



MENTAL HEALTH IN PRIMARY CARE

SCREENING, ASSESSMENT AND TREATMENT OF ADHD, ANXIETY, & DEPRESSION IN
CHILD AND ADOLESCENT HEALTH CENTERS

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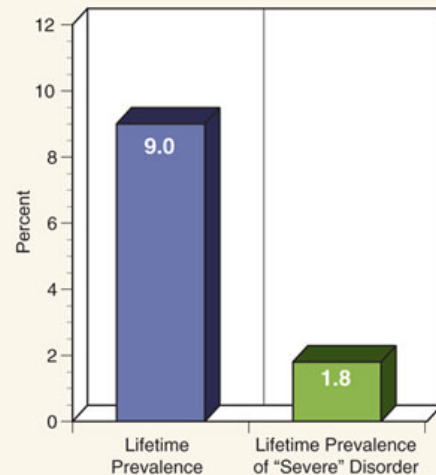
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PREVALENCE OF MENTAL HEALTH DISORDERS IN US CHILDREN AND ADOLESCENTS-ADHD

Attention Deficit Hyperactivity Disorder

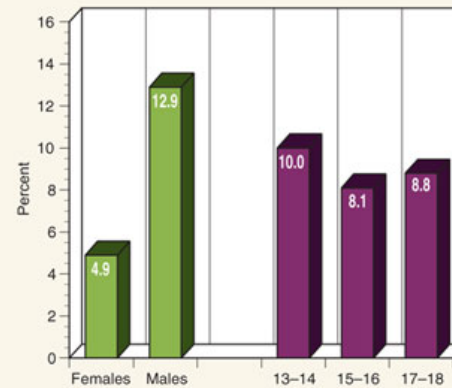
Lifetime Prevalence of 13 to 18 year olds

- **Lifetime Prevalence:** 9.0% of 13 to 18 year olds
- **Lifetime Prevalence of "Severe" Disorder:** 1.8% of 13 to 18 year olds have a "severe" disorder



Demographics (for lifetime prevalence)

• Sex and Age



• **Race:** Not Reported

Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry*. 2010 Oct;49(10):980-989.

ADHD is the most common neurobehavioral disorder in children and occurs in approximately 8% of children and Youth; the number of children with this condition is far greater than can be managed by the mental health system. There is now increased evidence that appropriate diagnosis can be provided for preschool-aged children (4 –5 years of age) and for adolescents.- AAP ADHD Guidelines

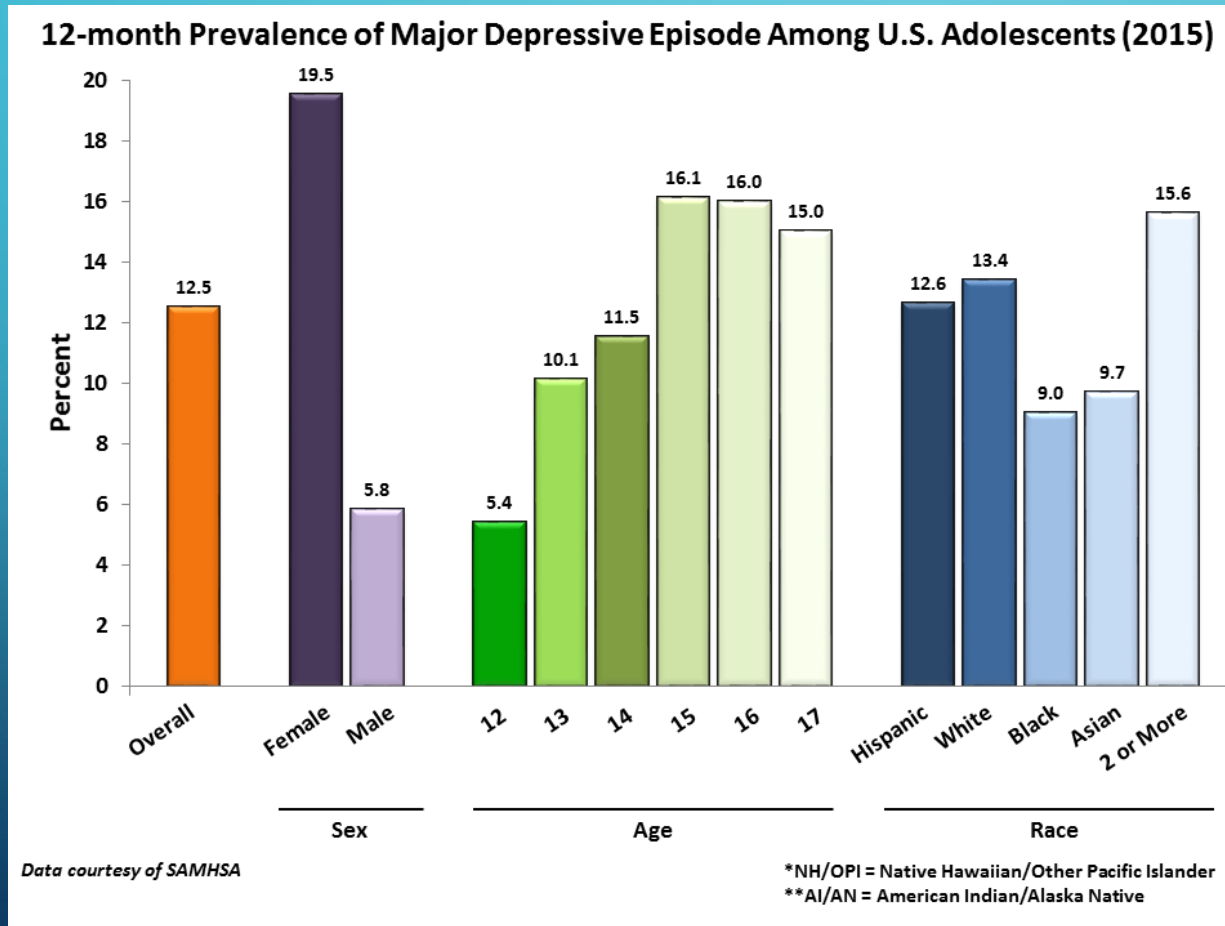


PREVALENCE OF MENTAL HEALTH DISORDERS IN US CHILDREN AND ADOLESCENTS- DEPRESSION

- In 2015, an estimated 3 million adolescents aged 12 to 17 in the United States had at least one major depressive episode in the past year. This number represented 12.5% of the U.S. population aged 12 to 17.
- 11% of youth will experience depression associated with academic difficulties, engagement in risky behaviors, and non-suicidal injury.
- 75% of individuals experiencing depression during adolescence will make a suicide attempt in adulthood.
 - Green et al 2003.



