Guidelines for Adolescent Depression in Primary Care: Navigating the GLAD-PC Recommendations and Toolkit

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Guidelines for Adolescent Depression in Primary Care

GLAD - PC
Part I

- *Pediatrics*. 2018;141(3):e20174081
  [http://pediatrics.aappublications.org/content/141/3/e20174081](http://pediatrics.aappublications.org/content/141/3/e20174081)

- **Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Practice Preparation, Identification, Assessment, and Initial Management**

- Zuckerbrot RA, Cheung AH, Jensen PS, Stein REK, Laraque D; GLAD-PC Steering Group
Part II

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- Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management

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Guidelines for Adolescent Depression in Primary Care

GLAD - PC

Toolkit
Why talk about adolescent depression?
How to Recognize the Moods of an Adolescent

- HAPPY
- DEPRESSED
- EXCITED
- ANXIOUS
- MANIC
- SUICIDAL
Depression is Common in Teens

- **Major Depressive Disorder (MDD)**
  - 1–2% for children (boys:girls – 1:1)
  - 4–8% for adolescents (boys:girls – 1:2)
  - By the end of adolescence: 11–20% lifetime

- **Dysthymia**
  - 1% for children
  - 5% for adolescents

- **Sub-syndromal Depressive Symptoms**
  - 5–10%
Depression Derails Kids’ Lives Now

- **Poor Self-Image**: Negative view of self \(\rightarrow\) hopeless view of one’s future \(\rightarrow\) suicidality

- **School**: Decreased concentration, lack of motivation, poor energy \(\rightarrow\) bad grades, school absences \(\rightarrow\) school drop-out or decreased level of achievement

- **Peers**: Irritable mood and decreased energy/motivation \(\rightarrow\) conflict, drama, and decreased involvement in activities \(\rightarrow\) loss of meaningful interpersonal relationships and a supportive social circle

- **Family**: Irritable mood \(\rightarrow\) conflict, drama \(\rightarrow\) dismissed as bad kid, help not provided

- **Community**: Irritable mood and decreased energy/motivation \(\rightarrow\) arguments with coaches/instructors, quitting activities \(\rightarrow\) social isolation
Depression Derails Kids’ Lives Later

- Psychosocial problems persist as deficits never gained
- Recurrent depressions
- Recurrent suicidality
- Substance abuse
- Poor employment if education disrupted
- Hospitalizations
Part I

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Clinical Assessment Flowchart

Preparation for Managing Depression in PC
Preparation through increased training, establishing mental health linkages, and increasing the capacity of practices to monitor and follow-up with patients with depression

All youth 12 years and older presenting at annual visit

Low risk
Systematically identify youth with depression risk factors, including chronic somatic complaints

High risk

Targeted screening with tool

Positive screen result

Do you clinically suspect depression?

If yes
(1) Stop assessment
(2) Repeat targeted screening at regular intervals

If no

If psychotic or suicidal
Refer to crisis or emergency services (may include subsequent referral to inpatient treatment)

Evaluation positive for MDD but not psychotic or suicidal

Evaluation negative for MDD but high depression symptoms

Clinical Decision
May follow depression treatment guidelines if appropriate or return for regular follow-up as high-risk with more frequent targeted screening

Evaluation negative for depression but positive for other MH conditions

(1) Refer to other treatment guidelines
(2) Evaluate for depression at future visits
(3) Book for follow-up visit

Preparation for Managing Depression in Primary Care

- Increased training
- Establishing mental health linkages
- Increasing the capacity to monitor and follow-up
Clinical Assessment Flowchart

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All youth 12 years and older presenting at annual visit

Low risk

Systematically identify youth with depression risk factors, including chronic somatic complaints

High risk

Targeted screening with tool

If yes

Do you clinically suspect depression?

