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Joshua D. Feder, MD
Editor-in-Chief

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IN THIS ISSUE

Assessment in Children and Adolescents

Learning Objectives

After reading these articles, you should be able to:

1. Describe the pros and cons of prescribing atomoxetine for ADHD in children and adolescents.
2. Understand the role of clinical assessment tools and assessment responses in diagnosing and treating children and adolescents.
3. Identify best practices for school inclusion to optimize patient success in the classroom.
4. Summarize some of the findings in the literature regarding psychiatric treatment for children and adolescents.

Atomoxetine for Children and Adolescents: An Update

Mikveh Warshaw, NP. Psychiatric mental health nurse practitioner, Community Health Center Inc. and faculty member of Center for Key Populations (CKP) Program, Middletown, CT.

Ms. Warshaw has disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Atomoxetine (ATX, Strattera) was approved by the FDA for ADHD treatment in 2002, and since then has become a second- or third-line option (after stimulants and sometimes after central alpha-agonists) for ADHD in both children and adults. With the recent approval of another non-stimulant ADHD medication (viloxazine, brand name Qelbree), it's a good time to revisit ATX. How effective is it? What are some of its pros and cons? This article clarifies the position of ATX in our toolbox for treating children and adolescents with ADHD.

Highlights From This Issue

Atomoxetine has a second-line role in treatment of ADHD, particularly when stimulants are relatively contraindicated.

Use structured assessments as part of your diagnostic and follow-up process to improve the accuracy of diagnoses and track treatment outcomes.

Expect discrepancies about symptoms and symptom severity among different sources.

Indications, dosing, and monitoring

Let's start with the basics. We know that we need to titrate stimulants weekly or biweekly early on for best effect (see *CCPR* Oct/Nov/Dec 2021 for detailed coverage on stimulant dosing).

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Q&A With the Expert

Using Clinical Scales in Child Psychiatry
Rajeev Krishna, MD, PhD, MBA

Medical Director of Inpatient Services for Behavioral Health at Nationwide Children's Hospital in Columbus, OH. Dr. Krishna's comments are his private opinions and do not represent Nationwide Children's Hospital.

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

CCPR: Welcome, Dr. Krishna. Could you tell us what drives your work in measurement-based care?

Dr. Krishna: Sure. I have a PhD in computer engineering as well as being a child psychiatrist. I'm a member of the American Academy of Child and Adolescent Psychiatry Healthcare Access and Economics Committee. I am an engineer at heart, and I'm interested in using technology to improve quality and accessibility of care. Measurement-based care is a natural nexus of these interests, and I believe effective use of self-reported outcome measures can dramatically improve the quality and efficiency of the services we provide.

CCPR: What's the rationale for using structured scales in assessment and treatment?

Dr. Krishna: We know from other medical disciplines that outcomes-based approaches improve the speed and quality of clinical improvement. In psychiatry, treating to a specific outcome and measuring progress

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results in more intentionally assertive treatment and more willingness to change directions when the current approach isn't working (Guo T et al, *AM J Psychiatry* 2015;172(10):1004–1013). Structured scales add precision and efficiency when time is limited. If the patient and family have already filled out assessments prior to the appointment, I have a wealth of information before we even start.

CCPR: In autism we have measures we can use every session, but the outcomes are bigger measures that we do about every six months, like the Childhood Autism Rating Scale (CARS), to see if we've made a dent in the overall pathology.

Dr. Krishna: The autism world is ahead of the curve. Every kid with a behavior plan has measures, whether it's frequency of aggressive episodes or of inappropriate social interactions or what have you. That is the essence of measurement-based care. It's not measuring everything under the sun all the time but targeting some areas until we agree that we need to work on something else. Treatment is dynamic. You adjust your targets based on trade-offs, such as balancing side effects with symptom control (Lambert MJ, *Psychotherapy Research* 2007;17(1):1–14). Consider a medical example: You wouldn't be OK with your physician treating your diabetes without checking your hemoglobin A1C. You need that measure to make choices about diet and medications. But in psychiatry we routinely just ask about symptoms during follow-up.

CCPR: What other studies show how outcome measurement improves child or adolescent psychiatric care?

Dr. Krishna: As clinicians we often disagree on diagnoses but agree more when we add structured instruments (Galanter CA and Patel VL, *J Child Psychol Psychiatry* 2005;46(7):675–689). In psychiatry we want to track remission, so we want measures that are sensitive enough to pick up on whether there is still a problem and specific enough to that particular condition. A number of scales have long-established utility. For example, PHQ-9 scores greater than 9 are 89.5% sensitive and 77.5% specific for picking up DSM-IV major depression in children (Richardson LP et al, *Pediatrics* 2010;126(6):1117–1123). The Brief Child Mania Rating Scale-Parent (B-CMRS-P) has an 84% sensitivity and 83% specificity of differentiating bipolar disorder from ADHD (Henry DB et al, *J Clin Psychol* 2008;64(4):368–381). For the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS), a score of 14 predicts remission with a sensitivity of 0.91 and specificity of 0.90 (Storch EA et al, *J Am Acad Child Adolesc Psychiatry* 2010;49(7):708–717). These scales do not replace clinical assessment, but they are great for helping you know if you are on the right track.

CCPR: What's your sense of how many psychiatrists currently use scales?

Dr. Krishna: There has been a reluctance to move toward using scales. We collected some unofficial data from the AACAP General Assembly group a couple of years ago and found that less than 25% of child psychiatrists were using scales consistently at a level that would reflect outcomes-based care. The reasons for this could be educational, generational, or regulatory. Psychiatrists primarily use their clinical interview and judgment. While we are using scales at an increasing rate, we tend to use scales that we learned during training. There are not a lot of resources for learning about other tools, and we stick to what we know.

CCPR: What are the barriers to implementing outcomes-based care?

