Treatment of Pediatric Anxiety & Depression

A Brief Overview

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Disclosure

Richard J. Miller, MD, FAACAP

- No commercial conflicts of interest
- Medications may be referred to by brand name, for clarity.
- Off-label use of medications will be discussed and identified

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Learning Objectives

At the conclusion of this continuing medical education activity, the participant will be able to:

1. Be familiar with at least one screening tool for pediatric anxiety and depression for use in the primary care setting.

2. Identify, initiate and titrate evidence based pharmacological treatment for anxiety and depression in children

3. Screen for suicidal ideation and behavior

4. Be aware of resources for parents and families on depression and anxiety and treatment.

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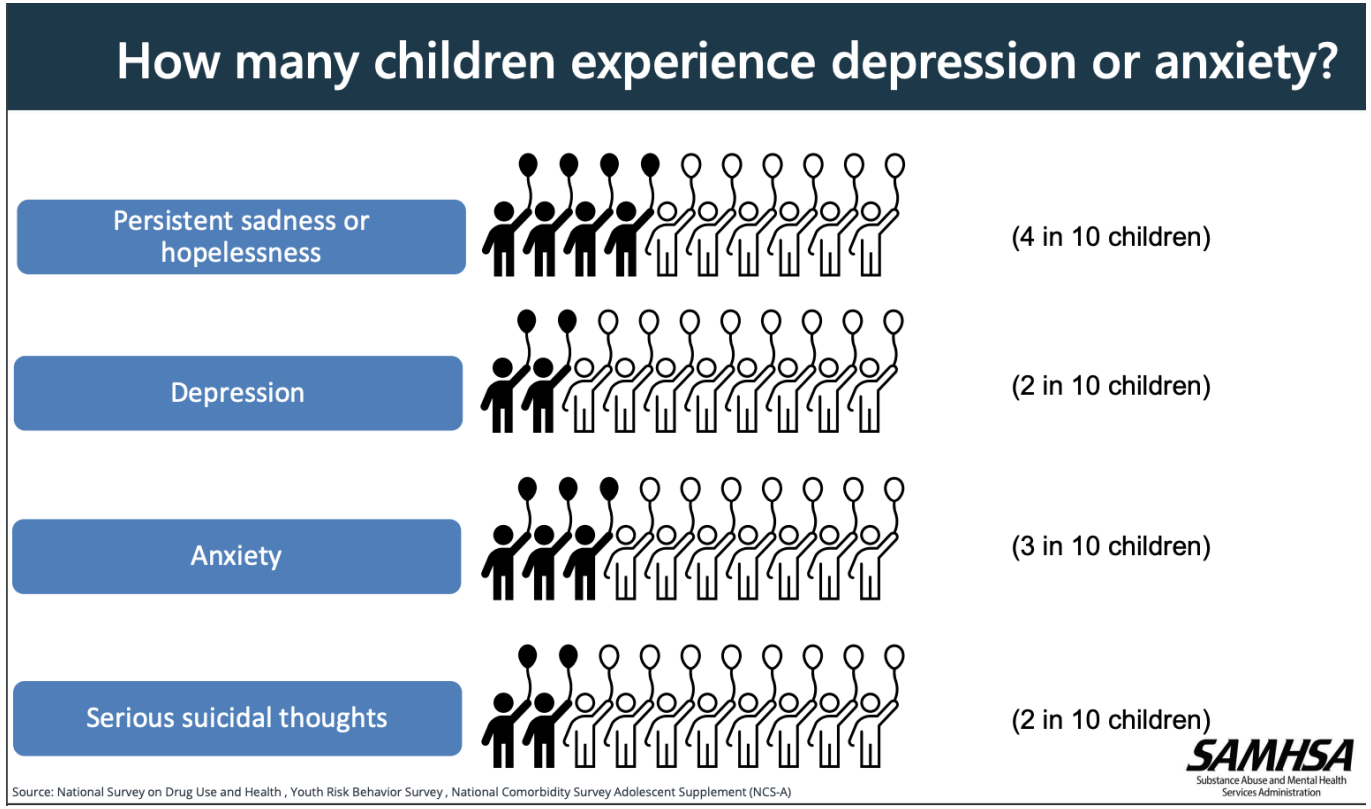
Why is this Important?

- Anxiety and depression are the most common mental health problems affecting children, adolescents and young adults.
- Primary care settings provide a unique opportunity to screen and intervene.
- Early identification and treatment can profoundly reduce short - and long-term morbidity and mortality



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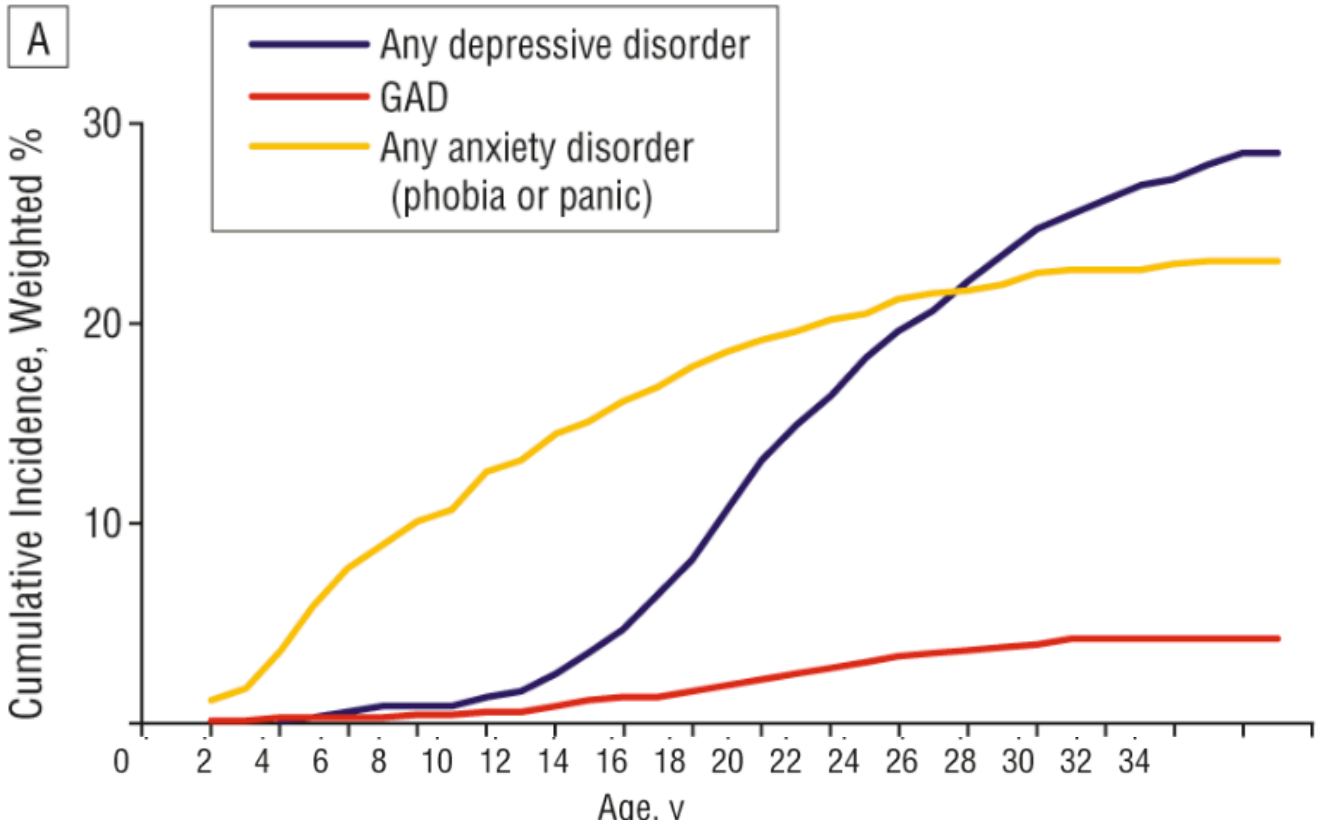
Incidence and Onset of Anxiety and Depression