PREVALENCE OF MENTAL HEALTH DISORDERS IN US CHILDREN AND ADOLESCENTS- DEPRESSION



PREVALENCE OF MENTAL HEALTH DISORDERS IN US CHILDREN AND ADOLESCENTS-ANXIETY

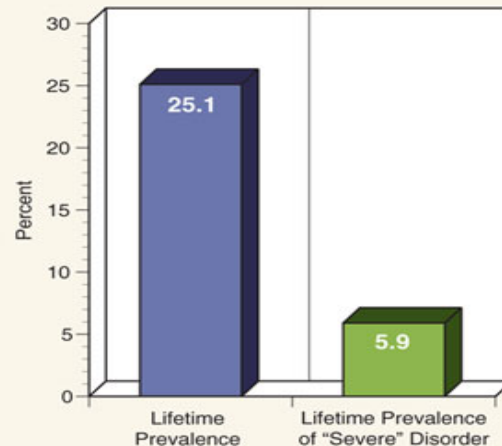
- **Anxiety disorders affect 25.1% of children between 13 and 18 years old.**
- **Research shows that untreated children with anxiety disorders are at higher risk to perform poorly in school, miss out on important social experiences, and engage in substance abuse.**



PREVALENCE OF MENTAL HEALTH DISORDERS IN US CHILDREN AND ADOLESCENTS-ANXIETY

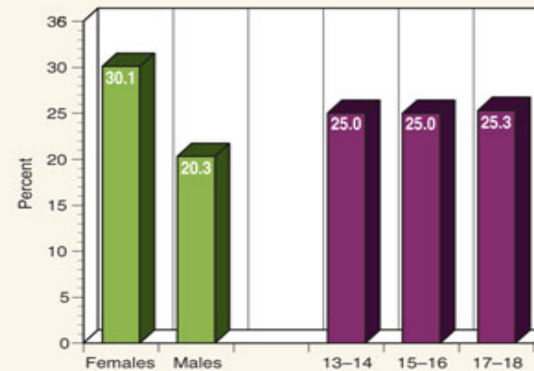
Lifetime Prevalence of 13 to 18 year olds

- **Lifetime Prevalence:** 25.1% of 13 to 18 year olds
- **Lifetime Prevalence of "Severe" Disorder:** 5.9% of 13 to 18 year olds have "severe" anxiety disorder



Demographics (for lifetime prevalence)

- **Sex:** Statistically different
- **Age:** Not statistically different



- **Race:** Statistically significant differences were found between non-Hispanic whites and other races

¹Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. *Lifetime prevalence of mental disorders in U.S. Adolescents*. Under review.



PREVALENCE OF TEEN SUICIDE



- 2nd leading cause of death in youth 10-34
 - Rate of 8.59 in 15-19 year-olds
 - More than 5079 teens die by suicide per year in the US
 - CDC and Prevention -2014 WISQARS data
- LGBTQ Youth
 - 5 times more likely to attempt suicide and to need medical treatment after an attempt compared to heterosexual youth.
 - 8.4 times more likely to attempt suicide if parents are rejecting vs. accepting.
 - 92% of transgender youth report attempting suicide before the age of 25.
 - www.thetrevorproject.org

WHY SCREEN?



- 50% of adults with MH disorders have symptoms by age 14.
- 75% of adults with MH disorders have symptoms by 24 years of age.
 - Kessler et al 2005
- More than 75% of children with MH disorders are undiagnosed and untreated.
- Screening is critical for early recognition and intervention.
 - Foy 2010
- Identify “red flags” that may signal underlying MH disorders.

WHY PRIMARY CARE?



- There are only 8400 trained pediatric psychiatrists in the US.
- Based on the population of children in the US, that is one pediatric psychiatrist to 4,968 children aged 10-19.
 - US Census Data from 2015



HEALTH DISPARITIES IN MENTAL HEALTH

- Disproportionate amount of Hispanic and African American children affected by MH conditions.
 - Family instability and malfunctioning
 - Stigma associated with MH conditions
 - Access to care and reimbursement for care provided
 - Lack of screening
 - Inadequate numbers of MH professionals
 - Genetics
 - Poverty
 - Violence exposure
 - Public housing
- Disproportionate amount of LGBTQ youth affected by MH conditions.
 - Stigma associated with sexuality and MH conditions.
 - Increased exposure to bullying, violence, parental conflict

RISK FACTORS IN MH DISORDERS IN CHILDREN AND ADOLESCENTS

- Parents with MH disorders, including Substance Use Disorders (SUD)
 - Parent with anxiety disorder: 40% prevalence in child
 - Parent with major depressive disorder: 42% prevalence in child
- Poor self-esteem
- Lack of developmental assets (coping skills, optimism, etc)
- Altered parenting (overprotective, permissive, authoritarian)
- Parental conflict (separation, divorce)
- Chronic Illness or handicap of the child or family member



RISK FACTORS IN MH DISORDERS IN CHILDREN AND ADOLESCENTS

- Hospitalization/ life-threatening medical procedures
- Learning Disabilities
- Poor or deteriorating grades
- Chronic traumatic stress/ Traumatic events
- Peer(s) who engage in risk-taking behaviors
- Social isolation
- Bullying by peers



RISK FACTORS IN MH DISORDERS IN CHILDREN AND ADOLESCENTS

- Difficult temperament
- Behavior problems
- Stressful home or school environment
- LGBTQ
- Substance Use/Abuse



AAP MENTAL HEALTH COMPETENCIES FOR PRIMARY CARE PEDIATRICS

- Promote MH resilience.
- Integrate a brief psychosocial update into primary care visit.
- **Select, use and interpret appropriate tools for: screening for MH conditions, functional assessments, and collection of information from collateral sources and diagnostic tools.**
- Conduct history and physical assessments and observation of parent-child interactions as indicated by positive screening tools or presenting MH concerns.
- **Conduct differential diagnoses** of behavioral variations, MH problems or disorders, physical conditions with MH manifestations, and med side effects.
- Identify co-existing learning disabilities.



AAP MENTAL HEALTH COMPETENCIES FOR PRIMARY CARE PEDIATRICS

- Recognize common MH comorbidities.
- Plan diagnostic assessment alone or in conjunction with MH professionals.
- Analyze results from MH screening and information from collaborators to assess for further assessment and follow-up needs.
- Provide guidance to families on managing common MH conditions.
- Recognize MH emergencies and severe conditions which require MH specialty care.
- Assist families in accessing and using MH specialty care.
- Develop a crisis plan for MH emergencies.
- Monitor positive and negative effects of non-pharmacologic and pharmacologic treatment.
- Integrate child's and family's strengths into plan of care.
- Implement care alone or in conjunction with MH professionals





USING THE WELL-VISIT

- PREVENTION- parental knowledge of limit-setting and behavioral boundaries, “catching a child being good,” educating on developmental behavior norms
....
- Assess Sleep- *Inability* to sleep vs resistance to sleep is identifier for psychiatric disorder or sleep disorder.
- Identify Environmental Stressors- ACE’s that may mimic ADHD, Depression and Anxiety.
 - Safe Environment for Every Kid (SEEK) Questionnaire (NHLBI)
 - CYW ACE-Q- child and teen version (Center for Youth Wellness)
 - 2 question screener- patient 13-18 write the number that apply to them only



USING THE WELL-VISIT

- Screen for Substance Abuse (CRAFFT Screen) and/or medication use that may cause presenting symptoms.
- Assess for Resiliency Factors and Strengths
 - 7 C's of resiliency: Confidence, Competence, Connection, Character, Contribution, Coping, Control
- Physical exam to exclude physical causes of symptoms
 - Ie iron-deficiency anemia, elevated lead level, thyroid disorders, sleep disorders, changes in blood sugar levels, seizure disorder, asthma, cardiac abnormality, vision/hearing screening, pregnancy test (If treatment with medication) etc.
- Reinforce confidentiality of services and limitations to services.
 - MH >14 years; 12 sessions or 4 months per request; Parental consent for medication

USING THE WELL-VISIT



- Always query the parent and child/teen as to the concerns or worries about their own or their child's mental/emotional health, and behavior at home and school.
 - Bright Futures screening tools*, GAPS and/or RAAPS, HEADSS*
 - Pediatric Symptom Checklist (PSC- 35 or 17)* 4-18 years of age
 - www.massgeneral.org/psychiatry/services/psc_home.aspx
 - Child Behavior Checklist (Parent report: 18 mos-5 yrs and 6-18 yrs; Youth Self-Report 11-18)
- Positive responses should trigger an assessment of:
 - Differentiate from “normal”
 - Degree of impairment
 - Patient and caregiver distress/severity of symptoms
 - Frequency, Intensity and Duration of symptoms
 - Actions used to respond to the concern, and degree that they are helpful

PERFORMING A MENTAL STATUS EXAM

- **Appearance:** how dressed or groomed
- **Attitude and interaction:** cooperative, avoidant, guarded?
- **Activity Level:** calm, active or restless? Presence of psychomotor activity, abnormal movements or tics?
- **Speech:** loud or quiet? Flat tone or full intonation? Slow or rushed? Does the child understand what is being said? Does the child express her/himself appropriately?
- **Thought Processes:** coherent, disorganized, flight of ideas (rapidly moving from topic to topic), blocking (inability to fill memory gaps), loosening associations (shifting of topics that are unrelated). Echolalia (mocking repetition of another's words), perseveration (repetition of motor or verbal response).

