MOOD AND ANXIETY DISORDERS CLINIC
Department of Child Psychiatry, Children's and Women's Health Center of British Columbia

CLINICAL PRACTICE GUIDELINES

1. Clinic Mandate

1.1. Referral Criteria:

The clinic provides consultation regarding childhood mood and anxiety disorders (Major Depressive Disorder, Bipolar Disorder, Obsessive Compulsive Disorder, Panic Disorder, Generalized Anxiety Disorder, Dysthymia) on referral from hospital and community physicians and mental health teams.

1.2. Selection of referred cases for consultation and for follow-up:

Due to the high prevalence of these disorders in the population, and the desirability of children and families receiving their treatment in their own communities, the emphasis is on providing consultation to secondary providers such as pediatricians, psychiatrists, child and youth mental health and hospital clinics (tertiary care). Depending on clinic capacity we may also provide limited consultation to family physicians (secondary care), but secondary care is usually only be provided when there is a shortage of local resources, or a specific indication within the teaching and research mandate or unique expertise of the clinic. If indicated, short term treatment will be provided until community resources can be accessed, and some complex or severe cases may receive ongoing care or repeated consultation in the clinic. At times, uncomplicated depression or anxiety disorder may be offered assessment and treatment as part of the teaching program or an active research program to develop and demonstrate more effective treatments for these disorders. Referrals will also be accepted specifically for the group treatment programs.

1.3 Age range:

Referrals are accepted up until the 19th birthday, but children under 6 may be re-directed to the Infant Psychiatry Clinic, and 18 year olds may be re-directed to adult services in their catchment area if this appears to be more appropriate.

1.4 Outreach:

The clinic provides outreach education to families, physicians, other mental health professionals, schools and public health agencies through psychoeducational materials and community teaching. Indirect telephone consultation is provided to referring agencies and physicians throughout the province.

1.5 Teaching:

University-based undergraduate, postgraduate and continuing medical education is provided for medical students, psychiatry residents, pediatric residents, postgraduate fellows, psychology interns and practicum students, social work students, and family physicians.

1.6 Research:

Research into the causation and treatment of mood and anxiety disorders is an integral aspect of the clinic activities. Research on outcome of group treatment, pharmacological studies, and other new research projects are currently integrated into the clinic.

2. Referral Procedure:

2.1

A written referral outlining the clinical symptoms and referral question is required from the referring physician or mental health center. These are sent by mail or fax to the Clinic Intake Secretary. Telephone referrals will be taken by the Intake Secretary, but faxed information must follow. Referrals are reviewed at the Clinic Intake Meeting by the team and placed on the waiting list if they are appropriate. If insufficient information is provided in the initial referral, the intake clerk will request further information, or a clinic staff member may contact the referring source for clarification. Referrals are reviewed by the entire clinic staff during the weekly administrative meeting, but urgent referrals may be reviewed by the clinic head or designate.

2.2 Referrals not accepted:

Referrals which do not meet our clinic mandate, or those which could be better served by community resources or other clinics, will be re-directed by letter sent to the referring source and family; depending on urgency, telephone contact to the physician or family may be provided as well. Referrals will not be accepted if they are out of the clinic age range, if they do not present symptoms suggestive of the diagnoses served by the clinic, if other resources are considered more appropriate, or if they have current community treatment in place, unless the community resource or family physician is seeking a second opinion. We require copies of prior assessments before considering suitability for the clinic, to avoid unnecessary duplication of medical services.

2.3. Urgent referrals:

Urgent referrals will be reviewed by the clinic director or designate and given priority as indicated or re-directed to the Urgent Assessment Clinic, emergency department or community urgent response services. Indirect telephone consultations may also be provided by the clinic director or designate if it appears that the case will need to wait for assessment, or if it appears that direct assessment is not necessary.

2.4 Waiting List of Cases accepted for assessment:

A clinic waiting list is maintained, and cases assigned to individual clinicians according to clinician availability and referring diagnosis. Cases are booked according to acuity and

severity, as well as order of referral and the schedule of the teaching program. Active efforts are made to maintain a short waitlist of approximately 6 weeks because children with a mood or anxiety disorder need to be seen in a timely fashion; however the primary mandate of this clinic is not urgent assessment, as there are more appropriate community and hospital resources for urgent psychiatric evaluation. Nevertheless, relative priority is given to acute cases of depression and severe anxiety. If the waiting list becomes longer than 6 weeks, a greater effort is made to redirect non-urgent and uncomplicated cases to community resources. Non-urgent second opinions on chronic cases may be expected to wait longer for assessment.