(1) Stop assessment
(2) Repeat targeted screening at regular intervals

If no

Universal screen with depression-specific tool

Positive screen result

Negative screen result

If yes

Youth or family presents with emotional issues as chief complaint

Perform regular history and physical

Negative screen result

Evaluation negative for depression but positive for other MH conditions

(1) Refer to other treatment guidelines
(2) Evaluate for depression at future visits
(3) Book for follow-up visit

Evaluation negative for MDD but high depression symptoms

Clinical Decision
May follow depression treatment guidelines if appropriate or return for regular follow-up as high-risk with more frequent targeted screening

Evaluation positive for MDD but not psychotic or suicidal

If psychotic or suicidal

Refer to crisis or emergency services (may include subsequent referral to inpatient treatment)

Assessment
(1) Assess with systematic depression assessment tool (if not used as screen)
(2) Interview patient and parent(s) to assess for depression and other psychiatric disorders with DSM-5 or ICD-10 criteria
(3) Interview patient alone
(4) Assess for safety and/or suicide risk

Other Advocates for Universal Screening

- The USPSTF recommends screening for major depressive disorder (MDD) in 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. (2016, 2009)
Other Advocates for Universal Screening (AAP 2016, 2014)

<table>
<thead>
<tr>
<th>Recommendations for Preventive Pediatric Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bright Futures/American Academy of Pediatrics</td>
</tr>
</tbody>
</table>

The table outlines various developmental and health care recommendations for children at different age groups. Each column represents a different age range, with specific health screenings and evaluations recommended. The table is comprehensive, covering various aspects such as growth and development, health status, and specific evaluations for conditions like Autism Spectrum Disorder. The recommendations are designed to ensure comprehensive care and monitoring for children's health and development.
Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit

The GLAD-PC Toolkit helps primary care providers to put the GLAD-PC guidelines into effect. This toolkit was developed with the input of experts from the areas of adolescent depression, primary care behavioral medicine, parent and family advocacy, guideline development, and quality improvement.

Whenever possible, we have adapted or borrowed generously (and with permission) from those pioneers who had already developed such materials for their own populations and settings. We especially want to thank our partners in depression care improvement from the Texas State Department of Health Services, Columbia University’s Treatment Guidelines Project, Intermountain Health Care, American Medical Association, Western Psychiatric Institute and Clinic, the National Alliance for the Mentally Ill, the Depression & Bipolar Support Alliance, and many others too numerous to mention who have shared time, expertise, and toolkit content.

On behalf the GLAD-PC Steering Committee, organization liaison representatives, and the many expert clinicians who contributed to this process to improve adolescent depression management in primary care, we thank you for your service and efforts for depressed teens.

Downloads:

Download the updated GLAD-PC Toolkit here
GLAD-PC Toolkit: www.gladpc.org
# Teen Screens

**PHQ-9: Modified for Teens (ages 11-17)**

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>Date: ______________________</th>
</tr>
</thead>
</table>

**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.

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

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

In the past year, have you felt depressed or had sad most days, even if you felt okay sometimes?

[ ] Yes  [ ] No

Has there been a time in the past month when you have had serious thoughts about ending your life?

[ ] Yes  [ ] No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

[ ] Yes  [ ] No

**Office Use Only:**

<table>
<thead>
<tr>
<th>SCORE:</th>
<th>Screener Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

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Modified with permission by the CLAD PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999). Revised PHQ-9 (Kroenke, 2002) and the CDS IDRC Development Group, 2009.

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### Columbia Depression Scale (Ages 11 and over)

**Present State (last 4 weeks)**

**TO BE COMPLETED BY PARENT OF FEMALE CHILD**

If the answer to the question is “No,” circle the 0; if it is “Yes,” circle the 1.

Please answer the following questions about your daughter (female child) as honestly as possible.

<table>
<thead>
<tr>
<th>In the last four weeks ...</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has she often seemed sad or depressed?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. Has it seemed like nothing was fun for her and she just wasn’t interested in anything?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>3. Has she often been grouchy or irritable and often in a bad mood, when even little things would make her mad?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4. Has she lost weight, more than just a few pounds?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>5. Has it seemed like she just lost her appetite or ate a lot less than usual?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6. Has she gained a lot of weight, more than just a few pounds?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>7. Has it seemed like she felt much hungrier than usual or ate a lot more than usual?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8. Has she had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>9. Has she slept more during the day than she usually does?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10. Has she seemed to do things like walking or talking much more slowly than usual?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11. Has she often seemed restless ... like she just had to keep walking around?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>12. Has she seemed to have less energy than she usually does?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>13. Has she done even little things seemed to make her feel really tired?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14. Has she often blamed herself for bad things that happened?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>15. Has she said she couldn’t do anything well or that she wasn’t as good looking or not as smart as other people?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>16. Has it seemed like she could think as clearly or as fast as usual?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>17. Has she often seemed to have trouble keeping her mind on her [schoolwork] or other things?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>18. Has it often seemed hard for her to make up her mind or to make decisions?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>19. Has she said she often thought about death or about people who had died or about being dead herself?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>20. Has she talked seriously about killing herself?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>21. Has she ever, in her WHOLE LIFE, tried to kill herself or made a suicide attempt?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>22. Has she tried to kill herself in the last four weeks?</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
Clinical Assessment Flowchart

