Medical Home Newsletter

Depression and Anxiety

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Welcome

The purpose of this publication is to support health care providers in the establishment and maintenance of Medical Homes for their pediatric patients by providing tools and information for use in their practices.

To offer comments, or suggest ideas for future newsletters, contact the Project Coordinator Barbara Ward, RN BS bward@utah.gov.

Copies of newsletters may be found on the Utah Medical Home web portal: http://www.medhomeportal.org (click on Newsletters/Conf. Calls)

Depression and Anxiety in children and adolescents

In the U.S. today, one in ten children suffer from a mental disorder severe enough to cause some level of impairment. All children feel sad, blue, irritable or nervous on occasion. However, when those emotions continue for an extended period or interfere with activities of daily living, the medical home should screen and consider interventions to improve the child's functioning and success in life. Increasingly the responsibility for providing mental health care falls to primary care providers. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is just going through a temporary "phase" or is suffering from depression.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Only in the past two decades has depression in children been taken very seriously. The depressed child may pretend to be sick, refuse to go to school, cling to a parent, or worry that the parent may die. Older children may sulk, get into trouble at school, be negative, grouchy, and feel misunderstood.

Anxiety is common in children and adolescents and has a comparable rate of occurrence to many physical disorders such as asthma. Since anxiety is developmentally appropriate during certain periods of life, the medical home should have the tools available to distinguish between normal anxiety and clinical anxiety. Prevalence rates vary according to the study but ranges between 5-9% of school age children meeting the criteria for one of the anxiety disorders.

Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Anxious children may also be quiet, compliant and eager to please, therefore their difficulties may be missed.

Medical Home Role

At a recent parent advocate retreat, parents reported that their Primary Care Health Provider screened by asking the parent if the child was depressed or anxious. However the parents stated they did not know the symptoms of depression and anxiety in children. They advise the medical homes to provide a handout of symptoms to watch for in elementary and high school age children. *See attached form*

Debbie Bilder, MD – Child psychiatrist at University of Utah Neuropsychiatric Institute (UNI), offers these guidelines to primary care providers:

- Screen for anxiety and depression when suspected.
- In children and adolescents, irritability rather than sadness may be the presenting symptom of depression
- If depressed, inquire about thoughts of self-harm
- If prescribing medication for depression or anxiety, strongly consider a referral for individual psychotherapy as well.
- Zoloft (sertraline) and Prozac (fluoxetine) are labeled for use in children. Zoloft tends to be better tolerated and easier to titrate from a low dose. Prozac is available as a generic and is consequently cheaper. Celexa (citalopram) is particularly useful for anxious/depressed patients with a lot of somatic complaints.
- Trial of 4-6 weeks at the expected therapeutic dose before considering dose increase.
- Although the starting doses are the same, effective doses for treating anxiety are usually higher than for depression.
- If suspect comorbid ADHD, treat anxiety and mood before evaluating and treating ADHD.
- If referring a patient to a child psychiatrist, the primary care provider can usually call for treatment suggestions while waiting for the initial psychiatric appointment.
- Screen for maternal depression in postpartum teens

Refer immediately for:

1. Personal or family history of Mania or Bipolar disorder (do not start SSRI)
2. Acutely suicidal or suicidal thoughts
3. Toddler or Preschooler
4. Unclear diagnosis
5. severe symptoms
6. Non-Verbal CSHCN

Special considerations for CSHCN

- Sometimes more difficult to identify specific disorder with CSHCN due to medical complexity and communication issues.
- CSHCN are more sensitive to medication effects and side effects
- Start low and go slow with medication
- Consider a medical cause of behavior such as pain
- Mood disorder and anxiety may manifest as agitation

Screening

The United States Preventive Services Task Force (USPSTF) found good evidence that screening improves the accurate identification of depressed patients in primary care settings and that treatment of depressed adults in primary care settings decreases clinical morbidity. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment.

The USPSTF concludes the evidence is insufficient to recommend for or against routine screening of children or adolescents for depression.

Red Flags for screening:

- School refusal
- Dropping grades
- Not functioning with friends/home/school
- Major changes in eating and sleeping

The USPSTF recommends starting with these two questions to detect primary symptoms of depression:

1. "Over the past two weeks have you ever felt down, depressed or hopeless?"
2. "Have you ever felt little interest or pleasure in doing things?"

A "yes" answer to either question should prompt use of a more comprehensive screening instrument.

In Utah, Intermountain Health Care has developed a mental health integration program with tools and resources for the primary care office available to all practitioners in the state on their website http://intermountainhealthcare.org/xp/public/physician/clinicalprograms/
Click on "Primary Care" under "Select a Clinical Program" then "Mental Health Integration."

The site offers the following downloadable packets, with screening and tracking tools for children and adolescents.

