# Adolescent Depression

## Screening, Follow-Up, And Co-Management Guidelines

**PCC – Therapist – Child & Adolescent Psychiatrist**

Community Care
OF NORTH CAROLINA

# Contents

# PCC – Therapist – Child & Adolescent Psychiatrist

**ASSUMPTIONS:** (links to resources provided)

PCCs (primary care clinicians) are familiar with and are implementing:

- Routine risks and strengths screening at annual well-visits for adolescents (Bright Futures Supplemental Questionnaire for Adolescents, Guidelines for Adolescent Preventive Services (GAPS), HEADSSS)
- Engagement of, and conversations with adolescents and their families utilizing Common Factors approach
- Confidentiality
- Algorithms A&B from AAP Mental Health Toolkit http://www.aap.org/mentalhealth, click on key resources, then Primary Care Tools

PCC's are conversant with the Adolescent tools from CCNC Pediatrics:
www.communitycarenc.com; go to Population Management, click on CCNC Pediatrics

- "One pagers" on screening, screening tools, common factors approach (click on Pediatric Essentials)
- School-age and Adolescent Getting Started Worksheet
- Engaging Adolescents videos
- MOC 4 on Adolescent Preventive Care

**NATIONAL QUALITY FORUM MEASURES (MEANINGFUL USE):**
Measure Title: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
NQF Measure Number: 0418
Measure Description: Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

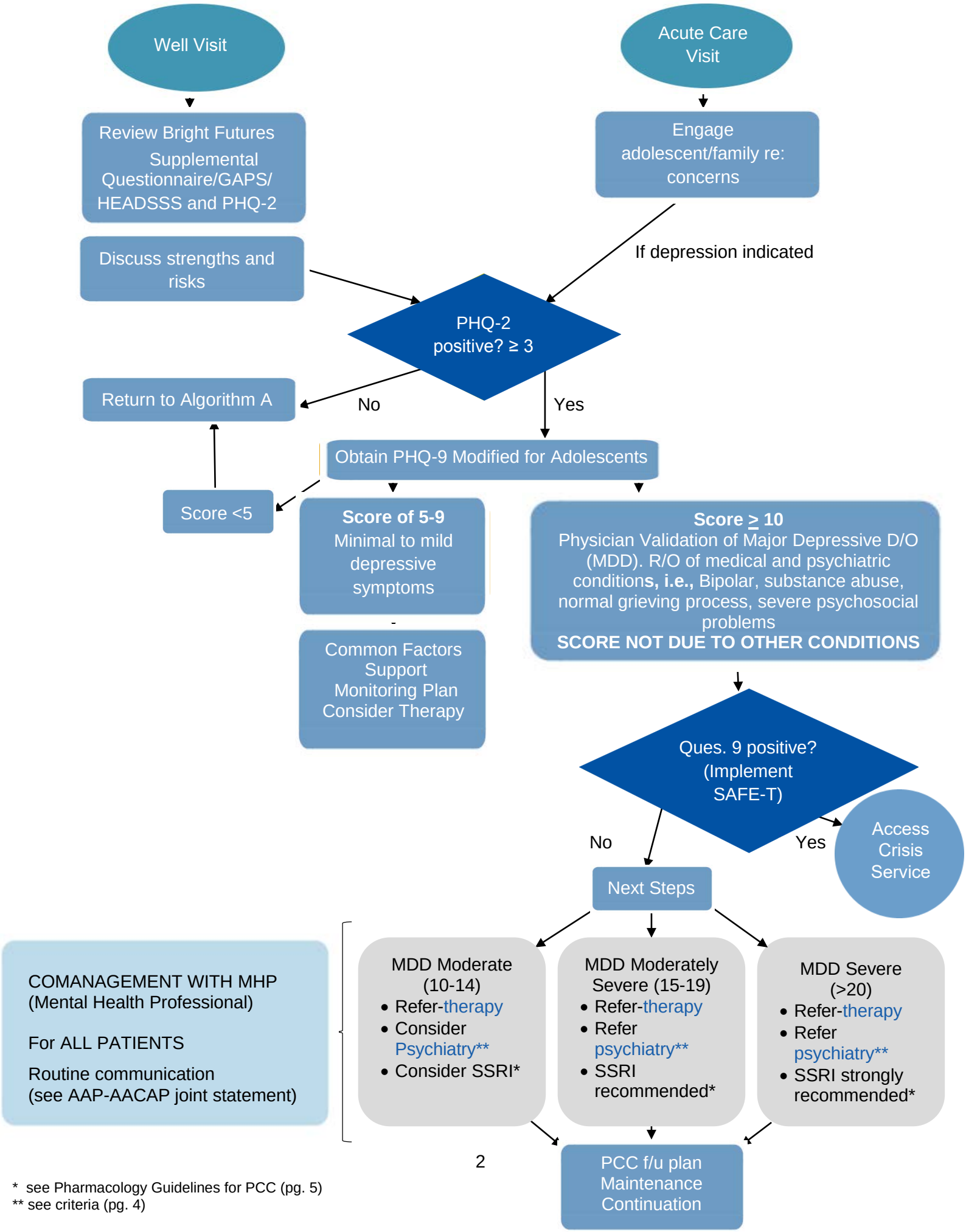
Measure Title: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
NQF Measure Number: 1365
Measure Description: Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk

