parents for what to do if they are in crisis or develop suicidal thoughts. This plan should include triggers that cause distress for the child, physical signs or behaviors that occur when they are in distress, ways parents or others can help them calm down or cope with the distress, ways they can help themselves cope, and other supports they can contact or utilize in a crisis including positive peers, supportive adults, and therapists. Local and national crisis lines and 911 can also be included.

Resources:

Crisis Hotlines:

- National Suicide Prevention Lifeline - 1-800-273-8255
- National Suicide Hotline – 1-800-784-2433
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

Books for Parents:

- Adolescent Depression: A Guide for Parents by Francis Mark Mondimore, MD and Patrick Kelly, MD
- The Childhood Depression Sourcebook by Jeffrey A. Miller, PhD

Helpful Apps:

- My3 – free app available in the apple app store and google app store that allows users to identify three contacts to have easy access to in a crisis, as well as update and review warning signs they are in a crisis and coping strategies they can use
- Mood Tools – free CBT-based app that provides information about depression, allows users to practice skills, and has places for documenting preferred coping skills and crisis plans for easy access in a crisis
- CBT Tools for Youth – CBT-based app developed specifically for youth to help them practice CBT skills and develop and record coping skills and safety plans. Has an associated cost.

Primary References

Birmaher B, Brent D. AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. J Am Acad Child Adolesc Psychiatry. 2007;46(11):1503–1526.

March J, Silva S, Petrycki S et al. The Treatment for Adolescents With Depression Study (TADS): long-term effectiveness and safety outcomes. Arch Gen Psychiatry. 2007;64(10):1132–1143.

AACAP, APA: "Depression: Parents' Medication Guide." Accessed 2/20 from www.aacap.org

Zuckerbrot RA, Cheung A, Jensen PS, Stein REK, Laraque D; GLAD-PC Steering Group. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): part I. practice preparation, identification, assessment, and initial management. Pediatrics. 2018;141(3):e20174081

Cheung AH, Zuckerbrot RA, Jensen PS, Laraque D, Stein REK; GLAD-PC STEERING GROUP. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): part II. Treatment and ongoing management. Pediatrics. 2018;141(3):e20174082

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THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.[1]

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or **"Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke's Medical Center.

[1] Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire." *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.

Depression: Parents' Medication Guide

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AMERICAN PSYCHIATRIC ASSOCIATION

Depression Parents' Medication Guide Work Group

CHAIR:
Graham J. Emslie, MD

MEMBERS:
Teri Brister, PhD, LPC, Representative from National Alliance on Mental Illness

Meredith Chapman, MD

Mina K. Dulcan, MD

Cathryn A. Galanter, MD

Jessica M. Jones, MA, LPA

Beth Kennard, PsyD

Jerry Pavlon-Blum, Representative from Depression and Bipolar Support Alliance

Theodore A. Petti, MD, MPH

Adelaide S. Robb, MD

Timothy E. Wilens, MD

STAFF:
Carmen J. Head, MPH, CHES, Director, Research, Development, & Workforce

Sarah Hellwege, MEd, Assistant Director, Research, Training, & Education

CONSULTANT:
Esha Gupta, Medical Science Writer

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health.

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Introduction

The original Parents Medical Guide on treating depression was published in 2005, and a revision was published in 2010, through collaboration by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA). The current revision has been updated to include new research on effective treatments for child and adolescent depression. The goal of this guide is to help parents make informed decisions about getting the best care for a child or adolescent with depression.

What is depression?

Depression is a serious illness that can affect almost every part of a young person's life and significantly impact his or her family.

Depression is a type of mood disorder that can damage relationships among family members and friends, harm school performance, and limit other educational opportunities. Depression can negatively affect eating, sleeping, and physical activity. Because it can result in so many health problems, it is important to recognize the signs of depression and get the right treatment. When depression is treated successfully, most children can get back on track with their lives.

Although depression can occur in young children, it is much more common in adolescents (youth ages 12–18 years). Depression before children reach puberty occurs equally in boys and girls. After puberty, depression is more common in girls.

Causes and Symptoms

Why does my child have depression?

We don't fully understand all the causes of depression; we think it's a combination of genetics (inherited traits) and environmental factors (events and surroundings). There is no single cause. Stressors or events that cause a stressful response and genetic factors can cause depression. Stressors can be triggers that result from pediatric illnesses and diseases, such as viral infections; diseases of the thyroid and endocrine system; head injury; epilepsy; and heart, kidney, and lung diseases. A family history of depression is a major genetic factor; a child can be more prone to becoming depressed if a parent or sibling has been diagnosed with depression. Stressors in everyday life also contribute to the development of depression, for example, the loss of a close loved one; parents frequently arguing, separating, or divorcing; school changes; and family financial problems. Finally, developmental factors, such as learning and language disabilities, are sometimes overlooked. Other mental illnesses and symptoms, such as attention-deficit/hyperactivity disorder (ADHD), anxiety, fears, and excessive shyness, in addition to not having opportunities to develop interests and show strengths and talents, can add to depression.

What are the symptoms of depression?

- Depressed, sad, or irritable mood
- Significant loss of interest or pleasure in activities
- Significant weight loss, weight gain, or appetite changes
- Difficulty falling asleep and/or staying asleep or sleeping too much
- Restlessness, unable to sit still (referred to as psychomotor agitation), or being slowed down (referred to as psychomotor slowing)
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate feelings of guilt
- Difficulties in concentrating or making decisions
- Constant thoughts of death, suicidal thinking, or a suicide attempt

According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, an episode of major depression is characterized by 5 or more of these symptoms (with at least one of the symptoms noted as a depressed and/or irritable mood or having reduced interests or little pleasure) that have lasted for at least 2 weeks and affected a child's performance at school, at work, with family, or with friends. These symptoms are not caused by medication, drug abuse, or alcohol and are not the result of another medical or mental illness.

The symptoms of major depressive disorder (MDD) in youth and adults are the same. However, the symptoms of depression may look differently in children and adolescents than in adults. For example, children may have difficulty expressing their sad mood and may complain of headaches or stomachaches instead. Listed below are other ways that depression may look differently in youth:

- Irritable or cranky mood
- Boredom, giving up favorite activities, toys, and interests
- Failure to gain weight as expected
- Delays in going to sleep, refusal to wake up for school or get out of bed
- Difficulty sitting still or very slowed movements
- Tired all the time, feeling "lazy"
- Self-critical or blaming self for everything
- Decline in school performance, failing grades or classes
- Frequent thoughts and discussion about death, giving away favorite belongings

How do the symptoms of depression differ from typical sadness?

It is normal for children and adolescents to feel sad sometimes or be irritated in response to stressors. Depression is different from occasional sadness. A child or adolescent with depression has a significant **change** in their typical mood and interest level and is persistent (ie, most of the time for several weeks). Youth with depression show symptoms that are significant enough to cause them problems at home, at school, and/or with friends and family. Youth with depression may report that their symptoms are in response to a stressful or upsetting event, or they may not know what caused them to feel this way.

Diagnosing Depression in Children and Adolescents

How is depression in children and adolescents diagnosed?

If you are concerned that your child is depressed, it's important to discuss this with your child's doctor. Your child's doctor may recommend a thorough assessment. A thorough assessment includes getting information about the degree and severity of symptoms, psychosocial stressors and functioning from the child, parent, caregiver and/or guardian who lives with the child and reports from the school.

This assessment should be done by someone with experience in evaluating children for mental illness, such as a child and adolescent psychiatrist. A child and adolescent psychiatrist is a doctor who specializes in the diagnosis and treatment of disorders of thinking, feeling and/or behavior affecting children, adolescents and their families. Child and adolescent psychiatry training requires four years of medical school, at least three years of residency training in general psychiatry with adults, and two years of additional specialized training in treating children, adolescents and families.

A medical history and physical exam, as well as a detailed history of biologically related family members, are also recommended to rule out or identify other co-existing medical and mental health conditions that may require treatment.

What other conditions can accompany depression?

Up to 50% of children and adolescents diagnosed with depression may have other mental health disorders, including bipolar disorder. Children and adolescents with depression may also have anxiety, ADHD, and learning differences or be at risk of abusing drugs or alcohol.

If you are concerned that your child is depressed, it's important to discuss this with your child's doctor.

Suicide and Youth with Depression

Youth with depression are at increased risk for suicide attempts and suicide. It is important to ask your child whether they are having thoughts about hurting themselves. If your child expresses suicidal thoughts, this is an opportunity to discuss taking precautions to make the child's environment safe. Talking with your child about suicide does not cause suicide, but it does let your child know that you are concerned and that you want to know whether they have any thoughts about it.

How common are suicidal thoughts, behaviors, and death by suicide in youth?

Among students in grades 9–12 in the United States in 2015, 18% reported seriously considering attempting suicide in the previous 12 months, whereas 15% actually made a suicide plan. Nine percent of students attempted suicide one or more times, and 3% made an attempt that resulted in an injury, poisoning, or an overdose that required medical attention.

In 2015, suicide was the third leading cause of death among youth between the ages of 10 and 14 years and the second leading cause of death among individuals between the ages of 15 and 34 years. Suicide claims more lives than many diseases in children and adolescents. More adolescents and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.

What factors other than depression may increase suicide risk?

Additional risk factors for suicide include having a family member who died by suicide or knowing someone else who died by suicide. Other factors include family conflict, sleep problems, substance use, school problems, impulsivity, other mental illnesses, not feeling connected to others, and easy access to lethal means of self-harm.

Do antidepressant medications increase the risk of suicide?

Determining whether antidepressant medications increase the risk for suicide is quite hard, particularly because children and adolescents with depression are more likely to think about suicide and attempt it than other children. With this concern, the FDA (US Food and Drug Administration) reviewed all published and unpublished clinical trials of antidepressants in children and adolescents, and in 2004, it issued a black box warning about an increased risk of suicidal thoughts and/or behaviors in youth who take antidepressants. There was no record of completed suicides in their review of over 2,000 youth who were treated with antidepressant medications, but the rate of suicidal thinking/behavior (including actual suicide attempts) was twice as high in youth taking medications (4%) than those taking placebo or sugar pills (2%).

Treating underlying depression in youth who are thinking about suicide is an important strategy, because antidepressant medications improve depressive symptoms, which is the best way to treat suicidal thoughts and behavior. Antidepressant medication may increase the risk for suicidal thoughts and/or behaviors in a small percentage of youth. If a doctor determines that medication is appropriate for your child, it is important to weigh the pros and cons of antidepressants. If your child has moderate to severe depression, the benefit of reducing depressive symptoms may outweigh the risks of medication side effects. Maintaining regular follow-ups and monitoring throughout treatment helps manage any uncertainty. It is important that your child be monitored closely for all side effects, including suicidal thinking and behavior, particularly in the first few weeks after beginning treatment with an antidepressant and after adjusting the antidepressant dose.

Treating Depression

The first step to treatment is a thorough assessment. Once your child has been diagnosed with depression, there are several important factors to consider before moving forward with treatment. It is important to get as much information as possible from your child's doctor on effective treatment options, potential side effects, and treatment expectations. You and your child should have the opportunity to ask questions about treatment options before you make a decision about your child's care.

It is important to share with your child's doctor your understanding of depression and related treatment options. Family values and norms—which can be heavily influenced by ethnicity and culture—may play a role in decision making regarding your child's wellness.

If your child's depression is not so severe or does not significantly impair his or her functioning and they do not have suicidal thoughts or psychosis, your child's doctor may recommend active support and monitoring. During a period of active support and monitoring, it is important for your child to have positive interactions with peers, to exercise, to follow a healthy diet, and to practice good sleep patterns. It is also important to reduce stressors, if possible. If your child's depressive symptoms get worse or do not improve, his or her doctor may recommend that you consider specific treatment, such as psychotherapy and/or antidepressant medications for your child.

The primary goals of treatment are as follows: 1) to shorten the duration of your child's depressive episode; 2) to provide treatment until your child's symptoms are in remission (having minimal or no depressive symptoms); and 3) to prevent relapse or recurrence (a return of depressive symptoms).

Will my child's depression pass without treatment?

A single episode of depression, if left untreated, often lasts from 6 to 9 months, which can be an entire school year for most children. When left untreated, the consequences can be serious, including a high risk for substance abuse, eating disorders, teenage pregnancy, and/or suicidal thinking and behaviors. Suicide attempts and completed suicide are risks of untreated depression. Children with untreated depression are also likely to have ongoing problems in school, at home, and with their friends; it can also lead to a higher risk of developing a more chronic, difficult-to-treat form of depression.

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Taking Medication for Depression

Are medications effective for depression in youth?

Antidepressant medications can be effective in relieving depressive symptoms in children and adolescents. Approximately 55–65% of children and adolescents will respond to initial treatment with antidepressant medication. Of those who don't respond to the first treatment, a high number will respond to another medication and/or a different form of therapy, such as cognitive-behavioral therapy (CBT) or dialectical behavior therapy (DBT).

What types of medications are available to treat my child's depression?

To date, fluoxetine [a selective serotonin reuptake inhibitor (SSRI), also known as Prozac] is the only antidepressant approved by the FDA for the treatment of depression in both children and adolescents (ages 8 years and older). Escitalopram (an SSRI also known as Lexapro) is approved by the FDA for the treatment of depression in adolescents (ages 12 years and older). No other antidepressants have been approved by the FDA for the treatment of depression in youth, although some have been approved for the treatment of other mental health conditions. Your child's doctor may prescribe other antidepressant medications that are not FDA approved based on available data. You should know that prescribing an antidepressant that has not been approved by the FDA for use in children and adolescents (referred to as off-label use or prescribing) is common and is consistent with accepted clinical practice.

Factors that might influence a doctor's choice(s) of medication include, but are not limited to, specific characteristics of the patient, comorbid or coexisting mental or medical conditions, and patient or parent/caregiver's preference for treatment with medication, psychotherapy, or combined psychotherapy and medication treatment.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Medications called SSRIs are the first-line treatment for youth with depression.

SSRIs work by increasing the levels of serotonin in the brain. Serotonin is a neurotransmitter that sends signals between brain cells. It is common to experience side effects from SSRIs right after beginning treatment; it can take up to 4 to 6 weeks of taking an SSRI regularly for the medication levels in the brain to be steady enough to decrease the symptoms of depression. SSRIs are also used for treating conditions other than depression, such as anxiety disorders.

The table on page 10 includes the most commonly used SSRIs for youth with depression.

Other Antidepressants

Although SSRIs are usually the first choice of medication for children and adolescents with depression, your doctor may recommend different types of medications if in certain circumstances, such as your child does not improve with an SSRI. These medications have unique qualities that make them effective, some of which involve serotonin and other neurotransmitters. The table on page 10 includes non-SSRI antidepressants that are approved by the FDA for adults with depression and are often prescribed for youth with depression in clinical practice.

Other prescribed antidepressant medications, such as tricyclic antidepressants (TCAs, eg, imipramine and amitriptyline) and older monoamine oxidase inhibitors [MAOIs, eg,

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SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Medication	Formulations	Daily Dose Range
Citalopram (Celexa)	Tablet: 10/20/40 mg Suspension: 10 mg/5 ml	10-40 mg
Escitalopram (Lexapro)*	Tablet: 5/10/20 mg Suspension: 1 mg/1 ml	10-20 mg (initial dose may be 2.5-5 mg)
Fluoxetine (Prozac)**	Tablet and capsule: 10/20/40/60 mg Suspension: 20 mg/5 ml	20-60 mg (initial dose may be 10 mg)
Fluvoxamine (Luvox)	Tablet: 25/50/100 mg	50-200 mg (initial dose may be 25 mg)
Paroxetine (Paxil)	Tablet: 10/20/30/40 mg Tablet CR: 12.5/25/37.5 mg Suspension: 10 mg/5 ml	10-50 mg
Sertraline (Zoloft)	Tablet: 25/50/100 mg Suspension: 20 mg/ml	50-200 mg (initial dose may be 12.5-25 mg)

Note: CR = controlled release
**FDA approved for children age 12 and up.*
***FDA approved for children age 8 and up.*

NON-SSRI ANTIDEPRESSANTS

Medication	Formulations	Daily Dose Range
Bupropion, Bupropion SR (Wellbutrin)	Tablet: 75/100 mg Tablet ER 12 hour: 100/150/200 mg	150-300 mg (first dose may be 37.5-75 mg)
Bupropion XL (Wellbutrin)	Tablet ER 24 hour: 150/300/450 mg	150-450 mg
Desvenlafaxine (Pristiq)	Tablet ER 24 hour: 25/50/100 mg	50-100 mg (first dose may be 25-50 mg)
Duloxetine (Cymbalta)	Tablet: 20/30/40/60 mg	40-60 mg (first dose may be 20 mg)
Levomilnacipran (Fetzima)	Capsule ER 24 hour: 20/40/80/120 mg	40-120 mg (first dose may be 20 mg)
Mirtazapine (Remeron)	Tablet: 7.5/15/30/45 mg Tablet disintegrating: 15/30/45 mg	15-45 mg (first dose may be 7.5-15 mg)
Trazodone (Desyrel)	Tablet: 50/100/150/300 mg	100-150 mg (first dose may be 25-50 mg)
Venlafaxine XR (Effexor)	Tablet: 25/37.5/50/75/100 mg Capsule and Tablet ER 24 hour: 37.5/75/150/225 mg	150-300 mg (first dose may be 37.5 mg)
Vilazodone (Viibryd)	Tablet: 10/20/40 mg	15-40 mg (first dose may be 10 mg)
Vortioxetine (Trintellix)	Tablet: 5/10/20 mg	20 mg (first dose may be 10 mg)

Note: SR = sustained release, ER = extended release, XL = extended release, XR = extended release

phenelzine (Nardil) and tranylcypromine (Parnate)], are not recommended as a first-line treatment for youth with depression because they have not been proven to be effective and have negative side effects. A newer MAOI called selegiline (Emsam) appears to be as good as other antidepressants in treating adults with depression, with few negative side effects. Although selegiline was not shown to be effective in treating adolescents with depression, it was safe and well tolerated in a recent study.

Sometimes more than one antidepressant medication may be prescribed for a youth who has shown only partial response to initial treatment, has lingering symptoms, or has not responded to treatment. Other types or classes of medications, particularly mood stabilizers and atypical antipsychotic medications, may also improve the effects of antidepressant medications, but they are not used as often because of the risk of more serious side effects like weight gain, obesity, and metabolic syndrome.

Side Effects

The most common side effects of SSRIs are as follows:

- gastrointestinal symptoms (nausea, stomachaches, and/or diarrhea)
- headaches
- agitation
- sleep disturbance
- irritability
- activation

Sexual side effects, increased bruising and/or bleeding, and mania are also possible, although they are less common side effects of SSRIs. The most common side effects of non-SSRI antidepressants vary quite a bit among the individual medications. If your child has been prescribed a non-SSRI antidepressant, you should ask your child's doctor about the side effects that are specific to that medication.

Some side effects may be managed easily. For example, if your child experiences the side effect of sleepiness throughout the day, it may be wise to take the antidepressant at bedtime, or if your child experiences nausea as a side effect, it might be helpful to take the antidepressant with meals. If your child experiences side effects from one SSRI, they will not necessarily experience the same side effects from all SSRIs, so it is important for you and your child to discuss all of their side effects with their doctor. It is important to contact your child's doctor immediately if your child experiences any unusual change in behavior at any time after starting treatment with an antidepressant.

Serotonin syndrome is a rare but serious potential side effect of SSRIs. Serotonin

syndrome occurs when high levels of serotonin accumulate in the body, and it most often happens when a person is taking more than one medication that affects the serotonin level. Symptoms of serotonin syndrome may include fever, confusion, tremor, restlessness, sweating, and increased reflexes.

Other medications, in addition to those that affect serotonin, can interact with SSRIs and other antidepressants and cause problems. Therefore, it is very important that you tell your child's doctor about all the medications and supplements that your child takes. It is also important to discuss with your child's doctor any new supplements or over-the-counter medications or medications prescribed to your child by other doctors before taking those medications.

How can I help monitor my child during treatment?

Because some youth have adverse physical and/or emotional reactions to antidepressants, parents should pay attention to any signs of increased anxiety, agitation, aggression, or impulsivity. Parents should also check their children for involuntary restlessness or unexplained happiness or energy accompanied by fast, driven speech, and unrealistic plans or goals. These reactions are more common at the start of treatment, but they can occur at any time during treatment. If your child shows any of these symptoms or any other concerning changes in behavior, consult your child's doctor immediately, because it may be necessary to adjust the dose, change to a different medication, or stop using the medication.

The following precautions for suicide prevention should be put into place if a child or any other family member has depression:

- Dangerous means of suicide, such as guns, should be removed from the home, and potentially dangerous medications, including over-the-counter drugs like acetaminophen (Tylenol) should be locked away.
- You should work with your child's doctor or other mental health provider to develop an emergency safety plan, which consists of a planned set of actions for you, your child, and your child's doctor to take if your child has more thoughts of suicide. This should include access to a 24-hour crisis phone number available to deal with such crises.
- If your child expresses new or more frequent thoughts of wanting to die or self-harm or takes steps to do so, you should implement the safety plan and contact your child's doctor immediately.

How do I know if my child's medication is working?

You may notice that your child's medication is working if your child's depressive symptoms (mood, interest, appetite, sleep, concentration, or suicidal thinking/behavior) improve or if they are functioning better at school, at home, or with peers. Your child's doctor will know whether your child's medication is working by collecting information from

you, your child's school team, and your child through clinical assessments and self-reports and parent questionnaires and other reports.

It is important for your child to have more frequent visits with their doctor soon after they start their treatment with an antidepressant. More frequent visits early in treatment and during times of antidepressant medication dose adjustments will allow your child's treatment provider to address any concerns about treatment response or side effects and to monitor your child for suicidal thinking and behavior.

What can be done if my child's depression is not improving on medication?

Depending on the specific antidepressant that your child is taking, it may take 4–6 weeks of treatment before your child's depressive symptoms begin to show improvement. This may be the case, even if your child started to have side effects shortly after taking an antidepressant for the first time. If your child's depressive symptoms have not improved after taking an antidepressant regularly for 4–6 weeks, their doctor may consider increasing the antidepressant dose. An appropriate trial of an antidepressant may last up to 12 weeks. If your child's depressive symptoms have not responded to an adequate trial of an antidepressant or if your child experiences unacceptable side effects from an antidepressant, their doctor may recommend switching to a different antidepressant or adding an additional antidepressant.

When a child or adolescent fails to respond to treatment with an SSRI, it is extremely important to understand why and address the cause. In addition to problems with finding the right dose or the duration of medication therapy, nonresponse may be the result of a number of other factors, including wrong diagnosis, another medical illness, extreme stress, poor management of comorbid mental conditions, or not properly following the instructions on taking the medication. If your child does not respond to a first SSRI, your child's doctor might recommend a second SSRI. Research has shown that approximately half of youth who don't respond to one SSRI will still respond to a second SSRI. If your child does not respond to a second SSRI, non-SSRI antidepressants are then considered.

Once my child is well, how long do they need to continue taking medication?

If your child responds to treatment with an antidepressant, which is when depressive symptoms are reduced by 50% or more, it is recommended that they continue taking antidepressants for 6–12 months after achieving this response. Youth who don't continue treatment, especially if they still have leftover symptoms, are at increased risk of sinking back into depression.

Six to 12 months after responding to treatment, stopping antidepressants medication may be the right choice for some youth. Stopping antidepressant treatment should be done only under the care and monitoring of your child's doctor. Youth who stop taking antidepressants should be reassessed by their doctor within 1–2 weeks to check for any withdrawal effects and/or return of depressive symptoms.

Psychosocial Treatments for Depression

What treatments other than medication are available to help my child's depression?

There is a great deal of scientific support showing the effectiveness of psychosocial treatments for youth with depression. Cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), and attachment-based family therapy are several examples.

Cognitive-behavioral Therapy

CBT is the most widely studied psychotherapy for the treatment of youth with depression. CBT is a form of psychotherapy that targets thoughts and behaviors that are related to mood. The individual is taught to identify patterns of thinking and behavior that add to their depressed mood. CBT may be used as a form of treatment by itself, or it can be combined with antidepressant medication. There is some evidence that CBT is most effective when combined with antidepressant therapy, particularly for adolescents with more severe depression or in those with treatment-resistant depression. Pediatric guidelines say that CBT alone may be an appropriate first-line treatment for those with mild depression.

Interpersonal Psychotherapy

Although there are fewer clinical trials of IPT compared with CBT, IPT is a well-established intervention in adolescents. IPT works by focusing on improving relationships with friends and family, increasing social support, and improving problem-solving skills.

Family-based Treatment

Studies involving family therapy are more difficult to evaluate because of the diversity of interventions. However, one treatment model—attachment-based family therapy—has been manualized, meaning that therapists follow the same process, and it has been shown to be effective in studies. This intervention, which promotes family alliances and connection, builds on family strengths and also improves the adolescent's success outside of the home.

Dialectical Behavior Therapy

DBT, originally developed in adults, has recently been adapted for adolescents. It has been proven to be effective in treating moderate to severe depression and co-occurring disorders, along with self-harm and suicidal behaviors. It was originally based on CBT but it also includes strategies for controlling emotions and handling stressful situations.

Supplementary Interventions

Other work has focused on using high-dose exercise programs to reduce depressive symptoms, improve mood, and reduce relapse into depression. Studies have shown that exercise can be an effective way to treat depression. Furthermore, interventions that improve sleep can also be used to improve depressive symptoms. Motivational interviewing strategies can be used to improve adolescents' participation with all interventions and improve their desire to stick with the treatment program.

Although there is little research to support its use to treat depression in children and adolescents, psychodynamic psychotherapy may be a helpful part of an individualized treatment plan for some youth.

Promoting wellness and emotional resilience, not just reducing depressive symptoms, is an overall goal of positive mental health. Strategies focus on youth participating in activities that develop self-confidence or a sense of purpose, increase feeling connected with other people, and foster gratitude or willingness to help others.

Promoting wellness and emotional resilience, not just reducing depressive symptoms, is an overall goal of positive mental health.

Other and/or Unproven Treatments for Depression

Several herbal supplements on the market (eg, St John's Wort, etc.) may claim to treat symptoms of depression; however, it is important to understand that there is little scientific research showing that these supplements work in treating depression. In addition, these supplements are not regulated by the FDA or any other agency. If you are considering giving your child herbal supplements, always check with the doctor as supplements may interact with prescribed medications.

There are treatments for MDD in youth that are currently being studied under the oversight of the FDA, including esketamine and transcranial magnetic stimulation (TMS). These treatments may or may not be available in your area. Youth who do not improve clinically during other stages of treatment may be candidates for such interventions. Before starting new or investigational treatment, your child's doctor may consider conducting a reassessment to determine whether the initial diagnosis was correct, evaluate whether there are ongoing or unrecognized comorbid disorders, and assess how well psychosocial interventions are being implemented.

Several herbal supplements on the market (eg, St John's Wort, etc.) may claim to treat symptoms of depression; however, it is important to understand that there is little scientific research showing that these supplements work in treating depression.

Helping the Depressed Child

What is my role in my child's treatment?

Provide Support and Reduce Stress

It is important to remember that depression is an illness, and you will need to provide support, avoid blame, and reduce as much stress as possible for your child. It will be necessary to work with your child to review their current schedule and/or activities to determine what might need to be adjusted. It may be necessary to modify your expectations for your child, at least until symptoms improve. When disciplining or punishing your child, don't deny them access to things that make them happy or help them cope (eg, don't take away access to friends or extracurricular activities, if possible). As needed, work with and involve school professionals to adjust academic workloads, pace, and expectations. Communicate to the teachers and other school staff that your child suffers from mental health challenges and that from time to time they may require special accommodations for learning and/or interaction with peers. Assumptions about what your child can manage in school, based only on periods of good moods (also known as euthymia), should be strongly avoided.

Help Teenagers Practice New Skills and New Ways of Thinking

It is important to be involved in your child's treatment. This includes knowing the new skills/strategies that your child is learning in treatment. Parents can help to model these skills at home and point out opportunities to practice and apply them in the home setting. Some therapists envision the parents' role as serving as a "coach" to help with learning these strategies and extending them to other settings.

Reduce Negative Emotion in the Home (Sarcasm, Criticism)

Having family members in the home who suffer from depression can be challenging. It is important to avoid criticism and blame. While your child is depressed you may consider calling a truce on "hot topics" or subjects that can lead to high conflict and disagreement. Finding activities that the family can do together to promote positive emotions and increase activity level can be helpful. Parents may seek out parent psychoeducation or couples therapy, and you may check to see whether parent coaching is available in the community. The National Alliance on Mental Illness (NAMI), Depression and Bipolar Support Alliance (DBSA), and other mental health organizations offer a variety of options for support and information. Because childhood or adolescent depression affects the whole household, all family members can benefit from supportive treatment.

Develop Communication Strategies

When there is conflict and when emotions are high, developing a solid communication plan is recommended. An "exit and wait" strategy to allow family members to gain control of their emotions can help to manage difficult communication and conflict.

Participate in Safety Plan; Keep Environment Safe

A safety plan that includes strategies for managing mood, getting support, and knowing when to get professional help is important. In addition, making the environment safe by removing all access to dangerous tools, such as medications, knives or other blades, weapons, and firearms, is an essential part of treating youth with depression.

Monitoring Social Media, Peer Influence, Social Stress

Youth who are depressed can be especially vulnerable to social media and conflict with peers. Teenagers may see others as having more friends or more fun than themselves, which may make them feel even more excluded or not liked by others. Constantly checking social media sites to make sure that they haven't been left out can be a source of stress for youth. Parents need to be vigilant and aware of the impact of social media and peers on their child. Protective monitoring, such as having guidelines and rules for using technology, is important. Technological tools, such as parental control software, to control and monitor use of media are more and more available and may be needed for youth who are negatively affected by social media and/or cyberaggression or cyberbullying by their peers.

Is there anything else that I can do to help my child?

It's important for parents and caregivers to practice self-care. Find support and learn more about what's going on with your child so that you can be as effective as possible in helping them get the care they need. The National Alliance on Mental Illness (NAMI), Depression and Bipolar Support Alliance (DBSA), and other mental health organizations offer a variety of options for support and information. Depression tends to run in families, so it's important to know that if anyone else in the family is experiencing symptoms of depression, they need to also seek treatment.

Resources

- American Academy of Child & Adolescent Psychiatry (AACAP) https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx
- National Alliance on Mental Illness (NAMI) https://www.nami.org/Find-Support/Family-Members-and-Caregivers
- Depression and Bipolar Support Alliance (DBSA) http://www.dbsalliance.org/site/PageServer?pagename=home
- National Institute of Mental Health (NIMH) https://www.nimh.nih.gov/health/publications/teen-depression/index.shtml

  https://www.nimh.nih.gov/health/publications/depression-what-you-need-to-know/index.shtml
- Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/childrensmentalhealth/depression.html

Author Disclosures

MEREDITH CHAPMAN, MD
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MINA K. DULCAN, MD
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GRAHAM J. EMSLIE, MD
Professor, Chief of the Division of Child and Adolescent Psychiatry, University of Texas Southwestern Medical Center

Chief of Service, Children's Medical Center

Advisor/Consultant: Assurex Health, Inc.; Syneos Health; Lundbeck; Otsuka America Pharmaceutical, Inc.

Research Funding: Duke University, Forest Research Institute, Inc.

CATHRYN A. GALANTER, MD
Training Director, Child and Adolescent Psychiatry, SUNY Downstate/Kings County Hospital

Advisor/Consultant: The REACH Institute

Books/Intellectual Property: American Psychiatric Association Publishing

JESSICA M. JONES, MA, LPA
No disclosures to report

BETH KENNARD, PSYD
Program Director, Clinical Psychology Graduate Program, University of Texas Southwestern Medical Center

School of Health Professions Promotion and Tenure Committee, University of Texas Southwestern Medical Center

Vice Protocol Chair, CBT Expert–IMPAACT

Board of Directors, Jerry M. Lewis, MD, Research Foundation

Royalties: Guilford Press

THEODORE A. PETTI, MD, MPH
President, American Society for Adolescent Psychiatry

ADELAIDE S. ROBB, MD
Advisor/Consultant: Allergan, Inc.; Bracket Global; Ironshore Pharmaceuticals Inc.; Lundbeck; Aevi Genomic Medicine, Inc.; Neuronetics; National Institute of Mental Health; Rhodes Pharmaceuticals; Sunovion Pharmaceuticals, Inc.; Tris Pharma; University of Cambridge

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Stock in IRA: Eli Lilly and Company; GlaxoSmithKline; Johnson & Johnson Services, Inc.; Pfizer Inc.

TIMOTHY E. WILENS, MD
Chief, Child and Adolescent Psychiatry Department

Co-director, Center for Addiction Medicine

Massachusetts General Hospital

Advisor/Consultant: Euthymics Bioscience; Neurovance; Otsuka America Pharmaceutical, Inc.; National Institute on Drug Abuse; Ironshore Pharmaceuticals Inc.; Alcobra Ltd.; US National Football League (ERM Associates); US Minor/Major League Baseball; Bay Cove Human Services; Phoenix House and Gavin Foundation

Books/Intellectual Property: Guilford Press; Cambridge University Press; Elsevier

Co-owner of a copyrighted diagnostic questionnaire: Before School Functioning Questionnaire (BSFQ)

Licensing agreement: Ironshore Pharmaceuticals Inc.

Research Funding: National Institute on Drug Abuse

Medication Tracking Form

Use this form to track your child's medication history. Bring this form to appointments with your provider and update changes in medications, doses, side effects and results.

Date	Medication	Dose	Side Effects	Reason for keeping/stopping

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PSYCHIATRY

WWW.AACAP.ORG

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Additional Resources for Depression

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Bipolar-Disorder-In-Children-And-Teens-038.aspx

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Depressed-Child-004.aspx

Putting Evidence Into Practice: Proven Approaches for Pediatric Anxiety and Trauma Related Disorders

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Jessica Hawks, PhD
Child & Adolescent Psychologist
Francescon Family Endowed Chair for Mood Disorders
Chief of Psychology, Pediatric Mental Health Institute, Children's Hospital Colorado
Associate Professor, Division of Child & Adolescent Psychiatry, CU School of Medicine

Disclosures

- I have no relevant financial disclosures with any ineligible companies.

Learning Objectives

1. Identify symptoms of anxiety related clinical concerns in youth
2. Understand the anxious-avoidance cycle and how it perpetuates anxiety
3. Summarize two evidence-based techniques/interventions for treating anxiety and trauma related disorders in youth

Anxiety

A normal reaction to stress or difficult times like paying bills, a breakup, landing or losing a job

A case of nerves or sweating before a big test or performance

Has a starting and ending point

Relaxing or breathing techniques often help you feel better

Lessens significantly when the stressful situation is over

Anxiety Disorder

Constant and unsubstantiated worry that causes significant distress

Disproportionate emotional response

Ongoing - lasts weeks or months

Interferes with daily life

Irrational fear or avoidance of an object, place or situation that poses little to no threat of danger

Feels impossible to control or manage

Normal Anxiety *These behaviors are typical and manageable*	Concerning Anxiety *These behaviors may need professional support*
✓ Nervous about first day of school but still gets on the bus	⚠ Fakes sick to avoid school or has meltdown every Sunday night
✓ Brief clinginess at drop-off that improves over 2-3 weeks	⚠ Intense distress at drop-off continuing for months
✓ Worried about a test, so studies harder	⚠ Physical symptoms (stomachaches, headaches) with no medical cause
✓ Occasional "what if" questions about upcoming events	⚠ Avoidance getting worse instead of better over time
✓ Some resistance to new situations but eventually participates	⚠ Can't function in daily activities due to worry

Anxiety presents itself in many different ways...

www.thepathway2success.com

DSM-5 Anxiety Disorders

Disorder	Source of Threat	Common Presentation
Separation anxiety disorder	Excessive fear or anxiety about losing major attachment figures or persistent worry about an untoward event (e.g. getting kidnapped, getting lost) that will cause separation from major attachment figures	Co-sleeps; follows caregiver around the home; avoids being in separate room from caregiver; repeatedly calls caregiver when separated; avoids school, camp, and other activities requiring separation
Social anxiety disorder	Fear of humiliation or embarrassment in situations involving performance or scrutiny by others	Avoids raising hand or speaking in class; avoids eye contact; avoids ordering food in restaurants; avoids talking on the phone, texting, or e-mailing peers; refuses to initiate conversations with peers
Panic disorder	Fear if recurrent panic attacks or their consequences (e.g. “going crazy,” “dying,” “losing control”)	Avoids places where panic attacks have occurred before; avoids activities that create strong physical sensations (e.g. heavy exercise)
Agoraphobia	Fear of places where immediate escape may be embarrassing or difficult or help not available	Avoids leaving home or relies on adult to leave home; avoids crowded and enclosed spaces
Specific phobia	Marked fear or anxiety about a subject or situation (e.g. animals, natural environment, needles, transportation)	Has intense fear and avoidance of insects, animals, storms, blood, needles, medical procedures, subways, planes or buses
Generalized anxiety disorder	General feeling of dread or unease associated with the perception of uncontrollability and unpredictability about a number of events or activities such as school performance, health, financial matters or family problems	Constantly seeks reassurance; has disrupted sleep, fatigue, irritability, restlessness, and/or difficulty focusing due to worries

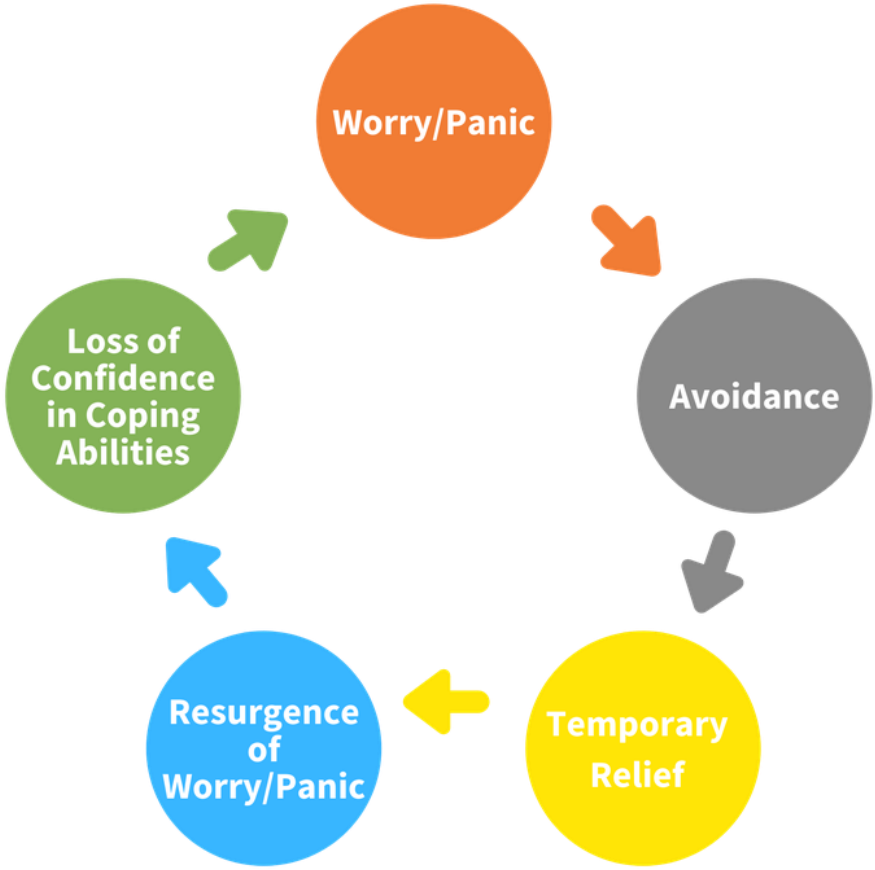
DSM-5 Obsessive and Compulsive Related Disorders

Disorder	Source of Threat	Common Presentation
Obsessive-compulsive disorder	Fear or intrusive and unwanted thoughts, urges, or images	Constantly worries about dirt or germs; fears harm or danger to a loved one or to self; practices ritualized washing; arranges or orders objects; repeats, rereads or rewrites; checks and rechecks; counts objects such as number of steps

DSM-5 Trauma and Stressor Related Disorders

Disorder	Source of Threat	Common Presentation
Trauma-and Stressor-Related Disorders	Exposure to a stressful, traumatic, overwhelming, or frightening experience	Various manifestations of re-experiencing the trauma (re-enactment, intrusive images/thoughts, distress at reminders); avoidance; negative mood/cognitions (restricted positive affect, withdrawal, distorted blame); hyperarousal (hypervigilance, difficulty concentration) irritability, reckless behavior)

Anxious-Avoidance Cycle



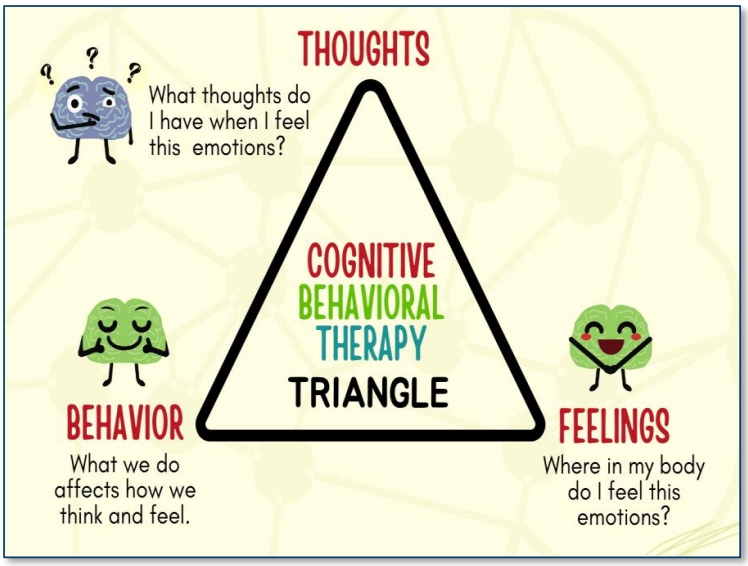
Cognitive Behavioral Therapy

- First line treatment for pediatric anxiety disorders
  - Psychoeducation
  - Emotional Awareness Training
  - Cognitive Flexibility
  - ***Exposures are the key active ingredient***

- Medication Management
  - If patient does not adequately response to psychotherapy alone
  - Moderate to severe symptoms and functional impairment

Psychoeducation

- Normalize anxiety
- Overview of CBT model
- Provide rationale for treatment
- Set clear expectations
  - Parent involvement (ideally)
  - In-session activities
  - Homework



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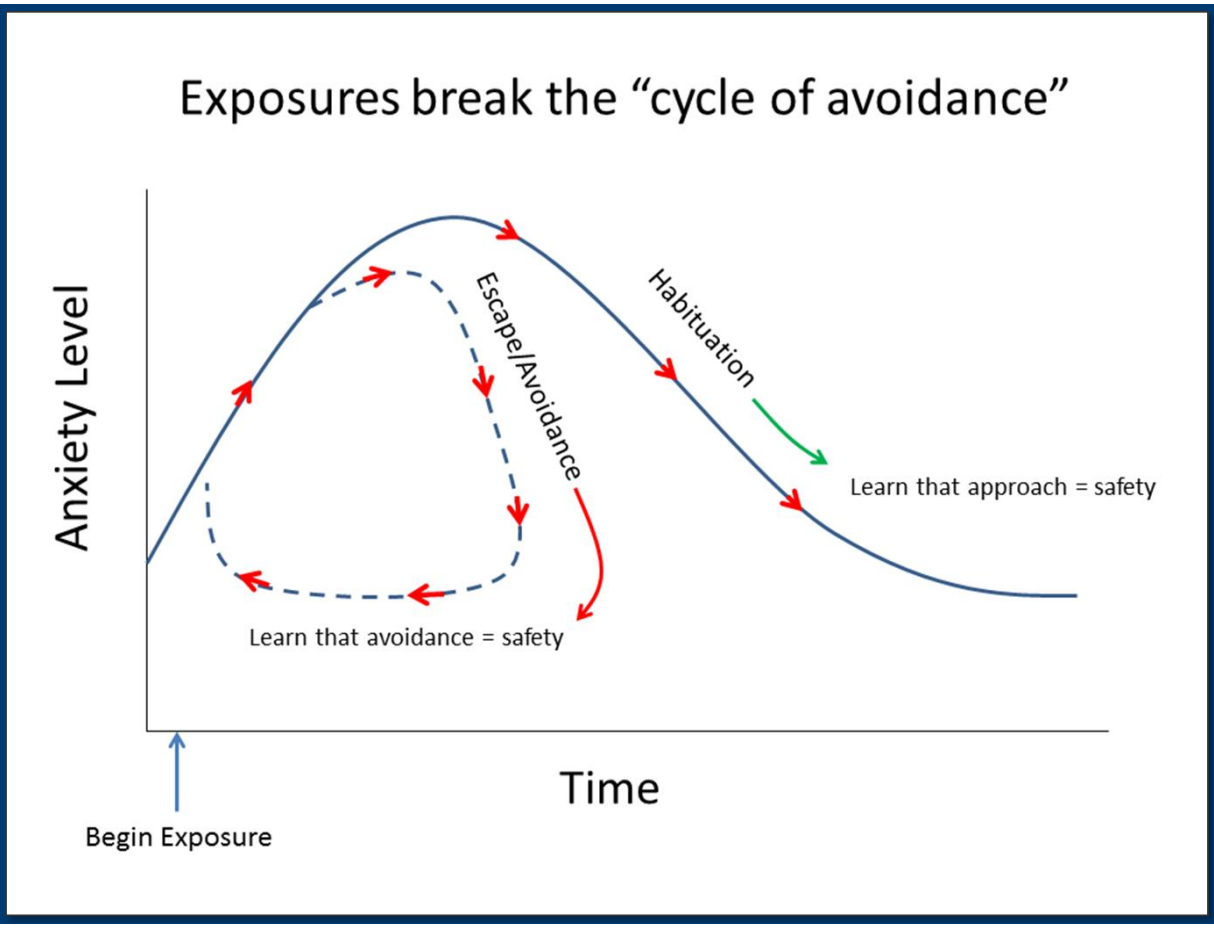


Building Insight Into Emotional Experiences

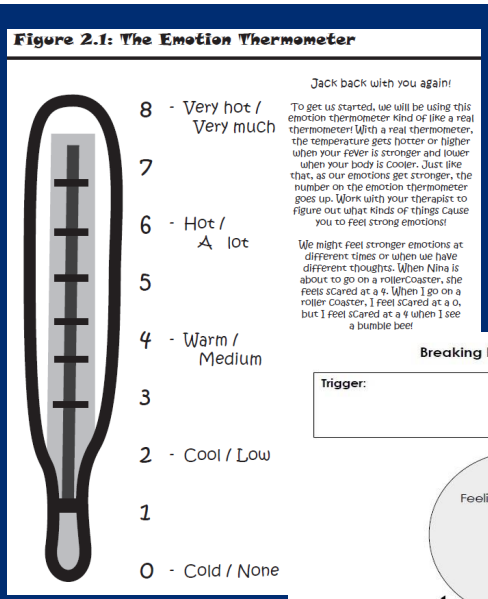
Tracking the Before, During and After

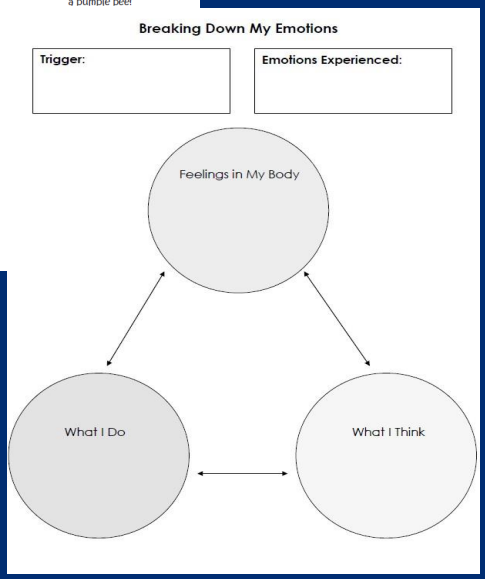
Each day, you will be asked to track the Before, During and After of your emotional experiences. In order to change your emotional experiences, it is important that you understand the patterns that may occur (e.g., what triggers your emotional experiences, what happens as a result of your emotional experiences). This form will help you understand these patterns. By keeping this form and referring back to it later, you will start to see how changing one part of the pattern can change everything. An example is provided.

What happened Before? (What was the trigger?)	What happened During? (What was your emotional response to the trigger?)			What happened After? (What were the consequences of your emotional responses?)	
	Thoughts	Feelings	Behaviors	Short Term	Long Term
Argument with my parents	They don't trust me I'm not allowed to do anything	Felt tense, warm, and agitated	Yelled, slammed my door, refused to come out of my room all night	Felt good to tell my parents how I felt; was still really angry	Things are still really tense, didn't get what I wanted

Emotional Awareness

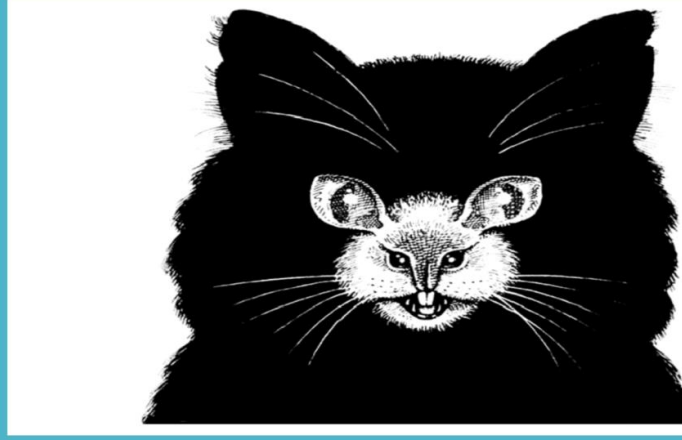
- 3 N's of emotions
- Function of emotions – they're just information!
- Understanding emotional experiences
- Identify and rate intensity of different emotions
- Relaxation vs Mindfulness





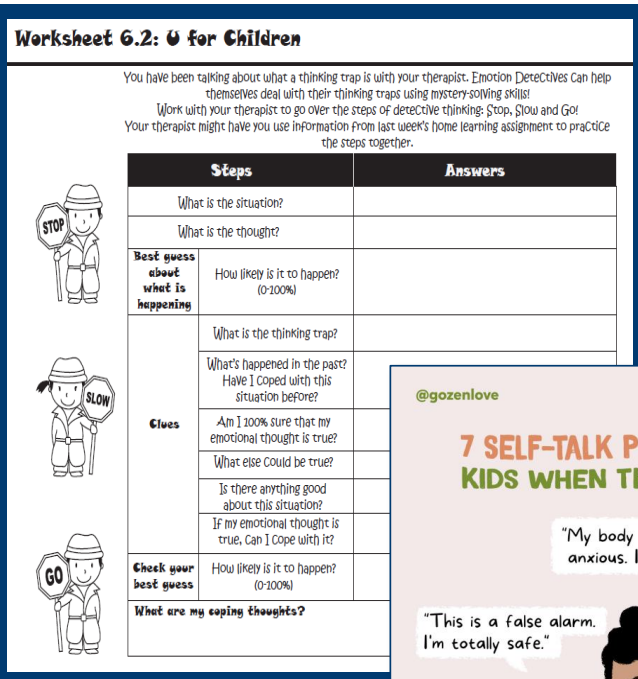
Cognitive Flexibility

- Automatic Thoughts
- Thinking Traps
- Flexible Thinking



Cognitive Flexibility

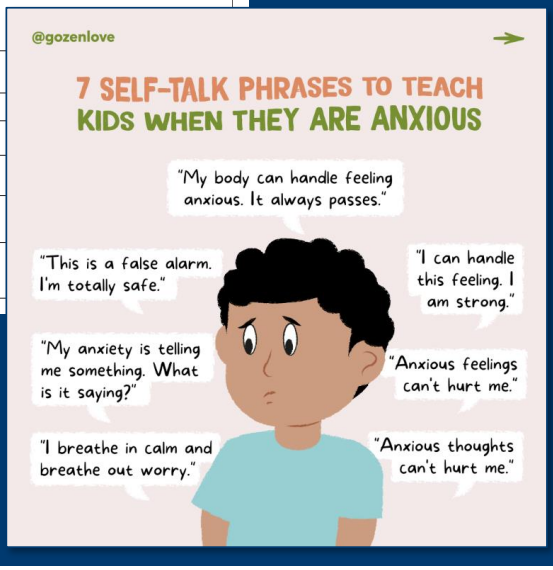
- Detective Thinking
  - Stop – Slow – Go
- Problem Solving
  - Define
  - Brainstorm
    - Hot headed vs cool headed
  - Rate
  - Act



Worksheet 6.2: 🕵 for Children

You have been talking about what a thinking trap is with your therapist. Emotion Detectives can help themselves deal with their thinking traps using mystery-solving skills!
Work with your therapist to go over the steps of detective thinking: Stop, Slow and Go!
Your therapist might have you use information from last week's home learning assignment to practice the steps together.

Steps		Answers
What is the situation?		
What is the thought?		
Best guess about what is happening	How likely is it to happen? (0-100%)	
Clues	What is the thinking trap?	
	What's happened in the past? Have I coped with this situation before?	
	Am I 100% sure that my emotional thought is true?	
	What else could be true?	
	Is there anything good about this situation?	
	If my emotional thought is true, Can I Cope with it?	
Check your best guess	How likely is it to happen? (0-100%)	
What are my coping thoughts?		



Exposures

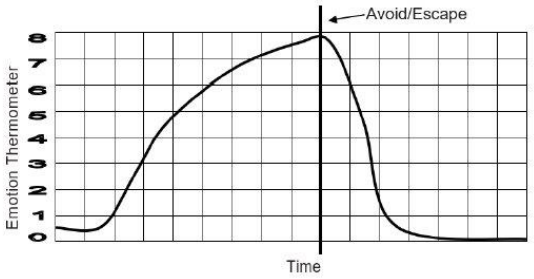
- ***Most impactful*** component of treatment
- Disrupts the anxious-avoidance cycle
- Gradual facing of fears in a supported way
  - Traditional Model: Habituation. SUDS should decrease by half
  - Inhibitory Learning Model: Teach youth to **tolerate** fear and teach their brain/bodies they are safe. Habituation less important.

