Child and Adolescent Psychiatry in the Primary Care Setting

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EXPLORE
HEALTHCARE SUMMIT

Disclosures

Objectives

- Learners will gain knowledge of evidence-based treatment approaches for managing depression and anxiety in pediatric patients, including pharmacotherapy and various forms of psychotherapy, and understand when to refer for specialized care.
- Learners will understand the significance of involving families in the management of mental health disorders in children and adolescents and will develop strategies for effective communication and collaboration with parents and guardians.
- Learners will be able to describe the prevalence rates, risk factors, and demographic trends associated with depression and anxiety disorders in children and adolescents, emphasizing the importance of early recognition and intervention.
- Learners will be equipped to utilize standardized screening tools and assessment techniques to effectively evaluate mental health status in children and adolescents, facilitating timely and appropriate interventions.
- Learners will be able to recognize the unique symptoms and manifestations of depression and anxiety in children and adolescents, differentiating them from adult presentations to improve diagnostic accuracy.
- Learners will be able to identify and discuss common systemic barriers that affect access to mental health services for children and adolescents and explore advocacy approaches and resources to enhance care accessibility for their patients.

Impact on Primary Care

"By 2020-2030, it is estimated that up to 40% of patient visits to pediatricians will involve long-term chronic disease management of physical and psychological/behavioral conditions."

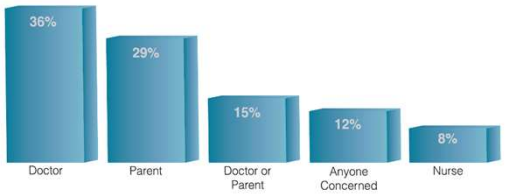
"In 2020 pediatricians have a wider array of skills including more in-depth knowledge of, and comfort treating, behavioral, developmental, and mental health concerns. Medical education includes mental health interventions, which are now an established aspect of pediatric care."

-AAP Task Force on the Vision of Pediatrics 2020

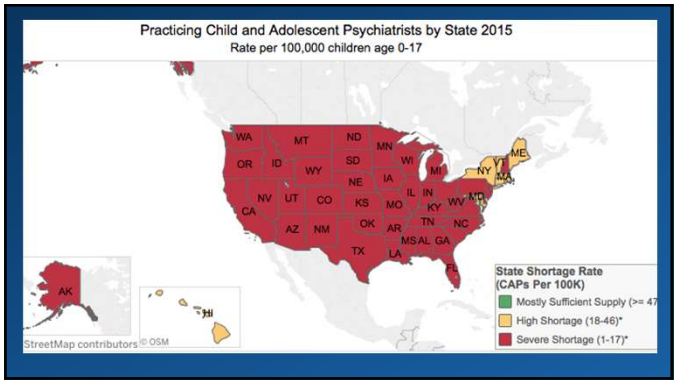
INITIATING COMMUNICATION

Starting the Conversation

When asked who should start a conversation about their child's mental health during a primary care visit, families replied as follows:

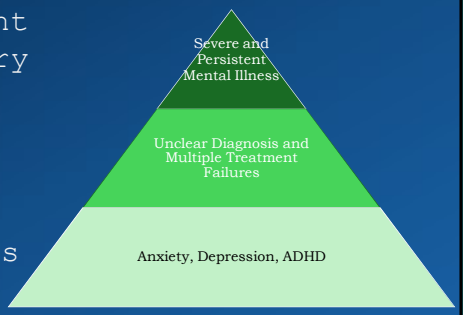


National Alliance of Mental Illness



Child and Adolescent Psychiatry

Pediatrics



Integrated Care Models in Child and Adolescent Psychiatry

	Behavioral Health Clinician Model	Child Psychiatry Access Programs	Collaborative Care Model
Behavioral Health Team	On Site: Behavioral health clinician: Social Worker, Psychologist, Nurse Practitioner (rarely psychiatrist)	Off-site Psychiatrist, therapist or care coordinator	On Site: Behavioral Health Care Manager Off/On Site: Psychiatric Consultant
Behavioral and Primary Care Physicians work:	In the same space, within the same facility, sharing health records	In separate facilities, health records are not typically shared	In the same space, within the same facility, sharing health records
Advantages in practice	Allows for collaboration of care, broad reach of the clinic population	Availability of immediacy of consultation, outreach of services (ability to reach more patients)	Measurable and definable, clinicians and teams can be held accountable to outcomes
Challenges in Practice	Cultural changes in clinical practice, defaulting to co-location, limited ability for more structured and intensive behavioral health interventions or care coordination	System issues may limit collaboration, financing of services	Sustainability issues, Limited Studies in pediatric population, financing of services