- Melnyk, pgs 3-4.

PERFORMING A MENTAL STATUS EXAM

- **Thought Content:** presence of delusions, obsessions, hallucinations, phobias, hypochondriasis
- **Mood/Affect:** depressed, anxious, flat, ambivalent, fearful, irritable, elated, euphoric inappropriate.
- **Suicidal/Homicidal Ideation:** presence or absence
- **Cognitive Functioning:** orientation to surroundings, attention span/concentration, recent and remote memory, ability to abstract (insight and judgement).
- **Parent-Child Interaction** (as able): warm, nurturing, conflicted, rejecting, appropriate use of limit setting, attuned to child/teen needs and feelings, affectionate, eye contact, body language.

EXAMPLE OF A WRITTEN MENTAL STATUS EXAM

“Samantha is a well-groomed, healthy appearing overweight adolescent who is cooperative and pleasant in her conversation. She sits calmly without making abnormal movements and makes good eye contact. Her rate and quality of speech are normal. Her thoughts are generally well-organized and free of delusions. Shannon states that she can go quickly from a 0 to a 10 in terms of anger. It is evident in that she has a pattern of depressive cognitive thinking as she degrades herself frequently.

On a scale of 0 to 10, Shannon rates her depression as a 6-7 out of 10 and talks about the act that she sometimes worries especially about how others view her. She denies hallucinations or any sleep problems. Shannon states that she needs help with anger management, She has poor impulse control as evidenced by frequent anger outbursts at home, Shannon denies suicidal or homicidal ideations. She has some insight into her problems and talks about her desire to be a landscape designer, Short and long-term memory are intact.”

FUNCTIONAL ASSESSMENTS



- Medication is usually not recommended in youth without clinically significant functional impairment.
- Strengths and Difficulties Questionnaire- Impact Scale*
 - 5 Items, <5 minutes to complete
 - Domains: home life, friendships, learning and play
- Teen Functional Assessment (TeFA)*
 - 3 Items, 5-10 minutes to complete
 - Domains: home, school work and friends, worries and parental concerns
- CAFAS- LMSW Required MH Assessment in MI for Medicaid

GENERAL APPROACH TO TREATING MH DISORDERS IN CHILDREN AND ADOLESCENTS

- After completion of the assessment:
 - Triage immediately (suicidality)
 - Intervene
 - Consult with a MH therapist
 - Refer to a MH professional
- Consider SEVERITY, PERSISTENCE, and RESISTENCE TO CHANGE
- Meds: Start LOW and GO SLOW!



SCREENING FOR ADHD



- Vanderbilt- Parent and Teacher checklists*
 - Children ages 6-12
 - Domains: Inattention, Hyperactivity/Impulsivity, Combined Subtype, ODD and Conduct Disorder, Anxiety and Depression Symptoms, Academic Performance and Classroom Behavioral Performance Scales
 - Parent and Teacher Versions
- SNAP-IV
 - James Swanson-UC-Irvine
 - 18 Item Assessment based on DSM-V criteria
 - Domains: Inattention, Hyperactivity/Impulsivity, and Combined Type
 - Behaviors scored on a Likert Scale
 - Scores determined by Average Rating per Domain
 - Compare to established Top 5% for Parent and Teacher ratings

DIAGNOSIS OF ADHD



- 6 behaviors from the inattentive or hyperactive-impulsive behaviors were present prior to age 12.
 - The behaviors must be present and sustained for at least 6 months, or 1 year if under 12.
- Criteria for the disorder are met in 2 or more settings (i.e. home and school, with parents and relatives).
- There must be clear evidence that the symptoms interfere with or reduce the quality of academic, social, or occupational functioning.
- The symptoms do not occur exclusively during the course of a major psychiatric disorder (ie schizophrenia), or are not explained by another disorder.
 - include assessment for other conditions that might coexist with ADHD, including:
 - emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders)
 - developmental (e.g., learning and language disorders or other
 - neurodevelopmental disorders)
 - physical conditions (e.g., tics, sleep apnea)



DIAGNOSIS OF ADHD- INATTENTION

- Often fails to pay close attention to details or makes careless mistakes in work.
- Often has difficulty sustaining attention in work or play.*
- Often does not seem to listen when spoken to directly.*
- Often does not follow-through on work or fails to complete work.*
- Often has difficulty organizing activities or work.*
- Often avoids or dislikes activities that require sustained attention (reading, chores).
- Often loses things necessary for work or activities.
- Is often easily distracted by extraneous stimuli.
- Is often forgetful of daily activities (work, chores).
 - *MUST BE CLEARLY PRESENT

DIAGNOSIS OF ADHD- HYPERACTIVITY/IMPULSIVITY



- Often fidgets, taps hands or feet or squirms in seat.
- Often leaves seat when sitting in seat is expected (class, dinner, etc).
- Often runs about or climbs un situations where it is inappropriate (Adolescents may present with feeling of restlessness).
- Unable to play or engage in leisure activities quietly.
- Often “on the go” or feels as though driven by a motor.
- Often talks excessively.
- Often blurts out answers before a question has been completed.
- Often has difficulty waiting on his/her turn.
- Often interrupts or intrudes on others.

<http://www.addrc.org>

Attention Deficit Hyperactive Disorder

Must meet **at least 6** of the criteria within A1 and/or A2, and have experienced for at least the past 6 months.

A1: Inattention

- a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
- b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or reading lengthy writings).
- c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked; fails to finish schoolwork, household chores, or tasks in the workplace).
- e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; poor time management; tends to fail to meet deadlines).
- f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, or reviewing lengthy papers).
- g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, or mobile telephones).
- h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
- i. Is often forgetful in daily activities (e.g., chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

A2: Hyperactivity and Impulsivity

- a. Often fidgets with or taps hands or feet or squirms in seat.
- b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, office or other workplace, or in other situations that require remaining seated).
- c. Often runs about or climbs in situations where it is inappropriate. (In adolescents or adults, may be limited to feeling restless).
- d. Often unable to play or engage in leisure activities quietly.
- e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable or uncomfortable being still for an extended time, as in restaurants, meetings, etc; may be experienced by others as being restless and difficult to keep up with).
- f. Often talks excessively.
- g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences and "jumps the gun" in conversations, cannot wait for next turn in conversation).
- h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
- i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission, adolescents or adults may intrude into or take over what others are doing).