Figure 9.1: Learning About Exposures

These pictures help us Emotion Detectives understand why it is important to experience our feelings, even with strong emotions.

We will use the example of Jack being afraid of dogs to explain how we can face tough situations and help ourselves feel better over time!

Emotion Curve: Avoidance/Escape



Look at this picture. This pattern might happen if Jack sees a dog, is very afraid of dogs, and runs away when he feels very scared. This running away makes his level of fear on the Emotion Thermometer go down fast, which feels good in the here and now. But running away when we are scared may get us further stuck in the cycle of avoidance and make us feel more scared in the long run.

Exposure Examples

- Types of Exposures: Imaginal; In-Vivo (situational); Interoceptive (Sensational); Response Prevention*

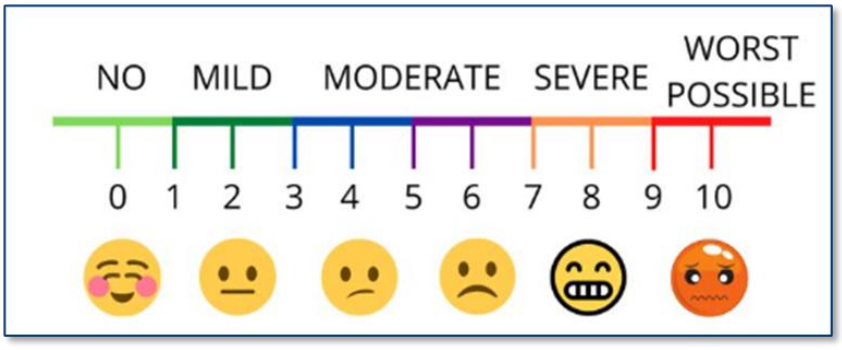
- Specific Phobia
  - Feared object
- Separation Anxiety
  - Separation from caregivers
- Panic Disorder/Agoraphobia
  - Avoided situations; Body sensations felt during panic
- Social Anxiety Disorder
  - Social situations (inducing embarrassment/judgment)
- Generalized Anxiety Disorder
  - Based on the worries (perfectionism, safety)

Maximizing Exposure Effectiveness

- Violate expectations/beliefs (did what you feared happen?)
- Break away from the hierarchy – vary the intensity of the exposures
- Multiple contexts
- Combine exposures together (e.g., sensational and situational)
- Check in and ask youth to report how they feel (reduce distraction/avoidance)
- Reduce safety behaviors
- Practice seeking out negative outcomes to promote learning to cope

Conducting Exposures

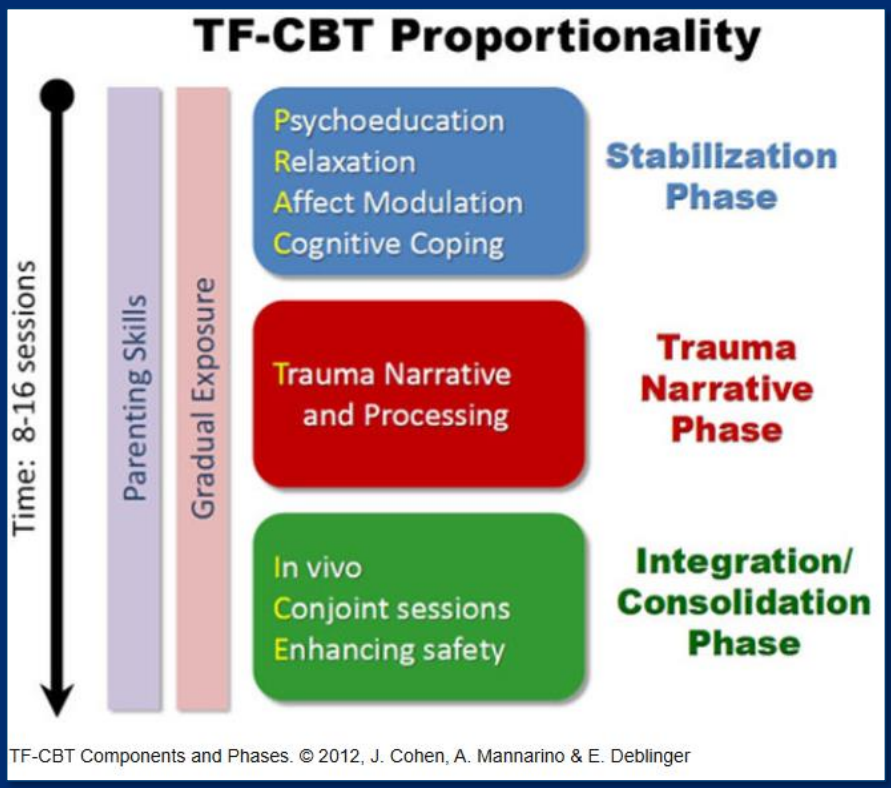
- Before
  - Ask youth to identify how they expect to feel and what they expect to happen
  - Rate distress (e.g., SUDS)
  - **Don't have a big discussion about it (can be avoidance tactic for both the youth and the therapist) - just do it!**
- During
  - Monitor and track the youth's responses throughout (e.g., SUDS ratings)
  - Support youth in experiencing emotion during exposure. Discourage safety/avoidant behaviors.



Conducting Exposures (cont)

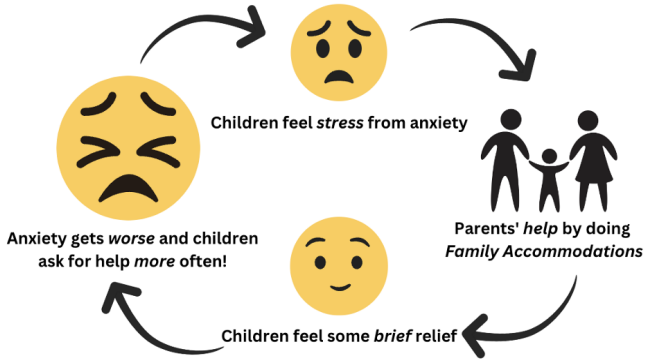
- After
  - Important to debrief!
    - Did what they expect to happen occur?
    - Anything that surprised them?
    - Did they learn anything new about the situation or their behavior?
    - When was their emotion level highest? What happened over the course of the exposure? What about after the exposure?
  - Did habituation occur? If not, discuss this with the youth to ensure they don't catastrophize this outcome.

Trauma and Stressor Related Disorders



Critical Role of Parents/Caregivers

- Reduce accommodation at home
  - Not reinforce safety behaviors
- Support use of strategies at home, school, and community
- Facilitate exposures
- Partner with the school
- Praise effort
- Model helpful behaviors



Questions?

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Book Recommendations for Anxiety and OCD

Dr. Lee and Dr. Mullin

Title	Age	Author	Publisher	Year	Synopsis
A Perfectly Messed-Up Story	2-7	Patrick McDonnell	Little Brown Books for Young Readers	2014	A hilarious, delightful book with a story that breaks the "fourth wall" and talks directly to the audience. This book discusses perfectionism in a very non-threatening manner.
When My Worries Get Too Big! A Relaxation Book for Children Who Live with Anxiety	4-8	Kari Dr. Buron	Autism Asperger Publishing Company	2006	A book placing anxiety on a scale of 1 to 5, pushing children to think about what makes them anxious and what it feels like at different degrees.
Wilma Jean the Worry Machine	6-12	Julia Cook	National Center for Youth Issues	2011	Wilma Jean worries too much about everything. She worries so much that she feels sick. But when she goes to school, she discovers that the things that she worries about seem to work themselves out. Her teachers help her feel more in control and this allows her worries not to bother her so much.
What to Do When You Worry Too Much	6-12	Dawn Huebner	Magination Press	2005	Lively metaphors and humorous illustrations make concepts and strategies easy to understand, while clear how-to steps and prompts to draw and write help children to master new skills related to reducing anxiety.
What to Do When Your Brain Gets Stuck: A Kid's Guide to Overcoming OCD	6-12	Dawn Huebner	Magination Press	2007	With engaging examples, activities, and step-by-step instructions, it helps children master the skills needed to break free from OCD's sticky thoughts and urges, and live happier lives.
What to Do When Good Enough Isn't Good Enough…	9-13	Thomas Greenspon	Free Spirit Publishing	2007	A self-help book for children and young adolescents whose perfectionism causes them to be their own worst enemies.

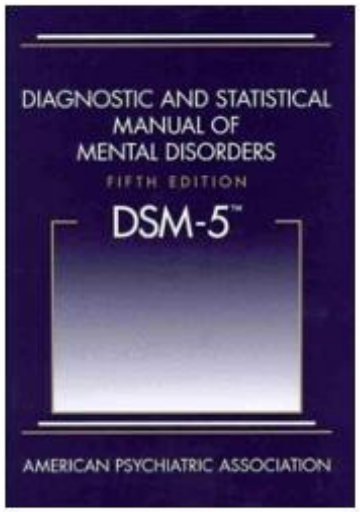
The Real Deal on Perfectionism					
Stuff that Sucks: A Teen's Guide to Accepting What You Can't Change and Committing to What You Can	13 and up	Ben Sedley	Instant Help	2017	Offers a compassionate and validating guide to accepting emotions, rather than struggling against them.
Stuff That's Loud: A Teen's Guide to Unspiraling When OCD Gets Noisy	13 and up	Ben Sedley Lisa W. Coyne	Instant Help	2017	While OCD can be difficult, you do not have to let it have power over you. Instead, you can live a life full of meaning, great relationships and joy.
Your Life, Your Way: Acceptance and Commitment Therapy Skills to Help Teens Manage Emotions and Build Resilience	13 and up	Joseph V. Ciarrochi Louise L. Hayes	Instant Help	2020	Readers will learn how to deal with all the changes and challenges of the tee years- and grow into the person that they want to be.
Getting Comfortable with Uncertainty for Teens: 10 Tips to Overcome Anxiety, Fear, and Worry	13 and up	Juliana Negreiros Katherine Martinez	Instant Help	2022	Learn to manage fears, live with confidence, and make a positive impact. Gain greater understanding of how uncertainty can trigger feelings of anxiety, worry, and self-doubt.
Breaking Free of Child Anxiety and OCD: A Scientifically Proven Program for Parents	Parents	Eli R. Lebowitz	Oxford University Press	2021	A completely parent-based treatment program for child and adolescent anxiety.

You and Your Anxious Child: Free Your Child from Fears and Worries and Create a Joyful Family Life	Parents	Anne Marie Albano Leslie Pepper	Avery	2013	Differentiates between separation anxiety, generalized anxiety, and social phobia, and guides parents on when and how to seek intervention.
Helping Your Anxious Child: A Step-by-Step Guide for Parents	Parents	Ronald Rapee Ann Wignall Susan Spence Vanessa Cobham Heidi Lyneham	New Harbinger Publications	2022	Includes the latest research and techniques for managing child anxiety and includes information on helping very young children and adolescents.

ANXIETY

• Anxiety Disorders •

Anxiety disorders are the most common psychiatric disorders diagnosed in childhood and adolescence. 7.1% of children aged 3-17 years (approximately 4.4 million) have diagnosed anxiety. For children aged 3-17 years with anxiety, more than 1 in 3 also have behavior problems (37.9%) and about 1 in 3 also have depression (32.3%).[1,2]



DSM-5 Anxiety Disorders

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder/Panic Attack
- Generalized Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition

Screening

CoPPCAP recommends pediatric providers use narrowband screening measures to further detect symptoms of anxiety if concerns arise from initial broadband screening. Narrowband anxiety screening forms can be utilized beyond initial screening efforts to track response to intervention 1-2 weeks after starting therapy/medication, to guide dose changes, and routinely every 6 months even when stable medication dose is achieved to monitor symptoms. Additionally, when tracking response to treatment intervention, consider use of the same screening form used at baseline prior to diagnosis.

AUTHORS:
Ryan Asherin, PhD, & Sandra Fritsch, MD

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
Anxiety	Screen for Child Anxiety Related Disorders 8 - 18 years Caregiver Report Self Report	SCARED ⇒ English ⇒ Spanish	The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder, and social phobia. In addition, it assesses symptoms related to school phobias.
Anxiety	Spence Children's Anxiety Scale preschool version 2.5 - 6.5 years child version 8 – 15 years Self-Report Caregiver Report	SCAS ⇒ English ⇒ Spanish	The Spence Children's Anxiety Scale (SCAS) is a psychological questionnaire designed to identify symptoms of various anxiety disorders, specifically social phobia, obsessive-compulsive disorder, panic disorder/agoraphobia, and other forms of anxiety, in children and adolescents between ages 8 and 15. Developed by Susan H. Spence and available in various languages, the 45 question test can be filled out by the child or by the parent. There is also another 34 question version of the test specialized for children in preschool between ages 2.5 and 6.5. Any form of the test takes approximately 5 to 10 minutes to complete.
Anxiety	Generalised Anxiety Disorder Assessment 14+ years Self Report	GAD-7 ⇒ English ⇒ Spanish	The Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item instrument that is used to measure or assess the severity of generalised anxiety disorder (GAD). Each item asks the individual to rate the severity of his or her symptoms over the past two weeks.

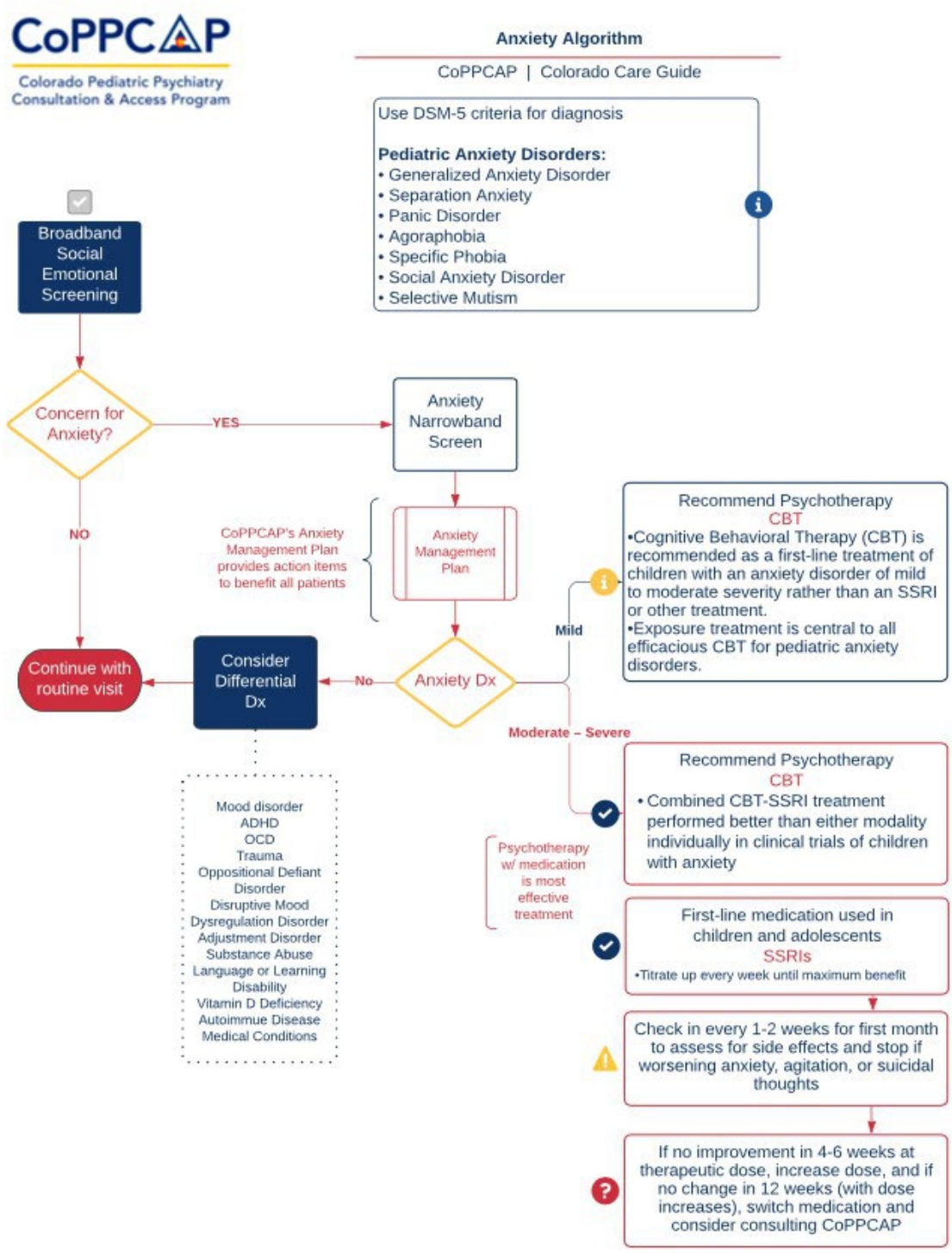
Anxiety Disorders

According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the Anxiety Disorders category consists of nine separate diagnoses, with Obsessive-Compulsive Disorders and Trauma and Stressor-Related Disorders identified as distinct categories.

Anxiety Disorder	Brief Description	ICD Code
Generalized Anxiety Disorder	Generalized anxiety disorder involves persistent and excessive worry that interferes with daily activities. This ongoing worry and tension may be accompanied by physical symptoms, such as restlessness, feeling on edge or easily fatigued, difficulty concentrating, muscle tension or problems sleeping. Often the worries focus on everyday things such as job responsibilities, family health or minor matters such as chores, car repairs, or appointments.	F41. 1

Separation Anxiety	A person with separation anxiety disorder is excessively fearful or anxious about separation from those with whom he or she is attached. The feeling is beyond what is appropriate for the person's age, persists (at least four weeks in children and six months in adults) and causes problems functioning. A person with separation anxiety disorder may be persistently worried about losing the person closest to him or her, may be reluctant or refuse to go out or sleep away from home or without that person, or may experience nightmares about separation.	F93.0
Panic Disorder	The core symptom of panic disorder is recurrent panic attacks, an overwhelming combination of physical and psychological distress. During an attack several of these symptoms occur in combination: Palpitations, pounding heart or rapid heart rate Sweating Trembling or shaking Feeling of shortness of breath or smothering sensations Chest pain Feeling dizzy, light-headed, or faint Feeling of choking Numbness or tingling Chills or hot flashes Nausea or abdominal pains Feeling detached Fear of losing control Fear of dying Sense of impending doom Because the symptoms are so severe, many people who experience a panic attack may believe they are having a heart attack or other life-threatening illness. They may go to a hospital emergency department. There may be identifiable triggers for panic attacks, including fear of subsequent panic attacks. The mean age for onset of panic disorder is 20-24. Panic attacks may occur with other mental disorders such as depression or PTSD.	F41.0
Agoraphobia	Agoraphobia is the fear of being in situations where escape may be difficult or embarrassing, or help might not be available in the event of panic symptoms. The fear is out of proportion to the actual situation and lasts generally six months or more and causes problems in functioning. A person with agoraphobia experiences this fear in two or more of the following situations: Using public transportation Being in open spaces Being in enclosed places Standing in line or being in a crowd Being outside the home alone The individual actively avoids the situation, requires a companion, or endures with intense fear or anxiety. Untreated agoraphobia can become so serious that a person may be unable to leave the house. A person can only be diagnosed with agoraphobia if the fear is intensely upsetting, or if it significantly interferes with normal daily activities.	F40.00

Specific Phobia	A specific phobia is excessive and persistent fear of a specific object, situation or activity that is generally not harmful. Patients know their fear is excessive, but they can't overcome it. These fears cause such distress that some people go to extreme lengths to avoid what they fear. Examples are public speaking, fear of flying, or fear of spiders.	F40.2
Social Anxiety Disorder	A person with social anxiety disorder has significant anxiety and discomfort about being embarrassed, humiliated, rejected or looked down on in social interactions. People with this disorder will try to avoid the situation or endure it with great anxiety. Common examples are extreme fear of public speaking, meeting new people or eating/drinking in public. The fear or anxiety causes problems with daily functioning and lasts at least six months.	F40.11
Selective Mutism	Consistent failure to speak in social situations in which there is an expectation to speak even though the individual speaks in other situations.	F94.0



click the algorithm above to enlarge

Options for Treatment: Psychotherapy

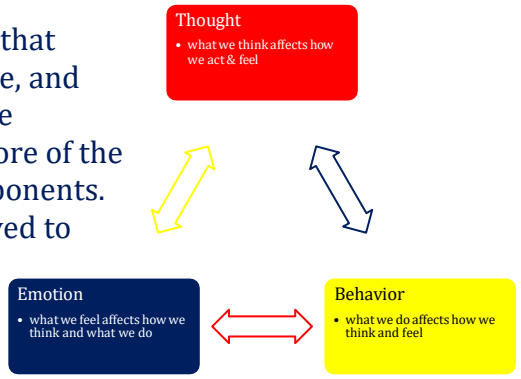
- Psychotherapy alone can be effective for mild to moderate anxiety. More severe anxiety is likely to require treatment with medication.
    - Consider importance of regulatory functioning with sleep, diet, and exercise when treating Anxiety

- If anxiety is not improving after six to twelve weeks of therapy, adding an adjunctive medication may be considered.

- **Cognitive Behavioral Therapy (CBT) is indicated for all the childhood anxiety disorders in children aged seven and older.**[3,4,5]

    - Exposure Therapy or Exposure Response Prevention (ERP) should be utilized as a CBT approach to effectively treat pediatric anxiety.
    - Children younger than seven may not possess the developmental abilities needed to understand and apply cognitive-behavioral strategies to their symptoms, but CBT has been adapted for delivery to parents of children with anxiety disorders, and for parents and children working together.[6]

- CBT conceptualizes anxiety as a tripartite construct that involves interaction between physiological, cognitive, and behavioral components. Change in one of these three components sets up a process of change in one or more of the other two. CBT includes several key treatment components. Each component targets mechanisms that are believed to maintain maladaptive anxiety:



    - Psychoeducation
    - somatic management skills
    - cognitive restructuring
    - exposure
        - exposure treatment is central to all efficacious CBT for pediatric anxiety disorders; this involves the child gradually but repeatedly experiencing the feared situation with the intent of reducing the associated anxiety, or learning to tolerate and manage normal, expected levels of anxiety.
    - relapse prevention
    - parental accommodation and family dynamics

Options for Treatment: Pharmacotherapy

- **CBT is always indicated as a first line treatment of pediatric anxiety**
- Medications are indicated for more moderate – severe forms of anxiety or in anxiety that has not responded to psychotherapy alone
- Approximately 55-65% of children and adolescents will respond to an initial antidepressant trial
- SSRIs are typically the first-line pharmacologic treatment in children and adolescent's serotonin-norepinephrine reuptake inhibitors (SNRIs) and tricyclic antidepressants have also shown efficacy in the treatment of pediatric anxiety disorders. Because they are associated with less easily tolerated side effects compared with SSRIs, these drugs are generally used second- or third- line.
- The most common side effects of SSRIs are gastrointestinal symptoms, headaches, agitation, sleep changes, irritability, motor restlessness (need to constantly move), and behavioral activation. These side effects are most likely to occur in the first 1-2 weeks after starting the medication, or when making dosage increases. Side effects experienced may be different based on individual medication.
- Concerning side effects of SSRIs include serotonin syndrome and increased suicidal thoughts.
    - When discussing antidepressant medications with families, always provide education about the FDA black box warning for increased suicidal thoughts when used in children and adolescents. This warning is based upon a 2004 review 24 clinical trials of children and adolescents who had been prescribed antidepressants. No suicides occurred in any of these studies, but 4 out of 100 children taking antidepressants reported suicidal thoughts or behaviors while 2 out of 100 children not on medication reported suicidal thoughts or behaviors. As a result, the FDA applied the black box warning for increased suicidal thoughts to all antidepressant medications.
- Frequent check ins are recommended during the first month to monitor for development of side effects or suicidal thoughts. Medication should be stopped if patient develops intolerable side effects or suicidal thoughts during this period.
    - Consider phone calls directly or via support staff to monitor mood and functioning weekly when first starting medication
- SSRIs can be titrated weekly, as tolerated, to a therapeutic dose (see depression medication chart below)
- Patients may have to take SSRIs for 4-6 weeks at an effective dose before experiencing any reduction in anxiety symptoms
    - If no benefit after 4-6 weeks, increase dose. If no benefit after 12 weeks, switch to a different medication.

- Patients should continue medication for 6-12 months following resolution of symptoms
- When discontinuing medications, taper slowly to minimize side effects (going down by the lowest titration increment every 1-2 weeks)

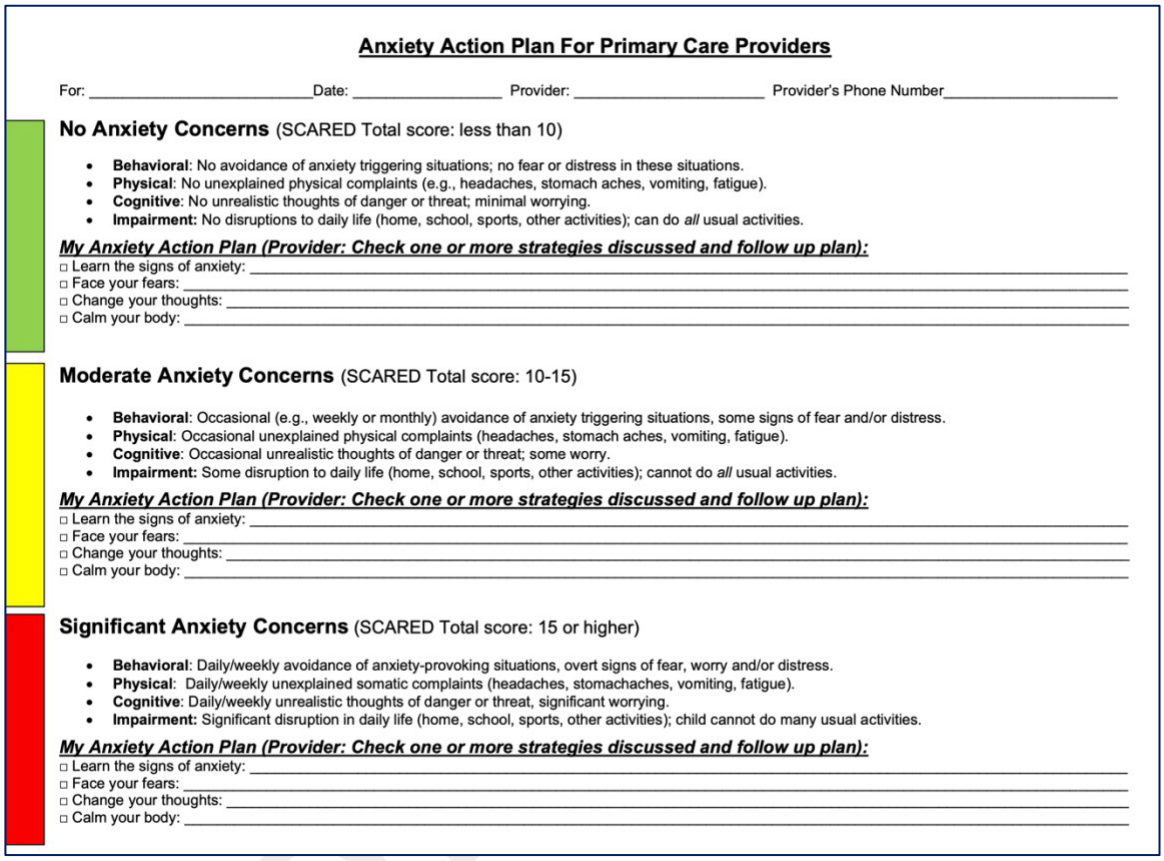
Anxiety Medications

Medications that may be used to treat anxiety disorders in children and adolescents						
Class	**Medication (Brand name)**	**Common dose range (mg/day)**	**Tablet size (mg)**	**Common side effects**	**Serious side effects**	**Uncommon, serious side effects**
SSRI	Citalopram/escitalopram (Celexa/Lexapro™)	10/5 - 40/20	10/5, 20/10, 40	• Headache • Insomnia • Diarrhea • Decreased appetite • Hyperactivity/restlessness • Vomiting • Increased anger/irritability • Sexual dysfunction • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Potential for abnormal heart rhythm • Mania	• Serotonin syndrome • Bleeding problems
	Fluvoxamine (Luvox™, Luvox CR™)	100 - 300	25, 50, 100, 150			
	Sertraline (Zoloft™)	25 - 200	25, 50, 100			
	Fluoxetine (Prozac™, Sarafem™)	10 - 60	10, 20, 40, 60			
	Paroxetine (Paxil™, Pexeva™)	10 - 50	10, 20, 40			
SNRI	Venlafaxine ER (Effexor™)	37.5 - 225	37.5, 75, 150, 225	• Sleepiness • Insomnia • Restlessness • Sexual dysfunction • Headache • Dry mouth • Increased anger/irritability • Increased blood pressure • Increased heart rate • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Mania	• Serotonin syndrome • Bleeding problems
	Duloxetine (Cymbalta™)	30 - 120	20, 30, 40, 60			
	Atomoxetine (Strattera™)	10 - 100	10, 18, 25, 40, 60, 80, 100			
Tricyclic antidepressant	Clomipramine (Anafranil™)	75 - 250	25, 50, 75	• Sleepiness • Dry mouth • Weight gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Heart rhythm problems; electrocardiogram and blood levels • Mania	• Serotonin syndrome
	Imipramine (Trofanil™, Trofranil-PM™)		10, 25, 50			
Benzodiazepine	Alprazolam (Xanax™, Alprazolam Intensol™)	0.5 - 1.5	0.25, 0.5, 1, 2	• Drowsiness • Clumsiness • Dry mouth • Dizziness • Abdominal pain	• Possible dependence • Withdrawal symptoms when used at high doses, especially when administered over long periods. Decreasing the dose gradually is a common strategy to decrease the risk of withdrawal symptoms. • Disinhibition • Memory impairment • Worsening depression	• Respiratory depression (possible at high doses and when combined with other central nervous system depressants)
Atypical anxiolytic	Buspirone (Buspar™)	15 - 60	5, 10, 15, 30	• Dizziness • Lightheadedness		

				• Tiredness		
Antihistamine	Diphenhydramine (Benadryl™, Banophen™, Diphenhist™)	12.5 – 50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• symptoms. • Abnormal heart rhythms • Agitation • Difficulty completely emptying the bladder • Harm to certain types of blood cells • Seizures	
	Doxylamine (Unisom™, WalSom™)	12.5 – 50	25, 50			
	Hydroxyzine (Atarax™)	25 – 50	10, 25, 50			

Anxiety Management Plan

CoPPCAP offers an Anxiety Management Plan for use in Primary Care settings to help provide psychoeducation & actionable items providers, caregivers, and patients can take after depression screening.



Anxiety Action Plan For Primary Care Providers

For: _____Date: _____ Provider: _____ Provider's Phone Number_____

No Anxiety Concerns (SCARED Total score: less than 10)

- **Behavioral**: No avoidance of anxiety triggering situations; no fear or distress in these situations.
- **Physical**: No unexplained physical complaints (e.g., headaches, stomach aches, vomiting, fatigue).
- **Cognitive**: No unrealistic thoughts of danger or threat; minimal worrying.
- **Impairment:** No disruptions to daily life (home, school, sports, other activities); can do *all* usual activities.

My Anxiety Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of anxiety: _____
□ Face your fears: _____
□ Change your thoughts: _____
□ Calm your body: _____

Moderate Anxiety Concerns (SCARED Total score: 10-15)

- **Behavioral**: Occasional (e.g., weekly or monthly) avoidance of anxiety triggering situations, some signs of fear and/or distress.
- **Physical**: Occasional unexplained physical complaints (headaches, stomach aches, vomiting, fatigue).
- **Cognitive**: Occasional unrealistic thoughts of danger or threat; some worry.
- **Impairment:** Some disruption to daily life (home, school, sports, other activities); cannot do *all* usual activities.

My Anxiety Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of anxiety: _____
□ Face your fears: _____
□ Change your thoughts: _____
□ Calm your body: _____

Significant Anxiety Concerns (SCARED Total score: 15 or higher)

- **Behavioral**: Daily/weekly avoidance of anxiety-provoking situations, overt signs of fear, worry and/or distress.
- **Physical**: Daily/weekly unexplained somatic complaints (headaches, stomachaches, vomiting, fatigue).
- **Cognitive**: Daily/weekly unrealistic thoughts of danger or threat, significant worrying.
- **Impairment:** Significant disruption in daily life (home, school, sports, other activities); child cannot do many usual activities.

My Anxiety Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of anxiety: _____
□ Face your fears: _____
□ Change your thoughts: _____
□ Calm your body: _____

click the image above to access the full Anxiety Management Plan
(used with permission from Gina Ginsburg, PhD)

Safety Assessment and Planning in Anxious Adolescents

- **Ask.** Providers and families should regularly ask about suicidal thoughts and behaviors.
- **Restrict means.** Providers should ask all families of anxious adolescents about access to potentially harmful items including firearms, other weapons, medications (prescription and over the counter), sharps objects like knives and razors, and items that could be used for strangulation like ropes and belts and recommend removing these items from the home or locking them up.
- **Monitor for risky or suicidal behaviors.** Watch for behaviors such as:
    - Expressing hopelessness
    - Expressing suicidal or self-harm thoughts
    - Behaving in an unusually impulsive or risky manner
    - Researching means of harming oneself
    - For young children, using death as a theme in play
    - Giving away possessions
    - Talking about being a burden to others
- **Watch for substance use.** Using substances including alcohol and drugs can make it more likely that a person with suicidal thoughts acts on those thoughts, so parents so closely monitor for substance use and remove any substances from their home.
- **Develop a crisis plan or safety plan.** Develop a plan with adolescents and their parents for what to do if they are in crisis or develop suicidal thoughts. This plan should include triggers that cause distress for the child, physical signs or behaviors that occur when they are in distress, ways parents or others can help them calm down or cope with the distress, ways they can help themselves cope, and other supports they can contact or utilize in a crisis including positive peers, supportive adults, and therapists. Local and national crisis lines and 911 can also be included.

Resources:

Crisis Hotlines:

- National Suicide Prevention Lifeline - 1-800-273-8255
- National Suicide Hotline – 1-800-784-2433
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

Books for Parents

Mental Health App reviews

One Mind PsyberGuide is a non-profit project run by a team of experts in mental health, technology, and technology delivered care based out of the University of California, Irvine and Northwestern University. One Mind PsyberGuide is not an industry website; its goal is to provide accurate and reliable information free of preference, bias, or endorsement.

Primary References

[1]Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. Archives of general psychiatry, 60(8), 837–844. https://doi.org/10.1001/archpsyc.60.8.837

[2]Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). Journal of the American Academy of Child and Adolescent Psychiatry, 49(10), 980–989. https://doi.org/10.1016/j.jaac.2010.05.017

[3]Kendall PC, Furr JM, Podell JL. Child-focused treatment of anxiety.. In: Evidence-based psychotherapies for children and adolescents., Weisz JR, Kazdin AE (Eds), Guilford, New York 2003. p.45.

[4]Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. Journal of clinical child and adolescent psychology : the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53, 37(1), 105–130. https://doi.org/10.1080/15374410701817907

[5]Ollendick, T. H., & King, N. J. (1998). Empirically supported treatments for children with phobic and anxiety disorders: current status. Journal of clinical child psychology, 27(2), 156–167. https://doi.org/10.1207/s15374424jccp2702_3

[6]Flavell JH, Miller PH, Miller SA. Cognitive Development, 4th ed, Prentice Hall, New York 2001.

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How to Help Your Child with Anxiety

When our children feel anxious, our natural instinct is to jump in and make them feel better

This can take many different forms:

- Talking for them in social situations
- Avoiding places or situations that your child finds anxiety provoking (e.g., crowds, restaurants)
- Providing a lot of reassurance to your child
- Sleeping in the same bed

These parenting behaviors are called *accommodations*.

Accommodations

Accommodations come from our love and care for our children. Unfortunately, research shows that they actually tend to promote and worsen anxiety in our children over time.

So...what can you do instead?

1. Let your child know that you understand that they feel anxious or fearful
2. Express confidence that your child can manage the situation on their own
3. Praise them for trying things that are hard and scary

Why do accommodations make anxiety worse?

When we jump in and accommodate, our actions tell our child that we agree that a situation is unsafe, and that we think they couldn't have handled it without us.

Accommodations also prevent our child from being able to learn that the feared situation is *safe* and that they *can* manage their anxiety on their own.

"I know that sleeping in your room alone feels really tough. And I know you can do it! Let me walk you back to your room. I'm proud of you for giving this a try"

Families who want more information are encouraged to obtain the book "**Breaking Free from Childhood Anxiety and OCD**" by Eli Lebowitz.

Please also feel free to reach out to COAP at Children's Hospital of Colorado for therapy services. 720-777-6200

Colorado OCD and Anxiety Program (COAP) at Children's Hospital colorado

Anxiety Disorders:
Parents' Medication Guide

American Academy of Child & Adolescent Psychiatry
www.aacap.org

American Psychiatric Association

Anxiety Disorders: Parents' Medication Guide Work Group

CO-CHAIRS:
John T. Walkup, MD
Jeffrey R. Strawn, MD

MEMBERS:
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Tanya Murphy, MD, MS
Daniel S. Pine, MD
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Carmen J. Thornton, MPH, CHES, Director, Research, Development, & Workforce
Sarah Hellwege, MEd, Assistant Director, Research, Training, & Education

CONSULTANT:
Esha Gupta, Medical Science Writer

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health.

Table of Contents

Introduction

The purpose of the *Anxiety Disorders: Parents' Medication Guide* is to provide parents with an easy-to-read and easy-to-understand resource on treating anxiety disorders in children. In this Guide, we discuss the most common forms of anxiety and related disorders, including the following:

- Specific phobia
- Separation anxiety disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Panic disorder
- Obsessive-compulsive disorder

What is anxiety?

Anxiety is a normal emotion that is critical for our survival and functioning. It can help us avoid potentially dangerous situations and prepare for challenges. Stressful life events, such as taking a test, starting a new school, or speaking in front of a group can trigger normal forms of childhood anxiety that are helpful in preparing a child for the challenge ahead. That said, sometimes there can be problems in expressing emotions that can negatively affect day-to-day living. Fear, anxiety, sadness, and even our capacity to enjoy ourselves can be a problem if these emotions become extreme and impair one's capacity to function.

How common are the anxiety disorders, and who is affected?

Anxiety disorders are common in children and adolescents, and typically begin during childhood and adolescence. In fact, some suggest that anxiety disorders may affect 1 in 8 children. The National Institute of Mental Health (NIMH) estimates that 25.1% of adolescents between the ages of 13 and 18 years will experience an anxiety disorder, and 5.9% will experience a severe anxiety disorder. Boys and girls are equally affected in childhood, and after puberty, girls appear to be more commonly affected than boys.

Both genetics and the environment play a role in the anxiety disorders. A genetic family history of anxiety disorder puts a young person at risk for developing an anxiety disorder. In addition, caregivers or relatives can respond to an anxious child in such a way as to make the child's anxiety even worse by unknowingly supporting avoidance instead of engagement and unintentionally reinforce fear and worry instead of good coping.

What is the difference between "normal" anxiety and an anxiety disorder?

Anxiety disorders are different from regular or typical anxiety, just like depression is different from everyday sadness or the way mania (elevated and expansive mood) is different from regular happiness and excitement.

Despite the different ways anxiety is expressed among children from different backgrounds and ethnicities, symptoms of anxiety disorders differ from those of normal anxiety in a number of important ways.

1. Normal anxiety occurs at all time points in life. Yet, the anxiety disorders **first affect children before puberty** and can begin or get worse unexpectedly "out of the blue."

2. Typical and developmentally appropriate activities that most children enjoy are **not manageable** for children with anxiety disorders. For a child with an anxiety disorder, going to school, participating in sleepovers or going to camp, making new friends at a party,

"showing off," and participating in new and potentially rewarding experiences (amusement parks) can be very anxiety provoking. As a matter of fact, the child's intense reaction is often surprising to their caregivers, as the triggering cause is often a routine and normal life event a child of a certain age is expected to be able to do.

3. Children with anxiety disorders often experience a number of **unexplained physical symptoms**, such as stomachaches, headaches, shortness of breath, chest pain, worrying about choking, and gagging or vomiting. They often worry about their overall health. Anxious children may pay too much attention to their body's sensations and mistakenly believe that these sensations are symptoms of an illness. As a result, these children are likely to appear as physically ill to their parents, and to visit the school nurse and/or pediatrician more often, potentially leading to missed school days and even unnecessary medical procedures.

4. The **persistence and consistency** of the anxiety symptom picture over time is key to diagnosing an anxiety disorder. That said, some anxious children can experience a sudden worsening of anxiety symptoms. For example, an 8-year-old child who has been mildly anxious as a younger child but enjoyed school may now suffer from separation anxiety and refuse to go to school.

5. Children with anxiety tend to cope by **avoiding situations** that make them anxious. If the triggering experiences are routine and necessary tasks of growing up, the child's everyday functioning and home or school life can be disrupted.

6. Children with anxiety disorders can **also have normal anxiety**. Trained professionals, such as child and adolescent psychiatrists, can recognize the symptom patterns of an anxiety disorder, in part because the types of symptoms are very similar among children with anxiety disorders.

Parents and caregivers often get into a pattern of anticipating a child's anxious behaviors and, in an effort to relieve their child's distress, will help their child avoid a potential anxiety trigger. Unfortunately, although the parents and caregivers have the best intentions, their actions may actually make the anxiety worse and prevent the child from coping with and adapting to typical and important developmental tasks. Avoidance, meltdowns, or other behaviors that continually keep a child from doing age-appropriate activities result in "functional" impairment. In addition, the physical and emotional distress of anxiety is "psychological" impairment. When a child with anxiety is experiencing *functional* and *psychological* impairment, they are suffering from an anxiety disorder.

The Anxiety Disorders

Anxiety disorders are categorized into different forms depending on the symptoms children display. **(Table 1)**

Common Symptoms Across All the Anxiety Disorders

Although there are specific symptoms associated with each of the anxiety disorders listed in Table 1, there are common symptoms among these disorders.

- Hypervigilance—continuous scanning of the environment for anything new and different.
- Reactivity—whereas most children are curious and interested in new things, children with anxiety often feel threatened by new or changing events or expectations and react accordingly.
- Physical complaints—headaches, fear of gagging, choking or vomiting, chest pain, shortness of breathing, poor appetite, stomachache, urgent bathroom trips, increased sweating, muscle tension, jitteriness, and difficulty falling asleep.
- Avoidance—the most common and easiest way for a child to cope with anxiety is to avoid. Instead of approaching a new situation with curiosity as most children do, children with anxiety disorders avoid their anxiety-triggering situations. Avoidance of important developmental tasks is a signal that the child's anxiety needs to be addressed.
- Behavioral issues—if the child cannot avoid an anxiety-triggering situation, he/she may demonstrate significant behavioral issues, often described as "meltdowns," such as refusing to participate, becoming oppositional, and having temper tantrums. Intense anxiety or meltdowns are very challenging for most caregivers and often leave them feeling powerless to help their child.

Table 1.

Anxiety and Related Disorders	
Specific Phobia	• Irrational or extreme fearful reactions to an object or situation (e.g., animals, heights, costume characters, and type of transportation) • Results in avoiding the objects or situations or in demonstrating distress when exposed to them in normal everyday life • Often the first sign of an anxiety disorder and can be associated with other anxiety disorders
Separation Anxiety	• Specific worry that something bad will happen to them or to their caregivers if they are apart (e.g., being in a different room in the house from their caregivers, falling asleep alone in their bed, going to school in the morning, attending a sleepover at a close friend's house, or worry when their caregivers are not home or late coming home) • They may be described as being clingy or easily homesick
Generalized Anxiety Disorder	• A variety of fears and worries about everyday life experiences (i.e., they often anticipate disaster [e.g., catastrophic thinking], worry about their health issues and financial status, as well as their families' health and finances, think about life and death, as well as family and interpersonal relationship problems, and feel intense academic pressures) • They may be described as being worriers, tense, uptight, inflexible, and perfectionistic • May feel as if "something bad will always happen," (if feelings of dread are extremely intense, may be misdiagnosed with depression) • May have problems falling asleep at night because of worry • Sometimes have problems focusing and concentrating in school because they are preoccupied with worry (if significant, may be misdiagnosed with attention-deficit/hyperactivity disorder)
Social Anxiety Disorder	• Fear or worry about their functioning in social interactions (i.e., they are extremely self-conscious and are afraid of being judged or humiliated in a social situation or doing something silly or embarrassing, frightened at the thought of becoming the focus of others' attention) • May be limited to specific settings (i.e., speaking in front of a group) or can be a global problem and affect them in 1:1 situations (i.e., ordering food in a restaurant and/or asking a safe stranger like a teacher a question or policeman for directions) • They are often considered to be shy, highly self-conscious, "slow to warm up," hesitant to talk in social settings, "soft spoken," and reluctant to ask others' questions, or may answer questions with short phrases and avoid making socially appropriate eye contact • Often have physical symptoms (i.e., blushing, sweating, trembling or shaking, or feeling nauseated or sick to their stomach) when they are confronting a social situation
Panic Disorder	• Experience panic attacks that are characterized by the sudden onset (within minutes) of intense fear that something bad is happening or going to happen or fear of losing control • The panic attack usually peaks in 10 minutes and lasts for approximately 15 to 30 minutes, but the effects of having had a panic attack can continue as the person worries about having another attack and what the attack could mean about their health, causing them to avoid situations associated with the feeling of panic • Physical symptoms of a panic attack may include shortness of breath, chest pain, sense of irregular heartbeat, heart beating too hard or too fast, increased breathing (hyperventilation) with tingling or numbness around the mouth and in the fingers, sweating, and shaking; although they feel life threatening, they are not dangerous
Obsessive Compulsive Disorder	• Characterized by obsessions, which are repeated and unwanted thoughts, urges, or mental images that cause anxiety, distress, and are linked to compulsive behaviors • Compulsive rituals seem to relieve the anxiety from these thoughts in the short run, but the child often spends a substantial amount of time obsessing or engaging in compulsions (more than 1 hour a day), which causes distress and daily dysfunction • Common obsessions include the following: fear of germs or contamination; unwanted, taboo thoughts about sex, religion, and harm to self or others; unwanted aggressive thoughts; and the need for things to be balanced, symmetrical, or in perfect order • Common compulsions include the following: excessive grooming and hand washing; ordering and arranging things in a particular and precise way; repeatedly checking on things such as whether the door is locked or whether the stove is off; and conducting mental rituals such as replacing a "bad thought" with a "good thought"

Assessment and Treatment

Regardless of the situation, when a child is having trouble handling their day-to-day life activities because of anxiety, they should be seen by a clinician for a complete assessment to see if treatment is recommended.

It is important that the clinician evaluating a child for an anxiety disorder is familiar with the diagnosis, life course, and treatment of anxiety disorders. Given the potential for the overlap of normal anxiety and anxiety disorders, some pediatricians, primary care doctors, school personnel, and mental health professionals may not understand what the anxiety disorders look like in children and may not fully recognize anxiety disorders as an important mental health problem.

Child and adolescent psychiatrists, physicians who specialize in the diagnosis and the treatment of mental health conditions in children and adolescents, are important members of your child's mental health care team, as they offer families the advantages of a medical education, the medical traditions of professional ethics, and medical responsibility for providing comprehensive care.

It is important to differentiate severe and ongoing anxious reactions to significant life events (i.e., "normal" anxious reactions to extreme life circumstance) from an anxiety disorder. Anxiety disorders require specific treatments and anxious reactions to extreme life circumstances are managed by providing children with safe, secure, and predictable environments and even treatment including psychological support. In both circumstances children having trouble handling their day-to-day life activities should be seen by a clinician for a complete assessment to see what kind of treatment is needed.

Because many of the symptoms of anxiety are experienced internally by a child (e.g., fear or worry), a caregiver may only recognize the functional impairment that the child is demonstrating; for example, difficulty falling asleep, not going to school, anxiety around performance situations, reluctance to engage in social activities and make friends, strong emotional reactions, and other avoidance behavior. A comprehensive evaluation by a clinician will likely include completing rating scales and interviewing the parent and child about the child's internal symptoms and functional impairment. The clinician will work to understand the child's pattern of anxiety symptoms, level of avoidance, and family readiness to engage in treatment. They will also determine whether the child has other problems that might make the treatment plan more challenging.

The clinician will consider many factors in deciding what treatment is needed for a child with an anxiety disorder. After the clinician has evaluated a child, he/she should communicate the results of the evaluation, specific treatment recommendations and the reason behind treatment recommendations. Treatment recommendations often include specific recommendations about how the family can best engage and support the child, essentially becoming "coaches" who work with the child to "take on" their fears and worries.

While it is a big decision to enter a child into treatment for an anxiety disorder, it is important to understand that it is also a big decision to not engage in treatment. Clinical studies suggest children with an anxiety disorder do not get better with just support and longer-term studies suggest anxiety, if not treated, is associated with a number of poor life outcomes including the risk for depression, substance misuse, suicidal thoughts and behaviors, and difficulties with adapting and coping.

Role of the Family in Assessment and Treatment

It is very important to have family involvement in the assessment and treatment of anxiety. Clinicians know about anxiety disorders in children, but they highly rely on the caregivers' active engagement in assessment and treatment to be able to do best by the child. The child's caregivers are the clinician's "eyes and ears." Treatment is much more effective when parents and clinicians work together to reduce the child's anxiety.

Medication as a Tool for Treating Anxiety

The United States Food and Drug Administration (FDA) oversees the approval process to show that a medication is safe and effective for a specific condition (e.g., generalized anxiety disorder). After a medication has been approved by the FDA, clinicians can use the medication for the specific condition (i.e., on-label prescribing) or for any other condition where studies have proven them effective or the physician believes the medication can be effective and safe (i.e., off-label prescribing).

It is important to recognize that clinicians who practice high quality "evidence-based" medication treatment for children and adolescents with anxiety disorders will often recommend and prescribe safe and effective medications "off label." This is not a bad thing, as the medications have been proven to be effective and safe, even though they have not gone through the FDA approval process.

For childhood anxiety disorders, only one medication, duloxetine, has received FDA approval and can be prescribed "on label" for children 7 years of age and older with generalized anxiety disorder. However, a number of other medications have been proven to be safe and effective for treating the childhood anxiety disorders but have not gone through the FDA approval process.

It is important to recognize that clinicians who practice high quality "evidence-based" medication treatment for children and adolescents with anxiety disorders often will recommend and prescribe safe and effective medications "off label."

The goal of treatment for a child is always remission (having few, if any symptoms) of the anxiety disorder.

What medications reduce anxiety and its symptoms consistently over time?

Antidepressant medications represent the foundation of medication treatment for youth with anxiety disorders and OCD. Many of the medications that benefit anxiety disorders and OCD were initially recognized as medications for depression and thus, called antidepressants. The most effective antidepressant medications, selective serotonin reuptake inhibitors (SSRIs), and selective norepinephrine reuptake inhibitors (SNRIs), increase the effects of serotonin and norepinephrine, chemical neurotransmitters in the human body that help regulate anxiety, mood, and social behavior.

Antidepressant medications that have proven to be effective for childhood anxiety disorders that can be prescribed "on label" include duloxetine (Cymbalta™) and "off label" include sertraline (Zoloft™), fluoxetine (Prozac™), fluvoxamine (Luvox™), paroxetine (Paxil™), and venlafaxine ER (Effexor XR™).

What is the goal of treatment in a child or teenager with anxiety?

The goal of treatment for a child is always remission (having few, if any symptoms) of the anxiety disorder. If remission is not achieved with either antidepressant treatment or antidepressant treatment combined with psychological treatment, the clinician may consider a variety of approaches, including medication changes or adding other psychological interventions. It is important to keep in mind that it is okay if a medication change is suggested to reach the goal of remission because a child may respond better to the second medication. Changing the treatment in youth who do not respond to initial medication treatment has been shown to be beneficial.

What have studies on antidepressant medication use in children and adolescents with anxiety disorders shown?

Nearly a dozen studies have evaluated antidepressant medications in children and adolescents with generalized, social, and separation anxiety disorders. **(Table 2)** In nearly all studies, youth who received antidepressant medication did better than those who received placebo (sugar pill). And those children who received a combination of medication and psychological treatment of anxiety did best. Likewise, in children with OCD, the SSRIs have been studied and are effective in reducing OCD symptoms. Studies that have compared SSRIs and psychotherapy in youth with OCD have generally shown that the combination of an antidepressant

medication and psychotherapy is far more effective than either psychotherapy or medication alone.

How are medications chosen?
A clinician will consider several factors in choosing whether to prescribe a specific medication for a child.

- Diagnosis
- Age of the child
- Medication effectiveness
- Side effects
- How quickly the medication works
- Interactions with other medications taken by the child
- Way in which the medication is taken (capsules, tablets, liquid)

How long does medication take to work?

Often, improvement from antidepressant medication begins in 2 to 4 weeks with additional improvement over 8 to 12 weeks. Some children show improvement at low doses of antidepressant medication very early in treatment, however, clinicians may increase the dose of the medication to ensure the child has the best chance for remission. In the clinical studies of medication, the best treatment dose is often identified in 8 to 12 weeks of treatment, with symptoms continuously improving even after that. Studies suggest the beneficial effects of SSRI treatment—regardless of whether it is given with cognitive-behavioral therapy (CBT)—reach maximum benefit at 6–9 months of treatment.

What medications are used occasionally for intense episodes of anxiety?

