Consensus Panel Recommendations

Consensus panel efforts focused on the minimization of potentially inappropriate exposure of children to antipsychotic medications by way of second opinion review and consultative advice by a child and adolescent psychiatrist to a prescribing clinician. The consensus panel identified several key components for a best practice approach to minimization of antipsychotic medications via second opinion:

- Identify the target symptom/behavior that chiefly concerns the patient/parents/guardian;
- Identify potential diagnoses (e.g., rule out psychosis);
- Take a history of current and prior medications and talk therapies used;
- Consider the potential for dose optimization and or switching medications (e.g., stimulants, antidepressants);
- Consider use of lower risk medications (e.g., mood stabilizers);
- Consider the potential for increased use of talk therapy and/or telemental health modality.

Members unanimously agreed that the guidance they developed should be organized around target symptoms (i.e., principle complaint) for three primary reasons: First, because diagnoses may be incorrectly applied. Second, there was some concern about "gaming" diagnoses in order to avoid a second opinion consult (e.g., entering a diagnosis of bipolar disorder to justify the prescribing of an antipsychotic for moderate mood lability). Third, a primary target audience for these recommendations is primary care providers and pediatricians treating a target symptom (e.g., impulsive aggression); that is, clinicians who are typically less confident in making mental health diagnoses.

Organization of Clinical Guidance Tables for the Safer Prescribing of Antipsychotics for Youth

TARGET SYMPTOM	EXAMPLES OF POSSIBLE RELATED DIAGNOSES
Anxiety	General anxiety and social anxiety disorders (GAD, SAD), panic disorders
Depression	Major depressive disorder (MDD), persistent depression
Disassociation flashbacks, nightmares	Post-traumatic stress disorder (PTSD)
Disruptive, aggressive, impulsive, dysregulated behaviors	Oppositional defiant, conduct, attention deficit hyperactivity disorders (ODD, CD, ADHD)
Eating Disorders	Anorexia nervosa (AN), bulimia nervosa (BN)
Insomnia	Behavioral and psychophysiological
Mania	Bipolar disorder I/II
Mood lability, irritability, mood swings (without mania)	Disruptive mood deregulation, oppositional defiant, conduct disorders (DMDD, ODD, CD)
Obsession and compulsion	Obsessive compulsive disorder (OCD)
Psychosis	Schizophrenia, schizoaffective disorders
Substance misuse	
Suicidal ideation	
Tics	Simple tics, Tourette's syndrome (TS)

ANXIETY	
Environmental factors to address first?	• Identify and remove triggers for anxiety, if possible. • Identify social factors potentially reinforcing anxiety and dysfunctional behaviors. • Decrease environmental stressors.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Determine diagnoses as precisely as possible with understanding that there is much overlap. E.g., panic attacks, GAD, OCD symptoms, agoraphobia. Rule out: • Developmentally appropriate anxiety • Anxiety related to identifiable triggers Depression: 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious) in conjunction with fluoxetine with close monitoring. 2nd line: Escitalopram trial at mid-range dosing for 8+ weeks plus CBT. 3rd line: Trial of another SSRI or SNRI plus CBT. 4th line: SSRI augmented with another agent (e.g., bupropion, lamotrigine, lithium). DMDD: 1st line: Behavioral modification or CBT as appropriate for age and circumstances. 2nd line: SSRI/antidepressant. OCD: 1st line: CBT, including exposure response prevention. 2nd line: 2 trials of SSRIs at optimized dose, or 1 SSRI trial followed by clomipramine at optimized dose. Medical etiology: Refer to specialist for assessment. Mood disorders: CBT or DBT therapies. If CBT or DBT don't work, refer for psychiatric evaluation and re-evaluate diagnosis. Nightmares: 1st line: Trauma-focused CBT, EMDR for night terrors. 2nd line: Consider alpha 2 agonist, or Prazosin, propranolol. Consider other sleep aids such as antihistamine or trazodone. PTSD, trauma or bullying: Trauma focused psychotherapy. Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.
General treatment considerations:	Never consider an antipsychotic if distress and impact are mild or moderate – unless associated with psychosis, etc. Never prescribe an antipsychotic for anxiety alone. Prescribe regular exercise to augment the treatments below. 1st line: 10-12 sessions of CBT, desensitization. If anxiety is severe, consider adding SSRI to CBT. 2nd line: 2 SSRI trials, mid-range dosing for 8+ weeks. 3rd line: SNRI (duloxetine) or another serotonin agent (mirtazapine or clomipramine - e.g., with severe recalcitrant OCD).