- B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12.
- C. Criteria for the disorder are met in two or more settings (e.g., at home, school or work, with friends or relatives, or in other activities).
- D. There must be clear evidence that the symptoms interfere with or reduce the quality of social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).

TREATMENT OF ADHD-PRE-REQUISITES

- Assess CV Risk: Family history, personal history of CV symptoms; EKG only if history warrants.
- Baseline height, weight, heart rate and blood pressure.
- Baseline appetite, sleep patterns, headaches, abdominal pain.
- History of SUD in the child or adolescent and the parent.
- Assess for CI to stimulants:
 - Symptomatic CV disease
 - Moderate to severe HTN
 - Hyperthyroidism
 - Known hypersensitivity or idiosyncratic reaction
 - Motor tics
 - Glaucoma
 - Anxiety/Agitation (relative; dosing adjustments required)
 - Recent or concurrent use of MAOI's



TREATMENT OF ADHD



- Treatment in children <6 years of age
 - Behavioral therapy is first-line therapy, methylphenidate if no response
- Treatment with stimulant is first-line therapy in children 6 and older
 - Parent or patient wishes to use non-stimulant medication
 - History of SUD in patient or family member (drug diversion)
 - 80% will respond to stimulant therapy- systematic approach
 - Consider duration of action
 - Consider drug preparation best for the individual
 - Consider the duration of action required for schoolwork, etc.
 - Short-acting vs. Long-acting substances
 - Consider age of the patient <6 years
 - Short-acting agents due to dosing and tolerance and PM coverage (before 4 pm) for homework for older children.
 - Titration to optimal dose for behavioral outcomes with the least side effects.

TREATMENT OF ADHD

- Titration to optimal dose for behavioral outcomes with the least side effects.
 - Increase dose every 3-7 days.
 - Appetite suppression may be an indicator of optimal dose.
 - Inadequate dosing may be suggested by shorter than expected duration of action.
 - Non-response to one stimulant, titrate on the other.
 - 50% response rate to medication switch.
 - During titration, monitor side effects and symptoms weekly, with monthly visits, minimally.
- Non-stimulant medications are weight based dosing
 - 0.6-1.2 mg/kg daily or divided BID
 - Maximum dose 100mg or 1.4 mg/kg whichever is less
 - Can stop abruptly when switching to a stimulant medication.
- Additive therapy with alpha-2adrenergics, SNRI
 - Overly active, easily frustrated, aggressive or over-aroused
 - Incomplete response to stimulant medications



ADHD OUTCOMES

- Large birth cohort 5718 patients followed until age 27, 379 had ADHD
- Of these, 29.3% had persistent ADHD into adulthood (no gender difference)
- Of the 29.3%, 23.7% had ADHD plus a comorbid psychiatric disorder, and only 5.6% had ADHD alone
- Overall survival equal in ADHD and non ADHD controls
- Accident incidence equal in both groups
- ADHD had a higher rate of suicide than controls
- 37.5% were free of adverse outcomes and symptoms

ADHD OUTCOMES

- ADHD cohort more likely than controls to have 1 or greater comorbid psychiatric disorders
 - 26.3% Alcohol abuse
 - 16.8% Antisocial personality disorder
 - 16.4% Other SUD
 - 15.1% hypomanic disorder
 - 14.2% Generalized Anxiety Disorder
 - 12.9% Major depression

ADHD OUTCOMES: MESSAGE TO PARENTS

- At least 1 /3 of kids with ADHD will have it as adults
- The majority will have at least one mental health problem in adulthood
- Increased risk of death by suicide
- Be prepared to get appropriate care across the lifespan

SELECTED ER STIMULANT PREPARATIONS- METHYLPHENIDATE

MODIFIED FROM WWW.UPTODATE.COM : PHARMACOTHERAPY FOR ADHD IN CHILDREN AND ADOLESCENTS

Medication	US Trade Name and Generic Availability	Duration of Action	Initial Dose	Dose Advancement	Maximum Dose per Day
Methylphenidate ER (10, 20 mg tabs) *swallow whole	Metadate ER + generic	Delayed onset with continuous release over 3-8 hours. May require BID dosing.	10 mg	Increments of 10mg every 3-7 days	≤50 kg: 60 mg >50 kg: 100 mg
Methylphenidate ER Chewables (20, 30 mg- scored; 40 mg- not scored)	Quillchew ER	Continuous release over 6-8 hours with DOA of up to 13 hours	20 mg	Increments of 10, 15, or 20 mg per day every 7 days	60 mg
Methylphenidate XR-ODT (8.6, 17.3, 25.9 mg equiv.10,20, 30 MHC) *Dissolved on tongue	Cotempla XR-ODT	25% IR; 75% ER for DOA of 12 hours	17.3 mg	Increments of 8.6 to 17.3 mg per day every 7 days	51.8 mg
Methylphenidate ER (18, 27, 36, 54 mg tabs) *swallow whole	Concerta + generic	20% IR 80% ER over 10-12 hours by osmotic delivery	18 mg	Increments of 9 to 18 mg per dose every 3-7 days	<13 years: 54 mg ≥ 13 years: 72 mg

SELECTED ER STIMULANT PREPARATIONS

Medication	US Trade Name and Generic Availability	Duration of Action	Initial Dose	Dose Advancement	Maximum Dose per Day
Methylphenidate LA (10, 20, 20, 40 mg)*swallowed whole or sprinkle	Ritalin LA + generic except 10 mg	50% IR, 50% DR over 8-12 hours (bimodal)	10-20 mg	Increments of 10 or 20 mg per dose every 3 to 7 days	≤50 kg: 60 mg ≥50 kg: 100 mg
Methylphenidate CD (10, 20, 30, 40, 50, 60mg caps)*Swallowed whole or sprinkle	Metadate CD	30% IR, 70% DR over 8-12 hours (bimodal)	20 mg	Increments of 10 mg per dose every 3-7 days	≤50 kg: 60 mg ≥50 kg: 100 mg
Methylphenidate XR (10,15, 20, 30, 40, 50, 60mg caps)*Swallowed whole or sprinkled	Aptensio XR	40% IR, 60% CR for duration of 12 hours	10 mg	Increments of 10mg every 7 days	60 mg
Methylphenidate XR Oral susp. (5mg/ml)	Quillivant XR	20% IR, 80% ER for duration of up to 12 hours	20 mg	Increments of 10 mg every 7 days	60 mg
Methylphenidate patch	Daytrana	Onset 2 hours after application ; CR over 9—12 hours	10 mg``	Increments of 5 mg per dose every 3 to 7 days	30 mg

SELECTED ER STIMULANTS-DEXMETHYLPHENIDATE AND AMPHETAMINES

MODIFIED FROM WWW.UPTODATE.COM : PHARMACOTHERAPY FOR ADHD IN CHILDREN AND ADOLESCENTS

Medication	US Trade Name and Generic Availability	Description of Release and DOA	Initial Dose	Dose Advancement	Maximum Dose per Day
Dexmethylphenidate XR (5, 10, 15, 20, 25, 30, 35, 4mg caps)*swallowed whole or sprinkled)	Focalin XR +generic	50% IR, 50% DR over 10-12 hours (bimodal)	5 mg	Increments of 5 mg every 3-7 days	40 mg
Amphetamine-Dextroamphetamine ER with salts (5, 10 ,15, 20, 25, 30 mg caps)* swallowed whole or sprinkled	Adderall XR + generic	Combination of IR and CR over 8-10 hours	5 mg	Increments of 5 mg per dose every 3 to 7 days	≤50 kg: 40 mg ≥50 kg: 60 mg
Lisdexamphetamine (10, 20, 30, 40, 50, 60, 70 mg caps and 10, 20, 30, 40, 50, 60 mg chews)	Vyvanse	Prodrug with bloodstream conversion to dexamphetamine over 10 hours	20 mg	Increments of 10 mg or 20 mg per day every 3 to 7 days	70 mg

