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CHILD PSYCHIATRY

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Editor-in-Chief

Volume 6, Number 1
January/February 2015
www.thecarlatchildreport.com

IN THIS ISSUE

Emergency Psychiatry in Children

Learning objectives for this issue:
1. Describe the best ways to manage psychiatric emergencies in children and adolescents. **2.** Summarize when it is appropriate to refer psychiatric cases to the emergency room. **3.** Detail some of the medications sometimes used to calm acutely agitated children. **4.** Evaluate some of the current findings in the literature regarding psychiatric treatment.

Medications for Agitated Kids– When Nothing Else Works

Here is a hypothetical situation that most child psychiatrists have encountered: You're an attending on a child psychiatric inpatient unit. An 11-year-old boy who was admitted for suicidal ideation just had a difficult meeting with his parents and the social worker.

He wants to go home, but is not yet ready for discharge, and he's angry about it. He marches up and down the hallway menacingly. He goes into his room and pulls the mattress off his bed and throws it around. Both you and your staff have tried to reason with him in order to de-escalate the situation, but nothing works.

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In Summary

- Before opting for medication, try to deescalate the situation by talking to the child or using behavioral interventions.
- Common prn medications include benadryl, antipsychotics, and benzodiazepines.
- Watch for disinhibition and extrapyramical reactions when using these medications.

Q&A With the Expert

Practical Tips for Handling Psychiatric Emergencies in Children and Adolescents

Ruth S. Gerson, MD

Director, Bellevue Hospital Children's Comprehensive Psychiatric Emergency Program, New York, NY
Clinical Assistant Professor of Child and Adolescent Psychiatry, NYU School of Medicine

Dr. Gerson has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Dr. Gerson, you direct the only emergency room (ER) in the US that is a dedicated child psychiatry ER. What have you learned that can be helpful for office-based psychiatrists who are evaluating a child who may or may not need to be sent to an ER?

Dr. Gerson: We have a unique program, and we're pretty busy—we see about 2,100 kids a year, many referred by schools or providers in the community. Office-based clinicians that we talk to have often been frustrated with their prior experiences of sending patients to the ER. Often they have sent a patient to the ER expecting inpatient admission, and then felt frustrated when admission didn't happen.

CCPR: What typically goes wrong?

Dr. Gerson: The problem often comes down to communication. When community providers send kids to the ER, families often have to wait several hours, usually in an ER that is also treating either adult psychiatric patients (who can be scary to kids and families) or medically ill children. Kids get scared and frustrated and when the ER clinician finally gets to talk to them, they are not forthcoming or they minimize the issues that brought them to the ER. And often the parent doesn't really understand why they are there. When the ER staff tries to reach the referring psychiatrist, it's late and the

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What do you do? Unfortunately, there are no clear answers, since we lack good research on the best ways to calm acutely agitated children. Your approach may likely be slightly different from a colleague's. In this month's interview, Ruth Gerson, MD, discusses a variety of verbal de-escalation strategies in child psychiatry emergencies, and we suggest you use these when you can. (See "Practical Tips for Handling Psychiatric Emergencies in Children and Adolescents" on p. 1.)

But, as with adults, children can lose behavioral control, putting themselves or others at risk, and in such cases it is our responsibility to figure out how to quickly ensure everybody's safety—which may include the use of medications, whether voluntary or involuntary. In this article we provide you with some tips and pearls, derived from the literature and from discussions with various child psychiatrists on the front lines.

Typical Situations Requiring Sedation

Situations requiring sedation boil down to potential harm to self or to others, with agitation usually a part of the mix. Common diagnoses leading to these situations include autism spectrum disorders, conduct disorder, depression and other mood disorders, psychotic disorders, and substance abuse. The behaviors will vary depending on age and developmental level, and can include explosive temper tantrums, verbal threats, frank violence towards others or property, and agitation or restlessness.

Pre-Medication Management

We want to avoid medications if possible, and we certainly want to avoid using physical restraints. Why avoid restraints? According to one study, children, especially those with histories of abuse and neglect, perceive restraints to be aggressive and punitive, potentially leading to further mistrust of mental health providers (General Accounting Office, 1999, http://1.usa.gov/17ObU8f).

