# Diagnosis and Management of Depression and Anxiety in the Primary Care Setting

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# Learning Objectives

1. Providers will become familiar with methods of screening for depression and anxiety.
2. Providers will become more comfortable with diagnosis and management of these common pediatric mental health issues.
3. Providers will be more at ease with initiation and management of antidepressant medications.

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# Overview

**Part I:**

- Screening for Depression and Anxiety
- Risk Assessment
- Diagnosis of Depressive Disorders
- Diagnosis of Anxiety Disorders

**Part II:**

- Treatment Approach in Primary Care
- Pharmacologic Treatments for Depression and Anxiety

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# Conflicts of Interest

Dr. Solages has no conflicts of interest to disclose.

Dr. Southammakosane has no conflicts of interest to disclose. The off-label use of some medications will be discussed in the presentation.

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# THE SCOPE OF THE PROBLEM

- 10-20% of children meet criteria for a psychiatric disorder
- Limited availability of mental health services
- Stigma related to accessing mental health services
- 20% of children with psychiatric illness receive mental health care

AAP, Committee on Psychosocial Aspects of Family Health and Task Force on Mental Health

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PEDIATRICIAN

# Medical Home

- Pediatricians are in a position to identify and treat mental health disorders
- Often have longitudinal relationship with the family
- May observe emerging psychosocial problems
- Can assess whole family functioning
- Pediatrician may be limited by issues of time and training

# Depression and Anxiety in the Primary Care Setting

1. Which symptoms raise the red flag for depression and anxiety?
2. How can primary care providers screen for depression and anxiety?
3. What are the elements of a risk assessment?
4. Which elements are required for diagnosis of a depressive disorder?

# “Red Flags”

- Mood and behavior changes
- Fatigue
- Aches and pains
- Sleeping problems
- Eating problems
- Temper tantrums
- School problems
- Avoidance of developmental tasks

# Screening

- Multiple screening tools are available
- AAP Mental Health Toolkit is a resource
- Children should be interviewed individually
- Open-ended questions to begin the discussion
- Use of formal tools may make mental health screening more efficient

# Key Questions

- Do you feel sad or down more often than not?
- Do you worry a lot?
- Do sad/worried/scary thoughts keep you from sleeping at night?
- Do sad/worried/scary thoughts keep you from doing fun things?
- Do you ever have thoughts about hurting or killing yourself?

# HEADSS ASSESSMENT

**H** ome and Environment

**E** ducation, Employment, Eating

**A** ctivities and peer relationships

**D** rugs

**S** exuality

**S** uicide and Depression, Safety

# Screening Tools

| | | | | | |
|---|---|---|---|---|---|
| **SCARED** | Anxiety Disorders (except OCD and PTSD) | Ages 8-18 | 41 items<br>5 minutes | Child Self-Report<br><br>Parent Report | Available Without Purchase |
| **CYBOCS** | Obsessive Compulsive Disorder | Ages 6-14 | 40 minutes | Self Report or Clinician Rated | Available Without Purchase |
| **UCLA PTSD Index** | Post Traumatic Stress Disorder | 7+ | 20-30 minutes<br>20 items (child)<br>22 items (teen) | Self-Report or Clinician Administered | Requires Licensing |

# Screening Tools

| | | | | | |
|---|---|---|---|---|---|
| Mood and Feelings Questionnaire (MFQ) | Depression | Ages 8-16 | < 5 minutes 13 items | Child Self-Report<br><br>Parent Report | Available without purchase |
| Edinburgh Postnatal Depression Scale | Postpartum Depression | N/A | < 5 minutes 10 items | Self Report | Available without purchase |
| Pediatric Symptoms Checklist | Depression | 6+ | 5 minutes 35 items | Child Self Report 11+ Parent Report | Available without purchase |

# Response to Positive Screens

1) Assessment of  Risk/Safety
2) Further Diagnostic Clarification
3) Initiation of Appropriate Treatment
4) Determination of need for referral to Mental Health specialists

# Acute Risk

- ED evaluation - focuses on safety and need for psychiatric admission
- ED evaluation may lead to inpatient admission or other intensive level of care (i.e. partial hospital program)
- ChAMPS

