1-844-30-DCMAP
(1-844-303-2627)

Upcoming Events:

- **4/14/16**: **6:00 –9:00pm:** DC AAP CME Symposium and Dinner: Understanding and Addressing Toxic Stress and Adverse Childhood Experiences

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Issue 5 **Newsletter Date: April 2016**

Welcome!

The DC MAP team continues to strive to support you in your pediatric practices. We have received calls from many of you and would love to get feedback on how we've been helpful, what can change, and what services you need. We encourage you to click on the link below and let us know your thoughts about your calls to us, your questions, your concerns and your feedback.

Link to our Satisfaction Survey at: https://cri-datacap.org/surveys/?s=LVEQKtr8BP

~DC MAP Team

Spotlight on Depression

As a medical provider you may encounter patients at varying emotional and behavioral states. As a pediatric provider, these states may vary widely and change as the patient ages.

How does one know when to be concerned about changes in a patient's mood and/or behavior?

One of our own DC MAP clinicians provides us with a great summary (see page 3) of depressive symptoms to be on alert for as well as treatment strategies which can be used as you provide on-going primary care.

AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders

Well child visits are always an excellent opportunity to check in with the patient as well as their parents/guardians about their emotional health.

Screenings are an important tool in identifying many things including depression.

Screening tools which can be used include:
Mood and Feelings Questionnaire

Children's Depression Inventory

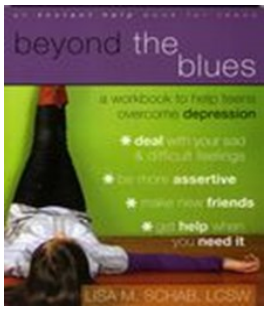
Beck Youth Inventories Second Edition (BYI-II)

Beck Depression Inventory II (BDI-II)

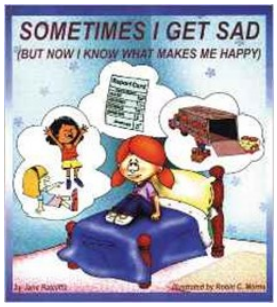
Resources for parents:
AACAP Facts for Families and Youth

NIMH information on depression

Books/Workbooks:



Beyond the Blues: A Workbook to Help Teens Overcome Depression



Sometimes I Get Sad (But Now I Know What Makes Me Happy)

Assessing Suicidality

All patients with depression should be evaluated for suicidal risk.

Questioning should begin with the assessment of thoughts of hurting self. If the response is positive, the patient should be questioned on whether they have a specific plan and intent and emergent admission must be considered. **Keep alert to the risk of suicide even after treatment has begun.** Some patients will take action once their energy level has increased in response to therapy but before further improvement has had time to occur.

FROM AACAP:

Assessment of suicidal patients requires an evaluation of the suicidal behavior and determination of risk for death or repetition, as well as an assessment of the underlying diagnoses or promoting factors.

Clinicians should be aware of which adolescent suicide attempters are at greatest risk for later suicide:

Suicidal history

- Still thinking of suicide
- Have made a prior suicide attempt

Demographics

- Male (esp. 16 to 19 yr olds)
- Live alone

Mental state

- Depressed, manic, hypomanic, severely anxious, or have a mixture of these states
- Substance abuse alone or in association with a mood disorder
- Irritable, agitated, threatening violence to others, delusional, or hallucinating

Assessment information should always be drawn from several sources, including child or adolescent, parents or guardians, school reports, and any other individuals close to the child. Structured or semistructured suicide scale questionnaires, whether delivered by the clinician or self-completed by the child or adolescent, have limited predictive value. They may complement but should never take the place of a thorough assessment or substitute for any aspect of assessment.

AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior

Sample questions to ask:

- "Did you ever feel so upset that you wished you were not alive or wanted to die?"
- "Did you ever do something that you knew was so dangerous that you could get hurt or killed by doing it?"
- "Did you ever hurt yourself or try to hurt yourself?"
- "Did you ever try to kill yourself?"
- "Did you ever think about or try to commit suicide?"