Coffey, et. al, 2017

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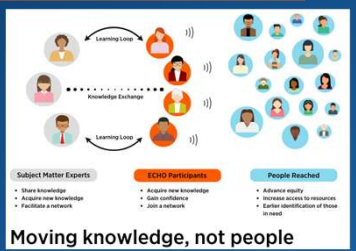

Moving knowledge, not people

Pediatric Behavioral and Emotional Health

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Get expert knowledge in a virtual learning network with Oklahoma State University Center for Health Sciences providers. Curriculum is designed to expand expertise in assessing and treating emotional and behavioral health conditions in primary care and school settings for ages 0 to 18.

Infant Mental Health

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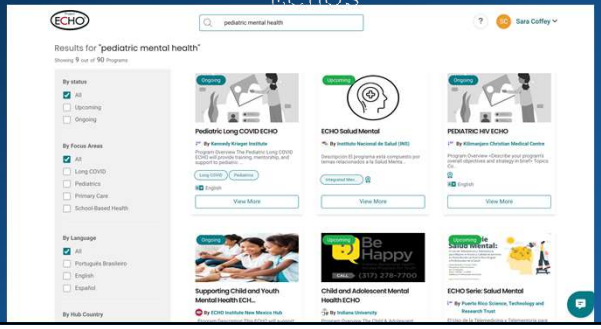

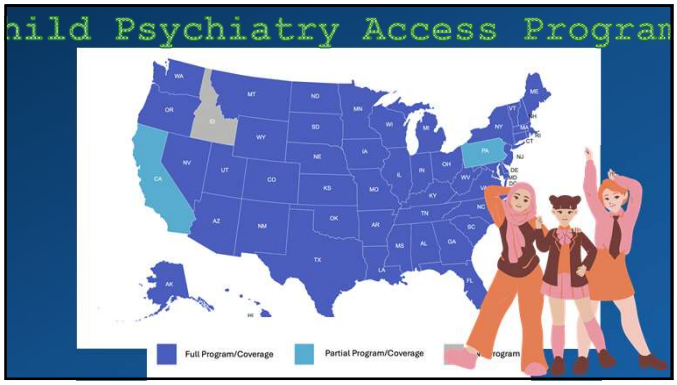
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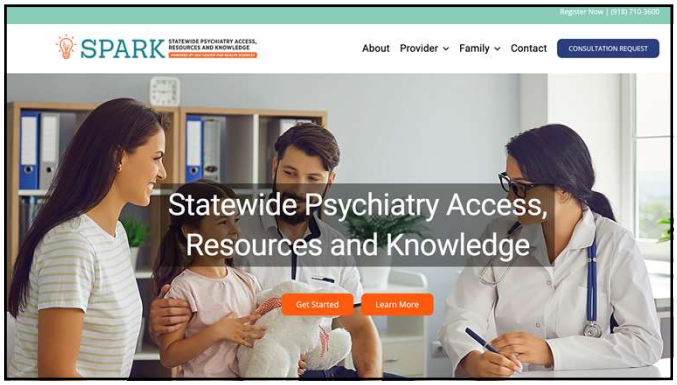
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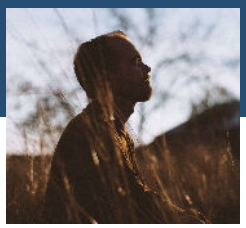
Depression

AT LEAST 5 OF THE FOLLOWING SYMPTOMS HAVE TO HAVE BEEN PRESENT DURING THE SAME 2-WEEK PERIOD (AND AT LEAST 1 OF THE SYMPTOMS MUST BE DIMINISHED INTEREST/PLEASURE OR DEPRESSED MOOD)



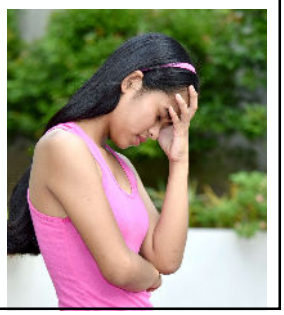
- Depressed mood: For children and adolescents, this can also be an irritable mood
- Diminished interest or loss of pleasure in almost all activities (anhedonia)
- Significant weight change or appetite disturbance: For children, this can be failure to achieve expected weight gain
- Sleep disturbance (insomnia or hypersomnia)
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness
- Diminished ability to think or concentrate; indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

