Benton-Franklin Child Health Notes

Four Prominent Health Organizations Develop Evidence-Based Nutritional Guidelines

An unprecedented collaboration of experts from the American Academy of Pediatrics, the Academy of Nutrition and Dietetics, the American Heart Association, and the American Academy of Pediatric Dentistry have developed recommendations to help parents and caregivers choose what drinks are best for their growing children.

Healthy Beverage Consumption in Early Childhood: Recommendations from Key National Health and Nutrition Organizations is designed for children from birth through age 5. The goal is to provide parents with a consistent message of healthy beverage advice from health professionals like pediatricians and dentists. In addition, these guidelines can impact the education around healthy beverages from federal programs like WIC, childcare centers and homes, food banks that assist families, and even restaurant options.

Too many kids consume too many sugary drinks like fruit-flavored drinks, sodas, and other beverages with added sugars. The Feeding Infant and Toddler study found that, on any given day, nearly one in three (29 percent) children ages 12 to 23 months and nearly half (46 percent) of children 36 to 47 months have a sugary drink. Further, sugary drinks are the number one source of added sugar from all foods and beverages for children 12 to 47.9 months of age.

What the Recommendations Say

For most kids, the following guidelines can help set children on the path for healthy growth and development:

- 0-6 months: Babies need only breast milk or infant formula.
- 6-12 months: In addition to breast milk or infant formula, offer a small amount of drinking water once solid foods are introduced to help babies get familiar with the taste—just a few sips at meal times is all it takes.
- 12-24 months: It's time to add whole milk, which has many essential nutrients, along with some plain drinking water for better hydration. A small amount of juice is ok now, but make sure it's 100% fruit juice to avoid added sugar. Better yet, serve small pieces of real fruit, which is even healthier.

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We need to put our children on a path to drinking healthier beverages early and these evidence-based recommendations are a perfect place to start. We are confident that these guidelines will supply parents, health care providers, childcare providers, and other caregivers with consistent information, messages, and tools for providing the right beverages for children at the right age and setting them up for optimal health.

They also provide policymakers and industry leaders with the information they need to set policies and make products that better support children's health.

Adapted from Robert Wood Johnson Foundation

SAFE KIDS WORLDWIDE™

Washington Child Passenger Safety Laws Changing January 1, 2020

Washington State child passenger safety laws are changing to keep kids better protected in motor vehicle crashes.

1. Children must ride in a rear-facing car seat until at least age 2: The American Academy of Pediatrics (AAP) recommends keeping children rear-facing as long as possible – to the limits of their car seat. Once the child has outgrown the Infant seat, they should ride in a convertible car seat, which will rear-face and forward-face. Rear-facing is safer than forward-facing because it protects the child's head, neck, and spine. We don't worry about their legs being too long; pay attention to the weight and height limits on the car seat.

2. Children must ride in a car seat with a harness until at least age 4: The AAP recommends children remain in each stage of protection for as long as possible. Most children are not mature enough to use a booster seat until at least age 5 or 6. Remember that a child in a booster seat is not restrained until the driver slams on the brakes or is in a collision. As long as children are still within the height and weight limits of their car seat with a 5-point harness, it's safer to keep them there.

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3. Children 4 years and older must ride in a car seat or booster seat until they are 4'9" tall: This is already Washington law, but the new language clarifies that most kids don't hit 4'9" tall until they are at least 10- to 12 -years-old. Seat belts are made for adults, not kids, and the booster keeps the seat belt properly positioned. If a parent says their child will have to go back into a booster seat in January, they should be in a booster seat NOW.

4. Kids must ride in the back seat until age 13: Again, this is already the law. It's not about height or weight; it's about bone density. Airbags come out with such tremendous force that they can seriously injure or kill a child.

Local help is available!

Call Safe Kids Benton-Franklin at (509) 460-4214. Safe Kids holds monthly car seat inspections in Richland on the 2nd Wednesday of every month by appointment. Call **(509) 460-4214** to make an appointment. Discounted car seats are available to families who qualify.