-Child and Adolescent Mobile Psychiatric Services

-sponsored by Catholic Charities

- Children ages 6-18 in the District

- 202-481-1440

- Montgomery County Mobile Crisis Team

- 240-777-4000

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# Acute Risk

- Don’t worry alone! If you have safety concerns, refer for urgent evaluation
- Many adolescents who attempt suicide have contacts with providers prior to attempt
- Pediatricians should be aware of risk factors for suicide and mood disorders

# Adapted SADPERSONS

- **S** ex
- **A** ge
- **D** epression and Affective Disorders
- **P** revious Attempt
- **E** thanol and Drug Abuse
- **R** ational Thinking Loss
- **S** ocial Supports Lacking
- **O** rganized Plan
- **N** egligent parenting, family stressors
- **S** chool Problems

# Risk Factors for Suicide

- Past history of attempts
- Passive vs. active suicidality
- Intensity of Thoughts
- Suicidal plans
- Suicidal intent
- Access to means (medications/weapons)

- Mood and Anxiety Disorder
- PTSD
- Insomnia
- Aggression and Impulsivity
- Substance Use Disorders
- Psychiatric Comorbidity

Shain and AAP Committee on Adolescence, 2007

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# Risk Factors for Suicide

- Male gender
- LGBTQ youth
- Homelessness
- Poor school functioning
- History of abuse

- Poor Supervision
- Parental Mental Health Problems
- Firearms at home
- Family Conflict

Shain and AAP Committee on Adolescence, 2007

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# Protective Factors

- Desire and willingness to seek help
- Supportive family
- Peer support
- Established relationship with treaters

*Safety contracts have not been shown to be effective

*Asking about suicide does not raise risk of suicidality

Shain and AAP Committee on Adolescence, 2007

# Diagnosis of Depressive Disorders

- Primary care pediatricians can identify and treat depressive disorder
- Rule out contributing medical disorders
- Labs to consider: thyroid, cbc, others with clinical judgment
- Obtain family history of mental health disorders (and effective treatments)
- Assess acute and ongoing stressors (including abuse)

# Differential Diagnosis for Depressive Symptoms

- General Medical Conditions
- Major Depressive Disorder*
- Dysthymia*
- Bereavement
- Adjustment Disorders
- Bipolar Disorder
- Substance Use Disorders

# Differential Diagnosis for Depressive Symptoms

- Adjustment Disorders most likely if clear precipitating stressor and do not meet full criteria for an Axis I disorder
- Red flags for Bipolar Disorder include: positive family history, past manic episodes, mood lability, history of activation on SSRIs. Refer to child psychiatry if high level of suspicion for bipolar disorder

# Major Depressive Disorder

- Sadness (or irritability in kids)
- Anhedonia (lack of interest)

- Associated symptoms
  - Increased or decreased sleep
  - Change in appetite
  - Low energy level
  - Poor motivation
  - Guilt and worthlessness
  - Suicidal ideation

# Differential Diagnosis for Anxiety

- General Medical Conditions
- Depression
- Bereavement
- Adjustment Disorders
- Bipolar Disorder
- Substance Use Disorders