2.5. Pre-Assessment Questionnaires:

When the case is accepted to the waiting list, questionnaires regarding developmental and family history, and symptom checklists are sent to the family for parent, child and teacher to complete with return by mail requested. A request is also made to the referring source and parents for all previous psychiatric or psychological assessments, medical reports and psycho-educational reports so that these are available for review by the clinician prior to the appointment.

3.0 Roles of Clinic Staff

.

3.1 Staffing:

Clinic staff include psychiatrists (approximately 1.2 FTE) , a part time psychologist (0.5), and a part-time social worker (0.5) .

3.1 Role in Triage, Assessment and Treatment:

All clinic members participate in the administrative and intake meeting and are involved in case triage and assignment. While the initial assessments are usually done by one of the psychiatric staff, other members may be involved at the initial assessment depending on the referring concerns. For cases from outside the lower mainland, a series of appointments over several days with various clinic staff may be arranged, and a summary conference held with the family.

Specific Roles:

a) Psychiatrists undertake initial assessment, make diagnosis and recommendations and provide follow-up in select cases. They may participate in group or individual treatment.

b) The social worker is involved in intake and community liaison as well as family assessment and therapy, group treatment and individual psychotherapy.

c) The psychologist may participate in initial assessment of selected cases, psychological assessment of referred cases, group treatment and individual therapy.

4. Assessment:

4.1. First assessment appointment:

All family members living with the child are requested to attend the first assessment appointment. During this appointment the entire family is usually seen at some point, and the child or adolescent is usually also interviewed separately. Referral information and questionnaires are reviewed and clarified with the child and family. The initial assessment appointment may range in length from 1.5 to 2.5 hours depending on the distance the family has traveled and the endurance of the patient and family; in some cases two or three appointments may be required to complete the basic assessment. Further assessment or treatment appointments will be set up at this time.

4.2. Minimum required assessment procedures:

Assessment procedure will typically include, interview of the identified patient and their parents to obtain identifying information, family constellation and social situation, presenting symptoms and comorbid psychiatric symptoms, past medical and developmental history, educational history, family history, review of systems, inquiry regarding substance use, and mental status examination. Suicidal ideation, intent and attempts are always evaluated during this initial assessment. Collateral information, with the patient and family's permission, is obtained, whenever possible, from school or community agencies involved.
Rating scales for specific disorders may be utilized as part of the assessment. The following are typical rating scales used in the clinic at initial assessment and for monitoring of response to treatment of specific conditions:

A diagnosis or differential diagnosis will be provided to the child and family, and a specific plan for further assessment appointments, or recommendations for intervention and other referrals, are made at this first appointment.

4.3. Continuing Quality Improvement: We aim to have 4 team based assessments per year using the one way screen. All clinic members participate. These assessments facilitate ongoing staff education and consistency of assessment and treatment recommendations.

4.4. Multidisciplinary Assessment: For complex Tertiary cases multiple team members will be involved in the assessment. This is limited by availability of allied health professionals (social work, psychology, Speech & Language Pathology & the absence of Occupational therapy).

4.5. Consultation report: The assessment findings, 5-axis DSMIV diagnosis, including diagnostic codes for Axis I and II, and recommendations are dictated in a psychiatric report. This is routinely sent to the referring physician and copied to the parents for children under 12, or to the adolescent for those 12 and over unless the adolescent requests that a report not be sent to them. Copies will also be sent with signed consent to other referring or follow-up agencies. This report is usually dictated after the first assessment appointment, but may be delayed until after the second appointment if key family members or key information are not available. This report may be updated with an addendum after further appointments to refine the diagnosis or document response to initial interventions.

4.6. Referral to Clinic Psychologist:

Cases will be referred to the clinic psychologist when questions of diagnosis or treatment planning require specific expertise in psychological assessment, or cognitive and behavioral treatments. Indirect consultation based on psychometric data from other resources, or on case presentation, may also be requested.

Referrals for anxiety group treatment are made to the psychologist who is involved in developing and delivering group treatment for pre-adolescents with anxiety disorders.

Psychological consultation reports are prepared for referred cases, according to professional and departmental standards.

4.7. Referral to Clinic Social Worker:

Cases will be referred to the clinical social worker for family assessment and intervention, or for individual psychotherapy when it is determined that continued treatment in the clinic is indicated. The social worker may also provide assistance to families for liaison with community agencies such as Ministry of Children and Families and financial aid resources.

Cases are also referred to the clinic social worker for an Adolescent Interpersonal Therapy Group as well as the Anxiety management group for children & parents, as the social worker in involved in managing and delivering group treatment in the clinic.

Social work consultation reports are prepared for referred cases, according to professional and departmental standards.

