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Common Issues for General Practitioners in the Medical Management of Child and Adolescent Psychiatric Care

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With a limited number of child and adolescent psychiatrists available to see youth patients, many common psychiatric problems in youth are managed by other providers. Clinical pearls from experts in child and adolescent psychiatry can help general practitioners with this management. Some common issues are discussed here for which practical guidance is offered, ranging from approaches to assessment and how to start and titrate medications for the treatment of attention deficit hyperactivity disorder, depression, and sleep problems.

ABBREVIATIONS AACAP, American Academy of Child and Adolescent Psychiatry; ADHD, attention deficit hyperactivity disorder; BMI, body mass index; DMDD, Disruptive Mood Dysregulation Disorder; GAD, generalized anxiety disorder; MTA, Multimodal Treatment of Attention Deficit Hyperactivity Disorder; OCD, obsessive-compulsive disorder; ODD, oppositional defiant disorder; SNRI, Serotonin and Norepinephrine Reuptake Inhibitor; SSRI, Selective Serotonin Reuptake Inhibitor

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Introduction

The United States and many other countries face a critical shortage of child and adolescent psychiatrists.[1] General providers in the community including pediatric, family medicine, and pharmacist practitioners play an important role in providing mental health care to children and adolescents, particularly when established, trusting relationships already exist between young patients and these community providers. However, such care can be complex; some clinical pearls that child and adolescent psychiatrists gain from their more specialized practice can be utilized by all who treat youth with psychiatric needs. The aim of this article is to provide an overview of a few such high yield clinical pearls that address some but certainly not all issues for children's mental health. First, pitfalls of general diagnosis and initiating medication treatment are addressed. Next, some ideas are offered around common issues that arise in the treatment of attention deficit hyperactivity disorder (ADHD) and depression. Lastly, specific guidance is given on topics of avoiding benzodiazepine prescription, using laboratory monitoring with some prescriptions, and addressing the common complaint of sleep disturbance in the setting of psychiatric problems.

Some Disorders of Childhood Are Misdiagnosed Relatively Often. Providers sometimes find it difficult to detect childhood disorders that have more internalizing features in part because children have less awareness of and ability to report their emotional states.[2] In particular, generalized anxiety disorder (GAD) and obsessive-compulsive disorder (OCD) can be misdiagnosed, especially in younger children in whom symptoms are not as discrete. However, in our experience performing second opinion evaluations, externalizing behavioral disorders can also be misdiagnosed, sometimes as bipolar disorder, particularly when they are difficult to treat.

Generalized anxiety disorder in children has similar features as that in adults, with both thought patterns and physical symptoms that are manifestations of a generally high anxiety state; though diagnostic criteria do not require the same level of impairment in Criteria C of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)—that is, only need 1 of 6 symptoms as opposed to 3 of 6 for adults.[3] It is common for children with significant anxiety to be misdiagnosed with depression and ADHD, in part because both are common disorders. In such cases, the topic of worries may be negative ideas resembling depressed thoughts, a focus on worries can appear to be poor attention and distractibility, and anxious movements can appear to be hyperactivity or psychomotor agitation. Anxiety may also lead to very severe dysphoria and even suicidal ideation when these feelings are intolerable,[4] at times leading to a diagnosis not of anxiety but of major depression because suicidal thoughts are one of depression's cardinal symptoms. Depression and anxiety can be comorbid and treatment approaches

similar (psychotherapy and Selective Serotonin Reuptake Inhibitor [SSRI] medication). However, tracking of symptoms differs between the 2 diagnoses, making an accurate diagnosis important.

Obsessive-compulsive disorder is a more common disorder than typically appreciated (0.5–2% in children) characterized by recurrent and intrusive thoughts and/or compulsions that are targeted at reducing those thoughts.[5] It is misdiagnosed more often in children because of a relative inability for children to spontaneously elaborate on the thought processes related to obsessions and compulsions. Children with OCD may be diagnosed with disruptive behavior disorder because there may be a high degree of inflexibility and subsequent behaviors that may occur due to the drive they have to perform compulsions. A focus of some children with OCD on people being harmed or dying also may resemble homicidal or suicidal ideation and make diagnosis challenging. At times, children are given the diagnosis of a psychotic disorder because the obsessions and compulsions are so ego-dystonic that they may be described by a child as "voices" or command hallucinations dictating what the child should do.

