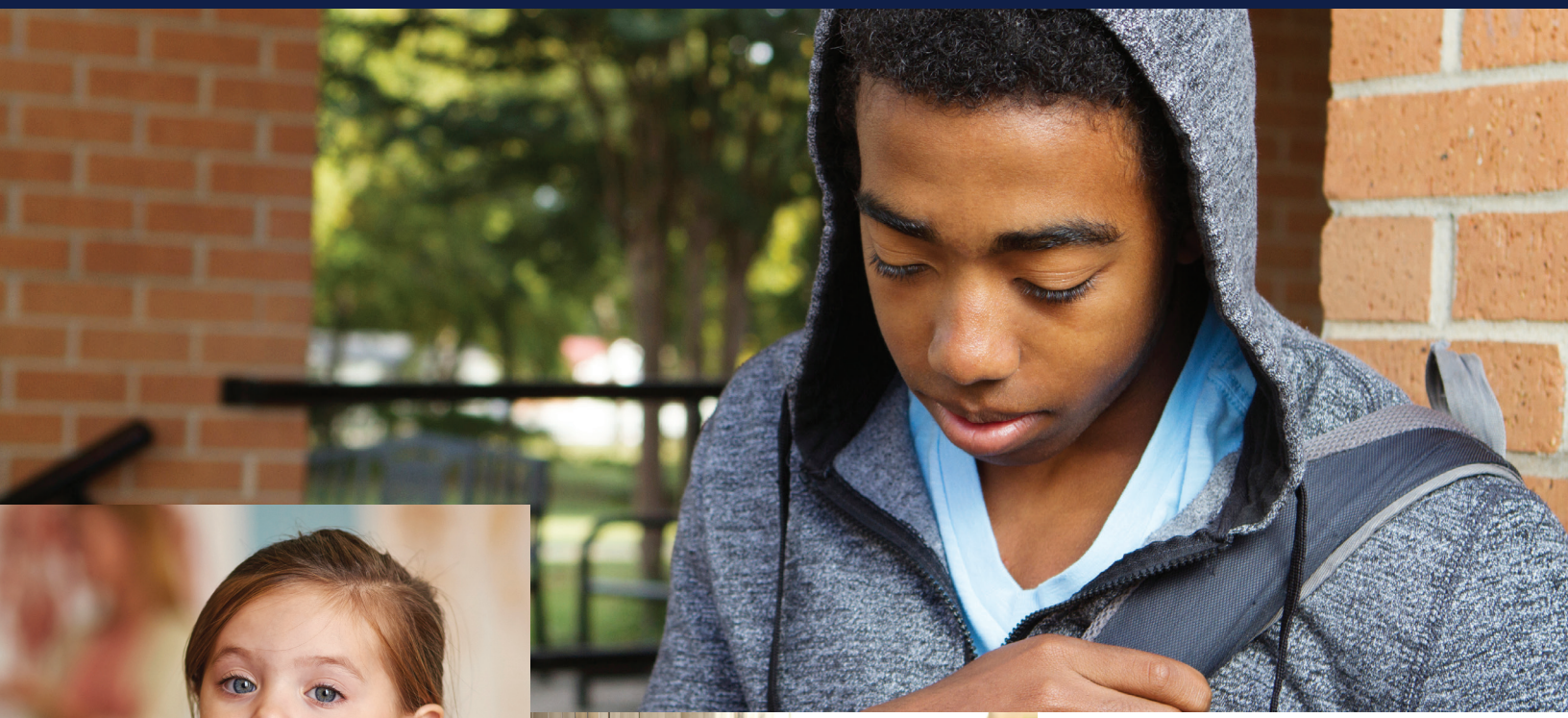
UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND

Mental Health Clinical Guidelines

Depression in Children and Adolescents



Text

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General Clinical Guidance

Pediatric primary care provides are on the front line for preventing, screening, assessing, treating, and monitoring pediatric mental health concerns.