Dr. Krishna: I break them into three categories: 1) psychological, 2) infrastructure- and workflow-related, and 3) economic. Psychological barriers have to do with clinician trust; infrastructure is about the mechanisms for delivering, scoring, and reporting the tests; workflow has to do with how you get the testing into the patient care experience; and economic barriers pertain to managing the costs of implementing the use of the tests.

CCPR: Tell us more about clinician trust in outcomes-based care.

Dr. Krishna: It's the idea that outcome measures are extraneous because clinical assessment and clinical judgment are better, or that measures are dangerous because they might replace that clinical assessment and judgment. Neither is true. Research shows that clinical assessment isn't as good as we think it is, and no one can realistically argue that a self-reported outcome measure in psychiatry has the diagnostic precision to eliminate clinical judgment (Hatfield D et al, 2010 *Clin Psychol Psychother* 2010;17(1):25–32).

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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.

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CCPR: So how should we think about these measures?

Dr. Krishna: Think about these assessments like lab values. They augment clinical decision making but they don't replace it. We all learned in medical school to treat the patient, not the lab value, and not to order a lab study unless we know what we are looking for and how we are going to use the result. But we also don't reject all labs just because some are not valid in a particular situation.

CCPR: Got an example?

Dr. Krishna: Sure. The PHQ-9 is well validated, but a patient who maximizes symptoms might consistently report high scores on the PHQ-9 that don't correlate with actual pathology (Hannan C et al, *J Clin Psychol* 2005;61(2):155–163). When a tool stops being useful for a patient, we use our clinical judgment, set aside the results, and document why. But we don't generalize to say that the PHQ-9 is never useful for anybody. On average it provides us with very useful information.

CCPR: What issues come up when health systems bring outcomes-based care to scale?

Dr. Krishna: We've been rolling this out in our large behavioral health program with psychiatrists, clinical social workers, counselors, and psychologists. Everyone comes to the table with different training and experience. Different disciplines also bring different concerns about using these tools. In my program psychiatrists are the most willing to accept the assessment data, but also the most willing to dismiss information if they don't find it useful. Clinical social workers are reluctant to dismiss information from rating scales when there's a mismatch with clinical assessment, and our psychologists are concerned about even administering assessments that may not be fully validated for a given age or population. At the end of the day, scales are meant to help us think about the case to bring our clinical judgment to bear, not to tell us what to do. If you convince practitioners of this, it strips away many psychological barriers.

CCPR: What are some examples of workflow barriers?

Dr. Krishna: There is the practicality of getting the information. Anybody who's tried to get an NICHQ Vanderbilt Assessment to a teacher through the parent knows that there is perhaps a 20% success rate. Even if you do manage to get the scale filled out, manually scoring a Vanderbilt is not fun. Trying to manually score a Screen for Child Anxiety Related Disorders (SCARED) is even less fun.

"Think about clinical assessments like lab values. They augment clinical decision making but they don't replace it. We all learned in medical school to treat the patient, not the lab value, and not to order a lab study unless we know what we are looking for and how we are going to use the result. But we don't reject all labs—or assessments in this case—just because some are not valid in a particular situation."

Rajeev Krishna, MD, PhD, MBA

CCPR: Any solutions?

Dr. Krishna: For barriers related to time spent scoring, technology could come into play. For example, the IMH offers the Patient-Reported Outcomes Measurement Information System (PROMIS measures) where you can download a bunch of measures for free (www.commonfund.nih.gov/promis/index). They have an electronic version where you pay a nominal sum to put it on a device, after which it will do the scoring for you. Several companies do this, and EHR systems are incorporating patient-reported outcomes as well.

CCPR: What about patient barriers?

Dr. Krishna: We have problems with folks not completing assessments at home or showing up late and not being able to complete them at the office. We incorporate time for the assessment into the patient's visit. For example, the patient is told to come in at 2:00, but the provider's schedule will say 2:15. We do tell them that they will do assessments prior to seeing their provider.

CCPR: Do they show up early?

Dr. Krishna: Yes. If you get the workflow right and you approach it right clinically, patients and families will complete the assessments because they see them as valuable. It's important to show patients that you are using these scales. If you get bloodwork done for a PCP but don't know why you need it and your PCP never talks about it, you might not get bloodwork done again the next time it is ordered.

CCPR: How do you talk with patients and families about the results?

Dr. Krishna: Assessments are great educational resources. You can say, "Hey, remember that assessment you filled out? Here's what it says about your depressive symptoms. Here's why you should be getting treatment for this disease." I tell families that these assessments are like getting your blood pressure during a physical. They help us have a more objective sense of how you are doing, so that we can look at that over time and really plan treatment with you.

CCPR: These assessments take time and personnel hours to process. What about the economic barriers to implementation?

Dr. Krishna: Technological solutions cost money to build, run, and maintain. Paper takes manpower too. You can't get around the resource costs, but you can recover some of them. For example, there are CPT codes that reimburse for reviewing clinical measures, maybe $4–$7 per measure each time the code is used, which adds up over time. Some

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payers cover it, but then you may need to pay someone to track recovered costs. As a field we need to advocate for payers to reimburse providers who have put in the work.

CCPR: How do these measures work in value-based care?

Dr. Krishna: In value-based care, payers might not reimburse you unless you show improvement on certain measures. They may stop paying or require extra reviews for a particular patient if a measure shows insufficient improvement. Measures should not replace clinical judgment, so an insurance company relying entirely on the numbers is problematic. Engage with insurance companies to shape their plans rather than waiting for them to define how these measures will be used.

CCPR: This sounds easier to implement in larger institutions.

Dr. Krishna: Regulatory bodies have been a major driver here. The Joint Commission requires behavioral health institutions under their purview to do outcomes-based care. Larger institutions have resources, but they also have more complicated workflows and stakeholders who need to work together. The costs also grow with bigger numbers, which shapes how you approach the problem. For example, we have as many as 250,000 patient visits per year. We cannot use anything that costs money as a first-round assessment. We start with public domain.