4.8. Medical Work-up:

Based on review of systems and clinical presentation, further medical work-up may be recommended such as blood work including TSH, CBC, liver or renal function tests, or other investigations including ECG or EEG or imaging.

Medical referrals to neurology, cardiology or other medical specialists will be made as indicated.

4.9. Other referrals:

Psychometric or psycho educational assessment by the school, or private psychologist or other available resources may be advised. Speech and language assessment will be obtained through the school, health unit or private SLP. A small number of referrals are made to the Speech and Language Pathologist (0.1 for the OPD) attached to the psychiatry outpatient clinics. Unfortunately due to lack of resources the clinic does not have access to occupational therapy. Therefore evaluations may be requested through the hospital or local health unit.

4.10. Referral to inpatient services:

If the severity or acuity of symptoms present an immediate risk to the child or adolescent's health, they will be directed to the nearest Emergency Room (either BCCH or VGH depending on their age) as the OPD cannot directly access CAPE. Factors such as psychosis, acute suicide risk and physical deterioration due to illness may necessitate inpatient referral. Referral to P1 or P2 assessment units requires referral through the Children and Youth referral coordinator for the child's geographic area.

4.11. Management of Suicidal Ideation:

If suicidal ideas or intent are present, suicidal risk will be evaluated. Please refer to the outpatient department *Protocol for Management of Suicidal Patients* for the procedure to be followed when patients present with suicidal ideation.

5.0. Clinical Management:
Evidence based practice, ongoing review of new research, and expert clinical experience form the basis of the clinic's treatment model. In the past, we have outlined in detail the recommendations for specific psychotherapies and medications and timelines for treatment of specific conditions, but with the development in the past decade of broadly accepted clinical practice guidelines for specific conditions through the recognized professional bodies (American and Canadian Academies of child and adolescent psychiatry) and with the participation of clinic staff members in the development of these guidelines, we now recommend the up to date guidelines from these professional bodies.

For sources, please refer to current general Clinical Practice Guidelines for mood and anxiety disorders listed in the Reference List below.

5.1. Preamble:

The complexity and high rate of comorbidity of childhood mood and anxiety disorders, the high rate of associated family psychopathology, and the limitations of resources available, makes it difficult to specify a particular treatment strategy which will be ideal or feasible in each individual case. These guidelines reflect current research and clinical practice regarding the best practices, and are normally applied in the clinic. Nevertheless, the rapid changes in this field, and the complexity of individual cases may lead to differences in approach in individual cases. Furthermore, novel treatments may be applied in treatment resistant cases, due to the role of the clinic in tertiary care. However, when a significant deviation from these usual practice guidelines is made in a particular case for reasons of the clinical presentation or the patient's circumstances, the rationale for this should be noted in the psychiatric report or progress notes. Novel or experimental treatments (i.e. based on case reports or limited research literature) in treatment non-responsive cases will also be documented as such and families informed.

It is also recognized that recommendations can be made to patients and families, and it is within their rights to decide whether or not to adhere to recommended intervention strategies, as long as this does not lead to harm to the child or adolescent.

5.2. Treatment model:

The treatment model adopted by the clinic is multimodal. Treatment recommendations commonly include biological, psychological, social and educational interventions. However, there is an emphasis on pharmacotherapy as this is specific expertise which the clinic has, as a tertiary care setting, and is able to provide to the larger community. Many referral questions are specifically related to the role of pharmacotherapy in managing difficult conditions.

The limited research on pharmacotherapy in children is acknowledged, but recent controlled research has demonstrated the effectiveness of pharmacotherapy in young people with major depression, bipolar disorder, social phobia, obsessive compulsive disorder and panic disorder, as well as providing supportive evidence of medication effectiveness in generalized anxiety.

Research on the efficacy of psychological therapies in children is even more limited, but practical guidelines can be derived. In OCD, both medication and CBT (exposure response prevention) have similar efficacy for milder cases, and for more severe cases combined therapy is the treatment of choice. Open studies have shown the effectiveness of cognitive behavioral group therapy and interpersonal group therapy for depression, and hence the clinic emphasizes group treatment for adolescents. Individual cognitive and behavioral and interpersonal therapy for adolescents are also recommended for depressed adolescents based on adult research and well-developed modifications for adolescent of these established treatments. Individual and group cognitive-behavioral strategies for anxiety disorders, especially panic disorder, are recommended based on adult research, and a body of primarily waitlist-controlled research in children. Ongoing outcome research is evaluating the effectiveness of the clinic's group CBT program ("Taming Worry Dragons") for children. Recent research demonstrating the effectiveness of mindfulness based cognitive therapy (MBCT) for depressive relapse prevention in adults, is leading to development of adolescent modifications of MBCT for depression and anxiety in the clinic.

