THE CARLAT REPORT
CHILD PSYCHIATRY

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UNBIASED INFORMATION FOR CHILD PSYCHIATRISTS

Caroline Fisher, MD, PhD
Editor-in-Chief
Volume 2, Number 6
October 2011
www.thecarlatchildreport.com

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Learning objectives for this issue: **1.** Describe the causes and some proven interventions for bullying. **2.** Explain some ways a psychiatrist can effectively communicate with a school system. **3.** Detail psychiatrists' roles in specialized education plans. **4.** Understand some of the current findings in the literature regarding psychiatric treatment.

You Can't Say You Can't Play: What Works for Bullying

Caroline Fisher, MD, PhD
Assistant professor of psychiatry
University of Massachusetts Medical School

Dr. Fisher has disclosed that she has no relevant relationships or commercial interests in any companies related to this educational activity.

While culturally we have become more aware of the prevalence and consequences of bullying, it remains a significant problem and a frequent reason for presentation for psychiatric care. National surveys indicate that bullying affects up to 50% of students (Pergolizzi F et al, *Int J Adolesc Med Health* 2011;23(1):11–8). Bullies and victims are more likely to have mental health problems—both direct consequences of the bullying such as depression, suicidality, and school refusal, and pre-existing problems such as learning and social difficulties. Bullies and victims do not differentiate by diagnosis, and many victims are also bullies (Wang J et al, *J Adolesc Health* 2009;45(4):368–375).

That said, psychiatrists may be called upon to weigh in on appropriate interventions and the task can seem insurmountable at times. Bullying interventions need to occur in four domains: the

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Effectively Working With Schools

Jess Morris, MD
Instructor
Harvard Medical School

Dr. Morris has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

As summer wanes and children return to school, it is a natural time to reconsider the relationship of child psychiatry and the schools. For the past 25 years, I have consulted to the Gifford School, a therapeutic day school in Weston, Mass, as well as to the Brookline, Massachusetts, public schools. I am writing for outpatient clinicians, about children for whom it is important to have contact between the school and the clinician. Of course, there are many children whose treatment does not merit school/clinician contact, and there are others for whom such contact might be helpful, but whose parents, for whatever reasons, refuse it.

The Role of Money

Of all the factors that can cause tension between psychiatrists, schools, and parents, the most significant one tends to be money. By mandating in PL 94-142 (the 1975 law governing education of handicapped children, now called the Individuals with Disabilities Education Act, or IDEA) that the public school must provide education to all, regardless of disability, Congress essentially handed public schools an enormous expense. A practitioner would be naive to approach an Individualized Education Program (IEP) meeting without an awareness that local budget constraints are a powerful and unspoken reality of the IEP process. To put it simply, some schools may not necessarily approve the educational plan that is best for the child, but rather offer only what's needed to show a small amount of academic progress. I have seen this happen when a child is provided with an aide, for example, when he or

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school system itself, the classroom, the family, and the individual, whether the child is a victim or a perpetrator.

In my own practice, which serves several different school districts, children who are bullied or bullying are likely to come from a few particular schools. I have spoken with the principal of one of the prime offenders, a middle school, and have been told that this bullying does not occur, and if it does occur, it is the natural consequence of having middle school students—it's how children are socialized to cultural norms. In reality, bullying thrives in environments that permit it. Many states are looking to legislate some acknowledgement of this fact. After a high school student and victim of unrelenting cyberbullying committed suicide, the state of Massachusetts passed legislation mandating that all schools have anti-bullying plans in place (Phoebe's Law).

Anti-Bullying Programs

There are several anti-bullying, school-wide programs that have been shown to be effective, and several that have not. What the effective programs seem to have in common are three basic assumptions: 1) the child's environment can encourage or discourage bullying, so 2) multidisciplinary school-wide interventions are needed, and 3) both bullying and victimization are skill deficits.