DEPRESSION	
Environmental factors to address first?	Parent/guardian depression, bullying, or trauma.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Conduct Disorder: Higher level behavior management (may include special school, day hospital, or residential facility). DMDD: 1st line: Psychotherapy, 2nd line: SSRI/antidepressant. ID/ASD: Functional analysis, ABA, social skills, augmentative MDD or anxiety – CBT, IPT or DBT. Rule out/address changes in environment, physical discomfort like ear infections, etc. Assist with communication. ODD: Behavior/contingency management preferred to medications. PTSD: Trauma focused psychotherapy. Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.
Underlying diagnoses for which to consider antipsychotics first?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder.
General treatment considerations:	Never consider an antipsychotic if distress and impact are mild. There is limited evidence of the efficacy of antipsychotics in treating persistent depression in youth. Consider augmentation strategies to the treatments below (e.g., phototherapy, exercise, sleep, meditation/mindfulness, etc.). 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious behaviors are present) in conjunction with fluoxetine. 2nd line: Escitalopram trial at mid-range dosing for 8+ weeks plus CBT. 3rd line: Trial of another SSRI or SNRI plus CBT. 4th line: SSRI augmented with another agent Monitor patients given SSRIs closely (e.g., efficacy, possible suicidal ideation), particularly if therapy is delayed or does not take place. For severe/persistent depression despite above treatments, consider augmentation with an antipsychotic. If prescribed, should be done with the goal of tapering and while psychosocial therapies are concurrently intensified. Should be seen by a psychiatrist within 3 months.

DISASSOCIATION FLASHBACKS, NIGHTMARES	
Environmental factors to address first?	• Mitigate unsafe environments or ongoing trauma to patient or caregiver. E.g., is the triggering situation or trauma ongoing? (e.g., complex medical condition, abuse, neglect, natural disaster, exposure to violence, parental deployment). Who else was exposed to the trauma? • Ascertain home, school and community deficits vs strengths and supports. E.g., are adults remaining calm/supportive (is parental mirroring a factor)?
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Anxiety disorders: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine). Borderline personality disorder: Course of individual and group DBT (10-12 sessions). Depression: 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious) in conjunction with fluoxetine with close monitoring. 2nd line: Escitalopram trial at mid-range dosing for 8+ weeks plus CBT. 3rd line: Trial of another SSRI or SNRI plus CBT. 4th line: SSRI augmented with another agent (e.g., bupropion, lamotrigine, lithium). PTSD or trauma: Trauma focused psychotherapy. See also AAP.org/trauma (toolkit to use with family suggestions, with red flags of what might be trauma, etc.).
General antipsychotic considerations:	Never consider an antipsychotic if distress and impact are mild or moderate. Remove patient from trauma-inducing situation (if possible). 1st line: Trauma-focused CBT, eye movement desensitization and reprocessing (EMDR). 2nd line: Consider an alpha 2 agonist, or Prazosin, propranolol. 3rd line: Consider another sleep aid such as antihistamine (note that trazodone is not helpful for nightmares). For more severe/persistent flashbacks or nightmares despite the above options and after rule out of any underlying diagnoses, an antipsychotic at a low dose is reasonable. When prescribed, done with concurrent psychosocial therapy and plan for subsequent tapering off. Should be seen by a psychiatrist within 3 months.

