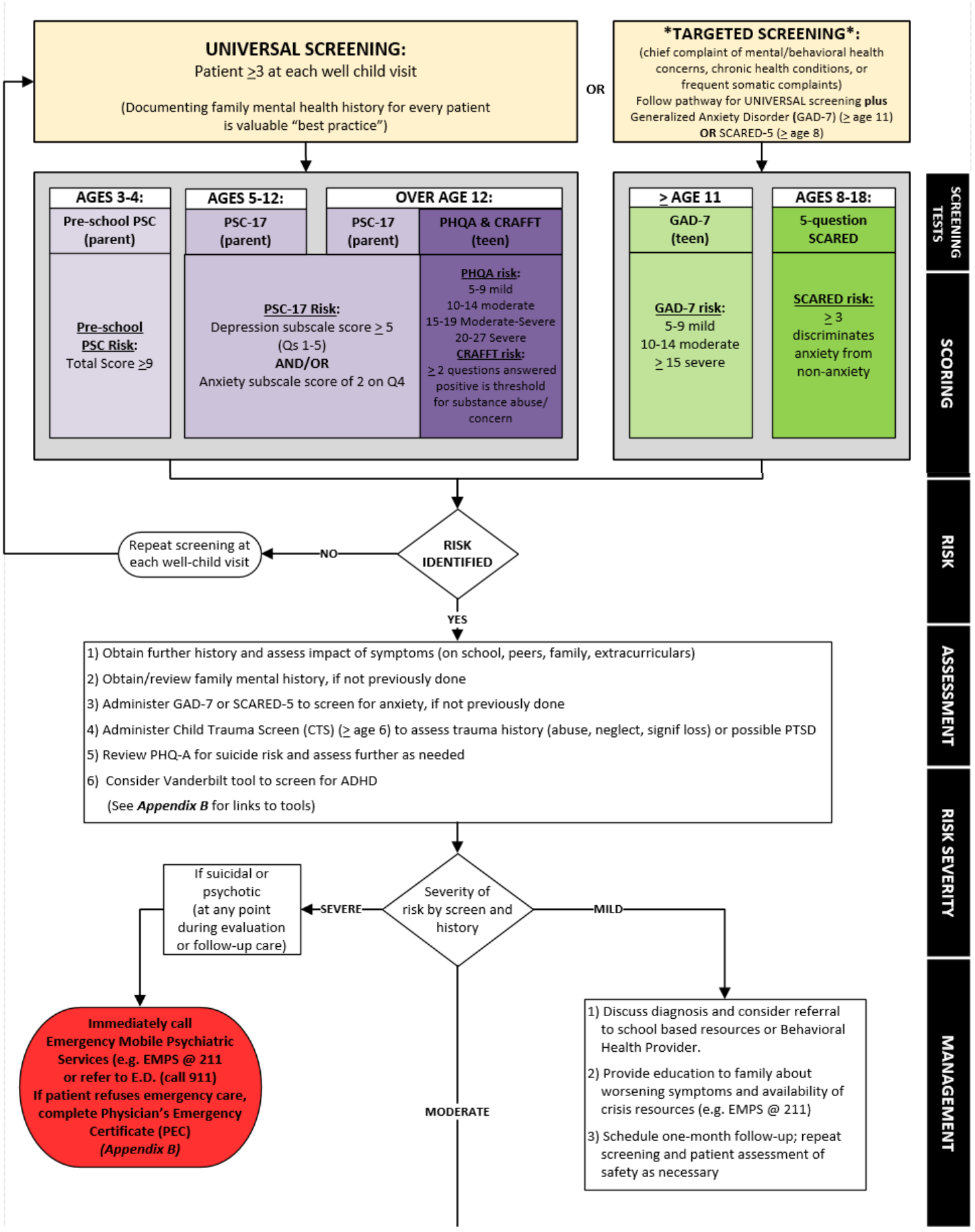
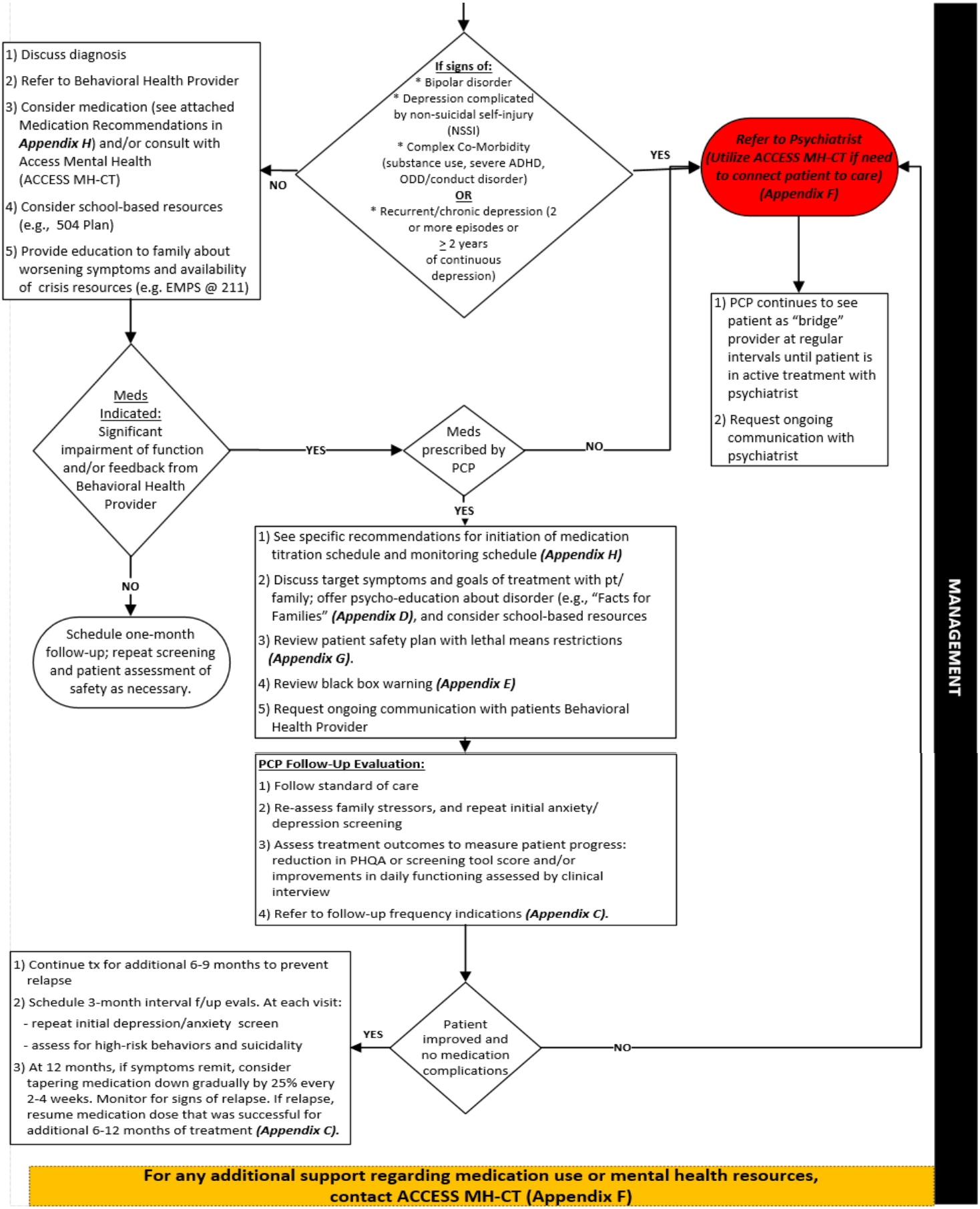
CT Children's CLASP Guideline

