General Clinical Guidance

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

The American Academy of Pediatrics (AAP) has recommended that the first step for addressing depression and other common pediatric mental health concerns be to develop standard office procedures. These procedures should include:

- Screening tools
- Treatment protocols
- Resource and referral guides
- Criteria for consultation
- 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 one in five teens having a history of depression at some point during adolescence. Major depressive disorder (MDD) in youth is under-identified and undertreated in primary care (PC) settings.

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

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

For More Information

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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, considering 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 in 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 his or her baseline.
- Frequent, unexplained aches and pains.
- Extreme emotional sensitivity: Feelings of worthlessness, making him or her 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 with 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.
- For more information, go to www.helpguide.org/articles/depression/teen-depression-signs-help.htm.

Objective

- Physical examination:
  - Assess for other possible comorbid medical conditions, including anemia, allergy, thyroid disease, sleep disorder, Crohn’s disease, lupus, celiac disease, Addison’s disease, and/or cancer.
  - CBC with Differential, Serology-Electrolytes, Ca, Mg, ESR, Bun/Cr, Glucose, LFTs, Serum B12, Folate, and Thyroid Function Tests (TSH and FT4) may be appropriate baseline labs.
  - Pregnancy test.
- Questionnaires for depression include PHQ-2 and PHQ 9 Modified for Adolescents (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.
  - For children aged 11 years or younger: the USPTF concludes that the current evidence is insufficient to assess the balance between 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 with the PHQ-2. The PHQ-2 does not establish a diagnosis or monitor depression severity, but it screens for depression as a “first step” approach. See the Appendix (page 10) for more information on the PHQ-2.
  - For patients that score positive on the questionnaire, evaluate if the depression symptoms endorsed are significant and causing impairment. Complete the PHQ-9 if the 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 (page 10) for PHQ-9 Adolescent.

Subjective

- Complete a history: Use the HEEDSSS mnemonic (Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/self-harming/depression, and Safety from injury and violence).
- Obtain a history of the presenting illness:
  - Prior evaluations and prior treatments.
  - Current treatments, including alternative/complementary treatments such as acupuncture, herbs, or yoga.
  - Rule out any mania symptoms.
- Obtain a family history of mental illness, with special emphasis on depression, bipolar disorder, history of violence/aggression, substance abuse, suicide attempts, or completed suicides.
- Obtain a sleep history.
- Obtain an adverse childhood experiences history and a trauma history.
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 suicide risk.
  - Clinic protocols should be in place to evaluate and manage psychiatric emergency evaluation for 5150 (involuntary psychiatric hospitalization) evaluation.
  - If the patient has suicidal ideation with a 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, rationale for interventions, and a follow-up plan.
    - Document a safety plan, including removal of firearms and lethal medications, substance abuse counseling; identification of support person(s), role of parent/caregiver, SI hotline number, 911/ER info, and other contact information.
    - Risk factors: mnemonic SaDPerSoNS (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 their primary care physician if none has been established.
  - Protective factors include strong familial/social ties, forward thinking, and faith/spiritual practice.
  - It is highly recommended to consult/collaborate with a colleague or supervisor and to include this as part of your documentation.
  - For further reading, See http://pediatrics.aappublications.org/content/105/4/871.long.
  - For additional screening of suicide, the Ask Suicide-Screening Questionnaire (ASQ) can be used. See the Appendix (page 11).

- 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.
  - If there are 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 for multiple comorbid psychiatric conditions, consider a referral to psychiatry.

- Screen for substances (if appropriate).
  - Perform 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 the Appendix (page 11) 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 use 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, and other health providers).
- Confirm that the patient meets the criteria for major depressive disorder.
To make the diagnosis of major depressive disorder, the DSM 5 criteria is as follows:
A. Five or more of the following symptoms present during the same two-week time period and represent a change from previous function. At least one symptom is (1) depressed mood or (2) loss of interest/pleasure.

Nearly every day the youth experiences:
1. Depressed mood most of the day (note that irritable and bored feelings are common for teens).
2. Markedly diminished interest/pleasure in all/almost all activities for most of the day.
3. Significant weight loss, decrease in appetite, or 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 or inappropriate guilt.
8. Diminished ability to concentrate or indecisiveness.
9. Recurrent thoughts of death, suicidal ideation, or suicide attempt.

B. Symptoms cause clinically significant distress or impairment.
C. The episode is not attributable to physiological effects of a substance or another medical condition.

Plan and treatment for major depressive disorder

Mild depression
- First-line treatment:
  - Use motivational interviewing to identify wellness goals for healthy sleep, healthy activities, healthy eating, healthy supports, and enhanced problem solving.
  - Create a 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 providers can greatly decrease symptoms in mild/moderate depression—“knowing someone cares.”
  - Continue to monitor for suicidal ideation, self-harming behaviors, and substance use.