Preparation for Managing Depression in PC
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All youth 12 years and older presenting at annual visit

Perform regular history and physical

Negative screen result

Universal screen with depression-specific tool

Positive screen result

Targeted screening with tool

High risk

Systematically identify youth with depression risk factors, including chronic somatic complaints

Low risk

Negative screen result

If yes

Do you clinically suspect depression?

If no

(1) Stop assessment
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Evaluation negative for depression but positive for other MH conditions

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Refer to crisis or emergency services (may include subsequent referral to inpatient treatment)

Evaluation Positive for Depression: Mild, Moderate, Severe, or Depression with Comorbidities

(1) Evaluate safety and establish safety plan
(2) Evaluate severity of depression symptoms (See^)
(3) Patient and/or family education (See^)
(4) Develop treatment plan based on severity-review diagnosis and treatment options with patient and/or family

Interview Patient with Parent and Alone

- Discuss limits of confidentiality and expectations of split visit
- Follow-up with further questions to determine coherence of story: Is it persistent? How long? Interfering with function?
- Confirm positives on written screens and clarify nature, duration, onset, precipitants, what’s been tried
- Look for comorbidity
- Screen suicidality
- Targeted physical examination
- Labs only as indicated by history, physical exam
Assess Psychosocial Functioning

- How impaired is this teen?
  - Is he missing class?
  - Is she getting good grades?
  - Has the school noticed a problem?
  - Is he still playing basketball on the team?
  - Has she continued to paint?
  - Are his friends still coming to visit?
  - Is she still going out to parties?
  - Does he participate in family outings?
DSM-5 criteria for depressive disorders can be found in the GLAD-PC Toolkit
Investigate for Suicide

- Ask adolescent directly about ideation, impulses, and acts.

- Ask parents directly about statements or behaviors suggesting suicidal ideation/feelings.
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Initial Management

A. Evaluate safety and establish a safety plan.
B. Decide if mild, moderate, or severe.
C. Patient and family education.
D. Develop a treatment plan based on severity.
A. Safety Planning

- Assess current risk.

- If safe to go home:
  - Encourage parents to “sanitize” the home.
    - Investigate access to means (eg, guns in home).
  - Make a written plan (or on a smartphone, tablet, etc.) with steps agreed upon by all parties as to what to do at what point—NOT A PROMISE TO NOT HARM.
    - Hierarchy of support systems and comforting activities (music, art, sports, etc.)
      - When should friends be contacted
      - When should parents be contacted
      - When should the primary care physician (PCP) be contacted
      - When should 911 be contacted
      - When should a suicide crisis line be contacted
Information for PCPs on Safety Planning

Safety Planning for Depressed Adolescents

(Adapted by GLAD-PC with permission from materials prepared by Families for Depression Awareness)

1. **Encourage adolescents and parents to make their homes safe.** In teens aged 10 to 19, the most common method of suicide is by suffocation (mostly hanging), followed closely by guns and firearms and poisoning. All ropes, cables, guns, and other weapons should be removed from the house, or at least locked up. Other potentially harmful items such as sharp knives, alcohol, drugs, and poisons should also be removed.

2. **Ask about suicide.** Providers and parents should ask regularly about thoughts of suicide. Providers should remind parents that making these inquiries will not promote the idea of suicide.