- Anxiety
  - Lifetime prevalence
    - 32% teens
  - Onset Elementary school
- Depression
  - Lifetime Prevalence 15%
  - Onset ~Middle School

Arch Gen Psychiatry. 2010;67(1):47-57. doi:10.1001/archgenpsychiatry.2009.177

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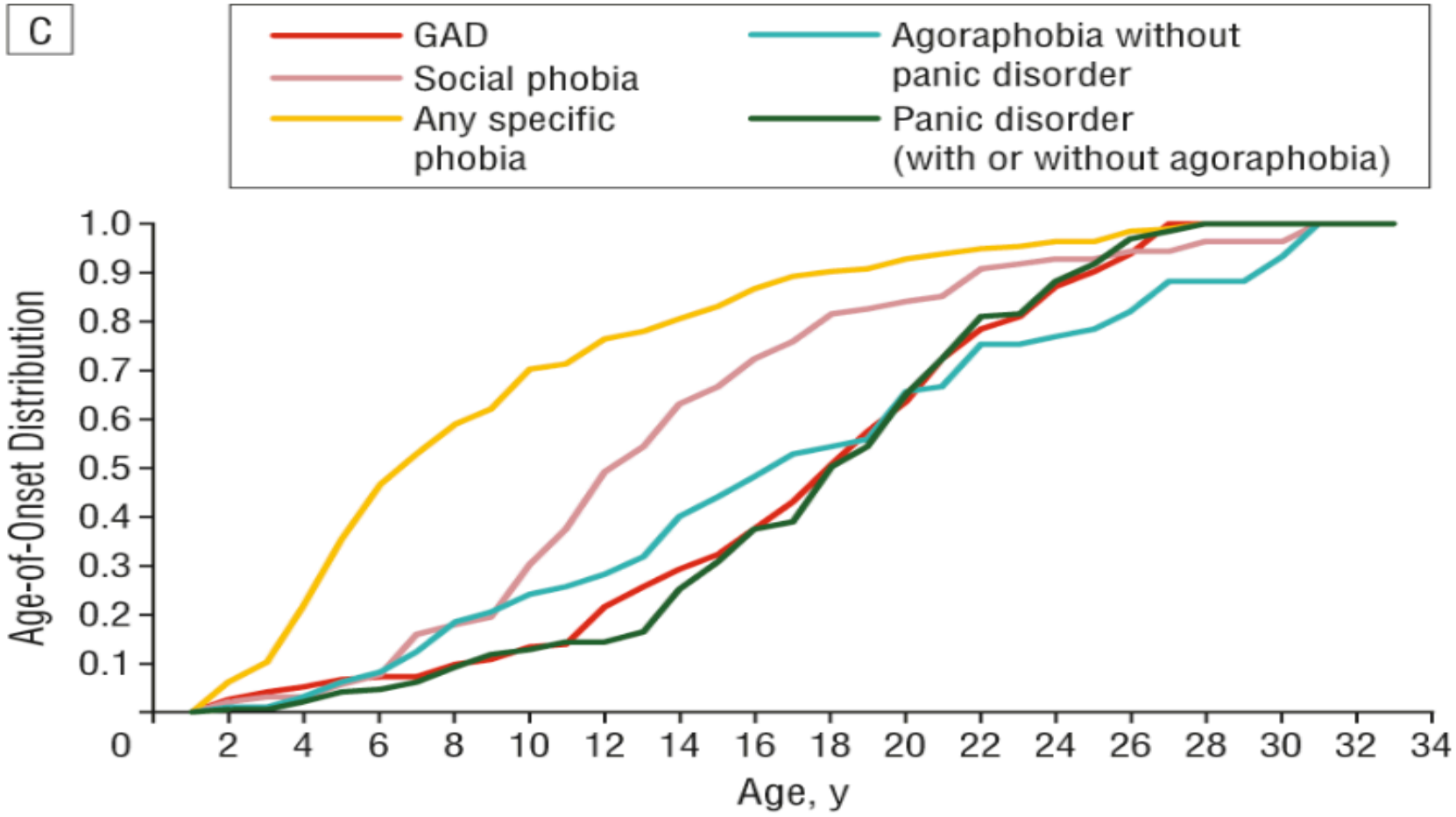
Onset of Anxiety Disorders Over Time



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Arch Gen Psychiatry. 2010;67(1):47-57. doi:10.1001/archgenpsychiatry.2009.177

Normal vs Disorder?
When to Worry about Worrying or Sadness

- Anxiety and sadness are the brain and body's healthy response to stressors such as threat, pain or loss. Although unpleasant and sometimes exaggerated, it is usually transient, but is adaptive, and not pathological.
- **Becomes a "disorder" when it interferes with functioning, is persistent, overly frequent, or severe.**
- Anxiety, in particular, manifests differently over the course of development. Consider the following to help sort out when to worry about worrying:

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Object of Fear:	Intensity of Fear:	Impairment:	Ability to Recover/Coping Skills:

• Is this something a child <u>of this age</u> should be worrying about?
• **Typical** "**Normal**" **developmental fears**:
  • **Toddlers-** imaginary creatures, darkness, separation anxiety
  • **School-age**- injury, natural disasters/events (ex: storms, earthquakes)
  • **Adolescents**- school-related, social competence-related, sexuality-related, health issues
	• **Is the degree of distress unrealistic** given the child's developmental stage and the object/event?	• Does the distress **interfere** with the child's daily life?
		  • Social functioning: unable to make friends, go on play dates, speak in class
		  • Academic functioning: failing classes, refusing
		  • Family functioning: creating conflicts, limiting family choices
		  • Health: Interfere with sleeping/eating
		  • Family functioning
			• Is the child able to recover from distress when the event is not present?
			• Tend to worry about future occurrences of event/object
			• Distress occurs across multiple settings