The American Academy of Pediatrics has recommended the first step for addressing depression and other common pediatric mental health concerns is to develop standard office procedures. They should include:

- Screening tools
- Treatment protocols
- Resource and referral guide
- Criteria for consultation
- Emergency psychiatric and social emergencies

See the readiness inventory in attachments

Overview

Studies have shown that up to 9 percent of teenagers meet criteria for depression at any one time, with as many as 1 in 5 teens having a history of depression at some point during adolescence. Major depressive disorder (MDD) in youth is under-identified and under treated in primary care (PC) settings.

Barriers to specialty mental health services have led primary care to become the de-facto mental health clinic with opportunities to provide early prevention and treatment.

While the American Academy of Pediatrics (AAP) has provided guidelines for adolescent depression, our guideline will address the screening, psycho-education and referral to treatment process for children (defined as under 12 years old) with depression.

These guidelines will cover the screening, assessment, treatment, and referral criteria. These guidelines will not cover how to make specific referrals for specialty care or therapy.

Pediatric Depression

It is not unusual for young people to experience "the blues" or feel "down in the dumps" occasionally in response to stressful life events. Adolescence is often an unsettling time, with the many physical, emotional, psychological, and social changes that accompany this stage of life. Teen depression is associated with drug and alcohol abuse, low self-esteem and self-mutilation, pregnancy, violence, and even suicide.

The following symptoms of depression are more common in teenagers than adults:

- Irritable or angry mood: Irritability, rather than sadness, can be the more predominant mood in depressed teens. A depressed teenager may be bored, grumpy, hostile, easily frustrated, or prone to angry outbursts in a way that is markedly different than their baseline.
- Frequent unexplained aches and pains.
- Extreme sensitivity to criticism: Feelings of worthlessness, making them extremely vulnerable to criticism, rejection, and failure. This is a particular problem for "over-achievers."
- Withdrawing from some, but not all people—adults tend to isolate themselves when depressed, teenagers usually keep up at least some friendships. However, teens with depression may socialize less than before, pull away from their parents, or start hanging out with a different crowd.
- www.helpguide.org/articles/depression/teen-depression-signs-help.htm

Subjective

- Complete a history: use the HEEADSSS mnemonic (Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/self-harming/depression, and Safety from injury and violence).
- Obtain history of presenting illness:
  - Prior evaluations, prior treatments.
  - Current treatments, including alternative/complementary treatment such as acupuncture, herbs, yoga, etc.
  - Rule out any mania symptoms.
- Obtain family history of mental illness, with special emphasis on depression, bipolar disorder, history of violence/aggression, substance abuse, suicide attempts or completed suicides.
- Obtain sleep history.
- Obtain adverse childhood experiences history, trauma history.

Objective

- Physical examination
  - Assess for other possible comorbid medical conditions (may include anemia, allergy, thyroid disease, sleep disorder, Crohn's disease, lupus, celiac disease, Addison's disease and cancer.)
    - » CBC with Differential, Serology-Electrolytes, Ca, Mg, ESR, Bun/Cr, Glucose, LFT's, Serum B12, Folate, and Thyroid Function Tests (TSH and FT4) may be appropriate baseline labs.
    - » Pregnancy Test
- Questionnaires for depression: PHQ-2, PHQ 9-Adolescent
  - Since 2009, the U.S. Preventive Task Force (USPTF) has recommended screening for major depressive disorder (MDD) for adolescents aged 12 to 18 years.
  - Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
  - The AAP and USPTF recommend that depression screening be conducted annually.
  - Children aged 11 years or younger: The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for MDD.
  - For pediatric primary care, a general depression screen can be used for all adolescents aged 12 to 18 years old with the PHQ-2. The PHQ-2 does not establish a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach. See Appendix for PHQ-2.
  - Patients that score positive on the questionnaire, evaluate if the depression symptoms endorsed are significant and causing impairment. Complete the PHQ-9 if PHQ-2 is positive.
  - For patients who score negative on the PHQ-9 Adolescent, it is recommended that the primary care provider briefly review the symptoms marked as "more than half days" and "nearly every day" with the patient. See Appendix for PHQ-9 Adolescent.

Pediatric Depression (cont.)