Clinicians often use medications from different classes to address a specific experience of anxiety such as flying on a plane, giving a speech, or other performance activity. Some of these medications come from the class of benzodiazepines, such as lorazepam (Ativan™) and clonazepam (Klonipin™). Benzodiazepines are generally used for short term treatment. When used for long periods of time, some patients have difficulty stopping the medication and experience withdrawal symptoms.

Some clinicians will also use antihistamines such as diphenhydramine (Benadryl™) or hydroxyzine (Atarax™, Vistaril™) to reduce anxiety for short periods of time. Also, medications from the class of beta-blockers such as propranolol (Inderal™) have been used for performance challenges such as public speaking events.

In the clinical studies of medication, the best treatment dose is often identified in 8 to 12 weeks of treatment, with symptoms continuously improving even after that.

Table 2.

Medications that may be used to treat anxiety disorders in children and adolescents.						
Class	**Medication (Brand name)**	**Common dose range (mg/day)**	**Tablet size (mg)**	**Common side effects**	**Serious side effects**	**Uncommon, serious side effects**
SSRI	Citalopram/escitalopram (Celexa/Lexapro™)	10/5-40/20	10/5, 20/10, 40	• Headache • Insomnia • Diarrhea • Decreased appetite • Hyperactivity/restlessness • Vomiting • Increased anger/irritability • Sexual dysfunction • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Potential for abnormal heart rhythm • Mania	• Serotonin syndrome • Bleeding problems
	Fluvoxamine (Luvox™, Luvox CR™)	100-300	25, 50, 100, 150			
	Sertraline (Zoloft™)	25-200	25, 50, 100			
	Fluoxetine (Prozac™, Sarafem™)	10-60	10, 20, 40, 60			
	Paroxetine (Paxil™, Pexeva™)	10-50	10, 20, 40			
SNRI	Venlafaxine ER (Effexor™)	37.5-225	37.5, 75, 150, 225	• Sleepiness • Insomnia • Restlessness • Sexual dysfunction • Headache • Dry mouth • Increased anger/irritability • Increased blood pressure • Increased heart rate • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Mania	• Serotonin syndrome • Bleeding problems
	Duloxetine (Cymbalta™)	30-120	20, 30, 40, 60			
Noradrenergic agent	Atomoxetine (Strattera™)	10-100	10, 18, 25, 40, 60, 80, 100			
Tricyclic antidepressant	Clomipramine (Anafranil™)	75-250	25, 50, 75	• Sleepiness • Dry mouth • Weight gain	• Boxed warning-suicidal thinking and behavior in children, adolescents, and young adults • Heart rhythm problems; electrocardiogram and blood levels • Mania	Serotonin syndrome
	Imipramine (Trofanil™, Trofranil-PM™)		10, 25, 50			
Benzodiazepine	Alprazolam (Xanax™, Alprazolam Intensol™)	0.5-1.5	0.25, 0.5, 1, 2	• Drowsiness • Clumsiness • Dry mouth • Dizziness • Abdominal pain	• Possible dependence • Withdrawal symptoms when used at high doses, especially when administered over long periods. Decreasing the dose gradually is a common strategy to decrease the risk of withdrawal symptoms. • Disinhibition • Memory impairment • Worsening depression	Respiratory depression (possible at high doses and when combined with other central nervous system depressants)
	Clonazepam (Klonopin™)	0.5-3	0.5, 1, 2			
	Lorazepam (Ativan™, Lorazepam Intensol™)	1-2	1, 2			
Atypical anxiolytic	Buspirone (Buspar™)	15-60	5, 10, 15, 30	• Dizziness • Lightheadedness • Tiredness		
Antihistamine	Diphenhydramine (Benadryl™, Banophen™, Diphenhist™)	12.5-50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• Abnormal heart rhythms • Agitation • Difficulty completely emptying the bladder • Harm to certain types of blood cells • Seizures	
	Doxylamine (Unisom™, WalSom™)	12.5-50	25, 50			
	Hydroxyzine (Atarax™)	25-50	10, 25, 50			

Adapted from Wilens, Hammerness. Straight Talk about Psychiatric Medications in Kids (Guilford Press, 2016).

What is the FDA warning?

The FDA added a "boxed warning" to all antidepressant medications to alert prescribing physicians and patients that special care should be taken when using antidepressant medications in children, adolescents, and young adults. The warning states that antidepressant medications are "associated with an increased risk of suicidal thinking and/or behavior in a small proportion of children and adolescents, especially during the early phases of treatment." Such "adverse events" (mostly suicidal thoughts) were reported by approximately 4% of all children and adolescents taking medication compared with 2% of those taking a placebo. More recent and larger studies suggest that the associated risk is even less. It is important to understand that it is not known why there is a small but somewhat greater risk for suicidal thoughts or behavior on medication than on placebo.

What medications are used for occasional sleep problems in youth with anxiety?

Sleep is often a significant problem in youth with anxiety. Treatment of the anxiety disorder with antidepressants and/or CBT is often beneficial in reducing anxiety and restoring normal sleep patterns. If the child's anxiety is under very good control and falling asleep is still a problem, behavioral approaches should be tried next. If behavioral approaches are not successful there are different medications that help children with anxiety sleep better. Clinicians often pick among medications such as melatonin, antihistamines, antidepressants that sedate like mirtazapine, and even some medications specifically marketed for insomnia in adults such as zolpidem (Ambien™) and zaleplon (Sonata™). While medicines used in adults for insomnia may be useful in children, they have not been studied extensively in children.

How is the medication dose selected and changed?

For the antidepressant medications, physicians select an initial dose based on studies that have evaluated the medication in children and adolescents. In general, children with anxiety are started on a low dose of medication, with incremental increases to reach the appropriate dose that offers the best chance for remission with minimal, if any side effects. Over the course of treatment, the caregiver and child will meet with the clinician regarding how the anxiety symptoms have changed and whether there are side effects. Some clinicians adjust doses more quickly (with more frequent check-in visits), and others may prefer a more gradual approach. "Going low and slow" is okay; however, it is important to understand that starting too low and going too slow may unnecessarily prolong a child's suffering. The common dose ranges for medications that are used to treat children with anxiety are shown in **Table 2**.

How are side effects managed?

Antidepressants such as SSRIs and SNRIs can have various side effects, as shown in **Table 2**. It is important to discuss medication side effects with your child's physician. Everyone worries about side effects but people and children with anxiety disorders are likely to worry more than others do. The presence of side effects is an important part of decision making for dose adjustments. Sometimes it is difficult to tell if the child is having a side effect or if it is the anxiety that is still impacting the child (e.g. stomachache).

Common side effects, which occur in approximately 10-20% of patients, include headaches, difficulty sleeping, appetite changes, abdominal pain, and diarrhea. Possible side effects, which may occur in 5% of patients, include weight gain, muscle pain, and common cold symptoms. Rare side effects, which occur much less frequently, include seizures, deliberate self-harm, abnormal heart rhythms, and mania. Suicidal thinking and behavior is discussed in the box to the left. It is important to know that this risk has not been shown in most studies of SSRIs in youth with anxiety disorders.

Perhaps of most concern to parents is whether the medication will change a child's behavior or personality in an unwanted way. In general, when SSRIs and SNRIs work well they reduce the child's anxiety greatly, and allow the child to function as they would if they were not anxious. It is important to know that the medications reduce anxiety, but don't solve all the problems a child might have.

Lastly, across all the SSRI and SNRI studies there is a common pattern of side effects that we call "activation syndrome"—an excessive and uncomfortable restlessness that occurs early in treatment or soon after a dose change. The activation may cause the child to be more irritable, impulsive, and overall more difficult to manage. Reducing the dose of medication or discontinuing it is the best management strategy until the activation symptoms go away. Since the activation symptoms most often occur early in treatment and at lower doses, it may be difficult to get a child to a full treatment dose if the medication seems to cause activation.

The usual strategy for managing side effects is to reduce the dose or discontinue the medication. However, adjusting the dose to minimize the side

effects may result in losing some of the benefit of the medication. It can be a delicate balance that a caregiver and the clinician have to manage together. If the clinician has to reduce the dose of the medication to reduce side effects and symptoms return, the clinician will review the treatment options with the caregiver so the child can have his/her best outcome. Switching medication is something that is commonly done when the first medication does not work or there are side effects.

How do I know the medication is working?

The question of whether treatment—medication, psychological treatment, or the combination of the two—is working is best answered by observing whether a child's anxiety decreases in frequency and severity and the child appears overall more comfortable and able to do things. Parents, caregivers, and clinicians may also answer this question by examining improvements in specific target symptoms, such as worrying excessively. In general, for kids with anxiety disorders, parents and caregivers will be able to observe that the child is able to do things now that they could not do before such as falling asleep quickly, spending the night at a friend's house, going to a party, attending school and camp, being around groups of people, going to malls or restaurants, etc. Anxiety-related physical symptoms (e.g., headaches, stomachaches, difficulty swallowing, etc.) will decrease or stop altogether.

How long should medication be continued?

As caregivers and the child consider when to stop antidepressant treatment, it is important to recall that the end goal of treatment is having few if any symptoms. The child has the best chance of discontinuing treatment if they have experienced remission and functional recovery. Any discussion regarding if

and when to discontinue treatment should only happen then. Children with ongoing symptoms of anxiety and associated impairment may not be the best candidates for stopping their medication. Increasing their medication or psychological treatment to achieve remission before considering stopping treatment may be best.

While a specific timeframe is not known, some experts recommend discontinuing medication 6–12 months after remission has been achieved. A child who has successfully worked with his/her family in psychotherapy along with medication treatment or a child with a faster response to treatment (more likely with antidepressant plus psychotherapy) might be ready to discontinue medication treatment more quickly. It is important to keep in mind that there is no evidence suggesting that long-term antidepressant treatment is unsafe when medication is overall well-tolerated.

A risk of discontinuing medication is the chance that anxiety symptoms will return even in children who have recovered. Families should only consider stopping antidepressant treatment during periods of low stress and specifically not when the child might be expected to be most anxious. For example, stopping medication before school starts in the fall in a child with separation anxiety who struggled to go to school is probably not a good idea. Also, for some children with anxiety, seemingly low stress periods like family vacations or holidays may seem like a good time to stop medication but may actually be stressful and the resulting anxiety be mistakenly blamed on the medication discontinuation.

If a child has successfully come off medication, it can be useful to monitor the child off medication to ensure that subtle anxiety symptoms do not return, and the child maintains their functional recovery.

Psychosocial Treatments for Anxiety

The clinician who assesses the child may recommend a specific psychological treatment such as cognitive-behavioral therapy (CBT), or a combination of CBT and medication, which are the evidence-based treatments for the childhood-onset anxiety disorders—specifically, separation, generalized and social anxiety disorders, and OCD.

The evidence-based psychological treatment (CBT) for the anxiety disorders and OCD begins with educating the child and family about the nature of the anxiety symptoms and how the symptoms may worsen over time, if not addressed effectively. For example, a child who is anxious, and copes by avoiding, may feel better in the short term but avoiding actually reinforces anxiety in the long term. After the child and family understand this important dynamic, the clinician should engage the child in a process called "exposure and response prevention." Exposure and response prevention treatment teaches the child two important things: 1) the fear or worry is not necessary for normal developmental tasks; and 2) with time, the fear or worry will go away or be better tolerated, and the child will learn how to cope without avoiding.

Although psychotherapy can be a very effective form of treatment for some children with anxiety disorders, this guide focuses on medication treatments. Other resources that discuss CBT in more detail are available. Also, psychotherapy may be used in combination with medication. Children who receive the combination of psychotherapy plus medication have fewer anxiety symptoms than children who receive medication only or psychotherapy only.

The evidence-based psychological treatment (CBT) for the anxiety disorders and OCD begins with educating the child and family about the nature of the anxiety symptoms and how the symptoms may worsen over time.

Resources

- American Academy of Child & Adolescent Psychiatry (AACAP)
  https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx
- Anxiety and Depression Association of America
  https://adaa.org
- Centers for Disease Control and Prevention (CDC)
  https://www.cdc.gov/childrensmentalhealth/depression.html
- National Alliance on Mental Illness (NAMI)
  https://www.nami.org/Find-Support/Family-Members-and-Caregivers
- National Institute of Mental Health (NIMH)
  https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml
- https://www.nimh.nih.gov/health/publications/anxiety-disorders-listing.shtml

Medication Tracking Form

Use this form to track your child's medication history. Bring this form to appointments with your provider and update changes in medications, doses, side effects and results.

Date	Medication	Dose	Side Effects	Reason for keeping/stopping

Author Disclosures

KAREEM GHALIB, MD
Assistant Clinical Professor, Department of Psychiatry
Columbia University Medical Center
No disclosures to report

KIMBERLY A. GORDON-ACHEBE, MD
Medical Director
Hope Health Systems, Inc.
Leadership Roles: Caucus of Black Psychiatrists; Council on Children, Adolescents, and Their Families, American Psychiatric Association

TANYA MURPHY, MD, MS
Endowed Chair, College of Medicine Pediatrics; Director and Professor, Rothman Center for Pediatric Neuropsychiatry; Professor, Pediatrics and Psychiatry, College of Medicine Pediatrics
University of South Florida
Research Funding: Centers for Disease Control and Prevention; F. Hoffmann-La Roche Ltd.; National Institute of Mental Health; Neurocrine Biosciences, Inc.; PANDAS Network; Pfizer Inc.; Psyadon Pharmaceuticals, Inc.; Shire; Teva Pharmaceuticals Industries, Ltd.; Tourette Association of America

Scientific Advisory Board: International OCD Foundation, PANDAS Network, Tourette Association of America

DANIEL S. PINE, MD
Chief, Emotion and Development Branch; Chief, Section on Development and Affective Neuroscience
National Institute of Mental Health
No disclosures to report

ADELAIDE S. ROBB, MD
Chief, Psychiatry and Behavioral Sciences
Children's National Health System
Advisor/Consultant: Allergan, Inc.; Neuronetics; National Institute of Mental Health; Supernus Pharmaceuticals, Inc.; University of Cambridge

Data and Safety Monitoring Board: National Institute of Mental Health for University of Cincinnati; Neuronetics; Otsuka America Pharmaceutical, Inc.

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Stock in IRA: Eli Lilly and Company; GlaxoSmithKline; Johnson & Johnson Services, Inc.; Pfizer Inc.

MOIRA A. RYNN, MD
Chair, Department of Psychiatry and Behavioral Sciences
Duke University School of Medicine
Books, Intellectual Property: American Psychiatric Association Publishing; UptoDate

Consultant: Allergan, Inc.

Data Safety Monitoring Board: Allergan, Inc.

Research Funding: National Institute of Child Health and Development; National Institute of Mental Health

JEFFREY R. STRAWN, MD
Associate Professor
University of Cincinnati
Books, Intellectual Property: Springer

In-Kind Services: Travel support from American Academy of Child and Adolescent Psychiatry

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Research Funding: Allergan, Inc.; Lundbeck; National Institute of Child Health and Development; National Institute of Environmental Health Sciences; National Institute of Mental Health; Neuronetics; Otsuka America Pharmaceutical, Inc.; Yung Family Foundation

JOHN T. WALKUP, MD
Professor, Department of Psychiatry, Northwestern University Feinberg School of Medicine; Director, Department of Psychiatry
Ann and Robert H. Lurie Children's Hospital of Chicago
Books, Intellectual Property: Guilford Press; Oxford Press

Honoraria: American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, Tourette Association of America

Research Funding: Abbott Laboratories; Eli Lilly and Company; The Hartwell Foundation; Pfizer Inc.; Tourette Association of America

TIMOTHY E. WILENS, MD
Chief, Child and Adolescent Psychiatry Department; Co-director, Center for Addiction Medicine
Massachusetts General Hospital
Advisor/Consultant: Bay Cove Human Services; Gavin Foundation; Ironshore Pharmaceuticals Inc.; KemPharm, Inc.; National Institute on Drug Abuse; Otsuka America Pharmaceutical, Inc.; US Minor/Major League Baseball; US National Football League (ERM Associates)

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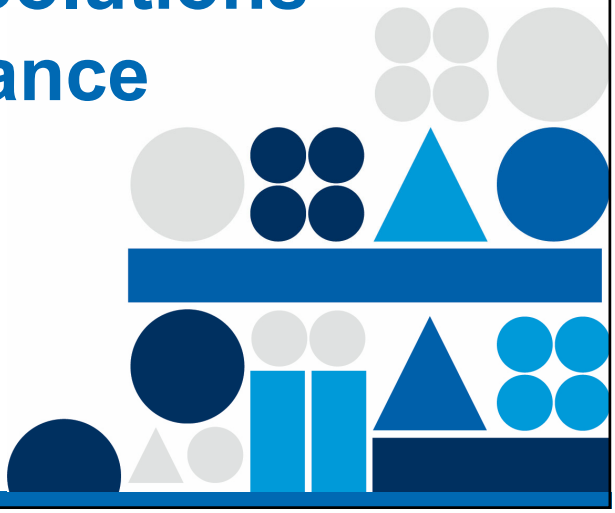
SEPT 8 2025

Multidisciplinary Solutions for School Attendance

Lauren Henry, PhD, NCSP
Licensed Child Psychologist



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Disclosure

I have no relevant financial relationships with ineligible companies.

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2

Learning Objectives

- Discuss risk and protective factors
- Apply a functional assessment model to identify drivers of non-attendance.
- Review evidence-based, developmentally appropriate interventions.
- Describe multidisciplinary roles (health, mental health, school, family, community).

"I know the kids don't like you and pick on you, but you have to go to school...you're the teacher."

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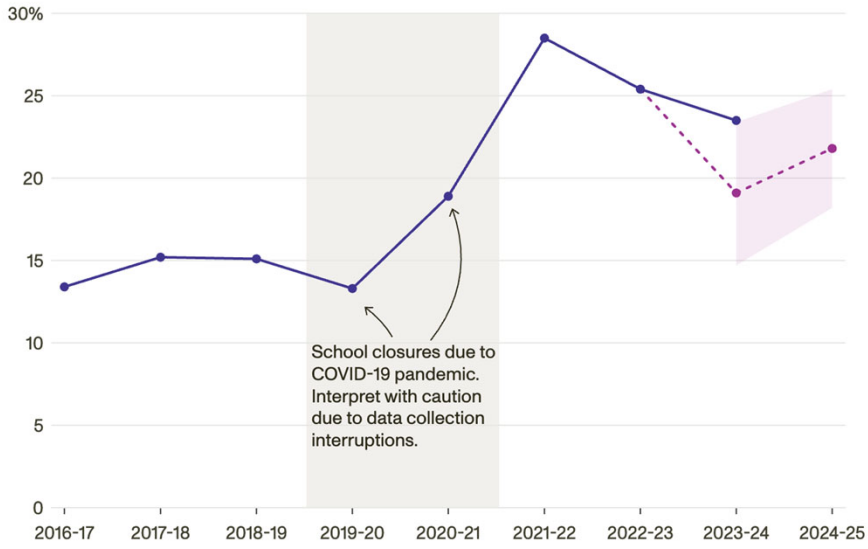
3

Chronic absenteeism remains elevated, with rates nearly double what they were pre-pandemic.



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(NCES; 2016–17 to 2023–24)

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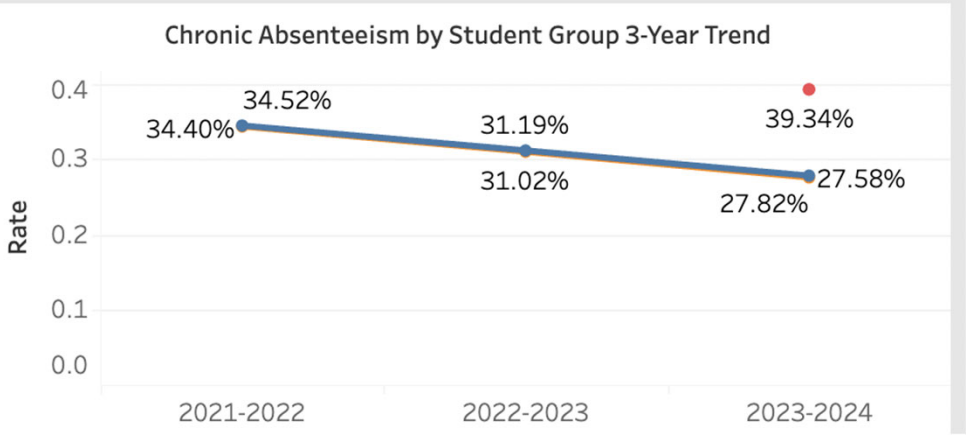
4

COLORADO
Department of Education

Chronically Absent Rate	Chronically Absent Students	Total Number of Students
27.70%	241,119	870,455



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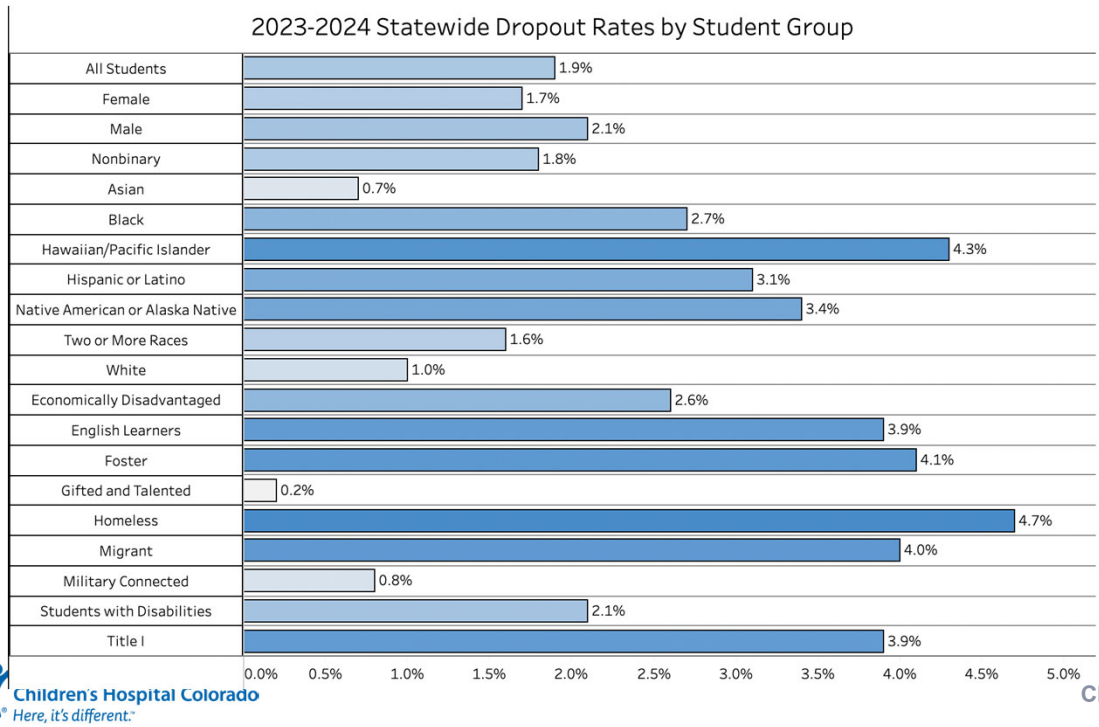

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6


Attendance
Avoidance
Refusal
Phobia
Diagnosis
Dropout
We want to understand: for this child, what is keeping the school avoidance going?
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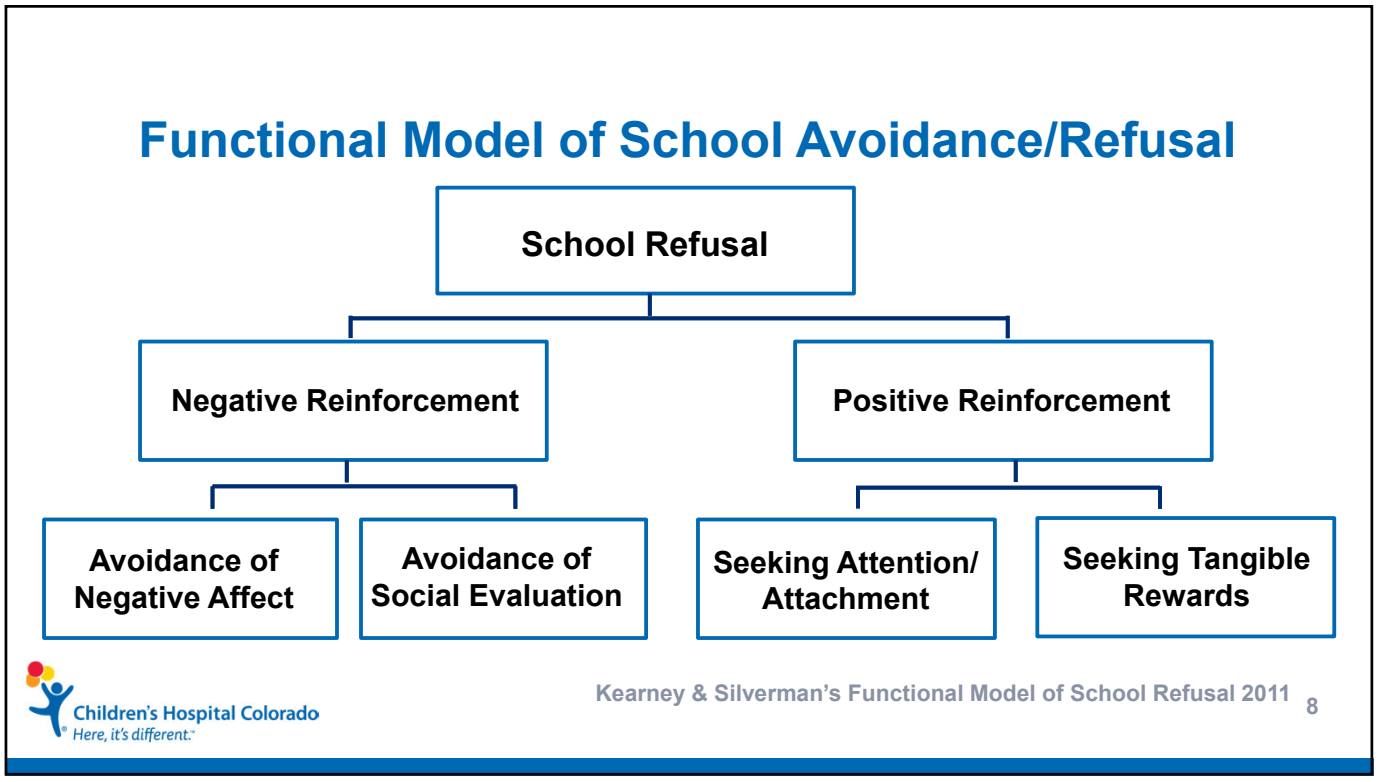
7


Functional Model of School Avoidance/Refusal
School Refusal
Negative Reinforcement
Positive Reinforcement
Avoidance of Negative Affect
Avoidance of Social Evaluation
Seeking Attention/ Attachment
Seeking Tangible Rewards
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Kearney & Silverman's Functional Model of School Refusal 2011
8

8

Risk Factors

Social Factors (bullying, social skills)
Educational Factors (LDs, developmental delays)
Family Factors (conflict, parental separation)
Mental Health Factors (anxiety, depression, trauma)
Societal Factors (racism, economic vulnerability)

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The Onset of School Refusal

- School attendance with stress and pleas for non-attendance
- Repeated misbehaviors in the morning to avoid school
- Repeated tardiness in the morning followed by attendance
- Periodic absences or skipping of classes
- Repeated absences or skipping of classes mixed with attendance
- Complete absence from school during a certain period of time
- Complete absence from school for an extended period of time

10

10

Early Warning Signs

- Physical complaints (headaches, stomachaches)
- Anxiety in the classroom
- Frequent trips to school counsellor & out of classroom
- Frequent calls/texts to parents and requests to go home during the school day
- Attempts to miss all or part of the school day
- Attention problems, irritability, changes in mood & class participation

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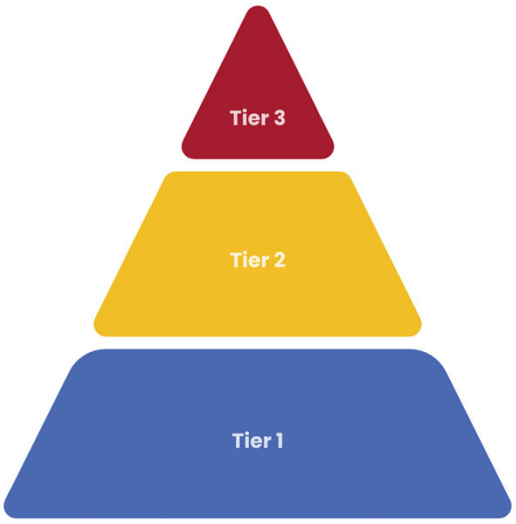
Tiered Systems & Multidisciplinary Roles

Tier 3
Intensive, In-School Clinical Support
For the 3-5% of students with the most severe emotional and behavioral challenges

Tier 2
Moderate Intensity Care
For students who have less intensive needs or who might not be on a school's radar screen

Tier 1
Professional Development, Coaching and Consulting
For educators focused on expanding the mental health and behavioral health toolkit of teachers and school staff



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Tier I Interventions

- School Climate and Engagement Strategies
- Family and Community partnerships
- Early Warning Systems

Foundational Practices

- Connected Relationships and Culture
- Strong Family and Community Partnerships
- Relevant and Engaging Learning Opportunities
- Data-Based Decision Making
- Aligned Policies and Practices to Build Coherence

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Early Warning Systems

- Establish a representative school team
- Engage parents/guardians
- Develop data-based decision-making process/protocol
- Implement continuous improvement cycles to examine school and team processes and trends in data in the EWS that may inform schoolwide practices.

Early Warning Intervention and Monitoring Systems significantly reduced the rate of chronic absence and course failure.

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Multidisciplinary Response

1. *Identify & Gather* the team
2. *Assess* the struggle
3. *Set the stage* for success
4. *Develop & Implement* the plan
5. *Communicate & Check in*

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Step 1: Identify & Gather the Team

Who is on the child's team?

- Caregivers
- School professionals
- External health professionals

Who will the school point person(s) be?

- They will lead the assessment & facilitate development of the plan
- They communicate with family, rest of school-based team, & external professionals

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Step 2: Assess the Struggle

Goal is to understand what is contributing to the challenges attending school, including…

- History of School Attendance
- Home and School Stressors
- Learning Impact
- Other Health Challenges
- Transport/Logistics Barriers
- Function (School Refusal Assessment Scale–Revised)

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Medical Assessment

- A Collaborative Team Approach
- Provide psychoeducation of "Brain/Body Connection."

*Physicians should avoid writing a non-judicial excuse note for children to stay out of school unless a medical condition makes it mandatory for them to stay home

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School Team

- Developing/executing school re-integration plan (with external consultation in some cases)
- Setting up internal school team meetings
- Liaising with mental health clinician/family

External MH Clinician (if applicable)

- Individual therapy and/or parent training
- Consulting with school team; attending school team meetings
- Keeping school up to date on plans/progress

Caregiver: Communicating confidence & setting effective limits

- Making sure the home setting is boring during school hours
- Ensuring child is getting enough sleep; awake in time for school

Child

- Engage in Intervention
- Being brave and going to school!

19

Step 2b: Assess the Severity

Attends regularly with distress	Misses full days or partial days infrequently	Regularly misses full or partial days	Misses multiple full days or weeks	Hasn't been at school for months or more

At risk → Developing → Significant → Long-standing

Team may consist of school & caregivers only

Team needs to be well-coordinated and likely include multiple school team members, caregivers, and external health professionals.

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Tier II Interventions

- Problem Solving Teams
- Evidence-based Practices for Academic Interventions
- Functional Behavioral Assessment
- Group/Individual CBT for Anxiety and Depression
- Check & Connect
- Interagency Communication

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Tier III Interventions

- Interagency, Multidisciplinary Teams
- Multicomponent CBT tailored to function of school refusal.
- Prescriptive treatments: Anxiety-based SRB: CBT with exposure.
- Attention-maintained SRB: Parent training, contingency management.
- Tangible reinforcement SRB: Limit access to reinforcers at home.

22

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Step 3: Set the Stage For Success

- Validate & Encourage
- Normalize the Struggle & Communicate Confidence
- Introduce the idea of the stepwise plan that will help get things back on track
- Assess Child's Self-Efficacy

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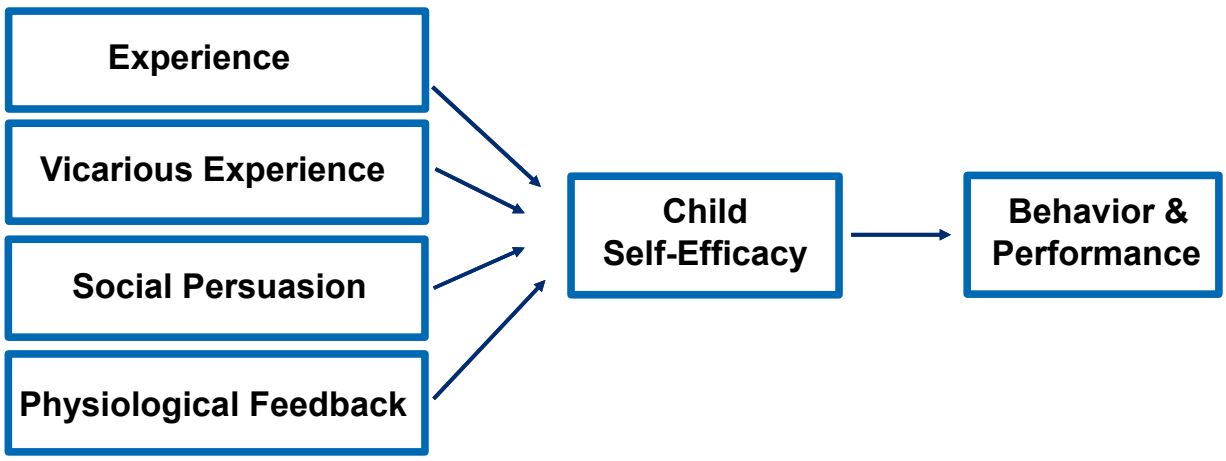
The Importance of Self-Efficacy



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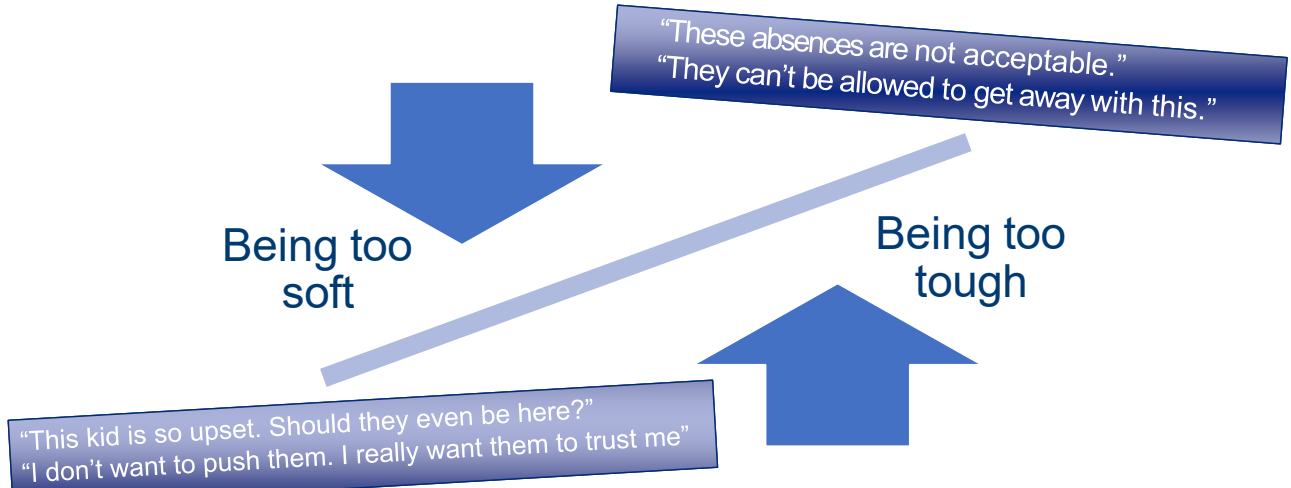
Step 4: Develop & Implement Plan



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CHILD: "I know it feels hard being here → …and I know you can do it. You are so brave."

CAREGIVER: "I know this feels really stressful and it would be easier to keep him home... → …and I know he's going to get through this one day at a time. Great work dropping him off today."

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Step 4a: Exposure Ladder

- Should be done collaboratively with defined rewards/praise for each step
- Ladder to address each of the problem areas discovered during assessment phase
- Reassure child that fears will be faced step by step & they will have all the support they need. Keep it light!
- You do NOT need to plan/share all the steps right away

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Do not let kids escape at the peak of their distress. They will learn that anxiety goes down when they avoid.

Avoid getting caught in prolonged anxiety- driven conversations & reassurance seeking

Remember: it's normal & expected that kids will be nervous & protest facing fears.

Remember to praise & reward bravery (even if the step seems small!)

Ignore anxious behaviors (e.g. dragging feet walking into class)

Remember: each time kids complete a step in their bravery ladder, confidence will increase!

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Step 4b: Plan School Re-entry

Make as many of the unknowns KNOWN

- Address Logistical Concerns (e.g., seating arrangement; cover story)
- Clearly Communicate Expectations
- Define reinforcement schedule and parent responses if refusal occurs.
- Decide on accommodations
- Document gradual re-entry plan
- Track data daily (attendance, anxiety ratings) and adjust quickly.

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Return-to-School Plan

- Same-day contact for any absence; daily plan agreed by family-school-clinician.
- Specify arrival time, who meets student, safe base location, and class sequence.
- Define reinforcement schedule and parent responses if refusal occurs.

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Step 5: Communicate & Check in

- Track data daily (attendance, anxiety ratings) and adjust quickly.
- Plan for ongoing check ins among team to ensure gains are maintained & progress continues
- Troubleshoot barriers early
- Regular communication with caregivers is important

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A Note on Self-Compassion

- It is not easy to support kids with school attendance challenges, especially when they are very long- standing
- School professionals have many competing demands
- It is unrealistic to support families on your own: a team-based approach is essential

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Resources:

Organizational Websites

- Kelty Mental Health Webinar Series on School Attendance Challenges https://keltymentalhealth.ca/school-attendance-webinars
- Effective School Solutions https://effectiveschoolsolutions.com/
- Just Ask Children's: Parenting Advice from Our Pediatric Experts https://www.childrenscolorado.org/just-ask-childrens/articles/school-refusal/
- Colorado Dropout Prevention Framework https://www.cde.state.co.us/dropoutprevention/dpframework

Parenting Support:

- Confident Parents Thriving Kids (Educators can refer) https://welcome.cmhacptk.ca/

Intensive Outpatient Anxiety Programs (Virtual Options)

- Charlie Health https://www.charliehealth.com/
- Pathlight Pathlight Mood & Anxiety https://www.pathlightbh.com/virtual-treatment/colorado
- Embark Behavioral Health https://www.embarkbh.com/treatment/programs/virtual-iop/
- Mountain Crest-Intensive Outpatient Programs (IOP) https://www.uchealth.org/services/behavioral-health/

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References

- Kearney CA & Silverman WK (1993, 2013). School Refusal Assessment Scale. J Clin Child Psychol.
- Kearney CA (2008). Interdisciplinary model of school absenteeism. Educ Psychol Rev.
- Heyne D et al. (2015/2019). Systematic reviews/meta-analyses of treatment. J Anxiety Disord; CAPMH.
- Tonge BJ et al. (2003). CBT + parent training RCT. JAACAP.
- Finning K et al. (2019). Anxiety & attendance: systematic review. J Affect Disord.
- Sinclair MF et al. (2005). Check & Connect randomized evaluation. J Negat Behav Interv.
- Ulaş, S., & Seçer, İ. (2024). A systematic review of school refusal. Current Psychology. Advance online publication. https://doi.org/10.1007/s12144-024-05742-x
- Walkup JT et al. (2008). CAMS trial for pediatric anxiety. N Engl J Med.

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Crisis Response: Effective Screening, Triage, and Intervention Strategies

Cassidy McNitt, M.D.

Assistant Professor, Dept. of Psychiatry, University of Colorado School of Medicine

Associate Medical Director, Colorado Pediatric Consultation and Access Program (CoPPCAP), University of Colorado Department of Psychiatry

Child and Adolescent Psychiatrist, Consultative and Ambulatory Divisions, Pediatric Mental Health Institute, Children's Hospital Colorado

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Financial Disclosures

I have no relevant financial relationships with ineligible companies.

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3

A Few Questions to Consider…

1. What types of behavioral health crises have you been asked to manage in your practice?
2. What is in your scope to manage?
3. When should you refer to a BH provider?
4. When should you send to the ED?

3

4

Learning Objectives

- Review the data behind the pediatric mental health crisis
- Identify evidenced-based tools available for evaluation of suicide risk in pediatric ambulatory settings
- Understand available routes for escalation of behavioral health care
- Explain the process involved in a behavioral health crisis evaluation

4

5

National State of Emergency in Child and Adolescent Mental Health

CHILDREN'S HEALTH

Pediatricians say the mental health crisis among kids has become a national emergency

OCTOBER 20, 2021 · 3:50 PM ET

- Joint declaration in Oct 2021 by:
  - American Academy of Pediatrics (AAP)
  - American Academy of Child & Adolescent Psychiatry (AACAP)
  - Children's Hospital Association (CHA)

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Behavioral Health in Community Practice

Volume 152, Issue 3
September 2023

FROM THE AMERICAN ACADEMY OF PEDIATRICS | POLICY STATEMENT | AUGUST 16 2023

The Management of Children and Youth With Pediatric Mental and Behavioral Health Emergencies FREE

Mohsen Saidinejad, MD, MS, MBA, FAAP, FACEP ✉; Susan Duffy, MD, MPH, FAAP; Dina Wallin, MD; Jennifer A. Hoffmann, MD, FAAP; Madeline M. Joseph, MD, FAAP, FACEP; Jennifer Schieferle Uhlenbrock, DNP, MBA, RN, TCRN; Kathleen Brown, MD, FAAP; Muhammad Waseem, MD, MS, FAAP, FACEP, CHSE-A; Sally Snow, BSN, RN, CPEN, FAEN; Madeline Andrew, MD; Alice A. Kuo, MD, PhD, MBA, FAAP; Carmen Sulton, MD, FAAP; Thomas Chun, MD, MPH, FAAP; Lois K. Lee, MD, MPH, FAAP, FACEP; AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee; EMERGENCY NURSES ASSOCIATION Pediatric Committee

Address correspondence to Mohsen Saidinejad, MD, MS, MBA. E-mail: moh@emedeharbor.edu

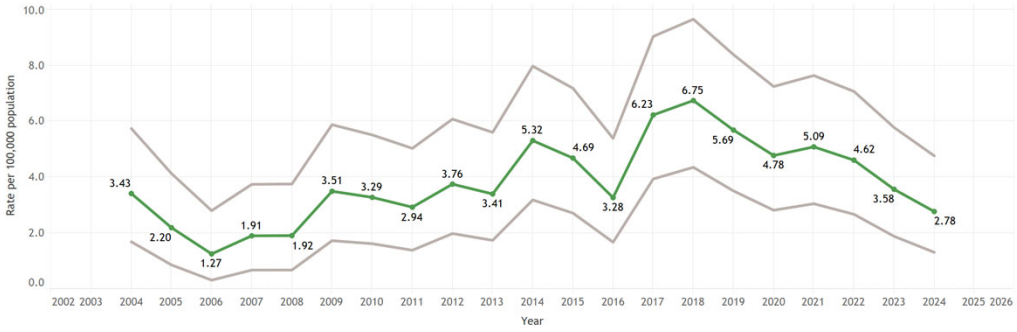
Pediatrics (2023) 152 (3): e2023063255.
https://doi.org/10.1542/peds.2023-063255 **Article history**

7

Pediatric Suicide Risk

- Colorado Data

Selected population for all charts on this page
Age: 10-14 yrs, Sex: All, Ethnicity: All, Race: All, Method: All methods, County: All
Crude rate of suicide per 100,000 population over time



*Rates and counts fewer than three are suppressed.
**Rates/data in this dashboard will differ slightly from Colorado Violent Death Reporting System data, due to the inclusion of out of state resident deaths.
Source: Vital Statistics Program, Colorado Department of Public Health and Environment.

COLORADO Department of Public Health & Environment

Accessibility statement and support: https://cdphe.colorado.gov/accessibility

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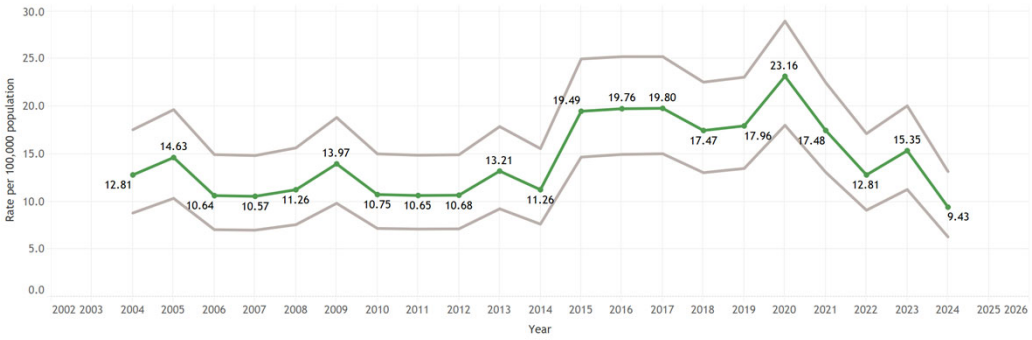
Pediatric Suicide Risk

- Colorado Data

Selected population for all charts on this page
Age: 15-18 yrs, Sex: All, Ethnicity: All, Race: All, Method: All methods, County: All
Crude rate of suicide per 100,000 population over time



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Crisis Landscape

2020

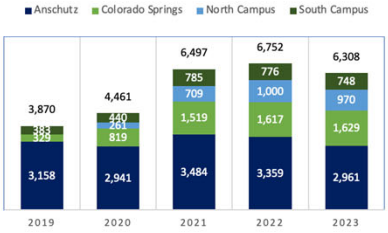
Behavioral health volumes rose, but a parallel drop in medical volumes enabled overflow capacity

2021-2022

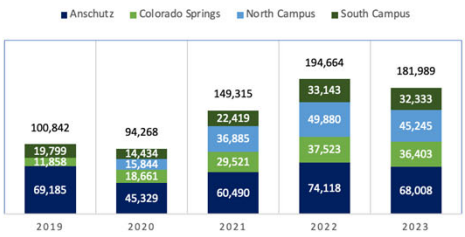
The convergence of rebounding medical volume and increased high-acuity BH volumes led to widespread space and resource deficits

Increased demand from overwhelmed primary care, community providers, and schools drove patients to the ED

BEHAVIORAL HEALTH ED VISITS



MEDICAL ED VISITS



26.8%

of Behavioral Health patients seen in the ED will return within the year.

18.4

Average Length of Stay in Hours

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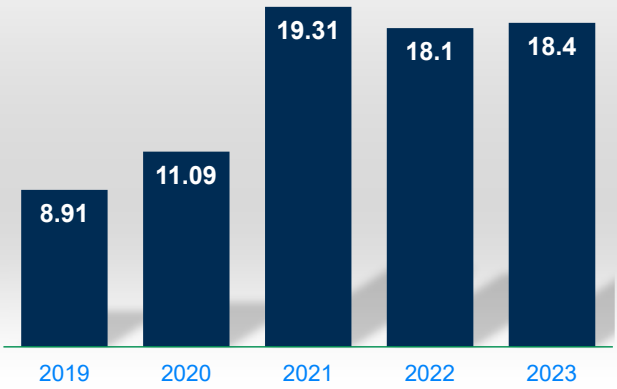
Behavioral Health ED LOS (Hours)



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AAP Screening Recommendations (2022)

American Academy of Pediatrics (AAP)/Bright Futures Recommendations for Preventative Pediatric Care recommends screening for suicide risk for all youth ages 12 and above.