CCPR: What are your favorite screening tools?

Dr. Krishna: I work on implementation and I am not an expert on the measures. But I can say that we use the Vanderbilt as first-line assessment for ADHD symptoms. The PHQ-9 is a great starting place for depressive symptoms. We are using the Pediatric Symptom Checklist-17 (PSC-17) as a broad assessment and as a universal measure of progress in treatment (www.depts.washington.edu/dbpeds/Screening%20Tools/PSC-17.pdf). We use the SCARED for anxiety, the B-CMRS-P for mania symptoms (www.brainandwellness.com/accordian/upload_file/CMRS-P_followup.pdf), and Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for substance use (www.crafft.org) (Jeffrey J et al, *Child Adolesc Psychiatric Clin N Am* 2020;29(4):601–629). I work primarily on the inpatient side, which is an added challenge because all of the measures we are talking about assess symptoms over weeks, not the days of a normal inpatient hospitalization.

CCPR: What about cultural biases in these assessments? The Ainsworth Strange Situation attachment assessment reports the bulk of northern European children to have aloof attachments.

Dr. Krishna: Some scales have been validated in different populations. But translations are not necessarily validated in the new population. If the results are not consistent with what you are seeing in a clinical evaluation, find a different tool. Look at the patient. When you develop an assessment plan, make sure it makes sense. The goal is not to administer a particular scale or at a particular frequency. The goal is to have a consistent way of measuring how your patient is doing so that you can set a clear treatment target that you can get to and track your progress.

CCPR: Thank you for your time, Dr. Krishna.

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By comparison, ATX dosing is more straightforward:

- Get baseline vitals and rule out narrow-angle glaucoma. No EKG is needed. Baseline LFTs are indicated if there is a history of hepatic dysfunction.
- For children below 70 kg, begin at 0.5 mg/kg/day, increasing every three days to 1.2 mg/kg/day.
- For children above 70 kg, begin at 40 mg, after three days titrate to 80 mg, and after several weeks you might try the maximum 100 mg.
- For all children who are also on bupropion, use half the dosage of ATX.
- At full dose, monitor weight, pulse, and blood pressure, and assess for side effects on an ongoing basis.

Potential advantages and possible side effects

ATX's main advantage over stimulants is its side effect profile. Relatively old research has shown that ATX does not tend to cause problems common to stimulant treatment, such as loss of appetite, weight loss, growth inhibition, insomnia, worsening tics, depression, or anxiety. ATX may also be safer than stimulants in children or teens with preexisting cardiac problems (Wernicke JF et al, *Drug Safety* 2003;26(10):729–740). Moreover, unlike most stimulant preparations, ATX has little or no propensity for abuse and a low street value.

ATX occasionally causes side effects such as nausea, vomiting, abdominal pain, decreased appetite, headache, mild weight loss, increased blood pressure, and tachycardia. Splitting the dose to twice-daily administration generally reduces these problems. More troubling, and similar to other antidepressants as well as stimulants, ATX can trigger mania, paranoia, or other forms of psychosis in otherwise uncomplicated ADHD. Withdrawal is another problem. If you need to stop ATX, take it slow, dropping about 20% every two or three days.

Perhaps most worrisome is the black box warning for ATX for suicidal ideation, although the actual frequency is rare. A 2008 meta-analysis found that the frequency of suicidal ideation was small but significantly greater in pediatric ADHD patients treated with

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ATX compared to placebo—five patients out of 1357, or 0.37% (Bangs ME et al, *J Am Acad Child Adolesc Psychiatry* 2008;47(2):209–218). Reassuringly, a 2014 meta-analysis found no statistically significant elevation of suicidal ideation in children and adolescents as compared to placebo (Schwartz S and Correll CU, *J Am Acad Child Adolesc Psychiatry* 2014;53(2):174–187).

Does ATX actually work for ADHD?
ATX can indeed improve some measures of ADHD. A 2004 pharmaceutical-funded study found significant reductions on the ADHD-RS-IV with an impressive effect size of 0.71 on parent reports (Kelsey DK et al, *Pediatrics* 2004;114(1):e1–e8). This study also suggests ATX works into the evenings with once-a-day dosing, but since there was no comparison arm, those claims are merely suggestive. In a 2011 randomized placebo-controlled trial of ATX on young children 5–6 years of age, parents and teachers recorded a reduction on ADHD-RS-IV scales with a 0.7 effect size vs placebo, with 62% of the ATX arm scoring as moderately to severely ill on the Clinical Global Impression Scale at study completion vs 78% for placebo and an effect size of 0.6. This was a short eight-week study, and a longer trial might have found a stronger effect since other studies show that ATX reaches maximum effect in 12+ weeks. This study was partially funded by Eli Lilly, the manufacturer of ATX (Kratochvil CJ et al, *Pediatrics* 2011;127(4):e862–e868).

How does ATX compare with stimulants for ADHD?
Not surprisingly, stimulants are faster and better than ATX in treating the core symptoms of ADHD. For example, a 2013 randomized clinical trial (RCT) found that lisdexamfetamine (LDX, brand name Vyvanse) was significantly more effective than ATX in patients who had not responded to MPH, with generally about 75% responding to LDX vs about 55% to ATX. Effect sizes were not calculated. As in other research, the study's nine-week duration may have underestimated the final effect of ATX (Dittmann RW et al, *CNS Drugs* 2013;27(12):1081–1092).

Since dextroamphetamine-based medications like LDX tend to have more side effects overall than methylphenidate (MPH)-based ones, we usually try the MPH ones first. How does ATX compare with MPH? Here again the stimulant wins out over ATX. A non-industry-funded, open-label RCT compared ATX (n = 78) and osmotic-release oral system methylphenidate (OROS-MPH, eg, Concerta) (n = 70). This 90-day head-to-head study looked at executive functioning (ie, response selection/inhibition, flexibility, and spatial planning/working memory). Both medications helped significantly ($p < 0.05$) across all three domains, although OROS-MPH performed far better for response selection/inhibition ($f = 8.05$) and much faster for spatial planning (visualizing objects in space) (Wu CS et al, *J Child Adolesc Psychopharmacol* 2021;31(3):187–196).