**EVIDENCE-BASED INTERVENTIONS FOR MDD IN ADOLESCENTS:**

Psychosocial Interventions

- CBT(Cognitive Behavioral Therapy) and medication
- CBT
- CBT with parents
- Family therapy

Psychopharmacological Intervention for Major Depressive Disorder (MDD)




* see Pharmacology Guidelines for PCC (pg. 5)
** see criteria (pg. 4)

# Screening Guidance

For the PHQ-9, a score ≥ 10 suggests MDD (Major Depressive Disorder), but requires clinical validation by the PCC.

- score of 5-9 , supportive self-care, common factors, monitoring
- score of 10-14, moderate
- score of 15-19, moderately severe
- score of 20-27, severe

**WHEN DEPRESSION SCREEN IS POSITIVE**

| | Score 5-9 | Score 10-15 | Score 15-19 | Score 20-27 |
|---|---|---|---|---|
| **PCC call/increase visit frequency** | Consider | All patients | All patients | All patients |
| **Referral: Therapy** | Consider | All patients | All patients | All patients |
| **Referral: Psychiatry** | | See criteria pg. 4 | All patients | All patients |
| **Co-management** | | All patients | All patients | All patients |
| **Medication (see PCC guidelines)** | N/A | See criteria pg. 5 | All patients | All patients |

# Referral and Co-management

For Emergency (see SAFE-T, attached) (free app from SAMHSA available – Suicide Safe)

****Psychiatry Referral Criteria**

- Severe depression
- Co-morbid substance abuse
- Co-occurring autism
- Psychotic/bipolar symptoms
- Severe psychosocial impact
- Previous episodes
- Prior suicide attempt
- Strong family history
- 2 failed SSRI trials
- PCC or parent discomfort with PCC managing alone

**While awaiting a referral:**

- Find agreement on goals and steps to reduce stress
- Find agreement on healthy activities (*eg*, exercise, time outdoors, limits on media, balanced and consistent diet, sleep [!!!!], one-on-one time with parents, reinforcement of strengths, open communication, pro-social peers)
- Educate family; de-mystify the condition; support them in monitoring for worsening of symptoms or emergencies
- Initiate care (even if planning referral) using "common factors" and/or "common elements" of evidence-based Rx
- Monitor progress (*eg*, telephone, electronic communication, return visit)
- Provide assistance with referral

**Co-management with Mental Health Professionals (MHP)**

- Established referral relationship
- Warm hand off to both therapist and psychiatrist
- Standardized exchange of information (see AAP-AACAP joint HIPAA statement on communication between PCC and MHP www.aap.org/mentalhealth click on Key Resources, then HIPAA Privacy Rule and Provider to provider Communication) **with both therapist and psychiatrist**
- Shared record if integrated or co-located

# Psychopharmacology

* "Guide to Psychopharmacology for Pediatricians." Center for Mental Health Services in Pediatric Primary Care, http://web.jhu.edu/pedmentalhealth/Psychopharmacolog%20use.html ; www.aap.org/mentalhealth key resources, then Primary Care Tools

- 3 drugs for treatment of MDD: Fluoxetine (Prozac), Sertraline (Zoloft), and Escitalopram (Lexapro).
- Titration: "start low and go slow;" titrate upward each 1-2 weeks toward target dose range; dose daily
- To D/C- taper dose down gradually. This affords less adverse effects and an opportunity to evaluate for continued need for Rx if symptoms recur.