The anti-bullying program recommended by the Federal Department of Education is called Positive Behavioral Intervention and Supports (PBIS), and it has several advantages, not the least of which is a whole lot of free resources and support for schools, as well as help with implementation (which you can find at www.pbis.org). Others include KiVa (Williford et al, *J Abnorm Child Psychol* 2011;Aug 6:online ahead of print), and Olweus Bullying Prevention Program (see www.olweus.org).

The aspects of environment and skill deficits are key to psychiatric treatment of bullying and victimization. Each child who presents with involvement in bullying (in any role) needs both an individual and an environmental work up. On the individual front, a full evaluation for any psychiatric disorders and learning disabilities should be undertaken, because it is clear that both bullies and victims are at higher risk for both kinds of disorders.

The second thing that helps is social skills training. Appropriate self-assertion, social problem solving, and perspective-taking skills are often lacking and can be effectively addressed in psychotherapy or in social skills groups. Third, the strength of friendships is a protective factor for victims (Wang et al, *op cit*), and can be an excellent focus for children and families. Fourth, many children who bully struggle to contain their anger, and a program to address self-regulation, such as collaborative problems solving, is useful. (For more on collaborative problem solving, see *CCPR* May 2010 or www.livesinthebalance.org.)

Evaluating the Environment

The environmental evaluation can be tricky. Ideally, one investigates all possible sources of modeled bullying behavior: at school, at home, in daycare, or in any other environment (from riding lessons to Boy Scouts to Grandma's house) that the child is in regularly. This can be both fascinating and alarming. An Israeli study linked verbal and physical abuse by teachers with bullying and victimization among peers (Khoury-Kassabri M, *Child Abuse Negl* 2009;33(12):914–923).

In my experience, I have directly observed children taunted by their teachers and shrieked at by their principals. In attending PBIS trainings with a local school district, the most frequent objection I heard was, "Why should we be nice to someone who isn't being nice to others? Isn't that just rewarding bad behavior? He should get a taste of his own medicine." It may require the psychiatrist to assume the role of advocate, both by explaining directly and by addressing the school or school district about the need for anti-bullying initiatives and expectations of staff, from the principal to the janitor. Teachers may also benefit from a concrete understanding of what the practicalities of a child's diagnoses are, especially ADHD and Asperger's. Although many people have a superficial understanding of both disorders, teachers don't necessarily understand that what seems like rude or defiant behavior can have an entirely different meaning.

The family is another common source of modeled bullying behavior. In a school I worked with, there were two second grade girls who could not leave each other alone. Each took turns doing something dreadful to the other. Things came to a head, however, when the father of one of the girls cornered the mother of the other, pinned her against the wall, and screamed that she better make her daughter stop picking on his kid.

A Center for Disease Control analysis of the 2009 Massachusetts Youth Health Survey showed that victims of bullying are almost three times as likely to

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EDITORIAL INFORMATION

Publisher: **Daniel J. Carlat, MD,** is the founder and editor-in-chief of *The Carlat Psychiatry Report*. He is an associate clinical professor of psychiatry at Tufts University School of Medicine and has a private practice in Newburyport, MA

Editor-in-Chief: **Caroline Fisher, MD, PhD,** is an assistant professor at UMass Medical School, medical director at Pediatric Behavioral Health in West Boylston, MA, and medical director of child psychiatry services at Providence Behavioral Health Hospital

Associate Editor: **Marcia Zuckerman, MD,** is associate editor of *The Carlat Psychiatry Report* and a psychiatrist at Arbour-HRI Hospital in Brookline, MA

Managing Editor: **Amy Harding, MA**

Editorial Board:

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Ken Talan, MD, is author of *Help Your Child or Teen Get Back on Track* and has a private practice in Amherst, MA

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

You Can't Say You Can't Play: What Works for Bullying

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be physically hurt by a family member, bullies almost four and a half times, and children who are both bullies and victims five times more likely to be hurt (CDC, *MMWR Morb Mortal Wkly Report* 2011;60(15):465–471).

