Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

Algorithm E

Disruptive Behavior and Aggression

E.1.

Child presents with any of the following concerns :

- Marked tantrums, rages and/or hostility.
- Persistent, excessive bullying (physical, verbal, or cyber).
- Persistent aggressive ideation, threats and/or behaviors (outside of child's development level, norms of peer group, and cultural context that indicate a disorder rather than a phase).

E.2.

Is the patient an immediate danger to self or others?

YES →

E.3.

Refer for emergency evaluation.

NO ↓

E.4. EVALUATE

PATIENT/FAMILY INTERVIEW

- History of symptoms:
  - Duration, severity, frequency
  - Circumstances of occurrence
- Mental health and educational history.
- History of self injurious and/or suicidal behavior.
- History of aggressive, violent or criminal behavior.
- History of alcohol or drug abuse.
- Adverse childhood experiences or trauma.
- Family history of psychiatric disorders (e.g., ODD/CD, psychosis, mood disorder).
- Family history, structure, functioning, social interaction.
- Peer relations, social skills.
- School performance and functioning.

PHYSICAL/DEVELOPMENTAL ASSESSMENT

- Perinatal, medical, and developmental histories.
- Physical illness including medically unexplained physical symptoms.
- Laboratory and/or directed physical examination if warranted by medical history.
- Current medications that may contribute to aggression (e.g., steroids).

E.5.
Has patient been previously treated?

YES

E.6.

1. Reconsider original diagnosis and target symptoms.
2. Consider conditions that might impact care (e.g., medical, environmental).
3. Reevaluate existing treatment plan.
4. Evaluate existing medication dosages for optimization and/or consider adding a medication for a particular target symptom.
5. Consider initiating or intensifying non-pharmacological treatments (e.g., psychosocial).
6. Consider diagnosis/conditions in E.7.

E.8.

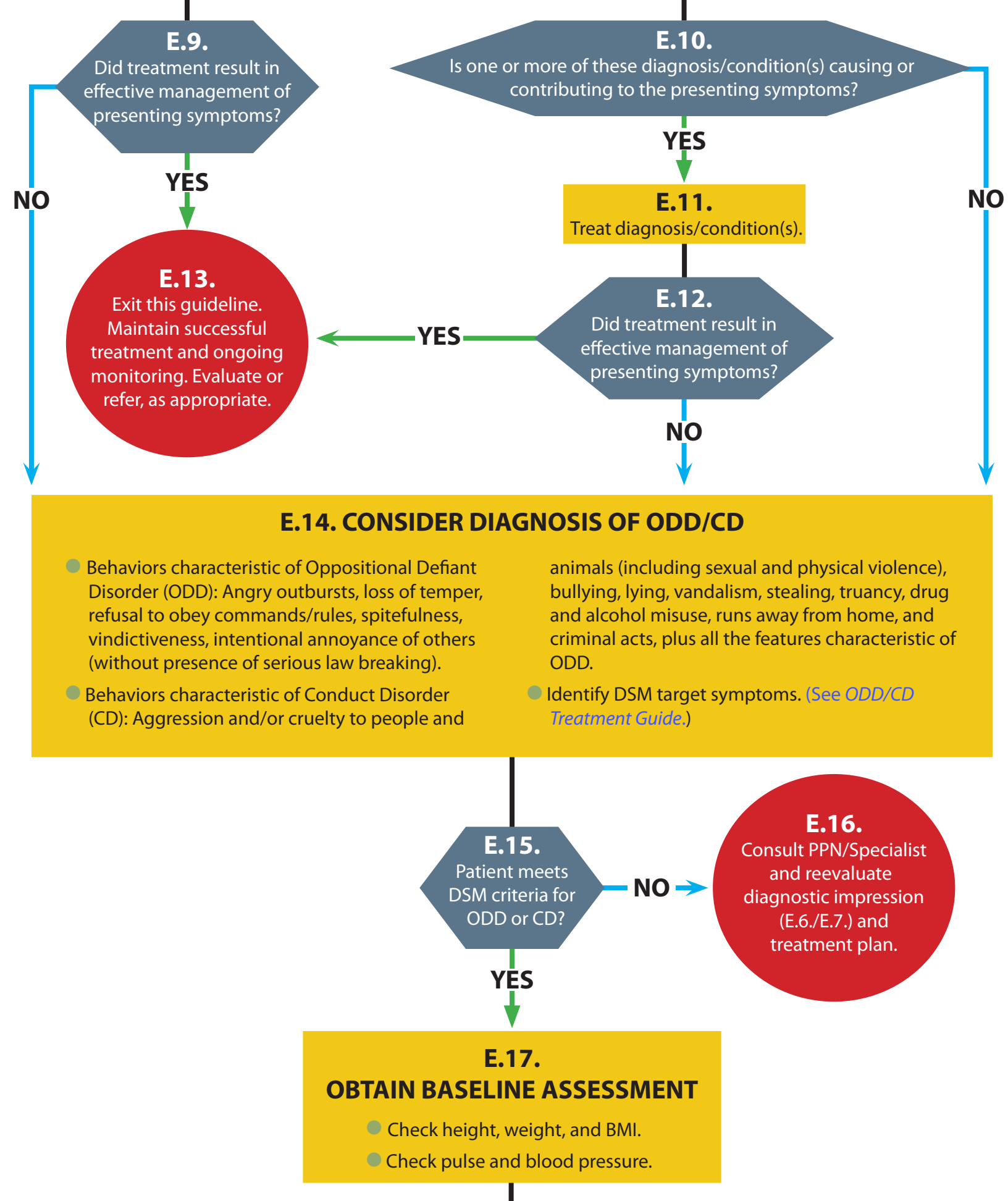
- Adjust treatment based on above considerations.