- Suicide screen
  - If a youth is being treated for a behavioral or emotional problem, The Joint Commission of Accredited Health Organizations now mandates screening for suicide risk. The PHQ-9 adolescent provides a screening mechanism for suicidal risk.
  - Clinic protocols should be in place to evaluate and manage psychiatric emergency evaluation for 5150 (involuntary psychiatry hospitalization) evaluation.
  - If the patient has suicidal ideation/suicidal plan, complete and document a suicide assessment. Identify and document the following:
    - » Risk factors, protective factors, suicide inquiry (thought, plan, behaviors, intent), risk level assessment, treatment plan to reduce risk and rationale for interventions and follow-up plan.
    - » Document safety plan including removal of firearms and lethal medications and substance abuse counseling, identify support person(s), role of parent/caregiver, SI hotline #, 911/ER info and other contact information.
    - » Risk factors: Mnemonic SADPERSONS algorithm (Sex, Age, Depression/Affective disorder, Previous attempts, Ethanol/drug abuse, Rational thinking loss, Social supports lacking, Organized plan, Negligent parenting, Stressors: significant family stressors, self-harming behaviors, suicidal modeling by parents/siblings/friends, school problems).
  - One of the highest risk factors is a previous suicide attempt. One of the highest risk times is after a psychiatric hospitalization. One of the key interventions in primary care is to make sure a recently psychiatrically hospitalized patient has follow-up care either with their behavioral health provider or with you if none has been established.
  - Protective factors include strong familial/social ties, forward thinking, faith/spiritual practice.
  - It is highly recommended to consult/collaborate with a colleague or supervisor and to include this as part of your documentation.
  - Further reading: http://pediatrics.aappublications.org/content/105/4/871.long
  - For additional screening of suicide, the Ask Suicide-Screening Questions (ASQ) can be used. See the Appendix.
- Screen for co-occurring mental health conditions such as anxiety (30-80 percent), attention deficit hyperactivity disorder (10-80 percent), substance use (20-30 percent), eating disorders (10 percent), bipolar and psychosis.
  - For anxiety, you can use the SCARED anxiety rating scale or RCADS anxiety rating scale. See Appendix.
  - If bipolar diagnosis concerns, consult with a psychiatrist. Starting a selective serotonin reuptake inhibitor could induce a manic episode.
  - Significant alcohol or benzodiazepine substance abuse increases risks of seizures.
  - For co-occurring mental and complicated medical conditions, or multiple comorbid psychiatric conditions, consider a referral to psychiatry.
- Screen for substances (if appropriate)
  - Toxicology Screen if appropriate.
  - Long-term use of marijuana increases risk of depression.
  - Recommend using the CRAFFT screening tool. The questionnaire takes less than five minutes to complete and score, and it can be scored by the doctor, nurse, medical technician or other office staff prior to the patient's exam with the PCP. See Appendix for the CRAFFT.
  - It is recommended that parents are informed that a behavioral health screening questionnaire will be administered as part of the exam. In order to obtain honest answers, patients should be left alone to complete the CRAFFT in a private environment and should be informed of their rights regarding confidentiality before the questionnaire is administered.
  - Substance use increases the risk of suicide attempts.
  - Alcohol uses and SSRI treatment can increase the risk of seizures.

Assessment

- It is important to interview the youth separately and to gather history for the parent/caregiver and collateral (therapist, school, other health providers).
- Confirm the patient meets the criteria for major depressive disorder.

Pediatric Depression (cont.)

To make the diagnosis of major depressive disorder, the DSM 5 criteria is as follows:

A. 5+ following symptoms present during same two-week time and represent a change from previous function: at least 1 symptoms is (1) depressed mood, or (2) loss of interest/pleasure.

Nearly every day:

1. Depressed mood most of day, (irritable and bored feelings common for teens).
2. Markedly diminished interest/pleasure in all/almost all activities most of day.
3. Significant weight loss, decrease in appetite, failure to gain weight as expected (for children).
4. Insomnia or hypersomnia.
5. Psychomotor agitation or retardation.
6. Fatigue or loss of energy.
7. Feelings of worthlessness, inappropriate guilt.
8. Diminished ability to concentration, indecisiveness.
9. Recurrent thoughts of death, suicidal ideation, suicide attempt.