- Age Recommendations:
  1. Youth ages 12+: Universal screening
  2. Youth ages 8-11: Screen when clinically indicated
  3. Youth age < 8: Screening not indicated.
     a. Assess for suicidal thoughts/behaviors if warning signs present

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Screening and Clinical Pathway Resources for Primary Care

AAP Screening for Suicide Risk in Clinical Practice

Screening Tools

Evidence-based, publicly available, validated tools for suicide risk screening in medical settings that can be used to detect suicidal ideation or behaviors:

- Ask Suicide-Screening Questions (ASQ)
- Suicide Behavior Questionnaire-Revised (SBQ-R)

https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice/

Other publicly available tools that are commonly used in primary care settings:

- Columbia Suicide Severity Rating Scale (C-SSRS) – Triage Version
- Patient Health Questionnaire – 9 Adolescent Version (PHQ-9A)
- Patient Safety Screener – 3 (PSS-3)

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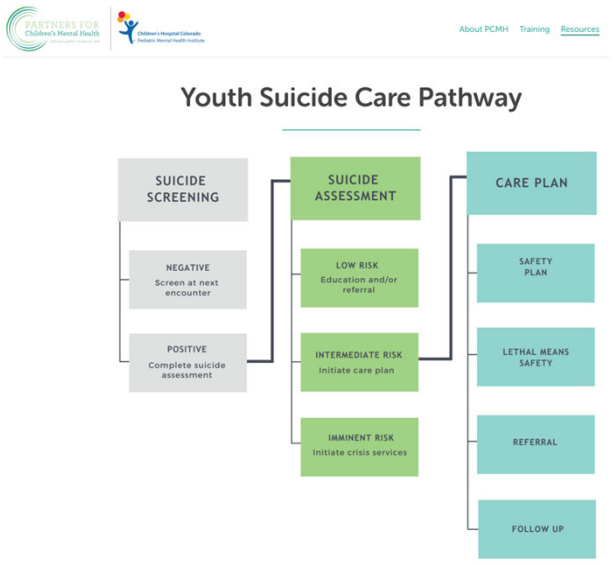
Screening and Clinical Pathway Resources for Primary Care

Partners For Children's Metal Health (PCMH) Youth Suicide Care Pathway



https://pcmh.org/youth-suicide-care-pathway/

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Screening and Clinical Pathway Resources for Primary Care

RESOURCES

- Download this card and additional resources at http://www.sprc.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide http://www.sprc.org/library/jcsafetygoals.pdf
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline
1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193
Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1. **IDENTIFY RISK FACTORS** — Note those that can be modified to reduce risk
2. **IDENTIFY PROTECTIVE FACTORS** — Note those that can be enhanced
3. **CONDUCT SUICIDE INQUIRY** — Suicidal thoughts, plans, behavior, and intent
4. **DETERMINE RISK LEVEL/INTERVENTION** — Determine risk. Choose appropriate intervention to address and reduce risk
5. **DOCUMENT** — Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis I psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live
- * *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
- * *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

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https://store.samhsa.gov/product/safe-t-pocket-card-suicide-assessment-five-

Suicide Risk Screening Tools

Ask Suicide–Screening Questions (ASQ)

- Patient report questionnaire
- Validated for ages 10-21
  a. **Yes** on #1-4: Non-Acute Positive
     a. Requires further triage/assessment
     b. Consider set up of practice
  b. **Yes** on #5: Acute Positive
     a. Requires Full Crisis/Safety Assessment
     b. ED referral

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

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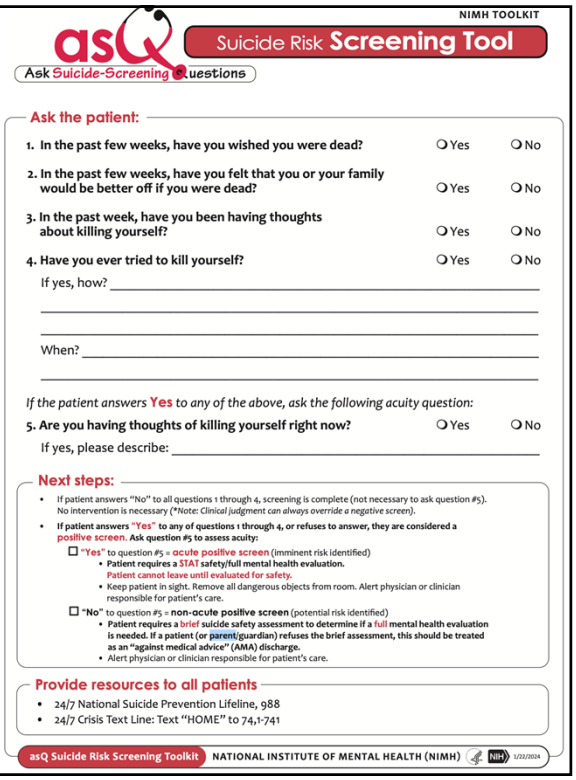
NIMH TOOLKIT

asQ Ask Suicide-Screening Questions — Suicide Risk Screening Tool

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. Have you ever tried to kill yourself? ❍ Yes ❍ No

If yes, how? _____

When? _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ❍ Yes ❍ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.**
    - **Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 74,1-741

asQ Suicide Risk Screening Toolkit · NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) · 1/22/2024

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Suicide Risk Screening Tools

Brief Suicide Safety Assessment (BSSA)

- Clinical triage tool to assist in level of risk determination for SI
- Meant to follow a non-acute positive on ASQ
  - Yes to Q#1-Q#4

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

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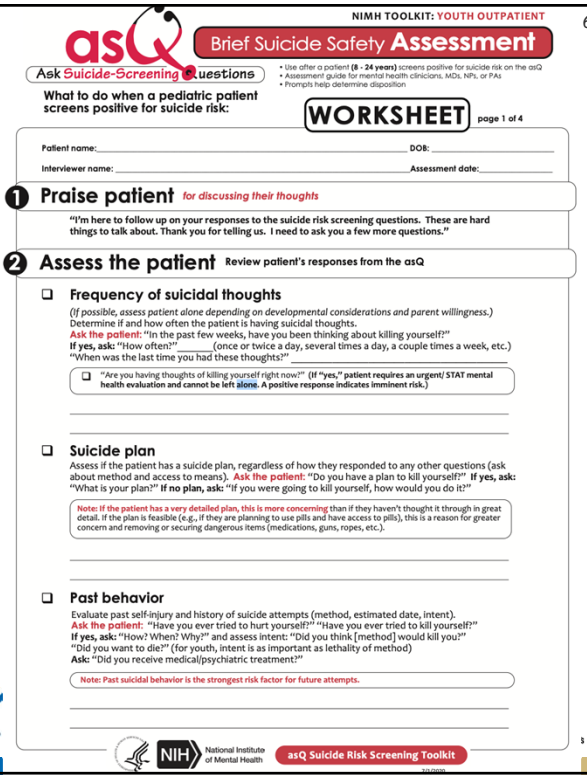
NIMH TOOLKIT: YOUTH OUTPATIENT 6

asQ Ask Suicide-Screening Questions — Brief Suicide Safety Assessment

- Use after a patient (**8 - 24 years**) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians. MDs, NPs, or PAs
- Prompts help determine disposition

What to do when a pediatric patient screens positive for suicide risk: WORKSHEET page 1 of 4

Patient name: _____ DOB: _____

Interviewer name: _____ Assessment date: _____

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient Review patient's responses from the asQ

☐ **Frequency of suicidal thoughts**

(If possible, assess patient alone depending on developmental considerations and parent willingness.)
Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?" _____ (once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" _____

☐ "Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

☐ **Suicide plan**

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

☐ **Past behavior**

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

NIH National Institute of Mental Health · asQ Suicide Risk Screening Toolkit

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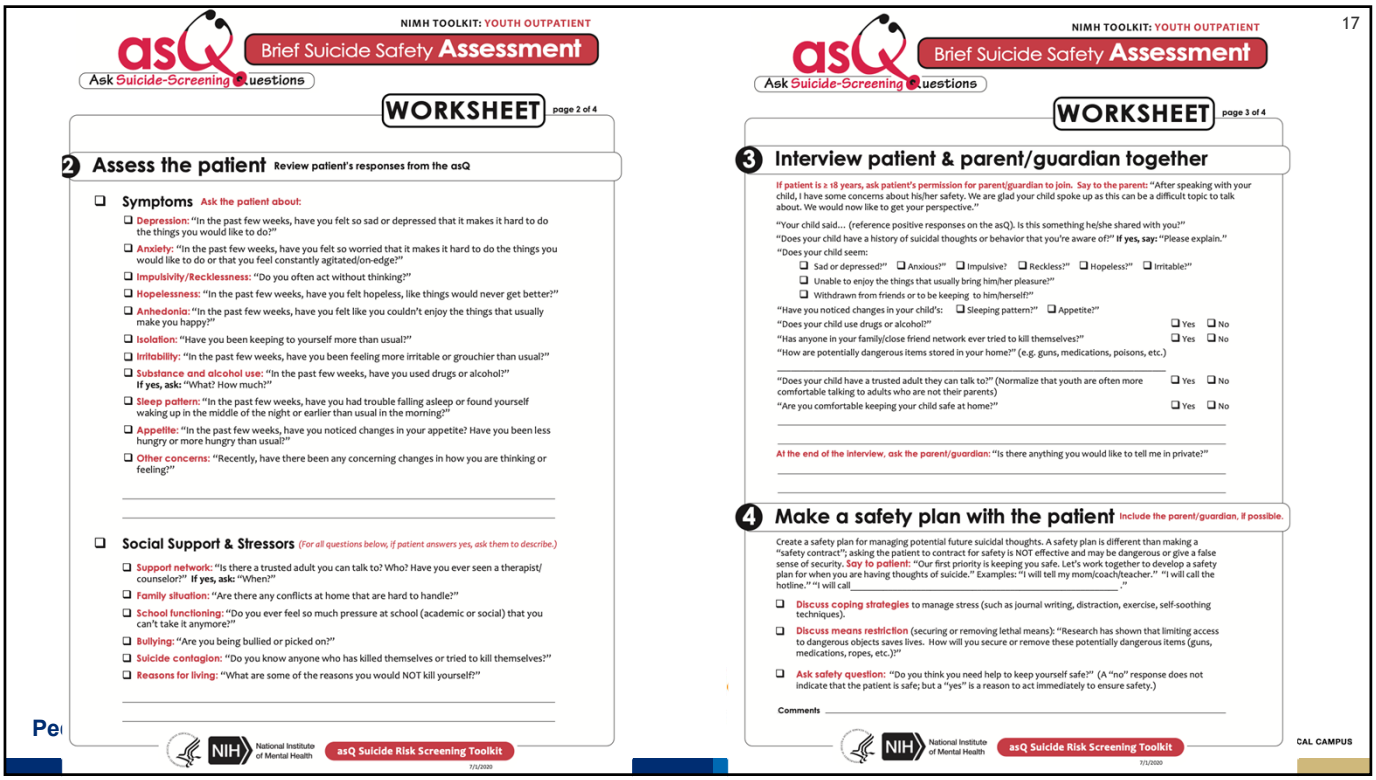

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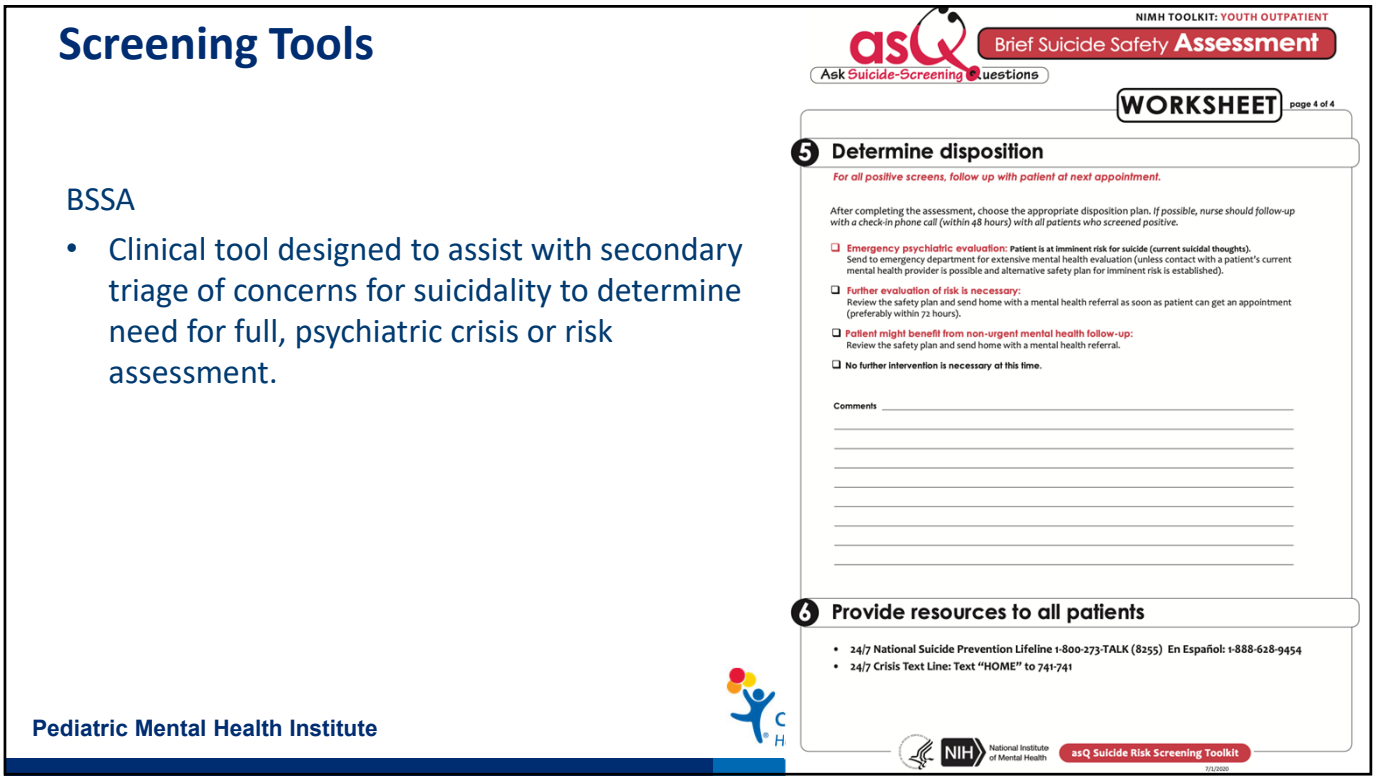
Screening Tools

BSSA

- Clinical tool designed to assist with secondary triage of concerns for suicidality to determine need for full, psychiatric crisis or risk assessment.



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Screening Tools

Columbia-Suicide Severity Rating Scale (C-SSRS)

- Age validation in some studies as young as 5 yo
- Multiple languages and screener versions available

https://cssrs.columbia.edu

Always ask questions 1 and 2.	Past Month
1) Have you wished you were dead or wished you could go to sleep and not wake up?	
2) Have you actually had any thoughts about killing yourself?	
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.	
3) Have you been thinking about how you might do this?	
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**

Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

988 SUICIDE & CRISIS LIFELINE

Any **YES** indicates that someone should seek behavioral healthcare.
However, if the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Pediatric Mental Health Institute

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Screening Tools

- Less Commonly Used
  1. Suicide-Questions Behaviors-Revised (SBQ-R)
  2. PHQ's (PHQ-2, PHQ-9, PHQ-A)

Suicide Screening

- Considerations for screening, triage, assessment in Primary Care
  - Make up of practice (Independent, Integrated, Co-Located, E-consult)
  - Available time
  - Scope and comfort of providers and or clinicians in practice

Pediatric Mental Health Institute

Children's Hospital Colorado Here, it's different.

Department of Psychiatry SCHOOL OF MEDICINE UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

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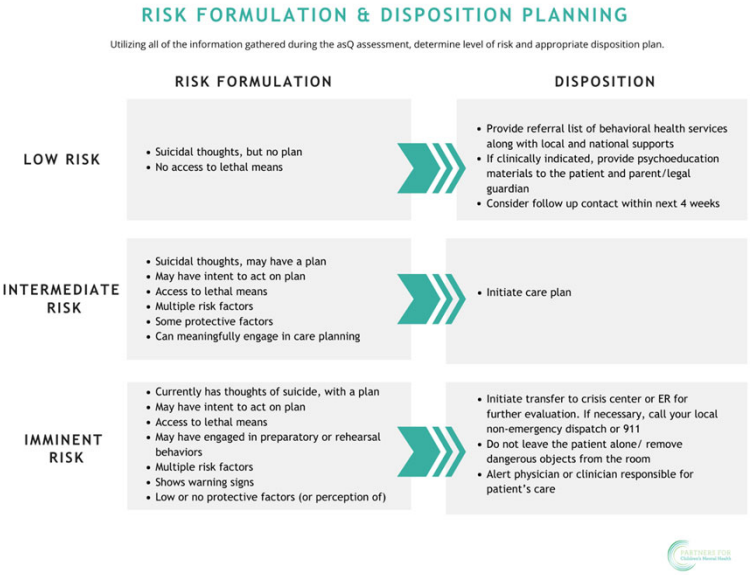
Triaging Risk in Primary Care



https://pcmh.org/youth-suicide-care-pathway/

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Care Plans for Moderate Risk Patients

1. Safety Plan (Stanley-Brown Safety Plan recommended)
2. Means Safety
3. Referral to BH Care
4. Close follow up

https://pcmh.org/wp-content/uploads/2024/09/UG24-Safety-Plan-Template.pdf

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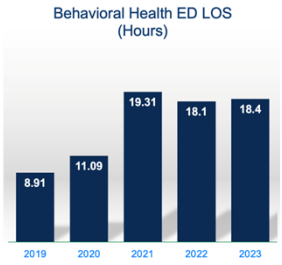
What Happens at the ED?

1. RN Sort/Triage
2. Medical Clearance Exam
3. Psychiatric Crisis Assessment



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Psychiatric Crisis Assessment

- Patient searched, gowned, moved to psych safe suite in ED with 1:1 staff
- Medical Clearance Exam conducted by PEM or pediatric provider
- Psychiatric Crisis Assessment conducted by LCSW, LPC and then staffed with a child psychiatrist
  - Evaluation includes: HPI, Psych Hx, trauma/abuse screen, substance use screen, Psych ROS, MSE, Full Columbia, Risk/Protective factors, child & guardian interview, collateral when available
  - Determination of: Imminent risk to self or others or grave disability and appropriate disposition (discharge vs inpatient admission)

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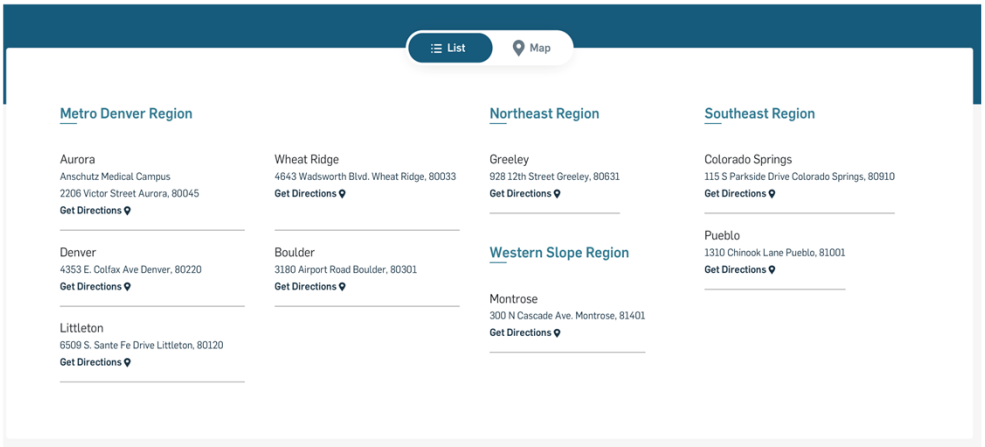
What Other Supports are Available for Escalating Behavioral Health Care in the Community?

- Crisis Walk-in Centers
- Mobile Crisis Response and Crisis Lines
- Community Mental Health Centers (CMHC's)
- PCP Tele or E-Consult models (CoPPCAP)
  - Colorado Pediatric Psychiatry Consultation & Access Program
- Established outpatient BH provider, therapist
  - Insurance matters: Commercial vs Medicaid vs Uninsured
  - Private Practice: largely fee-for-service models

Crisis Walk-In's, Crisis Lines, and Mobile Response



- Call or text 988
- Can also be connected to mobile crisis team or CIT team if calling 911

https://coloradocrisisservices.org/#map

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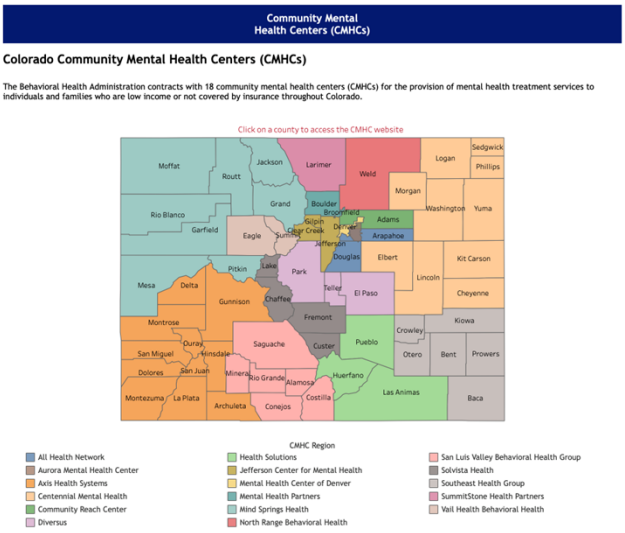
Community Mental Health Centers



https://bha.colorado.gov/get-behavioral-health-help#cmhc-so

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Tele or E-Consult Services (ie. CoPPCAP)

Pediatric Mental Health Support

Colorado Pediatric Psychiatry Consultation & Access Program

direct consultation provided to pediatric care providers by licensed child & adolescent psychiatrists, psychologists, and specialized community resource navigators

All Pediatric Primary Care, School Based Health Centers, and Family Medicine Clinics in Colorado Qualify for Services

No Insurance Based Restrictions for Consultation

Enroll Now

CoPPCAP SERVICES

- Telephone consultation (within 45 minutes of a request) with a child psychiatrist or e-consult answered within 24 hrs.
- Payor blind, all providers may seek consultation for any patient in their Colorado practice up to age 25.
- Access to information about community resources through a clinical care coordinator/navigator.
- Education on Mental Health matters unique to your practices & your communities via "Lunch & Learns", ECHO, & learning collaboratives.
- Direct face-to-face or telehealth consultation for patients with difficult diagnostic or treatment issues.
- FREE toolkit of screening tools and educational materials provided through our website.

https://www.coppcap.org

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Outpatient Services

- Established outpatient BH provider, therapist
  - Insurance matters: Commercial vs Medicaid vs Uninsured
  - Private Practice: largely fee-for-service models
- Resources for free or low cost, time-limited therapy:
  - I Matter Colorado, Second Wind Fund, school-based resources (i.e. Hazel in CCSD)

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Thank You

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CoPPCAP
Colorado Pediatric Psychiatry Consultation & Access Program

Colorado Pediatric Psychiatry Consultation and Access Program

Question: How do I assess and treat mental health concerns in primary care?

Answer: CoPPCAP! CoPPCAP aims to increase the ability and comfort of primary care clinicians to provide basic mental health assessment and treatment for their child and adolescent patients.

Core Components:

1) Telephone consultation (within 45 minutes of a request) with a child psychiatrist or e-consult answered within 24 hrs. **Toll-Free Number: 1-888-910-0153 (Monday - Friday 9:00 AM - 4:30 PM)**
2) Access to information about community resources through a clinical care coordinator/navigator.
3) Free education opportunities through different formats (see below)
4) A toolkit of screening tools and educational materials provided through website.
5) Direct face-to-face or telehealth consultation for patients with difficult diagnostic or treatment issues.
6) Payor blind, may seek consultation for any patient in practice up to age 25.
7) Community of Practice: monthly virtual gathering to discuss cases.

Sample of Free Educational Sessions			
ECHO Core Essentials (8 sessions, 3-4 times/year)	**ECHO Beyond Core Essentials (8 sessions, 3-4 times/year)**	**Learning Collaborative (September)**	**Lunch & Learn (as requested)**
Screening and Assessment	Treatment of Anxiety and Depression: Beyond 2 SSRIs	Motivational Interview	Screening Tools
What is Therapy?	Disruptive Behaviors in Preschoolers	Working with Parents of Preschoolers with Difficult Behaviors	Anxiety
ADHD	Disruptive Behaviors in School Age Children	Applying Acceptance and Commitment Therapy (ACT) in Primary Care	Suicide
Crisis and Chaos in the Primary Care Setting	Substance Use Disorder	Working with Interviewing Teens Around Mood (Depression) and Risk	Depression

What CoPPCAP participants have said:

- *Maura Capaul, FNP, Lafayette Pediatrics and Internal Medicine:* "I am so happy with your program. I take one piece of information from a consult and it's like a big cascade to apply with so many other patients!"
- *Michele Wallendal, MD, Pediatrics 5280:* "I want you to know that the last family you helped me find local resources for is extremely happy."
- *And always*: "Thanks so much; that was so very helpful."

Key Contacts:

Kristin Larpenter, MSEd, Coordinator,720-777-4124; Kristin.Larpenter@cuanschutz.edu
Sandra Fritsch, MD, Physician Leader, 720-777-3589; Sandra.fritsch@childrenscolorado.org
Xiaoshen Jin, PhD, Program Manager, 720-777-5443; Xiaoshen.Jin@cuanschutz.edu
Toll-Free Number: 1-888-910-0153; **Fax** Number: 720-777-7309; www.CoPPCAP.org

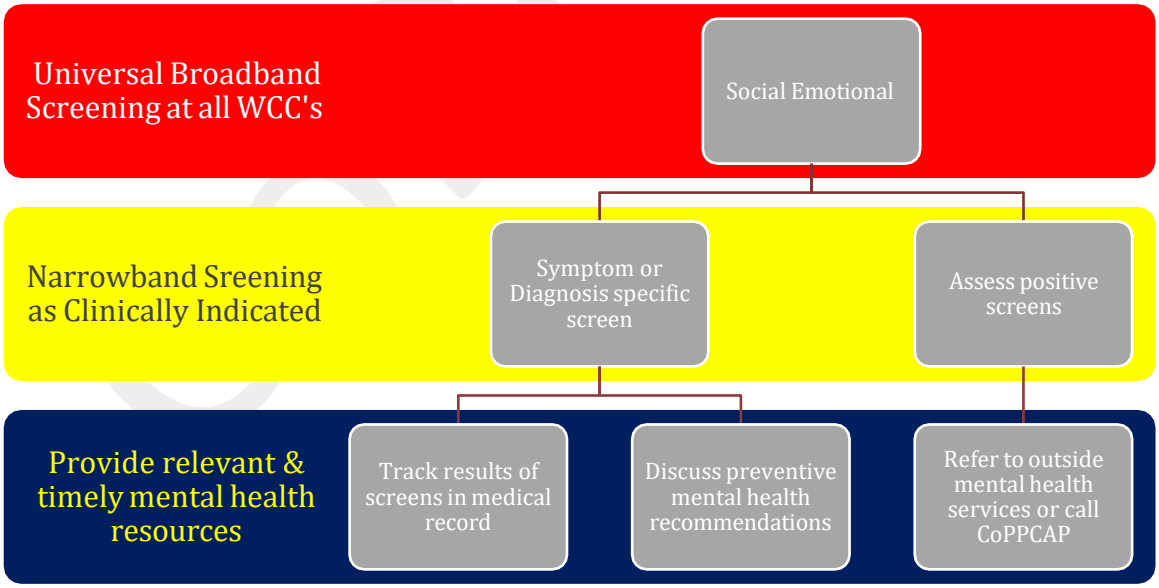
NOTE: Pediatric provider line; not intended for use by parents

In partnership with the Colorado Department of Public Health and Environment, this project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,851,222.00 with zero percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

HRSA
Health Resources & Services Administration

SCREENING & ASSESSMENT IN PEDIATRIC PRIMARY CARE

In primary care, CoPPCAP recommends providers consider the use of socioemotional screening "broadband" measures at annual well child visits. **Broadband screening** measures are meant to be used to assess multiple areas of functioning and quickly discern strengths and weaknesses in the general population. If concern is warranted, then a provider may consider the use of a **narrowband screening** form that further assesses symptomatology related to a particular disorder or condition. Taken together, the broadband and narrowband screening forms are complimentary to give primary care providers information about a child's overall level of functioning and aid in collecting specific information to help to make a specific diagnosis or to assess the severity of symptoms.



AUTHORS: Ryan Asherin, PhD, David Keller, MD, & Sandra Fritsch, MD

UNIVERSAL BROADBAND SCREENING AT ALL WCC'S

Broadband screening for social-emotional problems is recommended by the American Academy of Pediatrics for all Well Child Checks (WCC). Selection of an appropriate social-emotional broadband screen may be based off a patient's age. Federal guidelines recommend (EPDST) social-emotional broadband screening at yearly Well Child Checks (WCC). Below, CoPPCAP lists information on validated broadband social-emotional screening forms that are open source and may be used at no cost to the provider:

Screener. DxCategory	Screener.Name	Screener.Acronynm	Screener.Description
Social-Emotional Development	The Survey of Well-being of Young Children 2-60 months Caregiver Report	SWYC ⇒ English ⇒ Spanish	The Survey of Well-being of Young Children (SWYC)™ is a freely-available, comprehensive screening instrument for children under 5 years of age. The SWYC was written to be simple to answer, short, and easy to read. The entire instrument requires 15 minutes or less to complete and is straightforward to score and interpret. The SWYC is approved by MassHealth for compliance with the Children's Behavioral Health Initiative screening guidelines. The SWYC is copyright © 2010 Tufts Medical Center. Every SWYC form includes sections on developmental milestones, behavioral/emotional development, and family risk factors. At certain ages, a section for Autism-specific screening is also included. Age-specific SWYC forms are available for each age on the pediatric periodicity schedule from 2 to 60 months.
Social-Emotional Development	Preschool Pediatric	PPSC ⇒ English	The Preschool Pediatric Symptom Checklist (PPSC) is a social/emotional screening instrument for children 18–60 months of age. The PPSC was created as one part of a comprehensive screening instrument

	Symptom Checklist 18-60 months Caregiver Report	⇒ Spanish	designed for pediatric primary care and is modeled after the Pediatric Symptom Checklist.
Social-Emotional Development	Brief Early Childhood Screening Assessment 18-60 months Caregiver Report	Brief ECSA* ⇒ English	The Brief ECSA screens children 18-60 months for signs of emotional and behavioral problems.
Social-Emotional Development	Pediatric Symptom Checklist – 17 item 4-18 years Caregiver Report	PSC-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist is a 17-item screening questionnaire listing a broad range of children's emotional and behavioral problems that reflects parents' impressions of their child's psychosocial functioning. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-17 is used to screen for childhood emotional and behavioral problems including those of attention, externalizing, and internalizing.
Social-Emotional Development	Pediatric Symptom Checklist – Youth – 17 item 11-18 years	PSC-Y-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist - Youth - 17 is a 17 item screening questionnaire listing a broad range of behavioral and psychosocial problems in youth. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-Y-17 is used to screen for

	Self-Report		emotional and behavioral problems including those of attention, externalizing, internalizing, and suicidal ideation.
Social-Emotional Development	Ages & Stages Questionnaire: Social Emotional 1-72 months Caregiver Report	ASQ-SE $$$	SQ:SE- 2 is a set of questionnaires about behavior and social- emotional development in young children. There are nine questionnaires for different ages to screen children from 1 month to 6 years old.

NARROWBAND SCREENING AS CLINICALLY INDICATED

Narrowband screening for mental health problems is recommended whenever broadband measures suggest additional screening may be warranted, or if clinical concern arises during the primary care appointment. Selection of an appropriate narrow screen may be based off symptom profile or diagnostic category. Below, CoPPCAP lists information on validated narrowband screening forms that are open source and free from copyright infringement:

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
ADHD*	NICHQ Vanderbilt Assessment Scale Diagnostic Rating Scale 6-12 years Caregiver Report	Vanderbilt ⇒ English ⇒ Spanish	The Vanderbilt Assessment Scale is a 55-question assessment tool that reviews symptoms of ADHD. It also looks for other conditions such as conduct disorder, oppositional-defiant disorder, anxiety, and depression.

	Teacher Report		
Anxiety	Spence Children's Anxiety Scale 2.5 – 6.5 years (preschool) 8 – 15 years (child) Caregiver Report Self-Report	SCAS ⇒ English ⇒ Spanish	The Spence Children's Anxiety Scale (SCAS) is a psychological questionnaire designed to identify symptoms of various anxiety disorders, specifically social phobia, obsessive-compulsive disorder, panic disorder/agoraphobia, and other forms of anxiety, in children and adolescents between ages 8 and 15. Developed by Susan H. Spence and available in various languages, the 45 question test can be filled out by the child or by the parent. There is also another 34 question version of the test specialized for children in preschool between ages 2.5 and 6.5. Any form of the test takes approximately 5 to 10 minutes to complete.
Anxiety	Screen for Child Anxiety Related Disorders 8 – 18 years Caregiver Report Self-Report	SCARED ⇒ English ⇒ Spanish	The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder, and social phobia. In addition, it assesses symptoms related to school phobias.
Anxiety	Generalised Anxiety Disorder Assessment 13 – 18 years Self-Report	GAD-7 ⇒ English ⇒ Spanish	The Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item instrument that is used to measure or assess the severity of generalised anxiety disorder (GAD). Each item asks the individual to rate the severity of his or her symptoms over the past two weeks.
Autism	Modified Checklist for Autism in Toddlers, Revised 16 – 30 months Caregiver Report	M-CHAT-R ⇒ English ⇒ Spanish	The M-CHAT-R, which stands for Modified Checklist for Autism in Toddlers, Revised with Follow-Up, is a screening tool for parents to assess their child's risk for Autism Spectrum Disorder (ASD).The M-CHAT-R/F is an autism screening tool designed to identify children 16 to 30 months of age who should receive a more thorough

			assessment for possible early signs of autism spectrum disorder (ASD) or developmental delay.
Depression	Short Mood and Feelings Questionnaire 6 – 18 years Caregiver Report Self-Report	SMFQ ⇒ English ⇒ Spanish	The Short Mood and Feelings Questionnaire (SMFQ-short), child version, is an 13 item subscale from a longer 33-item questionnaire (the original MFQ). This instrument should be used an indicator of depressive symptoms and not as a diagnostic tool and therefore does not indicate whether a child or adolescent has a particular disorder. Diagnoses of mental disorder should only be made by a trained clinician after a thorough evaluation.
Depression	Patient Health Questionnaire - 9A (modified for teens) 13 – 18 years Self-Report	PHQ-9A ⇒ English ⇒ Spanish	The PHQ-9 is the nine item depression scale of the patient health questionnaire.* It is one of the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM 5.
Depression	Patient Health Questionnaire - 9 item 12+ Self-Report	PHQ-9 ⇒ English ⇒ Spanish	The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day).
Depression	Edinburgh Postnatal Depression Scale 18+ Self-Report	EPDS ⇒ English ⇒ Spanish	The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child.

Eating Disorders	Eating Attitudes Test 12 – 18+ Self-Report	EAT-26 ⇒ English	The Eating Attitudes Test (EAT, EAT-26), created by David Garner, is a widely used self-report questionnaire 26-item standardized self-report measure of symptoms and concerns characteristic of eating disorders. The EAT has been a particularly useful screening tool to assess "eating disorder risk" in high school, college and other special risk samples such as athletes. Screening for eating disorders is based on the assumption that early identification can lead to earlier treatment, thereby reducing serious physical and psychological complications or even death. Furthermore, EAT has been extremely effective in screening for anorexia nervosa in many populations.
Substance Abuse	CRAFFT 14 – 21+ years Self-Report	CRAFFT ⇒ English ⇒ Spanish	The CRAFFT Screening Test is a short clinical assessment tool designed to screen for substance-related risks and problems in adolescents. CRAFFT stands for the key words of the 6 items in the second section of the assessment - Car, Relax, Alone, Forget, Friends, Trouble.
Substance Abuse	Screening to Brief Intervention 12 – 17 years Self-Report	S2BI ⇒ English	The Screening to Brief Intervention (S2BI) tool consists of frequency of use questions to categorize substance use by adolescent patients ages 12-17 into different risk categories. The accompanying resources assist clinicians in providing patient feedback and resources for follow-up.
Suicide	Ask Suicide Screening Questions 10 – 24 years Self-Report	ASQ ⇒ English ⇒ Spanish	The Ask Suicide-Screening Questions (ASQ) Toolkit is a free resource for medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) that can help nurses or physicians successfully identify youth at risk for suicide.

Suicide	Columbia Suicide Severity Rating Scale 5+ years Provider interview	C-SSRS ⇒ English ⇒ Spanish	The Columbia–Suicide Severity Rating Scale (C-SSRS) is an assessment tool that evaluates suicidal ideation and behavior.
Trauma	Child PTSD Symptom Scale 8 – 18 years Self-Report	CPSS ⇒ English	The CPSS is designed to assess PTSD diagnosis and symptom severity in children ages 8–18 who have experienced a traumatic event. It has 24-items, 17 of which correspond to the DSM-IV symptoms. Each of the 17 items is rated on a scale from 0 to 3 with total score ranging from 0 to 51.
Trauma	Primary Care PTSD Screen 13+ years Self-Report	PC-PTSD ⇒ English	The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD.
Trauma	Trauma History Screener – Youth 3 – 18 years Caregiver Report Self-Report	THS-Y ⇒ English ⇒ Spanish	A measure of PTSD and related symptoms, including those related to complex trauma disorders.
Trauma	Young Child PTSD Screen 3 – 6 years Caregiver Report	YC-PTSD ⇒ English	The YCPS is intended to quickly screen for PTSD in the acute aftermath of traumatic events (2-4 weeks after an event) and/or in settings where there would not be time for longer assessments or more in-depth mental health assessment is not available. The screen is not intended for a general assessment of PTSD or to make a diagnosis.

PROVIDE RELEVANT & TIMELY MENTAL HEALTH RESOURCES

After providing recommended screening using broadband or narrowband efforts, as clinically indicated, it is important to document the results in the patient's medical record. Doing so allows the pediatric provider direct access to past screening results, recognition of increases/decreases in symptoms between visits, and encourages conversation around the patient's mental health. Additionally, after reviewing results of broadband or narrowband screening forms with patients, be sure to discuss relevant preventative mental health recommendations that may be effective in improving a patient's ability to function successfully and feel content. If results of screening forms or direct clinical questioning/observation warrant further mental health support, consider referring your patient to outside mental health services in your area or call CoPPCAP to discuss treatment options in Colorado.

Additionally, try to be mindful of the multiple factors (including social determinants of health) and adverse childhood experiences that can impact our mental health and optimal development. Social, biological and neurological sciences have provided insight into the role of risk and protective factors in the development of mental disorders. Biopsychosocial risk and protective factors have been identified across the lifespan from as early as fetal life. Many of these factors are modifiable and therefore potential targets for prevention and promotion efforts. High comorbidity among mental disorders and their interrelatedness with physical illnesses and social problems stress the need for integrated policies and access to resources.

BILLING & REIMBURSEMENT

Some states in the US have ratified legislation mandating reimbursement via Medicaid or insurance providers. In Colorado, the EPDS and PHQ-9 are

reimbursable by Medicaid. The table below shows reimbursement codes that have been utilized by screener.

Examples (not comprehensive)	96110[1]	96127[2]	96160[3]	96161[4]
Acute Concussion Evaluation (ACE)			x	
Ages and Stages Questionnaire (ASQ)	x			
Ages and Stages Questionnaire: Social Emotional (ASQ:SE)		x		
Beck Depression Inventory (BDI)		x		
Beck Youth Inventory – Second Edition (BYI-II)		x		
Behavior Assessment Scale for Children – 2nd Ed. (BASC-2)		x		
Children's Depression Inventory (CDI)		x		
Conners Rating Scale		x		*
CRAFFT Screening Interview		x	x	
Edinburgh Postnatal Depression Scale (EPDS)		x		*
Modified Checklist for Autism in Toddlers – Revised (MCHAT-R)	x			
Patient Health Questionnaire (PHQ-2 or PHQ-9)		x		*
Parents' Evaluation of Developmental Status (PEDS)	x			
Screen for Child Anxiety Related Disorders (SCARED)		x		
Vanderbilt ADHD rating scales		x		*

**When assessing caregiver, but billing under patient*

[1] **96110 Developmental screening** (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

[2] **96127 Brief emotional/behavioral assessment** [e.g., depression inventory, attention-deficit/hyperactivity disorder (ADHD) scale], with scoring and documentation, per standardized instrument

[3] **96160 Administration of patient-focused health risk assessment instrument** (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument

[4] **96161 Administration of caregiver-focused health risk assessment instrument** (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

Further Resources:

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

STAR CENTER | Screening Technical Assistance & Resource Center
CHILD DEVELOPMENT ★ MATERNAL DEPRESSION ★ SOCIAL DETERMINANTS OF HEALTH

Acknowledgements: PMHCA sites across multiple states.

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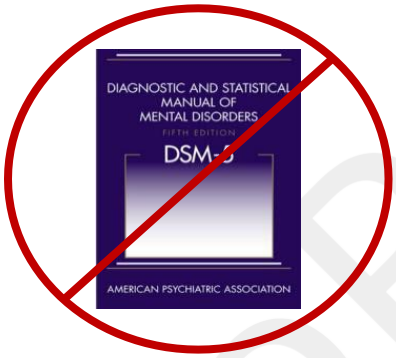
SUICIDE

• Suicide & Non-Suicidal Self Injury •

Suicide is a global pandemic with an estimated 1 million people dying from suicide per year worldwide. In the U.S. suicide is the second leading cause of death in youth aged 10yo-17yo, and in Colorado suicide is the leading cause of death in youth aged 10yo-24yo. Adolescent females are twice more likely to attempt suicide than males, and adolescent males are three times more likely to die by suicide. Adolescents are using increasingly lethal means to attempt suicide including firearms, hanging, jumping from heights, and medication overdose.



Diagnostic Criteria

Suicide and suicidal behaviors are not DSM-5 psychiatric diagnoses per se, however **suicide and suicidal behaviors are commonly seen in multiple psychiatric diagnoses** including:

- Depression
- anxiety
- disruptive behaviors
- substance use
- autism spectrum disorder

Depression is the most common diagnosis in youth who complete suicide in cases where there is a known psychiatric diagnosis. Children and adolescents that experience adversity and maltreatment including physical, sexual, emotional trauma, and neglect are at a higher risk for suicidality.

Terminology

Becoming comfortable with the following terminology facilitates improved communication between the clinician, the patient, patient's family, mental health providers, and others. The following is a list of frequently used terms:

AUTHORS:
Kolb, Eva, MD, Peterson, John, MD Ryan Asherin, PhD, & Sandra Fritsch, MD

Suicidal ideation – thoughts of killing oneself, can be passive (wish to be dead or not be around but without intent or plan) or active (desire to die with actual intent and/or plan)

Suicide attempt – purposeful self-harm with intent to die

Interrupted suicide attempt – suicidal behavior that is interrupted by another person

Aborted suicide attempt – suicidal behavior that oneself stops before completion

Nonsuicidal Self-Injury (NSSI) – intentional self-harm without intent to die that's not socially sanctioned.

Safety Plan - a written set of instructions that you create for yourself as a contingency plan should you begin to experience thoughts about harming yourself

Safety Assessment

A safety assessment allows clinicians to identify patients at risk for self-harm and helps guide intervention and treatment. The table below offers general suicide screening questionnaires that can be used with individuals 10 years of age and older (these narrowband screening forms available to download for free at https://www.coppcap.org//screening-tools).

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
Suicide	Ask Suicide Screening Questions 10 – 24 years Self-Report	ASQ ⇒ English ⇒ Spanish	The Ask Suicide-Screening Questions (ASQ) Toolkit is a free resource for medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) that can help nurses or physicians successfully identify youth at risk for suicide.
Suicide	Columbia Suicide Severity Rating Scale 5+ years Caregiver Report Self-Report	C-SSRS ⇒ English ⇒ Spanish	The Columbia–Suicide Severity Rating Scale (C-SSRS) is an assessment tool that evaluates suicidal ideation and behavior.

Depression	Edinburgh Postnatal Depression Scale 18+ years Adult Report	EPDS ⇒ English ⇒ Spanish	The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child.
Depression	Patient Health Questionnaire - 9A (modified for teens) 13 – 18 years Self Report	PHQ-9A ⇒ English	The PHQ-9 is the nine item depression scale of the patient health questionnaire.* It is one of the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM 5.
Depression	Patient Health Questionnaire - 9 12+ years Self Report	PHQ-9 ⇒ English ⇒ Spanish	The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day).

Once a patient has been identified as having a high risk for self-harm it is very important for the clinician to individualize a safety assessment for said patient and to continuously update this assessment during future appointments. The following is a list of items that should be considered and if possible, included in a safety assessment:

1. Identify Risk Factors including modifiable factors and non-modifiable factors: history of past suicide attempt, acute stressors (relationship losses, bullying, academic difficulties, family conflict, etc.), psychiatric diagnoses and chronic medical conditions (such as depression, chronic pain disorders, seizure disorders), substance use, insomnia and/or sleep disruption for other reasons, history of trauma, history of NSSI, access to means (such as guns and medications), male gender.

2. Identify Protective Factors including supportive family and peers, good problem-solving skills, engagement in mental health treatment, restricted access to lethal means (for example no guns in the home, medications in locked box controlled by parents)

3. Detailed suicide inquiry that includes existence of current active suicidal ideation, intent, and plan; recent and past history of suicidal

behaviors including suicidal behavior (including attempts, aborted attempts, interrupted attempts, etc)

4. Recommend appropriate interventions and document recommendations this could be sending the patient to the ED if at imminent risk for self-harm, developing a safety plan with both the patient and the patient's family, referring the patient to a therapist, etc

Safety Plan

Safety plans can help decrease risk for self-harm. The term "contracting for safety" or "safety contracts" are no longer used, as it is more important to work together to identify steps to ensure safety. It is important to encourage collaboration between the clinician, the patient, the patient's caregivers, and other members of the treatment team (such as therapists, school counselors, etc.). The following is not an exhaustive list of safety plan items but rather a starting point:

- **Ask.** Providers and families should regularly ask about suicidal thoughts and behaviors.
- **Restrict means.** Providers should ask all families of depressed adolescents about access to potentially harmful items including firearms, other weapons, medications (prescription and over the counter), sharps objects like knives and razors, and items that could be used for strangulation like ropes and belts and recommend removing these items from the home or locking them up.
- **Monitor for risky or suicidal behaviors.** Watch for behaviors such as:
    - Expressing hopelessness
    - Expressing suicidal or self-harm thoughts
    - Behaving in an unusually impulsive or risky manner
    - Researching means of harming oneself
    - For young children, using death as a theme in play
    - Giving away possessions
    - Talking about being a burden to others
- **Watch for substance use.** Using substances including alcohol and drugs can make it more likely that a person with suicidal thoughts acts on those thoughts, so parents so closely monitor for substance use and remove any substances from their home.
- **Develop a crisis plan or safety plan.** Develop a plan with adolescents and their parents for what to do if they are in crisis or develop suicidal thoughts. This plan should include triggers that cause distress for the child, physical

signs or behaviors that occur when they are in distress, ways parents or others can help them calm down or cope with the distress, ways they can help themselves cope, and other supports they can contact or utilize in a crisis including positive peers, supportive adults, and therapists. Local and national crisis lines and 911 can also be included.

Treatment Modalities

The goal of treatment for suicidal ideation or suicidal behaviors is to decrease risk and prevent suicide. Evidence based prevented treatments include:

- Psychotherapy:
  - Dialectical behavioral therapy (DBT) is a type of cognitive behavioral therapy. Cognitive behavioral therapy tries to identify and change negative thinking patterns and pushes for positive behavioral changes. DBT may be used to treat suicidal and other self-destructive behaviors.
  - Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) was developed using a risk reduction, relapse prevention approach and theoretically grounded in principles of cognitive behavior therapy, dialectical behavioral therapy, and targeted therapies for suicidal, depressed youth. CBT-SP consists of acute and continuation phases, each lasting about 12 sessions, and includes a chain analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention, and relapse prevention.

- Psychopharmacological:
  - The FDA has determined that the following points are appropriate for inclusion in the boxed warning:
    - Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with MDD and other psychiatric disorders.
    - Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increased suicidality with the clinical need.

        - Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.
        - Families and caregivers should be advised to closely observe the patient and to communicate with the prescriber.
        - A statement regarding whether the particular drug is approved for any pediatric indication(s) and, if so, which one(s).
    - Among the antidepressants, only Prozac is approved for use in treating MDD in pediatric patients. Prozac, Zoloft, Luvox, and Anafranil are approved for OCD in pediatric patients. None of the drugs is approved for other psychiatric indications in children.

Resources:

Crisis Hotlines:

- National Suicide Prevention Lifeline - 1-800-273-8255
    - **988** has been designated as the new three-digit dialing code that will route callers to the National Suicide Prevention Lifeline. While some areas may be currently able to connect to the Lifeline by dialing 988, this dialing code will be available to everyone across the United States starting on July 16, 2022.
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

Books for Parents:

- Adolescent Depression: A Guide for Parents by Francis Mark Mondimore, MD and Patrick Kelly, MD
- The Childhood Depression Sourcebook by Jeffrey A. Miller, PhD

Helpful Apps:

- My3 – free app available in the Apple app store and Google app store that allows users to identify three contacts to have easy access to in a crisis, as well as update and review warning signs they are in a crisis and coping strategies they can use
- Mood Tools – free CBT-based app that provides information about depression, allows users to practice skills, and has places for documenting preferred coping skills and crisis plans for easy access in a crisis
- CBT Tools for Youth – CBT-based app developed specifically for youth to help them practice CBT skills and develop and record coping skills and safety plans. Has an associated cost.
- Safe2Tell Colorado provides:
    - An anonymous way for students, parents, school staff and community members to report concerns regarding their safety or the safety of others.
    - Resources and materials for schools and communities to educate and promote the Safe2Tell Colorado initiative.
    - Technical assistance to schools and communities before and after tragic events.
    - Expertise in creating safer schools and communities through prevention and early intervention.
    - Education, awareness, and outreach to encourage reporting and breaking the code of silence.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

NAMI
National Alliance on Mental Illness

Primary References

Suicide Among Youth in Colorado, 2013-2017; Part 1, Ages 10-18; Colorado Department of Health and Environment. 2017

Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS). 2019. Available at: https://webappa.cdc.gov/sasweb/ncipc/leadcause.html. Accessed October 25, 2020.

Kann L, McManus T, Harris WA, et al. Youth Risk Behavior Surveillance-United States, 2017. MMWR CDC Surveill Summ. 2018;67:1-114.

Miron O, Yu K-H, Wilf-Miron R, Kohane IS. Suicide rates among adolescents and young adults in the United States, 2000-2017. JAMA. 2019;321:2362-2364.

Brent DA, Perper JA, Moritz G, Baugher M. Stressful life events, psychopathology, and adolescent suicide: a case control study. Suicide Life Threat Behav. 1993; 23:179-187.

Child & Adolescent Mental Health A Practical, All-In-One Guide, Jess P. Shatkin

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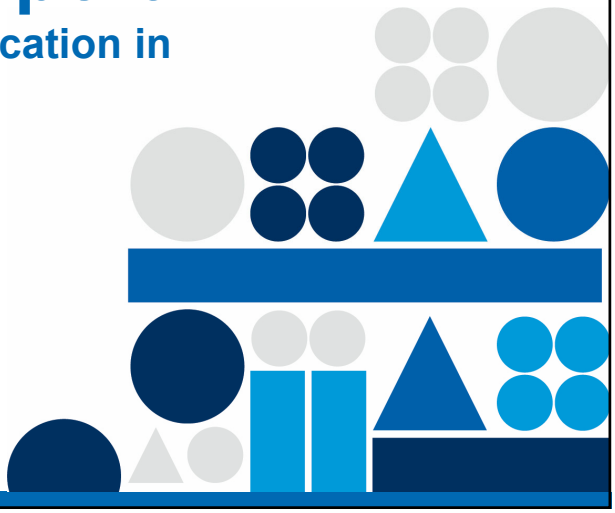
SEPT 8, 2025

Screen, Refer, Support:

Best Practices for Autism Identification in Children and Adolescents

Lauren Henry, PhD, NCSP
Licensed Child Psychologist



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Disclosure

I have no relevant financial disclosures with ineligible companies.

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Learning Objectives

1. Discuss the current evidence on autism prevalence and early identification.
2. Identify best practices and validated tools for autism screening and evaluation across developmental stages.
3. Call on community to review equitable and timely identification of autism

3

"Red Flags" of ASD Activity

4

Why This Matters

- Screen-positive children **diagnosed ~7 months earlier.**
- Early intervention → **improved outcomes** in communication, adaptive skills, academic and social functioning
- Delays in diagnosis **disproportionately affect minoritized** and **rural populations**

1 in 31

8-year-old children were identified with autism

Based on 2022 autism tracking data collected by the ADDM Network's 16 sites.

CDC, 2023; Daniels & Mandell, 2014; ADDM 2022

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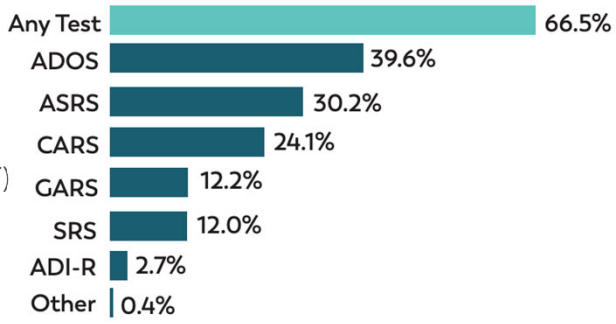
ASD Screening and Assessment

Screening:

Autism Spectrum Rating Scales (ASRS)
Childhood Autism Rating Scale (CARS)
Gilliam Autism Rating Scale (GARS)
Social Responsiveness Scale (SRS)
Modified Checklist for Autism in Toddlers (MCHAT)

Assessment:

Autism Diagnostic Observation Schedule (ADOS)
Autism Diagnostic Interview Revised (ADIR)



CDC, 2023; ADDM 2022

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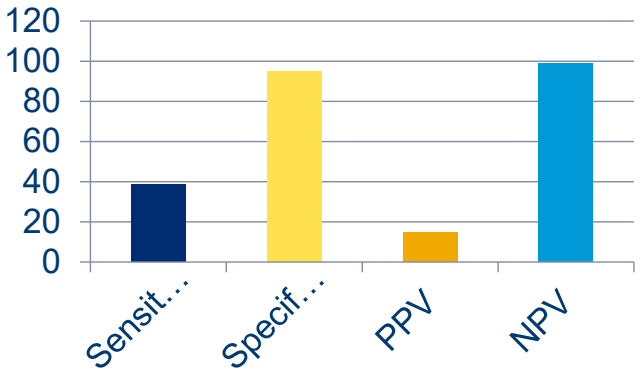
Modified Checklist for Autism in Toddlers (MCHAT)

- Imbalanced Sensitivity and Specificity
- Repeat screening improved sensitivity to 51.1%.
- Disparities: lower accuracy in girls, children of color, and lower-income families.



Source: Guthrie W, et al. (2019). Accuracy of Autism Screening. JAMA Pediatrics.

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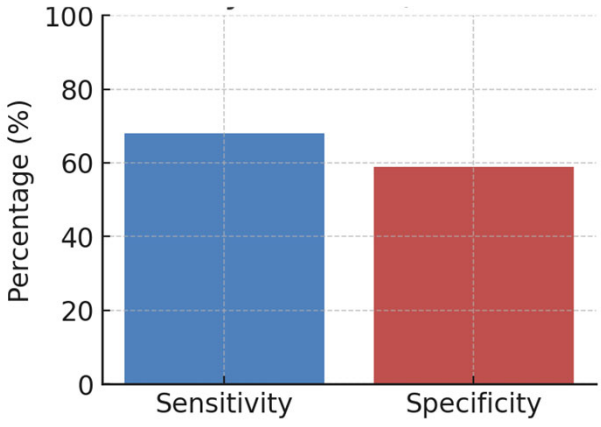
Social Communication Questionnaire (SCQ)

- False Positives: children showed higher internalizing and externalizing problems
- False Negatives: children had better social communication and adaptive skills
- Lowering cutoff to 11.



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Social Responsiveness Scale (SRS-2)

- Sensitivity & Specificity (high 80s/ low 90s)
- Strong Cross-Cultural Validity
- Limitations: Scores influenced by behavior problems, language/cognitive level, age

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Social Challenges Screening Questionnaire (SCSQ)

- The **SARRC/Think Autism initiative** emphasizes the tool's accessibility and utility for catching subtle social difficulties—even before referrals to clinical settings.
- **Validity:** Strong correlation with SRS-2 ($r = \mathbf{0.87}$, $p < 0.01$).
- **Accuracy: Sensitivity = 0.94**, **Specificity = 0.88** — indicates high screening efficiency.

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Screening Implications

- **Universal electronic screening is feasible**, but real-world accuracy of screening tools are lower than estimates from controlled research settings.
- **A single screen is insufficient**; repeat screening improves sensitivity and decreases missed cases.
- Persistent **health disparities** demand attention: screening tools may perform differently across subgroups, warranting culturally responsive approaches.
- Despite limitations, **positive screens have value** — they can lead to earlier diagnosis and access to interventions.

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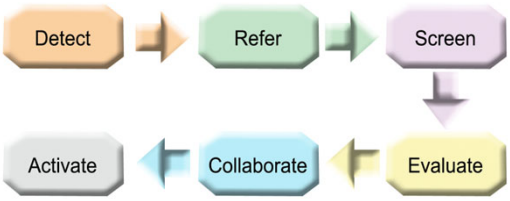
School-Based Screening for Autism



Early Detection in Schools:

- School-based universal screening can accelerate identification

Equity and Access:

- School screening can reduce disparities by reaching children across socio-demographic spectrums, including those less likely to be brought for clinical screening.

Implementation Considerations:

- brief, valid screening tools, training educators effectively, and ensuring follow-up evaluation pathways are in place.

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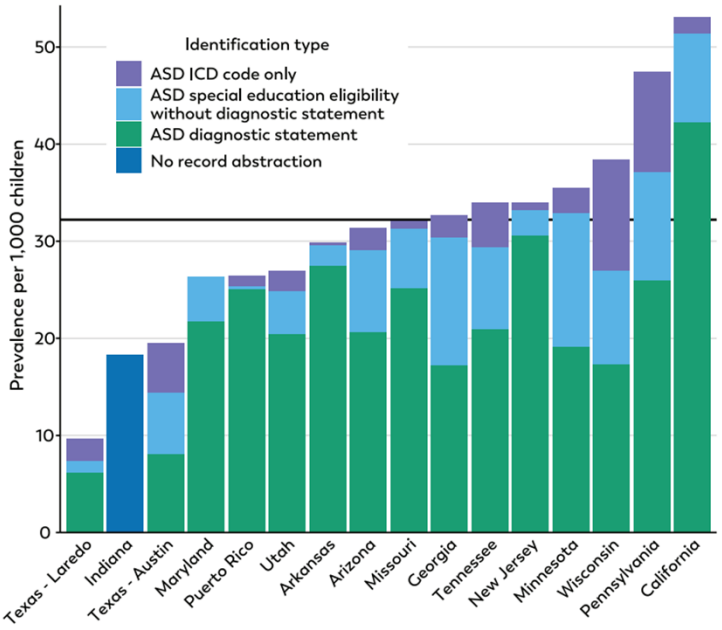
Role of Community

- **Collaborative care models** improve family satisfaction and reduce time to diagnosis
- Positive screen → referral for **comprehensive diagnostic evaluation**
- Importance of **multidisciplinary teams (**Pediatricians, Educators, Mental Health Providers, etc.)