For more information go to wacarseats.com or www.bfhd.wa.gov https://www.bfhd.wa.gov/programs_services/injury_violence_prevention/child_passenger_safety

Promoting early identification and partnerships between families, primary health care providers & the community

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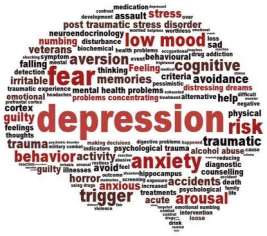
Child restraint system must comply with U.S. DOT standards and be used according to vehicle and child restraint manufacturer.

Adolescent Depression: Screening and Management in Primary Care



Studies have indicated that only 50% of adolescents with depression are diagnosed before reaching adulthood. Research has also revealed that up to 9% of teenagers meet criteria for depression at any one time, and in primary care (PC) settings prevalence rates are likely higher (up to 28%). In 2016, an estimated 3.1 million or 12.8% of adolescents aged 12 to 17 years in the United States had at least one major depressive episode with an estimated 2.2 million of this population having at least one major depressive episode with severe impairment. Of adolescents with major depressive episode, approximately 70% had severe impairment, or 9% of the U.S. population aged 12 to 17. The prevalence of major depressive episode was higher among adolescent females (19.4%) compared to males (6.4%), and was highest among adolescents reporting two or more races (13.8%).

The American Academy of Pediatrics (AAP) recently published updated guidelines for depression in youth aged 10 to 21 years. These guidelines address the screening, identification, assessment, diagnosis, treatment, and ongoing management of depression in PC.

References

Zuckerbrot, R. A., Cheung, A., Jensen, P. S., Stein, R. K., & Laraque, D. (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management. Pediatrics, 141(3), 1-21.

Cheung, A. a., Zuckerbrot, R. A., Jensen, P. S., Laraque, D., & Stein, R. K. (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management. Pediatrics, 141(3), 1-16. doi:10.1542/peds.2017-4082 doi:10.1542/peds.2017-4081

National Institute of Mental Health website. Major Depression. https://www.nimh.nih.gov/health/statistics/major-depression.shtml

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Risk factors for depression may be biological (i.e. family history of depression, chronic medical illness, obesity), psychological (i.e. history of suicide attempts, ineffective coping skills, low self-esteem, negative body image) or environmental (i.e. poor peer relationships, decreased physical activity, increased parental conflict, poor academic performance, low socioeconomic status, substance use).

Common symptoms of depressive disorders are:

- sad or irritable mood
- decreased interest or lack of enjoyment
- decreased concentration or indecision
- feelings of worthlessness or excessive guilt
- feelings of hopelessness
- insomnia or hypersomnia
- change of appetite or change of weight
- fatigue
- recurrent thoughts of death or suicidal ideation

Focus: Two Validated Mental Health Screening Instruments

Pediatric Symptom Checklist -Youth Report (PSC - Youth)

- Age 11 years and older
- 35 items, self-report
- General mental health screening and functional screening, including attention, externalizing, internalizing symptoms
- Time to administer: 5 minutes, scoring 1-2 minutes.
- Minimum expertise: No special qualifications for admin/scoring.
- Reliability: test-retest 0.45. Validity: "strong" con-current validity. Sensitivity: .94. Specificity: .88

Patient Health Questionnaire, Modified for Teens (PHQ-9, Modified)

- Ages 12-18
- 9 items, self-report
- Screen for depression & suicide risk. Wording slightly modified from PHQ-9.
- Time to administer: <5 minutes
- Minimum expertise: professional or office staff
- Reliability: No data found. Validity: No data found. Sensitivity: .73. Specificity: .94.