Approach to Diagnosis & Treatment

- **SCREEN**
- **FOCUSED ASSESSMENT**
- **DIAGNOSIS**
- **TREATMENT PLAN**
  - Education and counseling w/in PCP visit.
  - Home Management
    - Safety Planning
  - Therapy Referral
  - School Collaboration
  - Medication Management
  - Follow up

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Initial Screening

Screen for Behavioral Health Problems

Annually, **health maintenance visits**, other behavioral concerns, or if frequent unexplained somatic complaints, risk factors present

- **Informal interview-** Ask about problems or worries, feelings that interfere with activities or relationships. Avoidance? Unexplained Physical Complaints?
- **Pediatric Symptom Checklist** (PSC 17(cut point 15/5 internalizing), PSC 35) (age 4 -17)
  - internalizing sx, externalizing sx, and ADHD sx; Parent and youth versions; in over 40 languages
- **PHQ 9/9-A** (age 12 and up) cut point 10 moderate 20 severe
- **Suicide Risk Assessment** –Ask Suicide Questions, Columbia C-SSRS-
  - See ACCESS MH Webinar on psychiatric emergencies

PROVIDE FOLLOW UP ASSESSMENT IF SCREENS POSITIVE OR ANY RISK FACTORS
(SOMATIC SX, CHANGE IN FUNCTIONING, LGBTQ+, STRESSFUL EVENTS TRAUMA)

Follow up screens - Depression
- Depression PHQ 9/ 9-A
- CES-DC

Follow up screens - Anxiety
- SCARED, Parent and Child
- GAD- 7

Negative screens do not always mean there is no problem, When in doubt, check it out, and look further

Symptom Specific Rating Scales

- Administer and Review reports and Symptom Specific Rating Scales
  - Suggested scales
    - PHQ 9 or PHQ 9-A
      - Age 12 and up
      - (Cut-point 10, moderate, 20 severe
      - PHQ 9A includes ASQ risk screening questions)
    - CES-DC
      - DC –Age 6-17 Cut-point 15 (but increasing severity up to 60)
      - CESD= Adults (Cut-point 16)
    - SCARED SCALES parent and self report (Anxiety)
      - (cut off point 25 and above)
    - GAD 7 (Anxiety)
      - (cut-point 10 moderate, 15 severe)
    - ASQ (Ask Suicide Questions) Risk assessment
    - C-SSRS (Columbia Suicide Severity Rating Scale)

    - S2BI, SBIRT or CRAFFT for Substance use

  - (See WWW.ACCESSMHCT.COM Child>Resources
    for extensive listing and links to available recommended scales.)

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SUICIDE - An Opportunity to Screen and Intervene

- Second leading cause of death in youth (10-24y)
- Rates of pre-teen suicide have been increasing by 8% a year since 2008 (Ruch D, Horowitz, L JAMA 2024)

- **3/5 of youth who died by suicide had no previously documented mental health diagnoses! (CDC-)2024**

- **30%** of individuals who died by suicide had a healthcare visit in the 7-days before suicide.
- **>50%** within 30 days
- **>90%** within 365 days.

Chaudry, et al 2024

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Suicide Screening

CSSRS- Columbia Suicide Severity Rating Scale

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. If yes, was this within the past 3 months?		High Risk

988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Ask Suicide Questions

asQ Ask Suicide-Screening Questions

NIMH TOOLKIT
Suicide Risk Screening Tool

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. Have you ever tried to kill yourself? ❍ Yes ❍ No

If yes, how? _____

When? _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ❍ Yes ❍ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 741741

asQ Suicide Risk Screening Toolkit · NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) · NIH · 2/6/2024

See prior AMHCT talk on psychiatric emergencies

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FOCUSED ASSESSMENT

1. Obtain and review symptom specific rating scales
2. Review any information from obtained from school or collaterals.
3. Interview of parent(s)/caregiver and child
    - Problem Focused History
    - Mental Status
4. Medical Assessment
5. Differential Diagnosis
6. Suicide/Homicide/Self-Injury Risk Assessment

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ASSESSMENT - Interview with Family and Child

- **Include individual interview child (>8yo)**
- **Problem Focused History & Interview**
  - How problem evolved over time, what was done to help and how it worked.*
  - Assess level of associated distress and functional impairment
  - Obtain family history of anxiety, depression, other mood disorders substance abuse and stressful events (Adoption, Foster Placement DCF involvement)
  - Eating and sleeping patterns (family sleep habits)
  - LGBTQ+ and other gender or sexuality concerns
  - Assess substance use, including vaping–SBIRT(Nicotine, cannabis, opiates, alcohol etc.)
  - Check for other triggers, trauma, co-morbid conditions (OCD, anxiety, depression, etc.)
  - School, Social activity and stressors (bullying, social media)
  - Always assess for safety and self harm.
- **Review any information from obtained from school or collaterals.**

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Assess Family Functioning

- Assess for family stressors and strengths
- Other family members with substance or mental health issues
- Family stress or dysfunction related to patient issues or other factors.
- If parent has anxiety, depression, and/or substance abuse encourage their own therapy
- Screen for accommodation of anxiety
  - (Maladaptive pattern of protecting, reducing or avoiding stress instead of helping child cope. Exacerbates dysfunction.)
    - How does the child's difficulty affect family?
    - How much does the child and family restrict activates due to their difficulties (not going out, shopping?)
    - How much time is spent accommodating to their anxiety or mood?

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Consider: Comorbidities, Other Contributing Factors & Differential Diagnoses

- Other Mood Disorder, **Especially Bipolar, OCD**
- Trauma - Individual or family history of PTSD or abuse
- Autism Spectrum Disorder
- ADHD, behavior issues
- Sleep issues (insomnia, bedtime anxieties, co-sleeping)
- Body Issues, Eating Disorder, (including ARFID)
- Excessive or problematic media use
- Academic difficulties or learning disorder
- Adoption, out of home placement, foster care
- Substance Use
- LGBTQ+
- Medical conditions: medications, anemia, thyroid dysfunction, etc.

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Once Diagnosis Confirmed, Assess severity to determine Treatment

MILD

Few symptoms and discomfort

May not occur in all settings

Distressing but manageable

Minor impairment

PHQ 9 cut point 10

GAD7 Cut Point 10

SCARED Cut point 25

MODERATE

Multiple symptoms,

Persistent distress

Manageable but some impairment in multiple settings

PHQ 9 Cut point 15

SCARED cut-point >30

SEVERE

Symptoms are seriously distressing and unmanageable

Marked interference in functioning

PHQ 9 cut-point 20

GAD 7 cut-point 15

If concerned for safety or danger to self or others refer for urgent assessment.
211-1 (mobile crisis), UCC, 911, 988 or call AMHCT to advise

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Treatment Recommendations

ALL

Provide diagnosis, education, and recommendations
Review safety plan and resources
Office-based counseling
Guided self-management
Follow up

MILD

Consider referral to therapy

MODERATE

Refer to therapy

Consider medication

SEVERE

Refer to therapy

Recommend medication

Complex? Consider calling AMHCT

If concerned for safety or danger to self or others 211-1 (mobile crisis)/988/911, UCC or call AMHCT to advise

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Therapy

- Therapy is the first line treatment
  - “Skills before pills”
- Medication is adjunct
  - Rx Goal is to Reduce Sx so that they engage in Therapy
  - Rx benefits last the duration while therapy benefits persist
- Depression Tx
  - CBT, IPT (Inter-Personal Therapy), Behavioral Activation, DBT
- Anxiety Tx –
  - CBT, Exposure Response Prevention, Family Tx
- Call ACCESS Mental Health to facilitate referrals.