### Fluoxetine

- Comes in: 10,20,40 mg (capsule; only 10 is tablet); liquid 20 mg/5ml
- Start at: 5 or 10 mg
- Titration schedule to effect: 5, 10, 20, 30, 40; one step every 1-2 weeks until 20 mg; then increase at 1 month intervals because of time to efficacy.
- Most common dose range: 20-40 mg; max is 60 mg (if titrate to 60 with no effect – time to switch or refer to psychiatry)
- FDA approved for MDD (age 8); good evidence for anxiety disorders (FDA approved for OCD, age 7)

### Fluoxetine Pearls

- Dose in the AM because tends to be activating (particularly initially)
- Half-life is 2-5 days, so good option for teen/family who is not good with adherence to medication schedule
- Potent CYP2D6 inhibitor with higher potential for drug-drug interactions

### Sertraline

- Comes in: 25, 50, 100 mg tabs; liquid 20 mg/1ml
- Start at: 12.5 mg (1/2 tab)
- Titration schedule to effect: 12.5, 25, 50, 75, 100, 150, 200; first 3 steps within 3 weeks if possible and tolerated; then each subsequent step q month due to time to efficacy
- Most common dose range: 100-200 mg/day; max – 200 mg
- FDA approved (age 6) OCD; good evidence for anxiety disorders; some evidence for MDD

### Sertraline Pearls

- Dose in AM because somewhat activating
- But some patients feel more tired; if so, switch to bedtime.

### Escitalopram

- Comes in: 5, 10, 20 mg; liquid 5mg/5ml
- Start at: 5 mg
- Titration schedule to effect: 5, 10, 15, 20; go to 10 mg after the first 1-2 weeks if tolerated; may be increased to 20 mg after 3 weeks.
- Most common dose range: 10-20 mg. Maximum dose 20 mg
- FDA approved for MDD (age 12)

## SSRI's: Information for Patients and Families

How SSRIs Can Help:

- Decrease overall depression, enable people to be happy again
- Decrease overall anger/irritability
- Decrease feelings of hopelessness, worthlessness
- Improve energy level
- Improve concentration and memory
- Stabilize appetite and sleep
- Decrease getting "stuck" on certain worries/concerns/memories

*SSRIs can take 2-6 weeks to start working; they have to be taken every day to work their best.*

Possible Side Effects:

*Short Term*

- Stomach upset
- Increased anxiety/jittery feelings/moodiness
- Trouble with sleep (too tired or not able to sleep)
- For people <26 yo, possible increase in suicidal thinking

*Long Term*

- May decrease interest in, or pleasure with sex (20-30% of people)
- May cause weight gain (average 5 lbs in a year for adults)

# Resources

Community Care
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# Patient Health Questionnaire-2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.

**0** = Not at all

**1** = Several days

**2** = More than half the days

**3** = Nearly every day

Feeling down, depressed, or hopeless.

**0** = Not at all

**1** = Several days

**2** = More than half the days

**3** = Nearly every day

Total point score: _____

Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care.* 2003;41:1284–1292

Source:
Thibault JM, Steiner RW. Efficient identification of adults with depression and dementia. *Am Fam Physician.* 2004;70:1101–1110

# Patient Health Questionnaire-2
# Instructions for Use

The PHQ-2 includes the first 2 items of the PHQ-9. The stem question is, "Over the past 2 weeks, how often have you been bothered by any of the following problems?" The 2 items are "Little interest or pleasure in doing things" and "Feeling down, depressed, or hopeless." For each item, the response options are "Not at all," "Several days," "More than half the days," and "Nearly every day," scored as 0, 1, 2, and 3, respectively. Thus, the PHQ-2 score can range from 0 to 6.[2] A score of 3 points or more on this version of the PHQ-2 has a sensitivity of 83 percent and a specificity of 92 percent for major depressive episode.[1]