Additional clinical resource:
AAP Textbook of Pediatric Care:

Assessing and Treating Depression in Pediatric Primary Care: Tips from Dr. Mary Gabriel, DC MAP Psychiatrist

Prevalence:
It's more common than you think. Rates of depression are estimated at 2% in childhood and 4-8% in adolescence. Rates are equal in males and females until puberty, when the ratio increases in females by 2:1, more in line with adult ratios. What's more: ***60% REPORT HAVING THOUGHT ABOUT SUICIDE AND 30% ACTUALLY ATTEMPT SUICIDE***.

This means that up to 2 in every 100 of your child patients and 4-8 of every 100 adolescent patients is suspected to have depression. Screening for mood symptoms is key for early diagnoses and treatment

Symptoms:
All of us remember SIG E. CAPS or the DSM criteria: low mood, changes in sleep and appetite, low concentration and energy, feelings of worthlessness/guilt/hopelessness, decrease in interest, and anhedonia. While some of these symptoms are seen in the pediatric population, there are differences that are attributable to children's physical, emotional, cognitive and social developmental stages.

Common symptoms in depressed children are:

- mood lability, irritability, low frustration tolerance, temper tantrums, decline in school performance, somatic complaints, social withdrawal, low self-esteem

Children have fewer melancholic and psychotic symptoms than adults. Also, while children and adolescents can suffer from seasonal affective disorder (SAD), it is important to differentiate this from depression triggered by school stress, as both coincide with the school calendar.

Finally, comorbidity is frequent in psychiatric conditions. 40-90% of youths with depressive disorder have other psychiatric disorders, most often anxiety, but also disruptive disorders and ADHD. Due to this, any patient suspected of having depression should be screened for other psychiatric conditions.

Treatment:
The mainstays of depression treatment are therapy and medications. For more complicated depression or mild disease that has not responded to psychotherapy, a trial of antidepressant is indicated. The only FDA-approved antidepressants for pediatric patients are fluoxetine (8 years and older) and escitalopram (12 years and older). In practice, citalopram and sertraline have been used as well, especially if there is no response to the first two. The common adage in pediatric psychopharmacology holds here: start low, go slow. This is to avoid unwanted side effects and improve adherence. The following table details the dosing of the most common SSRIs used in children:

Medication	Starting Dose (mg/day)	Dosage range (mg/day)
Fluoxetine	10	10-40
Escitalopram	5	10-40
Sertraline	25	50-300
Citalopram	10	20-40

A few caveats:
-- For the very young with depression (2-5yo), dosing can start even lower, such as fluoxetine and citalopram at 5mg, and sertraline at 12.5 mg.
-- Because children metabolize sertraline much faster than adults, be sure to divide sertraline daily doses into BID dosing, up until age 15-16 years, which is when metabolism approaches adult-like states.
-- All medications above come in liquid forms

And most important, when discussing the risk, benefits, and side effects with patients and parents, **DO NOT FORGET THE BLACKBOX WARNING** regarding increased suicidality in adolescents on SSRIs.

As discussed with adult patients, SSRIs can take 4-6 weeks at an adequate dose to produce improvement in symptoms. However, in practice, children will usually show improvement within 2-3 weeks at a therapeutic dose. Thus, if you have started a patient on a low dose and don't find improvement in some symptoms after 2-3 weeks, you can increase to the next dose increment and reassess in another 2-4 weeks. If you have reached maximum dosing on 2 separate SSRIs and failed to see improvement, referral to a child psychiatrist is indicated for further care.

1-844-303-2627

TIPS: ***Information to have ready when calling DC MAP:***

-Provider NPI #

-Provider call back number and email

-If calling about a specific child:

- Child's name, date of birth, and insurance
- Parent's name and contact information

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www.dcmap.org

Using DC MAP Services:

•Free!!

•Call about any issue pertaining to mental health

•Child insurance status or home state does not matter

•Enrollment strongly encouraged (though not required). :

Practice Enrollment Form: https://cri-datacap.org/surveys/?s=XCj2q9Xbxk

Provider Enrollment Form: https://cri-datacap.org/surveys/?s=2TUbz7XwG6

•Provide basic information about your question/patient and we will connect you with the appropriate team member

•We will follow up with providers and families after consultations (survey links and/or calls) to determine if services were attained, assess satisfaction with consultation, and make changes as needed

Hours: Monday – Friday 9am-5pm (excluding major holidays)

Please note this is a provider-to-provider consultation service and not intended to be used by families.

For questions or to learn more contact:
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