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Refer for Immediate Crisis Assessment if:

- Evidence of recent suicidal behavior, active intent or planning
- Family or child lack of cooperation in assessment of safety
- Concerns that family will not access Emergency Services
- Presence of Psychosis

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Patient Education

- ***De-stigmatize*** the experience of being depressed or anxious
- ***Review the Assessment and Diagnosis***
  - Review the symptoms they described and how it fits the diagnosis and differs from normal sadness or worries
  - Use their own words and screening results.
- ***Educate*** the patient and family about the origins, time course, and treatment of their issue.

  Depression is episodic and may resolve without treatment. However, with treatment, especially therapy, it will likely resolve faster and is less likely to return.

  Anxiety disorders tend to progress over time and are more amenable to early intervention.
  - Review treatment options, including no treatment.
- ***Empower*** the patient and family to make changes and get the help they need.
- **Review the Risk of Suicide-**
  - Asking about suicide may help prevent, not promote, suicidal behavior
  - Create a safety plan
- **Review the importance of healthy sleep and diet** and of avoiding alcohol and recreational drugs (including cannabis)
  - can set and review goals related to these at each visit
- **Teach back-** Ask family to repeat back important instructions (to make sure you explained it clearly)
- **Encourage questions**
- **Give and/or recommend resources** to learn more about their issues

  -resources listed at end of talk.

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Safety Plan

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1.
2. 3.

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. 2. 3.

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ **2. Name:** _____ **3. Place:** _____

Contact: _____ **Contact:** _____ **4. Place:** _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ **2. Name:** _____ **3. Name:** _____

Contact: _____ **Contact:** _____ **Contact:** _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ **Phone:** _____ **Emergency Contact :** _____

2. Clinician/Agency Name: _____ **Phone:** _____ **Emergency Contact :** _____

3. Local Emergency Department: _____ **Emergency Department Address:** _____ **Emergency Department Phone :** _____

4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. 2.

www.Zerosuicide.edu.org

www.SuicideSafteyPlan.org

Suicide Safety plan APPs

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Patient Education Pearls & Scripting

	DEPRESSION	ANXIETY
	• **Review their diagnosis** using symptoms that they described, and you found on exam • It is not the patient's fault. It is caused by a combination of innate predisposition and stressors (past or recent) • Therapy?> Call ACCESS MH to assist with referrals	
General definition	Being sad is a normal reaction in difficult times. However usually, the sadness is temporary. In clinical depression it gets stuck interferes with functioning, unable to feel good when good things happen. Often the bad feelings are out of proportion don't go away, even when do things to feel better	Being scared or worried is a normal and healthy response to danger. The body has a built in alarm system do deal with danger. However, when you have an anxiety disorder the body and brains alarm system is out of balance. Going off the at the wrong time with false alarms , the wrong amount or even getting stuck. When you have an anxiety disorder it interferes with functioning and feeling happy
Disease course	Episodes that may last for months or even years. Frequently recurrent, sometimes persistent.	It usually has a more chronic, progressive course with fluctuating symptom levels, a high rate of relapse.
Effect of treatment	Treatment, especially evidence-based therapies can decrease the duration and severity of the depression and even decrease the chances of it recurring.	Treatment, especially evidence-based therapies can help the patient "re-set the alarm system" and decrease the duration and severity the anxiety. CBT is FIRST LINE TREATMENT
Role of medication	Medication can help the therapy work faster. Medication alone can help with the current episode. However, therapy benefits last longer.	If therapy alone does not help, or if anxiety is so severe that it interferes with treatment. Medication can help by turning down the sensitivity of the alarms (SSRIs) or decreasing the anxiety to give time for treatments to work.
Without treatment	Without treatment, the course tends to be more severe with a higher chance of recurrence.	Giving in to anxiety temporarily by avoiding relieves the anxious feeling but makes it more powerful. With therapy and practice the fear and worries get weaker and easy to ignore. Without treatment, the course tends to be more severe

Pearls for Office Based Counseling - Anxiety

- **Listen**
  - How does the family talk about fears?
  - Does the family accommodate, organize or adjust to avoid the child being afraid?
- **Encourage coping and overcoming the fears rather than avoiding**.
  - Help Parents move from protection to support
  - Bravery = doing what you need to do even though you are afraid
  - “Yes it is scary, but you can do this”
  - Model **Calm Coping**
  - Reward coping despite being afraid
  - “Feeding vs Starving the Beast”
- If parent has an anxiety disorder, encourage treatment.
  - Anxious parents accommodate to avoid their anxieties
  - “Breaking Free of Anxiety and OCD” by Eli Leibowitz/Space Program

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Address Accommodation

- **TEACH PARENTS - Protection vs Support**
- **PROTECTION**
  - Decreasing anxiety by relieving distress or avoiding the stress
  - Leads to limiting child's adaptation, contributes to seeing the world as dangerous, family organizes around fears
  - Fosters progression of disorder
- **SUPPORT**
  - Acknowledging fears and feelings
  - Confidence in the child's ability to cope
  - Noticing and encouraging brave behaviors
  - "Courage is the resistance to fear, mastery of fear not the absence of fear" - Mark Twain
  - ELI LEBOWITZ- SPACE program, "Breaking Free of Child Anxiety and OCD"
- PCPs can be very effective in reinforcing this
- Consider referral for family therapy or therapy for caregiver

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Accommodation - Reframing the Message

PROTECTION/ACCOMODATION	SUPPORTIVE
“It’s too upsetting for them”	“It’s difficult but they can learn to handle these challenges.”
“There is nothing to be afraid of”	“It’s scary but you will be okay.”
“Its my job to protect my child”	“I will help my child learn to deal with challenges and confront fears”

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Limited FDA Approved Medications

- **DEPRESSION**
  - **Fluoxetine**- ≥8y
  - **Escitalopram** ≥12y

- **ANXIETY**
  - **Duloxetine - GAD** (fibromyalgia)- ≥7y
  - **Hydroxyzine** ≤6y
  - Fluoxetine - MDD, OCD (Bipolar 1 with Olanzapine Combo) ≤10
  - Sertraline – OCD - ≥6y
  - Fluvoxamine- OCD - ≥7y
  - Clomipramine (TCA) -OCD ≤10y

- Not FDA approved, but evidence-based options for depression and anxiety
  - All other SSRIs

    Except Paroxetine not recommended (higher adverse effects, lower efficacy than alternatives!
  - All other SNRIs (Venlafaxine, Desvenlafaxine)
  - Bupropion (NDRI)