Screening with the PHQ-2 is only a first step. Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria for a depressive disorder.[2]

## Score interpretation:

| *PHQ-2 score* | *Probability of major depressive disorder (%)* | *Probability of any depressive disorder (%)* |
|---|---|---|
| **1** | **15.4** | **36.9** |
| **2** | **21.1** | **48.3** |
| **3** | **38.4** | **75.0** |
| **4** | **45.5** | **81.2** |
| **5** | **56.4** | **84.6** |
| **6** | **78.6** | **92.9** |

Sources:
1. Thibault JM, Steiner RW. Efficient identification of adults with depression and dementia. *Am Fam Physician.* 2004;70:1101–1110
2. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care.* 2003;41:1284–1292

# PHQ-9 modified for Adolescents (PHQ-A)

**Name:** _____ **Clinician:** _____ **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?<br><br>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? | | | | |

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

☐Yes ☐No

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

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

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

**Office use only:** **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

## RESOURCES

- Download this card and additional resources at **http://wwww.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s


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**National Suicide Prevention Lifeline**

**1-800-273-TALK (8255)**

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services


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# SAFE-T

## Suicide Assessment Five-step Evaluation and Triage

**1**

**IDENTIFY RISK FACTORS**

Note those that can be modified to reduce risk

**2**

**IDENTIFY PROTECTIVE FACTORS**

Note those that can be enhanced

**3**

**CONDUCT SUICIDE INQUIRY**

Suicidal thoughts, plans, behavior, and intent

**4**

**DETERMINE RISK LEVEL/INTERVENTION**

Determine risk. Choose appropriate intervention to address and reduce risk

**5**

**DOCUMENT**

Assessment of risk, rationale, intervention, and follow-up


U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

*Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.*

## 1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

## 2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

## 3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live

* *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

* *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

## 4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

| RISK LEVEL | RISK/PROTECTIVE FACTOR | SUICIDALITY | POSSIBLE INTERVENTIONS |
|---|---|---|---|
| **High** | Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant | Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal | Admission generally indicated unless a significant change reduces risk. Suicide precautions |
| **Moderate** | Multiple risk factors, few protective factors | Suicidal ideation with plan, but no intent or behavior | Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers |
| **Low** | Modifiable risk factors, strong protective factors | Thoughts of death, no plan, intent, or behavior | Outpatient referral, symptom reduction. Give emergency/crisis numbers |

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

## 5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

# HIPAA Privacy Rule and Provider to Provider Communication

American Academy of Child and Adolescent Psychiatry (AACAP) and the American Academy of Pediatrics (AAP)

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides an important privacy rights and protections standard for patients with respect to their health information. HIPAA provides a uniform minimum standard, which individual state laws may supersede by mandating additional restrictions. AAP and AACAP both support the importance of this HIPAA rule in helping to protect against the inappropriate release of private health information, as well as to optimize safe care by allowing important clinical information to be shared among the clinicians of the patient's care team. It is considered a best practice to inform patients and parents about the critical need for care providers to communicate with each other in providing high quality care.

Unfortunately there are misperceptions about the HIPAA Privacy Rule which have developed and persisted over the past decade, which can interfere with appropriate patient care. Collaborative and integrated care systems rely on the appropriate and timely sharing of clinical information among a patient's treatment providers. If professionals do not appropriately communicate about their shared patients under the belief that HIPAA requires a signed consent for each communication, then patient care may suffer. Therefore AAP and AACAP have created this issue brief to clarify what the HIPAA rule does and does not limit regarding clinical care information exchange among pediatricians, child psychiatrists and other physicians and mental health providers.

The following are answers to commonly asked questions:

1. **What information can be disclosed between treatment providers without a patient/legal guardian's written authorization under HIPAA?**

   Any pertinent clinical care information, including mental health treatment information, can be disclosed and discussed between a patient's current treatment providers without written disclosure authorization except for the following two types of information: A) the content of written psychotherapy notes (see below), and B) substance abuse treatment records that are maintained by a licensed substance abuse program (42 USC § 290dd–2; 42 CFR 2.11). Substance abuse information obtained in other treatment settings may be communicated among a patient's treating providers without written consent.