B. Symptoms cause clinically significant distress or impairment.

C. Episode is not attributable to physiological effects or substance or another medical condition.

Plan—Treatment for Major Depressive Disorder

Mild depression

- First line treatment:
  - Psycho-education: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/depression.aspx.
  - Use motivational interviewing to identify wellness goals for healthy sleep, healthy activities, healthy eating, healthy supports, enhanced problem solving.
  - Create treatment plan to monitor symptoms and goals (from the Adolescent Health Working Group Behavioral Health Tool Kit, www.ahwg.net/resources-for-providers.html).
  - Follow-up every week to bi-weekly: short, quality contact with provider can greatly decrease symptoms in mild/moderate depression “knowing someone cares.”
  - Continue to monitor for suicidal ideation, self-harming behaviors and substance use.
  - After 4 to 6 weeks of support or based on patient request, refer to therapy.
    - **Evidenced-based therapy for adolescent depression**
      - **Cognitive Based Therapy (CBT)**
        - Principle of CBT is that thoughts influence behaviors and feelings, and vice versa.
        - Treatment targets patient’s thoughts and behaviors to improve his/her mood.
        - Essential elements of CBT include increasing pleasurable activities (behavioral activation), reducing negative thoughts (cognitive restructuring), and improving assertiveness and problem-solving skills to reduce feelings of hopelessness.
      - **Interpersonal Therapy for Adolescents (IPT-A)**
        - Principle of IPT-A is that interpersonal problems may cause or exacerbate depression and that depression, in turn, may exacerbate interpersonal problems. Treatment will target patient’s interpersonal problems to improve both interpersonal functioning and his/her mood.
        - Essential elements of interpersonal therapy include identifying an interpersonal problem area, improving interpersonal problem-solving skills, and modifying communication patterns.

Moderate to severe depression

- First line treatment (see above).
- Consider referring to therapy before the 4 to 6 weeks of active support/monitoring.
- If continued partial response and functional impairment after 2-8 weeks consider starting medication treatment.

Medication Treatment

When to prescribe in primary care:

- Uncomplicated mild to moderate depression that persists after failed response to first line treatment and therapy.
- Significant functional impairment.
- Patient and family are not new to the clinic. We recommend not prescribing to a patient if they are new. Treatment follow-up is critical. Risk of side effects including activation or suicidal thinking is greatest in the first three months of treatment, when follow-up is most critical. Intermittent adherence can cause mood worsening, rather than improvement. This is why antidepressants are not prescribed upon presentation to the Emergency Room.
- Parental informed consent obtained if youth under 18 years old and not emancipated. Informed consent for psychotropic medication includes:
  - Diagnosis.
  - Risks of not treating with medication.
  - Alternative or additional treatments have been discussed.
  - Adverse effects discussed (short- and long-term).
  - Pharmacokinetic issues (laboratory monitoring if needed, dosing plan, drug-drug interactions).
  - Treatment adherence risks.
  - If off-label, document reasons.
  - Review of FDA warning:

    In May 2007, the FDA issued a revised medication guide that no longer includes specific mandates for monitoring SSRIs. Instead it focuses on information parents need to know regarding suicidality and antidepressants. The boxed warning is a warning and not a restriction.

    Antidepressants-induced suicidality is rare. The original FDA estimate based solely on data from more than 4,300 research participants in 23 studies was 2 percent of children and adolescents receiving placebo and 4 percent receiving an antidepressant developed suicidal thoughts or attempted suicide. Thus the risk difference was 2 percent. A subsequent analysis, based on data from 27 randomized controlled trials involving more than 5,300 participants found a significant risk difference of just 0.7 percent. The most recent estimate, which was based on data from 35 randomized controlled trials involving more than 6,000 participants found a risk difference of 0.9 percent, just missing statistical significant. The most recent and presumably best, analyses suggest that there may be a very slight increased risk of suicidality with antidepressants in children and adolescents, but not actual increased risk of completed suicide. Since the time of this black box warning, PCPs have prescribed less SSRIs, and the rates of suicide in youth have increased.