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Medications for Anxiety and Depression*

- **ANTIDEPRESSANTS**
  - SSRIs - **Fluoxetine,** Sertraline**, Escitalopram**, Citalopram, Fluvoxamine
  - SNRIs – **Duloxetine**, Venlafaxine, Des-venlafaxine
  - NDRI - Bupropion
- TCAs - Clomipramine, Imipramine
- **Other Medications used for Anxiety**
  - Benzodiazepines - Clonazepam, Lorazepam
  - Alpha agonists - Guanfacine, Clonidine
  - Antihistamines - Benadryl, **Hydroxyzine**
  - Beta blocker - Propranolol
  - Azapirone (Buspirone)
  - Mirtazapine
- **Other Medications** used for Depression (treatment resistant)
  - SGA (quetiapine, risperidone, aripiprazole, lurasidone etc.)
  - Lithium

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* Off label but evidenced based for children/adolescents

SSRIs/SNRIs - Common Adverse Effects

- Nausea or GI upset
- Diarrhea or constipation
- Appetite/Weight changes (Gain>Loss)
- Headache
- Irritability
- Sleepiness or insomnia
- Sexual Side Effects
  - Decreased libido, anorgasmia, impotence or delayed ejaculation

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Management of Common Adverse Effects

- **NAUSEA**
  - Ginger tea or ginger ale, Omeprazole
  - Try giving with food or before bed,
  - May diminish on its own
  - Switching SSRI, (more common with Zoloft) (titrate slowly) or switch to mirtazapine or SNRI
- **SEXUAL SIDE EFFECTS**
  - Decreased libido, anorgasmia, impotence or delayed ejaculation
  - Management
    - Wait,, may resolve in a few weeks.
    - Decrease dose
    - Add or switch to Bupropion
    - Cross titrate to antidepressant without Sexual Side effects
      - Bupropion, mirtazapine, vilazodone (Viibryd), vortioxetine (Trintellix)
      - Duloxetine <SE than Venlafaxine
- **WEIGHT GAIN**
  - Usually minimal but highly variable,
  - Most common with mirtazapine, paroxetine, citalopram
  - Less with venlafaxine, Least with bupropion
  - Management:
    - Switch to different SSRI (fluoxetine, sertraline) or bupropion
    - Decrease dose

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Less Common Adverse Effects

- Tremor/ jitteriness
- Akathesia
- Diaphoresis
- Mydriasis
- **Treatment Emergent Mania** (undiagnosed bipolar)*
- **Activation**
  - Occurs with younger children, early in treatment and quickly resolves.
  - Increased energy without improved mood – may include restlessness, insomnia, impulsivity, agitation, increased dysphoria or irritability.
  - This is not mania and usually does not indicate a bipolar disorder. However, it is more frequent with Bipolar. Stop and reassess before continuing.
  - Good reason to start low and go slow.
  - Consider re-evaluation/consultation.

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*Rhode R *Am J Psychiatry*. 2024;181(7):630-638.

FDA Black Box Warning for all Antidepressants (2004)

- Increased risk of suicidal thinking and behavior in children, adolescents, and young adults taking antidepressants
- Suicidal thoughts or behavior 2% in placebo, vs 3-4% in children and young adults taking antidepressants
- Paradoxically suicide rate increased significantly after warning and decreased prescribing of antidepressants.

Monitor patients closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.

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Adverse Effects - Serotonin Syndrome

- **RARE BUT DANGEROUS**
- **Symptoms often present within a day of starting a medication**
  - Sweating, GI symptoms, hyperthermia, tachycardia, increased blood pressure, confusion, and tremors.
- **Can occur, when using multiple serotonergic agents**:
  - particularly when combining serotonin agonists with reuptake inhibitors (Ex. SSRI +buspirone +SGA + dextromethorphan)
  - St. John's wort, S-adenosyl-L-methionine (SAMe), dextromethorphan cough preparations, MDMA/Ecstasy(methylenedioxymethamphetamine)
- **Can be life threatening!**
  - If suspected, DISCONTINUE MEDICATION AND REFER TO HOSPITAL FOR IMMEDIATE ASSESSMENT AND TREATMENT.

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Antidepressant Discontinuation Syndrome

- **Occurs 1-3 days after abrupt discontinuation of SNRIs, SSRIs & other antidepressants**
- **Symptoms can include Flu-like symptoms, nausea, sensory disturbance, hyperarousal, or insomnia.**
  - Can Occur in up to 20% of of patient when they discontinue the medication abruptly after taking it for months.
  - The shorter the ½ life of the medication, higher the dose, and longer duration, the more likely it can occur
  - Most common with SNRIs, bupropion and paroxetine.
  - Does not occur with fluoxetine (long ½ life)

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Review with Patient Before Starting Medication:

- Provide Informed consent
  - Review Medication Recommended and Reasons and expected benefits
  - Possible benefits and adverse effects including black box warning.
- **It takes at least 2-3 weeks for any benefit to occur once at a therapeutic range and may take up to 6 weeks for full benefit at any dose.**
- **Adverse effects tend to come when starting the medication and often decrease or go away before benefits occur. "The most common adverse effect is no adverse effect."**
- It is important to **take every day as directed**. Missed doses, inconsistency may not only prevent medication from being effective but may make moods worse and increase adverse effects.
- Most of the time the first medication tried is effective but sometimes need to try different medications before finding one that works for each individual.
- Notify PCP and pharmacist of any new prescriptions or over the counter medications to check for interactions
- Use of cannabis, vaping or other recreational drugs can interfere with medication working, cause adverse effects & worsen moods
- Immediately report any worsening of moods and any thoughts impulses or behaviors to harm self or others.
- **WWW.AACAP.ORG AACAP Parent Medication Guide** for detailed info on Dx and Rx. Provide copy or link to family and teen.

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Reccomended SSRI Dosing & Titration

Dosages – SSRI (6 – 18 y)

Medication	Start dose (older adol.)	Range	Titrate/Taper	Tab/Liq/ Time
Sertraline (zoloft)	12.5 mg (25 mg)	50 – 200 mg	12.5 mg/week (25)	Both, QAM
Escitalopram (Lexapro)	2.5mg (5mg)	5 – 20 mg (30 mg)	2.5mg/week (5)	Both, QAM
Fluoxetine (Prozac)	5mg (10 mg)	10 – 60 mg	5 mg /week (10)	Both, QAM
Fluvoxamine (Luvox) · OCD	25 mg (50 mg)	50 ·200 mg (300mg)	25 mg/week (50)	Tabs, BID >100 mg
Citalopram (Celexa)	2.5 mg (5 mg)	5 – 40 mg	2.5 mg/ week (5)	Both, QAM
Paroxetine (Paxil)	**Avoid Using - No efficacy data, SI, Discontinuation syndrome**			

<QTc prolongation risk

Citalopram not first line as it has CV risk of QTc prolongation and is contraindicated at higher doses. Consider EKG*