SELECTED ER STIMULANTS-NONSTIMULANTS

Medication	US Trade Name and Generic Availability	Description of Release and DOA	Initial Dose	Dose Advancement	Maximum Dose per Day
SNRI Atomoxetine (10, 18, 25, 40, 60, 80, 100 mg capsules)	Strattera + generic	10 -12 hours minimum	0.5 mg/kg per day for 3 days	Increase 1.2 mg/kg per day after 3 days	Lesser of 100mg or 1.4 mg/kg
Alpha-2 adrenergics Guanfacine ER (1,2,3,4 mg tabs **may not substitute for IR form on a mg/mg basis	Intuniv + generic	10-12 hours minimum	1 mg per day	Increments of 1 mg day at weekly intervals	≤12 years: 4 mg >12 years: 7 mg

Modified from www.uptodate.com : Pharmacotherapy for ADHD in children and adolescents

SELECTED ER STIMULANTS-IMMEDIATE RELEASE PREP

Medication	US Trade Name and Generic Availability	Description of Release and DOA	Initial Dose	Dose Advancement	Maximum Dose per Day
Methylphenidate (5, 10, 20 mg tabs; 2.5, 5 and 10 mg chews; 10mg/5 ml oral solution)	Ritalin Methylin chew Methylin susp + generics	3-5 hours	<25kg: 2.5 mg/day >25kg: 5 mg/day for 1 day, then 5 mg 2 times a day	<25kg: Increments of 2.5 mg per day every 3 to 7 days >25 kg: Increments of 5 mg per day every 3to 7 days	<25kg: 35mg >25kg: 60 mg
Dexmethylphenidate (2.5, 5 and 10 mg tabs)	Focalin + generic	5 to 6 hours	w/o methylphenidate: 2.5 mg BID With methylphenidate: Half current daily dose up to 10 mg BID	Increments of 1 mg day at weekly intervals	≤12 years: 4 mg >12 years: 7 mg
Amphetamine-Dextroamphetamine	Adderall +generic	4 to 6 hours	6 years plus: 5 mg for 1 day then 5 mg BID	Increments of 5 mg per day every 3 to 7 days	≤50 kg: 40mg ≥50 kg: 60 mg

COMMON PRESENTATION OF DEPRESSION IN SCHOOL-AGED CHILDREN

- Sadness
- Irritability
- Impulsive
- Crying spells
- Loss of pleasure or interest in activities
- Frequent complaints “No one likes me.”
- Somatic complaints
- Acting out or externalizing behaviors
- Drop in grades
- **Often misdiagnosed as ADHD



COMMON PRESENTATION OF DEPRESSION IN ADOLESCENTS

- Sadness
- Hopelessness
- Self-hatred
- Self-destructive behavior
- Withdrawal
- Loss of pleasure or interest in activities
- Neurovegetative symptoms (Increase or decrease in sleep appetite, concentration).
- Drug or alcohol use common
- Risky sexual behaviors
- Drop in grades
- **Often comorbid anxiety



COMMON PRESENTATION OF DEPRESSION IN ADOLESCENTS

- More Mood Lability
- More irritability
- Low frustration tolerance
- More somatic complaints
- More social withdrawal
- Fewer delusions



DEPRESSION IN AFRICAN-AMERICAN ADOLESCENTS

- Tend to express depressive feelings by complaining about conflicts with others
- Tend to complain about physical pains
- AA adolescent females were more likely to report poor self-esteem, abuse (physical, verbal and sexual), poor body image and antisocial behavior (fights, verbal abuse, defiance of authority theft, etc).
- CES-D does have somatic symptoms and interpersonal relations domains, but is not validated as a screening tool in AA adolescents.

- Science Daily January 2018.
www.sciencedaily.com/releases/2018/01/180108090232.htm



DEPRESSION SCREENS



- PHQ-A (Patient Health Questionnaire- Adolescent)*
 - 83 Items, self-report; 10-20+ minutes
 - Domains: Anxiety, Eating problems, mood problems, substance abuse
- PHQ-9 Modified for Teens* (12+)
 - 9 items plus severity items, 5 min
 - Domains: Depression and Suicidality
 - Scores of 15-19 indicate moderate depression; >20 severe depression
- CES-DC* (6-17 yrs.)
 - 20 items; 6th grade reading level; 5-10 minutes
 - Scores >15 may represent significant depression
 - Domains: depression, emotional turmoil

DEPRESSION SCREENS



- DASST (Depression, Anxiety and Safety Screening Tool)
 - 15 Items-Used at HFHS- not validated, but uses questions from validated tools, plus self-injury and suicidal ideation and past history of suicide (GAD2, PHQ9, C-SSRS)
- DISC (Columbia Diagnostic Interview Schedule for Children)*(9-17 yrs)
 - 22 items or abbreviated 8 item score; Training required
 - Computer –yes/no items evaluate 36 MH conditions based on DSM-IV criteria
- KADS (Kutcher Adolescent Depression Screen)*(12-17 years)
 - 6,11 or 16 items; 5 min
 - Depression only
- Short Mood and Feelings Questionnaire(SMFQ)*- children and adolescents; parent and child versions (8-16 yrs)
 - 13 items, 5 min
 - Depression only

DIAGNOSIS OF DEPRESSION

DSM-V Criteria for UNIPOLAR MAJOR DEPRESSION

- a period lasting at least two weeks with 5 or more of the following symptoms:
 - Depressed Mood
 - Anhedonia
 - Insomnia or hypersomnia
 - Change in appetite or weight
 - Psychomotor retardation or agitation
 - Low energy
 - Poor concentration
 - Thought of worthlessness or guilt
 - Recurrent thoughts about death or suicide
- Symptoms must cause significant distress or impairment in functioning
- Symptoms not due to the use of a psychoactive substance or medical disorder.

DEPRESSION SEVERITY



MILD TO MODERATE DEPRESSION

- No suicidal or homicidal ideation; Ideation does not cause immediate risk
 - No fleeting thoughts of suicide
 - No suicidal plan or intent
 - No feeling family would be better off if they were dead.
- No delusions or hallucinations
- Little to no aggressiveness
- Intact judgment or no risk of self or others being harmed.
- Functioning OK or impairment in 1 or more settings

SEVERE DEPRESSION

- Presence of suicidal or homicidal ideation
 - Fleeting thoughts of suicide
 - Suicidal plan or threat
 - May express feeling as though family or friends would be better off if they were dead.
- Agitation
- May experience delusions or hallucinations
- Impaired judgment or risk to self or others being harmed.
- Compromised functioning across all settings

COMMON SIGNS OF ANXIETY IN CHILDREN AND TEENS



PHYSICAL

- Restlessness and irritability (very common in younger children)
- Agitation
- Fidgeting
- Headaches
- Abdominal complaints
- Sleep difficulties
- Fatigue
- Palpitations
- Incr. HR
- Incr. BP
- Hyperventilation or SOB
- Muscle Tension
- Dizziness, tingling, weakness
- Tremors

• Melnyk, pg 62

COMMON SIGNS OF ANXIETY IN CHILDREN AND TEENS



BEHAVIORAL

- Escape/avoidant behaviors
- Crying
- Clinging to or fear of Separation from parents
- Soft Voice
- Variations in speech
- Nail Biting
- Thumb-sucking
- Vigilance and scanning
- Freezing
- Regression
- Insomnia
- Poor concentration
- Social withdrawal
- Social skills deficits
- Anger (esp. adolescents)

COMMON SIGNS OF ANXIETY IN CHILDREN AND TEENS



COGNITIVE

- “What if...”
- Catastrophic thoughts (low perceived control)
- Worry about things before they happen
- Constant worries or concerns about family, friends, or activities (school, sports)

“



WHEN DO WORRIES AND FEARS BECOME A DISORDER?