Parents don't always realize that their own behavior is bullying and may need some help making the connection while saving face in front of their children and the professional. I speak of a social "diet" (the way I also speak of an aggression diet in other situations) and say that while some yelling and such may be fine in other circumstances—like when the person you are interacting with is fairly far away or very hard of hearing, for example—for this child's particular circumstances, the parents need to make the most of any and all opportunities to show the child how to behave at school. Therefore parents need to model calm, problem solving behavior all the time. Of course, remember that parents who bully or are verbally abusive may not have alternative skills, so this is an easy time to go through more optimal parenting techniques under the guise of explaining what *the child* needs to know.

Resources for Clinicians and Families

In addition to the PBIS website, there are some other excellent online resources for parents, schools, and clinicians. The American Association of School Administrators has a nice one at www.education.com/topic/school-bullying-teasing. This website has a wide variety of articles on everything from what parents can do if they witness bullying to readable summaries of the relevant research on bullying and its causes and treatments. Some articles are in Spanish.

A great resource, where you can find "webisodes," short cartoons that show kids how the characters experience and then overcome bullying, is www.stopbullying.gov. There is also a link to one of my favorite initiatives, the It Gets Better Project, www.itgetsbetter.org. This is a series of videos encouraging GLBT youth who may be the victims of bullies. The videos are done by a huge variety of celebrities, and include original songs/music videos, brief interviews with celebrities about their own experiences with bullying (or coming out), and even a message from President Obama.

Effectively Working With Schools

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she really needs (much more expensive) therapeutic school placement.

A related issue is that insurance companies do not reimburse us for time spent talking directly to teachers and administrators. Most of us just absorb the cost of this consultation, since it is sometimes vital to our patients' well being. In my state, at least, an enlightened legislator is working on a bill to get insurance companies to cover this collateral time.

Clash of Professional Cultures

As mental health practitioners, we uphold the importance of confidentiality. Without signed releases, we are unable to exchange any information with the school. Good schools, however, need to have very permeable boundaries. Teachers are a resource to one another, sharing observations of mutual students. Children with behavioral problems may shuttle from the classroom to the vice-principal to the guidance counselor—it would be counter-productive for those individuals to keep their observations or ideas private. For an example, a child may reveal signs of abuse at home, being bullied at school, or self-harming thoughts or actions to a teacher he or she trusts, but not to other staff members. In cases like these, schools need to have porous boundaries—allowing and encouraging the sharing of information between educators, guidance counselors, and administrators. When these kinds of concerns arise in schools, decisions need to be made about informing family or treaters or involving social service agencies.

The Psychiatrist as Part of a Team

Child psychiatrists typically work in multidisciplinary teams. The psychiatrist focuses on medication management, while the therapist works with the child and collaborates with the family and school. But this role separation can leave psychiatrists vulnerable. If the therapist does not have time for school and parent meetings, or for communicating social information to the psychiatrist, we may end up prescribing without important feedback. Even when we see parents, their reports about a child's school life may be distorted in the context of a brief medication visit. School information provided by parents is second-hand, and parental feelings about medication may affect their rendition of the school's feedback. Clearly, everyone has feelings when it comes to the use of medication in children—teachers included—but I suggest personally reading any documentation the school has recorded about the child's difficulties in order to evaluate the veracity of the parent's version.

The Psychiatrist as Sole Practitioner

If you do not work in a clinic situation, you need to have more direct involvement with the family and teachers. I recommend that you make time for first-hand classroom observation. For a young child especially, an educational mismatch may account for behaviors that might explain school phobia, apparent attention deficit, mood swings, or a host of other problems.

Attend IEP meetings if possible. This will allow you to assess how attuned educators are to your patient's learning disability and to what degree they are truly making the accommodations recommended in the IEP.