3. **Watch for suicidal behavior.** Behaviors to watch for in children and teens include:
   - Expressing self-destructive thoughts
   - Drawing morbid or death-related pictures
   - Using death as a theme during play in young children
   - Listening to music that centers around death
   - Playing video games that have a self-destructive theme
   - Reading books or other publications that focus on death
   - Watching television programs that center around death
   - Visiting internet sites that contain death-related content
   - Giving away possessions

4. **Watch for signs of drinking.** If a child has depression, feels suicidal, and drinks a lot of alcohol, the person is more likely to take his or her life. Parents are usually unaware that their child is drinking. If a child is drinking, the parent will need to discuss this with the child and the clinician.

5. **Develop a suicide emergency plan and a safety plan.** Work with patients and parents to decide how to proceed if a child feels depressed and suicidal. It is important to be specific and provide adolescents with accurate names, phone numbers, and addresses.
B. Decide if Mild, Moderate, Severe

MILD

MODERATE

SEVERE

Clinical impressions from interview
Standardized rating scales
Number of *DSM-5* criteria
Level of impairment, safety issues
Severity Determination

Framework for Grading Severity of Depressive Episodes

In both the DSM-5 and the ICD-10, severity of depressive episodes is based on the number, type, and severity of symptoms, as well as the degree of functional impairment. The DSM-5 guidelines are summarized in the table below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of symptoms</td>
<td>Closer to 5</td>
<td></td>
<td>Closer to 9</td>
</tr>
<tr>
<td>Severity of symptoms</td>
<td>Distressing but</td>
<td></td>
<td>Seriously distressing and</td>
</tr>
<tr>
<td></td>
<td>manageable</td>
<td></td>
<td>unmanageable</td>
</tr>
<tr>
<td>Degree of functional</td>
<td>Minor impairment</td>
<td></td>
<td>Symptoms markedly interfere</td>
</tr>
<tr>
<td>impairment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* According to the DSM-5, in “moderate” episodes of depression, “the number of symptoms, the intensity of symptoms, and/or the functional impairment are between those specified for ‘mild’ and ‘severe.’”

In addition to the above framework, individual rating scales are associated with their own indicators of severity, as indicated elsewhere in this section.
C. Patient and Family Education

- Provide psychoeducation.
- Provide supportive counseling.
- Facilitate parental and patient self-management.
- Refer for peer support.
- Regularly monitoring of depressive symptoms and suicidality.
Psychoeducation on Diagnosis

- Explaining depression as a common and treatable condition is one of the most important steps to be done in primary care.

- Giving written materials to your patients can go a long way in helping to keep them engaged in the mental health process.
Supportive Counseling, Self-Management, Peer Support, Regular Monitoring

- See the GLAD-PC Toolkit.
D. Develop a Treatment Plan Based on Severity

- Review the Diagnosis and Treatment Plan with the patient and family.
Part II

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Treat with confidence. Trusted answers from the American Academy of Pediatrics.

Clinical Assessment Flowchart

If mild depression

Active support and monitoring for 6 to 8 weeks (every 1 to 2 weeks) (see #)

If persistent

If improved

Manage in primary care
1. Initiate medication and/or therapy in primary care (see #) with evidence-based antidepressant and/or psychotherapy
2. Monitor for symptoms and adverse events (see #)
3. Consider ongoing mental health consultation

If partially improved after 6 to 8 weeks

1. Consider
   - Adding medication if have not already; increasing to maximum dosage as tolerated if already on medication
   - Adding therapy if have not already
   - Consulting with mental health specialist
2. Provide further education, review safety plan (see #), and continue ongoing monitoring

If not improved after 6 to 8 weeks

1. Reassess diagnosis
2. Consider:
   - Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
   - Adding therapy if it has not already been done
   - Consulting with mental health specialist
3. Provide further education, review safety plan (see #), and continue ongoing monitoring

If improved after 6-8 weeks

1. Continue medication for 1 year after full resolution of symptoms (based on adult literature)
   AACAP recommends monthly monitor for 6 months after full remission
2. Continue to monitor for 6 to 24 months with regular follow-up whether or not referred to mental health specialist
3. Maintain contact with mental health specialist if such treatment continues

If severe depression or comorbidities

Consider consultation by mental health specialist to determine management plan

Should consider consultation by mental health specialist to determine management plan

Refer to mental health specialist if appropriate (see a,b)