DISRUPTIVE, AGGRESSIVE, IMPULSIVE, DYSREGULATED BEHAVIORS	
Environmental factors to address first?	Address bullying, strained family supports, social determinants of health, access to care.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	ADHD: Stimulants best effect on impulsivity, aggression. Other anti-ADHD medications (atomoxetine, alpha2 agonists) help too but are less efficacious. Conduct Disorder: Higher level behavior management (may include special school, day hospital, or residential facility). Depression: 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious) in conjunction with fluoxetine with close monitoring. 2nd line: Escitalopram trial at mid-range dosing for 8+ weeks plus CBT. 3rd line: Trial of another SSRI or SNRI plus CBT. 4th line: SSRI augmented with another agent (e.g., bupropion, lamotrigine, lithium). DMDD: 1st line: Psychotherapy, 2nd line: SSRI/antidepressant. ID/ASD: Functional analysis, ABA, social skills, augmentative MDD or anxiety – CBT, IPT or DBT. Rule out/address changes in environment, physical discomfort like ear infections, etc. Assist with communication. ODD: Behavior/contingency management preferred to medications. PTSD: Trauma focused psychotherapy. Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.
Underlying diagnoses for which to consider antipsychotics first?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder.
General antipsychotic considerations:	Never consider antipsychotics if distress and impact are mild. For mod/severe aggression and irritability not addressed by a diagnosis specific treatment: 1st line: Therapy involving caregiver as part of the intervention for a minimum of 10-12 sessions. 2nd line: Some evidence of non-specific efficacy to consider prior to an antipsychotic: • Stimulants • Alpha 2 agonists • Mood stabilizers For more severe/persistent problems despite the above options, an antipsychotic is reasonable. When prescribed, done with concurrent psychosocial therapy and a plan for subsequent tapering off. Should be seen by a psychiatrist within 3 months.

EATING DISORDER	
Environmental factors to address first?	Address bullying, anxiety, or trauma.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Anxiety: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine). Mood disorder: CBT or DBT therapies. Mood disorder co-occurring with ODD: Contingency management and behavioral modification. Trauma, PTSD or bullying: Trauma focused therapy
General antipsychotic considerations:	Never prescribe an antipsychotic for binge eating or bulimia. There is no high quality evidence for the efficacy of antipsychotic in treating eating disorders. Most medications are ineffective with extreme starvation (<85% of ideal body weight). • Treatments entail close coordination with PCP, and necessary medical monitoring (e.g. labs, ECG, vitals). 1st line: Follow a Collaborative Care model (medical, nutrition, psychosocial) with Maudsley method therapy or other family-based therapy (10-12 weeks). • Consider benzos before meals to curb anxiety; cyproheptadine to stimulate appetite. 2nd line: Refer to a nutritionist or specialty center. For severe/persistent problems despite the above options, an antipsychotic is a reasonable last resort for anorexia only. When prescribed, done with concurrent psychosocial therapy and a plan for subsequent tapering off. Should be seen by a psychiatrist within 3 months.

INSOMNIA	
Environmental factors to address first?	• Consider lack of regular exercise, consuming a large meal before bedtime or caffeinated beverages, exciting or scary shows before bedtime, stimulating devices or activities before bedtime. Establish calming bedtime routine. • Identify triggers and treatments that were helpful in the past. • Confirm any family history of sleep disorder (disorders are highly heritable). • Remove TV, computer, cell phone, and other devices from the bedroom.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Consider frequency (e.g., 3 or more night per week) and if chronic or acute. Ages 1-5: Behavioral sleep interventions (e.g., child sleeps in his/her own bed with parents at first sleeping in the room, then gradually moving out and into their own). ADHD: Stimulants have best effect but can cause insomnia. May consider alpha-2 agonists instead or adjunctively. See also 1st and 2nd line treatments below. Anxiety: 1st line: 10-12 sessions CBT. 2nd line: 2 SSRI trials. 3rd line: SNRI (duloxetine). Depression: 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious) in conjunction with fluoxetine with close monitoring. 2nd line: Escitalopram trial at mid-range dosing for 8+ weeks plus CBT. 3rd line: Trial of another SSRI or SNRI plus CBT. 4th line: SSRI augmented with another agent (e.g., bupropion, lamotrigine, lithium). Sleep disorder (e.g. Sleep disordered breathing, RLS, stereotypic movements) Consider ENT assessment if there are signs or symptoms of obstructive sleep apnea (OSA) – snoring ≥ 3 nights/week, enlarged tonsils. For suspected seizures a sleep-deprived clinical electroencephalogram (SDEEG) and referral to pediatric neurology OCD: 1st line: CBT, including exposure response prevention. 2nd line: 2 trials of SSRIs at optimized dose, or 1 SSRI trial followed by clomipramine at optimized dose. Nightmares: 1st line: Trauma-focused CBT, EMDR. 2nd line: Consider alpha 2 agonist, or an alpha 1 antagonist, propranolol. Consider an antihistamine or trazodone. Mania and hypomania: Antipsychotic may be appropriate. See table for mania. PTSD, trauma or bullying: Trauma focused psychotherapy. Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.
Underlying diagnoses for which to consider AP 1st?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder.
General antipsychotic considerations:	Never prescribe an antipsychotic. There is no high quality evidence for antipsychotic use for sleep disorders. 1st Line: CBT for sleep and sleep hygiene. Consider CBTi app to improve access. 2nd line: Melatonin (3-4mg prn, bad nights) for initial insomnia or sleep phase delay. 3rd line: Sedating antihistamine or trazodone.