Behavioral Interventions

If talking has not worked to calm your patient down, try behavioral or environmental changes. You can deploy these in a variety of settings, whether you are working in your office, in an emergency room, on an inpatient ward, or even if you are giving phone advice to panicking parents. (See "Some Guidelines for Working with Agitated Patients" on p. 3 for more tips.) Some tried and true methods include:

- **Separation from the trigger.** Put some space between the patient and people who may be aggravating him, such as parents or siblings, specific teachers, hospital staff whom the patient has singled out as "the problem", or security personnel who may have brought the child in for involuntary treatment.
- **Use media as a distractor.** Watching a little TV, playing a video game, or listening to some music can be helpful in soothing the cycle of agitation.
- **Milk and cookies.** Kids like treats, which can serve as a distraction, and the bonus is that they may like you better after you offer them.
- **Sports.** If available, a game of foosball, ping pong, or basketball can help dissipate the negative energy.
- **Relax.** Asking the patient to chill out by sitting or lying down in a quiet place can be helpful.

Pharmacologic Management

You've tried behavioral remedies, but your 11-year-old patient is still pacing and tearing up his room. Don't go right to physical restraints. First, see if you can convince your patient to voluntarily take a medication to calm himself down. Getting agitated kids to agree to a sedative is often not difficult, but it requires skill in the art of convincing. Here are some techniques:

- Normalize the situation by communicating an understanding of their reaction, and saying that you've seen it before. For instance, "I understand that being in a hospital can make you pretty stressed out. A lot of kids I've seen who get this stressed tell me they feel a lot better after taking a medicine."
- Give them a sense of control by framing the suggestion as a question. "What would you like to do to calm down? Can I give you something to help?"
- Give them some choices—usually just two is enough. "I can see you're pretty keyed up now. I have two suggestions—either take a seat on the couch and cool down, or take this medication. Which one do you choose?" Or, if the situation is more dire and teetering toward physical restraints, say, "Here's the deal. You have two choices. You can either take this medication or we're going to have to put you in restraints. You decide."

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Medication Options

Although Risperdal and Abilify do have FDA indications for the management of irritability associated with autism spectrum disorders, this evidence is based on standing doses and not when used "prn" or as needed. In fact, there are no FDA-approved medications for managing acute agitation in children, so in the absence of good research you'll probably settle on a few favorite go-to meds based mainly on your experience.

Benadryl. Benadryl (diphenhydramine), in doses from 12.5 mg to 50 mg, can be sedating and is generally safe when used prn. Potential problems with Benadryl include paradoxical excitation, in which the kid runs around like the Tasmanian devil instead of going to sleep, and its anticholinergic properties, which can lead to confusion if given at high doses too frequently. It is also unclear how much of Benadryl's sedating effect is due to placebo, since the only double-blind, placebo-controlled study of this agent, which enrolled 21 males between 5 and 13 years old, found prn Benadryl to be no different than placebo for aggression (Vitiello B et al, *J Clin Psychiatry* 1991;52(12):499–501).

Antipsychotics. Thorazine has an old FDA indication for severe behavioral disorders in children aged 1–12 years and is dosed identically to Benadryl (12.5 mg to 50 mg). It's a good sedative, though it may rarely cause significant drop in blood pressure, particularly when given as an intramuscular (IM) injection. Other child psychiatrists favor Haldol, finding that very low doses (in the range of 0.5 mg to 2.5 mg) are unlikely to cause dystonia, especially if given with some Benadryl.

Low dose quetiapine is another good choice to use for sedation, though it is more expensive, less studied for this use, and may also cause a dose-related drop in blood pressure. Zyprexa Zydis (olanzapine, at 2.5 mg to 5 mg) is popular among some psychiatrists, because it dissolves in the child's mouth and reduces the otherwise coercive feeling of having to swallow a pill. Other antipsychotics are available in orally disintegrating tablets, such as Risperdal M-tab (risperidone). Of course, you are free to use any of a number of other antipsychotics to treat agitation. (See the "Medications Used to Sedate Children and Adolescents" table on p. 5 for dosing). Most psychiatrists are conservative when treating children—which means giving preference to medications that have a longer track record of safety.