Lastly, several disorders of childhood that affect children severely and have a mood component are misdiagnosed as bipolar disorder which is in fact a rare disorder in children, particularly pre-pubertally (<1%).[6] Disruptive Mood Dysregulation Disorder (DMDD), ADHD, oppositional defiant disorder (ODD), GAD, and OCD can all dramatically affect a child's mood and emotional regulation; while some children with these problems present with more mild symptoms, very severe mood shifts can occur in any of these disorders. Some high yield factors to consider in distinguishing bipolar disorder from these other conditions is that symptoms should be "uncharacteristic of the individual" and that chronic irritability is not sufficient for the diagnosis. The rapidity with which mood shifts occur is also an important component–typically less than 4 times a year in bipolar disorder but with much greater frequency–even up to multiple times a day–in many other conditions.[7]

For Medication, a Good Rule of Thumb Is "Start Low and Go Slow." When treating children and adolescents with medication for psychiatric conditions one should account for the possibility that youth and their parents may have preconceptions about both the therapeutic effects and side effects that medications may cause. In our clinical experience with many young people and their parents, a sudden feeling of being "different" from how they previously were, even if symptoms were disabling, is not a wholly welcome one. Not only may this result in failure of the current treatment due to less willingness of the youth to take it, but it may also undermine the therapeutic alliance between the provider and the patient or family, reducing the success of any subsequent treatment. In addition, children with developmental disorders which are commonly comorbid with other psychiatric conditions have been documented to have a higher sensitivity to many psychiatric medications.[8] Starting medications at higher doses or rapid upward titration of medication over a few days to reach an effective dose more quickly should be avoided.

A couple of examples may be illustrative of the issues noted above. In the case of initiating treatment for ADHD, stimulant medications of either class (methylphenidate-based or dextroamphetamine based) are first line for most children 6 and over and are often safe to use with rapid changes in dose and even consecutive days on and off treatment.[9] However, when a stimulant medication is initiated at a higher, even effective dose, or increased in dose substantially from one day to the next, a youth may feel like their personality is suddenly less appealing or their parent may observe that they seem like a "zombie." This response is obviously concerning even if it reflects that the youth may be experiencing improvements in attention and/or reductions in impulsivity/hyperactivity. Treatment is often more successful with a low initial dose, such as 10 to 20 mg daily of methylphenidate for a 12-year-old child of average size, followed by an increase after 1 to 2 weeks to a dose twice that amount if the starting dose was tolerated and symptoms were partially addressed. In addition, adverse effects by titrating the medication too quickly can potentially result in distrust by caregivers and patients, therefore potentially leading to ruptures in caregiver, patient, and provider relationships.

Treatment with alpha-agonist medications for United States Food and Drug Administration (FDA)-approved use in ADHD and tic disorders and off-label use for sleep disturbance and post-traumatic stress disorder (PTSD) should also be started at low doses because of the range of unpleasant and dangerous side effects they may induce.[10] A dose such as 1.0 mg for guanfacine extended-release and 0.05 to 1 mg for clonidine extended-release in children ages six and up given once at bedtime due to potential sedation can be initiated. Dose can be increased in increments of 1 mg or 0.05 to 0.1 mg respectively and/or dosed multiple times a day over weeks/months to maximal doses of 4 to 7 mg/day and 0.3 to 0.4 mg/day respectively only if tolerated and effective. Potentially serious side effects of hypotension and orthostatic tachycardia may result from doses that are too high or too quickly titrated. Unpleasant and non-therapeutic side effects such as sedation, nausea, or constipation may also be less problematic if dosing starts low and upward titration is slow.

It is important to set realistic expectations with youth and families that medication is only one part of successfully addressing problems and that benefits may take time to be fully realized, particularly with a "start low and go slow" approach. Some practical tips for addressing this are to elicit all patient or family member concerns and "worst fears" while having an informed

consent discussion, have a patient or family member repeat back to you how a medication is expected to help them and their "biggest hopes," validate mixed feelings about and praise efforts to make change, and plan a time/appointment soon after starting a new medication to check in on progress.