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Educational Identification and Clinical Diagnosis of ASD

	EDUCATIONAL IDENTIFICATION	CLINICAL DIAGNOSIS
Source for definition of ASD in Colorado	IDEA/Colorado ECEA Rules	DSM-IV (APA, 2002) or DSM-5 (APA, 2013)
Decider: (i.e., who chooses the ED ID category?)	The Child Find or Individual Education Program (IEP) Team	Psychologist, Psychiatrist or Physician
Results are intended for:	Developing the student's Individualized Education Program in order to provide the student with a free and appropriate education.	Guiding parents to appropriate next steps in intervention (both in and outside of school)

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Key Takeaways

- **Screen early and often** – use validated tools
- **Refer promptly** – avoid delays in access to care
- **Support families** – provide resources, reduce stigma, emphasize strengths
- Community is crucial in the **screen–refer–support continuum**

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Questions?

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Additional Resources

- **CDC's Community Report on Autism (2025)** https://www.cdc.gov/autism/communication-resources/community-reports.html
- **CDE's Autism Spectrum Disorder (ASD) Resource Page** https://www.cde.state.co.us/cdesped/sd-autism#ed-id-resources
- **Colorado Early Intervention Services** https://dcfs.my.salesforce-sites.com/eicolorado/EI_Home?lang=en
- **Guidelines for the Educational Evaluation of Autism Spectrum Disorder** https://www.cde.state.co.us/cdesped/asd_guidelines
- **The Arc of Southwest Colorado** https://thearcofswco.org/
- **Autism Society of Colorado** https://www.autismcolorado.org/
- **Autism Speaks** https://www.autismspeaks.org/

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References

Guthrie, W., et al. (2019). Accuracy of Autism Screening. JAMA Pediatrics.

Marvin, A. R., et al. (2017). Analysis of Social Communication Questionnaire Screening for Children <4. Current Developmental Disorders Reports.

Lee, H., et al. (2023). Why are only some children with autism misclassified by the SCQ? Journal of Neurodevelopmental Disorders.

Corsello, C., et al. (2007). Identification of autism spectrum disorders in very young children. Journal of Autism and Developmental Disorders.

Oosterling, I., et al. (2009). SCQ in high-risk toddlers. Journal of Autism and Developmental Disorders.

Allen, C. W., et al. (2007). Diagnosis of autism spectrum disorders in young children. Clinical Pediatrics.

Wiggins, L. D., et al. (2007). Using SCQ cutoffs in public health ASD screening. Journal of Developmental & Behavioral Pediatrics.

Yang, X., et al. (2023). Validation of the Chinese preschool SRS-2. Research in Developmental Disabilities.

Kaiser, M. D., et al. (2022). Norwegian validation of SRS-2. Research in Autism Spectrum Disorders.

Cholemkery, H., et al. (2014). Differentiating ASD and social anxiety with SRS-2. European Child & Adolescent Psychiatry.

Capriola-Hall, N. N., et al. (2021). SRS-2 utility in socially anxious youth. Journal of Autism and Developmental Disorders.

Hus, V., et al. (2013). Factors influencing SRS scores. Journal of Child Psychology and Psychiatry.

Marlow, M., et al. (2019). Review of ASD/DD screening tools for LMICs. Autism Research.

James, S., et al. (2025). School-Based Universal Screening for Autism. School Psychology Review.

Golson, M. E., et al. (2021). Influences of student race/ethnicity and gender on autism classification. Psychology in the Schools.

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Your baby at 2 months

Baby's Name _____ **Baby's Age** _____ **Today's Date** _____

Milestones matter! How your baby plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your baby has reached by 2 months. Take this with you and talk with your baby's doctor at every well-child visit about the milestones your baby has reached and what to expect next.

What most babies do by this age:

Social/Emotional Milestones

- ☐ Calms down when spoken to or picked up
- ☐ Looks at your face
- ☐ Seems happy to see you when you walk up to her
- ☐ Smiles when you talk to or smile at her

Language/Communication Milestones

- ☐ Makes sounds other than crying
- ☐ Reacts to loud sounds

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Watches you as you move
- ☐ Looks at a toy for several seconds

Movement/Physical Development Milestones

- ☐ Holds head up when on tummy
- ☐ Moves both arms and both legs
- ☐ Opens hands briefly

Other important things to share with the doctor...

- What are some things you and your baby do together?
- What are some things your baby likes to do?
- Is there anything your baby does or does not do that concerns you?
- Has your baby lost any skills he/she once had?
- Does your baby have any special healthcare needs or was he/she born prematurely?

You know your baby best. Don't wait. If your baby is not meeting one or more milestones, has lost skills he or she once had, or you have other concerns, act early. Talk with your baby's doctor, share your concerns, and ask about developmental screening. If you or the doctor are still concerned:

1. Ask for a referral to a specialist who can evaluate your baby more; and
2. Call your state or territory's early intervention program to find out if your baby can get services to help. Learn more and find the number at **cdc.gov/FindEI**.

For more on how to help your baby, visit **cdc.gov/Concerned**.

Don't wait.
Acting early can make a real difference!

CDC Centers for Disease Control and Prevention

Download CDC's free *Milestone Tracker* app

App Store Google Play

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Help your baby learn and grow

As your baby's first teacher, you can help his or her learning and brain development. Try these simple tips and activities in a safe way. Talk with your baby's doctor and teachers if you have questions or for more ideas on how to help your baby's development.

- Respond positively to your baby. Act excited, smile, and talk to him when he makes sounds. This teaches him to take turns "talking" back and forth in conversation.
- Talk, read, and sing to your baby to help her develop and understand language.
- Spend time cuddling and holding your baby. This will help him feel safe and cared for. You will not spoil your baby by holding or responding to him.
- Being responsive to your baby helps him learn and grow. Limiting your screen time when you are with your baby helps you be responsive.
- Take care of yourself. Parenting can be hard work! It's easier to enjoy your new baby when you feel good yourself.
- Learn to notice and respond to your baby's signals to know what she's feeling and needs. You will feel good and your baby will feel safe and loved. For example, is she trying to "play" with you by making sounds and looking at you, or is she turning her head away, yawning, or becoming fussy because she needs a break?
- Lay your baby on his tummy when he is awake and put toys at eye level in front of him. This will help him practice lifting his head up. Do not leave your baby alone. If he seems sleepy, place him on his back in a safe sleep area (firm mattress with no blankets, pillows, bumper pads, or toys).
- Feed only breast milk or formula to your baby. Babies are not ready for other foods, water or other drinks for about the first 6 months of life.
- Learn when your baby is hungry by looking for signs. Watch for signs of hunger, such as putting hands to mouth, turning head toward breast/bottle, or smacking/licking lips.
- Look for signs your baby is full, such as closing her mouth or turning her head away from the breast/bottle. If your baby is not hungry, it's ok to stop feeding.
- Do not shake your baby or allow anyone else to—ever! You can damage his brain or even cause his death. Put your baby in a safe place and walk away if you're getting upset when he is crying. Check on him every 5–10 minutes. Infant crying is often worse in the first few months of life, but it gets better!
- Have routines for sleeping and feeding. This will help your baby begin to learn what to expect.

To see more tips and activities download CDC's Milestone Tracker app.

This milestone checklist is not a substitute for a standardized, validated developmental screening tool. These developmental milestones show what most children (75% or more) can do by each age. Subject matter experts selected these milestones based on available data and expert consensus.

www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)

Download CDC's free *Milestone Tracker* app

Download on the App Store | GET IT ON Google Play

Learn the Signs. Act Early.

Your baby at 4 months

Baby's Name **Baby's Age** **Today's Date**

Milestones matter! How your baby plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your baby has reached by 4 months. Take this with you and talk with your baby's doctor at every well-child visit about the milestones your baby has reached and what to expect next.

What most babies do by this age:

Social/Emotional Milestones

- ☐ Smiles on his own to get your attention
- ☐ Chuckles (not yet a full laugh) when you try to make her laugh
- ☐ Looks at you, moves, or makes sounds to get or keep your attention

Language/Communication Milestones

- ☐ Makes sounds like "oooo", "aahh" (cooing)
- ☐ Makes sounds back when you talk to him
- ☐ Turns head towards the sound of your voice

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ If hungry, opens mouth when she sees breast or bottle
- ☐ Looks at his hands with interest

Movement/Physical Development Milestones

- ☐ Holds head steady without support when you are holding her
- ☐ Holds a toy when you put it in his hand
- ☐ Uses her arm to swing at toys
- ☐ Brings hands to mouth
- ☐ Pushes up onto elbows/forearms when on tummy

Other important things to share with the doctor...

- What are some things you and your baby do together?
- What are some things your baby likes to do?
- Is there anything your baby does or does not do that concerns you?
- Has your baby lost any skills he/she once had?
- Does your baby have any special healthcare needs or was he/she born prematurely?

You know your baby best. Don't wait. If your baby is not meeting one or more milestones, has lost skills he or she once had, or you have other concerns, act early. Talk with your baby's doctor, share your concerns, and ask about developmental screening. If you or the doctor are still concerned:

1. Ask for a referral to a specialist who can evaluate your baby more; and
2. Call your state or territory's early intervention program to find out if your baby can get services to help. Learn more and find the number at **cdc.gov/FindEI**.

For more on how to help your baby, visit **cdc.gov/Concerned**.

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Help your baby learn and grow

As your baby's first teacher, you can help his or her learning and brain development. Try these simple tips and activities in a safe way. Talk with your baby's doctor and teachers if you have questions or for more ideas on how to help your baby's development.

- Respond positively to your baby. Act excited, smile, and talk to him when he makes sounds. This teaches him to take turns "talking" back and forth in conversation.
- Provide safe opportunities for your baby to reach for toys, kick at toys and explore what is around her. For example, put her on a blanket with safe toys.
- Allow your baby to put safe things in his mouth to explore them. This is how babies learn. For example, let him see, hear, and touch things that are not sharp, hot, or small enough to choke on.
- Talk, read, and sing to your baby. This will help her learn to speak and understand words later.
- Limit screen time (TV, phones, tablets, etc.) to video calling with loved ones. Screen time is not recommended for children younger than 2 years of age. Babies learn by talking, playing, and interacting with others.
- Feed only breast milk or formula to your baby. Babies are not ready for other foods, water or other drinks for about the first 6 months of life.
- Give your baby safe toys to play with that are easy to hold, like rattles or cloth books with colorful pictures for her age.
- Let your baby have time to move and interact with people and objects throughout the day. Try not to keep your baby in swings, strollers, or bouncy seats for too long.
- Set steady routines for sleeping and feeding.
- Lay your baby on her back and show her a bright-colored toy. Move the toy slowly from left to right and up and down to see if she watches how the toy moves.
- Sing and talk to your baby as you help her "exercise" (move her body) for a few minutes. Gently bend and move her arms and legs up and down.

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Learn the Signs. Act Early.

Your baby at 6 months

Baby's Name _____ **Baby's Age** _____ **Today's Date** _____

Milestones matter! How your baby plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your baby has reached by 6 months. Take this with you and talk with your baby's doctor at every well-child visit about the milestones your baby has reached and what to expect next.

What most babies do by this age:

Social/Emotional Milestones

- ☐ Knows familiar people
- ☐ Likes to look at himself in a mirror
- ☐ Laughs

Language/Communication Milestones

- ☐ Takes turns making sounds with you
- ☐ Blows "raspberries" (sticks tongue out and blows)
- ☐ Makes squealing noises

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Puts things in her mouth to explore them
- ☐ Reaches to grab a toy he wants
- ☐ Closes lips to show she doesn't want more food

Movement/Physical Development Milestones

- ☐ Rolls from tummy to back
- ☐ Pushes up with straight arms when on tummy
- ☐ Leans on hands to support himself when sitting

Other important things to share with the doctor...

- What are some things you and your baby do together?
- What are some things your baby likes to do?
- Is there anything your baby does or does not do that concerns you?
- Has your baby lost any skills he/she once had?
- Does your baby have any special healthcare needs or was he/she born prematurely?

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- Use "back and forth" play with your baby. When your baby smiles, you smile; when he makes sounds, you copy them. This helps him learn to be social.
- "Read" to your baby every day by looking at colorful pictures in magazines or books and talk about them. Respond to her when she babbles and "reads" too. For example, if she makes sounds, say "Yes, that's the doggy!"
- Point out new things to your baby and name them. For example, when on a walk, point out cars, trees, and animals.
- Sing to your baby and play music. This will help his brain develop.
- Limit screen time (TV, tablets, phones, etc.) to video calling with loved ones. Screen time is not recommended for children younger than 2 years of age. Babies learn by talking, playing, and interacting with others.
- When your baby looks at something, point to it and talk about it.
- Put your baby on her tummy or back and put toys just out of reach. Encourage her to roll over to reach the toys.
- Learn to read your baby's moods. If he's happy, keep doing what you are doing. If he's upset, take a break and comfort your baby.
- Talk with your baby's doctor about when to start solid foods and what foods are choking risks. Breast milk or formula is still the most important source of "food" for your baby.
- Learn when your baby is hungry or full. Pointing to foods, opening his mouth to a spoon, or getting excited when seeing food are signs that he is hungry. Others, like pushing food away, closing his mouth, or turning his head away from food tells you that he's had enough.
- Help your baby learn she can calm down. Talk softly, hold, rock, or sing to her, or let her suck on her fingers or a pacifier. You may offer a favorite toy or stuffed animal while you hold or rock her.
- Hold your baby up while she sits. Let her look around and give her toys to look at while she learns to balance herself.

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Learn the Signs. Act Early.

Your baby at 9 months*

Baby's Name _____ **Baby's Age** _____ **Today's Date** _____

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What most babies do by this age:

Social/Emotional Milestones

- ☐ Is shy, clingy, or fearful around strangers
- ☐ Shows several facial expressions, like happy, sad, angry, and surprised
- ☐ Looks when you call her name
- ☐ Reacts when you leave (looks, reaches for you, or cries)
- ☐ Smiles or laughs when you play peek-a-boo

Language/Communication Milestones

- ☐ Makes different sounds like "mamamama" and "babababa"
- ☐ Lifts arms up to be picked up

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Looks for objects when dropped out of sight (like his spoon or toy)
- ☐ Bangs two things together

Movement/Physical Development Milestones

- ☐ Gets to a sitting position by herself
- ☐ Moves things from one hand to her other hand
- ☐ Uses fingers to "rake" food towards himself
- ☐ Sits without support

* **It's time for developmental screening!**
At 9 months, your baby is due for general developmental screening, as recommended for all children by the American Academy of Pediatrics. Ask the doctor about your baby's developmental screening.

Other important things to share with the doctor...

- What are some things you and your baby do together?
- What are some things your baby likes to do?
- Is there anything your baby does or does not do that concerns you?
- Has your baby lost any skills he/she once had?
- Does your baby have any special healthcare needs or was he/she born prematurely?

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2. Call your state or territory's early intervention program to find out if your baby can get services to help. Learn more and find the number at **cdc.gov/FindEI**.

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Help your baby learn and grow

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- Repeat your baby's sounds and say simple words using those sounds. For example, if your baby says "bababa," repeat "bababa," then say "book."
- Place toys on the ground or on a play mat a little out of reach and encourage your baby to crawl, scoot, or roll to get them. Celebrate when she reaches them.
- Teach your baby to wave "bye-bye" or shake his head "no." For example, wave and say "bye-bye" when you are leaving. You can also teach simple baby sign language to help your baby tell you what he wants before he can use words.
- Play games, such as peek-a-boo. You can cover your head with a cloth and see if your baby pulls it off.
- Play with your baby by dumping blocks from a container and putting them back in together.
- Play games with your baby, such as my turn, your turn. Try this by passing a toy back and forth.
- "Read" to your baby. Reading can be talking about pictures. For example, while looking at books or magazines, name the pictures as you point to them.
- Limit screen time (TV, tablets, phones, etc.) to video calling with loved ones. Screen time is not recommended for children younger than 2 years of age. Babies learn by talking, playing, and interacting with others.
- Find out about choking risks and safe foods to feed your baby. Let him practice feeding himself with his fingers and using a cup with a small amount of water. Sit next to your baby and enjoy mealtime together. Expect spills. Learning is messy and fun!
- Ask for behaviors that you want. For example, instead of saying "don't stand," say "time to sit."
- Help your baby get used to foods with different tastes and textures. Foods can be smooth, mashed, or finely chopped. Your baby might not like every food on the first try. Give her a chance to try foods again and again.
- Say a quick and cheerful goodbye instead of sneaking away so your baby knows you are leaving, even if he cries. He will learn to calm himself and what to expect. Let him know when you return by saying "Daddy's back!"

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Learn the Signs. Act Early.

Your baby at 12 months

Baby's Name _____ **Baby's Age** _____ **Today's Date** _____

Milestones matter! How your baby plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your baby has reached by 12 months. Take this with you and talk with your baby's doctor at every well-child visit about the milestones your baby has reached and what to expect next.

What most babies do by this age:

Social/Emotional Milestones

- ☐ Plays games with you, like pat-a-cake

Language/Communication Milestones

- ☐ Waves "bye-bye"
- ☐ Calls a parent "mama" or "dada" or another special name
- ☐ Understands "no" (pauses briefly or stops when you say it)

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Puts something in a container, like a block in a cup
- ☐ Looks for things he sees you hide, like a toy under a blanket

Movement/Physical Development Milestones

- ☐ Pulls up to stand
- ☐ Walks, holding on to furniture
- ☐ Drinks from a cup without a lid, as you hold it
- ☐ Picks things up between thumb and pointer finger, like small bits of food

Other important things to share with the doctor...

- What are some things you and your baby do together?
- What are some things your baby likes to do?
- Is there anything your baby does or does not do that concerns you?
- Has your baby lost any skills he/she once had?
- Does your baby have any special healthcare needs or was he/she born prematurely?

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Help your baby learn and grow

As your baby's first teacher, you can help his or her learning and brain development. Try these simple tips and activities in a safe way. Talk with your baby's doctor and teachers if you have questions or for more ideas on how to help your baby's development.

- Teach your baby "wanted behaviors." Show her what to do and use positive words or give her hugs and kisses when she does it. For example, if she pulls your pet's tail, teach her how to pet gently and give her a hug when she does it.
- Talk or sing to your baby about what you're doing. For example, "Mommy is washing your hands" or sing, "This is the way we wash our hands."
- Build on what your baby tries to say. If he says "ta," say "Yes, a truck," or if he says "truck," say "Yes, that's a big, blue truck."
- Redirect your baby quickly and consistently by giving her a toy or moving her if she is getting into things you don't want her to get into. Save "no" for behaviors that are dangerous. When you say "no," say it firmly. Do not spank, yell, or give her long explanations.
- Give your baby safe places to explore. Baby-proof your home. For example, move sharp or breakable things out of reach. Lock away medicines, chemicals, and cleaning products. Save the Poison Help Line number, 800-222-1222, in all phones.
- Respond with words when your baby points. Babies point to ask for things. For example, say "You want the cup? Here is the cup. It's your cup." If he tries to say "cup," celebrate his attempt.
- Point to interesting things you see, such as a truck, bus, or animals. This will help your baby pay attention to what others are "showing" him through pointing.
- Limit screen time (TV, tablets, phones, etc.) to video calling with loved ones. Screen time is not recommended for children younger than 2 years of age. Babies learn by talking, playing, and interacting with others.
- Give your baby water, breast milk, or plain milk. You don't need to give your baby juice, but if you do, give 4 ounces or less a day of 100% fruit juice. Do not give your baby other sugary beverages, such as fruit drinks, soda, sports drinks, or flavored milks.
- Help your baby get used to foods with different tastes and textures. Foods can be smooth, mashed, or finely chopped. Your baby might not like every food on the first try. Give your baby a chance to try foods again and again.
- Give your baby time to get to know a new caregiver. Bring a favorite toy, stuffed animal, or blanket to help comfort your baby.
- Give your baby pots and pans or a small musical instrument like a drum or cymbals. Encourage your baby to make noise.

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Learn the Signs. Act Early.

Your child at 15 months

Child's Name **Child's Age** **Today's Date**

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by 15 months. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What most children do by this age:

Social/Emotional Milestones

- ☐ Copies other children while playing, like taking toys out of a container when another child does
- ☐ Shows you an object she likes
- ☐ Claps when excited
- ☐ Hugs stuffed doll or other toy
- ☐ Shows you affection (hugs, cuddles, or kisses you)

Language/Communication Milestones

- ☐ Tries to say one or two words besides "mama" or "dada," like "ba" for ball or "da" for dog
- ☐ Looks at a familiar object when you name it
- ☐ Follows directions given with both a gesture and words. For example, he gives you a toy when you hold out your hand and say, "Give me the toy."
- ☐ Points to ask for something or to get help

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Tries to use things the right way, like a phone, cup, or book
- ☐ Stacks at least two small objects, like blocks

Movement/Physical Development Milestones

- ☐ Takes a few steps on his own
- ☐ Uses fingers to feed herself some food

Other important things to share with the doctor...

- What are some things you and your child do together?
- What are some things your child likes to do?
- Is there anything your child does or does not do that concerns you?
- Has your child lost any skills he/she once had?
- Does your child have any special healthcare needs or was he/she born prematurely?

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Help your child learn and grow

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- Help your child learn to speak. A child's early words are not complete. Repeat and add to what he says. He may say "ba" for ball and you can say "Ball, yes, that's a ball."
- Tell your child the names of objects when he points to them and wait a few seconds to see if he makes any sounds before handing it to him. If he does make a sound, acknowledge him, and repeat the name of the object. "Yes! Cup."
- Find ways to let your child help with everyday activities. Let her get her shoes to go outside, put the snacks in the bag for the park, or put the socks in the basket.
- Have steady routines for sleeping and feeding. Create a calm, quiet bedtime for your child. Put on his pajamas, brush his teeth, and read 1 or 2 books to him. Children between 1 and 2 years of age need 11 to 14 hours of sleep a day (including naps). Consistent sleep times make it easier!
- Show your child different things, such as a hat. Ask him, "What do you do with a hat? You put it on your head." Put it on your head and then give it to him to see if he copies you. Do this with other objects, such as a book or a cup.
- Sing songs with gestures, such as "Wheels on the Bus." See if your child tries to do some of the actions.
- Say what you think your child is feeling (for example, sad, mad, frustrated, happy). Use your words, facial expressions, and voice to show what you think she is feeling. For example, say "You are frustrated because we can't go outside, but you can't hit. Let's go look for an indoor game."
- Expect tantrums. They are normal at this age and are more likely if your child is tired or hungry. Tantrums should become shorter and happen less as he gets older. You can try a distraction, but it is ok to let him have the tantrum without doing anything. Give him some time to calm down and move on.
- Teach your child "wanted behaviors." Show her what to do and use positive words or give her hugs and kisses when she does it. For example, if she pulls your pet's tail, teach her how to pet gently. Give her a hug when she does it.
- Limit screen time (TV, tablets, phones, etc.) to video calling with loved ones. Screen time is not recommended for children younger than 2 years of age. Children learn by talking, playing, and interacting with others.
- Encourage your child to play with blocks. You can stack the blocks and she can knock them down.
- Let your child use a cup without a lid for drinking and practice eating with a spoon. Learning to eat and drink is messy but fun!

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Learn the Signs. Act Early.

Your child at 18 months*

Child's Name **Child's Age** **Today's Date**

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by 18 months. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What most children do by this age:

Social/Emotional Milestones

- ☐ Moves away from you, but looks to make sure you are close by
- ☐ Points to show you something interesting
- ☐ Puts hands out for you to wash them
- ☐ Looks at a few pages in a book with you
- ☐ Helps you dress him by pushing arm through sleeve or lifting up foot

Language/Communication Milestones

- ☐ Tries to say three or more words besides "mama" or "dada"
- ☐ Follows one-step directions without any gestures, like giving you the toy when you say, "Give it to me."

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Copies you doing chores, like sweeping with a broom
- ☐ Plays with toys in a simple way, like pushing a toy car

Movement/Physical Development Milestones

- ☐ Walks without holding on to anyone or anything
- ☐ Scribbles
- ☐ Drinks from a cup without a lid and may spill sometimes
- ☐ Feeds herself with her fingers
- ☐ Tries to use a spoon
- ☐ Climbs on and off a couch or chair without help

*** It's time for developmental screening!**
At 18 months, your child is due for general developmental screening and an autism screening, as recommended for all children by the American Academy of Pediatrics. Ask the doctor about your child's developmental screening.

Other important things to share with the doctor...

- What are some things you and your child do together?
- What are some things your child likes to do?
- Is there anything your child does or does not do that concerns you?
- Has your child lost any skills he/she once had?
- Does your child have any special healthcare needs or was he/she born prematurely?

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- Use positive words and give more attention to behaviors you want to see ("wanted behaviors"). For example, "Look how nicely you put the toy away." Give less attention to those you don't want to see.
- Encourage "pretend" play. Give your child a spoon so she can pretend to feed her stuffed animal. Take turns pretending.
- Help your child learn about others' feelings and about positive ways to react. For example, when he sees a child who is sad, say "He looks sad. Let's bring him a teddy."
- Ask simple questions to help your child think about what's around her. For example, ask her, "What is that?"
- Let your child use a cup without a lid for drinking and practice eating with a spoon. Learning to eat and drink is messy but fun!
- Give simple choices. Let your child choose between two things. For example, when dressing, ask him if he wants to wear the red or blue shirt.
- Have steady routines for sleeping and eating. For example, sit at the table with your child when she's eating meals and snacks. This helps set mealtime routines for your family.
- Limit screen time (TV, tablets, phones, etc.) to video calling with loved ones. Screen time is not recommended for children younger than 2 years of age. Children learn by talking, playing, and interacting with others. Limit your own screen time when you are with your child so you are able to respond to her words and actions.
- Ask your child's doctor and/or teachers if your child is ready for toilet training. Most children are not successful at toilet training until 2 to 3 years old. If he is not ready, it can cause stress and setbacks, which can cause training to take longer.
- Expect tantrums. They are normal at this age and should become shorter and happen less often as your child gets older. You can try distractions, but it's ok to ignore the tantrum. Give him some time to calm down and move on.
- Talk with your child by facing her and getting down to her eye level when possible. This helps your child "see" what you're saying through your eyes and face, not just your words.
- Start to teach your child the names for body parts by pointing them out and saying things like "Here's your nose, here's my nose," while pointing to her nose and your own.

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Learn the Signs. Act Early.

Your child at 2 years*

Child's Name **Child's Age** **Today's Date**

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 2. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What most children do by this age:

Social/Emotional Milestones

- ☐ Notices when others are hurt or upset, like pausing or looking sad when someone is crying
- ☐ Looks at your face to see how to react in a new situation

Language/Communication Milestones

- ☐ Points to things in a book when you ask, like "Where is the bear?"
- ☐ Says at least two words together, like "More milk."
- ☐ Points to at least two body parts when you ask him to show you
- ☐ Uses more gestures than just waving and pointing, like blowing a kiss or nodding yes

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Holds something in one hand while using the other hand; for example, holding a container and taking the lid off
- ☐ Tries to use switches, knobs, or buttons on a toy
- ☐ Plays with more than one toy at the same time, like putting toy food on a toy plate

Movement/Physical Development Milestones

- ☐ Kicks a ball
- ☐ Runs
- ☐ Walks (not climbs) up a few stairs with or without help
- ☐ Eats with a spoon

*** It's time for developmental screening!**
At 2 years, your child is due for an autism screening, as recommended for all children by the American Academy of Pediatrics. Ask the doctor about your child's developmental screening.

Other important things to share with the doctor...

- What are some things you and your child do together?
- What are some things your child likes to do?
- Is there anything your child does or does not do that concerns you?
- Has your child lost any skills he/she once had?
- Does your child have any special healthcare needs or was he/she born prematurely?

You know your child best. Don't wait. If your child is not meeting one or more milestones, has lost skills he or she once had, or you have other concerns, act early. Talk with your child's doctor, share your concerns, and ask about developmental screening. If you or the doctor are still concerned:

1. Ask for a referral to a specialist who can evaluate your child more; and
2. Call your state or territory's early intervention program to find out if your child can get services to help. Learn more and find the number at **cdc.gov/FindEI**.

For more on how to help your child, visit **cdc.gov/Concerned**.

Don't wait.
Acting early can make a real difference!

Help your child learn and grow

As your child's first teacher, you can help his or her learning and brain development. Try these simple tips and activities in a safe way. Talk with your child's doctor and teachers if you have questions or for more ideas on how to help your child's development.

- Help your child learn how words sound, even if he can't say them clearly yet. For example, if your child says, "or nana," say "You want more banana."
- Watch your child closely during playdates. Children this age play next to each other, but do not know how to share and solve problems. Show your child how to deal with conflicts by helping her share, take turns, and use words when possible.
- Have your child help you get ready for mealtime, by letting him carry things to the table, such as plastic cups or napkins. Thank your child for helping.
- Give your child balls to kick, roll, and throw.
- Give toys that teach your child how to make things work and how to solve problems. For example, give her toys where she can push a button and something happens.
- Let your child play dress up with grown-up clothes, such as shoes, hats, and shirts. This helps him begin to pretend play.
- Allow your child to eat as much or as little as she wants at each meal. Toddlers don't always eat the same amount or type of food each day. Your job is to offer her healthy foods and it's your child's job to decide if and how much she needs to eat.
- Have steady routines for sleeping and feeding. Create a calm, quiet bedtime for your child. Put on his pajamas, brush his teeth, and read 1 or 2 books to him. Children this age need 11 to 14 hours of sleep a day (including naps). Consistent sleep times make it easier.
- Ask your child's doctor and/or teachers about toilet training to know if your child is ready to start. Most children are not able to toilet train until 2 to 3 years old. Starting too early can cause stress and setbacks, which can cause training to take longer.
- Use positive words when your child is being a good helper. Let him help with simple chores, such as putting toys or laundry in a basket.
- Play with your child outside, by playing "ready, set, go." For example, pull your child back in a swing. Say "Ready, set….", then wait and say "Go" when you push the swing.
- Let your child create simple art projects with you. Give your child crayons or put some finger paint on paper and let her explore by spreading it around and making dots. Hang it on the wall or refrigerator so your child can see it.

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Learn the Signs. Act Early.

Your child at 30 months*

Child's Name **Child's Age** **Today's Date**

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by 30 months. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What most children do by this age:

Social/Emotional Milestones

- ☐ Plays next to other children and sometimes plays with them
- ☐ Shows you what she can do by saying, "Look at me!"
- ☐ Follows simple routines when told, like helping to pick up toys when you say, "It's clean-up time."

Language/Communication Milestones

- ☐ Says about 50 words
- ☐ Says two or more words together, with one action word, like "Doggie run"
- ☐ Names things in a book when you point and ask, "What is this?"
- ☐ Says words like "I," "me," or "we"

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Uses things to pretend, like feeding a block to a doll as if it were food
- ☐ Shows simple problem-solving skills, like standing on a small stool to reach something
- ☐ Follows two-step instructions like "Put the toy down and close the door."
- ☐ Shows he knows at least one color, like pointing to a red crayon when you ask, "Which one is red?"

Movement/Physical Development Milestones

- ☐ Uses hands to twist things, like turning doorknobs or unscrewing lids
- ☐ Takes some clothes off by himself, like loose pants or an open jacket
- ☐ Jumps off the ground with both feet
- ☐ Turns book pages, one at a time, when you read to her

*** It's time for developmental screening!**
At 30 months, your child is due for general developmental screening as recommended for all children by the American Academy of Pediatrics. Ask the doctor about your child's developmental screening.

Other important things to share with the doctor...

- What are some things you and your child do together?
- What are some things your child likes to do?
- Is there anything your child does or does not do that concerns you?
- Has your child lost any skills he/she once had?
- Does your child have any special healthcare needs or was he/she born prematurely?

You know your child best. Don't wait. If your child is not meeting one or more milestones, has lost skills he or she once had, or you have other concerns, act early. Talk with your child's doctor, share your concerns, and ask about developmental screening. If you or the doctor are still concerned:

1. Ask for a referral to a specialist who can evaluate your child more; and
2. Call your state or territory's early intervention program to find out if your child can get services to help. Learn more and find the number at **cdc.gov/FindEI**.

For more on how to help your child, visit **cdc.gov/Concerned**.

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Help your child learn and grow

As your child's first teacher, you can help his or her learning and brain development. Try these simple tips and activities in a safe way. Talk with your child's doctor and teachers if you have questions or for more ideas on how to help your child's development.

- Encourage "free play," where your child can follow her interests, try new things, and use things in new ways.
- Use positive words and give more attention to behaviors you want to see ("wanted behaviors"), than to those you don't want to see. For example, say "I like how you gave Jordan the toy."
- Give your child food choices that are simple and healthy. Let him choose what to eat for a snack or what to wear. Limit choices to two or three.
- Ask your child simple questions about books and stories. Ask questions, such as "Who?" "What?" and "Where?"
- Help your child learn how to play with other children. Show him how by helping him share, take turns, and use his "words."
- Let your child "draw" with crayons on paper, shaving cream on a tray, or chalk on a sidewalk. If you draw a straight line, see if she will copy you. When she gets good at lines, show her how to draw a circle.
- Let your child play with other children, such as at a park or library. Ask about local play groups and pre-school programs. Playing with others helps him learn the value of sharing and friendship.
- Eat family meals together as much as you can. Give the same meal to everyone. Enjoy each other's company and avoid screen time (TV, tablets, and phones, etc.) during meals.
- Limit screen time (TV, tablets, phones, etc.) to no more than 1 hour per day of a children's program with an adult present. Children learn by talking, playing, and interacting with others.
- Use words to describe things to your child, such as big/small, fast/slow, on/off, and in/out.
- Help your child do simple puzzles with shapes, colors, or animals. Name each piece when your child puts it in place.
- Play with your child outside. For example, take your child to the park to climb on equipment and run in safe areas.
- Allow your child to eat as much or as little as she wants at each meal. Your job is to offer her healthy foods and it's your child's job to decide if and how much she wants to eat.

To see more tips and activities download CDC's Milestone Tracker app.

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Your child at 3 years

Child's Name **Child's Age** **Today's Date**

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 3. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What most children do by this age:

Social/Emotional Milestones

- ☐ Calms down within 10 minutes after you leave her, like at a childcare drop off
- ☐ Notices other children and joins them to play

Language/Communication Milestones

- ☐ Talks with you in conversation using at least two back-and-forth exchanges
- ☐ Asks "who," "what," "where," or "why" questions, like "Where is mommy/daddy?"
- ☐ Says what action is happening in a picture or book when asked, like "running," "eating," or "playing"
- ☐ Says first name, when asked
- ☐ Talks well enough for others to understand, most of the time

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Draws a circle, when you show him how
- ☐ Avoids touching hot objects, like a stove, when you warn her

Movement/Physical Development Milestones

- ☐ Strings items together, like large beads or macaroni
- ☐ Puts on some clothes by himself, like loose pants or a jacket
- ☐ Uses a fork

Other important things to share with the doctor...

- What are some things you and your child do together?
- What are some things your child likes to do?
- Is there anything your child does or does not do that concerns you?
- Has your child lost any skills he/she once had?
- Does your child have any special healthcare needs or was he/she born prematurely?

You know your child best. Don't wait. If your child is not meeting one or more milestones, has lost skills he or she once had, or you have other concerns, act early. Talk with your child's doctor, share your concerns, and ask about developmental screening. If you or the doctor are still concerned:

1. Ask for a referral to a specialist who can evaluate your child more; and
2. Call any local public elementary school for a free evaluation to find out if your child can get services to help.

For more on how to help your child, visit **cdc.gov/Concerned**.

Don't wait.
Acting early can make a real difference!

Help your child learn and grow

As your child's first teacher, you can help his or her learning and brain development. Try these simple tips and activities in a safe way. Talk with your child's doctor and teachers if you have questions or for more ideas on how to help your child's development.

- Encourage your child to solve her own problems with your support. Ask questions to help her understand the problem. Help her think of solutions, try one out, and try more if needed.
- Talk about your child's emotions and give him words to help him explain how he's feeling. Help your child manage stressful feelings by teaching him to take deep breaths, hug a favorite toy, or go to a quiet, safe place when he is upset.
- Set a few simple and clear rules that your child can follow, such as use gentle hands when playing. If he breaks a rule, show him what to do instead. Later, if your child follows the rule, recognize and congratulate him.
- Read with your child. Ask questions, such as "What is happening in the picture?" and/or "What do you think will happen next?" When she gives you an answer, ask for more details.
- Play counting games. Count body parts, stairs, and other things you use or see every day. Children this age are starting to learn about numbers and counting.
- Help your child develop his language skills by speaking to him in longer sentences than his, using real words. Repeat what he says, for example, "need nana," and then show how to use more "grown-up" words by saying, "I want a banana."
- Let your child help with making meals. Give him simple tasks, such as washing fruits and vegetables or stirring.
- Give your child instructions with 2 or 3 steps. For example, "Go to your room and get your shoes and coat."
- Limit screen time (TV, tablets, phones, etc.) to no more than 1 hour per day of a children's program with an adult present. Don't put any screens in your child's bedroom. Children learn by talking, playing, and interacting with others.
- Teach your child simple songs and rhymes, such as "Itsy Bitsy Spider" or "Twinkle, Twinkle, Little Star."
- Give your child an "activity box" with paper, crayons, and coloring books. Color and draw lines and shapes with your child.
- Encourage your child to play with other children. This helps him learn the value of friendship and how to get along with others.

To see more tips and activities download CDC's Milestone Tracker app.

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Learn the Signs. Act Early.

Your child at 4 years

Child's Name **Child's Age** **Today's Date**

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 4. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What most children do by this age:

Social/Emotional Milestones

- ☐ Pretends to be something else during play (teacher, superhero, dog)
- ☐ Asks to go play with children if none are around, like "Can I play with Alex?"
- ☐ Comforts others who are hurt or sad, like hugging a crying friend
- ☐ Avoids danger, like not jumping from tall heights at the playground
- ☐ Likes to be a "helper"
- ☐ Changes behavior based on where she is (place of worship, library, playground)

Language/Communication Milestones

- ☐ Says sentences with four or more words
- ☐ Says some words from a song, story, or nursery rhyme
- ☐ Talks about at least one thing that happened during his day, like "I played soccer."
- ☐ Answers simple questions like "What is a coat for?" or "What is a crayon for?"

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Names a few colors of items
- ☐ Tells what comes next in a well-known story
- ☐ Draws a person with three or more body parts

Movement/Physical Development Milestones

- ☐ Catches a large ball most of the time
- ☐ Serves himself food or pours water, with adult supervision
- ☐ Unbuttons some buttons
- ☐ Holds crayon or pencil between fingers and thumb (not a fist)

Other important things to share with the doctor...

- What are some things you and your child do together?
- What are some things your child likes to do?
- Is there anything your child does or does not do that concerns you?
- Has your child lost any skills he/she once had?
- Does your child have any special healthcare needs or was he/she born prematurely?

You know your child best. Don't wait. If your child is not meeting one or more milestones, has lost skills he or she once had, or you have other concerns, act early. Talk with your child's doctor, share your concerns, and ask about developmental screening. If you or the doctor are still concerned:

1. Ask for a referral to a specialist who can evaluate your child more; and
2. Call any local public elementary school for a free evaluation to find out if your child can get services to help.

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Help your child learn and grow

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- Help your child be ready for new places and meeting new people. For example, you can read stories or role play (pretend play) to help him be comfortable.
- Read with your child. Ask him what's happening in the story and what he thinks might happen next.
- Help your child learn about colors, shapes, and sizes. For example, ask the color, shapes, and size of things she sees during the day.
- Encourage your child to use "his words" to ask for things and solve problems but show him how. He may not know the words he needs. For example, help your child say, "Can I have a turn?" instead of taking something from someone.
- Help your child learn about others' feelings, and about positive ways to react. For example, when he sees a child who is sad, say "He looks sad. Let's bring him a teddy."
- Use positive words and give attention to behaviors you want to see ("wanted behaviors"). For example, say "You're sharing that toy so nicely!" Give less attention to those you don't want to see.
- Tell your child in a simple way why she can't do something you don't want her to do ("unwanted behavior"). Give her a choice of what she can do instead. For example, "You can't jump on the bed. Do you want to go outside and play or put on some music and dance?"
- Let your child play with other children, such as at a park or library. Ask about local play groups and pre-school programs. Playing with others helps you child learn the value of sharing and friendship.
- Eat meals with your child when possible. Let her see you enjoying healthy foods, such as fruits, vegetables, and whole grains, and drinking milk or water.
- Create a calm, quiet bedtime routine. Avoid any screen time (TV, phone, tablet, etc.) for 1 to 2 hours before bed and don't put any screens in your child's bedroom. Children this age need 10 to 13 hours of sleep a day (including naps). Consistent sleep times make it easier!
- Give your child toys or things that encourage his imagination, such as dress-up clothes, pots and pans to pretend cook, or blocks to build with. Join him in pretend play, such as eating the pretend food he cooks.
- Take time to answer your child's "why" questions. If you don't know the answer, say "I don't know," or help your child find the answer in a book, on the Internet, or from another adult.

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Learn the Signs. Act Early.

Your child at 5 years

Child's Name _____ **Child's Age** _____ **Today's Date** _____

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 5. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What most children do by this age:

Social/Emotional Milestones

- ☐ Follows rules or takes turns when playing games with other children
- ☐ Sings, dances, or acts for you
- ☐ Does simple chores at home, like matching socks or clearing the table after eating

Language/Communication Milestones

- ☐ Tells a story she heard or made up with at least two events. For example, a cat was stuck in a tree and a firefighter saved it
- ☐ Answers simple questions about a book or story after you read or tell it to him
- ☐ Keeps a conversation going with more than three back-and-forth exchanges
- ☐ Uses or recognizes simple rhymes (bat-cat, ball-tall)

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Counts to 10
- ☐ Names some numbers between 1 and 5 when you point to them
- ☐ Uses words about time, like "yesterday," "tomorrow," "morning," or "night"
- ☐ Pays attention for 5 to 10 minutes during activities. For example, during story time or making arts and crafts (screen time does not count)
- ☐ Writes some letters in her name
- ☐ Names some letters when you point to them

Movement/Physical Development Milestones

- ☐ Buttons some buttons
- ☐ Hops on one foot

Other important things to share with the doctor...

- What are some things you and your child do together?
- What are some things your child likes to do?
- Is there anything your child does or does not do that concerns you?
- Has your child lost any skills he/she once had?
- Does your child have any special healthcare needs or was he/she born prematurely?

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1. Ask for a referral to a specialist who can evaluate your child more; and
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- Your child might start to "talk back" in order to feel independent and test what happens. Limit the attention you give to the negative words. Find alternative activities for her to do that allow her to take the lead and be independent. Make a point of noticing good behavior. "You stayed calm when I told you it's bedtime."
- Ask your child what she is playing. Help her expand her answers by asking "Why?" and "How?" For example, say "That's a nice bridge you're building. Why did you put it there?"
- Play with toys that encourage your child to put things together, such as puzzles and building blocks.
- Use words to help your child begin to understand time. For example, sing songs about the days of the week and let him know what day it is. Use words about time, such as today, tomorrow, and yesterday.
- Let your child do things for himself, even if he doesn't do it perfectly. For example, let him make his bed, button his shirt, or pour water into a cup. Celebrate when he does it and try not to "fix" anything you don't have to.
- Talk about and label your child's and your own feelings. Read books and talk about the feelings characters have and why they have them.
- Play rhyming games. For example, say "What rhymes with cat?"
- Teach your child to follow rules in games. For example, play simple board games, card games, or Simon Says.
- Create a spot in your home for your child to go to when he's upset. Stay nearby so your child knows he is safe and can come to you for help calming as needed.
- Set limits for screen time (TV, tablets, phones, etc.) for your child, to no more than 1 hour per day. Make a media use plan for your family.
- Eat meals with your child and enjoy family time talking together. Give the same meal to everyone. Avoid screen time (TV, tablets, phones, etc.) during mealtime. Let your child help prepare the healthy foods and enjoy them together.
- Encourage your child to "read" by looking at the pictures and telling the story.
- Play games that help with memory and attention. For example, play card games, Tic Tac Toe, I Spy, or Hot and Cold.

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Su bebé a los 2 meses

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su bebé juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su bebé ha alcanzado a los 2 meses. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su bebé ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los bebés hacen a esta edad:

En las áreas social y emocional

- ☐ Se calma cuando le hablan o lo alzan
- ☐ Lo mira a la cara
- ☐ Parece estar feliz cuando usted se le acerca
- ☐ Sonríe cuando usted le habla o le sonríe

En las áreas del habla y la comunicación

- ☐ Hace sonidos como “agú”, “aahh”
- ☐ Reacciona a los sonidos fuertes

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Lo observa mientras usted se mueve
- ☐ Fija la vista en un juguete por varios segundos

En las áreas motora y de desarrollo físico

- ☐ Mantiene la cabeza alzada cuando está boca abajo
- ☐ Mueve ambos brazos y piernas
- ☐ Abre las manos brevemente

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su bebé? _____
2. ¿Cuáles son algunas cosas que su bebé disfruta hacer o que hace bien? _____
3. ¿Hay algo que su bebé hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su bebé alguna habilidad que antes tenía? _____
5. ¿Nació su bebé prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su bebé mejor que nadie. Si su bebé no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su bebé, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su bebé puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su bebé, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su bebé? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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☐ **¡Comparta esta lista de verificación y haga seguimiento a los indicadores del desarrollo!** Lleve esta lista al próximo chequeo de su hijo y asegúrese de compartirla con el médico y las otras personas que lo atienden. Haga el seguimiento descargando la *app* GRATUITA de los CDC *Sigamos el Desarrollo* o encuentre listas de verificación en línea en **www.cdc.gov/Indicadores**.

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- Alimente a su bebé únicamente con leche materna o fórmula. Los bebés no están listos para otros alimentos, agua ni otras bebidas durante los primeros 6 meses de vida aproximadamente.
- Aprenda cuándo su bebé tiene hambre buscando signos. Esté atento a los signos de hambre, como llevarse las manos a la boca, girar la cabeza hacia el pecho o el biberón, o chasquear o lamerse los labios.
- Busque señales de que su bebé está satisfecho, como cerrar la boca o alejar la cabeza del pecho o el biberón. Si su bebé no tiene hambre, está bien que pare de alimentarlo.
- Cuídese. ¡La crianza de los hijos puede ser un trabajo duro! Es más fácil disfrutar a su bebé cuando usted se siente bien.
- Háblele, léale y cántele a su bebé para ayudarlo a desarrollar y comprender el lenguaje.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga "Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda". No necesita la remisión de un médico para llamar a este programa.

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Nota para el doctor _____ :

- WIC (el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños) anima a las familias a hablar sobre el desarrollo de su niño con usted.
- Esta lista de verificación refleja los indicadores que está previsto que **LA MAYORÍA de los niños (al menos un 75 %)** alcancen para esta edad.
- No haber alcanzado algunos indicadores puede ser una señal de la necesidad de realizar pruebas del desarrollo. La Academia Estadounidense de Pediatría (AAP, por sus siglas en inglés) recomienda realizar pruebas del desarrollo entre las edades recomendadas para realizarlas, si surgen preocupaciones; esta lista de verificación no es un sustituto de una herramienta de pruebas estandarizada y validada.
- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

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1-800-CDC-INFO (1-800-232-4636)

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Aprenda los signos. Reaccione pronto.

Su bebé a los 4 meses

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su bebé juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su bebé ha alcanzado a los 4 meses. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su bebé ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los bebés hacen a esta edad:

En las áreas social y emocional

- ☐ Sonríe solito para llamar su atención
- ☐ Suelta una risita (todavía no una risa completa) cuando usted trata de hacerlo reír
- ☐ Lo mira, se mueve o hace sonidos para llamar o mantener su atención

En las áreas del habla y la comunicación

- ☐ Gorjea (“agú”, “aahh”)
- ☐ Responde con sonidos cuando usted le habla
- ☐ Voltea la cabeza hacia el sonido de su voz

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Si tiene hambre, abre la boca cuando ve el pecho o el biberón
- ☐ Mira sus propias manos con interés

En las áreas motora y de desarrollo físico

- ☐ Mantiene la cabeza firme, sin apoyo, cuando usted lo tiene en brazos
- ☐ Sujeta un juguete cuando usted se lo pone en la mano
- ☐ Usa su brazo para manotear a los juguetes
- ☐ Se lleva las manos a la boca
- ☐ Cuando está boca abajo, se levanta hasta apoyarse en los codos y antebrazos

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su bebé? _____
2. ¿Cuáles son algunas cosas que su bebé disfruta hacer o que hace bien? _____
3. ¿Hay algo que su bebé hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su bebé alguna habilidad que antes tenía? _____
5. ¿Nació su bebé prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su bebé mejor que nadie. Si su bebé no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su bebé, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su bebé puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su bebé, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su bebé? _____

_____

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- Alimente a su bebé únicamente con leche materna o fórmula. Los bebés no están listos para otros alimentos, agua ni otras bebidas durante los primeros 6 meses de vida aproximadamente.
- Deje que su bebé tenga tiempo para moverse e interactuar con personas y objetos a lo largo del día. Trate de no mantener a su bebé en un columpio, cochecito o silla mecedora por mucho tiempo.
- Permita que el bebé se ponga cosas en la boca, que no sean peligrosas, para explorarlas. Así es como los bebés aprenden. Por ejemplo, déjelo que toque cosas que no sean ilosas, no estén calientes ni sean demasiado pequeñas como para atragantarse.
- Acueste a su bebé boca arriba y muéstrele un juguete de colores brillantes. Muévalo despacito, de izquierda a derecha y de arriba a abajo, para ver si el bebé mira cómo se mueve el juguete.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga "Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda". No necesita la remisión de un médico para llamar a este programa.

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Nota para el doctor _____ :

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Aprenda los signos. Reaccione pronto.

Su bebé a los 6 meses

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su bebé juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su bebé ha alcanzado a los 6 meses. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su bebé ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los bebés hacen a esta edad:

En las áreas social y emocional

- ☐ Reconoce a las personas conocidas
- ☐ Le gusta mirarse en el espejo
- ☐ Se ríe

En las áreas del habla y la comunicación

- ☐ Se turna con usted para hacer sonidos
- ☐ Hace burbujas y sonidos con la boquita (saca la lengua y sopla)
- ☐ Hace sonidos de placer (gritos de alegría)

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Se pone cosas en la boca para explorarlas
- ☐ Estira el brazo para agarrar el juguete que quiere
- ☐ Cierra los labios para mostrar que no quiere más comida

En las áreas motora y de desarrollo físico

- ☐ Cuando está boca abajo, puede voltearse y quedar boca arriba
- ☐ Cuando está boca abajo, se levanta hasta sostenerse con los brazos derechos
- ☐ Usa las manos para apoyarse cuando está sentado

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su bebé? _____
2. ¿Cuáles son algunas cosas que su bebé disfruta hacer o que hace bien? _____
3. ¿Hay algo que su bebé hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su bebé alguna habilidad que antes tenía? _____
5. ¿Nació su bebé prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su bebé mejor que nadie. Si su bebé no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su bebé, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su bebé puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su bebé, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su bebé? _____

_____

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- Hable con el médico de su bebé acerca de cuándo comenzar con los alimentos sólidos y qué alimentos tienen riesgo de asfixia. La leche materna o la fórmula siguen siendo la fuente de alimentación más importante para su bebé.
- Señale cosas nuevas y dígale cómo se llaman. Por ejemplo, durante una caminata, señálele los autos, los árboles y los animales.
- Ponga al bebé boca abajo o boca arriba y coloque juguetes apenas fuera de su alcance. Anímelo a que se dé vuelta para llegar a los juguetes.
- Aprenda cuándo su bebé tiene hambre o está satisfecho. Señalar hacia los alimentos, abrir la boca cuando le muestra una cuchara o emocionarse al ver comida son signos de que tiene hambre. Otros, como alejar los alimentos, cerrar la boca o apartar la cabeza de la comida, le dicen que ya ha tenido suficiente.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

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Nota para el doctor _____ :

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Aprenda los signos. Reaccione pronto.

Su bebé a los 9 meses*

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su bebé juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su bebé ha alcanzado a los 9 meses. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su bebé ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los bebés hacen a esta edad:

En las áreas social y emocional

- ☐ Es tímido, inseguro o se muestra asustado alrededor de extraños
- ☐ Muestra varias expresiones faciales (contento, triste, enojado y sorprendido)
- ☐ Lo mira cuando usted lo llama por su nombre
- ☐ Reacciona cuando usted se va (lo busca con la mirada, estira los brazos hacia usted o llora)
- ☐ Sonríe o se ríe cuando usted juega a "¿Dónde está el bebé? ¡Aquí está!" (*peek-a-boo*)

En las áreas del habla y la comunicación

- ☐ Hace sonidos diferentes como "mamamama" y "babababa"
- ☐ Levanta los brazos para que lo alcen

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Busca objetos cuando estos caen donde no se pueden ver (como su cuchara o juguete)
- ☐ Golpea un objeto contra otro

En las áreas motora y de desarrollo físico

- ☐ Se sienta sin ayuda de nadie
- ☐ Se sienta sin apoyo
- ☐ Usa los dedos para acercar la comida hacia él
- ☐ Pasa objetos de una mano a la otra

* **¡Es hora de hacer pruebas del desarrollo!** A los 9 meses, a su bebé le deben hacer pruebas generales del desarrollo, según lo recomendado para todos los niños por la Academia Estadounidense de Pediatría. Pregúntele al médico sobre las pruebas del desarrollo de su bebé.