Benzodiazepines. Lorazepam tends to be the most used benzodiazepine for kids, because it doesn't have active metabolites that can accumulate and cause prolonged side effects. However, especially in younger kids (up to 14 or so), or those with developmental disorders including autism, it can cause disinhibition with aggressive and impulsive outbursts (Mancuso CE et al, *Pharmacotherapy* 2004;24(9):1177–1185).

Use a standing med as a prn. Many kids will already be on a medication regimen, and if so, the best strategy may be to use one of these medications as a prn. For example, if a child is taking Risperdal 1 mg twice daily, offer a single 0.5 mg dose for agitation. The advantage is that you know the patient is already tolerating the medication, and so you will likely not cause new side effects.

Injections—voluntary or involuntary. Most tranquilizing medications are available as IM injections as well as pills—and shots work twice as fast. Kids that have been in and out of the mental health system may know that shots work more quickly, and if they are motivated to calm down they may accept an injection voluntarily.

Physical restraints and involuntary medication. Once you are in a physical restraint situation, your goal is to calm your patient as quickly as possible so that you can remove the restraints, and you can accomplish this with IM medications. The typical adult cocktail of Haldol, Ativan, and Cogentin given together is often used with older teens (16 and up) and is an effective rapid sedative. With younger kids, you'll want to be more conservative, using lower doses of meds such as Thorazine, Haldol, Ativan, or Benadryl.

Some Guidelines for Working with Agitated Patients

Some guidelines to calm down agitated patients include the following:

1. Clearly introduce yourself and assure your patient that you are there to keep him or her safe; this is your job.
2. Use simple language, a soft voice, and slow movements.
3. Stay three to four feet away from the patient.
4. Maintain relaxed body language.
5. Ask the caregiver or patient about why they are upset and offer ways to calm him or her.
6. Maintain privacy and respect, have a nonjudgmental attitude, engage in active listening, and remain engaged.
7. Address a patient's hunger, thirst, comfort, and warmth.
8. Offer distracting toys or sensory modalities.
9. Explain what is to come next. Discuss restraints and offer a reward for calmer behavior.
10. Reduce environmental stimulation (for example, dim the lights, reduce noise, minimize visitors, and redirect traffic near the patient's room).
11. Remove access to breakable objects and equipment.
12. Prepare staff for the next step if the calming strategies fail. This might include doing medication calculations, etc.
13. Consult with others as needed: such as security staff, social workers, and psychiatry specialists.
14. Consider the need for physical restraints.
15. Prepare an algorithm for pharmacologic management if the above methods fail, including attention to the clinical situation, preexisting medications, intoxication status, medical history, and allergies.

Source: Adapted from Marzullo LR, *Pediatr Emerg Care* 2014;30(4):269–275.

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office is closed, so the ER staff never gets to hear the full story. So I suggest that referring clinicians call ahead of time to tell us what the issue is and what your concerns are, or leave us your cell phone number so that we can reach you.

CCPR: I'd imagine that you get some inappropriate referrals?

Dr. Gerson: Yes, occasionally. Often they come directly from the schools. Unfortunately, many schools have seen budget cuts to their mental health and counseling programs, and so we get a lot of kids sent in for "psychiatric clearance." For example, a kid has a tantrum and gets violent. Or, in order to get out of taking a test, the child writes, "I want to die" on the test page and then gets referred to the ER.

CCPR: What are some scenarios we see in our offices that we might be able to manage without resorting to sending our patients to the ER?