Identification and Mgmt of Anxiety & Depression in Primary Care

INTRODUCTION	Approximately 1 in 20 American children and adolescents experience anxiety and/or depression which may impair healthy development and functioning. Suicide rates which are higher in this population, have doubled since 2007, becoming the second leading cause of death in youth. AAP guidelines recommend universal and targeted screening for anxiety and depression for identification and initiation of effective interventions. These activities serve as an important quality indicator in primary care. Validated screening tools are available and an increasing number of primary care practices utilize practice workflows to support the screening process. WHEN ANXIETY & DEPRESSION CO-EXIST WITH CHRONIC HEALTH CONDITONS: Anxiety and depression often cause or exacerbate somatic symptoms, particularly when co-occurring with a pre-existing condition such as asthma or diabetes. It can complicate management and worsen treatment adherence. Conversely, a newly-diagnosed medical condition can trigger new onset anxiety and depression. Thus, it is no surprise that youth with chronic medical conditions represent a high-risk group. Repeated screening within this population allows for early identification and intervention and leads to improved health and cost outcomes. CHALLENGE #1: ACCESS to child psychiatrists: There is a mismatch between the child & adolescent psychiatry workforce and the increasing numbers of youth with anxiety and depression. A wide variation in referral rates among PCPs and in their capacity to manage youth with anxiety and depression coupled with the barriers families face in following through with referrals worsens this already delayed access. CHALLENGE #2: Lack of clarity on when to refer youth with anxiety and depression to a psychiatrist leads to wide variation in referral rates: It is not always clear when symptoms can be well managed in primary care versus when a referral to psychiatric care is indicated. Furthermore, resources for PCPs to expand their own scope of practice to manage more youth with anxiety and depression are not readily available. WHAT IS THE SOLUTION? The CLASP team has met with an interdisciplinary group of experts in primary care, psychology, and psychiatry and used the best available evidence and their sound clinical knowledge to develop an evidence-based approach to identifying and managing anxiety and depression RESULT: An easy to navigate pathway with clinical decision support tools to enable patients with anxiety and depression to be more confidently managed within primary care and appropriately referred and connected to behavioral health providers and psychiatrists. ACCESS MH-CT will serve as a resource for all levels of this pathway. GOAL: To provide a structured, collaborative, and evidence-based approach for the timely identification and provision of intervention for youth with anxiety and depression.
INITIAL SCREENING, EVALUATION AND MANAGEMENT	**See Appendix A - Pathway**
WHEN TO REFER	**See Appendix A - Pathway**
HOW TO REFER	**For information on how to contact ACCESS MT-CT, see Appendix F**