MANIA	
Environmental factors to address first?	Family history of bipolar disorder or of specific treatment response. Bullying.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Confirm diagnosis of mania using firm DSM-5 criteria (psychotic versus non-psychotic). Consider if the patient has a history of manic or hypomanic episodes. Determine if associated with inadequately treated underlying disorder. Treat co-morbid disorders (e.g., ADHD) after the mania is treated. Anxiety: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine). DMDD: 1st line: Behavioral modification or CBT as appropriate for age and circumstances. 2nd line: SSRI/antidepressant. Depression (unipolar): 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious) lithium ID/ASD: Functional analysis, ABA, social skills, augmentative MDD or anxiety – CBT, IPT or DBT. Rule out/address changes in environment, physical discomfort like ear infections, etc. Assist with communication. Medical or neurologic etiology: Refer to specialist for assessment. Narrow phenotype bipolar affective disorder in discrete episodes of five+ days with symptoms that include decreased need for sleep, psychotic/delusional thinking, grandiosity, racing thoughts, pressured speech, hyper sexuality and/or dangerousness. PTSD or trauma: Trauma focused psychotherapy. Sleep disorder: See guidance table for insomnia. Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.
Underlying diagnoses for which to consider antipsychotics first?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder. See the guidance table on mood lability / irritability / mood swings if unsure.
General antipsychotic considerations:	Confirm diagnosis before consideration of mood stabilizer or antipsychotic. If true mania, antipsychotics are appropriate. Should be seen by a child psychiatrist within 1-3 months of treatment initiation. Co-management with a psychiatrist is recommended for PCPs. 1st line (for confirmed diagnosis): Antipsychotic with goal of tapering to a maintenance dose after stabilization and intensifying psychosocial therapy. • There is some evidence that the efficacy of second generation antipsychotics may be greater than for lithium and valproate in pediatric mania. 2nd line: Antipsychotic concurrent with: • Mood stabilizers

MANIA	
	• Lithium (typically used in combination with another drug, but may consider monotherapy) • Appropriate anticonvulsants (usually in combination with an antipsychotic or with lithium) <u>Supplement medication(s) with</u>: • Higher level, supportive care and monitoring for acute phase. • CBT or IPT during depressive phases. • Psychoeducation for patient and family on illness along with addressing triggers and protective factors for prevention. • Sleep hygiene and social rhythm interventions.

MOOD LABILITY, IRRITABILITY, MOOD SWINGS (without MANIA)	
Environmental factors to address first?	• Ascertain home, school and community social stressors and evaluate deficits versus strengths and supports. • Consider care giver depression or mental illness. • Consider other support for stressed families (therapist for parent or sibling, or help address a family need). • Mitigate unsafe environments for ongoing trauma if present. • Review if antidepressants destabilize mood.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	ADHD: Stimulants best effect on impulsivity, aggression. Other anti-ADHD medications (atomoxetine, alpha2 agonists) help too but are less efficacious. Anxiety disorders: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine). ID/ASD: Functional analysis, ABA, social skills, augmentative MDD or anxiety – CBT, IPT or DBT. Rule out/address changes in environment, physical discomfort like ear infections, etc. Assist with communication. Consider low dose SSRI. Depression: 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious) in conjunction with fluoxetine with close monitoring. 2nd line: Escitalopram trial at mid-range dosing for 8+ weeks plus CBT. 3rd line: Trial of another SSRI or SNRI plus CBT. 4th line: SSRI augmented with another agent (e.g., bupropion, lamotrigine, lithium). DMDD: 1st line: Behavioral modification or CBT as appropriate for age and circumstances. 2nd line: SSRI/antidepressant. Mood disorders: CBT or DBT therapies. If CBT or DBT don't work, refer for psychiatric evaluation and re-evaluate diagnosis. ODD: Contingency management and behavioral modification preferred to medications. PTSD or trauma: Trauma focused psychotherapy. Sleep difficulties: 1st Line: CBT for sleep and sleep hygiene. 2nd line: Melatonin (3-4 mg prn on bad nights). 3rd line: Sedating antihistamine or trazodone. Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.
Underlying diagnoses for which to consider AP 1st?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder. If mania is present, see the mania table for guidance.
General antipsychotic considerations:	Antipsychotics are never recommended for mood swing or lability, or irritability. 1st line: 10-12 sessions of CBT DBT. If these therapies don't work, refer for psychiatric evaluation and re-evaluate diagnosis. If mania is present, see the mania table for guidance.