In some situations, you must take an active role in advising schools. In treating children with school phobia, for instance, clinicians should coach school personnel

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Expert Interview

Psychiatrists' Roles in Special Education

Richard Keelan, LMHC

Educational advocate
Pediatric Behavioral Health LLC

Mr. Keelan has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

CCPR: Mr. Keelan, you have been an advocate for children with special needs for more than 15 years. Working with schools can be difficult and confusing for parents and for doctors. Before we get into the ways to make this relationship work better, let's talk about the different types of educational plans and how they come to be.

Mr. Keelan: The two main interventions are the IEP (individualized education program) and the 504 plan. The Individuals With Disabilities Act (IDEA) says if a student has a disability, and he or she is not making effective progress, then specially-designed instruction and/or related services may be required in order to make effective progress. These special services and instruction are what make up an IEP. These students may require a special education teacher, speech therapist, occupational therapist, adjustment counselor, or a school psychologist. On the other hand, if a child's needs can be met within a regular education classroom, he or she can have a 504 plan. Children on a 504 do not need any special services, outside of what can be found through regular teachers and guidance counselors. A 504 does not modify the curriculum. Then, there are also just regular education student interventions, which are really designed for the kid where the parents are going through a divorce and the child becomes depressed, for example. This would be considered a transitory issue, but if it is affecting the student's school performance, the school could come up with a plan to help the child.

CCPR: Let's talk about how this system works. So a teacher notices a student is having problems, and requests an assessment? Or a parent does it?

Mr. Keelan: Either. Under the IDEA, school personnel must report a suspicion that a student has a disability that requires intervention. After the report, the school needs to get consent from the parents to evaluate the student. For the vast majority of the students, this is how it happens. However, parents always have a right to request an evaluation on their own. Generally, this is a written request that is dated and signed.

CCPR: Can a child's psychiatrist request an evaluation?

Mr. Keelan: You can request it, but you don't have any authority to require it. This is a case where you need to work closely with the parents to help your patient get what he or she needs from a school system. The parents should make the request, even if you tell them what to say.

CCPR: After the evaluation and testing, what happens?

Mr. Keelan: Then the child's "team" convenes to come up with a plan. The team could include the parents, the district, the special ed teacher, the evaluators, and any other people with relevant expertise. The big decisions are made in that meeting, and it is illegal to make the decision outside the meeting.

CCPR: And the parents have to be present at that meeting?

Mr. Keelan: The parents are supposed to be there, but they can't be forced to attend. Schools can have the meetings without the parents, but they can't put a child on an IEP without parental consent.

CCPR:. What do you think gets in the way of a good productive relationship between child psychiatry and schools?

Mr. Keelan: There is a fundamental disconnect between child psychiatry and the school system. Through the IDEA, special education is an assessment-driven system based on scientific, evidence-based, normed testing. Schools simply do not understand child psychiatry's methodology of diagnostic interviews, assessment of symptoms, and diagnosis. They have expectations of standardized assessments and reports, which leads to misunderstanding when a child is diagnosed using medical observation and experience rather than concrete, pen-and-paper assessment instruments.

CCPR: How can a child's psychiatrist help get the services or educational plan that's appropriate for his or her needs?

Mr. Keelan: One way is to write a letter to the school, with very specific information in it. So don't just write, "Johnny has ADHD." You should include information like: how you got that diagnosis, what evidence you have that he fits that diagnosis, what your methodology is, and if you used a standardized test. A lot of time and effort needs to be put into the letter. It should read more like: "Johnny has ADHD according to criteria from the DSM-IV-TR. This is demonstrated by his inability to focus on tasks, the extraordinary length of time it takes him to complete work, and his total distractibility during interview," and so forth. Schools also love tools like the Conner's rating scale or other checklists that compare to normed data. These are the kind of assessments that can be used to justify accommodations under the IDEA.

CCPR: So the team meets, they come up with an IEP or 504 plan, hopefully taking into account what we've written

in our letter, and the child is then served within the school. But not all kids can be effectively served in their district school. How do we figure out if they have tried long enough? How do we decide whether they are succeeding or failing in doing that?