Dr. Gerson: A common issue is when kids report hearing voices. In such cases we always have to consider new onset psychosis, which is indeed an indication for an ER visit. But new onset psychosis, particularly in a young child, is fairly rare, and voices can also be a symptom of anxiety, depression, or autism. The "voice" might actually be an imaginary friend. Depending on the age, kids can be very concrete, such as a young girl we saw recently who said "yes" when asked about hearing voices and then when I asked her more questions she elaborated, "I'm hearing your voice right now." I've also seen kids in the ER who said they were hearing voices in order to escape a punishment, such as a kid who steals something or hits someone and when confronted with punishment says, "The voice in my head told me to do it." So you have to look at the context: Do they only hear the voice when they get into trouble? Is it truly a hallucination or just an uncomfortable thought or their imagination? One kid came in to the ER for "hallucinations" of a talking doll with a knife, and his description sounded just like Chucky the doll, from the horror movie. I asked him, "Are you seeing Chucky?" and he said that in fact he and his dad had watched the movie recently, and that, "Every time I close my eyes I see Chucky."

CCPR: What about cases of kids with established psychiatric disorders who report voices? It may be hard to assess the level of urgency.

Dr. Gerson: It can be tricky. I once evaluated a child with OCD (obsessive-compulsive disorder) who was hearing voices saying that he was going to hurt himself or someone else. But when we asked more about the voices they seemed more like intrusive thoughts and worries than hallucinations. They were ego-dystonic (he said, "I don't want to do it"), always said the same thing ("You're going to hurt someone"), and only appeared when he was upset and anxious. We concluded that he didn't need to be hospitalized, but that he needed treatment for his OCD, starting with psycho-education. Just as you would for another kind of obsessional worry in OCD, we taught him that thoughts are just thoughts, that thoughts don't make things come true, and that he can learn to control his thoughts. For him, as with many kids with OCD, just telling him that "hearing" a voice doesn't mean he's going to act on it was therapeutic.

CCPR: What about kids who have become aggressive or violent? It will often be hard to determine what caused the violence and whether they need to go to the ER.

Dr. Gerson: If a kid is hurting people or can't be calmed down, go to the ER. But we see a lot of kids who have outbursts in the psychiatrist's office and these can often be de-escalated before an ER visit. It's important to step back and look at the trigger for the outburst. Did the mom set a limit? Did a kid tease him at school? Did a parent tell the psychiatrist something the kid is embarrassed about? Was he recently talking about a traumatic experience? Or is he getting aggressive because he's paranoid or hearing voices?

The first piece of a safety plan is, what are the early warning signs of an impending crisis?

Ruth S. Gerson, MD

CCPR: Can you tell us about the distinctions between types of aggression?

Dr. Gerson: I find that the distinction between reactive and instrumental aggression is helpful. "Reactive aggression" is reacting to some provoking trigger, such as someone teasing you or hitting you. Instrumental aggression is, "I want this, so I'll use aggression to get it," such as what criminals and sociopaths do. Most kids' aggression is reactive, and if you help the kid identify the trigger, you can teach him a different reaction. If a kid starts revving up in your office, help him voice what made him angry and empathize with him. For example, "Wow, when your mom said just now that you weren't working hard on your homework, that made you feel really upset." You're not approving of their behavior, just showing that you understand and empathize with their feelings. It's surprising how often a simple empathic statement can help to de-escalate a child. Kids are so used to adults immediately punishing them when they act up, that if instead, you make an empathic comment, often it really gives them pause and shuts down the tantrum. Then, you show the kid ways to think about problem solving. For the kid who got mad when talking about homework, you could ask, "I bet you've been trying hard on your homework but I wonder is there something that's been making it tougher to do? Was the assignment too hard or confusing, or was something else on your mind?" Often you can discover the kid is having learning difficulties or that there are distractions or stressors at home. Then you teach them other ways to express themselves and get their needs met—perhaps instead of throwing things and hitting, they can ask their mom for help or ask to take a five-minute break. You can also dig even deeper and see if sleep problems, parents' divorce, teasing at school, or untreated ADHD or anxiety are making a kid more vulnerable to having an aggressive outburst in response to a trigger. Then you can help the child and family address those things. Overall, you are using the crisis as a learning moment instead of sending them to the ER.

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Medications for Agitated Kids—When Nothing Else Works

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General Considerations

For suicidal children and adolescents, once the acute presentation has been managed, avoid medications that could be lethal in overdose (tricyclic antidepressants, benzodiazepines, narcotics). If these medications are necessary, provide only a few days' supply and have a responsible caregiver lock up the supply and directly provide single doses to the child.