OBSESSION AND COMPULSION	
Environmental factors to address first?	• Identify particular triggers; consider how to modify these. • Determine if stimulants or other substances may be contributing.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Neurological etiology: Refer to a neurologist for assessment. Post-streptococcal: Consider with regard to onset of symptoms. OCD is the most common consideration. Rule in/out OCD along with comorbid diagnoses including: Anxiety: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine). ID/ASD: Functional analysis, ABA, social skills, augmentative MDD or anxiety – CBT, IPT or DBT. Rule out/address changes in environment, physical discomfort like ear infections, etc. Assist with communication. Consider low dose SSRI. Mood disorders: CBT or DBT therapies. If CBT or DBT don't work, refer for psychiatric evaluation and re-evaluate diagnosis. PTSD or trauma: Trauma focused psychotherapy. Tic disorders: 1st line: Habit reversal training (HRT), minimum of 10-12 sessions or weeks. 2nd line: Alpha agonist for 10-12 weeks.
Underlying diagnoses for which to consider antipsychotics first?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder.
General antipsychotic considerations:	Never consider an antipsychotic if distress and impact are mild. 1st line: CBT, including exposure response prevention. 2nd line (option 1): Two trials of SSRIs at optimized dose. Recommended SSRIs are fluoxetine, fluvoxamine, sertraline. 2nd line (option 2): One SSRI trial followed by clomipramine at optimized dose. For more severe/persistent obsession and/or compulsion despite the above options, an antipsychotic is reasonable. When prescribed, intensify concurrent psychosocial therapy and plan for subsequent tapering off. Should be seen by a psychiatrist within 3 months.

PSYCHOSIS	
Environmental factors to address first?	Trauma, substance use, stimulant therapy.

Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Considerations include age of onset, auditory or visual hallucinations, current medications, any history of traumatic brain injury (TBI) or seizures.
	
	Any significant degree of confirmed psychosis is a candidate for antipsychotic use.
	
	Define specific psychotic disorder. Rule out:
	
	• Severe anxiety (especially < age 12)
	• Anxious paranoia
	• Magical thinking
	• Borderline traits
	• Developmental age-appropriate phenomena
	  ○ Especially if low IQ, autism-spectrum disorder
	• Substance-induced psychosis
	• Psychosis secondary to medical condition
	• Psychosis secondary to stimulant therapy
	  ○ Stop stimulant if cognitive dysfunction was misdiagnosed as ADHD
	
	Anxiety: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine).
	
	ID/ASD: Functional analysis, ABA, social skills, augmentative MDD or anxiety – CBT, IPT or DBT. Rule out/address changes in environment, physical discomfort like ear infections, etc. Assist with communication. Consider low dose SSRI.
	
	Mania and hypomania: Antipsychotic may be appropriate. See table for mania.
	
	Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.

General antipsychotic considerations:	Consult with pediatric psychiatrist. **Antipsychotic treatment generally needed.** If strong confirmation of psychosis diagnosis, consider antipsychotic early to prevent further exacerbation. Consider baseline risk factors in selection of agent (metabolic, family history of diabetes). • Provide supportive therapy or adapted CBT to psychotic beliefs as adjunctive therapy.