- Anxiety disorders involve intense worries and fears.
 - Extreme for the developmental stage of the child or adolescent
 - Childhood: separation disorder
 - Childhood through Adolescence: specific phobias, SAD, GAD, Panic
 - Interfere with daily functioning and attainment of developmental milestones.
 - Not dispelled with reassurance or reason.
- Most common age of onset is 11.
- Most prevalent disorder in youth <16.

COMMON PRESENTATION FOR ANXIETY DISORDER



- School Refusal
- Avoidant Behavior
- Non-compliance in a typically compliant child
- Aggressive behavior
- Fear
- Habit disorders

DIAGNOSIS OF ANXIETY DISORDERS



- DSM- V Criteria for GENERALIZED ANXIETY DISORDER
 - Excessive anxiety or worry occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
 - The individual finds it hard to control the worry.
 - The anxiety or worry are associated with three or more of the following: and present for more days than not for at least 6 months (only one required in children):
 - Restlessness or feeling keyed up or on edge
 - Being easily fatigued
 - Difficulty concentrating or mind going blank
 - Irritability
 - Muscle tension
 - Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep).
 - The anxiety , worry or physical symptoms cause clinically significant distress or impairment in social, occupational or other functioning.
 - The disturbance is not attributable to the physiologic effects of a substance of abuse or other medical condition.
 - The disturbance is not attributable to another mental health condition.

SCREENING FOR ANXIETY DISORDERS



- DASST (Depression, Anxiety and Safety Screening Tool)
 - 15 Items-Used at HFHS- not validated, but uses questions from validated tools, plus self-injury and suicidal ideation and past history of suicide (GAD2, PHQ9, C-SSRS)
- GAD-7, GAD-2 (Generalized Anxiety Disorder) *(Adolescents-validated in adults)
 - 7 or 2 items, Likert type scale, < 5 min
 - GAD, panic, SAD, PTSD
 - 5-mild, 10-moderate, 15-severe on 7 item; further assessment for 10+; >3 on GAD-2
- SCARED (Self-Report for Anxiety Related Emotional Disorders)* (8+yrs.)
 - 41 items; parent and youth report, 5min
 - Anxiety but not specific for OCD or PTSD
- Spence Children's Anxiety Scale (8-12yrs.)
 - 35-45 items, 5-10 min
 - Anxiety with Subscales for panic, SAD, phobias, separation, GAD, physical injury fears.

CRITICAL HISTORY-TAKING QUESTIONS



- Is the anxiety appropriate for the age of the child/teen?
- Does the child/teen have symptoms in response to a specific stimulus (ie social situations); Is it spontaneous (free-floating or present all of the time) or anticipatory?
- What are the situations or factors that trigger the anxiety symptoms? What are the reinforcers for anxiety symptoms?
- Has the child/teen experienced a traumatic event?
- Is there a history of a recent stressful life event?
- Does the anxiety interfere with the child/teen's daily functioning? Does the family make special accommodations for the symptoms?
- What impact do the symptoms have on the child/teen's sleep, energy, appetite and concentration?
- Is there a family history of anxiety disorders in biological relatives?
- Are there accompanying signs of depression?

-Melnyk pg. 63

MEDICATIONS OR SUBSTANCES THAT MAY CAUSE ANXIETY



- Caffeine
- Nicotine
- Diet pills
- Antihistamines
- Anti-asthmatics (theophylline)
- Marijuana
- Sympathomimetics (nasal decongestants)
- Stimulants including cocaine
- Steroids
- Antipsychotics
- SSRI's

-Melnyk pg. 64

TREATMENT OF DEPRESSION AND ANXIETY DISORDERS



- Initial Consideration:
 - Addressing safety concerns is the first priority
- Other Considerations:
 - Educate child/teen and parents about:
 - common signs and symptoms, clinical course, impact on relationships and social functioning, use of psychotherapy and pharmacotherapy, the role of caring adults in the treatment process, safety measures.
 - Environmental changes: promote optimal sleep, decrease stressors, establish predictable schedules and routines.
 - Enhance Coping skills (CBT, COPE)
 - Behavioral intervention- ie positive reinforcement of positive behaviors
 - Family Interventions, whenever possible

TREATMENT OF DEPRESSION AND ANXIETY DISORDERS



- Adjunctive therapy: Exercise, Nutrition and Sleep
 - Positive effect of exercise on depression and anxiety is well-documented (Spark- Ratey and Hagerman)
- Psychotherapy:
 - Cognitive Behavioral Therapy (CBT)
 - Interpersonal Psychotherapy (IP)
 - Group or individual therapy
 - Usually weekly therapy for 8-12 sessions
 - Treatment effect lasted for approximately 12 months.
- Medicate with First-Line Agent- SSRI

TREATMENT OF DEPRESSION AND ANXIETY DISORDERS



- Treatment measures are based on severity and duration of illness:
 - **Mild depression:** Psychotherapy alone. If no response in 6-8 weeks, add an SSRI.
 - TADS (Treatment of Adolescent Depression): Fluoxetine 10-40 mg per day plus CBT (15 sessions at 50-60 minutes) at 12 weeks of treatment superior to pharmacology or psychotherapy alone. AT 36 weeks, benefits of all three appear to be comparable.
 - **Moderate or Recurrent Depression:** Combination of psychotherapy and pharmacotherapy are better than either alone.
 - **Severe Depression:** Pharmacotherapy and immediate referral until stable. Then, co-management.



TREATMENT OF DEPRESSION AND ANXIETY DISORDERS

- Treat depressive symptoms for 6-12 weeks. If no improvement, consider cross-tapering and substituting another SSRI.
- Antidepressants should be used for 12 months after resolution of symptoms.
- Best practice to wean meds vs. stop abruptly to prevent withdrawal symptoms.
 - 50% reduction for 3 days followed by another 50% reduction for 3 days.

CHOOSING AN SSRI MEDICATION



FLUOXETINE (PROZAC)

- FDA approved for OCD ages 7-17 and Depression ages 8-18, considered first line treatment for depression
- Most-studied drug for depression in youth
- Long half-life: 13-15 days
- Low risk for sedation

ESCITALOPRAM (LEXAPRO)

- FDA approved for Depression ages 12-17
- No FDA approval for anxiety disorders.
- Well-tolerated
- Weight gain is a major issue with this SSRI
 - Wt. gain of 40-50# is common.
- Sedation is unusual.

SERTRALINE (ZOLOFT)

- FDA approved for OCD ages 6-17
- Considered first line for anxiety
- No FDA studies on depression.
- Little to know weight gain
- Decreased appetite more common
- Well-tolerated

CHOOSING AN SSRI MEDICATION



CITALOPRAM (CELEXA)

- Less activating than Prozac

FLUVOXAMINE (LUVOX)

- No FDA studies for Depressions.
- FDA approved for OCD over age 8
- Sedation is common- take at bedtime
- Most activating
- Also useful for patients with depression and co-occurring anxiety.
- Divide doses above 50mg/day into BID dose with the larger dose at bedtime.

