

Mental Health Care Guide

For Primary Care Clinicians

Aggression

OPAL-K

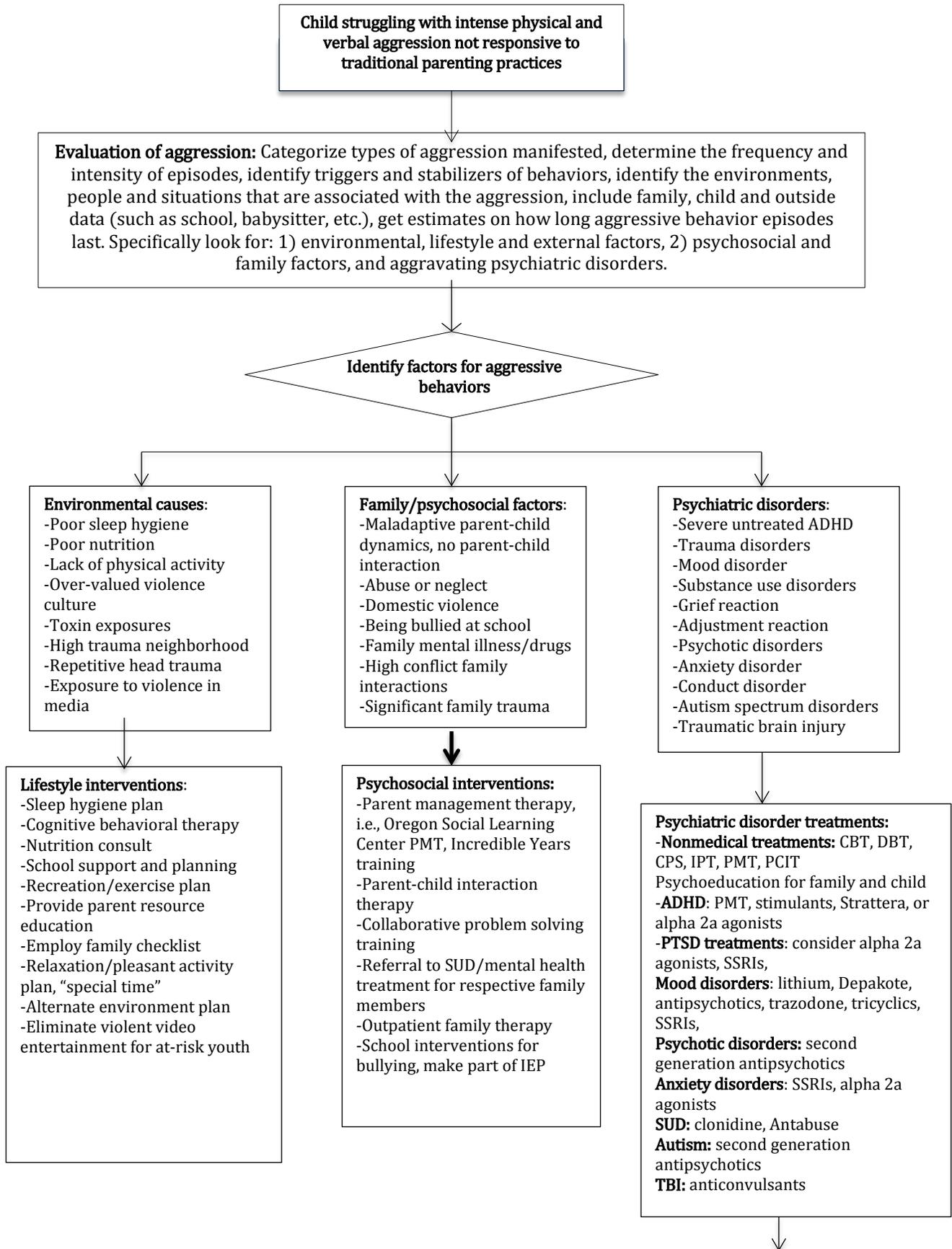
Oregon Psychiatric Access Line about Kids