SUBSTANCE MISUSE	
Environmental factors to address first?	Identify and address triggers, specific groups/friends enabling the behavior.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Consider the adequacy of previous substance abuse treatments attempted. Determine if used as coping mechanism for inadequately treated or unidentified disorder or if associated with other condition. Anxiety: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine). DMDD: 1st line: Behavioral modification or CBT as appropriate for age and circumstances. 2nd line: SSRI/antidepressant. Depression: 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious) in conjunction with fluoxetine with close monitoring. 2nd line: Escitalopram trial at mid-range dosing for 8+ weeks plus CBT. 3rd line: Trial of another SSRI or SNRI plus CBT. 4th line: SSRI augmented with another agent (e.g., bupropion, lamotrigine, lithium). Mania and hypo-mania: Antipsychotic may be appropriate. See table for mania. Mood disorders: CBT or DBT therapies. If CBT or DBT don't work, refer for psychiatric evaluation and re-evaluate diagnosis. PTSD or trauma: Trauma focused psychotherapy.
Underlying diagnoses for which to consider antipsychotics first?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder.
General antipsychotic considerations:	Never prescribe an antipsychotic to treat a substance use disorder. 1st line: Appropriate substance abuse treatment. • Consider augmentation with self-help groups, behavioral interventions, or motivational interviewing. There is no high quality evidence for antipsychotic medication use in substance use disorders.

SUICIDAL IDEATION	
Environmental factors to address first?	• Analyze environment to identify triggers and protective factors. • Conduct risk assessment and address safety (e.g., access to prescription medications, weapons and other lethal means).
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Consider any prior suicide attempts and if any prior treatment(s) helped or exacerbated the symptoms. Treat underlying disorder(s) of which suicidal ideation may be a manifestation. Anxiety: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine). DMDD: 1st line: Behavioral modification or CBT as appropriate for age and circumstances. 2nd line: SSRI/antidepressant. Depression: 1st line: 10-12 sessions CBT or IPT therapy (DBT if self-injurious) in conjunction with fluoxetine with close monitoring. 2nd line: Escitalopram trial at mid-range dosing for 8+ weeks plus CBT. 3rd line: Trial of another SSRI or SNRI plus CBT. 4th line: SSRI augmented with another agent (e.g., bupropion, lamotrigine, lithium). Mania and hypo-mania: Antipsychotic may be appropriate. See table for mania. Mood disorders: CBT or DBT therapies. If CBT or DBT don't work, refer for psychiatric evaluation and re-evaluate diagnosis. PTSD, trauma or bullying: Trauma focused psychotherapy. Sleep disorder: See guidance table for insomnia.
Underlying diagnoses for which to consider antipsychotics first?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder.
General antipsychotic considerations:	1st line: Cognitive-behavioral therapies (e.g., DBT), especially for chronic self-harm. Ensure adequate supervision. 2nd line: Higher level of care needed; establish a suicide contract. Never prescribe an antipsychotic unless suicidal ideation is associated with psychosis (e.g., auditory command hallucinations, paranoia), or severe treatment resistant depression (see table on depression). When prescribed, intensify concurrent psychosocial therapy and plan for subsequent tapering off. Should be seen by a psychiatrist.

TICS, TOURETTE'S SYNDROME	
Environmental factors to address first?	Address bullying or other possible sources of anxiety.
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Anxiety: 1st line: 10-12 sessions of CBT. 2nd line: 2 trials of an SSRI. 3rd line: SNRI (duloxetine). Complicated or comorbid: Refer to child psychiatrist for assessment/rule outs. Medication-induced: Determine if stimulants or other substances may be contributing. Consider atomoxetine or alpha agonist trials. Organic reasons: Refer to a neurologist for assessment/rule out. PTSD: Trauma focused therapy. Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.
General antipsychotic considerations:	Never consider an antipsychotic if distress and impact are mild or transient in nature. For moderate/severe tics not addressed by a diagnosis specific treatment: 1st line: Habit reversal training (HRT), minimum of 10-12 sessions or weeks. 2nd line: Alpha agonist for 10-12 weeks. If anxiety is present, an SSRI trial should also be considered or attempted before an antipsychotic. Consider an antipsychotic only after 1st and 2nd line treatment options fail. If an antipsychotic is prescribed, it should be done with the goal of tapering and intensifying psychosocial therapy.