Moderate to severe depression
- First-line treatment (see above).
- Consider referring for therapy immediately, before the four to six weeks of active support/monitoring.
- If there is continued partial response and functional impairment after two to eight weeks, consider starting medication treatment.
Medication Treatment

When to prescribe medication in primary care:

- Uncomplicated mild to moderate depression that persists after a failed response to first-line treatment and therapy.
- Significant functional impairment.
- The patient and family are not new to the clinic. We recommend not prescribing medication for 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 anti-depressants are not prescribed upon presentation to the Emergency Room.
- Parent-informed consent obtained if the youth is under 18 years old and not emancipated. Informed consent for psychotropic medication includes:
  - Diagnosis.
  - Risks of not treating with medication.
  - Discussion of alternative or additional treatments.
  - Discussion of adverse effects (short- and long-term).
  - Discussion of pharmacokinetic issues (laboratory monitoring if needed, dosing plan, drug–drug interactions).
  - Treatment adherence risks.
  - If off-label, documentation of reasons.
  - Review of FDA warning:

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

    Antidepressant-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 a 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 significance. 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 fewer 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 the foster care system, a court authorization (JV-220) is required to prescribe psychotropic medications.
Engaging and Informing Parents

For the purposes of this document, parents are defined as the legal guardian for the patient.

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

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

### Contraindications include:
- Known hypersensitivity (escitalopram and sertraline only).
- Serotonin syndrome and monoamine oxidase inhibitors (MAOIs) for all SSRIs.
  - Do not use SSRIs and MAOIs concomitantly.
  - Do not start SSRIs within 14 days of stopping MAOIs (escitalopram, fluvoxamine, sertraline).
  - Do not start fluoxetine within five 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.

<table>
<thead>
<tr>
<th>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)</th>
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<tbody>
<tr>
<td>GENERIC NAME</td>
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<tr>
<td>---------------</td>
</tr>
<tr>
<td><strong>Fluoxetine</strong></td>
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<tr>
<td><strong>Escitalopram</strong></td>
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<tr>
<td><strong>Sertraline</strong></td>
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<td><strong>Fluvoxamine</strong></td>
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In general, we do not recommend Paxil as a 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 or dose adjustment, or switching SSRIs**

- Dosage adjustment for SSRIs requires balancing the 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 one to four weeks. One practical approach is to increase the dose every seven days to the maximum dose if there are no adverse effects and there is minimal response. Ensure medication adherence before adjusting doses.

- During dose adjustment, a weekly phone check-in or face-to-face appointment is preferred.

- Monitor the patient weekly the first month, then bi-weekly the next month, then monthly for three months, then every one to three months depending on how stable the patient is. During the first month, you may consider a telephone check-in and face-to-face appointments every two weeks.

- If one SSRI fails or causes a partial response at the optimal dose or has adverse effects, switch to an alternate 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 one to two weeks.

- Discontinuation of treatment (escitalopram, sertraline, fluvoxamine) is recommended by 25 percent each week. Fluoxetine, self-tapers due to a long half-life.

**Monitoring for adverse reactions**

- Common initial (first one to three weeks, or with dose adjustment) adverse reactions include headaches and gastrointestinal reactions (nausea, diarrhea, and/or constipation). To help prevent these, encourage taking medication 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 an alternative SSRI.

- Other common adverse effects include changes in appetite or weight, sexual dysfunction, or diaphoresis.

- Often with sertraline and fluvoxamine, sedation occurs; however, these medications may also cause difficulties with falling asleep and, if these difficulties occur, medication should be changed to qam dosing.

- Less common reactions include abnormal bleeding, angle-closure glaucoma, hyponatremia, seizure, and QTC prolongation (fluoxetine).

- Other concerning side effects to monitor are restlessness (activation); hypomania or mania; suicide risk; and serotonin syndrome.

- Parents and youth are provided with information about when and whom to call for different situations (e.g., emergency, immediate call, or next-day call).

**Maintenance**

Once an optimal dose is determined, maintenance treatment begins. Frequency of monitoring can be reduced to follow-up every one to three months depending on the patient’s needs.

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

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

**When to refer the patient to Child Psychiatry**

1. Complexity or lack of clarity regarding a diagnosis.
2. Safety threat to the patient or to others.
3. Significant change in emotion/behavior with no obvious precipitant.
4. Moderate to severe substance abuse.
5. Primary caregiver has serious mental health problems (including substance abuse).
6. Psychosis or mania.
7. History of psychiatric hospitalization.
8. Partial response to two different SSRI treatments after six to eight weeks, or after more than two psychotropic medications.
10. Patient is 6 years old or younger.

For more information, please see 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)

<table>
<thead>
<tr>
<th>Over the past two weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

A score of 3 or higher indicates a positive screen, and with a positive screen, further screening is recommended via the PHQ-9 Modified for Adolescents.

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

- The PHQ-9 Modified for Adolescent indicates the likelihood that a youth is at risk for depression or suicide; its results are neither a diagnosis nor a substitute for a clinical evaluation.

PHQ-9 Modified for Adolescents

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

Ask Suicide Questionnaire (ASQ)
The ASQ has high sensitivity and negative predictive value, and it has been used to identify the risk of 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 Questionnaire 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 these 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.

References
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