NO

E.7.

Consider diagnosis/conditions that may be causing presenting symptoms:

- Undiagnosed psychiatric disorders such as:
  - ADHD (see tool kit section: *Inattention, Hyperactivity, Impulsivity*)
  - Mood Disorders especially if persistently irritable outside of presenting outbursts(see tool kit: section *Moodiness & Irritability*)
  - Anxiety, PTSD, Psychosis
  - Intermittent Explosive Disorder
- General medical conditions (e.g., traumatic brain injury, toxins).
- Developmental disorders (e.g., learning disorders, autism spectrum disorders, intellectual disability).
- Substance Abuse.
- Sleep deprivation/disorders.
- Home environment including Adverse Childhood experiences (ACE), trauma or bereavement.
- Specific environmental or social triggers, consider the following:
  - Psychosocial stresses (especially abuse, separation, divorce, or death of key attachment figures)
  - Educational potential, disabilities, achievement
  - Peer, sibling, and family problems/strengths
  - Environmental factors (disorganized home, lack of supervision, child abuse, psychiatric illness and/or substance abuse in parents, and environmental neurotoxins)
  - Developmental level and ability to form and maintain relationships


E.9.
Did treatment result in effective management of presenting symptoms?
YES
NO
E.10.
Is one or more of these diagnosis/condition(s) causing or contributing to the presenting symptoms?
YES
NO
E.11.
Treat diagnosis/condition(s).
E.12.
Did treatment result in effective management of presenting symptoms?
YES
NO
E.13.
Exit this guideline. Maintain successful treatment and ongoing monitoring. Evaluate or refer, as appropriate.
E.14. CONSIDER DIAGNOSIS OF ODD/CD
Behaviors characteristic of Oppositional Defiant Disorder (ODD): Angry outbursts, loss of temper, refusal to obey commands/rules, spitefulness, vindictiveness, intentional annoyance of others (without presence of serious law breaking).
Behaviors characteristic of Conduct Disorder (CD): Aggression and/or cruelty to people and animals (including sexual and physical violence), bullying, lying, vandalism, stealing, truancy, drug and alcohol misuse, runs away from home, and criminal acts, plus all the features characteristic of ODD.
Identify DSM target symptoms. (See ODD/CD Treatment Guide.)
E.15.
Patient meets DSM criteria for ODD or CD?
NO
E.16.
Consult PPN/Specialist and reevaluate diagnostic impression (E.6./E.7.) and treatment plan.
YES
E.17.
OBTAIN BASELINE ASSESSMENT
Check height, weight, and BMI.
Check pulse and blood pressure.

E.18. CONSUMER/PARENT ENGAGEMENT AND CONSENT

- Engage parents using interactive strategies such as motivational interviewing to achieve informed consent on ODD/CD treatment, including inpatient & outpatient options, evidence-based therapies, school interventions and/or medication.
- See *Shared Decision-Making Process.*

E.19. SELECT TREATMENT REGIMEN(S)

The treatment of ODD, not unlike the treatment of CD, should be multi-target, multi-modal, and extensive, often combining individual psychotherapy, family psychotherapy, pharmacotherapy, and ecological interventions (including placement and school-based interventions), especially when severe and persistent.

OPTION: EVIDENCED-BASED THERAPIES

- Parent-Management Training Programs and Family Therapy have been shown to be some of the most effective strategies for ODD.
- In addition, long term individual psychotherapy and social skills training are often used to manage ODD/CD.

