CT Children's CLASP Guideline

Identification & Management of Anxiety & Depression in Primary Care

INTRODUCTION

As many as 1 in 10 American children and adolescents experience anxiety and/or depression, which may impair healthy development and functioning. Suicide remains the second leading cause of death for youth ages 10 - 24-years-old. It is also known that there are higher rates of suicidality and suicide attempts in the BIPOC and LGBTQIA+ populations, among others. AAP guidelines recommend universal and targeted screening using validated tools for anxiety and depression for indication and initiation of effective interventions, such as counseling and/or medication management. Screening for suicide risk is also important and recommended by the Blueprint for Youth Suicide Prevention. These activities serve as important quality indicators in primary care.

Anxiety and depression often cause or exacerbate somatic symptoms, particularly when co-occurring with a pre-existing condition such as asthma or diabetes. These conditions can complicate management and worsen treatment adherence. Conversely, a newly diagnosed medical condition can trigger new onset anxiety and depression. More frequent screening may be of benefit in this population.

INITIAL SCREENING, EVALUATION AND MANAGEMENT

See Appendix A – **Identification & Management of Anxiety and Depression in Primary Care**

Screening:
Universal screening begins at age 3 years at all well child visits (PPSC for ages 3-4, PSC 17 for ages 5+, ASQ for ages 10+ and the PHQ9 and CRAFFT for ages 11+). Targeted screening for children with mental health or behavioral concerns, chronic illnesses and frequent somatic complaints includes the universal screening instruments plus specific anxiety screening (GAD 7 for ages ≥11 years or SCARED-5 for ages 8-18 years).

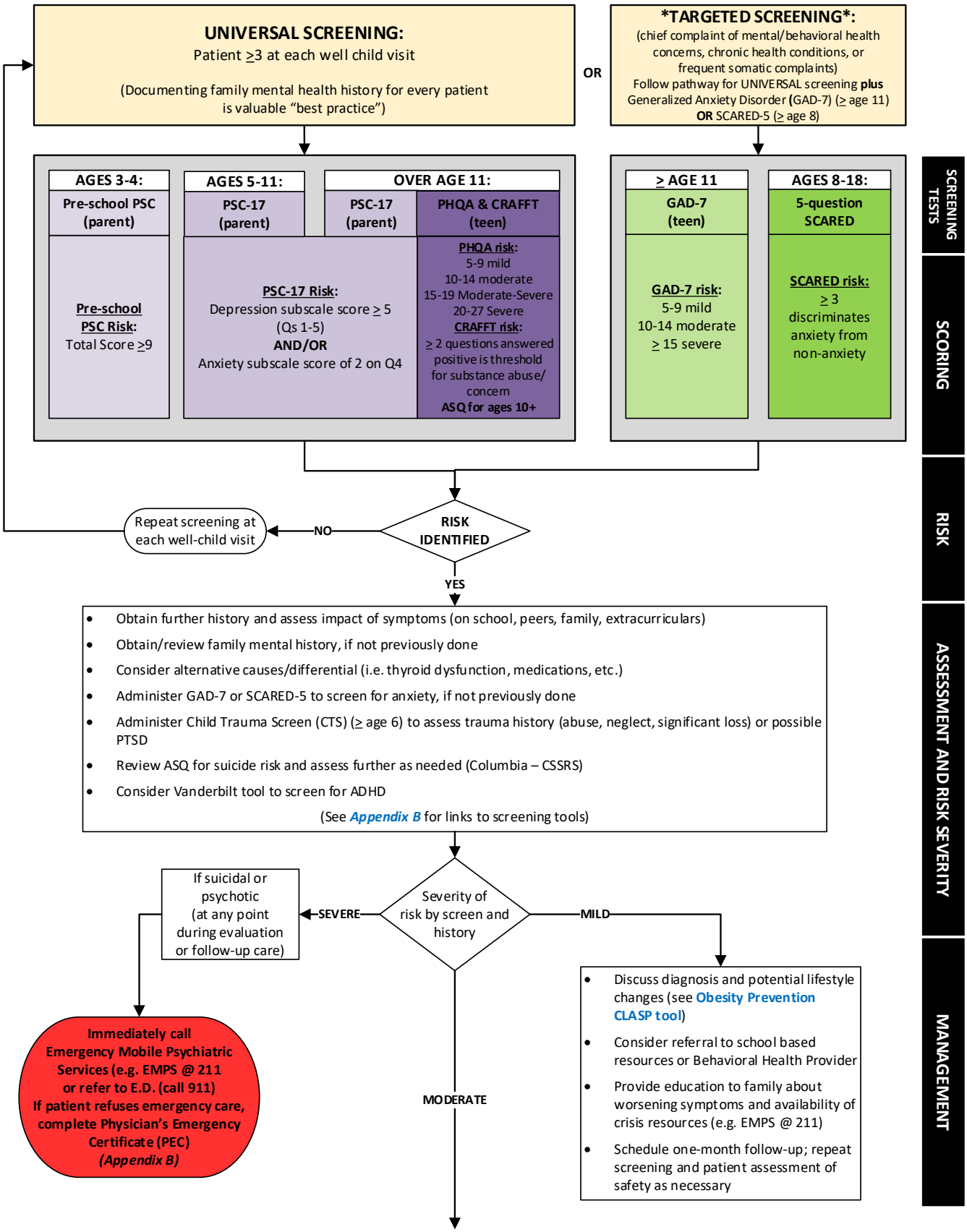
Evaluation:
If any screener is scored positive, assess symptoms further using clinical interview or a targeted screener. The GAD-7 (ages 11-adult) and the SCARED-5 (ages 8-18) are brief anxiety assessments. If the GAD-7 or SCARED-5 are negative, but there remain concerns for anxiety, consider using the full SCARED. The Columbia (CSSR-S) may be used with a positive ASQ). Consider screening for comorbid diagnoses using the Child Trauma Screen (CTS) to assess trauma history or possible PTSD and/or the Vanderbilt measure to screen for ADHD. Evaluate the impact of symptoms on functioning at home, school, extracurricular activities, and with relationships. Review family mental health history for biological predisposition. Using all of the data collected, determine the level of severity.