A: OPAL-K Aggression Care Guide

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A1 - A2: Opal-K Assessment & Treatment Flow Chart For Aggression
 (See following page for glossary of acronyms)



**A2: Opal-K Assessment & Treatment Flow Chart For Aggression
Glossary of Acronyms**

Psychosocial Interventions

Parent child interaction therapy (PCIT)
Collaborative problem solving (CPS) training
Substance use disorder (SUD) referrals
Individualized education program (IEP) interventions for bullying

Psychiatric Disorder Treatments

Non-medical treatments:

Cognitive behavioral therapy (CBT)
Dialectic behavioral therapy (DBT)
Collaborative problem solving (CPS) training
Interpersonal therapy (IPT)
Parent management therapy (PMT)
Parent-child interaction therapy (PCIT)

Conditions

Traumatic brain injury (TBI)
Attention Deficit Hyperactivity Disorder (ADHD)
Post-traumatic stress disorder (PTSD)

A3: OPAL-K Assessment Guidelines For Aggression From T-MAY

(Information from “Treatment of Maladaptive Aggression in Youth (T-MAY), The Rutgers Certs Pocket Reference Guide for Primary Care Clinicians and Mental Health Specialists.” (2010)

1. Relationship building can determine family and patient knowledge-base, identify perceived barriers to adherence to treatment, and affect the overall viability of the established treatment and management plan.
2. Considerations of the family’s current level of stress, functioning status and beliefs about treatment should be clearly understood
3. Get a clear picture of how they have attempted to deal with this overt aggression up to the point of your visit with them. Ask if they have reached out to other family members, community organizations, or other clinicians. If the answer is no, ask why they finally chose to seek medical treatment
4. Identify the family’s concerns, and the reasons they are seeking treatment by contextualizing the target symptoms in terms of time/space/location. Include both the family and the child displaying overt aggression in your question and answer
5. Determine their perceptions of the overt aggression: What is causing the aggressive symptoms to appear? Where do they occur mostly? What are the risks for injury of the child to self and others? What are their expectations for treatment? How do they want to be involved?
6. To rule out potential contributory co-occurring symptoms or disorders which, could have a significant effect on prognosis, all possible documentation of the child’s treatment history should be collected to grasp the character, intensity and frequency of target symptoms
7. Using the DSM or ICD diagnostic criteria to assess other psychiatric or medical comorbidities is an essential first step in initiating treatment and management planning
8. Assess target symptoms using available scales and rating tools (see appendix, please)
9. Perform necessary diagnostic laboratory tests

A4 – A5: OPAL-K Treatment Guidelines For Aggression From T-MAY

1. Multiple factors are likely related to the onset and maintenance of aggression in children and adolescents with mental health disorders. These factors span a wide variety of domains, including inborn biological and genetic anomalies, the media and larger socio-cultural forces, interactive family processes, school and community influences, limitations in the child's cognitive, physical, social and communication skills, as well as other contributors from relationships with parents, caretakers and peers. Determining the most likely set of factors underpinning and eliciting the child's aggression can be quite intricate, and often lies outside the scope of a single professional's area of expertise.
2. When acute aggression is the cause of concern, the child and family must be carefully interviewed to determine the level and likelihood of physical risk the child presents others and to him/herself. Assessing the child's intention to harm self or others, his/her degree of impulsivity, child and family history of aggression, family parenting style and the parents' methods of reward and punishment can help to ascertain the appropriate information about the frequency, duration, triggers and risk of the child's aggressive behaviors.
3. In addition to the family dynamic, clinicians should pay special attention to determining the impact of the child's social network and the potential role of drug and/or alcohol use/abuse in inciting aggression.
4. Given the varied environmental and psychiatric contexts in which aggression can occur, clinicians are encouraged to identify potential obstacles from their ongoing collection of data to optimize treatment conditions.
5. Engaging patients and their families from the start of the assessment phase better ensures their openness to participating in dialogues about impulsive aggression, DSM disorders that may be present and strategies to manage the child's behavior.
6. Clinicians should seek to maximize communication and effective learning by first inquiring about parents' and children's pre-existing concerns, beliefs and understandings about the causes, consequences and interventions for aggression. If assumptions are invalid or myth-based, providers should make complete, easy-to-read information materials available in the family's preferred language and format.
7. In order for families to fully understand the risks, benefits and trade-offs involved in addressing aggression, information should include (1): what is known about the causes of aggression; (2) consequences if not addressed; (3) the various environmental, psychosocial and medication interventions available; (4) types of medical and educational assistance the family can receive; (5) sources of culturally-appropriate family support and additional services and outlets for information in the local community.
8. Outlining the family's and community's role in this way can significantly impact the patient-clinician relationship, treatment adherence and outcomes in an optimistic and constructive way.