Using ATX together with stimulants
It isn't clear whether adding ATX to stimulants results in better outcomes with ADHD. Baker et al found four studies with mixed results for ATX and MPH in combination (Baker M et al, *J Child Adolesc Psychopharmacol* 2021;31(3):148–163). Even so, one RCT (n = 25) with a history of failed stimulant trials showed no difference between starting ATX alone vs starting ATX plus OROS-MPH.

ATX vs alpha-adrenergic agonists
There are no head-to-head trials comparing ATX with alpha-adrenergic agonist medications like guanfacine and clonidine. Both guanfacine and clonidine, used as monotherapy, have effect sizes that rival stimulants (Cortese S et al, *Lancet Psychiatry* 2018;5(9):727–738). There is indirect evidence that alpha-agonists may be more effective than ATX, and they are generally considered next in line after stimulants (and above ATX) for ADHD. Both of these meds can be combined with stimulants to increase efficacy and/or decrease stimulant side effects such as sleep disturbance and hypertension. In comparing risks of ATX vs alpha-agonists, remember that alpha drugs can cause hypotension, rebound hypertension, sedation, abdominal discomfort, and QT prolongation (see "Which Medications Have the Lowest Risk of Side Effects?" in *CCPR* Oct/Nov/Dec 2020).

What about psychotherapy vs ATX?
We know from the 1999 MTA study and its long follow-up that cognitive behavioral therapy (CBT) does not add value to the robust effects of stimulants for core symptoms of ADHD. There is no similar study of therapy added to ATX. However, in a small head-to-head study in which parents compared CBT with ATX, they reported robust effects for both treatments, but clinicians blinded to which treatment the child was getting saw no differences between the two (David D et al, *Child Adolesc Psychiatr Clin N Am* 2011;20(2):191–204).

Can ATX help ADHD with other comorbidities?
ATX may be specifically helpful in ADHD with anxiety. An industry-funded study found ATX effective for ADHD with an effect size of 0.5 (Geller D et al, *J Am Acad Child Adolesc Psychiatry* 2007;46(9):1119–1127) with some improvement in both depression and anxiety in an uncontrolled trial (Kratochvil CJ et al, *J Am Acad Child Adolesc Psychiatry* 2005;44(9):915–924). Many kids with autism spectrum disorder (ASD) have symptoms of ADHD, and stimulant side effects can be more pronounced in these kids. In 2021, a meta-analysis compared ATX, MPH, guanfacine, and clonidine in comorbid ADHD and ASD. This study found comparable if modest efficacy for ATX, MPH, and guanfacine, but included only one study for ATX with an n of 50. Interestingly, clonidine did not perform well (Farhat LC, *J Child Psychol Psychiatry* 2021;62(6):701–703).

CCPR VERDICT: For usual ADHD treatment, we place ATX slightly behind the central alpha-agonists in the group of medications to consider after two trials of stimulants. In this group, ATX might have fewer side effects than central alpha medications in some patients. ATX may also make sense for specific cases where patients cannot take stimulants due to adverse reactions like exacerbation of tics, cardiac problems, risk of drug diversion, and perhaps less propensity to drive paranoia and psychosis.

School Inclusion: What You Need to Know

Joshua Feder, MD. Private practice child and adolescent psychiatrist, San Diego, CA. Editor-in-Chief, The Carlat Child Psychiatry Report.

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

Yamila is a 9-year-old autistic 3rd grader from a Spanish-speaking home with an individualized education plan (IEP) who attends a special education classroom with seven other students. She is a role model for her peers, compliant and never complaining. For two months Yamila has often been absent with stomachaches. After an extensive workup, Yamila's pediatrician refers her for psychiatric consultation.

When a school placement is a bad fit, medication and therapy are unlikely to make much difference. This article will help you understand and assist your patients to optimize their success in the least restrictive placement.

What is school inclusion?

School inclusion refers to the practice of including students with disabilities in regular classes, rather than in separate special education classes. Inclusion is a legacy of the civil rights era, ending school segregation, consistent with current social emphasis on diversity and acceptance. The Individuals with Disabilities Education Act (IDEA) requires schools to provide a free and appropriate public education in the least restrictive environment—in other words, to mainstream students if possible (https://sites.ed.gov/idea/regs/b/b/300.101). While it is not always possible to fully include all students, the goal of IDEA is to press schools to do their best to include students as much as possible in more typical school experiences.

How does inclusion work?

IDEA requires public schools to assist students with known or suspected learning or social disabilities. This usually begins with response to intervention (RTI) in which the school tries out accommodations in general education settings, such as frequent check-ins between the student and teachers, help with organizing academic tasks, and seating with matched peers to support better social interaction. If the RTI effort is ineffective, the school conducts an assessment, typically psychoeducational testing, speech and language therapy (including pragmatics), occupational therapy (eg, for motor planning, motor tone, and sensory differences), and observations at school. The child may qualify for a 504 plan (ie, more accommodations) or an IEP. IEPs can range from therapy services to modifications of the curriculum in order to support student success. Once parents sign them, IEPs are legally binding for the school. Sometimes an IEP calls for segregated placement. This usually occurs when the staff does not feel qualified to educate and support the student in a mainstream classroom. In such a case, future meetings include discussion of whether or how the student can be placed in the least restrictive environment.