Management:
For **mild risk severity**, watchful waiting with periodic rescreening is appropriate. Discussing the diagnosis and potential **lifestyle changes** may be of benefit. Additionally, consider referral to school-based services or a behavioral health (BH) provider. Provide education to family about next steps in the event of worsening symptoms and about availability of crisis services. Schedule regular follow-up as necessary.

For **moderate risk severity**, discuss the diagnosis and provide education to family about what to do in the setting of worsening symptoms or need for crisis services. Referral to a behavioral health provider for further assessment is of benefit. Consider starting medication to assist with symptoms while awaiting referral. Medication recommendations are found in **Appendix H,** and additional consultation can be obtained from Access Mental Health. For those of moderate risk severity with a more complicated course (e.g. signs of bipolar disorder, complex comorbidity, recurrent/chronic depression, etc.), refer specifically to a psychiatrist. Offer bridging appointments to that referral as needed.

For **severe risk severity**, call Emergency Mobile Psychiatric Services (EMPS) at 2-1-1 or refer to the Emergency Department by calling 911. If a patient refuses emergency care, complete a Physician's Emergency Certificate.

	If **medications** are indicated (e.g. significant impairment of function, feedback/consultation with behavioral health provider, etc.), discuss target symptoms, goals of treatment and **lifestyle changes**. Provide psychoeducation, and consider school-based resources. Medication titration and monitoring schedules are found in **Appendix H**. may Consider the use of hydroxyzine PRN for anxiety. If initiating a medication with a Black Box warning (e.g. SSRI), discussion of the warning must occur. Review a safety plan and restrict access to lethal means. Facilitate ongoing communication with the patient's behavioral health provider, and schedule routine PCP follow-up as necessary. For patients who demonstrate **improvement in symptoms with medication**, continue treatment for an additional 6-9 months to reduce risk of relapse. Schedule follow-up evaluations every 3 months, repeat screenings and assess for high-risk behaviors and suicidality. At 12 months, if symptoms remain improved/remitted, consider tapering medication by 25% every 2-4 weeks. If signs of worsening symptoms occur, titrate to medication dose that was previously successful for an additional 6-12 months.
WHEN TO REFER	**See Appendix A – Identification & Management of Anxiety and Depression in Primary Care** If at any time the patient presents with suicidal or psychotic symptoms, immediately contact emergency mobile psychiatric services (211) or refer to the emergency department. If the patient refuses emergency care, complete the physician's emergency certificate. If a patient displays signs of bipolar disorder, complicated depression, complex comorbidity or recurrent chronic depression, refer to psychiatry including utilizing Access Mental Health Connecticut if needed. If the patient presents with moderate symptoms, refer to a behavioral health provider and school-based resources. With moderate symptoms and impairment of functioning, medication should be considered. Provider should see specific recommendations for medication schedule. Discuss target symptoms and goals of treatment with patient and family. Develop and review a patient safety plan with lethal means restriction and close supervision. Review black box warning with family and provide education about crisis resources for worsening symptoms. There should be communication with patient's behavioral health provider. Primary care provider should continue to see patient as a bridge or at regular intervals until patient is in active treatment with psychiatrist.
HOW TO REFER	**For information on how to contact ACCESS MT-CT, see Appendix F**