OPTION: MEDICATION

- Medication alone has not been proven effective in treating ODD/CD. Medication may be a useful part of a comprehensive treatment plan to help control specific behaviors and to treat coexisting conditions such as ADHD, anxiety, and mood disorders (see E.7.).

OPTION: SCHOOL INTERVENTIONS

- Early intervention social skills and school based programs have been shown to prevent ODD in very young children and be part of an effective treatment plan for most children.

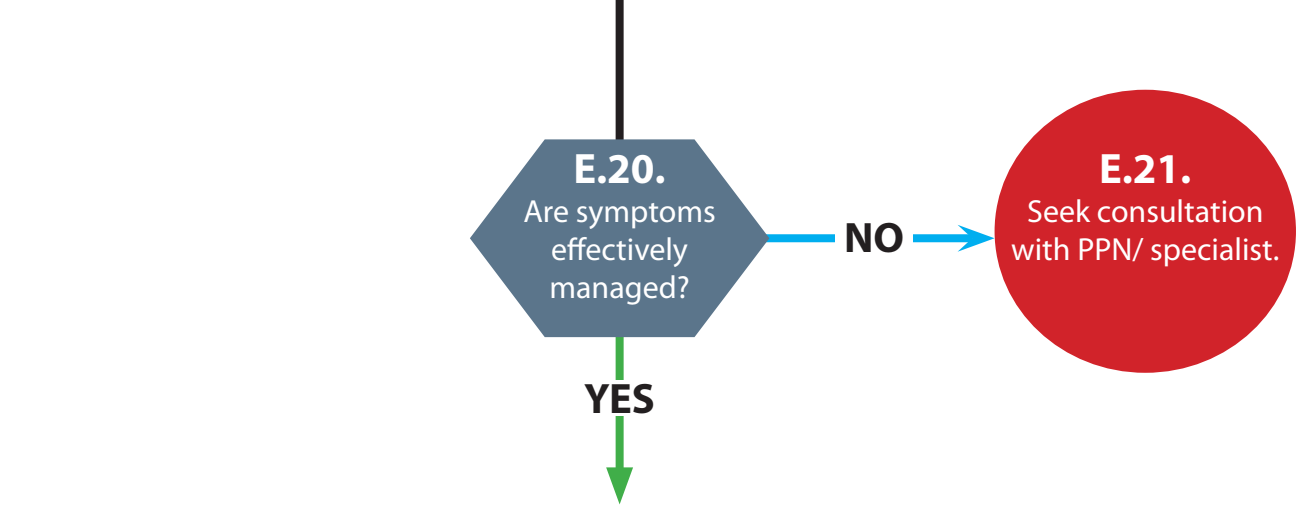
OPTION: DETERMINE LEVEL CARE

- See *Modified Overt Aggression Scale.*
- If patient is in child protective services, foster care system or on probation, involve case manager or officer.
- Refer to behavioral health provider for:
  - Day programs or in home wraparound services
  - In-patient or residential treatment

OPTION: OPTIMIZE TREATMENT OF COEXISTING CONDITIONS

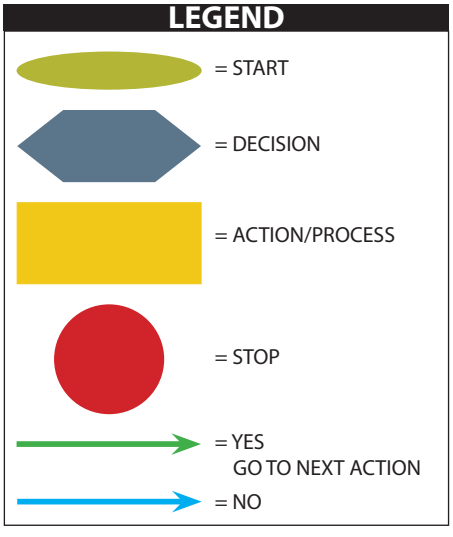
- ODD/CD are highly comorbid with disorders such as ADHD, mood disorders, substance abuse disorders, as well as others. Effective treatment of comorbid conditions may reduce disruptive behavior and aggression symptoms.

See *ODD/CD Treatment Guide.*



E.22. ONGOING MONITORING

- After initial program of family/parent training, assess need for additional sessions.
- **Every year,** conduct full reevaluations.
- Coordinate care provided by medical home and specialists, parents/caregiver, and school.



SOURCES:

1. American Academy of Child & Adolescent Psychiatry. *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Conduct Disorder*. 1997.
2. American Academy of Child & Adolescent Psychiatry. *Facts for Families #33, 55, 72.*
3. American Academy of Child & Adolescent Psychiatry. *ODD A Guide for Families.*
4. American Academy of Pediatrics. *Disruptive Behavior and Aggression from Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit.*