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SNRIs and Bupropion

Medication	Start dose (older adol.)	Range	Titrate/Taper	Tab/Liq/ Time
Venlafaxine ER (Effexor)	37.5 mg (75mg)	37.5–150 mg (225 mg)	37.5 mg (75)	Tabs, ER, Caps ER, QAM
Desvenlafaxine (Pristiq)	50mg	50 mg	50 mg only	Tabs, QAM
Duloxetine (Cymbalta)	30 mg x 2 weeks	30–120 mg	30 mg/ week	Tabs, daily
Bupropion (Wellbutrin)	75 mg IR (3 mg/kg) 150mg XL	75 · 300mg	75 mg IR !50 mg XL	Tabs, Tabs XL, QAM

*Duloxetine is the only medication on this slide with FDA approval for kids

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Medication Trial

First, Start with SSRI…

- Depression
  - Start with Fluoxetine (or Escitalopram)
- Anxiety
  - Start with Sertraline
- Consider family history when choosing medication
  - Ask about other family member's +/- medication response

Medication Guidelines

- Start with an SSRI
  - Informed consent
  - Black box warning
- Labs: CBC, comprehensive metabolic panel, TSH,
- **Start low, go slow**
- Therapeutic dose: If response noted, may pause there
- Adequate trial: 8-12 weeks
- Try a different SSRI
- Consider SNRI (second line agent)
- **Symptomatic relief: Bridge during trial**

Basu, S- AMHCT Webinar 2022

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Medication Titration and Monitoring Pearls

- **Repeat screening tools at follow up to assist and monitor progress**
- **Check for SI/SIB risk every step.**
- **Start Low-Go Slow** = less side effects, but if titrating quickly pause for weeks once in target dose range
- Consider starting at a tiny dose (1/2 the starting dose)for first few days, especially if patient has history of being sensitive to medication adverse effects (Ask about cold medications etc.)This helps decrease anxiety and fosters collaboration
- **Increase every 1- 2 weeks as tolerated. Include pt and family in choosing fast vs slow titration.** (lowest dose vs fastest response). Foster collaboration and joint decision making
- Benefits take 3-6 weeks once in the therapeutic range.
- If no improvement continue to titrate up until benefits appear, side effects limit, or non-response
- If no improvement after 6-8 weeks of full dose, cross taper to different SSRI or SNRI.
- If only partial improvement, consider change (or augmentation -Call AMHCT)
- Consult AMHCT any step of the way

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Switching Medication

- **When to switch? 6**-8 weeks with maximum dose, taken as directed, without response target symptoms or limited by side effects.
- **First** reconsider diagnosis and review compliance, substance use or other factors that may contribute.
- **There are many ways change medications**
  - Fully taper off, then starting fresh is considered the most conservative however this potentially causes more symptoms and greatly extends the time to potential relief.
  - **However, I recommend cross tapering**
  - Taper down every 1-2 weeks (by same dose increment as initial titration).
  - Once in low end of target range begin second medication and alternate titrating up on the new medication and tapering off first medication.
  - Fluoxetine does not need to be tapered as its long half life makes itself tapering over a month once discontinued.
  - Monitor closely as sometimes the medication was more helpful than it seemed or new medication less helpful than hoped.
  - Titrate down SNRIs and Bupropion very slowly as tolerated.(Short half-life more rebound)

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Sometimes Helpful For Anxiety

Propranolol

- Blocks the physical adrenergic "Side effects" of anxiety
- Useful for: Performance anxiety, Panic attacks, School refusal
- Start at 10mg (range 20-80mg)
- Contraindicated in Asthma
- Avoid if bradycardia/ hypotension, suggest EKG

Alpha Agonists

- Attenuates adrenergic hyperarousal
- Guanfacine IR or ER (1-4mg)– to bridge before SSRI , decrease panic incidence and severity (less sedating than clonidine)
- Useful for: Co morbid anxiety + ADHD, panics, Occasional aggressive outbursts w anxiety/PTSD

Clonidine IR- (0.1-0.3mg), sometimes used as PRN

- Adverse effects – hypotension, sedation, taper to d/c

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No approval for Anxiety

Honorable Mentions

Mirtazapine*	Buspirone*	Noradrenergic Reuptake Inhibitors	**Bupropion*** (NRDI)
• Anxiety or Depression with significant or unresolving Insomnia • Significant incidence of appetite increase and weight gain (can be problem or benefit)	• Minimal side effects, Can be used alone for GAD • Shorter onset (2weeks or more) than SSRIs • Sometime useful as a bridge but then need to be much lower and slower if adding SSRI • Used to augment SSRI	• Atomoxetine & Vortioxetine (Qelbree) • ADHD meds that have are related to antidepressants and may have some use with co-morbid ADHD and Anxiety.	• ADHD & Depression • Unable to tolerate SSRIs due to wt gain or Sexual Side effects • Decent antidepressant, not as good for anxiety • Can be used to augment SSRI

*Not FDA Approved for children and/or these indications

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Bridging/ Short term/ Rescue Strategies

Short Term/ Bridging

- SSRIs and Therapy takes weeks to take hold
- In severe anxiety that requires immediate intervention.
  - Severe Panic Attacks
  - School refusal

- **Single Use** –
  - Procedures, Single events
  - ”panic button” ”just in case”
  - Do Practice run before event (dosage adjustment and adverse effects)
  - Ask pt/family to keep journal for every dose
    - When, Why, What happened

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Bridging- Quick Relief Medications
While Waiting for the SSRI and Tx to Work

- **Antihistamines - Hydroxyzine**
    - **FDA approved for Anxiety** <6yo
    - 12.5-25mg/dose for anxiety PRN q6-8 or bid, 12.5-50mg PRN for insomnia
  - Mild anxiolytic & sedating
  - Useful as PRN for panic anxiety and insomnia
  - Sedation can last for 12 hours, dry mouth, constipation
- **Benzodiazepines**
  - Very effective for short term relief of anxiety
  - Try other alternatives first
  - Avoid use in younger children, can cause disinhibition and paradoxical
  - Sedation, incoordination, (driving risk) tolerance & dependency, Dangerous and potentially fatal on OD or especially when mixed with EtOH or other drugs.
  - Can interfere with treatment (alprazolam not recommended)

  >"Chemical accommodation"- reliance on external relief instead of coping and overcoming anxiety leads to exacerbating underlying anxiety disorder- must be carefully integrated with CBT and used with severe panic and anxiety interferes with function (ex. School refusal)

  Lorazepam
    - 0.25-1mg (q4-8hr)
    - Onset in 30 minutes+, duration 10-20-hours +

  Clonazepam
    - 0.25- 0.5mg once or twice PRN
    - Onset ~ 60minutes, 1-3 day half life , single dose duration may last 12 hour.
  - Pearl: May sometime at night give to help sleep and prevents onset of anxiety attacks before school

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Not FDA Approved for children and/or these indications

Poor Response?