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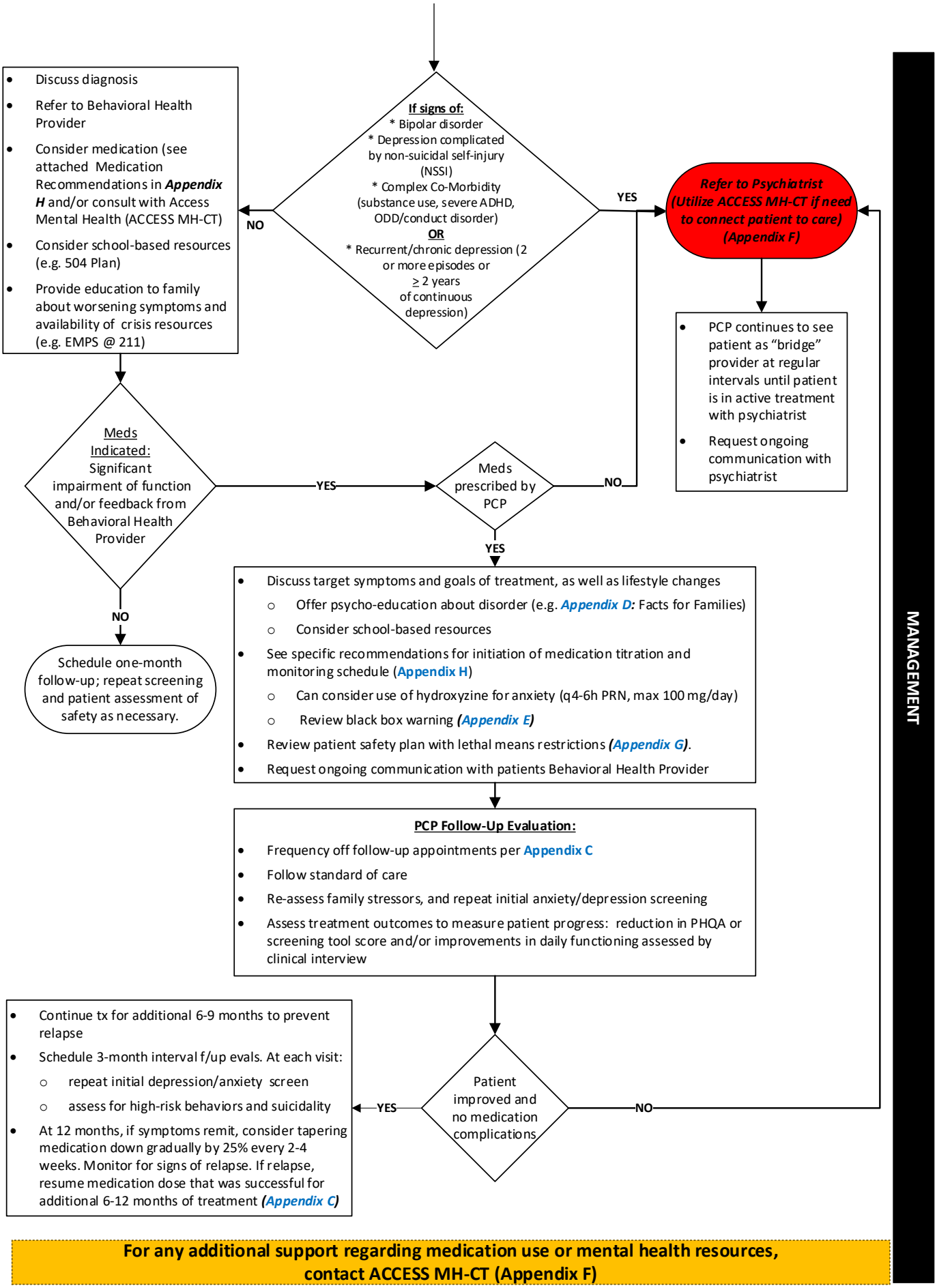