    Clinical prudence indicates the need to educate patients and parents about suicidality and to provide careful monitoring for suicidality and other adverse effects during the initial phase of treatment and throughout treatment.
- If the youth is in foster care system, a court authorization (JV-220) is required to prescribe psychotropic medications.

Engaging and Informing Parents

For the purpose of this guideline, parents are defined as the legal guardian for the patient.

- Inform parent of confidentiality rules for patient.
- Inform parent about the PHQ-9 screening results, treatment recommendations, follow-up plan, and referrals.
- Obtain written permission from parents to allow collaboration between primary care and behavioral health specialist.

Starting Medication Treatment

- Per AAP and American Academy of Child and Adolescent Psychiatry (AACAP), Selective Serotonin Reuptake Inhibitors (SSRI) are first line medication treatment for child and adolescent depression. No guidance regarding which SSRI is indicated.
- The selection choice may depend on FDA approval, insurance coverage, cost, patient and family preference, history of positive response by family members, medication adherence concerns, or other current medications prescribed (drug-drug interaction concerns).
- The initial dose (in table below) is recommended. In general, the younger the patient, the smaller the recommended initial dose. Pre-pubertal children are particularly sensitive to hyperkinesis, insomnia and restless (activation).
- Onset of effect generally occurs after 2 to 4 weeks at an effective dose, but some patients start to respond within a week.
- For all SSRIs, monitor height and weight. No specific laboratory studies are recommended.

Contraindications include:

- Known hypersensitivity (escitalopram and sertraline only).
- Serotonin syndrome and monomaine oxidase inhibitors (MAOIs) for all SSRIs.
  - Do not use SSRI sand MAOIs concomitantly.
  - Do not sart SSRI within 14 days of stopping MAOI (escitalopram, fluvoxamine, sertraline).
  - Do no start fluoxetine within 5 weeks of stopping MAOI.
- Do not use pimozide concomitantly with SSRIs.
- Do not use Thioridazine concomitantly with fluoxetine and fluvoxamine.

- Avoid administering or monitor carefully when co-administering other serotonergic agents, including triptans, tricyclic antidepressants, fentanyl, lithium, tramadol, tryptophan, buspirone, and St. John's wort.

Selective Serotonin Reuptake Inhibitors

GENERIC NAME	BRAND	US FDA	INITIAL DOSE, MG	MAX DAILY DOSE, MG	DOSING FREQUENCY	AVAILABLE UNIT DOSAGE FORMS	CLINICAL PEARLS
Fluoxetine	**Prozac**	MDD 8-17, OCD 7-17	10-20 mg	60 mg	Daily	Capsules: 10, 20, and 40 mg. Weekly capsules: 90 mg	Long half-life, no tapering required; good when medication adherence is a concern.
Escitalopram	**Lexapro**	MDD 12-17	10 mg	20 mg	Daily	Tablets: 5,10 (scored), and 20 (scored). Oral solution 1 mg/mL.	Good if there are concerns about drug-drug interactions; less effect on CYP450.
Sertraline	**Zoloft**	OCD 6-17	12.5-25 mg Over 13, 50 mg	200 mg	Daily	Scored tablets: 25,50, 100 mg. Oral solution 20mg/mL.	
Fluvoxamine	**Luvox**	OC 8-17	25 mg	8-11 yr 200 mg, 12-17 yr 300 mg	BID	Tablets 25, 50, and 100 mg.	

In general we do not recommend Paxil as first line agent due to increased side effects compared with other SSRIs, and slightly increased risk of suicidal ideation.

Starting Medication Treatment (cont.)