Benefits and challenges

Generally speaking, inclusion is more helpful than segregated instruction for students with disabilities. Outcomes for students in special education classrooms with more intensive services have not been as robust as hoped (Causton-Theoharis J et al, *Remedial Spec Educ* 2011;32(3):192–205). By contrast, a recent study by Cole at Indiana University tracked students with disabilities through several years and found that students included for most of the day did significantly better on state tests than those not included (Cole SM et al, *JSE* 2021;54(4):217–227). Similarly, a study by Gee et al in 2020 found that learners with complex support needs did better academically and otherwise (eg, communication skills) in inclusive classrooms (Gee K et al, *Res Pract Persons Severe Disabl* 2020;45(4):223–240).

What about inclusion's impact on "typical" students? Gottfried et al reported "spillover" impacts of including students with special needs with mainstream students (Gottfried MA et al, *Educ Eval Policy Anal* 2014;36(1):20–43). These include more frequent school absences, for example an average of ½ day per semester for each student. Another study found that mainstream students in inclusion classes had lower academic achievement in reading and math. This impact was greatest in reading scores for Black and Hispanic children in low-income districts (Fletcher J, *JPAM* 2010;29(1):69–83). There are also concerns about increased externalizing behaviors among mainstream students, and how to help them respond adaptively when a student with special needs has behavioral difficulty.

This is a continuing area of study, and Roldán et al recently found that students without disabilities actually benefit from learning with peers with disabilities (Roldán SM et al, *Front Psychol* 2021;12:661427). A recent literature review concluded that while older mainstream peers have more risk for spillover, inclusion is overall positive for all students and improves understanding and acceptance (Kart A and Kart M, *Educ Sci* 2021;11(1):16).

Some of the ways kids with special needs can benefit from inclusive classrooms are as follows:

- Acceptance by peers as equal members of the school community
- Greater enculturation and improved ability to function in society over their lifetime
- More opportunities for academic achievement
- Increased opportunities for participation in clubs, sports, and other activities
- Exposure to a more natural range of social behavior for all students

Conversely, some common challenges include:

- Persistent bias, discrimination, and fear on the part of the other students and families (the "not in my backyard" or "NIMBY" objection) despite research supporting the benefits of inclusion for all students
- Managing the sensory environment of a general education classroom
- Creative execution of push-in services, such as occupational therapy or speech and language therapy delivered in the classroom
- Safety or bullying considerations when there is inadequate supervision available in class or on the playground

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Q&A With the Expert

Assessing Feedback From Multiple Sources

Andres De Los Reyes, PhD

Editor-in-Chief, Journal of Child and Adolescent Clinical Psychology. *Professor of Psychology and Director of the Comprehensive Assessment and Intervention Program, University of Maryland, College Park, MD.*

Dr. De Los Reyes has disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Welcome, Dr. De Los Reyes. You've spent much of your career researching collateral clashes—how reports of kids' symptoms may vary depending on who is reporting those symptoms, eg, parents, kids, teachers, and others.

Dr. De Los Reyes: Yes, for the past 20 years I've been thinking about how different people in kids' lives have fundamentally different perspectives on their mental health functioning, and how these different perspectives represent a strength of our assessment processes rather than a barrier to making good decisions.

CCPR: Where do we usually first see this situation come up?

Dr. De Los Reyes: Parents tend to report disruptive symptoms, such as overactivity, and kids independently tend to report internalizing ones, such as depression and anxiety. It's a ubiquitous phenomenon. Back in the 1950s, Lapouse and Monk created an interview to assess the base rates of psychiatric symptoms with parallel items for parents and children to complete. Both groups showed very different reports about children's psychiatric symptoms (Lapouse R and Monk MA, *Am J Public Health* 1958:48(9):1134–1144). It's also true when you compare child reporting with teachers, clinical staff, trained observers, and even peers. In 1987, Achenbach and colleagues found a 0.28 correlation between informants like parents and kids and teachers, which is pretty low (Achenbach TM et al, *Psychological Bulletin* 1987;101(2):213–232). In 2015, we conducted the same meta-analysis with other studies and found the same 0.28 correlation (De Los Reyes A et al, *Psychological Bulletin* 2015;141(4):858–900).

> **"We should expect discrepancies and plan our assessments to include multiple informants and contexts: parents, teachers, peers, at home, at school, and in other activities."**
>
> Andres De Los Reyes, PhD

CCPR: How widespread is this finding?

Dr. De Los Reyes: It's global. In a recent meta-analysis we found that it manifests in every assessment in 30 countries on seven continents, in every language tested. The consistency of this discrepancy effect rivals the placebo effect (De Los Reyes A et al, *Review of General Psychology* 2019;23(3):293–319; Ashar YK et al, *Annu Rev Clin Psychol* 2017;13(1):73–98).

CCPR: What are the implications of these discrepancies for clinical care?

Dr. De Los Reyes: Clinicians tend to suppress or discount discrepant reports and think about what the data have in common. People do this in the clinic, in the laboratory, everywhere. But when you focus only on the commonalities, you leave out unique information that could impact clinical decision making.

CCPR: I've heard that these variations can occur even when people use supposedly objective rating scales. For example, the Autism Diagnostic Observation Scale (ADOS) may report more or fewer symptoms depending on how restrained or engaging the tester is.

Dr. De Los Reyes: Yes, you see these discrepancies regardless of how well established an instrument is. We've seen discrepancies when informants are distressed or depressed, or when they do not understand what we are assessing. The care we've taken in developing these instruments cannot remove these discrepancies, including the sensitivity to the characteristics of the person reporting.

CCPR: Since these discrepancies are a fact of clinical practice, how do you suggest we manage them?

Dr. De Los Reyes: Think about how phones track our locations. They're linked to satellites that triangulate on us. That's how we need to think about information sources. You don't get an accurate read on a patient's mental health status by getting all your data from one source. The trick is to triangulate—to get data from many sources, including your ongoing clinical exploration, and think about why those sources are saying different things. Only then can you make better decisions as the treatment unfolds.

CCPR: What kind of informants do you look for as you conduct an assessment for most kids?