APPENDIX B: Links to Tools

- **Child Trauma Screen (CTS):**
  http://www.surveygizmo.com/s3/3935491/CTS-Interest-Form-from-CHDI-web-site
- **Vanderbilt tool (Screening for ADHD for > age 7):**
  https://www.nichq.org/resource/nichq-vanderbilt-assessment-scales
- **Generalized Anxiety Disorder (GAD-7):**
  http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/GAD-7_English.pdf
- **Screen for Child Anxiety Related Disorders (SCARED):**
  http://www.ementalhealth.ca/index.php?m=survey&ID=54
- **Patient Health Questionnaire (PHQ-9):**
  https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/depression_patient_health_questionnaire.pdf
- **American Academy of Pediatrics (AAP) Blueprint for Youth Suicide Prevention:**
  https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention
- **Ask Suicide Questions (ASQ):**
  https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
- **Columbia Suicide Severity Rating Scale (C-SSRS):**
  https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english
  https://www.uacap.org/_files/ugd/1da6d0_f1e544ffa89426ba221ce7f8de22dec.pdf
- **Physician's Emergency Certificate (PEC):**
  http://www.ct.gov/dmhas/lib/dmhas/forms/15daypec.pdf
- **CRAFFT:**
  https://ceasar.childrenshospital.org/crafft/
- **PSC:**
  https://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/3%20Assessment/Standardized%20Measures/PSC-17%20English.pdf
- **PPSC:**
  https://www.floatinghospital.org/-/media/Brochures/Floating-Hospital/SWYC/2018/PPSC-v107.ashx?la=en&hash=6D817115CA616B56397829AA2FEEBF2862BFB700

FDA Statement: Ideally, such observation would include at least weekly, face-to-face contact with the patients or their family members or caregivers during the first 4 weeks, then biweekly x4 weeks, then at 12 weeks. Additional contact by telephone maybe appropriate between face-to-face visits.

NOTE There is no empirical evidence to support weekly face to face, evidence suggests telephone contact may be just as effective. AACAP recommends following FDA guidelines until more research findings available.

Weekly Follow Up Schedule

1*	2*	3*	4*		6*		8*				12*

* Face- to- Face

- After 12 weeks, visits every 1-2 months x 1year
- Continue medications until 9 months after remission is achieved
- REMEMBER: Start low, go slow. When stopping, small changes, go slow

APPENDIX D: "Facts for Families"

- http://kidshealth.org/ConnecticutChildrensXML/en/parents/understanding-depression.html
- http://kidshealth.org/ConnecticutChildrensXML/en/parents/anxiety-disorders.html

APPENDIX E: Black Box Warning

- https://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/antidepressant-medications-for-children-and-adolescents-information-for-parents-and-caregivers.shtml