1. **Child & Adolescent Baseline Evaluation Packet**
2. **Child & Adolescent Follow-up Evaluation Packet**
3. **Baseline School Packet**
4. **Follow-up School Packet**

For more information or printed packets, call Brenda Reiss-Brennan at 801- 442-3206 or email at Brenda.Reiss-Brennan@intermountainmail.org

Other Available Screeners, A comprehensive list of screening tools with descriptions of each and product availability is available at the Massachusetts General Hospital Psychiatry Program website www.mgh.harvard.edu/madiresourcecenter/schoolpsychiatry

1. **The Ages and Stages Social Emotional** Parents complete the questionnaires at eight designated intervals: 6, 12, 18, 24, 30, 36, 48, and 60 months. Available at www.brookespublishing.com **800-638-3775**
2. **Alarm Distress Baby Scale** is a scale to assess social withdrawal behavior in infants under 3 years of age. Available free at: www.adbb.net/gb-intro.html
3. **Pediatric Symptom Checklist (PSC)** is a brief screening questionnaire used to improve the recognition and treatment of psychosocial problems in children available free at http://psc.partners.org/ **617-724-3163**
4. **Center for Epidemiological Studies Depression Scale for Children (CES-DC)** is a 20 item self-report depression inventory available at www.brightfutures.org/mentalhealth **202-784-9556**
5. **The Children's Depression Inventory CDI is a** brief self-report test that helps assess cognitive, affective and behavioral signs of depression in children and adolescents 6 to 17 years old. Available at: **800-627-7271** http://www.pearsonassessments.com/
6. **The Reynolds Child and Adolescent Depression Scale and Beck Depression Scale** The RCDS was developed to screen for depression in children grades 3-6 and the adolescent scale for ages 11-20 years available at: **800-331-8378** http://www3.parinc.com/
7. **Spence Children's Anxiety Scale (SCAS)** is designed to evaluate symptoms related to separation anxiety, social phobia, obsessive-compulsive disorder, panic-agoraphobia, generalized anxiety, and fears of physical injury in children ages 8-12. A 34-item preschool form (for ages 2.5-6.5 years) can be completed by parents. The SCAS is available at: http://www2.psy.uq.edu.au/~sues/scas/

8. **Screen for Child and Anxiety Related Disorders** (SCARED) This tool screens children and adolescents age 8 and older for anxiety disorders. Child and parent forms available for download at www.wpic.pitt.edu/research **877-624-4100**
9. **Social Phobia and Anxiety Inventory for Children (SPAI–C)** Assess childhood social phobia across a broad range of situations for ages 8-14 available at: **800-211-8378** http://harcourtassessment.com/HAIWEB/Cultures/en-us/default
10. **State-Trait Anxiety Inventory for Children** The instrument is designed for use with upper elementary or junior high school aged children and consists of two twenty-item scales. The measure is easy to read and can be administered verbally to younger children. Available at: www.mindgarden.com **650-322-6300**
11. **Revised Children's Manifest Anxiety Scale (RCMAS)** is a 37-item self-report inventory used to measure anxiety in children in clinical settings. RCMAS is used with children and adolescents ages 6-19. **800-897-3202** www.proedinc.com/store/index.php?mode=product_detail&id=9239

Youth Outcome Questionnaire For primary care doctors who are treating the patient the is a brief 64 item parent report measure of treatment progress for children and adolescents (ages 4-17) receiving mental health intervention Available at **800-357-1200** **www.carepaths.com/**

Resources

For a complete list of statewide mental health centers click on the medical home website/ resources section www.medhomeportal.org

For a list of private providers and resources along the Wasatch front, contact Barbara Ward at **801-584-8584** or bward@utah.gov. Being on the list represents neither an endorsement of the provider nor a recommendation that a specific patient should be referred to a listed provider.

Bright Futures Mental Health Tool Kit: Jellinek M, Patel BP, Froehle MC, eds. 2002. Bright Futures in Practice: Mental Health-Volume Iand II. Tool Kit. Available for download at www.brightfutures.org/mentalhealth/

American Academy of Pediatrics medical home site: Community pediatrics section has excellent resources, handouts and tools for addressing mental health issues. www.medicalhomeinfo.org/health/behavior.html

AAP Mental Health Web Site aims to provide mental health information to child health care professionals and parents; covers a number of topics related to mental health, including general mental health and resources, resources, community and state mental programs, etc. www.aap.org/commpeds/dochs/mentalhealth/index.cfm

Online Toolkit on Childhood Depression and Anxiety The Washington State Department of Health, Children with Special Health Care Needs Program and the Center for Children with Special Needs have developed a new online toolkit for health care providers, advocacy and community groups, parents, and families. The Childhood and Adolescent Depression and Anxiety Toolkit, which includes Spanish language materials, is available at www.cshcn.org/resources/mentalhealthtoolkit.cfm.

Federation of Families for Children's Mental Health. The National family-run organization dedicated exclusively to helping children with mental health needs and their families achieve a better quality of life www.ffcmh.org/who.htm

Local Utah chapters contact

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Green River Families United Through Understanding & Respecting Each Others' Strengths (FUTURES) (Chapter)
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Post Partum Depression affects up to 18% of mothers during the 1st year after delivery, when a pediatrician may be the only doctor a woman sees. A 2005 study showed written questionnaires are more effective than interviews at identifying mothers with depression and lead to more referrals to mental health specialists. Routine screening of mothers at infant well checks has been recommended. (Olson AL, et al. Two approaches to maternal depression screening during well child visits. J *Dev Behav Pediatr.* 2005 Jun;26:169-76)

Edinburgh Postnatal Depression Scale provides an easy way to identify women with postpartum depression. It can be administered and scored by office staff and reviewed during the infant's office visit. Available free at **http://www.dbpeds.org/media/edinburghscale.pdf**