Monitoring therapeutic response, dose adjustment or switching SSRIs

- Dosage adjustment for SSRI requires balancing desire to reach a therapeutic dose as quickly as possible with the reality that the effect of a dose change may not be observable for 2 to 4 weeks. One practical approach is to increase the dose every 7 days to maximum dose if there are no adverse effects and minimal response. Ensure medication adherence before adjusting doses.
- During dose adjustment a weekly phone check-in or face-to-face appointment is preferred.
- Monitor weekly first month, then bi-weekly next month, then monthly for 3 months, then every 1 to 3 months depending on how stable the patient is. During the first month, you may consider telephone check in and face to face appointments every 2 weeks.
- If one SSRI fails or has partial response at optimal dose or has adverse effects, switch to an alternative SSRI. Switching from one SSRI to another can be staggered and overlapping, as long as the combined total daily dose remains equivalent and comparable over a couple of weeks. If fluoxetine is discontinued abruptly, dose escalation of the new SSRI can be based on an approximate half-life of fluoxetine of 1 to 2 weeks.
- Discontinuation of treatment (escitalopram, sertraline, fluvoxamine) is recommended by 25 percent each week. With fluoxetine, it self-tapers due to a long half-life.

Monitoring for adverse reactions

- Common initial (first 1 to 3 weeks, or with dose adjustment) adverse reactions include headaches and gastrointestinal reactions (nausea, diarrhea, constipation). To help prevent these, encourage taking medications with meals. If the headaches and GI effects persist consider BID dosing, changing from qam to qhs dosing if sedating (most common with sertraline) or changing to alternative SSRI.
- Other common adverse effects include change in appetite, weight, sexual dysfunction, or diaphoresis.
- Often with sertraline and fluvoxamine sedation occurs; however, these medications may also cause difficulties falling asleep as well and should be changed to qam dosing.
- Less adverse reactions include abnormal bleeding, angle-closure glaucoma, hyponatremia, seizure, QTC prolongation (fluoxetine).
- Most concerning side effects to monitor for are: restlessness (activation); hypomania or mania; suicide risk; and serotonin syndrome.
- Parents and youth are provided with information of when and whom to call for different situations (e.g., emergency, immediate call, or next day call).

Maintenance

Once an optimal dose is determine, maintenance treatment begins. Frequency of monitoring can be reduced to follow-up every 1 to 3 months depending on the patient's needs.

If mild to moderate depression, consider tapering and stopping after 9 months during a period of time when there is less stress for the patient.

If moderate to severe depression, consider collaborating with the patient's therapist and family to determine if a slow taper and stopping medication treatment is indicated after a year of medication treatment and at least 6 months of consistent therapy, preferably during a period of minimal stress or change.

When to refer to Child Psychiatry

1. Complexity or lack of clarity regarding diagnosis.
2. There is a safety threat to patient or others.
3. Significant change in emotion/behavior with no obvious precipitant.
4. Moderate+ substance abuse.
5. Primary caregiver has serious mental health problems (including substance use).
6. Psychosis, mania.
7. Psychiatrically hospitalized history.
8. Partial response to 2 different SSRI treatments after 6 to 8 weeks or more than 2 psychotropic medications.
9. Family psychiatric history suggests poor response to SSRI treatment.
10. Patient is <6 years old.
11. Chronic medical condition and patient's behavior seriously interferes with medical treatment.

    www.aacap.org/aacap/Member_Resources/Practice_Information/When_to_Seek_Referral_or_Consultation_with_a_CAP.aspx