- Due to adverse effects or lack of benefit?
- Review Compliance
- Mis-diagnosis
  - Reevaluate Dx (check for Trauma, Bipolar Disorder, Substance use
- “Missed-diagnosis”
  - Comorbid conditions are very common and can interfere with response to treatment unless identified and addressed.
- Consider Pharmacogenetic Testing (not usually recommended)
  - if non-response to several medications or atypical side effect sensitivity
  - Metabolic (pharmacokinetic) factors can change dosing
- Refer for consult (ACCESS-MH) or specialist for consult or treatment

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FOLLOW UP

- Acute Phase
  - Weekly or bi-weekly check ins with family during initial medication titration
  - Check rating scales and safety check
- Maintenance Phase
  - Q 1-3 months depending on functioning
  - Coordinate with therapist or other provider
- Medication Discontinuation
  - Monthly depending on rate of taper and other treatment modalities.
  - Follow up 1-2 months after discontinuation

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MAINTAINANCE and DISCONTNUATION

- IF GOOD RESPONSE…
  - **Continue medication for at least 6-12 months following symptom resolution**
    Decreased rate of relapse.
  - No rush, so choose the best time
    - (Ex. Not right before they go off to college)
  - Taper slowly (by the same increments recommended titrate up, but twice as slow. Checking for relapse each step.
  - Taper more slowly with anxiety, allowing pt to use coping skills.Pt may need CBT skills refresher.
  - If symptom recur, re-titrate back one step at a time until Sx resolves. Re-refer to therapy, if Tx discontinued.
  - Wait at least 6 months, then try again.
  - If recurs, re-asses diagnosis & consider psychiatric referral or consultation

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Other Considerations

- **OCD**
  - Was split off from anxiety disorders in DSM5
  - Primary Treatment is CBT/Exposure Response Prevention
  - SSRIs (Fluoxetine, Sertraline, Fluvoxamine)

  Doses required for OCD are significantly higher often double or more that of other forms of anxiety or depression
    - TCA (Clomipramine)
- **Seasonal Affective Disorder**:
  - DDx Depression related to school issues
  - Between the Equinox's
  - Consider Light Therapy Tx
  - Consider Bupropion Rx
  - Refer for Tx (Behavioral Activation, CBT)

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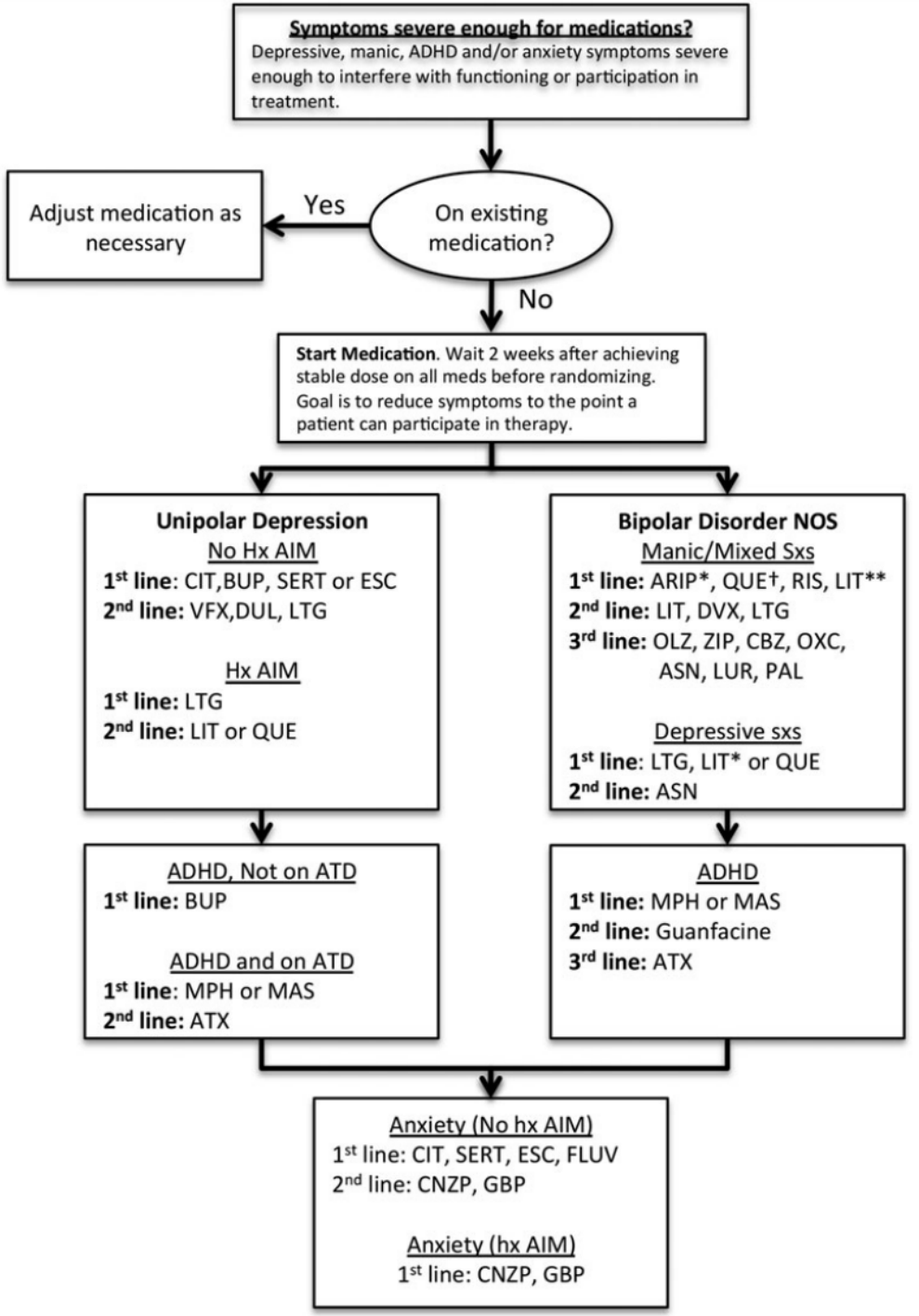
Rx of Anxiety or Depression with Family History of Bipolar Disorder

- Consider Psychiatric Consultation
- Review of family history including medication response.
- Assess for history/presence of mania, hypomania or ”mixed episodes” (depression with some features of mania (rapid speech, increased energy, impulsivity, decreased need for sleep, etc.).
- If patient has any history of mania refer for psychiatric consultation.
- Consider trial of escitalopram, sertraline or bupropion. Starting at half dose and going up more slowly. Discontinue and consult psychiatry (AMHCT) if any concerns about activation or mania.
- Avoid fluoxetine due to long half life.