2. **What constitutes psychotherapy note information that cannot be disclosed under HIPAA without a patient's explicit consent?**

   The HIPAA definition of a "psychotherapy note" is quite restrictive. A psychotherapy note per HIPAA can only consist of a mental health professional's written analysis of a conversation that occurred during a private counseling session that is maintained separately from the medical

record. These written analyses serve as working process notes about sessions to assist the therapist, and are not put into the medical record billing document. Anything which appears in the patient's medical record cannot be categorized as a psychotherapy note under the HIPAA rule. Specific content that has been listed as not falling under the "psychotherapy note" protections include medication management information, counseling session start and stop times, the type and frequency of treatment delivered, the results of clinical tests, diagnosis summaries, functional status, treatment plan, symptoms, prognosis, and progress to date. 45 CFR 164.501

3. **Can treatment providers who work in separate care systems communicate with each other about a shared patient?**

   Yes. Treatment providers do not have to share the same employer or share the same electronic health record in order to disclose pertinent protected health information about a mutual patient without consent from the patient or parent. The key component for this HIPAA allowance is that both providers have a treatment or consultative role with that patient. (See also http://www.hhs.gov/ocr/hipaa). Whenever PHI is transmitted electronically (eg, telephone voice response, text messaging, faxback, or email, etc) it is covered by the Security Rule and must be made secure by measures such as encryption, secure platforms, or closed systems. Voice mail messages, telephone conversations, and paper-to-paper faxes are not subject to the Security Rule. All PHI (eg, in oral, electronic and written forms) fall under the Privacy Rule.

4. **Does HIPAA allow for sharing treatment information via an electronic health record without written consent?**

   Yes, but there are additional regulations around the security standards needed for protecting electronic health records. Essentially, rules and procedures are required in the maintenance of an electronic health record to prevent their unauthorized access, alteration, deletion, and transmission. These security regulations for electronic records are outlined in the HIPAA security rule of 2005, and the HITECH act of 2009.

5. **Are there any other regulations that conflict with HIPAA communication allowances?**

   Yes. Providers need to be aware that any state regulations that are more restrictive than the HIPAA rules will take precedence in those states, and so providers need to be aware of their own state's information regulations. If you are unfamiliar with your state's regulations, it will be important to specifically seek out your state department of health's privacy rules. To obtain information on current state laws, you may also contact the AAP Division of State Government Affairs at stgov@aap.org

   Also, clinical information obtained at a certified substance abuse treatment center is subject to additional federal privacy rules, which at this time do not allow provider to provider communication without formal consent.

Case examples where HIPAA allows for provider to provider communication without a signed release:

1. At his 13 yr old well-visit, an adolescent (and his parent) tells his pediatrician that he is seeing a psychiatrist because of depression and he is doing better. The pediatrician contacts the psychiatrist to discuss medication and the pediatrician's role in supporting the young man and his family.
2. A 13 year old boy is receiving depression treatment from a child psychiatrist, including both a fluoxetine prescription and counseling. The same boy is also having problems with recurrent pain for which he regularly sees his pediatrician, who has been prescribing a low dose of amitriptyline for that problem. Because of treatment plan overlaps, both treatment providers discuss and coordinate their care.

3. A 15 year old girl has just completed a well child check at her pediatrician's office. It was noted that she had a blood pressure of 145/95 and pulse of 130. The pediatrician learns that she has recently started taking methylphenidate as prescribed by a child psychiatrist. Because high blood pressure may be a side effect of methylphenidate, the pediatrician contacts the child psychiatrist to discuss and coordinate care.
4. A 5 year old boy with significant behavior problems is being seen by a child psychiatrist. In the course of treatment, it becomes apparent that poorly skilled parenting practices at home are the main reason for his symptoms. The psychiatrist reaches out to the child's pediatrician to share this assessment and the behavior management advice that is being offered to the family.

View other case examples and the rest of the FAQs at www.aap.org/mentalhealth.