Mild Depression: Active Monitoring in Primary Care

- Active support and monitoring for 6–8 weeks
- Every 1–2 weeks
  - Psychoeducation
  - Supportive counseling
  - Facilitate parental and patient self-management
  - Refer for peer support
  - Regular monitoring of depressive symptoms and suicidality
GLAD-PC Toolkit Chapter IV

Chapter IV.
Treatment Information for Providers
Guide to the “Treatment Information for Providers” Section

Active Monitoring

Treatment Choices: Supportive Counseling and Problem-Focused Treatment

Treatment Choices: Evidence-based Psychotherapy

Evidence-based Pharmacotherapy

Depression Monitoring Flow Sheet

Suicidality in Adolescents and the Black Box Warning

Safety Planning for Depressed Adolescents

Assessment of High-Risk Teen Suicide Attempters
Psychoeducation on Treatment

- Explaining the treatment options and why they work can be very important.
- Giving written materials to your patients can help with this aspect of treatment.
- Make sure you partner specifically with the teen.
Active Monitoring & Close Follow-Up

Self-Care Success!

Things you can do to help yourself.
Name: __________________ Date: ________________

Instructions: When people are depressed they often forget to take care of themselves. By setting self-care goals you can take an active role in helping yourself feel better more quickly. Choose one or two of the steps below and set a goal. Make sure the goal is clear and reasonable. In the space below the boxes rate how likely you are to follow through on the goal(s) you set. If you are not very sure you can follow through on your goal you may want to find alternatives or make some adjustments.

- Stay Physically Active
  Each week during the next month I will spend at least ___ days doing the following physical activity for ___ minutes.
  (Pick a specific date and time and make it reasonable!)

- Schedule Pleasant Activities
  Even though I may not feel motivated I will commit to scheduling ___ fun activities each week for the next month. They are ___.
  (Specify when and with whom)

- Eat Balanced Meals
  Even if I don’t feel like it, I will eat ___ balanced meals per day to include ___.
  (Choose healthy foods)

- Spend Time With People Who Can Support You
  During the next month I will spend at least ___ days for at least ___ minutes at a time with: ___.
  (Who?) ___
  (What?) ___
  (e.g. talking, eating, playing)

- Spend Time Relaxing
  Each week I will spend at least ___ days relaxing for ___ minutes by participating in the following activities: ___.
  (e.g. reading, writing in a journal, deep breathing, muscle relaxation)

- Small Goals & Simple Steps
  The problem is: ___.
  My goal is: ___.
  Step 1: ___.
  Step 2: ___.
  Step 3: ___.

How likely are you to follow through with these activities prior to your next visit?
Not Likely  1  2  3  4  5  6  7  8  9  10 Very Likely

What might get in the way of your completing these activities prior to your next visit?
________________________
Solution(s) to the above barriers: __________________________
## Depression Monitoring Flow Sheet

<table>
<thead>
<tr>
<th>Week</th>
<th>Date</th>
<th>Assessing Clinician</th>
<th>Mode(s) of interview</th>
<th>Assessment Tool / Score</th>
<th>Change in Target Symptoms / Side Effects</th>
<th>Initial Action (i.e., Education, Medication, Consultation)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Remember to assess response 5-8 weeks after initiating treatment.
Moderate to Severe Depression
Clinical Assessment Flowchart

If mild depression

- Active support and monitoring for 6 to 8 weeks (every 1 to 2 weeks) (see a)

If moderate depression

- Consider consultation by mental health specialist to determine management plan

If severe depression or comorbidity

- Should consider consultation by mental health specialist to determine management plan

If persistent

Manage in primary care

- Initiate medication and/or therapy in primary care (see a) with evidence-based antidepressant and/or psychotherapy
- Monitor for symptoms and adverse events (see c)
- Consider ongoing mental health consultation

If partially improved after 6 to 8 weeks

- Consider:
  - Adding medication if have not already; increasing to maximum dosage as tolerated if already on medication
  - Adding therapy if have not already
  - Consulting with mental health specialist
- Provide further education, review safety plan (see a), and continue ongoing monitoring

If not improved after 6 to 8 weeks

- Refer to mental health specialist if appropriate (see a, b)

If not improved

- Reassess diagnosis
- Consider:
  - Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
  - Adding therapy if it has not already been done
  - Consulting with mental health specialist
- Provide further education, review safety plan (see a), and continue ongoing monitoring