Utilize Recommended First- and Second-Line Medications Initially in Treatment of Children. In addition to ensuring that starting doses of indicated psychotropic medications are tolerable and allow the patient to acclimatize to related neurophysiological changes, it is also imperative to prioritize first-line medications over others that come later in various clinical treatment algorithms and guidelines.[11–13] This includes either stimulant class for ADHD in children over 6 and any SSRI alongside psychotherapy for moderate to severe depression or anxiety. There are many reasons why individuals end up having trials with second-line medications instead of first-line medications in context of psychiatric treatment. For select individuals, these may be reasonable and appropriate, based on specific attributes of the patient in question, and effective. For example, with depression, appropriate alternative first choice medications may include mirtazapine for youth who are underweight or bupropion for youth with co-occurring ADHD.[11] However, for most youth, such second- or third-line treatments are not appropriate as a first step and may lead to both inadequate treatment of symptoms and unnecessary risk of side effects.

As with most areas of medicine it is critically important to obtain a good history, including collateral information from caregivers/teachers, to first arrive at an accurate diagnosis which can then guide treatment. In the psychiatric evaluation there can be overlap of individual symptoms which may lead to selection of a non-first line medication for the patient's diagnosis. For example, a child may be aggressive but further symptomatology or collateral may not be sought to speak towards a specific diagnosis; a provider may choose to target "aggression" as a symptom and utilize an atypical antipsychotic targeting the symptom of aggression before a first-line medication for other diagnoses. Aggression is frequently part of a cluster of outcomes which may occur due to a diagnosis of ADHD, anxiety or other conditions. It is also possible that ADHD or another diagnosis could be comorbid with ODD or disruptive behaviors. A failure to obtain collateral or make an accurate diagnosis may lead to the first-line medication not being utilized.

It is also possible that in some care settings, particularly in context of disparities in the availability of mental health care providers or child mental health care training, that individual providers giving care may be less familiar with treatment algorithms or general expert recommendations. Some providers may also be influenced by the strategies that their peers are utilizing, which can lead to practice patterns not necessarily rooted in the evidence-base and best practice guidelines. The American Academy of Child and Adolescent Psychiatry (AACAP) and American Academy of Pediatrics publish practice parameters and practice guidelines (https://www.aacap.org/aacap/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx and https://www.aap.org/en/patient-care/) which are good resources for understanding the evidence-base and current first-line treatment practices for common child psychiatric diagnoses.[12]

Undertreatment and Overtreatment of ADHD Is Common and Easily Addressable. Attention deficit hyperactivity disorder is one of the most common childhood psychiatric disorders encountered in practice. Under and over-treatment of ADHD can be seen in many clinical settings. Appropriate identification and referral of children for attention, hyperactivity, and impulsivity issues is the first step for minimizing or reducing the under-treatment of ADHD due to it not being recognized in an individual child with impairments. It is important to work with educators and parents regarding identifying children with ADHD symptoms. At the level of the provider, it remains important to adequately screen and take appropriate history, including obtaining supplemental information from school, to clarify whether ADHD is affecting the individual child.

In regard to treatment for confirmed ADHD, stimulant medications remain the gold standard, first-line treatment.[13] Based on package insert and prescribing recommendations, as discussed above, generally it is the practice of providers to start at a low dose, especially in treatment-naïve children. Typically, titration to higher doses is required to effectively treat ADHD symptoms. Failure to further titrate the stimulant can be a way in which undertreatment occurs. There are several strategies that may be complementary in the context of "starting low and going slow," as well as utilizing data and prior studies that have defined a typical dosing range based on weight. The AACAP practice parameter for the assessment and treatment of children and adolescents with ADHD is one such source.[13] Generally speaking, the goal is to use the lowest effective dose. It is also possible that some individuals are more sensitive to side effects and are not able to have treatment titrated to a dose that is efficacious for their symptoms without having significant side effects affecting appetite, sleep, and growth. This may lead a provider to next recommend a different stimulant and, if multiple stimulant trials are not tolerated, to appropriately utilize a non-stimulant strategy.

Prior studies have indicated that dosing strategies in the real-world population tends to differ from that in a research setting. A paper by Olfson et al[14] examined dosing in a database of pharmacy and clinical claims and showed that individuals tended to be on lower daily doses of methylphenidate than those used in the

Multimodal Treatment of Attention Deficit Hyperactivity Disorder (MTA) study (30.5 mg daily). They also noted that initial dose was a predictor of final dose over the period they examined. Though most individuals did have their dose titrated, there was a substantial minority that did not advance past the initial prescribed dose (mean of 11.2–23.8 mg daily depending on formulation), perhaps due to lack of follow-up which can be a major contributor to undertreatment. These facts could contribute to decreased or differing efficacy in community treatment compared to individuals in research settings.