# Diagnosis of Anxiety

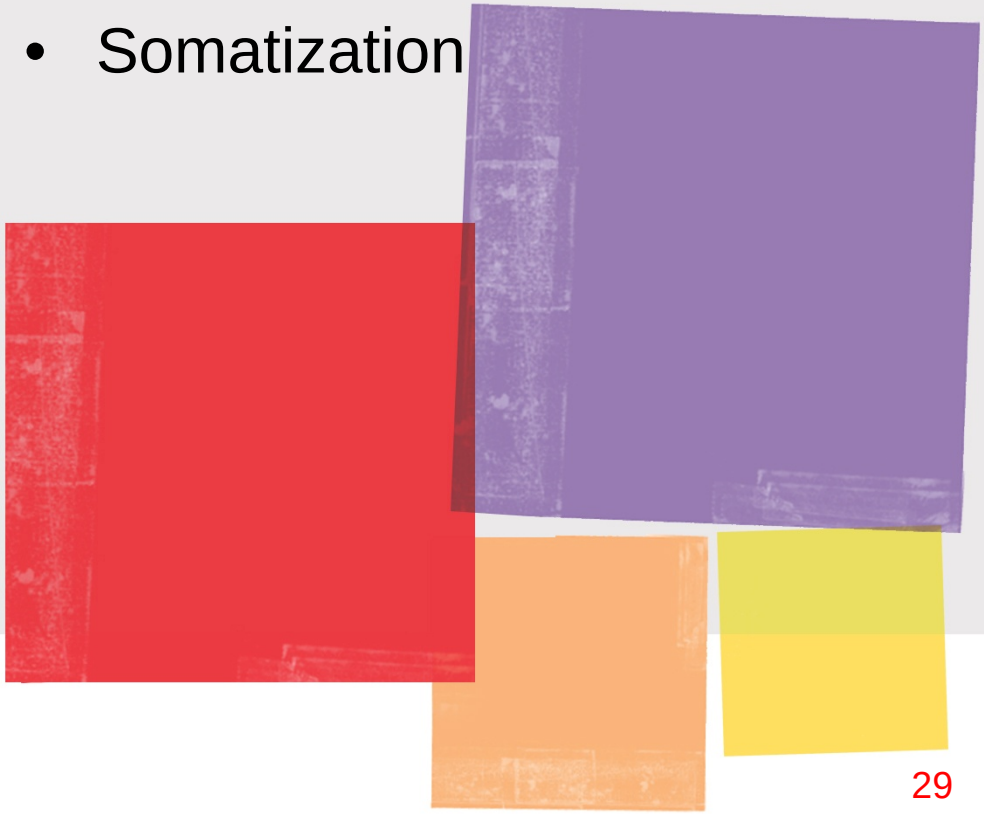
- Primary care pediatricians can identify and treat anxiety disorder
- Rule out contributing medical disorders
  - Labs to consider: thyroid, cbc, others with clinical judgment
- Obtain family history of mental health disorders (and effective treatments)
- Assess acute and ongoing stressors (including abuse)

# Risk Factors for Anxiety

- Genetics
- Parent psychopathology
- Temperament
- Parent attachment
- Parenting style

# Anxiety Traits

- Internalize
- People-pleasers
- Perfectionist
- Sensitive
- Self-conscious
- High reassurance seeking
- Rigidity / difficulty with transitions
- Low self-esteem
- Shy, social isolation
- School refusal
- Shy, social isolation
- Somatization



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# Nosology

- **Generalized Anxiety Disorder**
- **Separation anxiety**
- **Social phobia**
- **Specific phobia**
- Somatization disorder
- Selective mutism
- Trichotillomania / dermatillomania
- PTSD
- OCD

# PAN[D]AS

- OCD and/or tic disorder
- Abrupt onset and episodic course of symptoms.
- Temporal relation between group A streptococcal (GAS) infection and onset and/or exacerbation.

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# Child / Adolescent Anxiety Multimodal Study

| | |
|---|---|
| CBT | 59.7% response |
| Sertraline | 54.9% |
| Comb | 80.7% |
| Pbo | 23.7% |

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# Pediatric OCD Treatment Study

| | |
|---|---|
| CBT + SSRI | 53.6% remission |
| CBT | 39.3% |
| SSRI | 21.4% |
| Pbo | 3.6% |

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# Treatment for Adolescents with Depression Study

| | Phase 1 | Phase 2 | Phase 3 |
|---|---|---|---|
| Comb | 39% remission | 56 | 60 |
| Flx | 24% | 37 | 55 |
| CBT | 19% | 27 | 64 |
| Pbo | 19% | | |

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# Primary Care Management

- Follow-up appointments and increased frequency of clinical contacts
- Referral for therapy
- Pediatricians can provide  medication management
- Collaboration with therapist and school
- Consultation with Child Psychiatry

# Psychological Treatments

- CBT (Cognitive Behavioral Therapy) – best evidence base
- Supportive, interpersonal, psychodynamic, dialectical behavioral therapies also options
- For mild and moderate cases of MDD, Adjustment Disorder, Bereavement, and Dysthymia - therapy is first line
- For more severe cases, consider medications and therapy

# [Contra]indication

- Rule out Bipolar Disorder
  - Positive family history, past manic episodes, mood lability, history of activation on SSRIs.
- FHx