9. Developing an appropriate treatment plan with the patient and family should take into account their concerns, fears and expectations. Similarly, family members should agree on specific treatment goals in key areas of functioning.
10. Plans for the short-term, long-term and emergency situations are all equally important and deserve coordination. It is essential that a crisis plan be co-developed with the family that outlines how emergency situations should be handled.
11. Identifying potential inpatient and outpatient clinical services and discussing the roles of parents and clinical providers are key elements to plan when preparing the family for imminent distress.
12. Finding the right professional can be more difficult if family is economically disadvantaged or lives in a geographically isolated region. You should provide the referrals for the family (if necessary) to primary care physicians, insurance companies, local hospitals and universities and/or appropriate professional associations.
13. It is also important to refer families to relevant resources in the community, including parent advocates and relevant family support groups, to help them cope with disruptions in the family dynamic and to learn how to access educational and health care services that can secure stability.
14. A comprehensive assessment of aggression is necessary for symptom identification and for successfully treating and managing the symptoms. Above all, it is relevant to identify the limitations and barriers to the child's achievement in following a specific, recommended regimen.
15. Over the course of the assessment and following diagnosis, it is important to continually track and reassess aggression problems to verify the adequacy of the treatment response. Screening and assessment tools to characterize and/or quantify symptoms can serve as benchmarks of treatment progress and provide insights during monitoring of psychotropic medications.
16. Rating scales vary according to their data-gathering style, content, time frame, and scale. Most importantly, they should be culturally appropriate, valid and reliable to promote feedback from the family and child. Additional copies of the T-MAY toolkit can be downloaded without cost or ordered in print form at cost at www.t-may.org.
17. During follow-up visits with the patient and family, clinicians should evaluate environmental factors and/or changes that may improve or worsen the child's symptoms and determine adherence to prescribed treatment. Collecting family insights can aid in this level of surveillance.

A6: Opal-K Aggression Medication Treatment Algorithm

After parent management therapy (PMT), treatment of underlying psychiatric disorders may be the single most effective intervention for aggressive youth. For primary care clinicians, OPAL-K does not recommend using psychotropic medications without consultation if there is not FDA indication. For those patients who may need off-label treatment of aggression, we urge clinicians to obtain consultation from a child psychiatrist or OPAL-K consultant. The recommendations below use psychiatric disorder as an FDA indication for medications listed -- or the medication listed has FDA approval for another indication, thus ensuring that some safety studies have been conducted. All medications selected have some level of evidence that support its use for treating aggression associated with the psychiatric disorder listed.

ADHD: stimulants, atomoxetine, alpha 2a agonists

Mood disorders: fluoxetine, fluvoxamine, sertraline, Lexapro, clomipramine, imipramine, doxepin, lithium, oxcarbazepine, valproate

Anxiety disorders: fluoxetine, fluvoxamine, alpha 2a agonists, sertraline, Lexapro, clomipramine, imipramine, doxepin