The most common side effects of emergency psychiatric medications are respiratory depression and extrapyramidal reactions (EPS). With benzodiazepines in particular, vitals should be monitored, dosing should be limited to recommended ranges, and there should be consideration of other issues that may also affect respiratory or central nervous system (CNS) depression (illicit drugs, alcohol, opiates, apnea). EPS can be managed with Benadryl or Cogentin or by using the antipsychotics less likely to produce EPS.

DR. CARLAT'S VERDICT: Avoid meds for agitation if you can—and if you must, try voluntary meds by mouth first. Physical restraints are a last resort.

Medications Used to Sedate Children and Adolescents*

Drug	Dosing ** C = children A = adolescents	Notes
Diphenhydramine (Benadryl)	C: 12.5 mg–25 mg A: 25 mg–50 mg	• Watch out for paradoxical excitation • High doses may cause sedation or delirium
Chlorpromazine (Thorazine)	C: 12.5 mg–25 mg A: 25 mg–50 mg	• Be cautious regarding possible drop in blood pressure, particularly if using intramuscular (IM) injection
Lorazepam (Ativan)	C: 0.5 mg–1 mg A: 1 mg–3 mg	• Studies lacking • Significant limitation is possibility of disinhibition, including agitation in any kids, but especially younger ones or those with developmental disorders
Haloperidol (Haldol)	C: 0.5 mg–2.5 mg A: 2.5mg–5 mg	• Controlled trials lacking • Caution regarding EPS, particularly dystonia in this young population
Risperidone (Risperdal)	C: 0.25 mg–1 mg A: 1 mg–2 mg	• Effective and safe • Majority of data in outpatient setting (autism) • Good choice if willing to take orally (sublingual also available) • Caution regarding EPS and orthostasis
Olanzapine (Zyprexa)	C: 2.5 mg A: 5mg–10 mg	• Not well studied • Avoid using IM with benzodiazepines due to risk of cardiorespiratory depression • Orally disintegrating tablet an option
Ziprasidone (Geodon)	C: 5 mg A: 10 mg–20 mg	• Most studied atypical antipsychotic (as IM) for inpatient aggression in kids and adolescents probably because it was the first available as IM • Higher risk of QTc prolongation
Aripiprazole (Abilify)	C: 1 mg–2 mg A: 5 mg–10 mg	• Most available data is outpatient management of autism
Quetiapine (Seroquel)	C: 25 mg–100 mg A: 50 mg–300 mg	• One small outpatient conduct disorder study

* With the exceptions of Risperdal and Abilify, which are approved for irritability associated with autism when used as standing medications, these medications and doses are not necessarily FDA-approved. Use as general guidelines.
** Time to onset for most oral medications is about 30 minutes; IM medications take about 15 minutes.

Expert Interview

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CCPR: Do you have any tips for how we can evaluate kids who have injured themselves?

Dr. Gerson: It is important to distinguish suicidal self-injury from non-suicidal self-injury. Non-suicidal self-injury does not always require an ER visit, but if the self-injurious behavior has been escalating in frequency or severity, then an ER evaluation is probably a good idea. If you see a child in your office who has engaged in self-injury, such as cutting, it is important to ask very detailed questions to understand what the cutting is about and the context in which it occurred. The child may say, "I was cutting because I wanted to die." Or she may say that it makes her feel numb and allows her not to think about something upsetting such as a recent trauma or breakup, or the opposite—that she was feeling numb or dissociated and the pain of cutting makes her feel more grounded and present. I always ask kids to describe what was going on just before the cutting. What were their thoughts and feelings? Were they feeling lonely and rejected? Were they feeling angry and frustrated because of an argument? I ask them what they cut with, where they were (alone in their room, or with other people around), and whether they told anyone about the cuts or showed

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Research Updates IN PSYCHIATRY

BIPOLAR DEPRESSION

Symbyax Helps Kids with Bipolar Depression—But Has Downsides

A new study on the safety and efficacy of Symbyax (olanzapine/fluoxetine combination or OFC) in kids with bipolar I depression is in press and will be published soon.