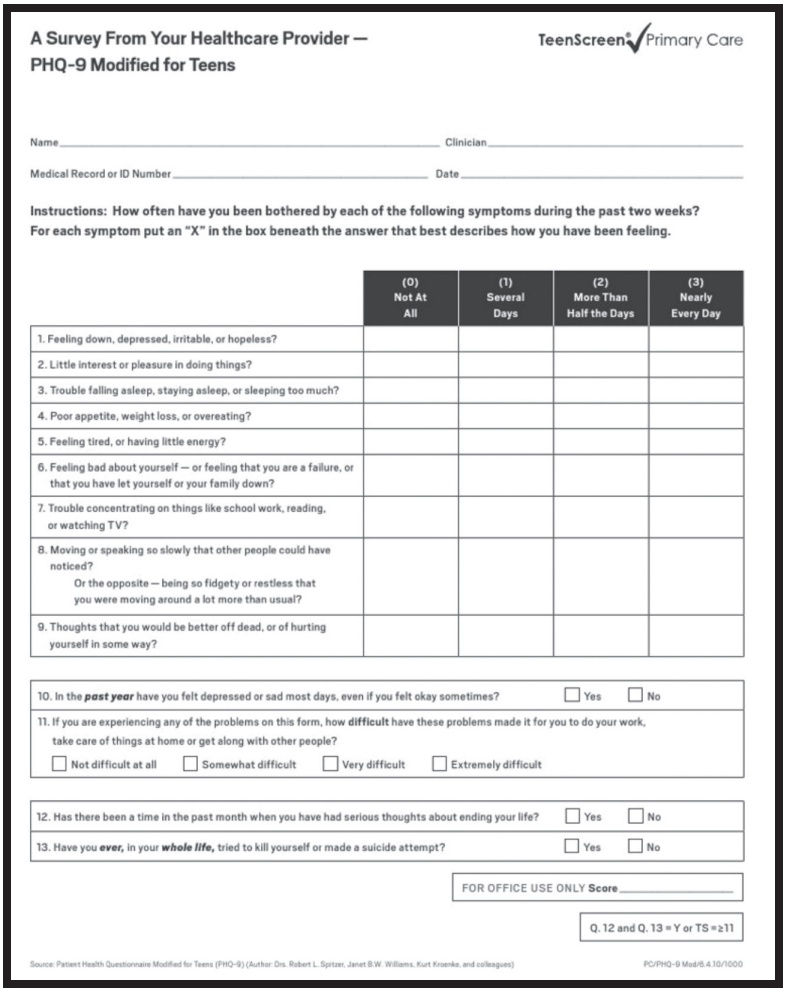
Appendix

Patient Health Questionnaire-2 (PHQ-2)				
Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
SCORE OF 3 or higher indicates a positive screen and further screening is recommended with PHQ-9 Adolescent				

Patient Health Questionnaire-9 (PHQ-9) Modified for Adolescent

- The PHQ-9 Modified for Adolescent questionnaire indicates the likelihood that a youth is at risk for depression or suicide; its results are not diagnosis or a substitute for a clinical evaluation.
- Free download of PHQ-9 Adolescent

  http://www.integration.samhsa.gov/images/res/8.3.4%20Patient%20Health%20Questionnaire%20(PHQ-9)%20Adolescents.pdf



A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

TeenScreen Primary Care

Name _____ Clinician _____

Medical Record or ID Number _____ Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

FOR OFFICE USE ONLY **Score** _____

Q. 12 and Q. 13 = Y or TS =≥11

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues) PC/PHQ-9 Mod/6.4.10/1000

PHQ-9 Modified for Adolescent

- Can be administered and scored by a nurse, medical assistant, physician or other staff.
- Patients should be left alone to complete in private area.
- Patients should be informed of their confidentiality rights before the screen is administered.
- Scoring:
  - ≥11 is a positive screen
  - 1-4 Minimal depression
  - 5-9 Mild depression
  - 10-14 Moderate depression
  - 15-19 Moderately severe
  - 20-27 Severe depression
- Suicidality: regardless of PHQ-9 score, endorsement of serious suicidal ideation or past suicide attempt (question 12 and 12) should be considered positive screen.

Appendix (cont.)

Ask Suicide Questionnaire (ASQ)

The ASQ has high sensitivity and negative predictive value, and has been used to identify the risk for suicide in patients presenting to pediatric emergency departments. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. Published online October 1, 2012. doi:10.1001/archpediatrics.2012.1276.

Ask Suicide Screening questions

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself? If yes, how? When?

   Positive responses to one or more of the questions may indicate a risk factor for suicide in youth.

CRAFFT—adolescent substance use screening

1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?
4. Do you ever **FORGET** things you did while using alcohol or drugs?
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

CRAFFT Scoring: Each "yes" response, scores 1 point. A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

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