Dr. De Los Reyes: It's important to get informants from a variety of contexts, like home and school. We try to get good observers from familial and non-familial authority figures as well as peers. Think about reasons why informants might disagree, clinically relevant reasons such as observing behavior in different contexts. Select informants who will reliably produce these discrepancies, including young children. And we want self-reports from patients as well.

CCPR: How do we get this from our young patients?

Dr. De Los Reyes: You can try the Berkeley Puppet Interview, which does not require

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kids to verbalize responses and can be integrated with reports from parents and teachers (Kraemer HC et al, *Am J Psychiatry* 2003;160(9):1566–1577).

CCPR: How do you explain this phenomenon to parents?

Dr. De Los Reyes: Normalize the process. I tell them it's like asking people to estimate how many marbles are in a jar—there's an objective answer, but each person will estimate differently. And different people rating behavior can have even more divergent views. For instance, the same child with the same strengths and challenges can get along great with one teacher and not at all with another. That might have to do with the teacher or the situation or both.

CCPR: What do we do when parents and teachers are more or less discrepant in their reports?

Dr. De Los Reyes: Tracking these discrepancies can track treatment response. Look at whether the discrepancies change. For example, we found that you tend to get more agreement between parents and teachers in autistic children when the challenges are more severe (Lerner MD et al, *J Child Psychol Psychiatry* 2017;58(7):829–839). But successive reports can change over time, with one or the other informant seeing lessening severity of symptoms. We have yet to study this, but one thought might be that growing disagreement between informants over the course of treatment signals that the child's functioning is improving.

CCPR: So if you see somebody doing worse in one circumstance and better in another, you can learn from that and duplicate it?

Dr. De Los Reyes: Exactly. The notion that context may vary by contingencies is embedded in texts by Skinner. We expect certain behaviors to be present in some contexts and absent, or present to a lesser degree, in others (Skinner BF. *Science and Human Behavior.* New York, NY: MacMillan; 1953). If it looks like most of the action is present in one particular context, you might focus on that for a while.

CCPR: How do we know if a discrepancy is truly meaningful?

Dr. De Los Reyes: Well, some might be junk. An informant may have had a bad day or an instrument may not have performed the way you were hoping. I tell my team to trust but verify. Find independent assessments, numbers apart from these sources, to help corroborate whether the discrepancies feel real or whether you're getting noise. *(Editor's note: Informant reports can be impacted by additional factors such as denial of mental health conditions, over-identification with the child, implicit bias, and structural inequities such as limited categories for individual educational planning.)*

CCPR: Can you give an example?

Dr. De Los Reyes: Let's say you have a mother who brings her 3rd grader to you because the teacher says he won't follow instructions in class, that he's defiant. The parents don't see any problem. It's common for us to agree more with whomever brings the child, so your tendency may be to go with the parents' impression. You need to look at the whole picture. Gather grades, school records, and an observation of the family interacting at home. Talk with the teacher—is this report true oppositionality or a mismatch involving a teacher who expects more organization than the child can muster? Behavior varies across contexts, and no one information source provides a complete picture of how the patient behaves across circumstances.

CCPR: This can be tricky. With ADHD, we don't diagnose unless there are symptoms across two or more settings.

Dr. De Los Reyes: ADHD really trips people up. Say a child has trouble concentrating in class and completes only half of her schoolwork. Her grades are terrible, and her parents bring her in asking about ADHD. The criteria for ADHD require that you see the symptoms in more than one setting, and the parents aren't seeing any problems at home. You can't formally diagnose ADHD, and it throws into question whether you are likely to succeed with any ADHD-specific treatment.

CCPR: Right. So how important is it that the child has symptoms across settings?

Dr. De Los Reyes: It's a glaring hole in our evidence base. We need studies to see whether the cross-contextual criterion is necessary for an ADHD diagnosis, looking at differences using objective, independent markers of impairment between patients for whom parents and teachers agree and disagree on ADHD symptoms. Studies like these have been done in disruptive behavior and autism, but not ADHD (De Los Reyes A, *J Abnorm Child Psychol* 2009;37(5):637–652).

CCPR: What do we do to sort it out?

Dr. De Los Reyes: Look at independent assessments like grades or observations of peer relations. Computerized performance testing is not diagnostic per se, but it can give additional data about the child's cognitive attention and impulsivity. If the outside evidence weighs toward ADHD, then the child may benefit from treatment. Otherwise we're missing out on kids who would benefit from care because they don't have symptoms in two settings so they don't meet the diagnostic threshold.

CCPR: What about kids with depression who might appear OK when they are in the company of people but suicidal when they are alone?

Dr. De Los Reyes: For a long time, we've said that getting kids active with other people doesn't bring much change in depression. But in the meta-analyses there's a discrepancy—the children report positive effect sizes that are several times larger than what the parents report (Weisz JR et al, *Psychological Bulletin* 2006;132(1):132–149). We tend to think, "Well, if parents aren't seeing a big change, then how much stock can we put into the kids' reports?" I think these kids are telling us that cognitive behavioral therapy does help them with some problems, like when they're with their peers, but not necessarily at home when they're with their parents. However, to truly sort this out we need carefully conducted studies with independent assessments of how children behave with peers over the course of treatment.

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Research Updates IN PSYCHIATRY

DEPRESSION

Intravenous Ketamine for Teen Depression

Pavan Madan, MD. Dr. Madan has disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

REVIEW OF: Dwyer JB et al, *Am J Psychiatry* 2021;178(4):352–362

TYPE OF STUDY: Randomized midazolam-controlled trial

Treatment-resistant depression (TRD) is a growing concern in teenagers. Although intravenous ketamine has shown clear and immediate improvement of TRD in adults, there is little research to show its effectiveness in teens, and each infusion may cost about $450, with a total of $3000–$4000 for a course of treatment in adults (www.tinyurl.com/cv4yw77s). A recent study tried to fill the gap in the literature.