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su bebé? _____
2. ¿Cuáles son algunas cosas que su bebé disfruta hacer o que hace bien? _____
3. ¿Hay algo que su bebé hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su bebé alguna habilidad que antes tenía? _____
5. ¿Nació su bebé prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su bebé mejor que nadie. Si su bebé no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su bebé, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su bebé puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su bebé, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su bebé? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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- Averigüe sobre los riesgos de asfixia y los alimentos seguros para alimentar a su bebé. Deje que practique cómo comer solo, usando sus dedos, y cómo usar una taza con una pequeña cantidad de agua. Siéntese cerca de su bebé y disfruten juntos la hora de la comida. No tenga dudas de que habrá derrames. ¡Aprender es un lío, pero es divertido!
- Dígale lo que desea que haga. Por ejemplo, en lugar de decir “no te pares”, diga “es hora de sentarse”.
- Ayude a su bebé a acostumbrarse a los alimentos con diferentes sabores y texturas. Los alimentos pueden estar licuados, en puré o picados finamente. Es posible que a su bebé no le gusten todos los alimentos la primera vez que los pruebe. Dele la oportunidad de probar los alimentos una y otra vez.
- Juegue con su bebé sacando los bloques de un recipiente y volviéndolos a poner juntos.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

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Nota para el doctor _____ :

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Aprenda los signos. Reaccione pronto.

Su bebé a los 12 meses

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su bebé juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su bebé ha alcanzado al año de edad. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su bebé ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los bebés hacen a esta edad:

En las áreas social y emocional

- ☐ Juega con usted, como a dar palmaditas con las manos ("*pat-a-cake*")

En las áreas del habla y la comunicación

- ☐ Dice "adiós" con la mano
- ☐ Llama a sus padres "mamá" o "papá", o con algún otro nombre especial
- ☐ Entiende la palabra "no" (hace una pausa breve o se detiene cuando usted la dice)

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Pone algo en un recipiente, como un bloque de juguete dentro de una taza
- ☐ Busca las cosas cuando ve que usted las esconde (como un juguete debajo de una manta)

En las áreas motora y de desarrollo físico

- ☐ Jala algo para ponerse de pie
- ☐ Camina apoyándose en los muebles
- ☐ Bebe de una taza sin tapa, mientras usted la sujeta
- ☐ Levanta cosas entre el dedo índice y el pulgar, como trozos pequeños de comida

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su bebé? _____
2. ¿Cuáles son algunas cosas que su bebé disfruta hacer o que hace bien? _____
3. ¿Hay algo que su bebé hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su bebé alguna habilidad que antes tenía? _____
5. ¿Nació su bebé prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su bebé mejor que nadie. Si su bebé no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su bebé, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su bebé puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su bebé, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su bebé? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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Sus próximos pasos

☐ **¡Comparta esta lista de verificación y haga seguimiento a los indicadores del desarrollo!** Lleve esta lista al próximo chequeo de su hijo y asegúrese de compartirla con el médico y las otras personas que lo atienden. Haga el seguimiento descargando la *app* GRATUITA de los CDC *Sigamos el Desarrollo* o encuentre listas de verificación en línea en **www.cdc.gov/Indicadores**.

☐ **Apoye el desarrollo de su hijo con estos consejos y mucho más de la página www.cdc.gov/Indicadores o en la *app* de los CDC *Sigamos el Desarrollo***

- Dele a su bebé agua, leche materna o leche sola. No es necesario que le dé jugo, pero si lo hace, dele 4 onzas o menos al día, y que sea 100 % de fruta. No le dé a su bebé otras bebidas azucaradas, como bebidas frutales, refrescos (gaseosas), bebidas deportivas o leches saborizadas.
- Ayude a su bebé a acostumbrarse a los alimentos con diferentes sabores y texturas. Los alimentos pueden estar licuados, en puré o picados finamente. Es posible que a su bebé no le gusten todos los alimentos la primera vez que los pruebe. Dele la oportunidad de probarlos una y otra vez.
- Permita que su bebé tenga lugares seguros para explorar. Tome precauciones en su hogar para proteger a su bebé. Por ejemplo, coloque las cosas filosas o rompibles fuera del alcance del bebé. Guarde bajo llave los medicamentos, las sustancias químicas y los productos de limpieza. Guarde en todos sus teléfonos el número de la línea de ayuda para intoxicaciones y envenenamientos, 1-800-222-1222.
- Forme las palabras que su bebé está tratando de decir. Si dice “le”, diga “sí, leche”, o si él dice “leche”, diga “sí, la leche es muy rica”.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga “Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda”. No necesita la remisión de un médico para llamar a este programa.

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Nota para el doctor _____ :

- WIC (el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños) anima a las familias a hablar sobre el desarrollo de su niño con usted.
- Esta lista de verificación refleja los indicadores que está previsto que **LA MAYORÍA de los niños (al menos un 75 %)** alcancen para esta edad.
- No haber alcanzado algunos indicadores puede ser una señal de la necesidad de realizar pruebas del desarrollo. La Academia Estadounidense de Pediatría (AAP, por sus siglas en inglés) recomienda realizar pruebas del desarrollo entre las edades recomendadas para realizarlas, si surgen preocupaciones; esta lista de verificación no es un sustituto de una herramienta de pruebas estandarizada y validada.
- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

www.cdc.gov/pronto
1-800-CDC-INFO (1-800-232-4636)

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Aprenda los signos. Reaccione pronto.

Su hijo a los 15 meses

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su hijo juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su hijo ha alcanzado a los 15 meses. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su hijo ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los niños hacen a esta edad:

En las áreas social y emocional

- ☐ Copia a otros niños mientras juega, como sacar juguetes de un contenedor cuando otro niño lo hace
- ☐ Le muestra a usted un objeto que le gusta
- ☐ Aplaude cuando se emociona
- ☐ Abraza una muñeca u otro juguete de peluche
- ☐ Le muestra afecto (lo abraza, acaricia o besa)

En las áreas del habla y la comunicación

- ☐ Trata de decir una o dos palabras, además de "mamá" o "papá", como "ota" (por "pelota") o "ito" (por "perrito")
- ☐ Mira un objeto conocido cuando usted lo nombra
- ☐ Sigue las instrucciones que se le dan con un gesto (acción). Por ejemplo, le pasa un juguete cuando usted estira la mano y le dice: "Pásame el juguete"
- ☐ Señala con la mano para pedir algo o para obtener ayuda

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Trata de usar las cosas de la manera correcta, como un teléfono, una taza o un libro
- ☐ Coloca, uno sobre otro, al menos 2 objetos pequeños como dos bloques

En las áreas motora y de desarrollo físico

- ☐ Da unos pasos solo
- ☐ Usa los dedos para llevarse a la boca algunos alimentos

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su hijo? _____
2. ¿Cuáles son algunas cosas que su hijo disfruta hacer o que hace bien? _____
3. ¿Hay algo que su hijo hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su hijo alguna habilidad que antes tenía? _____
5. ¿Nació su hijo prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su hijo mejor que nadie. Si su hijo no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su hijo, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su hijo puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su hijo, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su hijo? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Sus próximos pasos

☐ **¡Comparta esta lista de verificación y haga seguimiento a los indicadores del desarrollo!** Lleve esta lista al próximo chequeo de su hijo y asegúrese de compartirla con el médico y las otras personas que lo atienden. Haga el seguimiento descargando la *app* GRATUITA de los CDC *Sigamos el Desarrollo* o encuentre listas de verificación en línea en **www.cdc.gov/Indicadores**.

☐ **Apoye el desarrollo de su hijo con estos consejos y mucho más de la página www.cdc.gov/Indicadores o en la *app* de los CDC *Sigamos el Desarrollo***

- Establezca rutinas para dormir y alimentar al niño. Cree un ambiente tranquilo y silencioso a la hora de dormir del niño. Póngale su pijama, lávele los dientes y léale 1 o 2 libros. Los niños que tienen entre 1 y 2 años necesitan de 11 a 14 horas de sueño por día (incluidas las siestas). ¡Mantener los horarios constantes hace que sea más fácil!
- Deje que su hijo use un vaso sin tapa para beber y que practique comer con una cuchara. Aprender a comer y beber puede ser un lío, ¡pero es divertido!
- Limite el tiempo que pase frente a una pantalla (televisión, tableta, teléfono, etc.) a las videollamadas con los seres queridos. No se recomienda que los niños menores de 2 años pasen tiempo frente a una pantalla. Los niños aprenden hablando, jugando e interactuando con otras personas.
- Cante canciones con gestos, como “Las ruedas del autobús”. Vea si su niño trata de hacer algunos de los gestos.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga “Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda”. No necesita la remisión de un médico para llamar a este programa.

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Nota para el doctor _____ :

- WIC (el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños) anima a las familias a hablar sobre el desarrollo de su niño con usted.
- Esta lista de verificación refleja los indicadores que está previsto que **LA MAYORÍA de los niños (al menos un 75 %)** alcancen para esta edad.
- No haber alcanzado algunos indicadores puede ser una señal de la necesidad de realizar pruebas del desarrollo. La Academia Estadounidense de Pediatría (AAP, por sus siglas en inglés) recomienda realizar pruebas del desarrollo entre las edades recomendadas para realizarlas, si surgen preocupaciones; esta lista de verificación no es un sustituto de una herramienta de pruebas estandarizada y validada.
- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

www.cdc.gov/pronto
1-800-CDC-INFO (1-800-232-4636)

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Aprenda los signos. Reaccione pronto.

Su hijo a los 18 meses*

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su hijo juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su hijo ha alcanzado a los 18 meses. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su hijo ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los niños hacen a esta edad:

En las áreas social y emocional

- ☐ Se aleja de usted, pero lo busca para asegurarse de que está cerca
- ☐ Señala para mostrarle algo que le llama la atención
- ☐ Extiende las manos para que se las lave
- ☐ Mira algunas páginas de un libro con usted
- ☐ Ayuda cuando lo viste, pasando los brazos por las mangas o levantando los pies

En las áreas del habla y la comunicación

- ☐ Intenta decir tres palabras o más, además de mamá o papá
- ☐ Sigue instrucciones de 1 paso sin hacerle gestos; por ejemplo, le entrega un juguete cuando le dice "dámelo"

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Imita las tareas que hace usted, como barrer con la escoba
- ☐ Juega con juguetes de manera sencilla; por ejemplo, empuja un carrito de juguete

En las áreas motora y de desarrollo físico

- ☐ Camina sin agarrarse de alguien o a algo
- ☐ Hace garabatos
- ☐ Bebe de una taza sin tapa y a veces puede derramar la bebida
- ☐ Se alimenta usando los dedos
- ☐ Intenta usar la cuchara
- ☐ Se sube y baja de un sofá o silla sin ayuda

* **¡Es hora de hacer pruebas del desarrollo!** A los 18 meses, a su hijo le deben hacer pruebas generales del desarrollo, según lo recomendado para todos los niños por la Academia Estadounidense de Pediatría. Pregúntele al médico sobre las pruebas del desarrollo de su hijo.

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su hijo? _____
2. ¿Cuáles son algunas cosas que su hijo disfruta hacer o que hace bien? _____
3. ¿Hay algo que su hijo hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su hijo alguna habilidad que antes tenía? _____
5. ¿Nació su hijo prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su hijo mejor que nadie. Si su hijo no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su hijo, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su hijo puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su hijo, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su hijo? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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Sus próximos pasos

☐ **¡Comparta esta lista de verificación y haga seguimiento a los indicadores del desarrollo!** Lleve esta lista al próximo chequeo de su hijo y asegúrese de compartirla con el médico y las otras personas que lo atienden. Haga el seguimiento descargando la *app* GRATUITA de los CDC *Sigamos el Desarrollo* o encuentre listas de verificación en línea en **www.cdc.gov/Indicadores**.

☐ **Apoye el desarrollo de su hijo con estos consejos y mucho más de la página www.cdc.gov/Indicadores o en la *app* de los CDC *Sigamos el Desarrollo***

- Deje que su hijo use un vaso sin tapa para beber y que practique comer con una cuchara. Aprender a comer y beber puede ser un lío, ¡pero es divertido!
- Ofrézcale opciones sencillas. Deje que el niño elija entre dos cosas. Por ejemplo, cuando lo vista, pregúntele si quiere ponerse la camisa roja o la azul.
- Empiece a enseñarle a su hijo los nombres de las partes del cuerpo, señalándolas y diciendo cosas como “aquí está tu nariz, aquí está mi nariz”, mientras señala la nariz del niño y la suya.
- Establezca rutinas para dormir y comer. Por ejemplo, siéntese a la mesa con su niño cuando él esté comiendo sus comidas y sus meriendas. Esto ayuda a establecer rutinas para la hora de la comida de su familia.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga “Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda”. No necesita la remisión de un médico para llamar a este programa.

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Nota para el doctor _____ :

- WIC (el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños) anima a las familias a hablar sobre el desarrollo de su niño con usted.
- Esta lista de verificación refleja los indicadores que está previsto que **LA MAYORÍA de los niños (al menos un 75 %)** alcancen para esta edad.
- No haber alcanzado algunos indicadores puede ser una señal de la necesidad de realizar pruebas del desarrollo. La Academia Estadounidense de Pediatría (AAP, por sus siglas en inglés) recomienda realizar pruebas del desarrollo entre las edades recomendadas para realizarlas, si surgen preocupaciones; esta lista de verificación no es un sustituto de una herramienta de pruebas estandarizada y validada.
- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

www.cdc.gov/pronto
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Aprenda los signos. Reaccione pronto.

Su hijo a los 2 años*

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su hijo juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su hijo ha alcanzado a los 2 años. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su hijo ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los niños hacen a esta edad:

En las áreas social y emocional

- ☐ Se da cuenta cuando otra persona está lastimada o triste; por ejemplo, se detiene o pone cara triste cuando alguien está llorando
- ☐ Lo mira a la cara para ver cómo reaccionar en una situación nueva

En las áreas del habla y la comunicación

- ☐ Señala las cosas que aparecen en los libros cuando le pregunta; por ejemplo, "¿dónde está el osito?"
- ☐ Dice al menos dos palabras juntas, como "más leche"
- ☐ Señala al menos 2 partes del cuerpo cuando le pide que le muestre
- ☐ Usa más gestos, además de solo saludar con la mano o señalar cosas, como soplar besos o decir que sí con la cabeza

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Sostiene algo en una mano mientras usa la otra; por ejemplo, sostiene un recipiente mientras le quita la tapa
- ☐ Intenta usar las manijas o botones de los juguetes
- ☐ Juega con más de un juguete a la vez; por ejemplo, pone comida de juguete en un plato de juguete

En las áreas motora y de desarrollo físico

- ☐ Patea una pelota
- ☐ Corre
- ☐ Sube varios escalones caminando (sin gatear) con o sin ayuda
- ☐ Come con cuchara

* **¡Es hora de hacer pruebas del desarrollo!** A los 2 años, a su hijo le deben hacer una prueba de autismo, según lo recomendado para todos los niños por la Academia Estadounidense de Pediatría. Pregúntele al médico sobre las pruebas del desarrollo de su hijo.

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su hijo? _____
2. ¿Cuáles son algunas cosas que su hijo disfruta hacer o que hace bien? _____
3. ¿Hay algo que su hijo hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su hijo alguna habilidad que antes tenía? _____
5. ¿Nació su hijo prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su hijo mejor que nadie. Si su hijo no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su hijo, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su hijo puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su hijo, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su hijo? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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☐ **¡Comparta esta lista de verificación y haga seguimiento a los indicadores del desarrollo!** Lleve esta lista al próximo chequeo de su hijo y asegúrese de compartirla con el médico y las otras personas que lo atienden. Haga el seguimiento descargando la *app* GRATUITA de los CDC *Sigamos el Desarrollo* o encuentre listas de verificación en línea en **www.cdc.gov/Indicadores**.

☐ **Apoye el desarrollo de su hijo con estos consejos y mucho más de la página www.cdc.gov/Indicadores o en la *app* de los CDC *Sigamos el Desarrollo***

- Permita que su hijo coma la cantidad que quiera en cada comida. Los niños pequeños no siempre comen la misma cantidad o el mismo tipo de alimento todos los días. Usted debe encargarse de ofrecerle alimentos saludables y su hijo debe decidir si necesita comer y cuánto.
- Establezca rutinas para dormir y alimentar al niño. Cree un ambiente tranquilo y silencioso a la hora de dormir del niño. Póngale su pijama, lávele los dientes y léale 1 o 2 libros. A esta edad, los niños necesitan de 11 a 14 horas de sueño por día (incluidas las siestas). Mantener los horarios constantes hace que sea más fácil.
- Pregúntele al médico o a los maestros de su hijo sobre aprender a usar el baño para saber si el niño está listo para comenzar. La mayoría de los niños no son capaces de aprender a ir al baño hasta los 2 o 3 años. Comenzar demasiado pronto puede causarle estrés y retrocesos, lo cual puede hacer que le lleve más tiempo lograrlo.
- Observe a su hijo de cerca cuando juegue con otros niños. A esta edad, los niños juegan uno al lado del otro, pero no saben cómo compartir y resolver problemas. Muéstrele a su hijo cómo hacer frente a los conflictos ayudándolo a compartir, turnarse y usar palabras cuando sea posible.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga "Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda". No necesita la remisión de un médico para llamar a este programa.

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Nota para el doctor _____ :

- WIC (el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños) anima a las familias a hablar sobre el desarrollo de su niño con usted.
- Esta lista de verificación refleja los indicadores que está previsto que **LA MAYORÍA de los niños (al menos un 75 %)** alcancen para esta edad.
- No haber alcanzado algunos indicadores puede ser una señal de la necesidad de realizar pruebas del desarrollo. La Academia Estadounidense de Pediatría (AAP, por sus siglas en inglés) recomienda realizar pruebas del desarrollo entre las edades recomendadas para realizarlas, si surgen preocupaciones; esta lista de verificación no es un sustituto de una herramienta de pruebas estandarizada y validada.
- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

www.cdc.gov/pronto
1-800-CDC-INFO (1-800-232-4636)

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Aprenda los signos. Reaccione pronto.

Su hijo a los 30 meses*

El nombre del niño **La edad del niño** **Fecha**

¡Los indicadores son clave! La manera en que su hijo juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su hijo ha alcanzado a los 30 meses. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su hijo ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los niños hacen a esta edad:

En las áreas social y emocional

- ☐ Juega al lado de otros niños y a veces con ellos
- ☐ Le muestra lo que puede hacer diciendo "¡mírame!"
- ☐ Sigue rutinas simples cuando se le pide; por ejemplo, ayuda a recoger los juguetes cuando le dice "es hora de recoger los juguetes"

En las áreas del habla y la comunicación

- ☐ Dice aproximadamente 50 palabras
- ☐ Dice dos o más palabras, siendo una de ellas una acción, como "perrito corre"
- ☐ Nombra las cosas que ve en un libro cuando usted las señala y le pregunta "¿qué es esto?"
- ☐ Dice palabras como "yo", "mi" o "nosotros"

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Juega imaginariamente con las cosas; por ejemplo, alimenta una muñeca con un bloque de madera como si fuera comida
- ☐ Muestra habilidades sencillas para resolver problemas; por ejemplo, se para sobre un banquito para alcanzar algo
- ☐ Sigue instrucciones de dos pasos, como "deja el juguete ahí y cierra la puerta"
- ☐ Demuestra que sabe por lo menos un color; por ejemplo, señala un crayón rojo si usted le pregunta: "¿Cuál es rojo?"

En las áreas motora y de desarrollo físico

- ☐ Usa las manos para girar cosas; por ejemplo, gira la manija o perilla de las puertas o desenrosca tapas
- ☐ Se quita algunas prendas de vestir por sí solo como pantalones holgados o una chaqueta desabotonada
- ☐ Salta levantando los dos pies
- ☐ Pasa las páginas de un libro, de una página a la otra, cuando usted le lee

*** ¡Es hora de hacer pruebas del desarrollo!**
A los 30 meses, a su hijo le deben hacer pruebas generales del desarrollo, según lo recomendado para todos los niños por la Academia Estadounidense de Pediatría. Pregúntele al médico sobre las pruebas del desarrollo de su hijo.

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su hijo? _____
2. ¿Cuáles son algunas cosas que su hijo disfruta hacer o que hace bien? _____
3. ¿Hay algo que su hijo hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su hijo alguna habilidad que antes tenía? _____
5. ¿Nació su hijo prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su hijo mejor que nadie. Si su hijo no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su hijo, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame al programa de intervención temprana de su estado o territorio para saber si su hijo puede recibir servicios para ayudarlo. Obtenga más información y averigüe el número telefónico en **cdc.gov/IntervenciónTemprana**.

Para obtener más información sobre cómo ayudar a su hijo, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su hijo? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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☐ **¡Comparta esta lista de verificación y haga seguimiento a los indicadores del desarrollo!** Lleve esta lista al próximo chequeo de su hijo y asegúrese de compartirla con el médico y las otras personas que lo atienden. Haga el seguimiento descargando la *app* GRATUITA de los CDC *Sigamos el Desarrollo* o encuentre listas de verificación en línea en **www.cdc.gov/Indicadores**.

☐ **Apoye el desarrollo de su hijo con estos consejos y mucho más de la página www.cdc.gov/Indicadores o en la *app* de los CDC *Sigamos el Desarrollo***

- Dele a su hijo opciones de alimentos que sean simples y saludables. Déjelo elegir qué comer para la merienda o qué ponerse. Limite las opciones a dos o tres.
- Juegue con su niño al aire libre. Por ejemplo, llévelo a un parque para que se suba a los juegos y que corra en áreas seguras.
- Fomente el "juego libre", en el que su hijo pueda seguir sus intereses, probar cosas nuevas y usar las cosas de maneras novedosas.
- Ayude a su hijo a aprender a jugar con otros niños. Muéstrele cómo hacerlo ayudándolo a que comparta, se turne y use sus "palabras".
- Permita que su hijo coma la cantidad que quiera en cada comida. Usted debe encargarse de ofrecerle alimentos saludables y su hijo debe decidir si quiere comer y cuánto.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga "Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda". No necesita la remisión de un médico para llamar a este programa.

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Nota para el doctor _____ :

- WIC (el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños) anima a las familias a hablar sobre el desarrollo de su niño con usted.
- Esta lista de verificación refleja los indicadores que está previsto que **LA MAYORÍA de los niños (al menos un 75 %)** alcancen para esta edad.
- No haber alcanzado algunos indicadores puede ser una señal de la necesidad de realizar pruebas del desarrollo. La Academia Estadounidense de Pediatría (AAP, por sus siglas en inglés) recomienda realizar pruebas del desarrollo entre las edades recomendadas para realizarlas, si surgen preocupaciones; esta lista de verificación no es un sustituto de una herramienta de pruebas estandarizada y validada.
- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

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Aprenda los signos. Reaccione pronto.

Su hijo a los 3 años

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su hijo juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su hijo ha alcanzado a los 3 años. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su hijo ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los niños hacen a esta edad:

En las áreas social y emocional

- ☐ Se tranquiliza dentro de 10 minutos después de que lo deja; por ejemplo, en la guardería
- ☐ Nota a los otros niños y se une a ellos para jugar

En las áreas del habla y la comunicación

- ☐ Conversa con usted usando por lo menos dos frases de intercambio
- ☐ Hace preguntas con "quién", "qué", "dónde" o "por qué"; por ejemplo, "¿dónde está mami o papi?"
- ☐ Dice la acción que está ocurriendo en una imagen o en un libro cuando se lo preguntan; por ejemplo, "corriendo", "comiendo" o "jugando"
- ☐ Dice su nombre cuando se lo preguntan
- ☐ Habla lo suficientemente bien como para que otros lo entiendan, la mayor parte del tiempo

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Dibuja un círculo cuando le muestra cómo hacerlo
- ☐ Evita tocar los objetos calientes, como la estufa, cuando usted se lo advierte

En las áreas motora y de desarrollo físico

- ☐ Inserta objetos en un hilo, como cuentas grandes, cereal o macarrones
- ☐ Se pone alguna ropa solito, como pantalones flojos o una chaqueta
- ☐ Usa el tenedor

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su hijo? _____
2. ¿Cuáles son algunas cosas que su hijo disfruta hacer o que hace bien? _____
3. ¿Hay algo que su hijo hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su hijo alguna habilidad que antes tenía? _____
5. ¿Nació su hijo prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su hijo mejor que nadie. Si su hijo no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su hijo, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame a cualquier escuela primaria pública para solicitar pruebas gratuitas a fin de averiguar si su hijo puede obtener servicios para ayudarlo.

Para obtener más información sobre cómo ayudar a su hijo, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su hijo? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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☐ **Apoye el desarrollo de su hijo con estos consejos y mucho más de la página www.cdc.gov/Indicadores o en la *app* de los CDC *Sigamos el Desarrollo***

- Permítale que lo ayude a preparar comidas. Dele tareas sencillas, como lavar las frutas y verduras o revolver.
- Dele a su hijo instrucciones de 2 o 3 pasos. Por ejemplo, "ve a tu cuarto y trae tus zapatos y tu abrigo".
- Anime a su hijo a que resuelva sus propios problemas con su apoyo. Hágale preguntas para ayudarlo a comprender el problema. Ayúdelo a pensar en soluciones, probar una y probar otra más si es necesario.
- Hable sobre las emociones de su hijo y dele palabras para ayudarlo a explicar cómo se siente. Ayude a su hijo a manejar los sentimientos estresantes enseñándole a respirar profundamente, abrazar a su juguete favorito o ir a un lugar tranquilo y seguro cuando esté molesto.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga "Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda". No necesita la remisión de un médico para llamar a este programa.

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Nota para el doctor _____ :

- WIC (el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños) anima a las familias a hablar sobre el desarrollo de su niño con usted.
- Esta lista de verificación refleja los indicadores que está previsto que **LA MAYORÍA de los niños (al menos un 75 %)** alcancen para esta edad.
- No haber alcanzado algunos indicadores puede ser una señal de la necesidad de realizar pruebas del desarrollo. La Academia Estadounidense de Pediatría (AAP, por sus siglas en inglés) recomienda realizar pruebas del desarrollo entre las edades recomendadas para realizarlas, si surgen preocupaciones; esta lista de verificación no es un sustituto de una herramienta de pruebas estandarizada y validada.
- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

Su hijo a los 4 años

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su hijo juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su hijo ha alcanzado a los 4 años. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su hijo ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los niños hacen a esta edad:

En las áreas social y emocional

- ☐ Imagina ser otra persona o cosa cuando está jugando (maestro, superhéroe, perro)
- ☐ Pide ir a jugar con otros niños si no hay ninguno alrededor; por ejemplo, "¿puedo jugar con Alex?"
- ☐ Consuela a otros que están lastimados o tristes; por ejemplo, abraza a un amigo que está llorando
- ☐ Evita peligros; por ejemplo, no salta desde lugares altos en el patio de recreo
- ☐ Le gusta ser un "ayudante"
- ☐ Cambia de comportamiento según donde se encuentre (lugares religiosos, biblioteca, patio de recreo o juegos)

En las áreas del habla y la comunicación

- ☐ Forma oraciones con 4 o más palabras
- ☐ Dice algunas de las palabras de una canción, cuento, o rima infantil
- ☐ Habla de al menos una cosa que haya sucedido durante su día; por ejemplo, "jugué al fútbol"
- ☐ Responde preguntas sencillas como "¿Para qué es el abrigo?" o "¿Para qué es el crayón?"

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Dice algunos colores de objetos
- ☐ Dice lo que sigue en un cuento que conoce bien
- ☐ Dibuja personas con 3 o más partes del cuerpo

En las áreas motora y de desarrollo físico

- ☐ Agarra una pelota grande cuando se la arrojan, la mayor parte del tiempo
- ☐ Se sirve comida o agua con la supervisión de un adulto
- ☐ Desabotona algunos botones
- ☐ Sostiene un crayón o lápiz entre los dedos y el pulgar (no con la mano empuñada)

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su hijo? _____
2. ¿Cuáles son algunas cosas que su hijo disfruta hacer o que hace bien? _____
3. ¿Hay algo que su hijo hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su hijo alguna habilidad que antes tenía? _____
5. ¿Nació su hijo prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su hijo mejor que nadie. Si su hijo no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su hijo, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame a cualquier escuela primaria pública para solicitar pruebas gratuitas a fin de averiguar si su hijo puede obtener servicios para ayudarlo.

Para obtener más información sobre cómo ayudar a su hijo, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su hijo? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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☐ **Apoye el desarrollo de su hijo con estos consejos y mucho más de la página www.cdc.gov/Indicadores o en la *app* de los CDC *Sigamos el Desarrollo***

- Cuando sea posible, coma las comidas con su hijo. Deje que lo vea disfrutando los alimentos saludables, como frutas, verduras y granos integrales, y bebiendo leche o agua.
- Ayude a su hijo a aprender sobre los sentimientos de los demás y las formas positivas de reaccionar. Por ejemplo, cuando él vea a un niño que está triste, diga "se lo ve triste. Llevémosle un osito de peluche".
- Use palabras positivas y preste atención a los comportamientos que desee ver ("comportamientos deseados"). Por ejemplo, diga "¡estás compartiendo ese juguete muy bien!" Preste menos atención a los que no quiera ver.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga "Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda". No necesita la remisión de un médico para llamar a este programa.

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Nota para el doctor _____ :

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- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

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Aprenda los signos. Reaccione pronto.

Su hijo a los 5 años

El nombre del niño _____ **La edad del niño** _____ **Fecha** _____

¡Los indicadores son clave! La manera en que su hijo juega, aprende, habla, actúa y se mueve ofrece información importante sobre su desarrollo. Marque los indicadores que su hijo ha alcanzado a los 5 años. Lleve esta información y en cada visita médica de rutina del niño hable con el médico sobre los indicadores que su hijo ha alcanzado y qué esperar a continuación.

Lo que la mayoría de los niños hacen a esta edad:

En las áreas social y emocional

- ☐ Sigue las reglas o se turna cuando juega algún juego con otros niños
- ☐ Canta, baila o actúa para usted
- ☐ Hace tareas de la casa simples, como juntar las medias iguales o levantar la mesa después de comer

En las áreas del habla y la comunicación

- ☐ Cuenta historias que ha escuchado o que ha inventado incluyendo al menos 2 eventos; por ejemplo, un gato que no puede bajar de un árbol y un bombero que lo salva
- ☐ Contesta preguntas sencillas sobre un cuento después de oírlo
- ☐ Mantiene una conversación con más de 3 intercambios
- ☐ Usa o reconoce rimas simples (gato-pato, casa-taza)

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Cuenta hasta 10
- ☐ Dice algunos números entre el 1 y el 5 cuando usted se los señala
- ☐ Usa palabras sobre el tiempo, como “ayer”, “mañana”, “la mañana” o “la noche”
- ☐ Presta atención por 5 a 10 minutos durante una actividad; por ejemplo, cuando le cuenta una historia o hace manualidades (el tiempo delante de la pantalla no cuenta)
- ☐ Escribe algunas de las letras de su nombre
- ☐ Dice algunas letras cuando usted se las señala

En las áreas motora y de desarrollo físico

- ☐ Se abotona algunos botones
- ☐ Salta en un pie

Otras cosas importantes para compartir con el médico...

1. ¿Qué es lo que más disfruta hacer usted con su hijo? _____
2. ¿Cuáles son algunas cosas que su hijo disfruta hacer o que hace bien? _____
3. ¿Hay algo que su hijo hace o que no hace y que le preocupa? _____
4. ¿Ha perdido su hijo alguna habilidad que antes tenía? _____
5. ¿Nació su hijo prematuro o tiene alguna necesidad especial de atención médica? _____

_____

Usted conoce a su hijo mejor que nadie. Si su hijo no está alcanzando los indicadores del desarrollo, si ha perdido destrezas que antes tenía, o si usted está preocupado por algo más, no espere. Reaccione pronto. Hable con el médico de su hijo, comparta sus preocupaciones y pregunte sobre las pruebas del desarrollo. Si usted o el médico siguen preocupados:

1. pida una remisión a un especialista y,
2. llame a cualquier escuela primaria pública para solicitar pruebas gratuitas a fin de averiguar si su hijo puede obtener servicios para ayudarlo.

Para obtener más información sobre cómo ayudar a su hijo, visite **cdc.gov/Preocupado**.

¿Qué le preocupa sobre el desarrollo de su hijo? _____

_____

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

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Sus próximos pasos

☐ **¡Comparta esta lista de verificación y haga seguimiento a los indicadores del desarrollo!** Lleve esta lista al próximo chequeo de su hijo y asegúrese de compartirla con el médico y las otras personas que lo atienden. Haga el seguimiento descargando la *app* GRATUITA de los CDC *Sigamos el Desarrollo* o encuentre listas de verificación en línea en **www.cdc.gov/Indicadores**.

☐ **Apoye el desarrollo de su hijo con estos consejos y mucho más de la página www.cdc.gov/Indicadores o en la *app* de los CDC *Sigamos el Desarrollo***

- Quizás su hijo empiece a "contestarle" para sentirse independiente y probar qué pasa. Limite la atención que le preste a las palabras negativas. Encuentre actividades alternativas para que él haga y que le permitan liderar y ser independiente. Asegúrese de notar el buen comportamiento. "Te mantuviste tranquilo cuando te dije que era la hora de dormir".
- Coma las comidas con su hijo y disfrute del tiempo en familia hablando juntos. Sirva la misma comida a todos. Evite el tiempo frente a una pantalla (televisión, tabletas, teléfonos, etc.) durante el horario de las comidas. Deje que su hijo ayude a preparar comidas saludables y disfrútenlas juntos.
- Anime a su hijo a "leer" mirando las ilustraciones y contando la historia.
- Use palabras para ayudar a su hijo a comenzar a entender el tiempo. Por ejemplo, cante canciones sobre los días de la semana y dígale qué día es. Use palabras sobre el tiempo, como hoy, mañana y ayer.

Si su hijo no está alcanzando algunos de los indicadores del desarrollo o usted tiene otras preocupaciones:

☐ **Llame al médico de su hijo.** Haga una cita de seguimiento con el médico lo más pronto posible. Dígale que desea hablarle sobre el desarrollo del niño. Lleve esta lista de verificación con usted y pídale que le hagan pruebas del desarrollo.

☐ **Llame para obtener servicios de ayuda.** Llame al _____ y diga "Me preocupa el desarrollo de mi hijo(a) y quisiera que le hagan una evaluación para saber si cumple con los requisitos para recibir servicios de ayuda". No necesita la remisión de un médico para llamar a este programa.

No espere. ¡Reaccionar pronto puede marcar una gran diferencia!

Nota para el doctor _____ :

- WIC (el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños) anima a las familias a hablar sobre el desarrollo de su niño con usted.
- Esta lista de verificación refleja los indicadores que está previsto que **LA MAYORÍA de los niños (al menos un 75 %)** alcancen para esta edad.
- No haber alcanzado algunos indicadores puede ser una señal de la necesidad de realizar pruebas del desarrollo. La Academia Estadounidense de Pediatría (AAP, por sus siglas en inglés) recomienda realizar pruebas del desarrollo entre las edades recomendadas para realizarlas, si surgen preocupaciones; esta lista de verificación no es un sustituto de una herramienta de pruebas estandarizada y validada.
- Si las pruebas del desarrollo muestran algo preocupante o usted, o el padre o la madre todavía tienen preocupaciones, haga una remisión al programa de intervención temprana de su estado _____ _____ y, al mismo tiempo, para otra evaluación médica y del desarrollo.
- Para obtener recursos GRATUITOS de apoyo para la vigilancia del desarrollo, visite **cdc.gov/ActEarly/Healthcare**.

www.cdc.gov/pronto
1-800-CDC-INFO (1-800-232-4636)

Descargue la aplicación gratuita de los CDC *Sigamos el desarrollo*
Descargar de la App Store
DISPONIBLE EN Google Play

Aprenda los signos. Reaccione pronto.

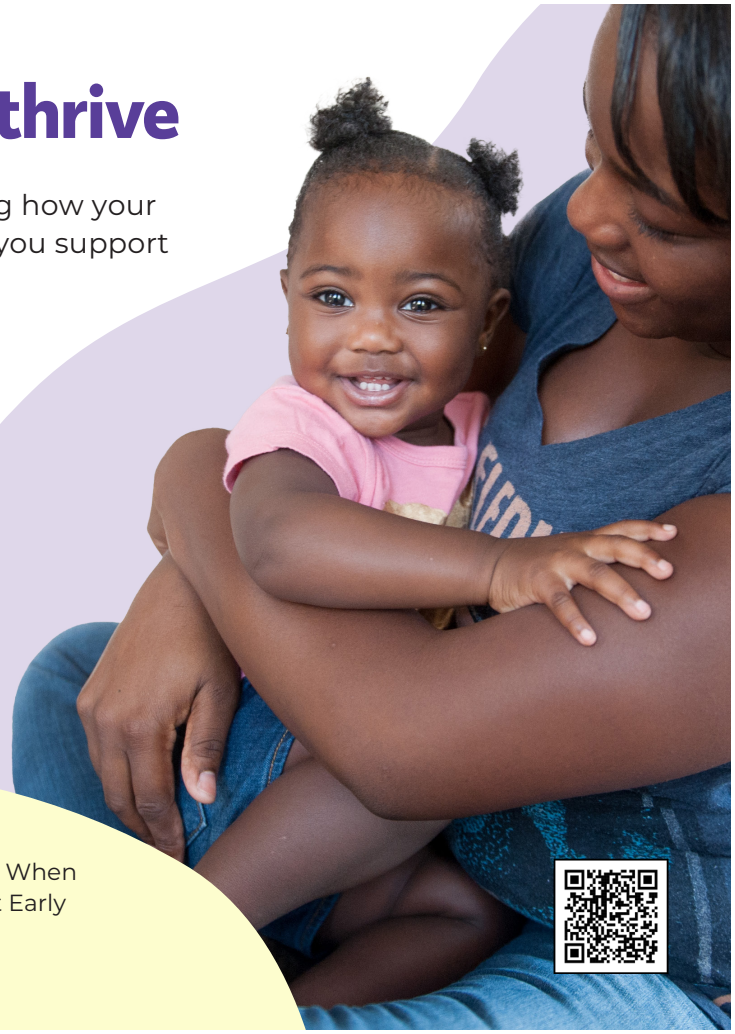
Help your child grow and thrive

Your child's early years are so very important. Tracking how your little one plays, learns, speaks, acts, and moves helps you support their development.

Download CDC's free *Milestone Tracker* app to find fun and easy activities for each age.

Download on the App Store

GET IT ON Google Play



Track & Share Milestones

Get Tips & Activities

Learn When to Act Early

Learn more at **cdc.gov/MilestoneTracker**

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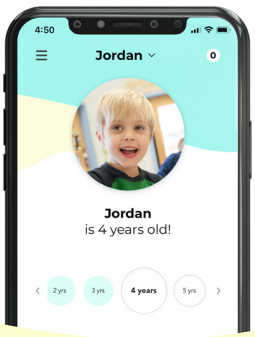

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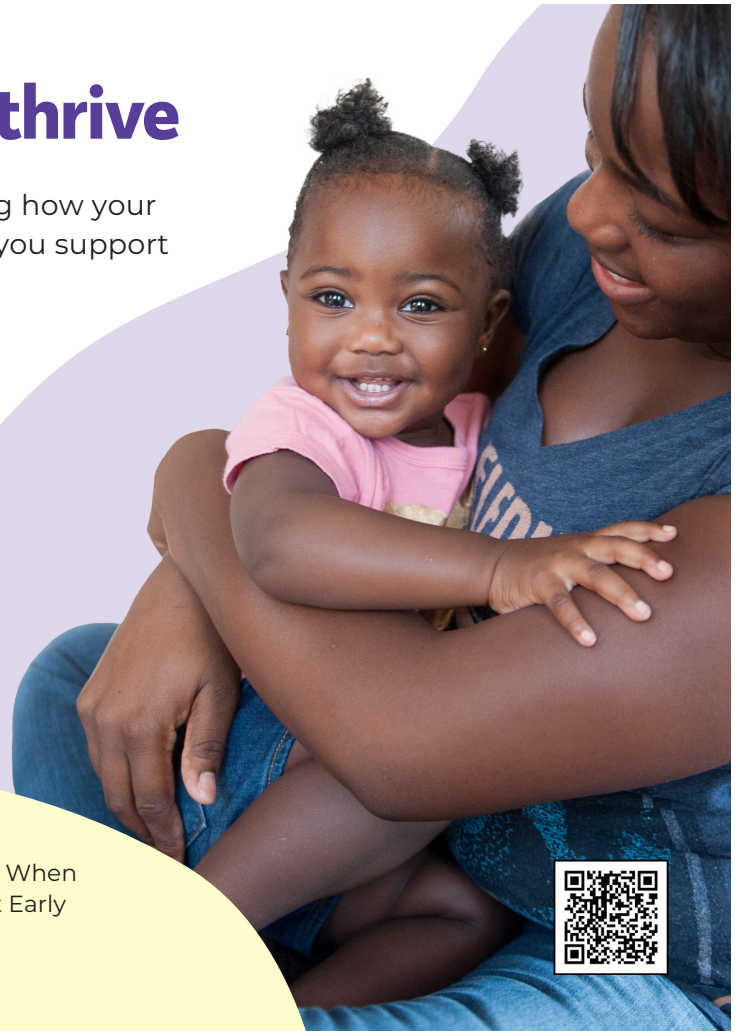

Track & Share Milestones

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Learn more at **cdc.gov/MilestoneTracker**

Apoye su desarrollo y crecimiento

Los primeros años de su hijo son muy importantes. Seguir cómo su pequeño juega, aprende, habla, actúa y se mueve lo puede ayudar en su desarrollo.

Descargue la aplicación gratuita de los CDC *Sigamos el desarrollo* para encontrar actividades fáciles para cada edad.

Consíguelo en el App Store

DISPONIBLE EN Google Play

Siga y comparta los indicadores del desarrollo

Vea consejos y actividades

Sepa cuándo debe reaccionar pronto

Encuentre más información en **www.cdc.gov/Sigamos**

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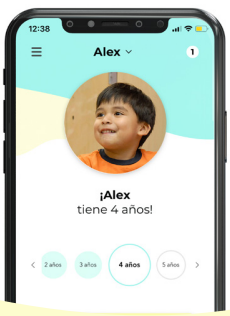

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Supporting Youth Mental Health and Resiliency: The Critical Role of Parents

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Jessica Hawks, PhD
Child & Adolescent Psychologist
Francescon Family Endowed Chair for Mood Disorders
Chief of Psychology, Pediatric Mental Health Institute, Children's Hospital Colorado
Associate Professor, Division of Child & Adolescent Psychiatry, CU School of Medicine

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Learning Objectives

1. Discuss how the parent-child relationship influences a child's mental health and well-being.
2. Describe parenting factors that impact their child's mental health and well-being.
3. Summarize strategies that parents can use to promote emotional well-being and resiliency in their children.

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How are parents doing?

- U.S. Surgeon General's Advisory on the Mental Health & Well-Being of Parents: *Parents Under Pressure*
  - 48% of parents say their stress is completely overwhelming most days (compared to 26% of other adults)
    - More isolated
    - "Second shift"
    - Social media (unrealistic expectations = feel like they're not doing enough)
    - Stress over the state of the world
    - Finances
  - 1 in 4 parents are struggling with their mental health
    - 40% of teens are worried about the mental health of a parent

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Parent-Child Relationship

- The **#1 most important protective factor** for youth is a strong, safe, and stable relationship with their parent.
- Learning/Growth is fueled through the parent-child relationship
  - Comfort Zone: No stress, feel safe and secure
    - If overly focused on avoiding distress, prevent growth
  - Growth Zone: Just beyond the child's current capacity, allows for maximal learning
    - Scaffolded by parents, encouraged to take risks

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Parenting Factors

- Parenting Style
  - Authoritarian and/or Permissive = Problematic
- Parent Mental Health
  - Strong correlation between parent and youth MH
- Modeling
  - #1 way youth learn is by watching

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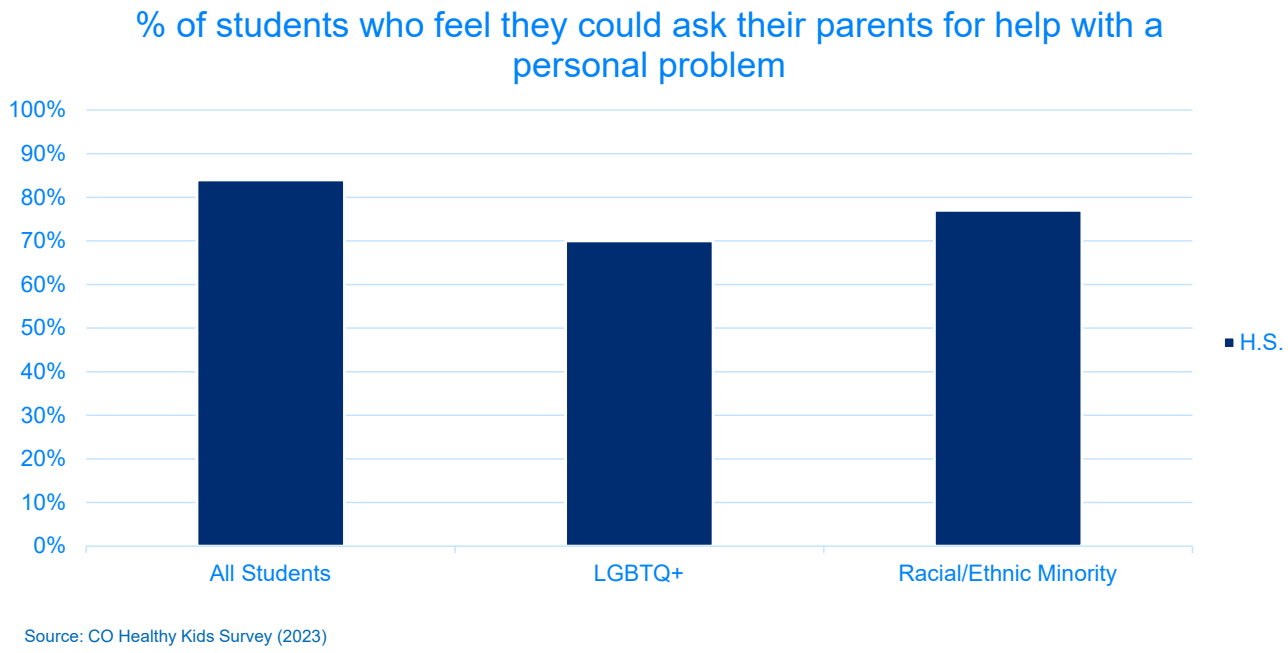

Source: CO Healthy Kids Survey (2023)

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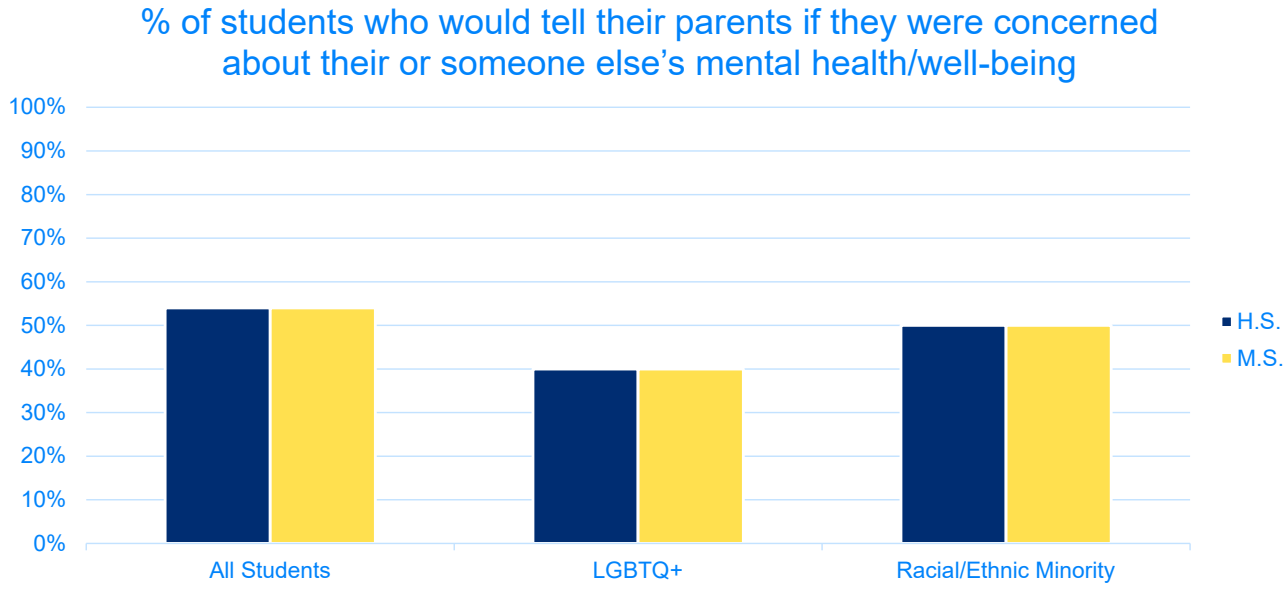

Source: CO Healthy Kids Survey (2023)

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Strategies for Promoting Wellness & Resiliency

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Building a Supportive Family Culture

- Never too early to start
- Promote secure attachment
  - Safety & Freedom
- Normalize Emotions
  - 3 Ns (Normal, Natural, Not Harmful)
- Encourage ***approach-oriented*** solutions
  - "Act opposite" to difficult emotions

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Connection through Conversation

- Regular check-ins
- Follow their lead
- Empathize (not the same as agreeing)
  - Don't minimize, blame, etc.
  - "It sounds like you're feeling…"
- Empower
  - Collaborative problem solving (avoiding jumping to this too quickly!)
  - Importance of self-efficacy

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Healthy Coping

- Focus on the Basics
  - Sleep
  - Nutrition
  - Physical Activity
  - Being Outside
- Daily Routines
  - Avoid over-scheduling
- Be a good role-model

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Positive Parenting: Warmth + Boundaries

- Quality Time (w/o distractions)
  - Eat a meal together
  - Parent monitoring
- Strategic Attention
  - Praise effort vs outcome
- Clear & Consistent Expectations
  - It's okay to set limits
  - Effective consequences

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When to Seek Professional Help

- Functional Impairment
  - Home
  - School
  - Extra Curricular Activities
  - Peers/Family
- Self-Harm/Suicidality
- Substance use/abuse
- Significant Peer or Family Conflict

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Questions?

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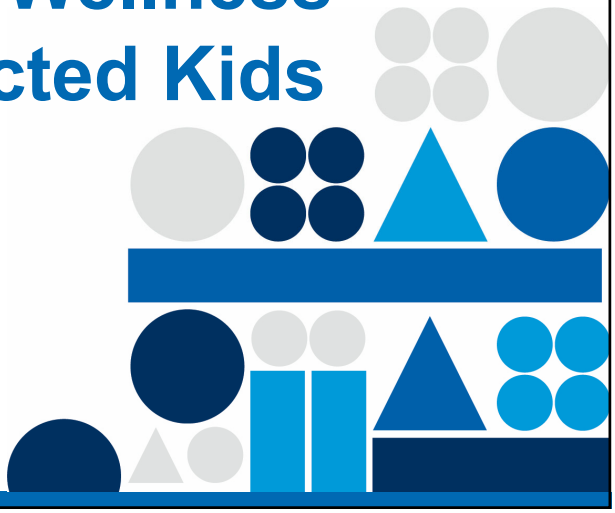
SEPT 9 2025

Promoting Mental Wellness in Digitally Connected Kids

Lauren Henry, PhD, NCSP
Child Psychologist



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Learning Objectives

1. Identify the potential benefits and harms of phone use /social media, distinguishing between digital wellness and signs of concern.

2. Discuss practical, developmentally appropriate strategies to support families and educators navigating screen time, social media, and online interactions with kids.

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Why This Matters

- 95% of teens use social media; 1 in 3 online 'almost constantly'
- Teens average 90 mins of smartphone use during school.
- Adolescents: Hypersensitivity to Social Feedback
- Younger children increasingly exposed despite age restrictions.
- Families, educators, and healthcare providers raising concerns.

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Source: Common Sense Media, 2023; JAMA, 2025; APA, 2024

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Key Findings from Research

- Social Media has been linked with worsening youth mental health
- Social media's impact depends on context, content, and vulnerability.
- Social media does have benefits (connection, identity).

Source: Common Sense Media, 2023; Surgeon General, 2023; APA, 2024

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Benefits

- Social Connection
- Identity Exploration/ Self Expression
- Stress Relief
- Communication Tool
- Networking
- Empowerment/ Civic Engagement

Risk

- Relationship Skill Development
- Depression & Anxiety
- Body Image
- Sleep
- Attention & Academic Performance
- Cyberbullying
- Harmful Content Exposure.

Source: Surgeon General, 2023; Parents & Social Media, 2024; APA, 2024

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Our Goal: Digital Wellness

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Colorado's New School Cell Phone Policy Law (HB 25-1135)

- Signed by Governor Jared Polis in May 2025
- Mandates all Colorado public school districts must adopt a formal policy regarding student use of communication devices during the school day.
- Districts must adopt and post a device-use policy by July 1, 2026.
- Policy Requirements: Must define prohibitions, exceptions, and disability-related accommodations.
- DOE Playbook: Co-design device policies with youth and families.

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Practical Strategies for Families

KEEP COMMUNICATING.

- Develop a family media plan with clear boundaries.
- Encourage screen-free routines around bedtime and meals.
- Prioritize communication over surveillance.

KEEP CURRENT.

- Whenever Your Child Tries New Tech, You Try It Too
- Promote media literacy: teach youth to question and manage online content.

KEEP CHECKING.

- Active Supervision

Source: Surgeon General, 2023; Parents & Social Media, 2024; APA, 2024

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Social Media Plan

SOCIAL MEDIA PLAN

A social media plan can help you reflect on the connection between your mental health and social media use. Making a plan like this can help you understand yourself better, find balance, keep you safer, and know who you can turn to for support. It's also benefits to include your support people and revisit this plan as often as needed.

What content makes me feel happy or promotes my mental health?