Mr. Keelan: Typically, an IEP is open for a year. Anybody, either the parents or the district, has the right to reconvene a team meeting prior to the end of the year if they think the program isn't working. The effectiveness of the plan is determined through the same standardized measures that you would use for other students. "No child left behind" testing, grades, behavioral performance, discipline records, and standardized educational testing all inform the team's decision about whether the student is making effective progress.

Resources for Understanding Education Plans

U.S. Department of Education: www.ed.gov
Individuals with Disabilities Act (IDEA) website: http://idea.ed.gov
The Federation for Children: www.fcsn.org
Your state's department of education website

CCPR: Let's say a child is on an IEP for a year, and is not making effective progress according to the team. What happens next?

Mr. Keelan: Then the team reconvenes and decides what is the next least restrictive intervention they can use in order to make effective progress. For example, do they change the plan, add services, or add accommodations?

CCPR: Now it seems like this is where a lot of things break down. Sometimes the family feels that the child needs education outside of the school, but the school feels that they can accommodate the child within the school. Is there a way that child psychiatrists can help in this process?

Mr. Keelan: Yes, child psychiatry can be extremely helpful to school systems in explaining the nature of certain disorders and the kind of treatments that are known to be effective. When it comes to complex psychiatric disorders, schools often lack the expertise to fully understand the neurological and psychiatric issues that might be causing certain behaviors. You can inform them through letters or speaking with certain members of a child's care team. If there's a school system that a lot of your patients go to, it's worth knowing the names and roles of certain people. And, of course, you need to have the parents onboard, as well. They need to understand that within the federal law, they are the drivers of change.

CCPR: Thank you, Mr. Keelan.

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as to how to handle separation anxiety at school. While we may treat phobic anxiety with medication, we cannot neglect the behavioral reality of the parent-child dyad unhappily stuck at the school entry.

Children with pervasive developmental disorders often need our direct advocacy to make sure they get all the pieces of the treatment they need. If the mainstream class is not providing occupational therapy, social skills training, and academic supports, you may need to meet directly with teachers or principals to encourage a change in educational plan.

When children threaten themselves or others, we may be lulled into believing that an emergency room referral is necessary—and it often is. However, the psychiatrist is usually more able to handle such crises because of familiarity with a child and his or her family. True, we don't have a crystal ball when it comes to predicting future behavior, yet it is fair for schools to ask us to determine which children merit hospital evaluation or placement in more restrictive settings than the general classroom, and which can be safely returned to school.

Tips for Effective Consultation

Most often, contacts with schools are less urgent and more elective in nature. Over the years, in my clinic and private work with children, I have developed some practices to facilitate routine contacts. Because it is impractical to connect with multiple educators and/or administrators at a child's school, I ask parents to nominate one point person they trust to be my contact. I then ask that person to organize school feedback from multiple sources to me. While schools often use email quite productively for academic and behavioral feedback to parents, I am uncomfortable with email with schools because of its lack of confidentiality. I favor feedback via confidential voicemail or (often better) faxes to my office. When following a child's medication progress I find it can be helpful to have rating scales faxed to me on a regular basis by the point person. These scales then become a part of the chart and enter into the conversation I have with parents when doing medication follow-up.

When a child has a learning disability, neuropsychological testing offers customized recommendations for school accommodations. At times when such tests are pending or will not be available for whatever reason, I have turned to other resources for help in considering school based accommodations and to think critically about what the special educators may be offering. Clinicians can find considerable online help in suggestions for school accommodations at www2.massgeneral.org/schoolpsychiatry, a website geared to help clinicians, parents, and educators improve this compli-

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Research Updates IN PSYCHIATRY

BIPOLAR DISORDER

Review of Pediatric Bipolar Meds Finds Atypicals Better than Mood Stabilizers

Controversies about the diagnosis and treatment of bipolar disorder in children continue to be a stock feature of journals and blogs. Recently, the most comprehensive review and meta-analysis of pediatric bipolar medication options was published—and the results will likely encourage you to prescribe atypical antipsychotics over mood stabilizers.