This study was conducted at the Yale Child Study Center. Researchers enrolled 17 teenagers aged 13–17 years with severe major depressive disorder but without active suicidal ideation or comorbid substance use disorder. Teens could continue their current psychotropic medications. While the participants were required to have failed only one antidepressant trial, on average they had failed three antidepressants and six total psychotropic medications, excluding ADHD medications.

The researchers conducted a randomized, double-blinded, active-controlled, crossover study. Patients were given a single infusion of ketamine (0.5 mg/kg) or midazolam (0.045 mg/kg) and switched to the other treatment after two weeks. The primary endpoint was a greater than 50% improvement in the Montgomery-Åsberg Depression Rating Scale (MADRS) score 24 hours after treatment.

Subjects who received ketamine reported a remarkable improvement in depression following ketamine treatment. Their average baseline MADRS score of 33 dropped significantly lower with ketamine (to 15.4) compared to midazolam (24.1) with a strong effect size of 0.78 ($p = 0.03$). Overall, 75% of the group responded to ketamine compared to 35% with midazolam. Two weeks following the infusion, responders to ketamine maintained partial improvement in depression, whereas responders to midazolam returned to their baseline level of depression. The main adverse effects seen with ketamine were an increase in pulse and blood pressure during the infusion, and dissociation up to two hours after the infusion.

CCPR'S TAKE

Based on this small study, intravenous ketamine appears to be a promising new tool for TRD in teens. Still, we are concerned not only with the high cost of this treatment but the propensity of preliminary studies to cause families to pursue it. We need larger studies on ketamine in children and teens, especially ones that include patients with active suicidal ideation.

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Expert Interview—Assessing Feedback From Multiple Sources

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CCPR: That reminds me of kids who are passive and anxious when I see them with their parents but less anxious when I see them alone.

Dr. De Los Reyes: Sure. Say you have a child referred for assessment of anxiety. The parents report that the child is avoiding social situations. He won't go to birthday parties, refuses most playdates, and fusses when he's supposed to go to soccer practice. Then you see the child, who says he's fine with other kids and has no problem engaging in activities with them. This is opposite of our usual expectation that kids will report anxiety symptoms that parents don't notice because they are not disruptive.

CCPR: How do you explain the discrepancy?

Dr. De Los Reyes: An anxious kid might not want you to judge them, so they deny the reports of their difficulties. They don't want to look bad, especially in front of strangers like you. So, when the parents' and kid's reports differ, you need to consider two possibilities. Either the kid is downplaying the concerns or the parents aren't aware of circumstances where the child is doing quite well.

CCPR: What do you do here?

Dr. De Los Reyes: Same as before—look for more data. See if you can find out from peers and teachers how the child is doing. Maybe the child is standing back and not engaging on the school playground even though the child reports that they are "fine" in that situation. Then you have a better idea that the child is indeed anxious.

CCPR: What is the impact of cultural or racial influences on assessing these discrepancies?

Dr. De Los Reyes: If you have a non-white child who is having learning difficulties, what do you usually do? You tell the family to ask the school for psychoeducational testing. Let's say that the testing comes back and shows that the child has problems with reading comprehension. She doesn't do well answering questions about the standard stories on reading comprehension tests, like building and floating boats at the local park or "pet day at the fair," so the school gives the student extra help. But three months later you see the child back and she's doing no better than before.

CCPR: What went wrong?

Dr. De Los Reyes: Parents from different cultures or communities may over- or underreport symptoms. Also, our tests have been normed on groups of patients whose backgrounds are very similar, which means they might not

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School Inclusion: What You Need to Know
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The bottom line is that general education placement should not be viewed as a "geographic" process but one that is carefully considered and titrated to maximize success for all students.

Talking with patients and families

Families frequently find it challenging to navigate the educational options available to their child. When meeting with patients and parents to talk about building a good plan for school, consider these talking points for productive discussion:

- What have been the best moments in your child's educational career? What made these moments special? Tell me some of your child's education inclusion success stories (eg, helpful projects, effective adaptations). Let's think about how those can be replicated.
- What do you think are the child's strengths and challenges? Most importantly, what is meaningful to them?
- Help me understand the most important goals you have for your child this year.
- Tell me how you want your child's education to look this year.
- Tell me what you think your child might need to be successfully included in the classroom, whether in person or virtual. Think about areas of sensory, motor, visual, communication, and executive function. Consider noise-canceling headphones, headsets that amplify the teacher's voice, specific seating, allowances for pacing during class, yoga ball chairs, fidgets, or extra time on assignments and tests.
- Compared with virtual learning, do you see any ways in which in-person learning is helping or could help your child (eg, fewer transitions in the day, use of certain tech tools to make learning more accessible, better mental health)? Let's figure out how we can lean into these benefits now and in the future.
- What barriers—cultural, practical, and others—might make inclusion difficult, and how can we work to overcome these barriers in a supportive fashion?

On evaluation, Yamila refers to her special education classmates as "friends" but is frightened by some and avoids all of them. She has no playdates and spends her time repeatedly drawing a specific Disney logo. Yamila's parents agree to your request to meet with the IEP team to recommend that the team consider placing Yamila in a less restrictive setting where she might feel safer and have more opportunities for social interaction.

Working with schools

Once you have a good idea of what might work for the student, it's time to look at how those measures can work at school. Given the need to optimize learning for the student while supporting mainstream peers and staff, consider these factors as you work with schools and families:

- Where will the student have a better chance of meeting their academic and social goals?
- Where will the student have more social opportunities?
- Can therapies be delivered in the mainstream classroom?
- For which specific activities can the student join the mainstream class? Sometimes a student requires a different environment for certain activities (eg, test taking) or for some more focused academic instruction.
- How can staff manage the mix of students to maximize success and minimize loss of academic or social learning for other students? Programs such as The Good Behavior Game (https://goodbehaviorgame.air.org) can help teachers to foster cooperative learning.
- What support do the mainstream children and their families require? Sometimes in-class education programs, such as Circle of Friends or Autism Is, help students and families learn acceptance, foster inclusion, and reduce bullying.
- What support will staff require to optimize the experience for all the students in the class? This may include specialized consultation and regular and frequent protected time for reflective problem solving.