Through our weekly rounds and monthly journal club meetings, clinic staff continue to review new developments in the understanding of, and innovative treatments for, mood and anxiety disorders.

Because of the limited knowledge in some of these areas, parents are specifically informed of the state of research at the present time, and assisted to weight the risks, costs and potential benefits of specific treatment recommendations. Treatment outcome is monitored using specific target symptoms and monitoring of side effects with the family and patient. An SSRI information and monitoring form has been developed to facilitate this. Other pamphlets on medications are provided to families.

Refer to practice parameters for specific conditions, in the Reference List, for a summary of current knowledge and research literature on psychiatric management.

5.4 Continuing Staff Development

The clinic staff are committed to their own continuing education and, modification of practice in accord with research evidence as it is available, through inservices and CME.

Internally, in-service rounds, sharing of papers and knowledge, will ensure that clinic practices are consistent with the current best evidence. Staff are encouraged to undertake additional training and supervision in psychotherapy.

5.5 Participation in Treatment Research

The clinic has a commitment to contribute to the growing body of research on treatment of child and adolescent mood and anxiety disorders through developing research projects to evaluate our own practices, and by participating with our colleagues across North America in collaborative multi-centre projects. These include two Vancouver area school based outcome studies on early intervention CBT based programs for anxiety, one funded by CIHR, and two CIHR funded maintenance therapy pharmacological studies in adolescent depression, as well as a knowledge translation study for IPT training.

5.6 Knowledge Translation

Staff members contribute to the development of government and professional guidelines for treatment management of mood and anxiety disorders, and provide outreach education and training for physicians and community mental health resources as well as public education.

5.7 Current Group Programs

The clinic has ongoing group programs based on the Taming Worry Dragons CBT anxiety management model for children, and Worry Taming for Teens as well as Social Anxiety adolescent group. Adolescent depression treatment groups have included CBT based groups (modification of the Coping with Depression program), and more recently, the development of Interpersonal Therapy groups (IPT) for depressed adolescents.

Reference List

Practice Parameters of the American Academy of Child and Adolescent Psychiatry are available in DPF form and are found at this site : http://www.jaacap.com/content/pracparam

1. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents with bipolar disorder. Vol 46 Jan 2007

2. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders. *J Am Acad Child Adoles Psychiatry* Vol 46 Feb 2007

3. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. *J Am Acad Child Adoles Psychiatry* Vol 46, Nov 2007 .

4. American Academy of Child and Adolescent Psychiatry. Practice Parameters for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. *J Am Acad Child Adoles Psychiatry* 1998;**37(suppl)**:27S-45S.

5. CANMAT guidelines for treatment of Mood and Anxiety disorders, were also reviewed at this year's clinic program review, and include applicable avidence-based recommendations for child and adolescent management. http://www.canmat.org/guides.php

6. GPAC BC: Guidelines and protocols Committee Guidelines on treatment of Anxiety and Depression in Youth (January 2010) available at. http://www.bcguidelines.ca/alphabetical.html

7. 2008 Position Paper on the Use of SSRIs in Children and Adoelscents, Canadian Academy of Child Psychiatry http://www.cfpc.ca/projectassets/templates/resource.aspx?id=1228&langType=4105

Pamphlets and Psychoeducational Books Produced by Mood and Anxiety Disorders Clinic:

Pamphlets: see also Anxiety Disorders Association of BC Website for updated materials
"Depression in Young People"
"Antidepressants in Young People"
"Helping Anxious Children"
"Panic disorder in young people"
"OCD in young people"
"Managing bipolar disorder takes teamwork"

Manuals:

Anxiety Management

(available through C&W Bookstore online http://bookstore.cw.bc.ca)

Taming Worry Dragons: A manual for children, parents and other coaches. E. J. Garland and S. L. Clark, 2010 (5 th edition, revised; 1st edition 1995)

Tools for Taming and Trapping Worry Dragons: Children's Workbook. SL Clark

Facilitator's Guide for Taming Worry Dragons (group and individual)

Worry Taming for Teens. E. J. Garland and S. L. Clark (2002)

The Kid's Guide to Taming Worry Dragons (classroom)

Classroom Manual for Taming Worry Dragons

DVD's:

"Therapeutic Assessment and Brief Cognitive Behavioral Therapy for Anxious Chidlren" E. Jane Garland

"Taming Worry Dragons: Practical Applications for Individual or Group Therapy" SL clark

Depression Self-Help or Therapist/Doctor Coached:

Dealing with Depression: Antidepressant Skills for Teens (MAD clinic produced with MCFD:)

http://www.mcf.gov.bc.ca/mental_health/teen.htm