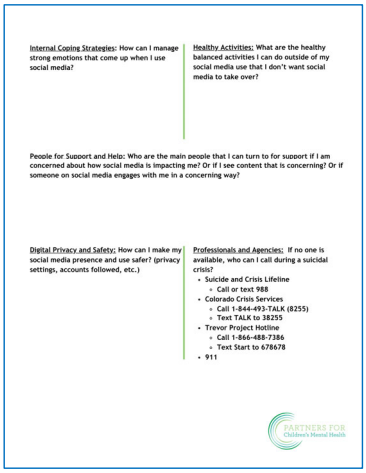
Where are screen free zones or times I can put my device away?

Warning Signs: What are my warning signs that tell me I'm starting to get overwhelmed by social media?

Thoughts | Emotions | Body sensations | Behaviors

If people notice any of my warning signs, they can help by:

Stanley & Brown 2008 adapted by PCMH 2020



Internal Coping Strategies: How can I manage strong emotions that come up when I use social media?

Healthy Activities: What are the healthy balanced activities I can do outside of my social media use that I don't want social media to take over?

People for Support and Help: Who are the main people that I can turn to for support if I am concerned about how social media is impacting me? Or if I see content that is concerning? Or if someone on social media engages with me in a concerning way?

Digital Privacy and Safety: How can I make my social media presence and use safer? (privacy settings, accounts followed, etc.)

Professionals and Agencies: If no one is available, who can I call during a suicidal crisis?

- Suicide and Crisis Lifeline
  - Call or text 988
- Colorado Crisis Services
  - Call 1-844-493-TALK (8255)
  - Text TALK to 38255
- Trevor Project Hotline
  - Call 1-866-488-7386
  - Text Start to 678678
- 911

1. Positive Content
2. "Screen Free" Reflection
3. Warning Signs
4. How Others Can Help
5. Coping Strategies
6. Healthy Activities
7. People to Support and Help
8. Digital Privacy and Safety
9. Resources

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CDE Media Literacy Resource Bank

https://www.cde.state.co.us/medialiteracy/media-literacy-resource-bank

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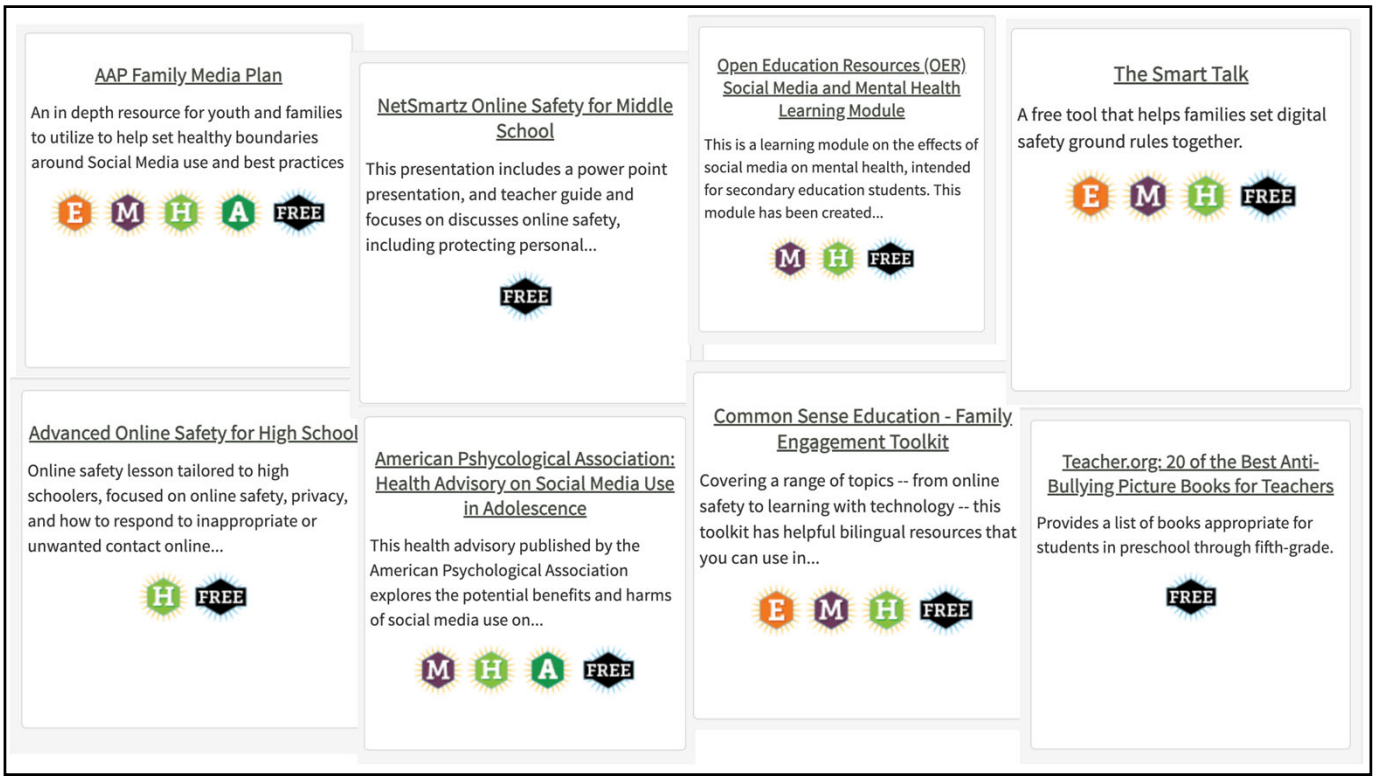

13

References

- Common Sense Media (2023) – Teen Smartphone Use
- U.S. Surgeon General's Advisory on Social Media & Youth (2023)
- U.S. DOE Playbook on Student Device Policies (2024)
- JAMA (2025) – Smartphone & Mental Health
- IES (2025) – Screen Time & Outcomes
- Parents, Social Media, and Youth Mental Health Report (2024)
- APA (2024) – Youth and Social Media

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Evidence-Based Practices for the Assessment and Treatment of ADHD and Disruptive Behavior Disorders

Pediatric Mental Health Institute

1

Jessica Hawks, PhD
Child & Adolescent Psychologist
Francescon Family Endowed Chair for Mood Disorders
Chief of Psychology, Pediatric Mental Health Institute, Children's Hospital Colorado
Associate Professor, Division of Child & Adolescent Psychiatry, CU School of Medicine

Pediatric Mental Health Institute

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Learning Objectives

1. Outline common screening tools used for identification of ADHD/Disruptive Behaviors.
2. Discuss the developmental progression of ADHD and Disruptive Behaviors.
3. Describe psychotherapeutic treatments for ADHD/Disruptive Behaviors.

Introduction[1,2]

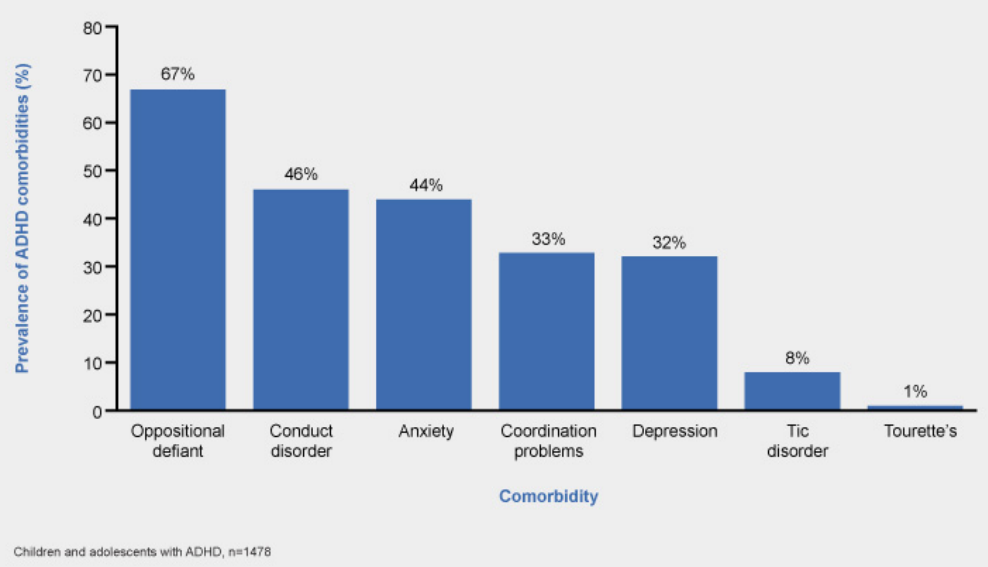
- Per the CDC, ADHD/behavioral concerns are the most common mental health concerns in youth.[1]
  - 9.8% have received an ADHD diagnosis
  - 8.9% have received a disruptive behavior diagnosis
- ADHD Risk Factors: First degree relative with ADHD, premature birth/low birth-weight, perinatal exposure to cigarettes/drugs/alcohol
- DBD Risk Factors: A "difficult temperament," comorbid MH difficulties, authoritarian/permissive parenting, low SES, parental stress/MH concerns
- Possibility of a variety of negative life outcomes including mental health concerns, substance abuse, educational/career difficulties, poorer physical health, legal problems, and social concerns.

Screening & Diagnosing

ADHD & DBDs in Community Settings[2,3]

- Children with ADHD/DBDs are most likely to present to their PCP
- Boys more likely to be diagnosed
  - White youth are more likely to be diagnosed with ADHD
  - Black and Latino youth are more likely to be diagnosed with DBDs
- Critical importance of avoiding blaming language when talking with parents
  - High degree of shame/stigma that can be a barrier to seeking treatment

Comorbidities are common[4,5]



Screening Measures

- ADHD
  - NICHQ Vanderbilt Assessment Scale[6]
- DBDs
  - Eyberg Child Behavior Inventory (ECBI)[7]
- Broadband Measures
  - Pediatric Symptom Checklist (PSC)[8]
  - Strengths and Difficulties Questionnaire (SDQ)[9]
- Narrowband Measures
  - PHQ-A (depression)[10], GAD-7 (anxiety)[11]
  - CATS (trauma)[12]
  - PROMIS Measures (depression, anxiety, anger)[13]

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention 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 activities (not due to refusal or failure to understand)	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 necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other 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 when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3

Diagnosing ADHD

- Medical exam, including vision/hearing screenings
- Clinical interview
  - Functional Assessment
  - Symptoms **must** be present in at least 2 major settings
- Behavioral Observations
- ***Should always assess for mental health comorbidities***

DSM-5 Diagnostic Criteria for ADHD[14]

- ADHD reclassified as a neurodevelopmental disorder

Type of ADHD	Symptoms	
Inattentive (6/9)	• Doesn't pay attention to details/Makes careless mistakes • Difficulty sustaining attention • Doesn't seem to listen when spoken to • Doesn't follow through with instructions/fails to finish tasks	• Difficulty organizing • Avoids tasks requiring sustained mental effort • Loses things • Easily distracted • Forgetful
Hyperactive/ Impulsive (6/9)	• Fidgets/squirms • Leaves seat when sitting is expected • Runs/climbs in inappropriate situations • Unable to play quietly	• Is "driven by a motor" or restless • Talks excessively • Blurts out answers • Difficulty waiting their turn • Interrupts or intrudes on others
Combined	Meets criteria for Inattentive and Hyperactive/Impulsive Criteria	

Additional Diagnostic Criteria[14]

- Several symptoms must be present prior to age 12 and persist for 6+ months to a degree that is **inconsistent with developmental level**
- Symptoms must be present in **2 or more settings**
- Cause **clinically significant impairment**
- Symptoms aren't better explained by another disorder
  - Noncompliance due to ODD, Inattention due to depression or anxiety
- Autism is no longer an exclusion criterion

Developmental Progression of ADHD

Early Childhood	Middle Childhood	Adolescence/Early Adulthood
• Behavioral disinhibition • Emotional lability • Delays/Concerns with speech, language, and motor development	• Academic/school problems • Executive functioning challenges • Social difficulties • Psychiatric comorbidities emerge	• Engagement in risky behaviors (drugs/alcohol, reckless driving) • Continued academic & work problems • Hyperactivity decreases, inattention remains

Disruptive Behaviors & the DSM-5[14]

- Disruptive, Impulse Control, and Conduct Disorders
  - Oppositional Defiant Disorder
  - Conduct Disorder
  - Intermittent Explosive Disorder
  - Unspecified Disruptive Behavior Disorder
- Attention-Deficit/Hyperactivity Disorder
  - Reclassified but highly comorbid
- Disruptive Mood Dysregulation Disorder
  - Internalizing disorder but oftentimes manifests externally

DSM-5 Diagnostic Criteria for ODD & DMDD[14]

Diagnosis	Symptoms	

ODD	• Often loses temper
	• Often touchy or easily annoyed
	• Often angry and resentful
	• Often argues with adults
	• Often actively defies/refuses to comply
	• Often deliberately annoys others
	• Often blames others for their mistakes
	• Spiteful or vindictive (at least 2x/6 mos)
		• Symptoms present for at least 6 months
		  • Under 5, occur most days
		  • 5+, occurs at least once per week
		• Mild (1 setting), Moderate (2 settings), Severe (3+ settings)

DMDD	• Severe, recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion to situation (3+/week) • Persistently irritable/angry mood, most of the day, nearly every day	• Symptoms present for at least 12 months • Symptoms present in at least 2 settings • Do not diagnose before age 6 • Cannot coexist with ODD, IED, or Bipolar

Developmental Progression of DBDs

Continuous nature of behavior concerns	Early Starter Pathway	Callous-Unemotional Trait
• Normative vs. Atypical • Noncompliance as a "keystone behavior."	• Onset in preschool years • High degree of continuity • Predictive of worse outcomes	• Unique predictor of more severe and stable symptoms • High emotional dysregulation and low behavioral inhibition

Psychotherapeutic Interventions

Psychosocial Treatment of ADHD

- Under 6: Parent Management Training (PMT) as first line treatment[15]

- Meta-Analysis[16]
  - Treatment components predictive of largest effect included:
    - Positive Reinforcement (Praise)
    - Natural/logical consequences (Ignoring, Timeout)

  - Components with moderate or trending effect included:
    - Proactive Parenting (Rules, Monitoring)
    - Parental Self-Management (Emotion Regulation, Problem Solving)

Psychosocial Treatment of ADHD[17]

- Ages 6+: Gold standard = Behavior therapy + med management

School-Based Interventions[18,19]

Classroom Supports	• Daily Report Card • Preferential Seating • Organizational Planner • Time Limits
Social Supports	• Friendship Group • Peer Tutor
Formal Supports	• 504 Plan • Individualized Education Plan

Pharmacological Interventions

- ADHD
  - Under 4 years = First line is PMT
  - 6+ years = First line is stimulants (methylphenidates > amphetamines)
- DBDs
  - NO FDA-approved medications for Disruptive, Impulse Control, and Conduct Disorders
  - Focus on medications for co-morbid disorders (mood, anxiety, ADHD)
- Colorado Pediatric Psychiatry Consultation & Access Program (CoPPCAP)
  - https://www.coppcap.org/resources

Resources

- Children's Hospital Colorado Online Resources
  - https://www.childrenscolorado.org/doctors-and-departments/departments/psych/mental-health-professional-resources/
  - https://www.childrenscolorado.org/conditions-and-advice/parenting/mental-health-family-resources/
- Books
  - Taking Charge of ADHD (Barkley)
  - The Kazdin Method for Parenting the Defiant Child (Kazdin)
  - The Explosive Child (Greene)
- Websites
  - www.chadd.org
  - https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/index.html

Questions?

References

1. Centers for Disease Control and Prevention. https://www.cdc.gov/childrensmentalhealth/data.html
2. Reuben, C. & Elgaddal, N. (2024). Attention-Deficit/Hyperactivity Disorder in Children Ages 5-17 Years: United States, 2020-2022. NCHS Data Briefs, 499. Centers for Disease Control and Prevention, National Center for Health Statistics.
3. Glascoe, F. (2015). Evidence-based early detection of developmental-behavioral problems in primary care: What to expect and how to do it. Journal of Pediatric Health Care: Official Publication of National Association of Pediatric Nurse Associates & Practitioners, 29(1), 46-53.
4. Danielson, M.L., Claussen, A.H., Bitsko, R.H., Katz, S.M., Newsome, K., Blumberg, S.J., Kogan, M.D., & Ghandour, R. (2024). ADHD Prevalence Among U.S. Children and Adolescents in 2022: Diagnosis, Severity, Co-Occurring Disorders, and Treatment. Journal of Clinical Child and Adolescent Psychology, 53(3), 343-360.
5. Preuss, U., Ralston, S.J., Baldursson, G., Falissard, B., Lorenzo, M.J., Pereira, R.R., Vlasveld, L., Coghill, D., ADORE Study Group (2006). Eur Child Adolesc Psychiatry [Suppl 1] 15:I/4-I/14.
6. National Institute for Children's Health Quality. NICHQ Vanderbilt Assessment Scales. 2002
7. Eyberg, S., & Pincus, D. (1999). Eyberg Child Behavior Inventory & Sutter-Eyberg Student Behavior Inventory-Revised: Professional Manual. Odessa, FL: Psychological Assessment Resources.
8. Massachusetts General Hospital. https://www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist
9. Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry, 38, 581-586.
10. Johnson JG, Harris ES, Spitzer RL, Williams JBW: The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolescent Health 30:196–204, 2002.
11. Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166:1092-7.
12. Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., … Goldbeck, L. (2017a). International development and psychometric properties of the child and adolescent trauma screen (CATS). Journal of Affective Disorders, 210, 189-195.
13. Quinn H, Thissen D, Liu Y, Magnus B, Lai JS, Amtmann D, Varni JW, Gross HE, DeWalt DA. (2014) Using item response theory to enrich and expand the PROMIS® pediatric self-report banks. Health and Quality of Life Outcomes, 12:160.
14. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Association.

References

15. Centers for Disease Control and Prevention. https://www.cdc.gov/adhd/treatment/behavior-therapy.html#:~:text=For%20children%20younger%20than%206,at%20home%2C%20and%20in%20relationships
16. Leijten P, Gardner F, Melendez-Torres GJ, van Aar J, Hutchings J, Schulz S, Knerr W, Overbeek G. Meta-Analyses: Key Parenting Program Components for Disruptive Child Behavior. (2019). J Am Acad Child Adolesc Psychiatry, Feb;58(2):180-190.
17. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/adhd/infographics/behavior-therapy-parents.html
18. American Academy of Pediatrics (2016). Understanding ADHD: Information for Parents About Attention-Deficit/Hyperactivity Disorder. https://www.healthychildren.org/English/health-issues/conditions/adhd/pages/Your-Child-At-School.aspx
19. Centers for Disease Control and Prevention (2024). School changes – Helping children with ADHD. https://www.cdc.gov/adhd/articles/school-changes-helping-children.html

ADHD

• Attention Deficit Hyperactivity Disorder •

Attention Deficit Hyperactivity Disorder (ADHD) occurs in roughly 9.4% of children, with boys being more likely diagnosed (12.9%) than girls (5.6%)[1].

DSM-5 criteria for ADHD

≥5 symptoms per category **in adults**, ≥6 months; age of onset ≤12 years; noticeable in ≥2 settings; impact on social, academic or occupational functioning; not better accounted for by another mental disorder

Inattention

(a) Lack of attention to details / careless mistakes
(b) Difficulty sustaining attention
(c) Does not seem to listen
(d) Does not follow through on instructions (easily side-tracked)
(e) Difficulty organising tasks and activities
(f) Avoids sustained mental effort
(g) Loses and misplaces objects
(h) Easily distracted
(i) Forgetful in daily activities

Hyperactivity / Impulsivity

(a) Fidgetiness (hand or feet) / squirms in seat
(b) Leaves seat frequently
(c) Running about / feeling restless
(d) Excessively loud or noisy
(e) Always "on the go"
(f) Talks excessively
(g) Blurts out answers
(h) Difficulty waiting his or her turn
(i) Tends to act without thinking

Download a free ADHD medication guide!

Screening

CoPPCAP recommends pediatric providers consider use of multi-informant rating scales to, diagnose ADHD, track response to intervention 2-3 weeks after starting medication, to guide dose changes, and routinely every 6 months

even when stable medication dose is achieved to monitor symptoms. Additionally, when tracking response to treatment intervention, consider use of the same screening form used at baseline prior to diagnosis.

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
ADHD	NICHQ Vanderbilt Assessment Scale Diagnostic Rating Scale 6-12 years Caregiver Report Teacher Report	Vanderbilt ⇒ English ⇒ Spanish	The Vanderbilt Assessment Scale is a 55-question assessment tool that reviews symptoms of ADHD. It also looks for other conditions such as conduct disorder, oppositional-defiant disorder, anxiety, and depression.
ADHD	ADHD Rating Scale IV - Preschool Version 3-5 years Caregiver Report	ADHD Rating Scale IV - Preschool Version ⇒ English	The ADHD Rating Scale-IV obtains parent ratings regarding the frequency of each ADHD symptom based on DSM-IV criteria. Parents are asked to determine symptomatic frequency that describes the child's home behavior over the previous 6 months. The ADHD Rating Scale-IV is completed independently by the parent and scored by a clinician. The scale consists of 2 subscales: inattention (9 items) and hyperactivity-impulsivity (9 items). If 3 or more items are skipped, the clinician should use extreme caution in interpreting the scale. Results from this rating scale alone should not be used to make a diagnosis.
ADHD	Swanson, Nolan, and Pelham (SNAP) Questionnaire – IV 3-5 years Caregiver Report Teacher Report	SNAP-IV ⇒ English ⇒ Spanish	The SNAP-IV 18-item scale is an abbreviated version of the Swanson, Nolan, and Pelham (SNAP) Questionnaire (Swanson, 1992;Swanson et al., 1983). Items from the DSM-IV criteria for attention-deficit/hyperactivity disorder (ADHD) are included for the two subsets of symptoms: Inattention (items 1–9) and Hyperactivity/Impulsivity (items 10–18).
ADHD	Connors, 3rd Edition 6 – 18 years Caregiver Report Teacher Report Self-Report	Conners 3 ⇒ $$$	The Conners 3 assesses cognitive, behavioral, and emotional problems, with a focus on ADHD and comorbid disorders–providing teacher, parent, and student perspectives.
ADHD	Child Behavior Checklist 6 – 18 years Caregiver Report Teacher Report Self-Report	CBCL ⇒ $$$	The Child Behavior Checklist (CBCL) is a common tool for assessing depression in children, as well as ADHD, and other emotional and behavioral problems.

ADHD	Behavior Assessment System for Children, 3rd Edition 2 – 21 years Caregiver Report Teacher Report Self-Report	BASC 3 ⇒ $$$	BASC-3 applies a triangulation method for gathering information. It analyzes a child's behavior from three perspectives: self, teacher, and parent.

Diagnosis

- 314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

- 314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

- 314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met but Criterion A1 (inattention) is not met over the past 6 months.

Specify if:

◊ In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:

- Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in only minor functional impairments.
- Moderate: Symptoms or functional impairment between "mild" and "severe" are present.
- Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

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ADHD Algorithm

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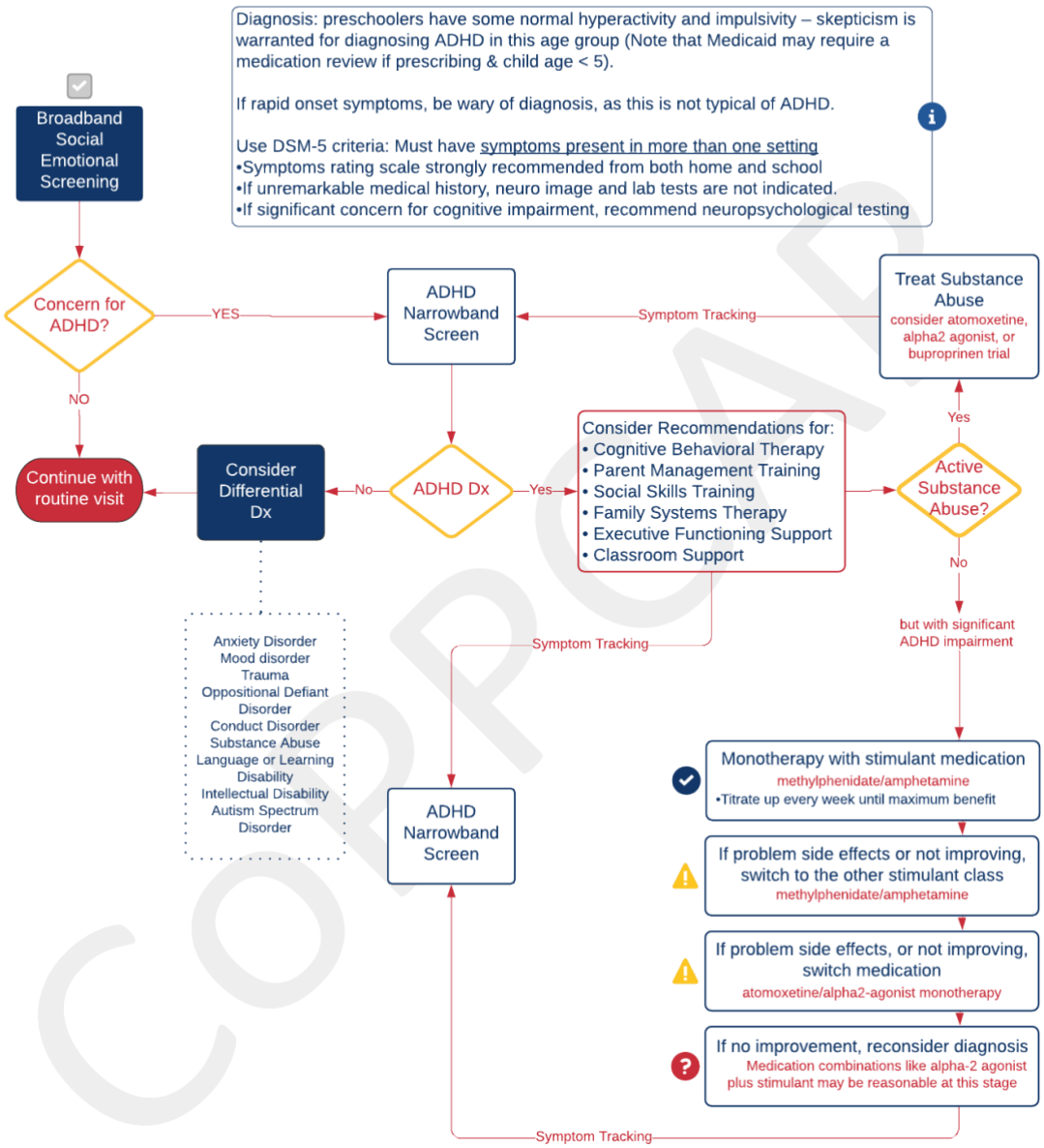

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Treatment Modalities

Therapy: when ADHD symptoms are mild patients and families can consider therapy alone, otherwise evidence-based research supports use of intervention with both therapy and medication. When recommending therapy services, consider evidence-based therapies such as:

- Cognitive Behavioral Therapy (CBT)
- Parent Management Training
- Social Skills Training
- Family Systems Therapy
- Executive Function Coaching
- Video Games?
    - In 2020 the FDA approved EndeavorRx, a prescription-only, game-based treatment that is indicated to improve attention function as measured by computer-based testing. It is the first digital therapeutic intended to improve symptoms associated with attention deficit hyperactivity disorder (ADHD), as well as the first game-based therapeutic granted marketing authorization by the FDA for any type of condition.

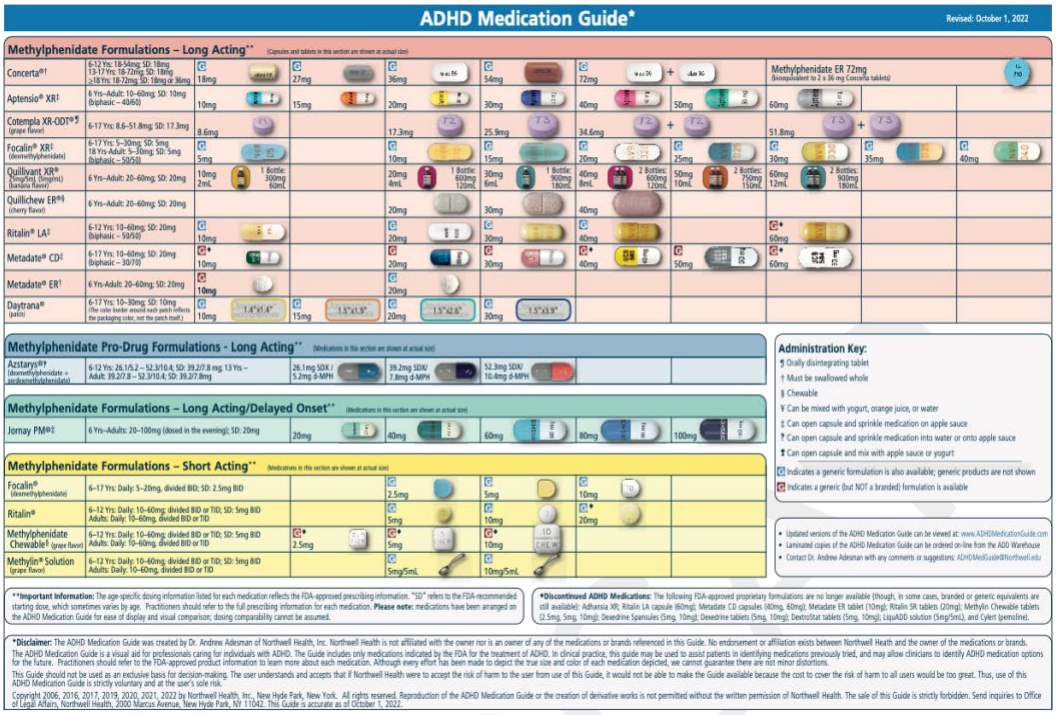
Pharmacological: when ADHD symptoms are moderate or severe, treatments using an evidenced-based therapy and medication in combination provide the best efficacy.

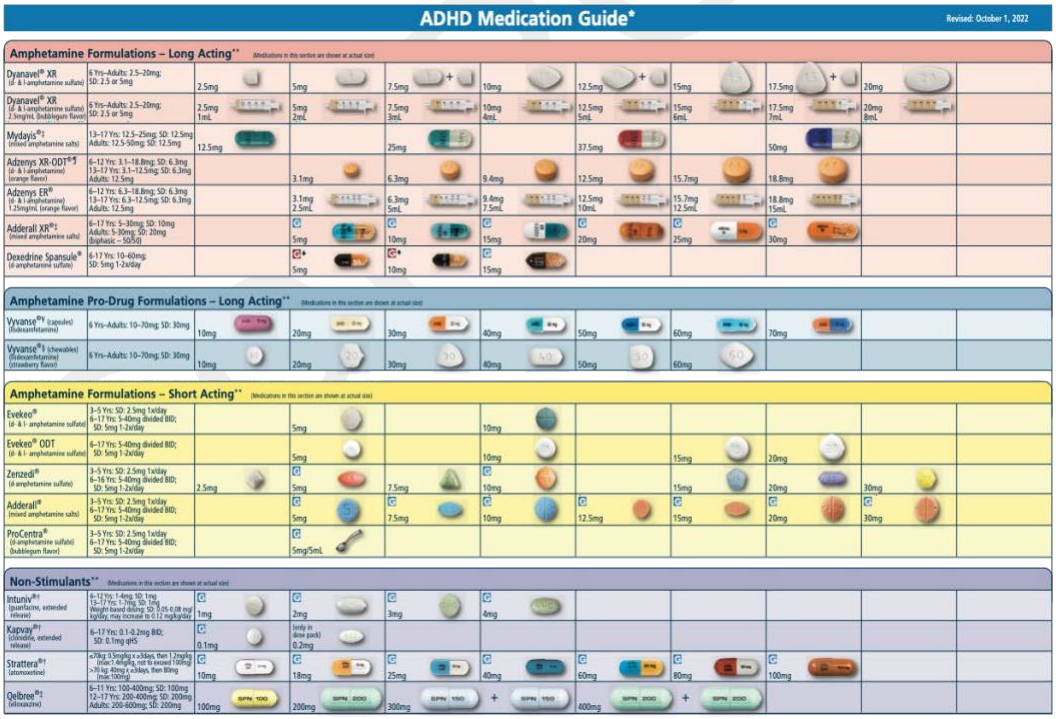
- Medical workup recommended if medication will be used.
    - Obtain the patient's and patient's family's cardiovascular history (if patient or family has a cardiac history of sudden death, and/or cardiac symptoms patient should obtain more intensive cardiac workup before initiating stimulant treatment), risk of lead poisoning, history of sleep apnea, patient's height, weight, blood pressure, and substance use history. It is advisable to follow up every 2 weeks until appropriate dose achieved, then monitor all of the above every 3 months.
- Stimulants are first line treatment. All stimulants are based on two formulations…
    - Methylphenidate derivatives (includes Ritalin, Focalin, Concerta, etc): FDA approved starting at age 6yo.

- Amphetamine derivatives (includes Adderall, Vyvanse, etc): some are FDA approved starting at age 3 yo (i.e. Adderall)
    - common side effects include decreased appetite, headache, insomnia, GI discomfort, increased anxiety, possibly worsens tics
    - less common side effects: anxiety, activation

- Non-stimulants (FDA approved starting at age 6yo):
    - Alpha-2 adrenergic agonists: Guanfacine, Clonidine
        - side effects include sedation, constipation, hypotension, dizziness, rebound hypertension if stopped suddenly
    - Selective NE reuptake inhibitor: Atomoxetine
        - side effects include suicidal ideation, severe liver injury, priapism
    - Viloxazine is a prescription medication that was approved by the FDA in 2021 to treat attention deficit hyperactivity disorder (ADHD) in children and adults. It is a noradrenergic reuptake inhibitor (NRI), which means that it works by increasing the levels of norepinephrine in the brain. Norepinephrine is a neurotransmitter that plays a role in attention, focus, and impulse control.
        - The most common side effects of viloxazine are: nausea, vomiting, diarrhea, stomach pain, headache, dizziness, sleepiness, dry mouth, blurred vision.
        - Viloxazine can also cause more serious side effects, such as: suicidal thoughts or actions, liver problems, seizures, heart problems, blood pressure problems

- Other medications to consider
    - note that **none** of the following are FDA approved for ADHD
        - Bupropion
        - Venlafaxine
        - TCAs
        - Modafinil
        - Natural Therapies (e.g. Omega3, attentional OTC “medications”)





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Educational Interventions: recommend families contact the child's school district to learn more about the availability and process to obtain the following educational interventions, or visit http://www.cde.state.co.us/cdesped/iep

- IEP: Federal law (i.e. it's federally funded) entitles children/teens with specific disabilities to obtain a free & appropriate public education which may include services including Psychological services, PT, OT, and Speech amongst others. ADHD falls under the "Other Health Impairment" classification. Obtaining an IEP is usually an involved process.
- 504 Plans: typically provide for classroom accommodations (i.e. extended testing time, student placement near teacher, etc) and may be easier to obtain than an IEP. 504 plans are managed by the school (principal, guidance counselor, teacher, etc) and need to be rewritten each year.

Free Resources:

- AACAP – ADHD: Parents' Medication Guide
- AAP – Caring for Children With ADHD: A Practical Resource Toolkit for Clinicians, 3rd Edition

Acknowledgements: PMHCA sites across multiple states.
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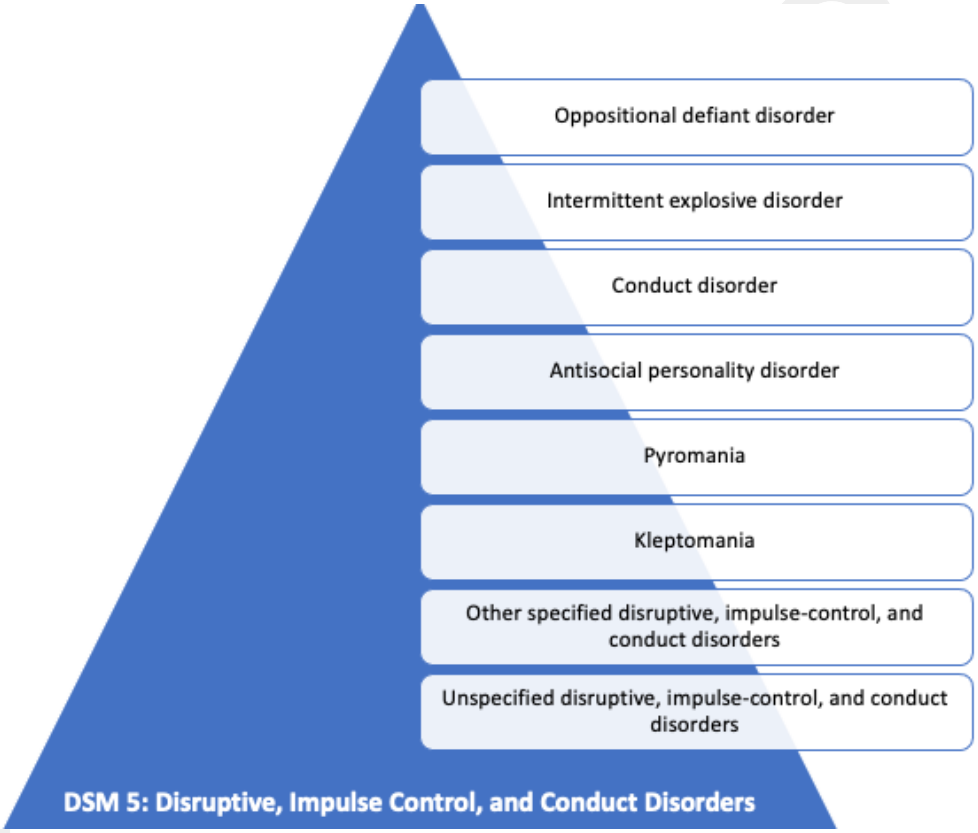
DISRUPTIVE BEHAVIORS

• Disruptive Behaviors •

Disruptive, Impulse-control, and Conduct Disorders involve problems in the self-control of emotions and behaviors which result in the violation of another one's rights and/or cause significant conflict with societal norms or authority figures.



Epidemiology[1]

Recent data collected as part of the National Survey of Children's Health (survey years: 2016 – 2019) reported an 8.9% prevalence rate of children and adolescents aged 3–17 years with a diagnosis of behavior problems, with a 7.0% point prevalence rate at the time of the survey. Children aged 6–11 years had higher rates of behavior problems than children who were less than 6 years or older than11 years. Similar to rates of ADHD, boys had more than twice the estimated prevalence of behavior problems compared with girls. When considering factors related to race, Black children had the highest estimated prevalence of behavior problems, followed by

AUTHORS:
Ryan Asherin, PhD, & Sandra Fritsch, MD

White and Hispanic children, with the lowest estimates among Asian children. Socioeconomic factors determined that the highest prevalence of behavior problems was among children in homes affected by poverty and among children with public health insurance; the prevalence of behavior problems was also higher among children of parents with a high school education (or less) as compared to those families with parents attaining more than a high school education. Additionally, it was found that the prevalence of behavior problems was higher among children living in rural areas than among those in urban or suburban areas.

Diagnostic Criteria

The revision of DSM-IV to DSM-5 added a chapter specifically categorizing disruptive, impulse-control, and conduct disorders. This revision brought together disorders that were previously included in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter "Impulse-Control Disorders Not Otherwise Specified" (i.e., intermittent explosive disorder, pyromania, and kleptomania). Evidenced based research supported the underpinnings of these disorders to all be characterized as problems in emotional and behavioral self-control.

Of note, ADHD is frequently comorbid with the disorders in this chapter but is now listed in DSM 5 within the chapter categorizing Neurodevelopmental Disorders. It had previously (DSM-IV TR) been considered within the Disruptive Behavior Disorders. Please review the ADHD Colorado Care Guide for further information on the assessment, diagnosis, and treatment of ADHD.

Click the links below to review diagnostic criteria for each of the DSM-5 categorized disruptive, Impulse control, and conduct disorders:

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania
- Other specified disruptive, impulse control, and conduct disorders
- Unspecified disruptive, impulse control, and conduct disorders

Etiology

Several biological and environmental risk factors have been associated with the development of disruptive behaviors.

Biological Risk Factors

- Parent with a diagnosis of:
  - o Alcohol Dependence
  - o Antisocial Personality Disorder
  - o Attention Deficit/Hyperactivity Disorder
  - o Conduct Disorder
  - o Schizophrenia
- Sibling with a Disruptive Behavior Disorder
- ODD: Familial Pattern ODD is more common in families in which at least one parent has a history of Mood Disorder, ODD, CD, ADHD, ASPD, or a Substance Related Disorder. Some studies suggest a link between maternal depression and ODD; however, the direction of causality is suspect. ODD is more common in the families where there is serious marital discord
- CD: Familial Pattern Twin and adoption studies show genetic and environmental factors
- Maternal smoking during pregnancy

Environmental Risk Factors

- Parental rejection/neglect
- Harsh discipline
- Inconsistent parenting/multiple caregivers
- Lack of Supervision
- Large family size
- Single parent status
- Marital discord
- Abuse – emotional, physical or sexual
- Poverty
- Abuse and Neglect
- Parental criminality & psychopathology

- Drug and alcohol use by parents/caregivers
- Exposure to violence

Screening

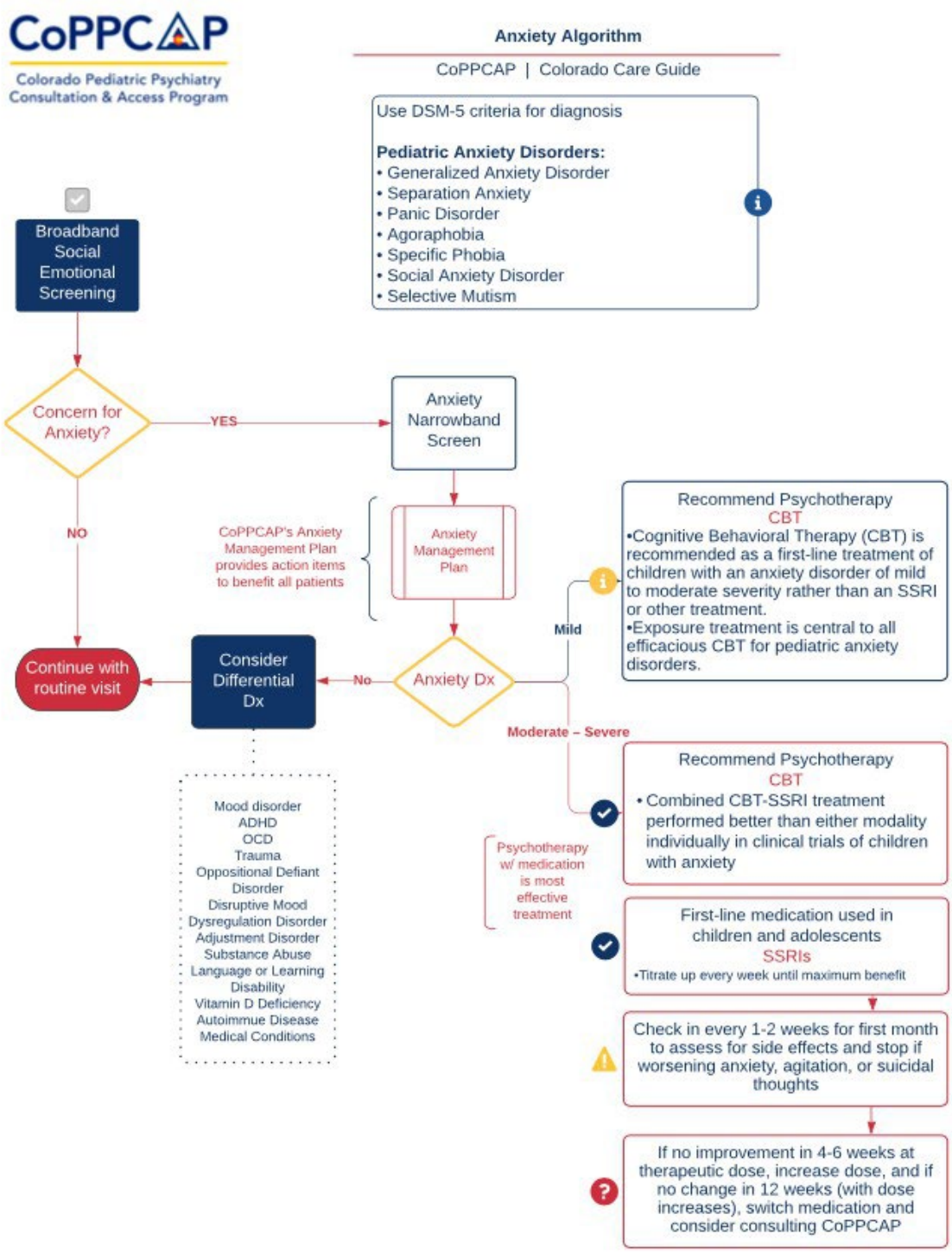
CoPPCAP recommends pediatric providers initially use an age-appropriate broadband screening measures to better understand the symptom profile. When clinically indicated, narrowband screening measures, especially ones that collect information from multiple reports and within multiple environments may be utilized to further detect symptoms of a disruptive behavior disorder. Consider the use of the following screening measures that include several open source options that are free for use:

Screener. DxCategory	Screener.Name	Screener.Acronynm	Screener.Description
Social-Emotional Development	The Survey of Well-being of Young Children 2-60 months Caregiver Report	SWYC ⇒ English ⇒ Spanish	The Survey of Well-being of Young Children (SWYC)™ is a freely-available, comprehensive screening instrument for children under 5 years of age. The SWYC was written to be simple to answer, short, and easy to read. The entire instrument requires 15 minutes or less to complete and is straightforward to score and interpret. The SWYC is approved by MassHealth for compliance with the Children's Behavioral Health Initiative screening guidelines. The SWYC is copyright © 2010 Tufts Medical Center. Every SWYC form includes sections on developmental milestones, behavioral/emotional development, and family risk factors. At certain ages, a section for Autism-specific screening is also included. Age-specific SWYC forms are available for each age on the pediatric periodicity schedule from 2 to 60 months.
Social-Emotional Development	Preschool Pediatric Symptom Checklist 18-60 months Caregiver Report	PPSC ⇒ English ⇒ Spanish	The Preschool Pediatric Symptom Checklist (PPSC) is a social/emotional screening instrument for children 18–60 months of age. The PPSC was created as one part of a comprehensive screening instrument designed for pediatric primary care and is modeled after the Pediatric Symptom Checklist.

Social-Emotional Development	Brief Early Childhood Screening Assessment 18-60 months Caregiver Report	Brief ECSA* ⇒ English	The Brief ECSA screens children 18-60 months for signs of emotional and behavioral problems.
Social-Emotional Development	Pediatric Symptom Checklist – 17 item 4-18 years Caregiver Report	PSC-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist is a 17-item screening questionnaire listing a broad range of children's emotional and behavioral problems that reflects parents' impressions of their child's psychosocial functioning. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-17 is used to screen for childhood emotional and behavioral problems including those of attention, externalizing, and internalizing.
Social-Emotional Development	Pediatric Symptom Checklist – Youth – 17 item 11-18 years Self-Report	PSC-Y-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist - Youth - 17 is a 17 item screening questionnaire listing a broad range of behavioral and psychosocial problems in youth. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-Y-17 is used to screen for emotional and behavioral problems including those of attention, externalizing, internalizing, and suicidal ideation.
Social-Emotional Development	Ages & Stages Questionnaire: Social Emotional 1-72 months Caregiver Report	ASQ-SE $$$	SQ:SE- 2 is a set of questionnaires about behavior and social- emotional development in young children. There are nine questionnaires for different ages to screen children from 1 month to 6 years old.

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
ADHD	NICHQ Vanderbilt Assessment Scale Diagnostic Rating Scale 6-12 years Caregiver Report	Vanderbilt ⇒ English ⇒ Spanish	The Vanderbilt Assessment Scale is a 55-question assessment tool that reviews symptoms of ADHD. It also looks for other conditions such as conduct disorder, oppositional-defiant disorder, anxiety, and depression.

	Teacher Report		
ADHD	ADHD Rating Scale IV - Preschool Version 3-5 years Caregiver Report	ADHD Rating Scale IV - Preschool Version ⇒ English	The ADHD Rating Scale-IV obtains parent ratings regarding the frequency of each ADHD symptom based on DSM-IV criteria. Parents are asked to determine symptomatic frequency that describes the child's home behavior over the previous 6 months. The ADHD Rating Scale-IV is completed independently by the parent and scored by a clinician. The scale consists of 2 subscales: inattention (9 items) and hyperactivity-impulsivity (9 items). If 3 or more items are skipped, the clinician should use extreme caution in interpreting the scale. Results from this rating scale alone should not be used to make a diagnosis.
ADHD	Swanson, Nolan, and Pelham (SNAP) Questionnaire – IV 3-5 years Caregiver Report Teacher Report	SNAP-IV ⇒ English ⇒ Spanish	The SNAP-IV 18-item scale is an abbreviated version of the Swanson, Nolan, and Pelham (SNAP) Questionnaire (Swanson, 1992;Swanson et al., 1983). Items from the DSM-IV criteria for attention-deficit/hyperactivity disorder (ADHD) are included for the two subsets of symptoms: Inattention (items 1–9) and Hyperactivity/Impulsivity (items 10–18).
ADHD	Connors, 3rd Edition 6 – 18 years Caregiver Report Teacher Report Self-Report	Conners 3 ⇒ $$$	The Conners 3 assesses cognitive, behavioral, and emotional problems, with a focus on ADHD and comorbid disorders–providing teacher, parent, and student perspectives.
ADHD	Child Behavior Checklist 6 – 18 years Caregiver Report Teacher Report Self-Report	CBCL ⇒ $$$	The Child Behavior Checklist (CBCL) is a common tool for assessing depression in children, as well as ADHD, and other emotional and behavioral problems.
ADHD	Behavior Assessment System for Children, 3rd Edition 2 – 21 years Caregiver Report Teacher Report Self-Report	BASC 3 ⇒ $$$	BASC-3 applies a triangulation method for gathering information. It analyzes a child's behavior from three perspectives: self, teacher, and parent.



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Options for Treatment: Psychotherapy

Without intervention, it is likely that Disruptive Behavior Disorders may progress. There are several promising treatments that are available and if completed have enduring benefits. A thorough review of Boggs et. al. (2004) demonstrated that Parent-Child Interaction Therapy shows significant positive change after completing therapy, however this was not true for parents who discontinued treatment.