# SSRIs

- FDA-approved
  - Sertraline
    - 12.5mg daily ≤ 11yo, 25mg daily > 11yo, 50mg daily older adolescents
    - Titrate at 25-50mg increments
    - Max 200mg daily
  - Fluoxetine
    - 5mg daily, 10mg daily, 20mg daily
    - Titrate at 5mg increments
    - Max 20mg daily
  - Escitalopram
    - 10mg daily
    - Max 20mg daily
  - Luvoxamine
  - Citalopram

# SSRIs

- 4-6 wks for initial effect
- Adequate trial also involved maximum effective dose for at least three weeks

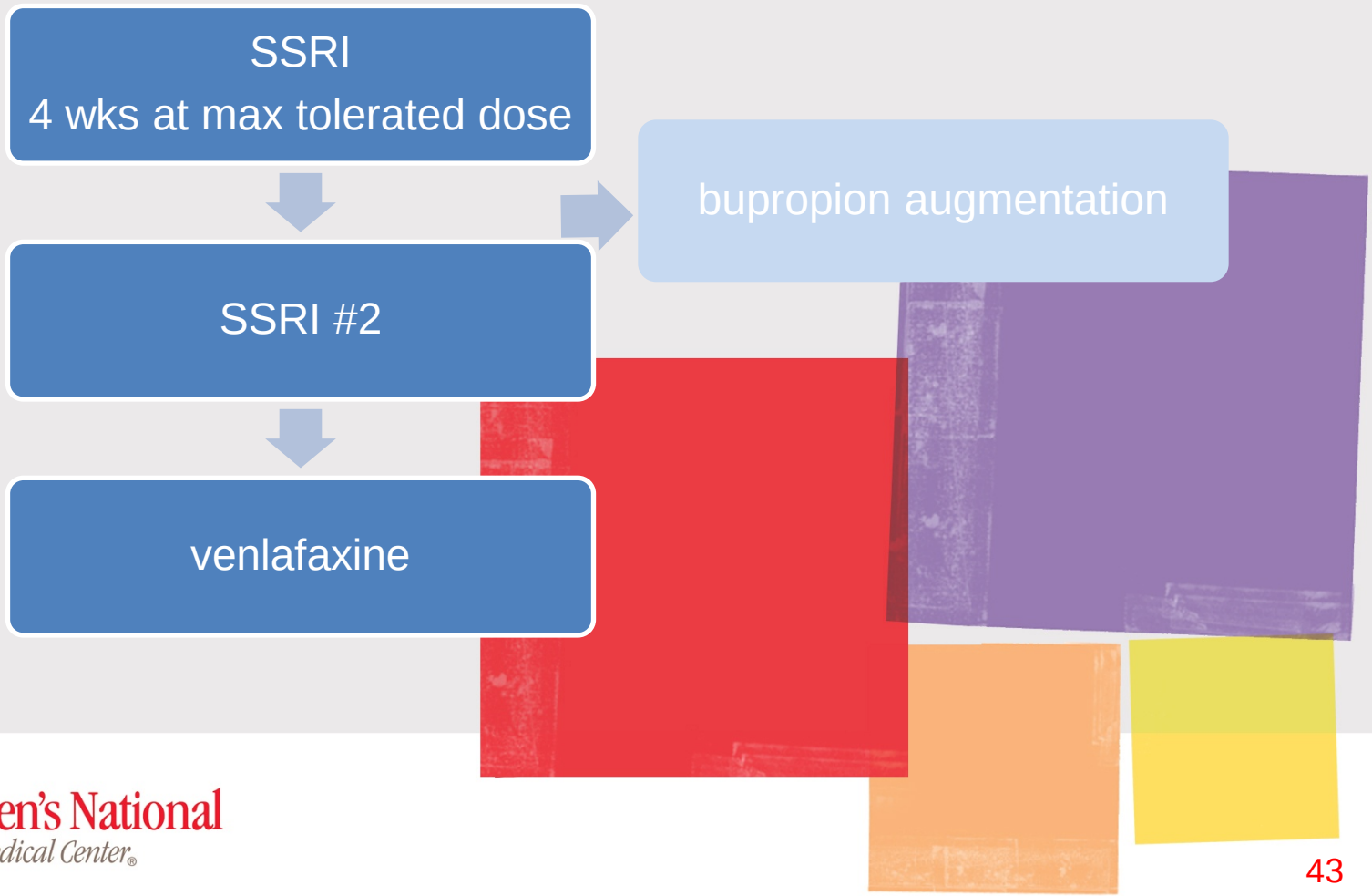
# SSRIs

- ADRs
  - Black box warning: SI
  - Worsening mood or anxiety
  - Disinhibition vs manic activation
  - GI upset, HA
  - Sexual dysfunction
  - Caution- bleeding diathesis

# SSRIs

- Withdrawal symptoms
  - Taper over 6 wks, at least
  - Flu-like symptoms
  - Resume dose and taper slowly
  - Prozac self-taper
- Serotonin syndrome
  - AMS, myoclonus / hyperreflexia, htn/ tachycardia, fever
  - Other ADs, triptans, zofran, meperidine, linezolid, reglan, INH

# Depression

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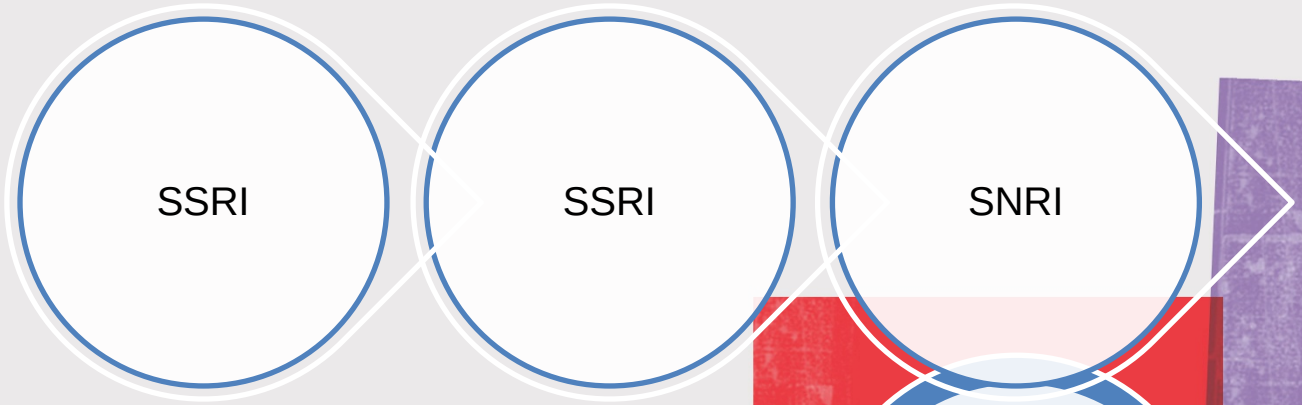
# Anxiety

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# Monitoring