Psychosis: risperidone, aripiprazole, quetiapine, haloperidol,

A7 – A8: OPAL-K Medication Table for Aggression

(Medication information based on www.epocrates.com) pricing subject to change

Drug/Category SSRIs	Dosing/Half-life	FDA Approval	Comments/Monitoring	Warnings/Precautions	Cost for Monthly Supply
<p>Fluoxetine (Prozac)</p> <p>Forms available: tablets, pulvules and liquid</p> <p>selective serotonin reuptake inhibitor</p> <p>(SSRI)</p>	<p>Initial dosing: 10-20 mg/day</p> <p>Maximum Dosing 30-60 mg/day</p> <p>Half-life: 48-72 hrs, active metabolites 2 weeks</p>	<p>Approved for treatment of depression in youth ages 8 years and older</p>	<p>Weight gain unusual Sedation gain unusual Sexual dysfunction not unusual Higher rates of drug-drug interactions Rarely lethal in monotherapy overdose</p>	<p>Increase birth defects in given during 3rd trimester Higher rates of drug-drug interactions than other SSRIs</p>	<p><u>Generic</u></p> <p>10 mg -- \$\$</p> <p>20 mg -- \$\$</p> <p>40 mg -- \$\$\$</p> <p><u>Prozac</u></p> <p>10 mg -- \$\$</p> <p>20 mg -- \$\$</p> <p>40 mg -- \$\$\$</p>
<p>Sertraline (Zoloft)</p> <p>Forms available: tablets and liquid</p> <p>(SSRI)</p>	<p>Initial dosing: 12.5-25 mg/day</p> <p>Maximum dosing: 200 mg/day</p> <p>Half-life: 22-36 hrs, active metabolites 62- 104 hrs</p>	<p>Approved for treatment of OCD in youth ages 6 years and older</p>	<p>Higher rates of diarrhea than other SSRIs. Sexual dysfunction not uncommon Rarely lethal in monotherapy overdose Weight gain and sedation uncommon</p>	<p>Rare/mild dopamine reuptake blocking activity could contribute to agitation, anxiety and agitation early in dosing</p>	<p><u>Generic</u></p> <p>25 mg -- \$\$</p> <p>50 mg -- \$\$</p> <p>100 mg -- \$\$</p> <p><u>Zoloft</u></p> <p>25 mg -- \$\$\$\$</p> <p>50 mg -- \$\$\$\$</p> <p>100 mg -- \$\$\$\$</p>
<p>Escitalopram (Lexapro)</p> <p>Forms available: tablets and liquid</p> <p>(SSRI)</p>	<p>Initial dosing: 5-10 mg/day</p> <p>Maximum dosing 20 mg/day</p> <p>Half-life: 27-32 hrs</p>	<p>Approved for treatment of depression in youth 12 years and older</p>	<p>May have faster onset than citalopram because of higher potency May be better tolerated than citalopram. Fewer drug-drug interactions than other SSRIs</p>		<p><u>Lexapro</u></p> <p>5 mg -- \$\$\$\$</p> <p>10 mg -- \$\$\$\$</p> <p>20 mg -- \$\$\$\$</p>

Fluvoxamine (Luvox)	Initial dosing: 25 mg/day	Approved for treatment of OCD in youth ages 8 years and older	Higher rate of side-effects and drug-drug interactions. May also have a higher side-effect profile than other SSRIs. Short half-life for regular release. Can be fairly sedating	Fluvoxamine has been reported to slow the metabolism of acetaminophen, caffeine, propranolol and theophylline	<u>Generic</u> 50 mg -- \$\$\$ 100mg -- \$\$\$ <u>Luvox CR</u> 100 mg -- \$\$\$\$ 150 mg -- \$\$\$\$
Forms available: tablets, liquid and continuous release (SSRI)	Maximum dosing: 200-300 mg/day Half-life: 9-28 hrs				

OPAL-K Antidepressant Table: Other Antidepressants

Drug/Category: Other Antidepressants	Dosing	FDA Approval	Comments/Monitoring	Warning/Precautions	Cost for Monthly Supply
Doxepin (Silenor, Sinequan, Adapin) Available forms: capsules and liquid Tricyclic antidepressant (TCA)	Initial dosing: 25-50 mg/day Maximum dosing: 100 mg/day Half-life: 8-24 hrs	FDA approved for the treatment of depression in youth 12 years and older	Very antihistaminic so good for depression with insomnia. Sedation and weight gain common	Lethal in OD. Prolonged QT risk like other TCAs	<u>Generic</u> 10 mg -- \$\$ (90 tabs) 25 mg -- \$\$ (60 tabs) 50 mg -- \$\$ (60 tabs) 75 mg -- \$\$ 100 mg -- \$\$ 150 mg -- \$\$ 10 mg/cc -- \$\$ (120cc)

For all antidepressants:

In general, antidepressant improvement occurs in 2-4 weeks if they are going to work. After 8 weeks consider dose change if no improvement.