C Schneck 2017

AUGMENTATION

- Augmentation is complex and requires re-consideration of diagnoses co-morbid condition, nature or partial responses
- Augmentation may be considered if:
  - Treatment Resistant Depression (or Anxiety)
  - Especially if there is partial improvement, or response plateaus.
  - Common Evidence Based augmentation agents:
    - SGAs , Lithium, Mirtazapine, Bupropion, Buspirone, Thyroid, etc
- If considering Augmentation: recommend reevaluation, psychiatric referral or consultation (good use of ACCESS MH)

All augmentation is off label for children and adolescents

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www.accessmhct.com

AMHCT is a state supported program that offers free, timely behavioral health consultation for primary care practitioners including:

- **Free Telephone Consultations 9-5 M-F** with a Child and Adolescent Psychiatrist at the time of, or within 30 minutes of your call.
- **Linkage to Care Assistance** for families to appropriate local behavioral health services.
- **Face to Face Psychiatric Consultation** to assist with diagnosis, recommendations for medication management, treatment and appropriate community-based care. AMHCT does not provide treatment.
- **Interim Support** for Families or patient provided by a licensed clinician or family peer specialist.
- **Communication back to your office** on outcomes of consultations or care linkage services.
- **Now funded to serve serve youth through age 21**

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Resources For Practitioners

- ACCESS Mental Health CT- WWW.ACCESSMHCT.COM
  - Webinars/Trainings- Resources.
  - Clinical Conversation Webinars on Depression, Anxiety, School Avoidance, Psychiatric Emergencies and more
  - ACCESS MH- Toolkits will be posted later this year for ADHD, Depression and Anxiety. More to come.
  - Educational videos for families soon to be released.
  - AMHCT for Moms program for Perinatal Mental Health Consultation, Resources Referrals and Webinars

- Academy of Child and Adolescent Psychiatry Resources WWW.AACAP.ORG
  - AACAP Parent Medication Guides www.aacap.org
  - AACAP Facts For Families
  - Clinician Resources (available for non members)

- SCREENING TOOLS
  - https://www.accessmhct.com/youth/resources-2/trainings/#
  - (Comprehensive listing of screening tools, resources and trainings)
  - https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf

  - Ask Suicide-Screening Questions (ASQ) Toolkit - National Institute of Mental Health (NIMH) (nih.gov)
  - C-SSRS Columbia Suicide Risk Screening tool. https://cssrs.columbia.edu/

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Some Resources for Families

- AACAP Medication Guides www.aacap.org:
- AACAP Facts for Families & Resource Guides: www.aacap.org >Families and Youth Tab
- Child Mind www.childmind.org.
- SAMHSA : https://www.samhsa.gov/families/parent-caregiver-resources
- Eli Leibowitz, PHD “Breaking Free of Child Anxiety and OCD” & SPACE program for parents www.spacetreatment.net
- CDC: Anxiety and Depression in Children: Get The Facts
  - www.cdc.gov/childrensmentalhealth/features/anxiety-depression-children.html
- 211-1 MOBILE CRISIS INTERVENTION SERVICE
- 988 - Suicide hotline
- 911 - Police, Fire, Emergency Medical Services
- URGENT CRISIS CENTERS
  - Village for Children, Hartford – 860-297-0520
  - Wellmore, Waterbury 203-580-4928
  - Yale, New Haven 203-688-4707
  - Child and Family Agency of SW CT 860-440-7128

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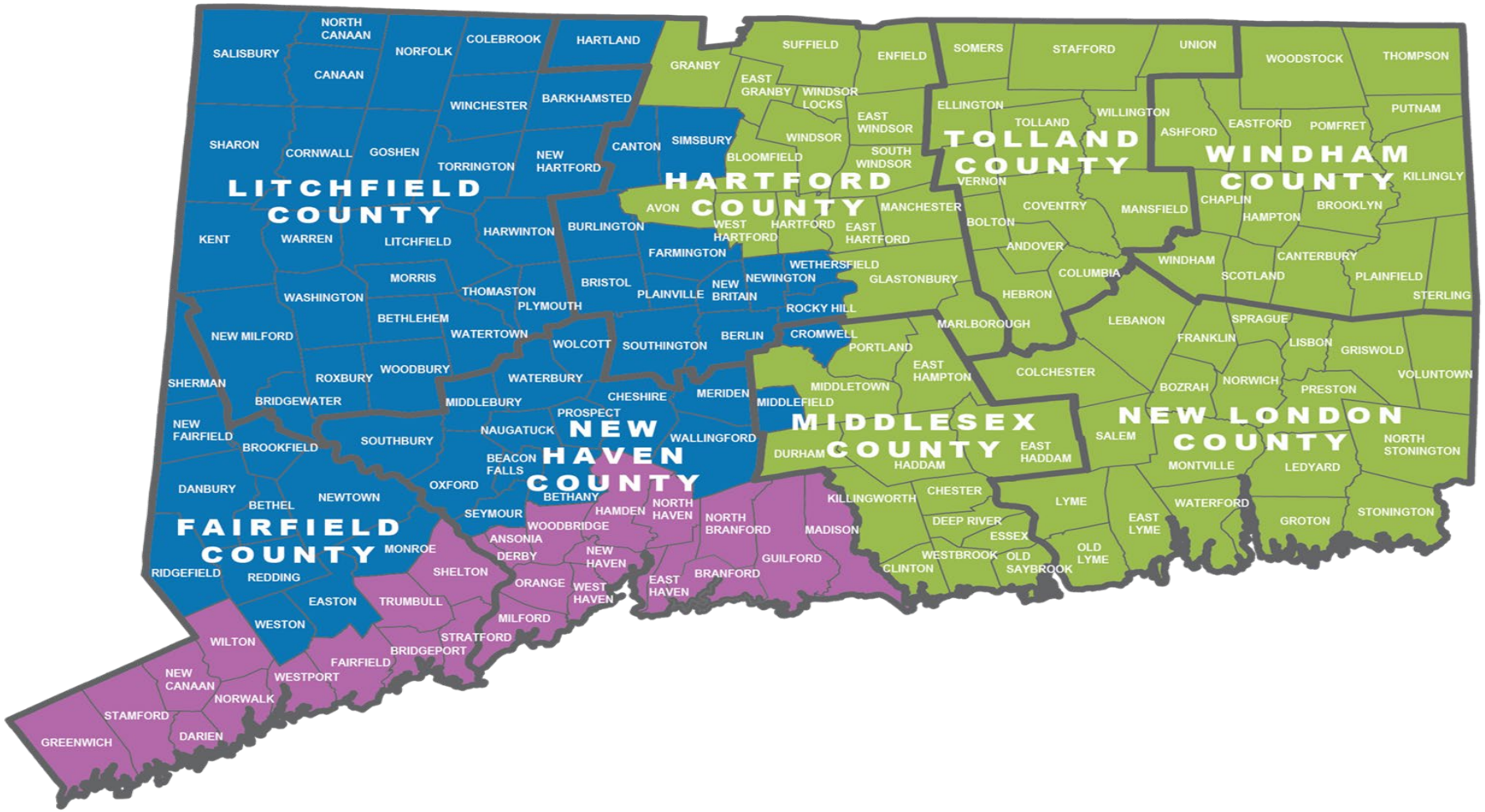
Call us with any questions, need for resources, assistance with referrals

- Yale Child Study Center 844.751.8955
- Wheeler Clinic, Inc. 855.631.9835
- Hartford Hospital 855.561.7135



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