Researchers surveyed both published and unpublished studies over the past 20 years on the treatment of mania in children. They found a total of 46 relevant studies: 29 open-label trials and 17 randomized trials, reporting on 2,666 pediatric patients. To be included, studies must have focused on treatment of bipolar mania (bipolar depression studies were excluded), they had to use DSM-IV criteria for bipolar disorder, and they had to use a validated mania rating scale, which was typically the Young Mania Rating Scale (YMRS).

This was a large study which used the narrow criteria for bipolar disorder rather than the broad criteria. The studies focused specifically on the treatment of mania. (Of note, the use of the YMRS in children has been criticized.) Here are some of the more clinically relevant findings from the study:

1. Mood stabilizers don't appear to work very well in children and they cause lots of side effects. While some open label studies showed positive results for lithium, the three controlled studies either showed no separation from placebo or had too high a drop-out rate to evaluate. Valproic acid (Depakote) was pretty impressive in open label trials, but of three double blind studies, one found that Depakote was inferior to quetiapine (Seroquel), one showed no separation from placebo, and the third had an unacceptably high dropout rate. Neither oxcarbazepine (Trileptal) nor topiramate (Topamax) have separated from placebo (though we're talking only one study for each drug). Neither carbamazepine (Tegretol) nor lamotrigine (Lamictal) has been tested in a controlled trial for bipolar children. Of the two, the authors were more impressed with Lamictal because the open label response rate in one study was 54%, higher than what is typically found in open label trials of other anticonvulsants used as monotherapy.

2. Second generation antipsychotics (SGAs) have been more extensively studied than mood stabilizers and the results are better. Average YMRS response rates in double-blinded studies of SGAs were relatively high, ranging from a low of 49% for olanzapine (Zyprexa) to 73% for Seroquel. Based on these results, the FDA has approved the following SGAs for manic episodes in youths: aripiprazole (Abilify), risperidone (Risperdal), and Seroquel for ages 10 to 17, and Zyprexa for ages 13 to 17. The two studies reviewed using ziprasidone showed no effect.

However, there are downsides to SGAs. As the authors point out, studies have shown that youths are more vulnerable than adults to the SGA-induced side effects of weight gain and somnolence. On the other hand, youths are less likely than adults to experience akathisia. Given the effects of cumulative exposure on tardive dyskinesia, SGAs should be prescribed to young people with caution.

3. Very little data on natural treatments are available, with one open-label study of fish oil showed modest benefits and one double-blinded study of flax seed showed no efficacy (Liu HY et al, *J Am Acad Child Adolesc Psychiatry* 2011;50(8):749–762).

CCPR's Take: Mood stabilizers do not appear effective for mania and are associated with a lot of side effects. SGAs should be the treatment of first choice for mania in pediatric bipolar disorder, but you need to monitor these children very closely for weight gain and be aware of the length of time a child stays on the medication. None of these studies looked at prevention of manic episodes, so don't conclude that long term SGA is recommended here. See the December 2010 issue of *CCPR* for the data on on safety, or lack thereof, of antipsychotics in children. Also, the fact that mood stabilizers are not effective and that SGAs can have sedating effects beyond mania is relevant when considering the ongoing debate over the validity of even "narrow" phenotype PBD.

SUBSTANCE ABUSE

Misuse and Diversion of Psychiatric Drugs Among Adolescents

Prescription drug abuse is a growing problem among adults and adolescents, and we all know that painkillers, benzodiazepines, and amphetamines can be bought on the street by people who don't need them for medical reasons. However, not a lot of research has been done on misuse of prescription drugs by kids with legitimate prescriptions.