Symptoms of Depression in Youth

- Irritability or anger
- Continuous feelings of sadness and hopelessness
- Social withdrawal
- Fatigue and low energy
- Increased sensitivity to rejection
- Changes in appetite and sleep-either increased or decreased
- Impaired thinking or concentration, failing grades
- Somatic complaints
- Decreased interest in activities
- Feelings of worthlessness or guilt
- Thoughts of death or suicide

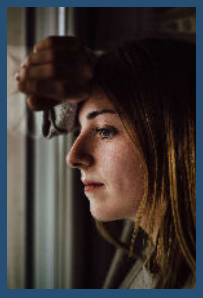
Consequences of Youth Depression

- Children who develop depression often continue to have episodes in adulthood
- Outlook is poorer with
  - younger age of onset
  - greater number of episodes
  - more time spent sick
  - greater severity and comorbidity



Depression Risk Factors

- Previous episodes
- Family history
- Other psychiatric disorders
- Substance use
- Trauma
- Psychosocial adversity
- Chronic medical illness



ADOLESCENT DEPRESSION CO-MORBIDITY

- Greater risk of substance use disorders
- Early pregnancy
- Poor academic performance,
- Impaired social functioning
- Suicide was the second leading cause of death for children, Youth, and young adults ages 10–24 years in the US in 2017 (19.2% of deaths).

The Percentage of High School Students Who:*	2013 Total	2015 Total	2017 Total	2019 Total	2021 Total	2023 Total	Trend (All Years Available)	2-Year Change (2021-2023)
Experienced persistent feelings of sadness or hopelessness	30	30	31	37	42	40		
Experienced poor mental health†	–	–	–	–	29	29	–	
Seriously considered attempting suicide	17	18	17	19	22	20		
Made a suicide plan	14	15	14	16	18	16		
Attempted suicide	8	9	7	9	10	9		
Were injured in a suicide attempt that had to be treated by a doctor or nurse	3	3	2	3	3	2		

*For the complete wording of YRBS questions, refer to Appendix A.
†Question introduced in 2021.

Highschool students

In wrong direction
No change
In right direction

PACES

PROTECTIVE AND COMPENSATORY EXPERIENCES

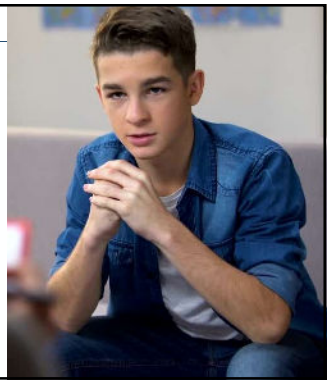
- Parent/caregiver unconditional love
- Spending time with a best friend
- Volunteering or helping others
- Being active in a social group
- Having a mentor outside of the family
- Living in a clean, safe home with enough food
- Having opportunities to learn
- Having a hobby
- Being active or playing sports
- Having routines and fair rules at home

Clinical Pearls

•Approximately 2% of children and at least 4% of adolescents suffer from depression at any given time; by the end of high school, one in five will have had at least one episode of depression

•First-line treatment for mild depression is psychotherapy and an addition of a Selective Serotonin Reuptake Inhibitors (SSRIs), for moderate-to-severe depression not responsive to therapy.

•If abuse is suspected, ensuring the safety of the patient is the first priority of treatment.



Clinical Pearls

•Depression is closely associated with suicidal thoughts and behavior; thus, it is imperative to evaluate these symptoms at the initial and subsequent assessments.

•Removing access to firearms and other lethal means in an important part of suicide prevention

•Comorbid diagnoses (anxiety, disruptive disorders, ADHD, substance use disorder) are common; depression increases the risk of the development of non-mood psychiatric problems (e.g., conduct disorder, substance abuse disorders).

Rating Scales

•Center for Epidemiological Studies Depression Scale for Children (CES-DC): ages six-17

•Patient Health Questionnaire (PHQ-9) Modified for Adolescents (PHQ-A): ages 11-17

•Columbia-Suicide Severity Rating Scale (C-SSRS)

Treatment Approach

Stage 1

• Diagnostic assessment (DSM-5 criteria with concurrent therapy in place, mild-to- moderate depression can be diagnosed and treated in the medical home.