Streiner and Remsing (2007) identify the importance of skill training in problem-solving and family intervention that provides behavior management training

Eyberg, Nelson and Boggs (2008) have identified 16 evidence-based treatments for disruptive behaviors. Fifteen are identified as probably efficacious while one is evaluated as having well established treatment outcomes. Two examples are:

- **Parent Management Training** (PMT) is directed toward parents and teaches them to identify antecedents, resulting behaviors and the associated consequences for their children as well as themselves. Ultimately, the training focuses on reinforcing desired behaviors.
- **Parent-Child Interaction Therapy** (PCIT) emphasizes improvements in the relationship between the parent and child and offers tools to help manage behaviors that are disruptive

Early intervention during preschool years is imperative & offers promising results

Nixon (2002) has identified that effective parent management interventions may be offered via a number of modalities including face-to-face counseling, videotaped training and telephonic

Options for Treatment: Pharmacotherapy

- **CBT is always indicated as a first line treatment of pediatric anxiety**
- Medications are indicated for more moderate – severe forms of anxiety or in anxiety that has not responded to psychotherapy alone
- Approximately 55-65% of children and adolescents will respond to an initial antidepressant trial

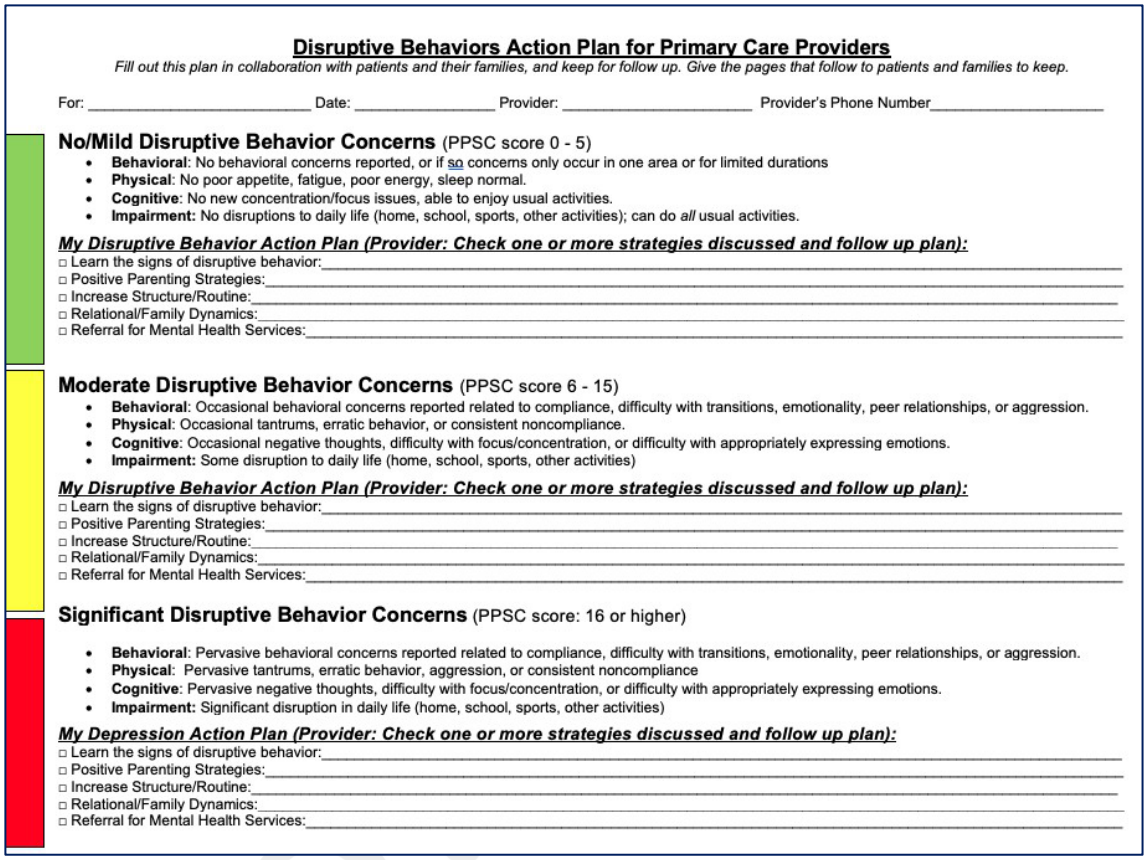
- SSRIs are typically the first-line pharmacologic treatment in children and adolescent's serotonin-norepinephrine reuptake inhibitors (SNRIs) and tricyclic antidepressants have also shown efficacy in the treatment of pediatric anxiety disorders. Because they are associated with less easily tolerated side effects compared with SSRIs, these drugs are generally used second- or third- line.
- The most common side effects of SSRIs are gastrointestinal symptoms, headaches, agitation, sleep changes, irritability, motor restlessness (need to constantly move), and behavioral activation. These side effects are most likely to occur in the first 1-2 weeks after starting the medication, or when making dosage increases. Side effects experienced may be different based on individual medication.
- Concerning side effects of SSRIs include serotonin syndrome and increased suicidal thoughts.
    - When discussing antidepressant medications with families, always provide education about the FDA black box warning for increased suicidal thoughts when used in children and adolescents. This warning is based upon a 2004 review 24 clinical trials of children and adolescents who had been prescribed antidepressants. No suicides occurred in any of these studies, but 4 out of 100 children taking antidepressants reported suicidal thoughts or behaviors while 2 out of 100 children not on medication reported suicidal thoughts or behaviors. As a result, the FDA applied the black box warning for increased suicidal thoughts to all antidepressant medications.
- Frequent check ins are recommended during the first month to monitor for development of side effects or suicidal thoughts. Medication should be stopped if patient develops intolerable side effects or suicidal thoughts during this period.
    - Consider phone calls directly or via support staff to monitor mood and functioning weekly when first starting medication
- SSRIs can be titrated weekly, as tolerated, to a therapeutic dose (see depression medication chart below)
- Patients may have to take SSRIs for 4-6 weeks at an effective dose before experiencing any reduction in anxiety symptoms
    - If no benefit after 4-6 weeks, increase dose. If no benefit after 12 weeks, switch to a different medication.
- Patients should continue medication for 6-12 months following resolution of symptoms
- When discontinuing medications, taper slowly to minimize side effects (going down by the lowest titration increment every 1-2 weeks)

Anxiety Medications

Medications that may be used to treat anxiety disorders in children and adolescents						
Class	**Medication (Brand name)**	**Common dose range (mg/day)**	**Tablet size (mg)**	**Common side effects**	**Serious side effects**	**Uncommon, serious side effects**
SSRI	Citalopram/escitalopram (Celexa/Lexapro™)	10/5 – 40/20	10/5, 20/10, 40	• Headache • Insomnia • Diarrhea • Decreased appetite • Hyperactivity/restlessness • Vomiting • Increased anger/irritability • Sexual dysfunction • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Potential for abnormal heart rhythm • Mania	• Serotonin syndrome • Bleeding problems
	Fluvoxamine (Luvox™, Luvox CR™)	100 – 300	25, 50, 100, 150			
	Sertraline (Zoloft™)	25 – 200	25, 50, 100			
	Fluoxetine (Prozac™, Sarafem™)	10 – 60	10, 20, 40, 60			
	Paroxetine (Paxil™, Pexeva™)	10 – 50	10, 20, 40			
SNRI	Venlafaxine ER (Effexor™)	37.5 – 225	37.5, 75, 150, 225	• Sleepiness • Insomnia • Restlessness • Sexual dysfunction • Headache • Dry mouth • Increased anger/irritability • Increased blood pressure • Increased heart rate • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Mania	• Serotonin syndrome • Bleeding problems
	Duloxetine (Cymbalta™)	30 – 120	20, 30, 40, 60			
	Atomoxetine (Strattera™)	10 – 100	10, 18, 25, 40, 60, 80, 100			
Tricyclic antidepressant	Clomipramine (Anafranil™)	75 – 250	25, 50, 75	• Sleepiness • Dry mouth • Weight gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Heart rhythm problems; electrocardiogram and blood levels • Mania	• Serotonin syndrome
	Imipramine (Trofanil™, Trofranil-PM™)		10, 25, 50			
Benzodiazepine	Alprazolam (Xanax™, Alprazolam Intensol™)	0.5 – 1.5	0.25, 0.5, 1, 2	• Drowsiness • Clumsiness • Dry mouth • Dizziness • Abdominal pain	• Possible dependence • Withdrawal symptoms when used at high doses, especially when administered over long periods. Decreasing the dose gradually is a common strategy to decrease the risk of withdrawal symptoms. • Disinhibition • Memory impairment • Worsening depression	• Respiratory depression (possible at high doses and when combined with other central nervous system depressants)
Atypical anxiolytic	Buspirone (Buspar™)	15 – 60	5, 10, 15, 30	• Dizziness • Lightheadedness • Tiredness		
Antihistamine	Diphenhydramine (Benadryl™, Banophen™, Diphenhist™)	12.5 – 50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• symptoms. • Abnormal heart rhythms • Agitation • Difficulty completely emptying the bladder • Harm to certain types of blood cells • Seizures	
	Doxylamine (Unisom™, WalSom™)	12.5 – 50	25, 50			
	Hydroxyzine (Atarax™)	25 – 50	10, 25, 50			

Disruptive Behaviors Management Plan

CoPPCAP offers a Disruptive Behaviors Management Plan for use in Primary Care settings to help provide psychoeducation & actionable items providers, caregivers, and patients can take after depression screening.



Disruptive Behaviors Action Plan for Primary Care Providers

Fill out this plan in collaboration with patients and their families, and keep for follow up. Give the pages that follow to patients and families to keep.

For: _____ Date: _____ Provider: _____ Provider's Phone Number_____

No/Mild Disruptive Behavior Concerns (PPSC score 0 - 5)

- **Behavioral**: No behavioral concerns reported, or if so concerns only occur in one area or for limited durations
- **Physical**: No poor appetite, fatigue, poor energy, sleep normal.
- **Cognitive**: No new concentration/focus issues, able to enjoy usual activities.
- **Impairment:** No disruptions to daily life (home, school, sports, other activities); can do *all* usual activities.

My Disruptive Behavior Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:_____
□ Positive Parenting Strategies:_____
□ Increase Structure/Routine:_____
□ Relational/Family Dynamics:_____
□ Referral for Mental Health Services:_____

Moderate Disruptive Behavior Concerns (PPSC score 6 - 15)

- **Behavioral**: Occasional behavioral concerns reported related to compliance, difficulty with transitions, emotionality, peer relationships, or aggression.
- **Physical**: Occasional tantrums, erratic behavior, or consistent noncompliance.
- **Cognitive**: Occasional negative thoughts, difficulty with focus/concentration, or difficulty with appropriately expressing emotions.
- **Impairment:** Some disruption to daily life (home, school, sports, other activities)

My Disruptive Behavior Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:_____
□ Positive Parenting Strategies:_____
□ Increase Structure/Routine:_____
□ Relational/Family Dynamics:_____
□ Referral for Mental Health Services:_____

Significant Disruptive Behavior Concerns (PPSC score: 16 or higher)

- **Behavioral**: Pervasive behavioral concerns reported related to compliance, difficulty with transitions, emotionality, peer relationships, or aggression.
- **Physical**: Pervasive tantrums, erratic behavior, aggression, or consistent noncompliance
- **Cognitive**: Pervasive negative thoughts, difficulty with focus/concentration, or difficulty with appropriately expressing emotions.
- **Impairment:** Significant disruption in daily life (home, school, sports, other activities)

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:_____
□ Positive Parenting Strategies:_____
□ Increase Structure/Routine:_____
□ Relational/Family Dynamics:_____
□ Referral for Mental Health Services:_____

click the image above to access the full Disruptive Behaviors Management Plan

Resources:

Crisis Hotlines:

- National Suicide Prevention Lifeline - 1-800-273-8255
- National Suicide Hotline – 1-800-784-2433
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

Books for Parents

Mental Health App reviews

One Mind PsyberGuide is a non-profit project run by a team of experts in mental health, technology, and technology delivered care based out of the University of California, Irvine and Northwestern University. One Mind PsyberGuide is not an industry website; its goal is to provide accurate and reliable information free of preference, bias, or endorsement.

Primary References

[1]Bitsko RH, Claussen AH, Lichstein J, et al. Mental Health Surveillance Among Children — United States, 2013–2019. MMWR Suppl 2022;71(Suppl-2):1–42. DOI: http://dx.doi.org/10.15585/mmwr.su7102a1

1.

Acknowledgements: PMHCA sites across multiple states.

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NICHQ Vanderbilt Assessment Scales

Used for diagnosing ADHD

NIC Q

National Institute for
Children's Health Quality

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child □ was on medication □ was not on medication □ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention 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 activities (not due to refusal or failure to understand)	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 necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other 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 when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	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 or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	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 resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie,"cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	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 cruel to animals	0	1	2	3
36. Has deliberately set fires 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, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

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Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child □ was on medication □ was not on medication □ not sure?

Symptoms	Never	Occasionally	Often	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 instructions 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 sustained 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 (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's 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 (eg, "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

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
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 or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

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Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child □ was on medication □ was not on medication □ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention 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 activities (not due to refusal or failure to understand)	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 necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other 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 when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	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 or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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HE0352

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

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child □ was on medication □ was not on medication □ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention 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 activities (not due to refusal or failure to understand)	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 necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other 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 when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	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 or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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HE0353

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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11-22/rev0303

Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 compo- nents: symptom assessment and impairment in performance.
On both the parent and teacher initial scales, the symptom assess- ment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive respon- ses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problem- atic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity	ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity
Oppositional-Defiant Disorder Screen ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Oppositional-Defiant/Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section seg- ment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

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NICHQ
National Initiative for Children's Healthcare Quality

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Consumer & Specialty Pharmaceuticals

ADHD Medication Guide*

Revised: May 7, 2024

Methylphenidate Formulations – Long Acting, Oral**

(Capsules and tablets in this section are shown at actual size)

Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg	G 18mg	G 27mg	G 36mg	G 54mg	Relexxii® (bioequivalent to corresponding Concerta dosing)	G 45mg	G 63mg	G 72mg
Focalin® XR‡ (dexmethylphenidate)	6-17 Yrs: 5-30mg; SD: 5mg 18 Yrs-Adult: 10-40mg; SD: 10mg (biphasic - 50/50)	G 5mg		G 10mg	G 15mg	G 20mg G 25mg	G 30mg	G 35mg	G 40mg
Cotempla XR-ODT®¶ (grape flavor)	6-17 Yrs: 8.6-51.8mg; SD: 17.3mg	8.6mg		17.3mg	25.9mg	34.6mg + 2 × 25mg	51.8mg		
Aptensio® XR‡	6 Yrs-Adult: 10-60mg; SD: 10mg (biphasic - 40/60)	G 10mg	G 15mg	G 20mg	G 30mg	G 40mg G 50mg	G 60mg		
Quillivant XR® 25mg/5mL (5mg/mL) (banana flavor)	6 Yrs-Adult: 20-60mg; SD: 20mg	10mg 2mL 1 Bottle: 300mg 60mL		20mg 4mL 1 Bottle: 600mg 120mL	30mg 6mL 1 Bottle: 900mg 180mL	40mg 8mL 2 Bottles: 600mg 120mL 50mg 10mL 2 Bottles: 750mg 150mL	60mg 12mL 2 Bottles: 900mg 180mL		
QuilliChew ER®§ (cherry flavor)	6 Yrs-Adult: 20-60mg; SD: 20mg (biphasic - 30/70)			20mg	30mg	40mg			
Ritalin® LA‡	6-12 Yrs: 10-60mg; SD: 20mg (biphasic - 50/50)	G 10mg		G 20mg	G 30mg	G 40mg	G♦ 60mg		
Metadate® CD‡	6-17 Yrs: 10-60mg; SD: 20mg (biphasic - 30/70)	G♦ 10mg		G♦ 20mg	G♦ 30mg	G♦ 40mg G♦ 50mg	G♦ 60mg		
Metadate® ER†	6 Yrs-Adult: 20-60mg; SD: 20mg	G♦ 10mg		G♦ 20mg					

Methylphenidate Pro-Drug Formulations - Long Acting, Oral**

(Medications in this section are shown at actual size)

Azstarys®♀ (dexmethylphenidate + serdexmethylphenidate)	6-12 Yrs: 26.1/5.2 - 52.3/10.4; SD: 39.2/7.8 mg; 13 Yrs - Adult: 39.2/7.8 - 52.3/10.4; SD: 39.2/7.8mg	26.1mg SDX / 5.2mg d-MPH	9.2mg SDX/ .8mg d-MPH	52.3mg SDX/ 10.4mg d-MPH	

Methylphenidate Formulations – Long Acting/Delayed Onset, Oral**

(Medications in this section are shown at actual size)

Jornay PM®‡	6 Yrs-Adults: 20-100mg (dosed in the evening); SD: 20mg	20mg	40mg	60mg	80mg	100mg	

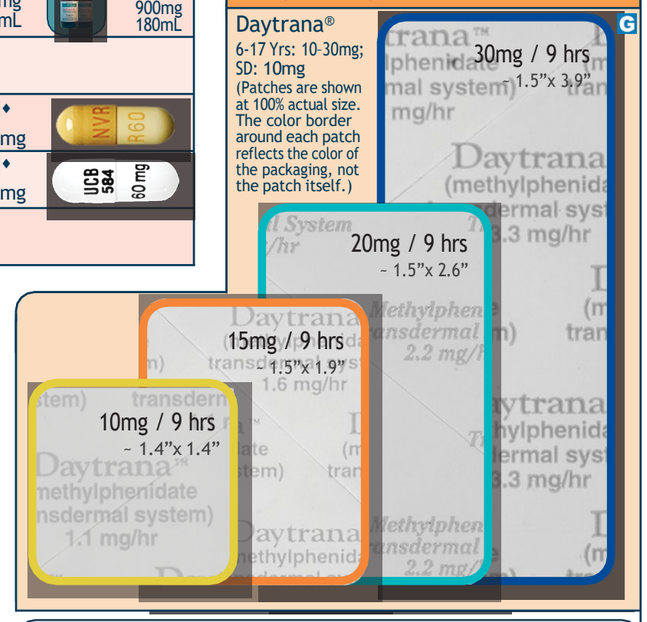
Methylphenidate Formulations – Short Acting, Oral**

(Medications in this section are shown at actual size)

Focalin® (dexmethylphenidate)	6-17 Yrs: Daily: 5-20mg, divided BID; SD: 2.5mg BID		G 2.5mg	G 5mg	G 10mg	
Ritalin®	6-12 Yrs: Daily: 10-60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10-60mg, divided BID or TID		G 5mg	G 10mg	G 20mg	
Methylin Chewable§ (grape flavor)	6-12 Yrs: Daily: 10-60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10-60mg, divided BID or TID	G♦ 2.5mg	G♦ 5mg	G♦ 10mg		
Methylin® Solution (grape flavor)	6-12 Yrs: Daily: 10-60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10-60mg, divided BID or TID		G 5mg/5mL	G 10mg/5mL		

Methylphenidate Formulations - Long Acting, Transdermal

Daytrana®
6-17 Yrs: 10-30mg; SD: 10mg
(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)



Administration Key:

¶ Orally disintegrating tablet
† Must be swallowed whole
§ Chewable
¥ Can be mixed with yogurt, orange juice, or water
‡ Can open capsule and sprinkle medication on apple sauce
♀ Can open capsule and sprinkle medication into water or onto apple sauce
❣ Can open capsule and mix with apple sauce or yogurt

G Indicates a generic (but NOT a branded) formulation is available

♦ **Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhansia XR; Adzenys ER (liquid); Cylert (pemoline); Dexedrine Spansules (5mg, 15mg); Dexedrine tablets; DextroStat tablets; LiquADD solution; Metadate CD capsules; Metadate ER tablet (10mg); Methylin Chewable tablets; Ritalin LA capsule (60mg); Ritalin SR tablets (20mg).

****Important Information:** The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SD" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication. **Please note:** medications have been arranged on the ADHD Medication Guide for ease of display and visual comparison; dosing comparability cannot be assumed.

- Updated versions of the ADHD Medication Guide can be viewed at: www.ADHDMedicationGuide.com
- Laminated copies of the ADHD Medication Guide can be ordered on-line from the ADD Warehouse
- Contact Dr. Andrew Adesman with any comments or suggestions: ADHDMedGuide@Northwell.edu

Cohen Children's Medical Center
Northwell Health®

ADHD Medication Guide*

Revised: May 7, 2024

Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

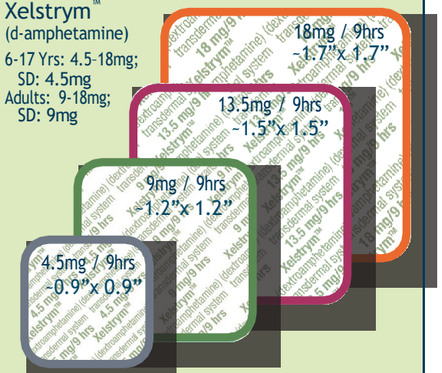
Dyanavel® XR (d- & l-amphetamine sulfate)	6 Yrs-Adults: 2.5-20mg; SD: 2.5 or 5mg		5mg		10mg		15mg		20mg	
Dyanavel® XR (d- & l-amphetamine sulfate) 2.5mg/mL (bubblegum flavor)	6 Yrs-Adults: 2.5-20mg; SD: 2.5 or 5mg	2.5mg 1mL	5mg 2mL	7.5mg 3mL	10mg 4mL	12.5mg 5mL	15mg 6mL	17.5mg 7mL	20mg 8mL	
Mydayis®‡ (mixed amphetamine salts)	13-17 Yrs: 12.5-25mg; SD: 12.5mg Adults: 12.5-50mg; SD: 12.5mg	G 12.5mg		G 25mg		G 37.5mg		G 50mg		
Adzenys XR-ODT®¶ (d- & l-amphetamine) (orange flavor)	6-12 Yrs: 3.1-18.8mg; SD: 6.3mg 13-17 Yrs: 3.1-12.5mg; SD: 6.3mg Adults: 12.5mg		3.1mg	6.3mg	9.4mg	12.5mg	15.7mg	18.8mg		
Adderall XR®‡ (mixed amphetamine salts)	6-17 Yrs: 5-30mg; SD: 10mg Adults: 5-30mg; SD: 20mg (biphasic - 50/50)		G 5mg	G 10mg	G 15mg	G 20mg	G 25mg	G 30mg		
Dexedrine Spansule® (d-amphetamine sulfate)	6-17 Yrs: 10-60mg; SD: 5mg 1-2x/day		G♦ 5mg	G 10mg	G♦ 15mg					

Amphetamine Pro-Drug Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Vyvanse®¥ (capsules) (lisdexamfetamine)	6 Yrs-Adults: 10-70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg	G 70mg		
Vyvanse®§ (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs-Adults: 10-70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg			

Amphetamine Formulations - Long Acting, Transdermal

Xelstrym™ (d-amphetamine)
6-17 Yrs: 4.5-18mg; SD: 4.5mg
Adults: 9-18mg; SD: 9mg



(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

Amphetamine Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

Evekeo® (d- & l- amphetamine sulfate)	3-5 Yrs: SD: 2.5mg 1x/day 6-17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg		G 10mg					
Evekeo® ODT (d- & l- amphetamine sulfate)	6-17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	5mg		10mg		15mg	20mg		
Zenzedi® (d-amphetamine sulfate)	3-5 Yrs: SD: 2.5mg 1x/day 6-16 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	G 5mg	7.5mg	G 10mg		G 15mg	G 20mg	G 30mg	
Adderall® (mixed amphetamine salts)	3-5 Yrs: SD: 2.5mg 1x/day 6-17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg	G 7.5mg	G 10mg	G 12.5mg	G 15mg	G 20mg	G 30mg	
ProCentra® (d-amphetamine sulfate) (bubblegum flavor)	3-5 Yrs: SD: 2.5mg 1x/day 6-17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg/5mL							

Non-Stimulants** (Medications in this section are shown at actual size)

Intuniv®† (guanfacine, extended release)	6-12 Yrs: 1-4mg; SD: 1mg 13-17 Yrs: 1-7mg; SD: 1mg Weight-based dosing: SD: 0.05-0.08 mg/kg/day; may increase to 0.12 mg/kg/day	G 1mg	G 2mg	G 3mg	G 4mg					
Kapvay®† (clonidine, extended release)	6-17 Yrs: 0.1-0.2mg BID; SD: 0.1mg qHS	G 0.1mg	(only in dose pack) 0.2mg							
Strattera®† (atomoxetine)	≤70kg: 0.5mg/kg x ≥3days, then 1.2mg/kg (max:1.4mg/kg, not to exceed 100mg) >70 kg: 40mg x ≥3days, then 80mg (max:100mg)	G 10mg	G 18mg	G 25mg	G 40mg	G 60mg	G 80mg	G 100mg		
Qelbree®‡ (viloxazine)	6-11 Yrs: 100-400mg; SD: 100mg 12-17 Yrs: 200-400mg; SD: 200mg Adults: 200-600mg; SD: 200mg	100mg	200mg	300mg	+	400mg	+			

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Additional Resources for ADHD

1. ADHD Medication Guides for families
    a. English: https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/ADHD_Medication_Guide-web.pdf
    b. Spanish: https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/ADHDSpanishMedicationGuide-web.pdf
    c. ADHD and ASD: https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/ADHDwithASD_Web.pdf
2. https://www.cdc.gov/adhd/treatment/behavior-therapy.html
3. https://www.cdc.gov/adhd/communication-resources/index.html
4. https://www.cdc.gov/parenting-toddlers/site.html
5. https://www.cdc.gov/parenting-teens/about/index.html
6. https://www.cdc.gov/child-development/positive-parenting-tips/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/index.html
7. FDA handout for atomexetine. http://www.accessdata.fda.gov/drugsatfda_docs/label/2009/021411s029s030lbl.pdf
8. FDA handout for viloxazine. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/211964s003lbl.pdf
9. FDA handout for clonidine. http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022331s001s002lbl.pdf
10. FDA handout for guanfacine ER. https://www.fda.gov/media/116457/download

Meeting Kids Where They Are: Trauma-Informed Approaches for Child Serving Professionals

Lauren Eckhart, PsyD
Clinical Director, Colorado Springs Division
Associate Professor of Clinical Practice

Children's Hospital Colorado
Here, it's different.™

1

Disclosure:

I have no relevant financial disclosures with ineligible companies.

2

2

Today's Objective

- Identify 2 practical trauma informed strategies for recognizing and responding to the needs of children impacted by trauma

Today's Overview

- Neurological effects of trauma
- The stress response and associated behaviors
- Trauma informed interventions and conversations

3

3

A New Question:

Moving from:

"What's wrong with you?"

To:

"What happened to you?"

AND how do I do things DIFFERENTLY because of what's happened to you?

4

4

A Matter of Framing

These individuals are not “manipulative,” or “disrespectful,” “defiant,” “rude,” “attention seeking” etc.

They are trying to survive.

These behaviors are not “problems,” “issues,” or “concerns”

They are ways to communicate needs.

5

5

Trauma and the Brain

6

6

What is Trauma?

- Any event that overwhelms an individual's capacity to cope
- Traumatic experiences are
  - Overwhelming
  - Invoke intense negative affect
  - Involve a degree of loss of control or vulnerability

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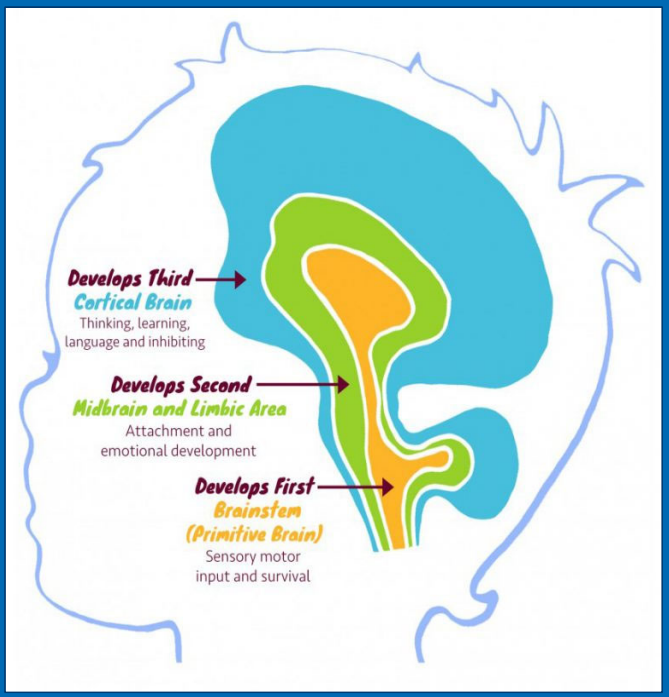

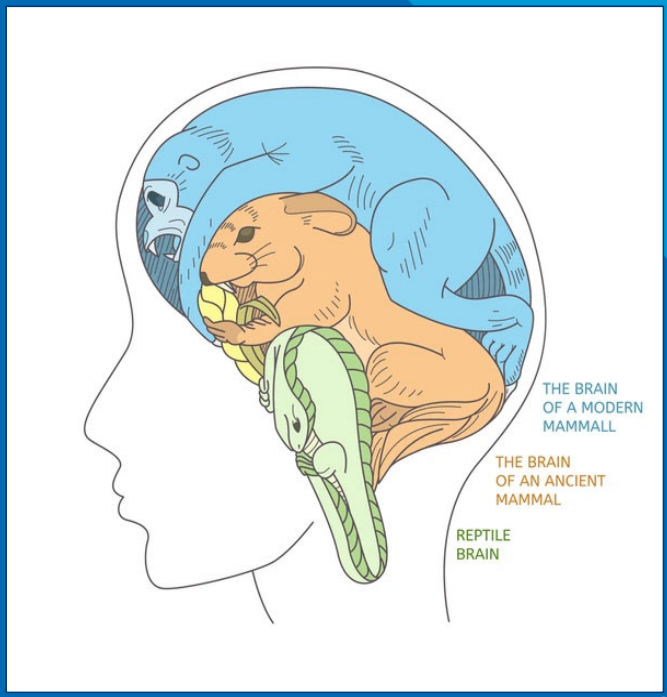

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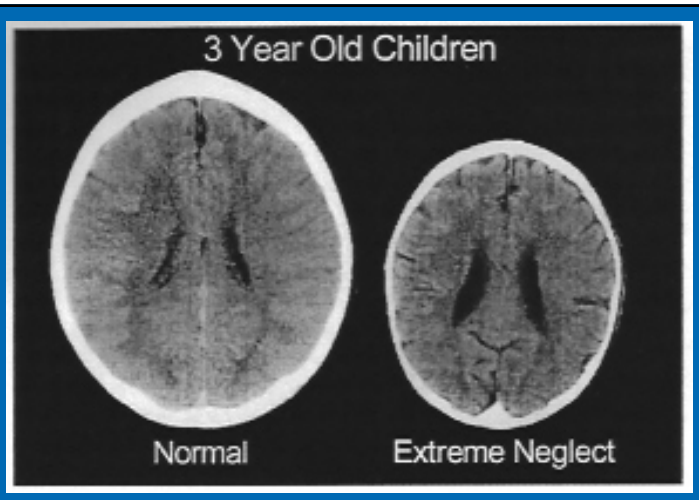


"In the CT scan on the left is an image from a healthy three-year-old with an average head size (50th percentile). The image on the right is from a three-year-old child suffering from severe sensory-deprivation neglect. The child's brain is significantly smaller than average (3rd percentile) and has enlarged ventricles and cortical atrophy."

- Bruce D. Perry

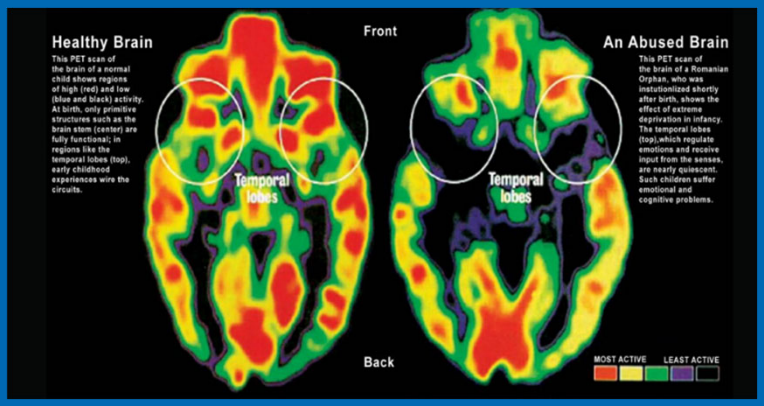
"Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture." Brain and Mind 3: 79-100, 2002

9

9

Trauma changes the brain!!

People who experienced trauma possess brains that are disorganized and dysregulated which can explain why they perceive the world differently and why thinking consequentially and sequentially is challenging.



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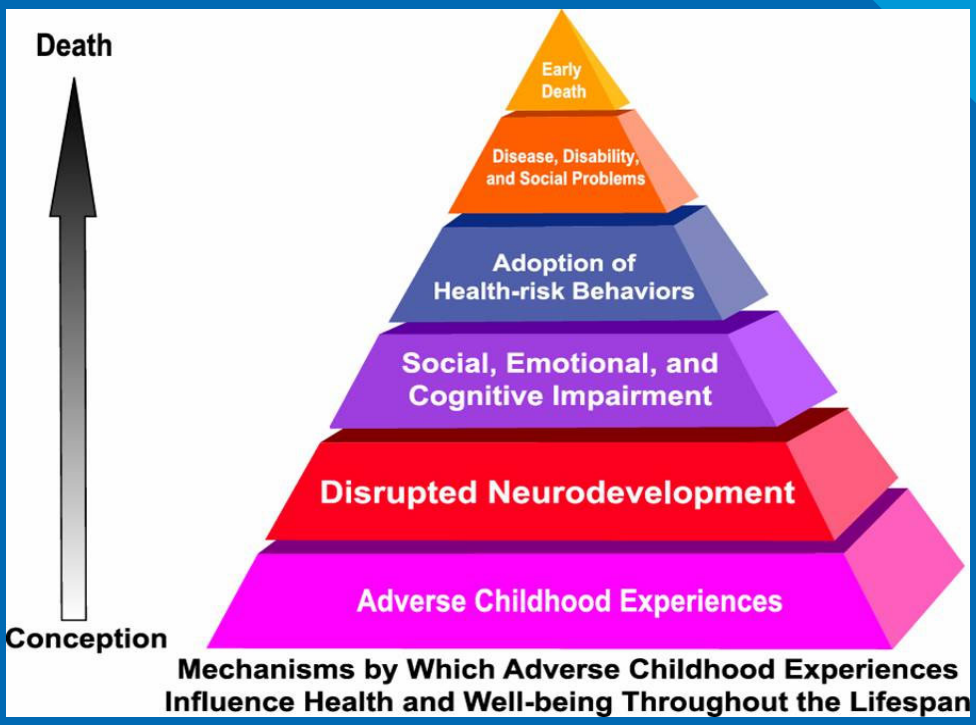

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The Trauma Response

12

12


Trama and Perception
13

13


What do you see?
Think? Feel?
What might someone has experienced intimate partner violence see? Think? Feel?

14

C-PTSD TRIGGERS

People	linked to the person who had the control over you
Places	associated to the trauma
Things	reminding you of the trauma
Situations	that may induce uncontrollable emotions, e.g. arguments
Boundaries	having them pushed or tested
Senses	sensitive to noises (loud bangs) or intense visuals (flashing lights)
Dates	memorable dates, like anniversaries, birthdays
Dreams	nightmares where you relive the trauma
Connections	difficulty trusting new people

Common Trauma Triggers

- Unpredictability or sudden change
- Loss of control
- Feelings of vulnerability or rejection
- Confrontation, authority, or limit setting
- Sensory overload
- Loneliness
- Situations perceived as unfair or unjust

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Trauma Event and/or Trauma Trigger

Stress/Danger Response

Fight | Flight | Freeze | Fawn

Try to recognize the behavioral responses as fight, flight or freezing behaviors

If we focus on the problems, we will miss the opportunity to understand where the behaviors originated

Slide from Ellen Williams, LCSW; Center for Child & Family Services

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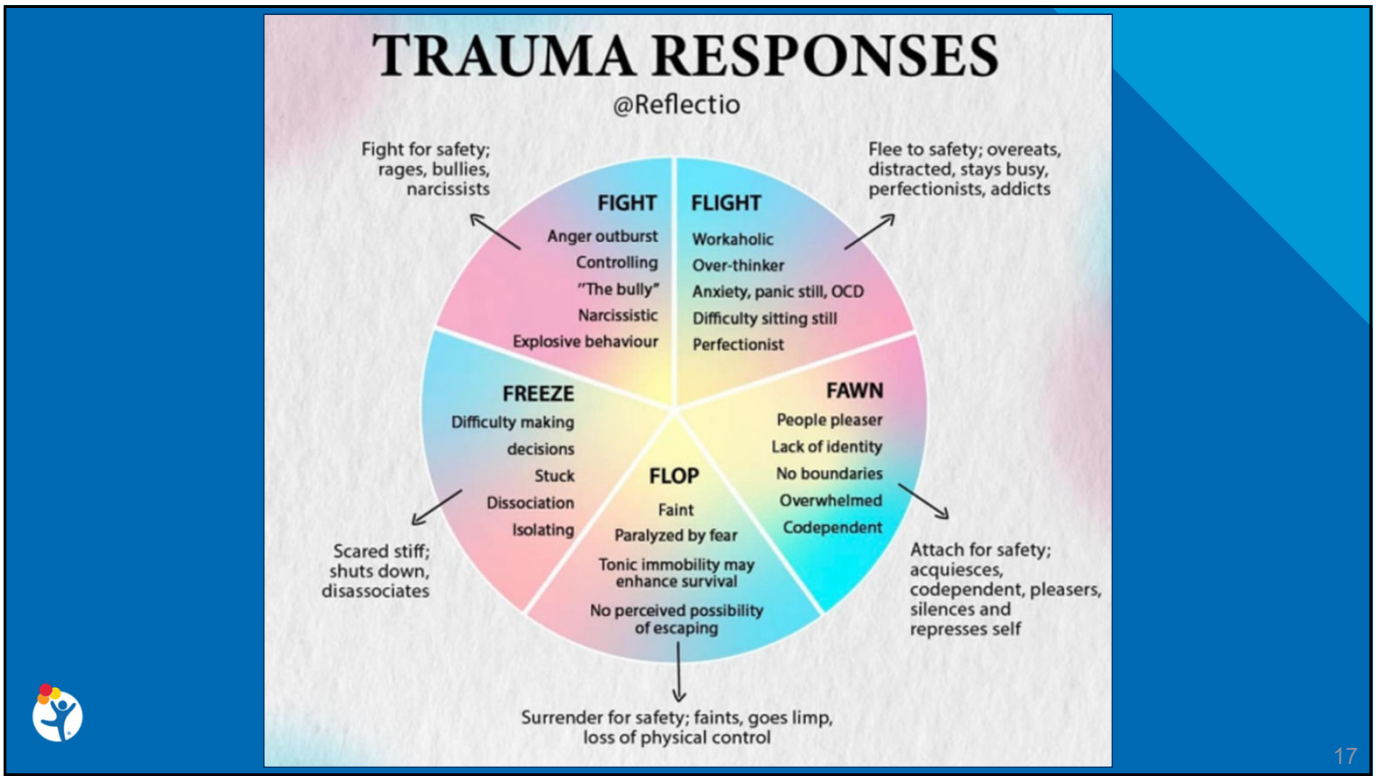
TRAUMA RESPONSES
@Reflectio
Fight for safety; rages, bullies, narcissists
Flee to safety; overeats, distracted, stays busy, perfectionists, addicts
FIGHT
Anger outburst
Controlling
"The bully"
Narcissistic
Explosive behaviour
FLIGHT
Workaholic
Over-thinker
Anxiety, panic still, OCD
Difficulty sitting still
Perfectionist
FREEZE
Difficulty making decisions
Stuck
Dissociation
Isolating
FAWN
People pleaser
Lack of identity
No boundaries
Overwhelmed
Codependent
FLOP
Faint
Paralyzed by fear
Tonic immobility may enhance survival
No perceived possibility of escaping
Scared stiff; shuts down, disassociates
Attach for safety; acquiesces, codependent, pleasers, silences and represses self
Surrender for safety; faints, goes limp, loss of physical control
17

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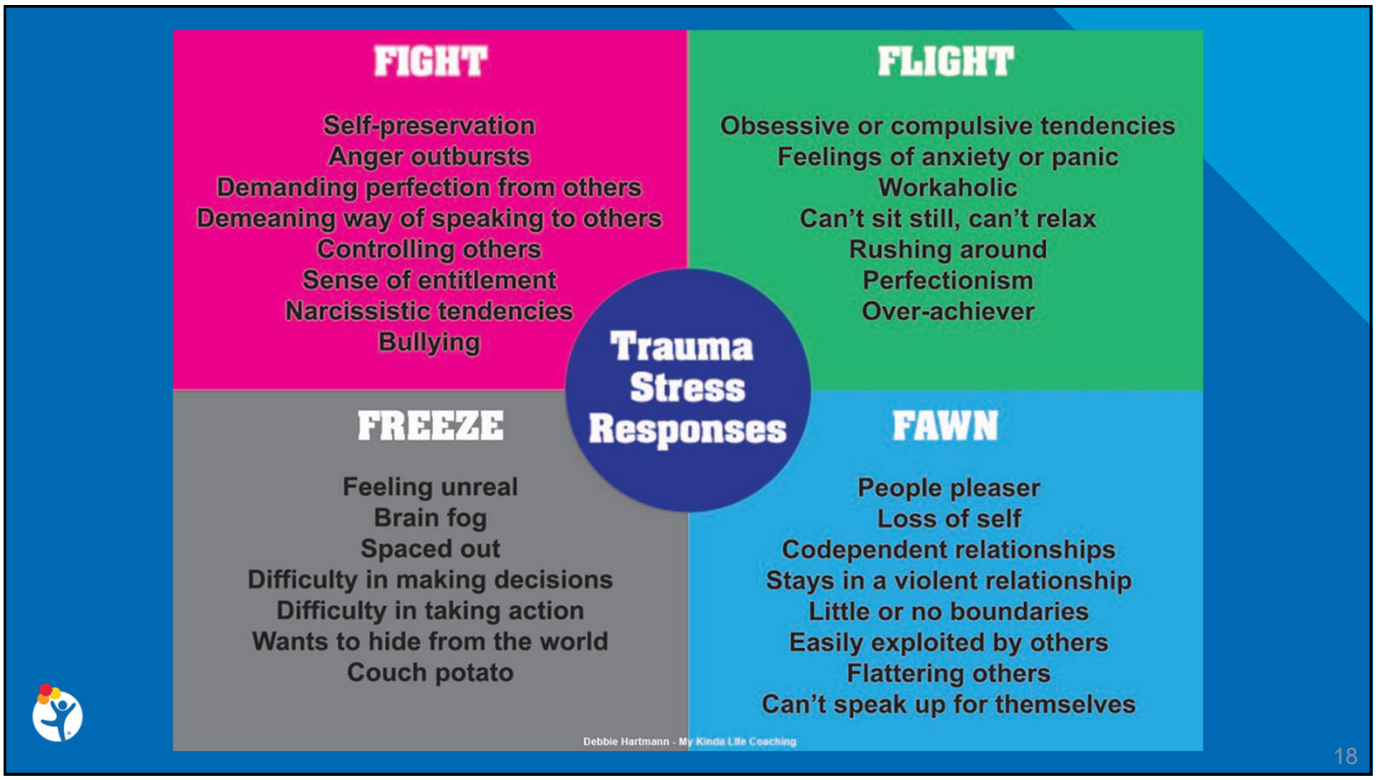

FIGHT
Self-preservation
Anger outbursts
Demanding perfection from others
Demeaning way of speaking to others
Controlling others
Sense of entitlement
Narcissistic tendencies
Bullying
FLIGHT
Obsessive or compulsive tendencies
Feelings of anxiety or panic
Workaholic
Can't sit still, can't relax
Rushing around
Perfectionism
Over-achiever
Trauma Stress Responses
FREEZE
Feeling unreal
Brain fog
Spaced out
Difficulty in making decisions
Difficulty in taking action
Wants to hide from the world
Couch potato
FAWN
People pleaser
Loss of self
Codependent relationships
Stays in a violent relationship
Little or no boundaries
Easily exploited by others
Flattering others
Can't speak up for themselves
Debbie Hartmann - My Kinda Life Coaching
18

18

Trauma-Informed Interventions

19

19

We must……

Respond to the need

Not react to the behavior

Seek connection; not compliance

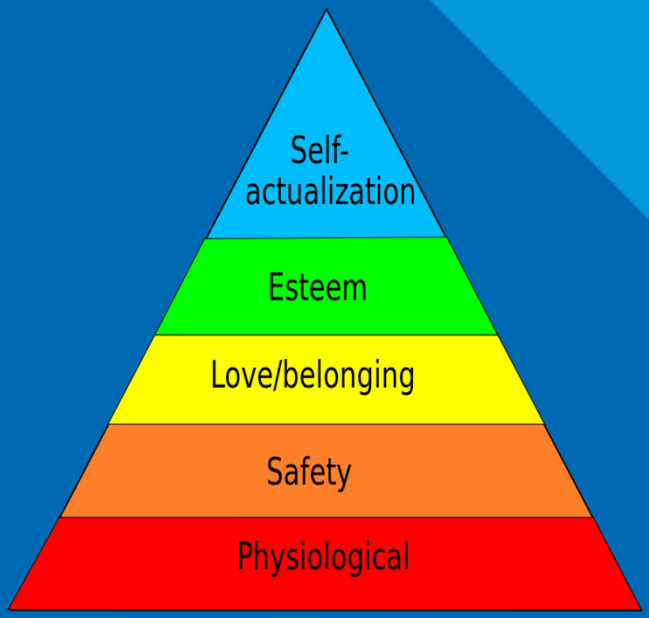
20

20

What do they need?

We all need food, water, safety, touch, attention, affirmation, acceptance, fun, and love

- Consider ways to meet these needs in your unique setting!



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Trauma Informed Care Considerations

- Does this cultivate a sense of **safety**?
- Am I showing **respect**?
- Does this build **trust**?
- How can I foster **autonomy**?
- How do I create **routine**?

Blaustein & Kinniburgh 2010

https://kdphospital.com/service/pediatric-services/

22

22

Essential Elements of a Trauma-Informed Integrated Healthcare System

1. Creating a trauma-informed office.
2. Involving and engaging family in program development, implementation, and evaluation.
3. Promoting child and family resilience, enhancing protective factors, and addressing parent/caregiver trauma.
4. Enhancing staff resilience and addressing secondary traumatic stress.
5. Assessing trauma-related somatic and mental health issues.
6. Providing coordinated, integrated care across child- and family-service systems.

Essential Elements | The National Child Traumatic Stress Network (nctsn.org) 23

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Create a Trauma Informed Environment

- Offer water and/or snacks
- Explain processes and procedures
- Evaluate your processes, where can you give people a choice
- Learn and provide ways to help kids and family members regulate their strong emotions

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Normalize – Ask – Pause – Connect

NORMALIZE

- Communicate that emotional difficulties are common and expected.
- Set up the discussion to promote emotional disclosure.
- Minimize the likelihood of "I'm fine."
  - "I know from working with other teens that it's common to feel down or depressed when [illness-specific stressor]."
  - "I hear from a lot of parents that they grieve the loss of [pre-illness experience]."
  - "I always ask about [emotion] because how you are emotionally is just as important as how you are physically."

PAUSE

Communicate non-verbally that you want to hear the answer.

Give the patient/family time to gather their thoughts and decide whether to share.

ASK

- Use open-ended questions.
- Keep your questions brief.
- Pay attention to your non-verbal communication.
  - "How about you/your family?"
  - "How has your family been affected?"
  - "What has [illness-specific stressor] been like for you?"

CONNECT

- Use reflection to communicate that the patient/family was heard and understood.
- Validate feelings.
- Connect to additional providers and resources when available.
  - "Thank you for sharing. It sounds like this has been a really hard time. I appreciate learning more about how you are doing so that we can continue to support you/your family."
  - "I can understand why you might feel this way."
  - "Our team has a [resource/person] that may be able to provide additional support around [challenge/concern]. Is it okay if I connect you?"

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Tips

1. Trust your instincts – don't overthink! These are likely skills you already have and use.
2. You don't need to have all the answers – families don't expect you to be behavioral health experts!
3. Asking and listening is an intervention – when families know that their feelings are normal and safe to discuss with you this increases emotional health and wellness!
4. What families disclose is likely the tip of the iceberg – families may not be comfortable sharing everything the first time you ask! If you continue to ask they are likely to share more over time.

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Types of Listening Skills

Attentive listening involves:

- Holding eye contact
- Maintaining good posture
- Nodding
- Mirroring speaker's body language to show interest
- Allowing speaker to complete entire thoughts

Reflection listening involves:

Repeating and paraphrasing what speaker has said to show that you truly understand what they are telling you

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Validation

What It Is

- Making space for someone's feelings
- Recognizing it's okay to not be okay
- Allowing a person to feel their feels
- Communicate that those feels are okay

What It Isn't

- Agreeing
- Encouraging someone to stay stuck
- Giving advice or trying to fix whatever the problem is
- Bringing out "shoulds" or other expectations

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Regulating Responses

How to respond in the moment to reduce distress

Engage the senses
Movement
Distraction
Listening

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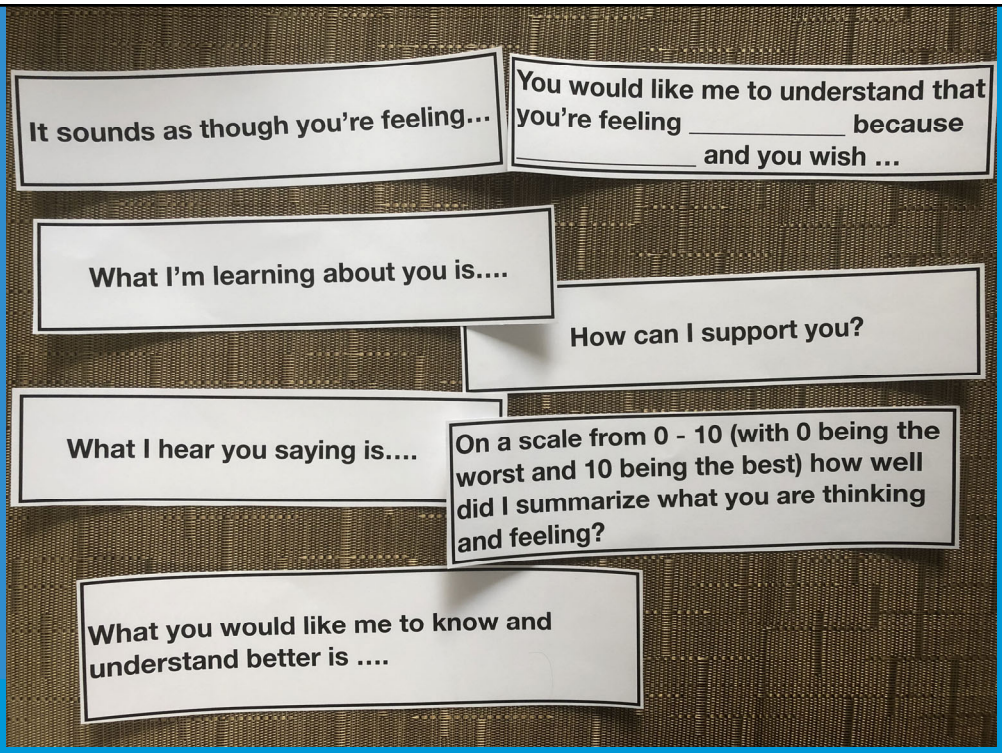

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TYPES OF COPING SKILLS

Self-Soothing
(Comforting yourself through your five senses)
1. Something to touch
   (ex: stuffed animal, stress ball)
2. Something to hear
   (ex: music, meditation guides)
3. Something to see
   (ex: snowglobe, happy pictures)
4. Something to taste
   (ex: mints, tea, sour candy)
5. Something to smell
   (ex: lotion, candles, perfume)

Distraction
(Taking your mind off the problem for a while)

Examples:
Puzzles, books, artwork, crafts, knitting, crocheting, sewing, crossword puzzles, sudoku, positive websites, music, movies, etc.

Opposite Action
(Doing something the opposite of your impulse that's consistent with a more positive emotion)
1. Affirmations and Inspiration
   (ex: looking at or drawing motivational statements or images)
2. Something funny or cheering
   (ex: funny movies / TV / books)

Emotional Awareness
(Tools for identifying and expressing your feelings)

Examples:
A list or chart of emotions, a journal, writing supplies, drawing / art supplies

Mindfulness
(Tools for centering and grounding yourself in the present moment)

Examples:
Meditation or relaxation recordings, grounding objects (like a rock or paperweight), yoga mat, breathing exercises.

Crisis Plan
(Contact info of supports and resources, for when coping skills aren't enough.)

Family / Friends
Therapist
Psychiatrist
Hotline
Crisis Team / ER
911

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Understanding the Internal Senses

- The 5 Senses
- Vestibular—movement and balance
- Proprioceptive—the body's ability to sense itself

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Grounding: 5 Things (5-4-3-2-1)

How to practice:

1. Name 5 things you can see around you.
2. Name 4 things you can feel/touch around you.
3. Name 3 things you can hear around you.
4. Name 2 things you can smell around you.
5. Name 1 thing you can taste, such as toothpaste or a flavor from lunch.

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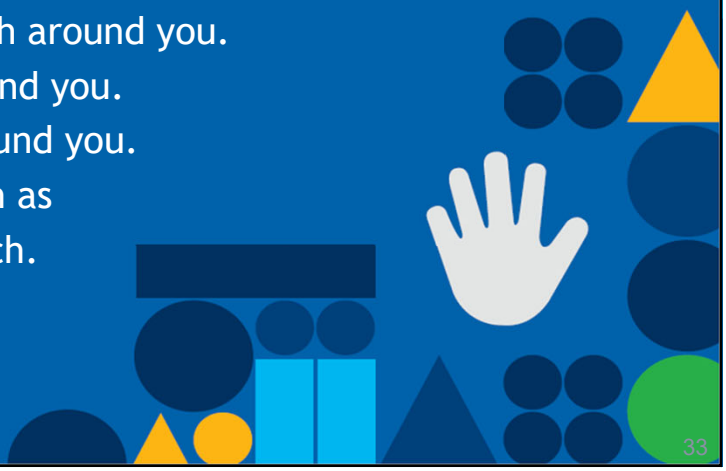

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Grounding: ABC Around the Room

How to practice:

1. Name something in the room that starts with the letter A.
2. Name something in the room that starts with the letter B.
3. Name something in the room that starts with the letter C
4. Keep going through the alphabet.

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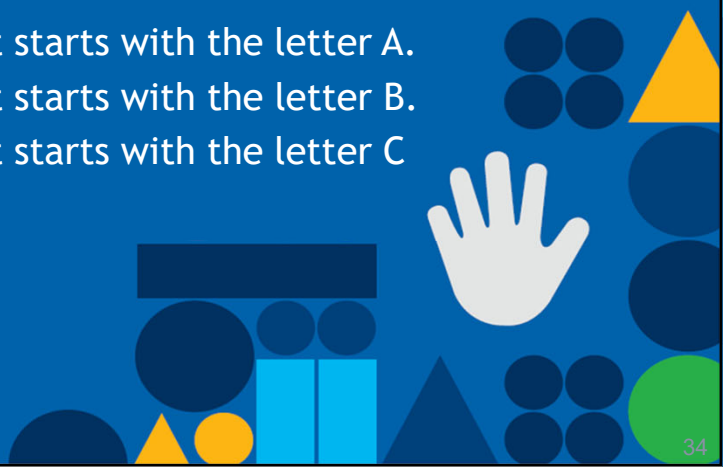

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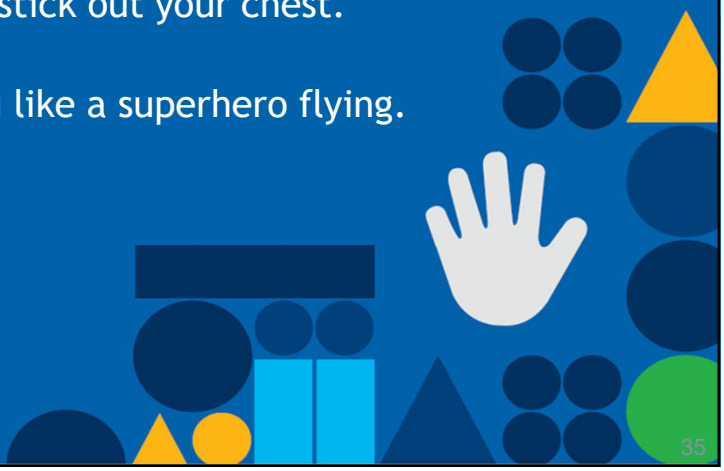
Superhero Breathing

How to practice:

1. Stand with your feet a little bit apart or sit up straight.
2. Put your hands on your hips and stick out your chest. Breath in while you count to 4.
3. Put your arms out in front of you like a superhero flying. Breath out as you count to 4.
4. Repeat 5 times.



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Questions????

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