Reference: https://mn.gov/dhs/assets/mh-screening-instruments-2017_tcm1053-313430.pdf

Structured depression screening is required by WA Medicaid for children age 12 years and older, Use procedure code 96127

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Initial Management of Depression Recommendations from Seattle Children's Partnership Access Line (PAL) Primary Care Principles for Child Mental Health

Mild Depression (noticeable, but basically functioning OK)

- Educate patient and family:
- Support increased peer interactions
- Behavior activation, exercise
- Encourage good sleep hygiene
- Reduce stressors, if possible
- Remove any guns from home
- Offer parent/child further reading resources
- Follow up appointment in 2-4 weeks to check if situation is getting worse
- Repeating rating scales helps comparisons
- Those not improving on their own are referral candidates for counseling

Moderate/Severe Depression (significant impairment in one setting, or moderate impairment in multiple settings)

Recommend individual psychotherapy:

- Cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) are preferred, where available
- Psychoeducation, coping skills, and problem solving focus are all helpful therapy strategies
- Educate patient and family (as per mild problem list on left)
- Consider family therapy referral

Consider starting SSRI, especially if severe:

- Fluoxetine is the first line choice
- Escitalopram/Sertraline second line
- Third line agents are other SSRIs, bupropion, mirtazapine
- Wait four weeks between dose increases to see changes
- Check for side effects every 1-2 weeks in first month of use to ensure no new irritability or suicidality (phone or in person)
- Stop SSRI if get agitation, anxiety, or suicidal thoughts
- Consult MH specialist if monotherapy is not helping
- Monitor progress with repeat use of rating scale

References

Zuckerbrot, R. A., Cheung, A., Jensen, P. S., Stein, R. K., & Laraque, D. (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management. Pediatrics, 141(3), 1-21. doi:10.1542/peds.2017-4081, Cheung, A. a., Zuckerbrot, R. A., Jensen, P. S., Laraque, D., & Stein, R. K. (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management. Pediatrics, 141(3), 1-16. doi:10.1542/peds.2017-4082

National Institute of Mental Health website. Major Depression. https://www.nimh.nih.gov/health/statistics/major-depression.shtml

Hilt, R. (2017). Seattle Children's Primary Care Principles for Child Mental Health. Version 7.1. 2017-2018.

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Adolescent Depression: Screening and Management in Primary Care

Special Needs Information and Resources		
Local	(1)Comprehensive Healthcare (2)Lourdes Health & Crisis Services (3)Lutheran Community Services (4)Catholic Charities (5)Recovery & Wellness Center	509-412-1051 509-783-0500 509-735-6446 509-545-6145 509-619-0519
Regional	Partnership Access Line (PAL) Care Guides and Resources	http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/resources/
	WCAAP Adolescent & Maternal Depression Screening (CME)	https://wcaap.org/webinar-adolescent-and-maternal-depression-screening/
	State Mental Health Crisis Lines DSHS	https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/state-mental-health-crisis-lines
National	Guidelines for Adolescent Depression in Primary Care Toolkit	http://gladpc.org/
	Teen Self-Help Cognitive Behavior Therapy (CBT) guidance	www.dartmouthcoopproject.org/teen-mental-health-2/
	National Crisis Hotline (Hopeline) National Suicide Prevention Lifeline START text	1-800-784-2433 (1-800-SUICIDE) 1-800-273-8255 741741 www.crisistextline.org/
	Mayo Clinic: Diagnosis and Treatment of Depression	https://www.mayoclinic.org/diseases-conditions/teen-depression/diagnosis-treatment/drc-20350991
	American Family Physician Treatment Resource	https://www.aafp.org/afp/2012/0901/p442.html

Fatherhood Alliance Update

Benton-Franklin Health District is proud to be a part of the Fatherhood Alliance of Benton and Franklin Counties. For more information about the work being done and how to get involved, please see the latest Newsletter or contact Vanessa McCollum at vanessam@bfhd.wa.gov.

Here is the link to the Fatherhood Alliance Newsletter:
https://www.bfhd.wa.gov/UserFiles/Servers/Server_10765972/File/Flyers%20and%20Newsletters/FA%

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