Stage 1A

•Several psychiatric and medical disorders may co-occur with or mimic major depressive disorder (e.g. hypothyroidism, mononucleosis, side effects to medications).

Treatment Approach

Stage 2

•For patients with mild or brief depression: supportive therapy (education, support, and case management related to stressors in the family and school).

Stage 2A

•Monitor for response to supportive therapy (four to six weeks) with rating scale. If improving, continue treatment.

Treatment Approach

Stage 3

•For patients who do not respond to supportive psychotherapy or who have moderate- to-severe depression (including chronic or recurrent depression, psychosocial impairment, suicidality, agitation, and psychosis) there are recommended specific types of psychotherapy and/or antidepressants:

- Cognitive-behavioral therapy (CBT) or interpersonal therapy (IBT); and
- **Selective Serotonin Reuptake Inhibitors (SSRIs)**: fluoxetine is FDA approved in ages eight and older; escitalopram is FDA approved in ages 12 and older.

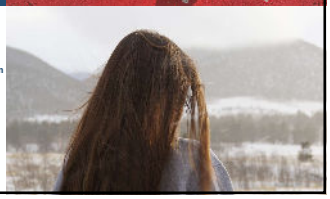
Black Box Warning:

•Antidepressants can increase the risk of suicidal thinking and behavior in children, adolescents, and young adults with MDD. Patients of all ages should be closely monitored for clinical worsening and emergence of suicidal thoughts and behaviors.

•Despite the above black box warning, SSRIs are first-line pharmacotherapy for pediatric/adolescent depression. It is important to note that depression is closely associated with suicidal thoughts and behavior, and untreated depression increases the risk of suicide.

TREATMENT APPROACH

•Stage 3A:Monitor for treatment response (four to six weeks) with rating scale; also monitor for suicidal thoughts and behaviors.

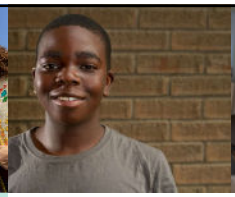


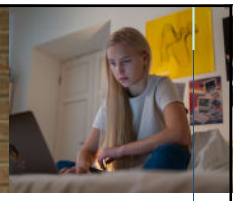
•IF IMPROVING, CONTINUE TREATMENT.

•If tolerating treatment but incomplete response, consider increasing SSRI dose (or consider adding SSRI or psychotherapy, if not already on combination of SSRI + psychotherapy).

•If not tolerating treatment/side effects, stop treatment/SSRI and consider alternative treatments (alternative SSRI and/or psychotherapy).

•If no or minimal response after at least eight weeks of treatment (including dose optimization) with two different SSRIs, consider consultation with mental health specialist (and referral, if appropriate).





TREATMENT APPROACH:

•Stage 4:For depressed patients with psychosis or bipolar disorder, specific treatments may be required (atypical antipsychotics plus antidepressants, light therapy, mood-stabilizing agents). Consultation (and/or referral) with mental health specialist is indicated (See above).

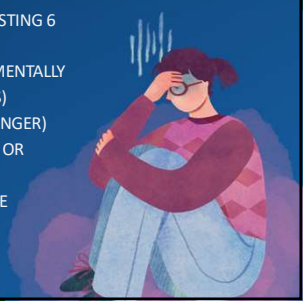
•Stage 5: Once the patient has been asymptomatic for six to 12 months, the prescriber should determine if maintenance therapy (and the type and duration of therapy) is indicated, taking into account the severity of the episode of depression and/or number of recurrences, with the goal of fostering healthy growth and development and preventing recurrences.

988 SUICIDE & CRISIS LIFELINE

24/7 CALL,TEXT,CHAT

ANXIETY DISORDERS

- GENERALIZED ANXIETY DISORDER (GAD) (LASTING 6 MONTHS OR LONGER)
- SEPARATION ANXIETY DISORDER (DEVELOPMENTALLY INAPPROPRIATE; LASTING AT LEAST 4 WEEKS)
- SOCIAL ANXIETY (LASTING 6 MONTHS OR LONGER)
- SPECIFIC PHOBIAS (LASTING FOR 6 MONTHS OR LONGER)
- PANIC DISORDER (RARE IN CHILDREN BEFORE ADOLESCENCE)