APPENDIX A: Algorithm: Identification and Management of Anxiety & Depression in Primary Care





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
- **PHQ-9 Modified for Adolescents (PHQ-A):** http://www.uacap.org/uploads/3/2/5/0/3250432/phq-a.pdf
- **SCARED:** http://www.ementalhealth.ca/index.php?m=survey&ID=54
- **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

APPENDIX C: Follow-Up Frequency

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

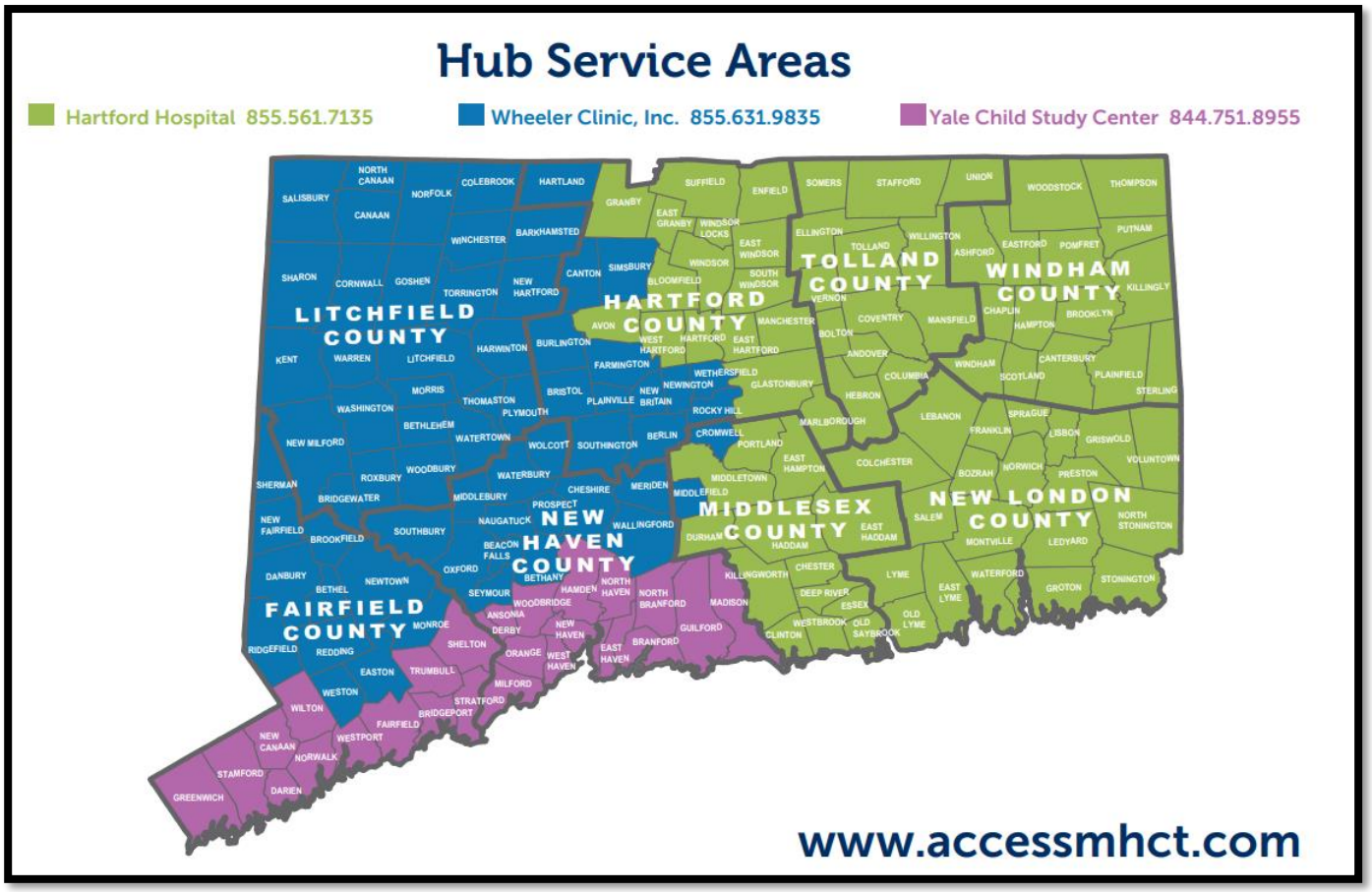
Who We Are

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: 741-741
- 211, press 1 for Emergency Mobile Psychiatric Services (EMPS):
- 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)							
Metabolized by Cytochrome	**Medication**	**Starting Dose**	**Week 2**	**Week 3-4**	**Pause Week 4-6**	**Effective Dose Range**	**Contraindicated**
Major – 2C19 Minor – 2D6	Celexa® (Citalopram) Liquid form is available	10 mg/5 ml 2 mg=1 ml 1 ml daily	Increase to 2 ml (4 mg) daily	Increased to 2.5 ml (5 mg) daily or ½ tab 10 mg (5 mg) daily	Consider increased to 10 mg daily. *Never increase more than 5 mg every 2 weeks.	5-20 mg daily. Maximum of 40 mg daily.	Monoamine oxidase inhibitors (MAOIs)
Major – 2D6 Minor – 2C9	Prozac® (Fluoxetine) Liquid form is available	20 mg/5ml 5 mg = 1 ml 1 ml daily or ½ tab 10 mg (5 mg) daily	Increase to 2 ml (8 mg daily)	Increase to 2.5 ml (10 mg) daily or 10 mg tab daily	Consider increase to 15 mg daily x2 weeks, then consider increase to 20 mg daily. *Never increase more than 5 mg every 2 weeks	10-20 mg daily. Maximum of 50 mg daily.	Monoamine oxidase inhibitors (MAOIs)