If improved after 6-8 weeks

- Continue medication for 1 year after full resolution of symptoms (based on adult literature)
- AACAP recommends monthly monitor for 6 months after full remission
- Continue to monitor for 6 to 24 months with regular follow-up whether or not referred to mental health specialist
- Maintain contact with mental health specialist if such treatment continues

Making the Most of Your Referral

- Explain to the family why you are referring them somewhere.
- Explain to the family what the referral provider will do.
- Explain to the family your continued role in their care for this issue.
- Communicate with referral provider.
- Establish roles and responsibilities with mental health provider.
FORM I: Referral from Primary Care to Mental Health Provider (to be given to parent by PCP)

Dear Colleague:

I am happy to be referring: ______________________ on ______________ for ______________________

(Patient’s Name- Please Print) (Date) (Reason/Diagnosis)

Summary:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

The patient has the following allergies: ________________________________________

Is on these medications: ______________________________________________________

And has these significant health problems: ______________________________________

The patient had these recent tests:

Lab tests for the following:  _____ CBC Date: __________  _____ Thyroid Studies Date: __________
Results: __________  Results: __________

_____ Chem Panel Date: __________  _____ EKG Date: __________
Results: __________  Results: __________

Other:

I am  I am NOT willing to help manage mental health medications.

***I would like to hear back from you at your earliest convenience. I have attached Forms IIA and IIB to facilitate this feedback.

__________________________________________________________________________

(Provider Signature) (Printed Name and Title) (Phone) (Fax)

Address: ___________________________________________________________________
Clinical Assessment Flowchart

If mild depression
- Active support and monitoring for 6 to 8 weeks (every 1 to 2 weeks) (see a)
  - If persistent
    - If improved
      - Manage in primary care
        1. Initiate medication and/or therapy in primary care (see a) with evidence-based antidepressant and/or psychotherapy
        2. Monitor for symptoms and adverse events (see c)
        3. Consider on going mental health consultation
    - If partially improved
      - If partially improved after 6 to 8 weeks
        1. Consider
           - Adding medication if have not already; increasing to maximum dosage as tolerated if already on medication
           - Adding therapy if have not already
           - Consulting with mental health specialist
        2. Provide further education, review safety plan (see d), and continue ongoing monitoring
  - If not improved
    - If not improved after 6 to 8 weeks
      1. Reassess diagnosis
      2. Consider:
         - Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
         - Adding therapy if it has not already been done
         - Consulting with mental health specialist
      3. Provide further education, review safety plan (see d), and continue ongoing monitoring
    - If improved

If moderate depression
- Consider consultation by mental health specialist to determine management plan
  - If not improved
    - If not improved after 6 to 8 weeks
      1. Reassess diagnosis
      2. Consider:
         - Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
         - Adding therapy if it has not already been done
         - Consulting with mental health specialist
      3. Provide further education, review safety plan (see d), and continue ongoing monitoring
    - If improved

If severe depression or comorbidities
- Should consider consultation by mental health specialist to determine management plan
  - If not improved
    - If not improved after 6 to 8 weeks
      1. Reassess diagnosis
      2. Consider:
         - Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
         - Adding therapy if it has not already been done
         - Consulting with mental health specialist
      3. Provide further education, review safety plan (see d), and continue ongoing monitoring
    - If improved

Psychotherapy for Depression

- Cognitive Behavioral Therapy (CBT)
- Interpersonal Psychotherapy-Adolescent (IPT-A)
- Other therapies are difficult to manualize and test in a randomized controlled trial (does not mean that they are ineffective)
CBT

- Most evidence for adolescent depression at this point

GETS KIDS MOVING and BUILDS SKILLS

- Behavioral activation (Go watch the other kids play basketball even if you are too tired and not interested.)
- Cognitive restructuring (The world is not out to get you. That is the depression talking.)
- Coping skills training (What can you do next time when you get into a fight instead of trying to hurt yourself?)
- Stress management (Deep breathing, listening to music, etc.)
# Evidence-Based Psychotherapy: Information for PCPs