CLINICAL PEARLS

•ANXIETY DISORDERS ARE THE MOST COMMON PSYCHIATRIC DISORDER IN CHILDREN AND ADOLESCENTS, AFFECTING BETWEEN 15-20% OF YOUTH

•ANXIETY IN YOUTH MAY PRESENT AS CRYING, IRRITABILITY, ANGRY OUTBURSTS, OPPOSITIONALITY OR DISOBEDIENCE

•FIRST-LINE TREATMENT IS PSYCHOTHERAPY (MILD-MODERATE) AND/OR PSYCHOTROPIC MEDICATIONS (IF SEVERE OR UNRESPONSIVE TO THERAPY)

CLINICAL PEARLS CONT

•ONE ANXIETY DISORDER IS HIGHLY COMORBID WITH OTHER ANXIETY DISORDERS.

•ADDITIONAL PSYCHIATRIC DISORDERS FREQUENTLY DEVELOP BY LATE ADOLESCENCE OR EARLY ADULTHOOD, SUCH AS DEPRESSION AND SUBSTANCE USE DISORDERS.

•PARENTAL ANXIETY CAN BE A CONTRIBUTING FACTOR TO ANXIETY IN YOUTH; AND IF YOUTH ANXIETY IS NOT IMPROVING TREATING OF PARENTAL/CAREGIVER ANXIETY MAY BE INDICATED

Rating Scales/Screening Tools

- THE SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)
- KUTCHER GENERALIZED SOCIAL ANXIETY DISORDER SCALE FOR ADOLESCENTS (K-GSADS-A)

EVALUATION AND TREATMENT

- STAGE 1A: SCREENING: EARLY INTERVENTION AND PREVENTION
- STAGE 1B: DIFFERENTIAL DIAGNOSIS (DSM-5 CRITERIA)
  - OTHER PSYCHIATRIC DISORDERS, PHYSICAL CONDITION, AND MEDICATION INDUCED ANXIETY SHOULD BE RULED OUT AS SOME HAVE SIMILAR SYMPTOMS
- Stage 1C: Assess Severity and Impairment to guide treatment options

<u>STAGE 2A:</u>

PARENT AND CHILD EDUCATION ABOUT ANXIETY DISORDERS (SEE RESOURCE FOR CHILD MIND INSTITUTE BELOW)

MILD TO MODERATE SEVERITY AND IMPAIRMENT

FIRST LINE TREATMENT SHOULD BE PSYCHOTHERAPY
(e.g. COGNITIVE BEHAVIORAL THERAPY)

SECOND LINE TREATMENT SHOULD BE CONSIDERED IF INADEQUATE RELIEF OF SYMPTOMS HAS NOT OCCURRED AFTER ADEQUATE TRIAL OF PSYCHOTHERAPY

• SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)* (FLUOXETINE AND SERTRALINE)

•START AT LOW DOSE AND IF THERE IS NO SIGNIFICANT IMPROVEMENT AFTER 4 WEEKS OF THERAPY INCREASE DOSE

MODERATE TO SEVERE SEVERITY AND IMPAIRMENT

- Combination CBT and psychotropic medication
- Psychotropic medications*
  - **First line** is an SSRI (fluoxetine and sertraline)
  - **Second line** is a different SSRI
  - In order to avoid polypharmacy slowly titrate down dose of 1st SSRI while titrating up 2nd SSRI

STAGE 2C: MODERATE TO SEVERE SEVERITY AND IMPAIRMENT

- Third line is a Serotonin Norepinephrine Reuptake Inhibitor (SNRI)
- Third line due to increased risk of more severe Adverse Events (AEs) such as weight loss, nausea, dizziness, palpitations, or oropharyngeal pain
- Black Box Warning regarding children and adolescents have an increased risk of suicidal ideations at therapy initiation and patients should be monitored closely

NOT RECOMENDED

- Tricyclics are no longer recommended due to the cardiac monitoring requirements and a greater risk for overdose. May consider if other therapies are not working.
- Benzodiazepines have shown no benefits in clinical trials
- Buspirone has shown small benefits in adults, but no evidence in children

- No good clinical studies on when to stop therapy
- Consider stopping therapy at 9-12 months during a period of low stress and anxiety
- When stopping SSRIs and SNRIs the dose should be decreased gradually over time (stair step down dosing with several weeks between decreases)
- CBT "boosters" maybe helpful to maintain remission and symptom relief

WHEN TO STOP THERAPY

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THANK YOU

For Questions, please email sara.coffey@okstate.edu