2C9	Zoloft® (Sertraline) 20 mg/1 ml not recommended highly concentrated	12.5 mg daily or ½ of 25 mg tablet	Increase to 25 mg daily	25 mg daily	Consider increase to 37.5 mg daily x 2 weeks, then consider increase to 50 mg daily. *Never increase more than 12.5 mg every 2 weeks.	25-50 mg daily. Maximum of 200 mg daily.	Monoamine oxidase inhibitors (MAOIs)
2C19	Lexapro® (Escitalopram) 5 mg/5 ml	1 mg=1 ml 1 ml daily	Increase to 2 ml daily	Increase to 2.5 ml daily or ½ of 5 mg tablet	Consider increase to 7.5 daily x 2 weeks, then consider increase to 10 mg daily. *Never increase more than 2.5 mg every 2 weeks.	5-10 mg daily. Maximum of 20 mg daily.	Monoamine oxidase inhibitors (MAOIs)

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

First line medication for Anxiety and Depression SSRI Titration Schedule (> 12 years)							
Metabolized by Cytochrome	**Medication**	**Starting Dose**	**Week 2**	**Week 3-4**	**Pause Week 4-6**	**Effective Dose Range**	**Contraindicated**
Major – 2C19 Minor – 2D6	Celexa® (Citalopram)	5 mg daily	5 mg daily	Increase to 10 mg daily	Consider increase to 15 mg daily x 2 weeks, then consider increase to 20 mg daily	10-20 mg daily. Maximum of 40 mg daily.	Monoamine oxidase inhibitors (MAOIs)
Major – 2D6 Minor – 2C9	Prozac® (fluoxetine)	5 mg daily	Increase to 10 mg daily	Increase to 15 mg daily	Consider increase to 20 mg daily	10-20 mg daily. Maximum of 60 mg daily.	Monoamine oxidase inhibitors (MAOIs)
2C9	Zoloft® (Sertraline)	12.5 mg daily	Increase to 25 mg daily	Increase to 37.5 mg daily	Consider increase to 50 mg daily	25-50 mg daily. Maximum of 200 mg daily.	Monoamine oxidase inhibitors (MAOIs)
2C19	Lexapro® (Escitalopram) Remember, dosing of Lexapro® and Celexa® are NOT equal/ not 1:1	5 mg daily	Increase to 10 mg daily	10 mg daily	Consider increase to 15 mg daily x 2 weeks, then 20 mg daily	10-20 mg daily. Maximum of 20 mg daily.	Monoamine oxidase inhibitors (MAOIs)

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