Beyond initial dosing and titration strategies it is also very important to continue to obtain supplementary information during the titration process to assess benefits and guide further treatment. This information would include feedback and ratings scales from parents and teachers. It is also important to take into consideration comorbid diagnoses and treatment of these symptoms. In some individuals there may be comorbidities not addressed by a stimulant that affect the perceived effectiveness of ADHD treatment. This may at times lead to continued titration of a stimulant into a higher dosing range without subsequent benefit. Such comorbidities include anxiety, depression, disruptive behavior disorders, and other childhood psychiatric illnesses.

As well as looking at individual medications, initial dosing strategies, and titration, it is also important to consider that though the mechanism of different stimulant medications and their possible side effects are similar, an individual patient may tolerate and derive benefit from one stimulant while not tolerating another. To adequately treat ADHD symptoms, it may be necessary to sequentially trial multiple medications to come to a treatment that is tolerated from a side effect profile and adequately treats the ADHD symptomology. For example, a hypothetical child may first have no benefit from short-acting mixed amphetamine salt at initial or titrated dose, then experience benefit but appetite suppression with a short-acting methylphenidate, leading to successful, tolerated treatment with extended-release methylphenidate.

Ensure That Adequate Trials of Antidepressants Are Utilized. Depression and anxiety are other commonly encountered illnesses in child and adolescent psychiatry. Psychotherapy is usually recommended as first-line for mild symptoms, and it is worth noting that therapy in combination with medications offers superior results than therapy alone (Treatment for Adolescents with Depression Study).[15] Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs) are effective and mostly well-tolerated medications for pediatric anxiety and depression. Studies indicate that only about 60% of youth respond to an initial complete trial of such medications,[15] suggesting that many may need additional trials of an alternative medication as the next step or therapeutic combinations of medications. It is well-known that SSRIs and SNRIs take about 6 to 8 weeks to show maximum benefit; though side effects usually appear in the first week and some partial benefits may be seen around 4 to 6 weeks. In addition, upward titration after starting doses (e.g., sertraline 25 mg daily, fluoxetine 10 mg daily) to doses which typically show more benefit (sertraline 150 mg, fluoxetine 40 mg daily) is often necessary. A common pitfall is to discontinue a medication before the time that it needs to show an effect because benefits are not seen in the earlier weeks while self-limited side effects are experienced. Such medications are then incorrectly labeled as failed trials. A compilation of incorrectly conceptualized and documented "failed trials" can lead to the misdiagnosis of "treatment-resistant" depression.

A related potential treatment decision is determining when it is advisable to augment an antidepressant rather than change to a different medication. If partial benefits are seen, and the medication is well-tolerated at an optimized dose, augmentation with medications for anxiety, such as buspirone, or for depression, such as bupropion, should be considered.[16]

Limit Antidepressant Medication Treatment Timeframes in Youth Treated for First Time Depression, When Possible. Research from multiple studies and databases has shown that antidepressants can significantly reduce suicidal ideation, suicide attempts, and depressive symptoms in young people. When evaluating for treatment of depression, providers should carefully weigh the risks of potential harm due to depression versus the risks of starting a medication and then join with the family to come to a decision about starting a medication.[17]

Often there is some response and patients show clinical improvement with a medication trial. An important question then becomes—how long should children stay on the medication if they are doing well? Studies indicate that the median duration of a depressive episode for children ranges from 1 to 8 months in various samples and that there is a high probability of recurrence, up to 20% to 60% by 1 to 2 years after remission.[11] Given the benefits of treating depression and the high relapse rate, treatment with an antidepressant should be continued for 6 to 12 months for all patients who have responded to acute treatment so as to maximize and maintain benefits and reduce chance of relapse. In clinical practice, this means that once the patient has a significant reduction in depressive symptoms, the clock for continuing the antidepressant starts, and treatment should be monitored for 6 to 12 months. At the 6- to 12-month point, if the child/adolescent has remained asymptomatic, it may be time to consider tapering off the medication.[11] Ultimately, there are no significant treatment studies to guide providers on which cases to continue treatment in after the 6- to 12-month period. This again becomes a clinical decision for the provider to make along with the family. Factors to be considered

with regards to tapering off medication include treatment of comorbid conditions, severity of illness, environmental stressors, and adherence to treatment. For example, if a child has a severe comorbid anxiety and a current conflictual family situation, then the pros and cons should be weighed again on whether medication should be tapered off; while depression may have been alleviated, given the other factors, it may be best to continue the child on the medication.