Since Symbyax is now available as a generic, it may be surprising to see that this study is funded by the brand name manufacturer (Eli Lilly), however, the study was required by the US Food and Drug Administration (FDA) under the Pediatric Research Equity Act (PREA). PREA allows the FDA to require pediatric studies for certain drugs when the agency believes they may be useful for this age group. Regardless of the motivation, this is a welcome study, since pediatric bipolar depression remains an understudied area.

The study included 255 kids between 10 and 17 years old with a moderately severe depressive episode of bipolar illness. Two-thirds of the participants received OFC (flexible dosing of 6 mg/25 mg, 6 mg/50 mg, 12 mg/25 mg, or 12 mg /50 mg/day olanzapine/fluoxetine with the most common dose being 12 mg/50 mg/day) and one-third received placebo for eight weeks in a double-blind, controlled fashion. The primary efficacy measure was the Children's Depression Rating Scale-Revised (CDRS-R).

Kids on OFC did significantly better on the CDRS-R than those on placebo as early as the first week and maintained this difference throughout the eight weeks. And, although placebo response was high, response and remission were significantly higher in the OFC group than the placebo group (78% vs. 59% responded and 59% vs. 43% remitted).

In terms of side effects, there were no big surprises: OFC caused significantly more weight gain, increased appetite, sedation, somnolence, and tremor compared with placebo. Kids on OFC gained an average of 11 pounds over eight weeks compared to kids taking placebo who gained an average of one pound. In terms of weight, 52% of OFC kids gained ≥7% of baseline body weight (FDA's definition of significant weight gain), compared to 4% of placebo kids. Elevated prolactin occurred significantly more in the OFC group and five of the girls taking OFC were symptomatic with menstrual changes and lactation. QT interval was prolonged more significantly in the OFC group as well, and this was likely due more to the fluoxetine component than the olanzapine.

OFC is currently the only FDA-approved treatment for bipolar depression in kids. For adults, there are more options: Latuda and Seroquel XR are approved and Lamictal has some positive data to support its use. Of these three, you can eliminate Seroquel as a potential treatment for kids because two controlled trials found it no better than placebo. Latuda data in kids will likely be forthcoming (Detke HC et al, *J Am Acad Child Adolesc Psychiatry* 2015;ahead of print).

CCPR's Take: OFC is an option for bipolar depression in kids, but its high side effect burden will likely cause it to gather dust on pharmacy shelves. However, the fact that a combination antidepressant/atypical antipsychotic has been shown effective for pediatric bipolar depression is good news. It gives us an excuse to try other such combinations off-label, using less weight-inducing antipsychotics, such as Abilify or Latuda.

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them to anyone. I also always ask if they had any suicidal thoughts during or after the moment of cutting, or if they were hoping to die by cutting. And I ask about current urges to cut, how much control the kid feels over those urges, and how motivated they are to try not to cut.

CCPR: Sometimes kids will say they want to hurt themselves, which may prompt an automatic ER visit. How should we evaluate these situations?

Dr. Gerson: When kids are sent to the ER for suicidal thoughts, we do a detailed assessment to really understand the nature of the suicidal thoughts and the context when they happened—and a lot of this can be done in the office as well. One kid was referred to us by her school for suicidal ideation. The story was that the kid had entered a radio contest to get tickets to see a popular band, and when she didn't win she said to her friend in the hallway, "I'm so mad I could kill myself." A teacher overheard and called 911, but she had no history of self-harm or suicidality, she was overall a happy kid with no depression, trauma, or other risk factors, and she had no intention of harming herself. This is very different from the kid who is comes to the guidance counselor with suicidal ideation who has also been feeling depressed for three weeks, is having trouble sleeping, has been anhedonic, and has been researching on the computer what pills are the most lethal.

CCPR: And what is your approach to safety planning before you allow a child to go home after there's been a question of suicidality?