APPENDIX F: ACCESS MH-CT

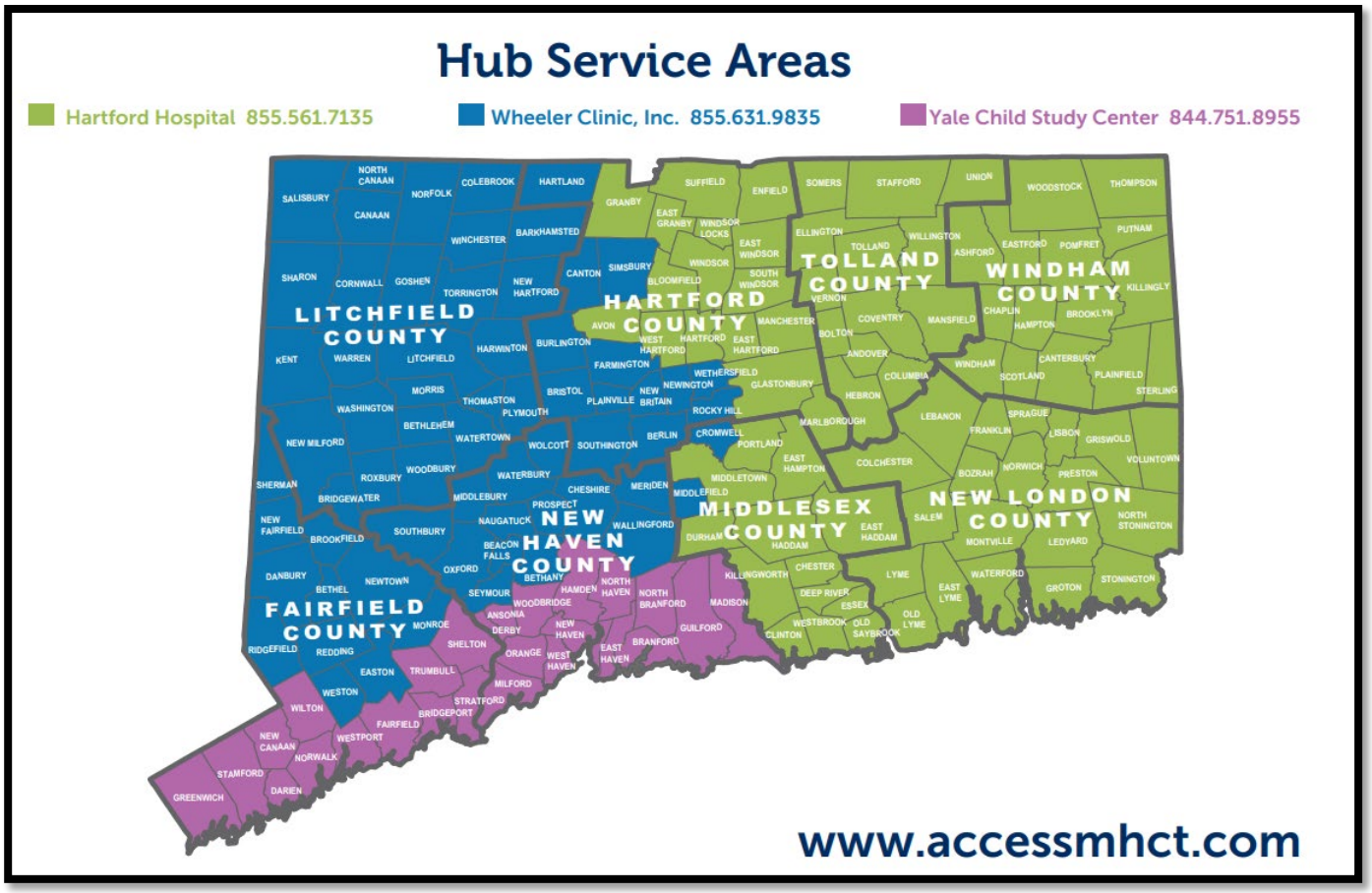
Who We Are

The ACCESS Mental Health CT program consists of expert pediatric psychiatry consultation teams located throughout the state of Connecticut to help PCPs meet the needs of children and adolescents with mental health problems.

Each Hub consultation team includes child and adolescent psychiatrist(s), behavioral health clinician(s), a program coordinator and a family peer specialist.

What We Do

- Provide free telephone consultation within 30 minutes of initial call
- Assist with finding community behavioral health services
- Offer behavioral health training and education



APPENDIX G: Patient Safety Plan

Keep an eye out for changes in:

- Mood
- Irritability or behavior problems
- Isolation or avoiding others
- Not wanting to engage in activities that used to be enjoyable
- Sleep (more or less sleep)
- Appetite (eating more or less or changes in weight)
- Worrying
- Grades

Coping strategies:

- Listen to music
- Take a walk
- Talk to a trusted friend or family member: _____
- Find a safe space: _____
- Other: _____
- Other: _____

Professionals or agencies to contact during a crisis:

- Primary Care Provider _____ Phone _____
- Clinician Name_____ Phone_____
- Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- Crisis Text Line: Text “HOME” to 741-741
- 211, press 1 for Mobile Crisis Intervention Services (formerly EMPS)
- 988 Suicide & Crisis Lifeline, dial 9-8-8 to be connected to 24/7 free and confidential support
- The Trevor Project:
    a. Call: 1-866-488-7386
    b. Or Text “START” to 678-678
- 911

Making the environment safe:

- Eliminate access to fire arms
- Eliminate access to all sharp or dangerous items
- Eliminate access to household cleaners /chemicals
- Eliminate access to medication and alcohol

APPENDIX H: **Medication Titration & Monitoring Schedule (Page 1 of 3)**

First line medication for Anxiety and Depression
SSRI Titration Schedule (< 12 years)