- Weekly f/u
- At least monthly office f/u

- Re-evaluate need after 6-12 mos stability

# Conclusions

- Be vigilant for “red flag” symptoms and screen as clinically indicated
- Safety evaluation- if in doubt, refer for more comprehensive assessment
  - CNMC Emergency Room
  - CHAMPS/Mobile Crisis
- Refer for therapy

# Conclusions

- If depression or anxiety are severe or refractory to therapy, treat with SSRI
  - Fluoxetine
  - Sertraline
  - Escitalopram

# Resources

- CNMC OPD
  - 202-476-4733
  - enoel@childrensnational.org
- Bipolar Research Group
  - 202-476-6067

- DC Access Helpline
  - 1-888-7WE-HELP or 1-888-793-4357
- CHAMPS (Children and Adolescent Mobile Psychiatric Service)
  - Crisis Hotline: 202-481-1450
  - Access Helpline: 202-561-7000

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# Resources

- PG County
  - Mobile Crisis Team: 301-429-2185
  - Access Helpline:  301-864-7161
- Montgomery County Mobile Crisis Team
  - 240-777-4000
- Arlington County Crisis Counselors
  - 703-527-4077
- Fairfax County
  - Mobile Crisis Team: 703-573-5679
  - Access Referrals: 703-383-8500

- *DC Mental Health Access Project*