**Table 1. Cognitive Behavioral Therapy and Interpersonal Therapy**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Key Components</th>
<th>Manuals/Websites</th>
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</thead>
</table>
| CBT         | 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. | Treating Depressed Children: Therapist Manual for “Taking Action”  
Adolescent Coping with Depression Course  
Gregory Clarke, Ph.D., Peter Lewinsohn, PhD, Hyman Hops, Ph.D. 1990  
https://research.kpchr.org/ResearchAreas/Mental-Health/Youth-Depression-ProgrammedDownloads  
USING CBT WITH CHILDREN  
MGH Academy  
http://mgh.org/peps/coap/cognitive_behavioral_therapy |
| IPT         | Interpersonal problems may cause or exacerbate depression and that depression, in turn, may exacerbate interpersonal problems. Treatment targets 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 | Interpersonal Psychotherapy for Depressed Adolescents, 2nd ed.  
Laura Mufson, Kristen Pollack Dorta, Donna Moresu, and Myma M. Weissman. New York, Guilford Press 2011 (paperback), 315 pp |

CBT=Cognitive Behavioral Therapy  
IPT=Interpersonal Therapy
Psychopharmacotherapy for Depression

- Selective Serotonin Reuptake Inhibitors (SSRIs) are first-line treatment in adolescent depression.
Which SSRI?

FDA approval for MDD in teens?
- Fluoxetine
- Escitalopram

Evidence base for MDD in teens?
- Fluoxetine
- Escitalopram
- Sertraline (off-label)
- Citalopram (off-label)
Which SSRI?

FDA approval for other disorders (safety established)?
- Fluoxetine
- Sertraline
- Fluvoxamine

Other considerations?
- Prior treatment history
- Comorbidity
- Family member response
- Family preference
- Clinician experience
Treatment of Adolescent Depression Study (TADS)

- 439 adolescents, 12–17 years old, 13 sites, 12 weeks

Study groups:

- Medication (fluoxetine) alone: 60.6%
- CBT alone: 43.2% (not statistically different from placebo at 12 weeks)
- CBT + fluoxetine: 71%
- Placebo: 34.8%

Follow-Up
Follow-Up

If mild depression

Active support and monitoring for 6 to 8 weeks (every 1 to 2 weeks) (see a)

If persistent

If improved

Manage in primary care
1. Initiate medication and/or therapy in primary care (see a) with evidence-based antidepressant and/or psychotherapy
2. Monitor for symptoms and adverse events (see a)
3. Consider ongoing mental health consultation

If partially improved

If not improved after 6 to 8 weeks
1. Consider:
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If improved after 6-8 weeks
1. Continue medication for 1 year after full resolution of symptoms (based on adult literature)
   AACAP recommends monthly monitor for 6 months after full remission
2. Continue to monitor for 6 to 24 months with regular follow-up whether or not referred to mental health specialist
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Should consider consultation by mental health specialist to determine management plan

If not improved after 6 to 8 weeks
1. Reassess diagnosis
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   • Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
   • Adding therapy if it has not already been done
   • Consulting with mental health specialist
3. Provide further education, review safety plan (see a), and continue ongoing monitoring

If not improved

Refer to mental health specialist if appropriate (see a,b)
FOLLOW-UP: How’s it Going?

- Going well – full remission! >> Educate about the natural history of depression, goal of treatment for about 12 months after improvement
- Partial response – increase dose
- Doing poorly
  - Reassess diagnosis
  - Make a change in dose or medicine, add evidence-based psychotherapy
  - Call Your State’s Child Psychiatry Pediatric Consultation Hotline (www.NNCPAP.org)
  - Refer to Mental Health
SSRI How-Tos: Part I

- Try to start with a first-line medication (FDA approved) unless other considerations take precedence.
- Start at a dose lower than the expected therapeutic dose (eg, fluoxetine 5 or 10 mg instead of fluoxetine 20 mg or escitalopram 5 mg instead of 10 mg).
- If there are no side effects, go up in a week.
- Warn families that the early doses are to acclimate and test the waters and not to expect a sudden recovery.
- Get to a therapeutic dose in 2–4 weeks (clinical judgement).
- Patients should respond somewhat to therapeutic dose in 2–3 weeks.
- If no response, increase dose.
- If some response, wait 4–6 weeks (for full response to take effect) to decide if dose should be increased.
SSRI How-Tos: Part II

✓ Monitor for side effects.
✓ Monitor for suicidality.
✓ Monitor for improvement in symptoms and functioning.
✓ If patient does not respond at higher doses of SSRI, consider changing medication.
✓ Next step in medication is to try a different SSRI (not to switch classes).
✓ How to switch from one medication to another (cross-tapering vs stopping and starting, cross-tapering slowly vs cross-tapering quickly, etc.) depends on many factors, including but not limited to, which specific SSRIs, the side effects, the response, and the clinical picture. ➔ CALL Child Psychiatry for help.
What Could Go Wrong?