Medication	Starting Dose	Week 2	Week 3-4	Pause Week 4-6	Effective Dose Range	Metabolized by Cytochrome	Tips & Notes
Lexapro® (Escitalopram) **Formulations: tabs** (5mg, 10mg,20mg) **and liquid** (5mg/5mL)	**1 mg=1 ml** **1mg daily**	**Increase to 2mg daily**	**Increase to 2.5mg daily**	**Consider increase to 7.5mg daily x 2 weeks, then consider increase to 10mg daily.** ***Do not increase more than 2.5 mg every 2 weeks.***	**5-10mg daily.** **Maximum of 20 mg daily.**	**2C19**	**FDA approved for treating MDD in ages 12+** **Good for depression, irritability and anxiety**
Prozac® (Fluoxetine) **Formulations**: **capsules** (10mg, 20mg, 40mg, 60mg); **tabs** (10mg); **liquid** (20mg/5mL)	**5mg daily**	**Increase to 10mg daily**	**Increase to 10mg daily or hold at 10mg daily**	**Consider increase to 15mg daily x2 weeks, then consider increase to 20mg daily.** ***Do not increase more than 5 mg every 2 weeks***	**10-20mg daily.** **Maximum of 50 mg daily.**	**Major – 2D6** **Minor – 2C9**	**FDA approved for treating MDD in ages 8+ and OCD in ages 7+** **Helpful for depressed or irritable mood, amotivation, anhedonia and low energy as well as anxiety**
Zoloft® (Sertraline) **Formulations: tabs** (25mg, 50mg, 100mg), **and liquid** (20mg/mL) *Liquid formulation is VERY concentrated and does not taste good!*	**12.5mg daily**	**Increase to 25 mg daily**	**25mg daily**	**Consider increase to 37.5mg daily x 2 weeks, then consider increase to 50mg daily.** ***Do not increase more than 12.5 mg every 2 weeks.***	**25-50 mg daily.** **Maximum of 200 mg daily.**	**2C9**	**FDA approved for treating OCD in ages 6+** **Good for obsessions, compulsions, depressed or irritable mood, anxiety**

APPENDIX H: Medication Titration & Monitoring Schedule (Page 2 of 3)

First line medication for Anxiety and Depression

SSRI Titration Schedule (> 12 years)

Medication	Starting Dose	Week 2	Week 3-4	Pause Week 4-6	Effective Dose Range	Metabolized by Cytochrome*	Tips & Notes**
Lexapro® (Escitalopram) **Formulations: tabs** (5mg, 10mg,20mg) **and liquid** (5mg/5mL)	**5mg daily**	**Increase to 10 mg daily**	**10mg daily**	**Consider increase to 15 mg daily x 2 weeks, then 20 mg daily**	**10-20mg daily.** **Maximum of 20mg daily.**	**2C19**	**FDA approved for treating MDD in ages 12+** **Good for depression, irritability and anxiety**
Prozac® (fluoxetine) **Formulations**: **capsules** (10mg, 20mg, 40mg, 60mg); **tabs** (10mg); **liquid** (20mg/5mL)	**5mg daily**	**Increase to 10 mg daily**	**Increase to 15mg daily**	**Consider increase to 20 mg daily**	**10-20mg daily.** **Maximum of 60mg daily.**	**Major – 2D6** **Minor – 2C9**	**FDA approved for treating MDD in ages 8+ and OCD in ages 7+** **Helpful for depressed or irritable mood, amotivation, anhedonia and low energy as well as anxiety**
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***Using Cytochromes:** Cytochromes, especially the CYP450 system, influence drug effectiveness and drug-drug interactions. When starting a medication it is important to check for interactions. A medication that induces a cytochrome may decrease drug effectiveness and necessitate a higher target dose, while a medication that inhibits a cytochrome may cause side effects due to drug buildup, necessitating a lower target dose or alternative medication. When changing medications due to lack of efficacy or side effects, choosing a drug metabolized by a different cytochrome can be considered. For a list of CYP450 inducers and inhibitors, please see: CYTOCHROME P450 DRUG INTERACTION TABLE (iu.edu)

****Side Effects:** The most common side effects of SSRIs include gastrointestinal (nausea, diarrhea, loss of appetite, constipation),sleep changes (insomnia or fatigue), headaches, dizziness, reduced sex drive and difficulty achieving orgasm/erection. If side effects occur, most mild effects will resolve within 4-7 days. For symptoms that persist, consider adjusting dosing, timing or changing medications.

WHEN CONSIDERING STARTING A MEDICATION or MAKING A DOSE CHANGE

Consult the Big T's and the Little T's:

2 Big T's

- **TARGET** symptoms - identify clear goals for symptom reduction
- **TOLERANCE** - is patient having side effects? Are they tolerable or intolerable

5 Little T's

- This is a **TRIAL**
- It takes **TIME** to work
- Have parent/patient **TELL** about concerns
- Ask about **TREATMENT** adherence
- Sometimes you have to hold **TIGHT** and re-evaluate