The FDA has given all antidepressants a Black Box Warning for possible increase in risk for suicidal thinking and behavior.

All the antidepressants listed are rated Class C for pregnancy.

All antidepressants can increase the risk of aggravating or inducing mania/hypomania.

Cost Code:

\$ -- \$10 or less \$\$ -- \$11 to \$49 \$\$\$ -- \$50 to \$99 \$\$\$\$ -- \$100 to \$499 \$\$\$\$\$ -- \$500 or more

A9: Aggression Intervention Checklist for Families and their Aggressive Child

Living with a child who is aggressive can be confusing, frustrating and at times scary. The following checklist can help families become more effective in managing the behavior issues associated with aggressive children and adolescents.

Checklist for parents:

- Make list of triggers for aggression and have a plan for what to do when triggers occur
- All guns and weapons should be secured or removed from the house
- Remove other potentially harmful items such as ropes, cords, sharp knives, alcohol, prescription drugs and poisons
- Eliminate any negative statements or scolding (try to stay positive)
- Help your child set up a written schedule for home and activities in the community
- Watch for signs of drinking or use of other drugs. Use of substances increase aggression risk
- Develop an aggression emergency plan. Parents and their aggressive child and siblings should decide how to proceed if a child feels out of control. Be specific with your plan and provide everyone with accurate names, phone numbers and addresses for crisis resources

Checklist for siblings:

- Make sure you understand what causes aggression in the home and what to expect from your aggressive sibling
- Don't feel responsible for your sibling's behavior
- Don't hesitate to communicate worries to your parents about your siblings aggression or your own safety
- Don't hesitate to ask your parents for attention when you need it
- Do be patient if your parents are unable to meet your needs immediately
- Have a plan of how to handle negative and aggressive behavior from your sibling

Checklist for schools:

- Check in with student about work load and adjust as needed (late arrival or early dismissal, decreased number of classes and assignment requirements)
- Be aware of classmates and situations that can trigger aggression and have a plan for intervention
- Be aware of multiple trancies or absences and communicate this to parents
- Report excessive irritability or social crises to parents
- Assist in evaluation for individualized education program (IEP) or 504 accommodations when indicated

Checklist for child:

- Practice being aware when you are about to be aggressive
- Be aware of people and situations that trigger your anger and aggression
- Practice using coping skills to manage anger
- Ask for medication, as needed, if your doctor has provided this for you
- Make sure to tell your doctor if your medicine is bothering you
- Spend time with people who can support you
- Schedule time for relaxation and rest

A10: Aggression Resources For Patients, Families And Teachers

Kidpower Teenpower Fullpower International teaches positive personal safety skills to protect people of all ages from bullying, molestation, abduction and other violence.

<http://www.kidpower.org>

Think:Kids teaches collaborative problem solving (CPS) to help children with behavioral challenges.

<http://www.thinkkids.org>

National Association of School Psychologists helps children do their best in school, at home and in life.

<http://www.nasponline.org>

Information about preventing and controlling youth violence from the Centers of Disease Control and Prevention (CDC).

<http://www.cdc.gov/Violenceprevention/youthviolence/index.html>

Striving to Reduce Youth Violence Everywhere (STRYVE) is a national initiative led by the CDC to prevent violence before it starts.

<http://vetoviolence.cdc.gov/STRYVE/>

A11: Aggression Resources For Professionals

The Research Institute

<http://www.thereachinstitute.org/>

The Treatment of Severe Child Aggression (TOSCA) study.

<http://www.capmh.com/content/5/1/36>

Experts' Recommendations for Treating Maladaptive Aggression in Youth.

<http://www.ncbi.nlm.nih.gov/pubmed/22196314>

A12 – A13: Aggression Bibliography

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