PAROXETINE (PAXIL)

- FDA approved for OCD ages 7-17
- Less activating than other SSRI's
- Sedation is common
- Preferred for depression with co-occurring anxiety, but avoid in depression only patients (poor efficacy).
- Higher risk for sexual dysfunction



CHOOSING AN SSRI

- Consider using the SSRI that has worked for other members of the family.
- Avoid SSRI's that a negative response or side effects in family members.
- Genetic testing
 - Genesight free for Medicaid and Medicare health plans

SSRI DOSING AND TITRATION



Medication	Starting Dosage	Usual Effective Dose	Maximum Dose
Fluoxetine (Prozac)	10mg PO QAM	20mg PO QAM	60mg PO QAM
Citalopram (Celexa)	10mg PO QAM	20mg PO QAM	40mg PO QAM
Fluvoxamine (Fluvox)	50mg PO QAM	100-150mg PO Daily	100mg PO BID
Paroxetine (Paxil)	10mg PO QAM	20mg PO QAM	60mg PO QAM
Sertraline (Zoloft)	25mg PO QAM	50 -100mg PO QAM	150mg PO QAM
Escitalopram (Lexapro)	5mg PO QAM	10mg PO QAM	20mg PO QAM

TREATMENT OF DEPRESSION AND ANXIETY DISORDERS



Treatment Resistant Depression:

- Depression that does not respond to treatment using therapeutic doses within 6-12 weeks.
 - Re-evaluate the diagnosis
 - Assess for co-morbid conditions
 - Assess ongoing stressors
 - Assess for non-adherence.
- TORDIA (Treatment of Resistant Depression in Adolescents) Adolescents responded better to SSRI switch with the addition of CBT than switching SSRI alone. Less side-effects experienced with citalopram (Celexa), fluoxetine (Prozac), or paroxetine (Paxil) vs venlafaxine (Effexor).

SSRI MEDICATION COMMON SIDE EFFECTS:



- Gastrointestinal
- Weight changes
- Dry mouth
- Insomnia
- Somnolence
- Anxiety
- Headaches
- Irritability
- Sexual side effects
- Sweating
- Tremor
- Tiredness

SSRI MEDICATION LESS COMMON BUT SERIOUS SIDE EFFECTS:



- Agitation
- High energy
- Thoughts of suicide
- Easy bruising or bleeding
- Muscle weakness or spasms
- Shakiness (tremors)
- Decreased interest in sex
- Changes in sexual ability
- Unusual weight loss

SSRI MEDICATION SIDE EFFECTS TO REPORT IMMEDIATELY:



- Hives
- Difficulty breathing
- Swelling of lips, tongue or mouth
- Bloody, black or tarry stools
- Coffee ground emesis
- Fast or irregular heart beat
- Fainting
- Seizures
- Suicidal thoughts or ideation (2%)
- Change in frequency of urination
- Eye pain, swelling or redness
- Vision changes
- Erection lasting longer than 4 hours (<2%)
- Symptoms of Serotonin Syndrome (<1%):
 - Fast heart rate
 - Hallucinations
 - Loss of coordination
 - Severe dizziness
 - Severe diarrhea or vomiting
 - Twitching muscles
 - Unexplained fever unusual agitation or restlessness

SIDE-EFFECT AND SYMPTOM MONITORING



- Follow-up with patient weekly for 4 weeks, bi-weekly for 2 weeks, then monthly.
 - Suicidality is the highest during the first 4 weeks of treatment.
 - Use of an antidepressant side effect scale
 - ASEC (Antidepressant Suicide Scale)
 - Use initial screening tool to monitor changes in symptoms over time.
- Annual screen for: height, weight, waist circumference, fasting glucose (FG) and fasting lipid panel (FLP)*
- 4 weeks: weight and BMI*
- 12 weeks: BMI and FG, FLP*
 - * required monitoring for children in foster care by the Center for Health Care Strategies.

OTHER CONSIDERATIONS AKATHISIA AND MANIC SWITCHING



- Akathisia (5-25%)
 - Inner restlessness, “driven”, pacing or bilateral movements of specific muscle groups
 - Peak incidence 2-6 weeks after initiation of therapy
 - Consider alternative agent or short-term treatment with beta blocker
- Manic Switching (1-10% in unipolar depression; 2-70% in bipolar depression)
 - Silliness, giggling, angry outbursts, lack of sleep
 - Peak incidence 2-4 weeks after initiation or increase in therapy
 - If impairing, consider mood stabilizers after mania resolves
 - Consider alternate SSRI at low dose and titrate slowly

OTHER CONSIDERATIONS WITHDRAWAL SYNDROME & APATHY



- Withdrawal Syndrome(4-18%):
 - Dizziness, Paresthesias, Nausea, increased irritability
 - Usually occurs 1-7 days of stopping or decreasing an SSRI
 - Occurs more frequently in shorter acting than long-acting formulations
 - Resume agent and titrate slowly
- Apathy
 - May occur 24-72 weeks after initiation of therapy.
 - Consider augmentation with another antidepressant at a low dose
 - Bupropion SR 100 mg PO QAM

OTHER CONSIDERATIONS

BLACK BOX WARNING



- Retrospective study if more than 40 controlled trials sheds doubt on the use of SSRI's *increasing* suicidality risk in both adults and children.
 - Suicide closely follows the severity of depression in both adults and children.
 - Treatment of depression with fluoxetine (Prozac) in children and teens reduced depressive symptoms significantly, but did not decrease suicidality. However, treatment did not *increase* suicidality.
 - Theorized that suicidality risk has more to do with aggression and impulsivity in youth.
- Gibbons, R et al (2012) Archives of General Psychiatry. 69: 580-587

OTHER CONSIDERATIONS

FDA APPROVAL



- The following medications have FDA approval for the stated indication

MEDICATION	DEPRESSION	OCD/PANIC DISORDER
Fluoxetine (Prozac)	8-18	7-17
Sertraline (Zoloft)	N/A	6-17
Escitalopram (Lexapro)	12-17	N/A
Fluvoxamine (Luvox)	N/A	>8
Paroxetine (Paxil)	FDA Advises against	7-17

OTHER CONSIDERATIONS

FDA APPROVAL



- Medication approval in children and adolescents is complicated by the scarcity of studies conducted on treatment in this population.
 - FDA requires that individual studies be conducted for each indication desired for a drug.
 - Therefore, make clinical decision for treatment based on class and side effect profile of the individual drug.
- Age-Related Factors
 - There are no studies supporting the use of SSRI's for depression in children or pre-adolescents.
 - SSRI's have shown efficacy for use in children for anxiety compared to placebo.