VIOLENT IDEATION	
Environmental factors to address first?	• Identify and address triggers. • Ensure safety of others (access to weapons, etc.).
Any underlying diagnoses with preferred treatments before even considering an antipsychotic?	Consider the context for prior violent behaviors and if prior treatment helped or exacerbated the symptoms. ID/ASD: Functional analysis, ABA, social skills, augmentative MDD or anxiety – CBT, IPT or DBT. Rule out/address changes in environment, physical discomfort like ear infections, etc. Assist with communication. Consider low dose SSRI. Mania and hypo-mania: Antipsychotic may be appropriate. See table for mania. Mood disorders: CBT or DBT therapies. If CBT or DBT don't work, refer for psychiatric evaluation and re-evaluate diagnosis. ODD: Contingency management and behavioral modification preferred to medications. PTSD or trauma: Trauma focused psychotherapy. Substance use disorder: Appropriate substance abuse treatment, may be augmented by self-help groups, behavioral interventions, or motivational interviewing.
Underlying diagnoses for which to consider antipsychotics first?	Bipolar disorder (if ever had a history of true mania) or any psychotic disorder.
General antipsychotic considerations:	Never consider an antipsychotic if distress and impact/risk are mild and not associated with mania or psychosis. 1st line: A CBT intervention and referral to a child psychiatrist. • Refer to T-MAY Toolkit psychosocial intervention guidance: Family Collaboration Treatment Plan and Action Plans. • Ensure that adequate supervision is in place. • Assess if a higher level of care is needed. For more severe/persistent violent ideation despite the above options, an antipsychotic is reasonable. When prescribed, intensify concurrent psychosocial therapy and plan for subsequent tapering off. Should be seen by a psychiatrist.

National Expert Consensus Panel Members

- *Christoph Correll, MD*: Professor of Psychiatry, Hofstra Northwell School of Medicine, New York and Medical Director, Recognition and Prevention (RAP) program, Zucker Hillside Hospital, New York.
- *Stephen Crystal, MD*: Board of Governors Professor of Health Services Research at Rutgers University and Director, Center for Health Services Research and AHRQ Center for Education and Research on Mental Health Therapeutics (CERTs).
- *Marian F. Earls, MD, MTS, FAAP*: Director, Pediatric Programs for Community Care of North Carolina; Clinical Professor of Pediatrics, University of North Carolina Medical School and Medical Director, Neonatal Follow-up Clinic, Level III NICU at Women's Hospital, Greensboro.
- *Robert Hilt, MD*: Associate Professor of Psychiatry, University of Washington; Seattle Children's Hospital Program Director for both the Partnership Access Line and the Medicaid Psychiatric Medication Second Opinion Programs of Wyoming, Washington and Alaska, and MDT Consult Service in Wyoming.
- *Kelly Kelleher, MD*: Professor of Pediatrics, Psychiatry and Public Health, Colleges of Medicine and Public Health, The Ohio State University; Vice President, Community Health and Services Research, Nationwide Children's Hospital, and Center Director, Center for Innovation in Pediatric Practice, The Research Institute at Nationwide Children's Hospital, Columbus, Ohio.
- *Robert A. Kowatch, MD, PhD*: Professor of Psychiatry, The Ohio State University and Senior Psychiatrist at Nationwide Children's Hospital in Columbus, OH.
- *Larry S. Marx, MD*: Medical Director, Behavioral Health Support Services' Operations, Kaiser Permanente Washington [formerly Group Health Cooperative], Seattle, Washington.
- *Douglas Newton, MD, MPH*: Clinical Lead, Pediatric Behavioral Health at Kaiser Permanente Care Management Institute; Physician Lead, Behavioral Health with Kaiser Permanente Community Benefit; Regional Specialty Chief, Integrated Behavioral Health; and Department Value Advisor, Child Psychiatry at Kaiser Permanente Colorado.
- *Adelaide Robb, MD:* Professor, Child and Adolescent Psychiatry, George Washington University and Psychopharmacologist, Psychology and Behavioral Health Departments, Children's National Health System, Washington D.C.
- *Kelly Rogalski, MD*: Senior Pediatric Psychiatrist and Medical Director, Outpatient Pediatric Psychiatry, Henry Ford Health System, Detroit, Michigan.
- *Benedetto Vitiello, MD*: Adjunct Professor of Psychiatry, Johns Hopkins University, Baltimore, Maryland and Chief, Treatment and Preventive Intervention Research Branch, National Institute of Mental Health, Bethesda, Maryland.