Two other significant factors that may indicate a necessity for longer treatment for depression are how long it takes a patient to recover and a higher number of recurrences. For example, a patient who has only had one depressive episode, was able to obtain asymptomatic status on medication, and is otherwise doing well would be a very good candidate to taper off an antidepressant in 6 to 12 months. However, a patient who has had multiple severe depressions may benefit from staying on medication longer.[11] This approach is similar for youth with anxiety disorders in whom discontinuation can be attempted after 12 months. However, anxiety symptoms are more likely to be chronic, and patients may benefit from continuing medication.[18]

Avoid the Use of Hypnotics Such As Benzodiazepines in Youth Unless for Short Term Treatment of Anxiety. The general impression among many practitioners when benzodiazepines first became available is their capacity as a novel form of anxiety treatment. Since then, they have been commonly prescribed to adults and have amassed a significant amount of research indicating significant pros and cons, much of which is still ongoing. Benzodiazepine treatment for children and adolescents however lacks the controlled studies seen with adults, and so it can be complicated knowing when benzodiazepine treatment is an option in this age group.

When treating psychiatric disorders in children and adolescents, benzodiazepines should be used very sparingly, limited to short term treatment for intense, impairing anxiety and/or in the context of panic attacks/panic disorder.[18] Benzodiazepines can easily foster dependence and withdrawal, making it hard to discontinue them. There are numerous potential side effects. Common side effects include clumsiness, drowsiness, dry mouth, dizziness, and abdominal pain. Serious side effects include dependence, withdrawal, disinhibition, memory impairment, and worsening depression. The most dangerous side effect, though fortunately rare, is respiratory depression.[19] There are significant risks of withdrawal associated with rapid discontinuation, including seizures and death. Due to the concern for potential serious adverse events, other medications should be trialed prior to initiating treatment with a hypnotic.

There Are Common Treatments for Which Laboratory Testing and Other Specific Monitoring Is Necessary. Many psychotropic medications have potential side effects or a therapeutic window which necessitate close monitoring of physical and laboratory parameters.[18] Common examples include stimulants for ADHD and antipsychotics for indications such as aggression, mood stabilization, and augmentation of antidepressant medications. Some examples of monitoring recommendations are presented in the Table.

Table 1. Monitoring Recommendations for Psychotropic Medications

Medication Class	Monitoring Recommendations
Stimulants[13]	Baseline: personal and family cardiac and seizure history, weight, height, blood pressure and heart rate Ongoing: weight, height, blood pressure and heart rate
Atypical antipsychotics[20,21]	Baseline: Fasting lipid panel, hemoglobin A1c (or fasting glucose), waist circumference, weight, BMI 3 months and annually thereafter if normal: Fasting lipid panel, hemoglobin A1c (or fasting glucose). Ongoing: waist circumference, weight or BMI N.B. Thyroid function tests are indicated at baseline and every 6 months for quetiapine. Prolactin concentration is indicated for certain atypical antipsychotics such as risperidone if relevant endocrinologic symptomatology is encountered. EKG monitoring guidelines can be found here.[23] Monitoring use of clozapine can be found here.[24]
Lithium[25]	Baseline: Complete blood count, thyroid function tests, urinalysis, blood urea nitrogen, creatinine, serum calcium concentrations, pregnancy test Every 3–6 months once on stable lithium dose: serum lithium concentration, renal and thyroid function, urinalysis.
Valproate[25]	Baseline: Liver function tests, complete blood cell count, pregnancy test Every 3–6 months: serum drug concentration, hepatic and hematological indices