• Downloaded from <http://pediatrics.aappublications.org/> by 1089206 on December 6, 2017

OTHER CONSIDERATIONS- PARENTAL MEDICATION INFORMED CONSENT AND YOUTH ASSENT**



Highly recommended that the Provider obtain and Informed consent with the use of any psychoactive medication. Consent should include:

- Diagnosis
- Target symptoms and duration to expected improvement
- Purpose of the medication
- Alternative treatments
- Expected dosage and monitoring with the medication (including visits and labwork)
- List the more frequent side effects
- List the less frequent side effects
- When to notify a provider immediately
- Message to not stop medications abruptly- wean required
- Black Box Warning
- Lack of FDA Approval

**Required for Youth in the Foster Care system in MI

OTHER CONSIDERATIONS- PSYCHOEDUCATION, SUPPORT AND MIND-BODY THERAPIES



- Highly recommended that the Provider assess for coping strategies that have been effective for the patient.
- Reinforce that all people need help at some point in their lives to deal with stress.
- Normalize developmental struggles
- Encourage good self-care

OTHER CONSIDERATIONS- PSYCHOEDUCATION, SUPPORT AND MIND-BODY THERAPIES



POSITIVE WAYS TO DEAL WITH STRESS

- Talking about your feelings or journaling
- Exercise
- Seeking a trusted adult
- Positive thoughts from negative thinking

REGULATION OF EMOTION

- Positive self-talk
- Counting to 100 or saying ABC's
- Deep breathing
- Walk away
- Physical activity

MINDFULNESS

- Bounce a ball and count along
- Repetitive clapping
- Tapping
- Yoga
- Meditation
- Tai Chi

ASSESSING AND RESPONDING TO MH EMERGENCIES

- Assess for guns and meds in home that could facilitate a suicide attempt.
- Parents ability and comfort in monitoring the child/teen.
- Assess responses to intent to inform with feelings of self-injury
- Safety contracts
 - No proof that these work; May provide clinician with false sense of security
- Provide emergency number and number to Suicide Hotline.
 - 1.800.273.8255
- Frequent check-ins
 - Combination of Medical, MH and telephone visits



SCREENING FOR SUICIDALITY



- Behavioral screening at well checks include asking about suicidality. Screening for suicide risk does NOT give a suicidal student “ideas.”
- Those diagnosed with depression are six times more likely to commit suicide than their peers without depression. **However, youth do not have to have depression to have suicidal ideation!!**
- Black youth are more likely than white youth to attempt suicide.
- Warning Signs:
 - Making suicidal statements
 - Being unhappy for an extended period
 - Suddenly withdrawing from friends or school activities
 - Being increasingly aggressive or irritable

SCREENING FOR SUICIDALITY



- ASQ- Ask Suicide-Screening Questionnaire (All Ages)
 - 5 items, <2 min, clinician administered
 - Positive screen for any “Yes” answer to questions 1-4
 - Positive screen- ask question #5 to assess acute risk-implement emergency plan
 - Horowitz LM et al Arch Pediat Adol Med 2012, 66(12) 1170-1176
 - Available at https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/emergencydepartment/pdfs/information-sheet_155389.pdf
- SAD-PERSONS (Elementary and Middle School)
 - 10 Item Interview
 - Sex, Age, Depression or affective disorder, Previous attempt, Ethanol-drug abuse, Rational thinking loss, Social supports lacking, Organized plan, Negligent parenting, significant family stressors, suicide modeling by parents or siblings, School problems

SUICIDALITY RISK BY DEMOGRAPHIC AND MORBIDITY FACTORS



- Elementary school children (5-11 years of age) more likely to:
 - have a diagnosis of ADD, with or without hyperactivity) (59.3% vs 29%)
 - have problems with family and friends
 - to be black
 - to be male
 - to die by hanging, strangling or suffocation and die at home.
 - 3.9% also tested positive for opiates.

• Sheftall, AH et al. Pediatrics (2016) DOI:10.1542/peds.2016-0436

SUICIDAL RISK BY DEMOGRAPHIC AND MORBIDITY FACTORS



- Early adolescents (12-14) were more likely to:
 - have co-existing depression (65.6% versus 33.3%)
 - have girlfriend or boyfriend problems/ conflict with parents
 - Have a history of sexual abuse
 - Youth with a history of physical or sexual abuse are 20 times more likely to attempt suicide.
 - More likely to display psychotic features or hallucinations prior to suicide attempt than late adolescents.
 - Less likely to have a substance abuse issue vs late adolescents
 - 7.5% tested positive to opiates (not all drugs or all persons tested)
 - Most likely to use medication ingestion as method of suicide
 - Most likely to use hanging as a method for suicide vs late adolescents.
 - Over 50% had a previous suicide attempt.

• Sheftall, AH et al. Pediatrics (2016) DOI:10.1542/peds.2016-0436

SUICIDALITY RISK BY DEMOGRAPHIC AND MORBIDITY FACTORS



- Late Adolescents (15-18)
 - More likely to have a romantic relationship as a preceding factor.
 - Most likely to use medication ingestion as a method of suicide
 - More likely to have substance abuse vs early adolescents
 - Over 50% had a previous suicide attempt.
- Overall, severity of depression is associated with greater risk of suicide.

COMORBIDITY OF CONDITIONS



- ADHD, Anxiety and Depression often co-occur
 - Assessment of one condition should also involve assessment of the others.
 - Anxiety and Depression- 40% (same treatment)
 - Anxiety and ADHD 25% (treatment of ADHD can drive anxiety)
 - Anxiety and ODD or CD 30%
 - Treat the condition that is most prevalent and impairs functioning the most.
- ADHD and ODD and CD
 - Increased risk for SUD; Tx with medication did not have a mediating effect.
- Comorbid conditions have a greater risk for SUD and AUD.
 - Caution on the use of substances, especially alcohol, with antidepressants.

SPECIALTY CO-MANAGEMENT AND CONSULTATION OR REFERRAL



- Indications for Referral

- Uncertainty about the diagnosis
- Discomfort in managing the condition
- Current agitation, suicidal or homicidal behavior, history of suicide attempt or inability of the family to monitor the safety of the child.
- Psychotic features
- Bipolar depression
- Acute comorbid disorder that are not amenable to treatment
- Recurrent or chronic depression (>2 years)
- Severe functional impairment or psychosocial stressors
- Lack of response to initial treatment
- Administration of psychotherapy

SPECIALTY CO-MANAGEMENT AND CONSULTATION OR REFERRAL



- Symptoms Suggesting Bipolar Disorder
 - Family history of diagnosed bipolar disorder
 - Pressured speech
 - Lack of sleep
 - Impulsivity
 - Initial presentation of sudden severe depression “out of the blue”
 - Excessive sleeping
 - Very slowed down

SPECIALTY CO-MANAGEMENT AND CONSULTATION OR REFERRAL



- Disruptive Behavioral Problems and Disorders/Conduct Disorders
 - Risk Factors
 - Patient with cognitive deficits
 - Limited problem-solving skills
 - Developmental delays or learning or language disorders
 - History of abuse, family violence, parental discord
 - Difficult temperament, poor goodness of fit with family
 - Common Presenting Complaints
 - Threat of school expulsion
 - Fire-setting or animal cruelty behaviors
 - No respect for authority
 - Parental complaints of poor listening, anger and irritability- “Acts like a Boss”
 - Avoid eye contact, refuse to speak or are defiant and uncooperative

TAKEAWAY MESSAGES



- Our population is high-risk for depression and anxiety.
- Primary Care Providers are the main source of care for youth with mental health disorders.
- NP's and PA's have a responsibility to be lifelong learners.
 - If you don't feel comfortable, do what it takes to get comfortable!
 - Take seminars, do CME, go to a conference
 - Establish and use your area resources to assist you in the care of youth with MH conditions

TAKEAWAY MESSAGES



- Screen for behavioral issues with all visits.
- If “red flags”- continue with diagnostic screening tools.
- Functional assessment to determine impact of symptoms on QOL.
- Start pharmacotherapy in collaboration with the patient and family.
- Monitor for treatment effects and side effects at frequent intervals initially, as suicide risk is greatest in the first month after initiation of treatment.
- Provide psychoeducation and information on Mind Body Therapies (MBT).
 - Screening, assessment and treatment initiation over multiple appointments.
 - Kutcher -teenmentalhealth.org