Dr. Gerson: We're very systematic about safety planning. We want to make a plan so that if the situation ever happens again, everybody is in agreement about how to respond. There are five elements to a good safety plan, and we make sure that the family writes each one down before they leave. Those elements are as follows:

1. The first piece is, what are the early warning signs of an impending crisis? This is important for all kids whether the issue is self-injury, aggression, substance abuse, or something else. What are the things that make them more vulnerable to using cocaine, or

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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. "Reactive" aggression refers to which of the following (Learning Objective #1)?
   [ ] a) Sociopathic behavior
   [ ] b) Paradoxical aggressive reactions to certain medications
   [ ] c) A reaction to a provoking trigger
   [ ] d) Aggression requiring restraints

2. There are no FDA-approved medications specifically for managing an episode of acute agitation in children (LO #1)?
   [ ] a) True
   [ ] b) False

3. Use caution when prescribing benzodiazepines (such as lorazepam) to children because it can cause which of the following (LO #1)?
   [ ] a) Dystonia
   [ ] b) Unpredictable low blood pressure
   [ ] c) Serotonin syndrome
   [ ] d) Disinhibition

4. When referring a patient to the emergency room, which of the following is the best way to handle communication (LO #2)?
   [ ] a) Leave it to the professionals there to sort out the issues, that's why you sent the child
   [ ] b) Rely on the parent to relate what is occurring with their child
   [ ] c) Call ahead to explain what your concerns are or leave a cell phone number where emergency staff can reach you
   [ ] d) The child will be able to best explain their feelings to the ER staff

5. A study on the use of Symbyax (olanzapine/fluoxetine combination or OFC) in children with bipolar I depression showed which of the following results (LO #4)?
   [ ] a) Children on OFC initially did significantly better than those on placebo, but did not maintain the difference throughout the eight week trial
   [ ] b) Children on OFC did significantly better than those on placebo, both initially and throughout the eight week trial
   [ ] c) Children on placebo did the same as those on OFC
   [ ] d) Children on placebo actually responded better than those on OFC

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Expert Interview

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running away, or hurting themselves? We base this on looking at what happened just before the event. And we help the family start to watch for these warning signs. For example, one kid might have a pattern of cutting after she gets a negative report card. Another kid, whose parents are divorced, might feel angry and sad if his father doesn't pick him up for the weekend, and this makes him more likely to get aggressive. A younger kid might say that when she forgets to eat lunch she gets cranky, which can lead to a tantrum. If we know these warning signs we can avoid them, or give extra support and attention to the child when she needs it.

2. The second element of the safety plan is, "What can *I* do as a kid." What are some coping skills they can use? For example, they can take deep breaths, they can ask the teacher for a five minute timeout to go talk to the guidance counselor, or at home they can call a friend or watch a funny video to distract themselves.

3. The third element is, "Who can I reach out to for help?" Here we are asking the kids to write down their social support network. For example, first they'll call their best friend, but if she doesn't pick up then who? Or if the guidance counselor is busy, or mom is at work, then who will they call? And we always put on there the number for the ER and the number for the suicide hotline, in case they can't reach anyone else.

4. The fourth element is, "What can other people do to help me?" In other words, what can those people in their support network actually do to help during a crisis? For example, they might help by listening, or distracting, or coaching the child on their coping skills.

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This Issue's Focus:
Emergency Psychiatry in Children

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Expert Interview

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5. Finally, we ask them to write down reminders of things that are worth living for. What do they care about? They write things such as, "I love my little sister," "I'm excited about the soccer tournament next week," or "I want to be a doctor when I grow up." Kids forget about these things in the heat of a crisis, and reading these reminders can be powerful. [A helpful one-sheet safety plan is available at http://bit.ly/1DZJi85 and can be freely downloaded and adapted for use in your practice setting.]

CCPR: Thank you, Dr. Gerson.

Editor's note: Dr. Gerson is the co-editor of the book *Helping Kids in Crisis*, along with Fadi Haddad, MD (Haddad F, Gerson R, eds. *Helping Kids in Crisis*. Arlington, VA: American Psychiatric Publishing; 2015).

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