In your joint meeting, the team recognizes that they need to transition Yamila out of her special education classroom. They will try her in mainstream classes, one at a time, beginning with art class as Yamila's interest in drawing can help facilitate social interaction. The team plans to look for mainstream Spanish-speaking peers who might partner with Yamila in push-in speech and language therapy. The class will receive a program to foster inclusion and acceptance, and the staff will have follow-up support every other week from the district special educational specialist.

A good plan generally leads to academic and social progress for the student. But special education, including mainstreaming, is expensive. School districts often provide inadequate resources, resulting in little headway for students. In their effort to show progress, schools may document small gains that mean little in terms of actual function. You have a role in monitoring. Expect to see substantive changes not in a few weeks, but over seasons. That said, meaningful progress should not take years, and a recent Supreme Court case ruled that minimal progress is inadequate progress.

Three months later, Yamila no longer has stomachaches. Her attendance is good, she has regular playdates, and she enjoys her new Girl Scout troop.

CCPR VERDICT: Special education accommodations must be made in the least restrictive way possible. The good news is that the bulk of research supports inclusion as beneficial for all students. Help your patients and families to build successful inclusion plans.

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1. In a 2021 study of children with ADHD, osmotic-release oral system methylphenidate (OROS-MPH) significantly outperformed atomoxetine (ATX) on which domain(s) of executive functioning (LO #1)?
   - [ ] a. Flexibility
   - [ ] b. Flexibility & response selection/inhibition
   - [ ] c. Response selection/inhibition & spatial planning/working memory
   - [ ] d. No significant improvement with OROS-MPH vs ATX

2. What is the strength of correlation between psychiatric symptom reports obtained from different informants (eg, kids, parents, and teachers) who observe a child's behavior in separate contexts (LO #2)?
   - [ ] a. Weak correlation
   - [ ] b. Strong correlation
   - [ ] c. Strong correlation, but only between parents and teachers
   - [ ] d. No correlation

3. In recent studies, how did children with disabilities in inclusive classrooms perform academically compared to those in segregated classrooms (LO #3)?
   - [ ] a. Segregated instruction improved academic performance compared to inclusive instruction
   - [ ] b. Inclusive instruction had no effect on academic performance compared to segregated instruction
   - [ ] c. Inclusive instruction significantly improved state test performance compared to segregated instruction
   - [ ] d. Inclusive instruction significantly worsened academic performance compared to segregated instruction

4. In a recent study of teenagers with major depressive disorder, what was the effect size of ketamine treatment compared to midazolam, based on changes in Montgomery-Åsberg Depression Rating Scale scores (LO #4)?
   - [ ] a. Small effect size
   - [ ] b. Medium effect size
   - [ ] c. Large effect size
   - [ ] d. No significant difference between ketamine and midazolam

5. For children and adolescents with ADHD, how does ATX compare to stimulants in terms of efficacy and propensity of triggering mania (LO #1)?
   - [ ] a. Significantly more effective; is not associated with triggering mania
   - [ ] b. Significantly less effective; is associated with triggering mania
   - [ ] c. Significantly more effective; is associated with triggering mania
   - [ ] d. Significantly less effective; is not associated with triggering mania

6. According to Dr. Krishna, which of the following about measurement-based care is true (LO #2)?
   - [ ] a. Measurement-based care does not inform treatment changes to balance side effects with symptom control
   - [ ] b. Adding structured instruments increases diagnostic agreement among clinicians
   - [ ] c. The PHQ-9 has no utility in picking up major depression in children
   - [ ] d. Self-reported outcome measures have the diagnostic precision to eliminate clinical judgment

7. Under the Individuals with Disabilities Education Act, schools must provide a free and appropriate public education in the least restrictive environment (LO #3).
   - [ ] a. True
   - [ ] b. False

8. In children and adolescents with ADHD, ATX reaches its maximum effect after how many weeks of treatment (LO #1)?
   - [ ] a. Two weeks
   - [ ] b. Four weeks
   - [ ] c. Eight weeks
   - [ ] d. 12+ weeks

Expert Interview—Assessing Feedback From Multiple Sources

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be as accurate for people with different cultural, racial, and ethnic backgrounds. So if the tests indicate that this student is struggling, it might be because she has not been exposed to the information or experiences she needs to be successful on those tests.

CCPR: What do we do in this kind of situation?

Dr. De Los Reyes: Get assistance in culturally sensitive assessment specific to this child and family by talking with colleagues and using specific tools for thinking through the problem (*Editor's note: For more on cultural competence, see* CCPR *Jan/Feb/Mar 2021).*

CCPR: Any final thoughts?

Dr. De Los Reyes: We should expect discrepancies and plan our assessments to include multiple informants and contexts: parents, teachers, peers, at home, at school, and in other activities. Assess the problem by getting independent data such as grades, other testing, and additional observations to either corroborate reports or suss out noise that can be disregarded. Since a clinical problem might be localized to a specific circumstance, plan treatment to address the problem where it occurs.

CCPR: Thank you for your time, Dr. De Los Reyes.

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Note From the Editor-in-Chief

The pandemic continues and our kids' problems are growing. We hope this issue helps you in your assessments—using scales, embracing discrepant stories. We also offer thoughts on effective school inclusion and the place of atomoxetine and IV ketamine in our work.

One side note: Fentanyl deaths are rising—warn your patients and families about fake and deadly over-the-counter medications including OxyContin, Percocet, Vicodin, Adderall, and Xanax (www.tinyurl.com/2p8yctjk).

Check out our new book, *Prescribing Psychotropics: From Drug Interactions to Genetics*. It's an updated edition of *Drug Metabolism in Psychiatry* by Daniel Carlat. For more information, go to: www.thecarlatreport.com/prescribing

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