Researchers recently examined this group to see what they could learn about misuse of certain prescribed medications. In a five-month period from late 2009 to early 2010, 2,597 high school students from the Detroit area completed a web-based survey on prescription drug use. The respondents were almost evenly split between boys and girls, and the mean age was around 15.

Eighteen percent of respondents reported prescribed medical use of at least one pain, anxiety, stimulant, or sleeping medication within the past year. Of those with prescriptions, 22% reported misuse of their drugs. Misuse could include taking too much, using the medication to enhance the effects of other drugs or alcohol, or taking it to intentionally get high. By far, the most common form of misuse was taking too much.

Frequency of use was correlated with misuse for all drugs except stimulants (ie, those who took pain medication more often were more likely to abuse it than those who only had a short-term prescription or only took a few doses). Multiple prescriptions across medication classes also increased the likelihood of abuse. When assessed for overall substance abuse, those adolescents who misused their prescription medications were significantly more likely to have a

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CME Post-Test

CME Notice: The test below is intended to be for **practice only.** All subscribers must take their tests online at www.thecarlatchildreport.com. If you cannot take your test online, please call 866-348-9279 or email info@thecarlatreport.com.

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Below are the questions for this month's CME post test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

1. A 2009 CDC study found what to be true of bullies (Learning Objective #1)?
   [ ] a. They are no more likely to be hurt at home than any other children in the general population
   [ ] b. They are almost three times as likely to be physically hurt by a family member
   [ ] c. They are four and half times as likely to be hurt by a family member
   [ ] d. They are five times as likely to be hurt by a family member

2. According to Jess Morris, in most cases insurance companies will reimburse you for time spent speaking directly to teachers and administrators (LO #2).
   [ ] a. True [ ] b. False

3. According to Richard Keelan, a child's psychiatrist can require a school to evaluate a child for a IEP (LO #3).
   [ ] a. True [ ] b. False

4. In the McCabe et al study of medication misuse, how many teens who took their medication as prescribed admitted to selling, giving away, or trading their medication (LO #4)?
   [ ] a. 12.9% [ ] b. 22% [ ] c. 36.9% [ ] d. 78%

5. In the Liu et al meta-analysis, what was the average YMRS response rate for quetiapine (Seroquel) (LO #4)?
   [ ] a. 29% [ ] b. 49% [ ] c. 54% [ ] d. 73%

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cated collaboration.

While child psychiatrists draw upon many traditions in their efforts as helping professionals, the past decades have been dominated by the expansion of the biological treatment we have offered children—as well as the cautionary reevaluations of some of those therapies. Despite those important controversies, our role in offering psychiatric medication is unlikely to end.

The fall may be good times to remind ourselves of the power of the other roles that we may play that clearly have potency in the life of a child, those of advising and helping a child's family and school. Children have no choice but to return to school when the summer ends. We can predict that over the ensuing months as the school year progresses, youngsters will present to us with problems related to their lives at school. The children we treat will be rewarded over time for our efforts when we can, as allowed and appropriate, advise and collaborate with the educators with whom they share their school days.

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positive screen for any type of substance abuse.

Those adolescents who misused their own prescriptions were more likely to sell, give away, or trade their meds than those who took their medications as prescribed (36.9% of misusers vs 12.9% of appropriate medical users) (McCabe SE et al, *Arch Pediatr Adolesc Med* 2011;165(8):729–735).

CCPR's Take: The good news is that 78% of kids who took these highly abusable drugs took them how and when they were supposed to. (At least they thought they did; because responses were confidential, there was no verification that students were actually taking the drugs the way their doctors had prescribed.) The bad new is the other 22%. We should be sure to check in with our patients taking these meds regularly, and watch for the usual signs of drug abuse and diversion.

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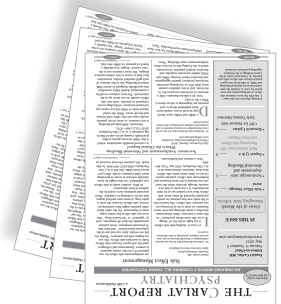

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