BMI, body mass index; EKG, electrocardiogram

Sleep Disturbances Should Be Treated With Medications Only After Behavioral Interventions Have Been Utilized and Sleep Hygiene Optimized. Between 25% to 40% of children struggle with sleep difficulties.[26] Children with mood, anxiety, and behavioral disorders have more resistance to bedtime and struggles falling asleep. Often the origins of the sleep difficulties are related to poor sleep practices and lack of bedtime structure. Having a bedtime routine, defined as "the predictable activities that occur in the hour before lights out and before the child falls asleep," has been shown to lead to positive outcomes with better cognitive development, socio-emotional functioning, behavioral functioning, and improved maternal mood and marital satisfaction. Sleep routines include cues that are only associated with sleep—lying in bed (when only used for sleep), white noise, and darkness. Essential oils and weighted blankets can be considered sleep associations if limited only to the bedtime routine. Setting time limits on internet use, shutting off the internet, or having set times for turning in electronics to parents can help facilitate better sleep hygiene, with no use 30 minutes before bedtime as a common recommendation.[26,27]

New routines typically take three weeks to solidify into habits. Parents should expect resistance to change initially. Children and adolescents are rarely motivated for these changes. Adolescents can understand the benefits to sleep but the power of social media and fear of missing out socially can overwhelm their resolve to change. For younger kids, the "excuse me" drill by Dr Brett Kuhn which gradually introduces parental separation can be quite helpful for kids pushing parents to be present while they fall asleep.[28] This also tends to reduce night waking when kids learn to fall asleep on their own. "Bedtime passes," limiting the number of times children leave their bed, tend to be effective for children resistant to staying in their room at bedtime. Cognitive behavior therapy for insomnia can be a useful as an intervention for motivated children.[29,30] Bedtime complaints of hunger and night waking in children with ADHD can be related to reduced daytime food intake if treated with stimulants, with bedtime snacks being an intervention to reduce these behaviors.[31]

Other medical and psychiatric disorders may also contribute to sleep problems. Snoring can be related to obstructive sleep apnea and often warrants further evaluation. Obstructive sleep apnea has been increasing in prevalence related to increasing rates of obesity. Unfortunately, poor sleep furthers hunger and increases in ghrelin which further drive obesity.[32,33] Insomnia is also one of the most common complaints with depression and anxiety. Effective treatment, often with therapy and/or SSRI medication, may improve sleep difficulties in these cases.[34] Utilizing a sleep aid while starting an SSRI or other treatment can be helpful and should be time limited, (i.e., indication or need should be monitored and a trial off the sleep aid be conducted to understand if there is ongoing need).[35]

When sleep hygiene has been maximized for at least a month and if sleep difficulties are still causing functional day time impairments, medical intervention may be warranted.[36] Melatonin can help promote sleep initiation starting at small doses of melatonin 0.5 mg and titrating up, no greater than 9 mg, taken 30 to 45 minutes before bed.[37] For children with delayed sleep phase, taking melatonin 0.5 mg at dinner time can help drive their sleep time earlier in the evening.[38] Low doses of anti-histamine medication like diphenhydramine can be used intermittently to help with sleep initiation and maintenance, typically dosed based on weight, up to 50 mg maximum. There is a risk of activation with diphenhydramine in younger children and children with developmental delays. Antihistamine medications can also have unpleasant side effects with dry mouth, headache, and daytime sedation. Trazodone (25–50 mg) is often used as a sleep aid for its anti-histaminergic, sedating effects with added risk of priapism in males. There are no studies for use of trazodone in children. Clonidine is often used in children with ADHD.[39] Clonidine is sedating and only lasts about 8 hours, which can be helpful with less morning sedation but problematic if there is night waking. Educating parents on the limits of sleep medication is critical. There is limited evidence for daily use or long-term use. Sedative hypnotics should be avoided in children due to side effects and higher risk of psychological dependence on sleep medication with age. Medications will be most effective when combined with the right bedtime routine. An unstructured bedtime routine can easily negate the typically mild sedating effects of medication.

Conclusion

Many different practitioners have relationships with youth and families that can benefit care of child and adolescent psychiatric disorders. The rapport between general, community practitioners and youth they know well can be the cornerstone upon which nuanced treatment is built. This is particularly true when symptoms of different disorders mimic each other and when thoughtful changes in treatment require guidance, adjustment, and monitoring over time. How to address these problems and how to select the appropriate medications and doses may require the expertise of child and adolescent psychiatrists. From their targeted training and extensive experience, they can offer tips to general practitioners through reviews such as this one or through consultation programs. Such access consultation programs are being developed throughout the United States to offer guidance and can expand access when general practitioners utilize them. These programs may allow for youth to continue care in the general, community setting with practitioners who know them best and may provide for more youth mental health needs to be met.[40]

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