- Side effects – Many are possible (see GLAD-PC Toolkit for list)
  
  **Suicidality**: Medication-induced vs medication undertreatment?

  * Gi / stomach upset: Usually transient after a few weeks.
  * Sexual: Must be discussed at onset alone with teens.
  * “Call if you notice any problems, any issues.”
  * Ask specifically at follow-up visits as teens may be too embarrassed to bring it up.

* Patients stopping medication for “side effects” that are actually just part of the primary disorder: fatigue, appetite changes, etc.

* Recurrence is more likely if you treat partially (too low a dose or too short a duration).
The Boxed Warning
WARNING: SUICIDALITY AND ANTIDEPRESSANT DRUGS

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Insert established name] or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. [Insert Drug Name] is not approved for use in pediatric patients. [The previous sentence would be replaced with the sentence, below, for the following drugs: Prozac: Prozac is approved for use in pediatric patients with MDD and obsessive compulsive disorder (OCD). Zoloft: Zoloft is not approved for use in pediatric patients except for patients with obsessive compulsive disorder (OCD). Fluvoxamine: Fluvoxamine is not approved for use in pediatric patients except for patients with obsessive compulsive disorder (OCD).] (See Warnings: Clinical Worsening and Suicide Risk, Precautions: Information for Patients, and Precautions: Pediatric Use)
Managing Depression in Children and Adolescents

- Depression in children and adolescents is common, identifiable, and treatable.
- Psychotherapy acceptable/emphasized as a first-line in mild/moderate MDD.
- Based on FDA meta-analysis, share with families
  - There is a 2–4% of suicidal ideation vs 1–2% on placebo.
  - TADS shows 60–70% chance of improvement of MDD with medication treatment.
- Fluoxetine and Escitalopram are FDA-approved to treat depression in children and adolescents (although may have good reason to use others).
- Educate families to watch for and report
  - Increase in agitation or uncharacteristic behavior change or suicidal/self-injurious thoughts/behaviors and how to get help if concerned.
- Monitor closely.
In Summary...

INITIAL MANAGEMENT IN PRIMARY CARE (safety planning, psychoeducation, and treatment planning based on severity) is a vital component.

TAILOR THE TREATMENT (psychotherapy, SSRI, or both).

FOLLOW-UP to see if adequate (see often and soon).

ADJUST (dosage, meds, therapy).

FOLLOW-UP as story unfolds.

STAY INVOLVED.
DO NOT MAKE KIDS SUFFER
Additional Resources to Consider


The **AAP Screening Technical Assistance Resource (STAR) Center website and resources** to assist general pediatricians in implementing screening for child development, maternal depression, and social determinants of health! Check out the screening tool widget to help you find the right screening tools, the Screening Time: Tuning in to the Needs of Families e-Learning course, subscribe to the e-newsletter, ask questions about implementation and billing, and much more! Available at [https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/default.aspx](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/default.aspx).
New Mental Health Resources for Your Practice!

Promoting Mental Health in Children and Adolescents
This ground-breaking resource provides surveillance and screening tools to help identify early signs and symptoms of mental health disorders and provides interventions to care for children and adolescents with mental health issues.
MA0886
Retail Price: $99.95  Member Price: $79.95

Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians
An indispensable resource for treating children with a variety of mental health issues such as anxiety, low mood, disruptive behavior, inattention, family dysfunction, sleep disturbance, substance abuse and more.
MA0860
Retail Price: $99.95  Member Price: $79.95

Save $20 with Mental Health Resource Package
- Promoting Mental Health in Children and Adolescents
- Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians
MA0902
Retail Price: $179.90  Member Price: $139.90

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