Curbside Consult with a CAP: Comprehensive Assessment and Management of Depression in Youth
Today’s Presenters

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Funder & Partners

New Jersey Department of Health

Cooper University Health Care

Atlantic Health System
Goryeb Children’s Hospital

American Academy of Pediatrics
New Jersey Chapter

Hackensack Meridian Health

The Children’s Hospital
AT SAINT PETER’S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER’S HEALTHCARE SYSTEM
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St. Joseph’s Health
ST. JOSEPH’S CHILDREN’S HOSPITAL

American Academy of Pediatrics
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New Jersey Chapter
There Are No Disclosures
Learning Objectives: Comprehensive Assessment and Treatment Approaches for Depression

As a result of attending the webinar presentation, participants will be able to:

1. Define signs, symptoms, risk factors, and criteria for diagnosing depressive disorders in adolescence.
2. Understand best ways to utilize age-appropriate, validated mental/behavioral health screening tools to identify patients with depressive disorders.
3. Effectively communicate screening results with the patient and family, and appropriately refer at-risk patients to their local PPC Hub or other resource.
4. Understand how to collaborate with child and adolescent psychiatrists to integrate identification, treatment and management of mental/behavioral health care in primary care.
5. Integrate effective strategies for addressing co-morbid issues related to depression into their practice
True or False: Starting youth on an SSRI is an emergency:
- True
- False

How long does it take for antidepressants to work?
- 1-2 days
- 2-4 weeks
- 4-6 weeks
- 12-16 weeks

Per FDA guidelines, at what age could Lexapro be started?
- 8
- 6
- 12
- 16

Per FDA guidelines, at what age could Prozac be started?
- 6
- 8
- 12
- 14

True or False: If a patient with past history of Suicidal Ideation/attempt/psychiatric hospitalizations, comes in for a sick visit, you should use it as an opportunity to follow up with the patient regarding depressive symptoms and suicidality:
- True
- False
Referral from pediatrician indicated the following:

- 13 Year Old Female
- Symptoms: Depression, Sleep problems, Suicidal Ideation, Social Problems
- PSC-Y score – 14 (primary screening)
  - Indicates in the last three months she has attempted to kill herself
- CRAFFT score – 0 (primary screening)
- PHQ score- 16 (secondary screening)
  - Indicated previous suicide attempt and suicidal ideation
Referral from pediatrician indicated the following:

- 9 Year Old Male
- Symptoms: School Issues, Other: anger outburst and concerns with depression
- Existing Dx: ADD
- PSC-35 score – 0 (primary screening)
- SCARED score (parent) – (secondary screening)
  - Highest scores in separation and social anxiety
Use of **Primary** screening tool(s):  

- Pediatric Symptoms Checklist (PSC-35, PSC-Y 37)  
  - Available in multiple languages and a pictorial version  
  - PSC-35 (completed by parent of children 6-11 y.o.)  
  - PSC-Y-37 (completed by youth 11 y.o. and up)  
  - PSC-Y-37 has two questions to screen for suicidal ideation  
  - Additionally, screens for the following symptoms/behaviors:  
    - Internalizing Problems (i.e. Depression or Anxiety)  
    - Attention Problems (i.e. ADHD)  
    - Externalizing Problems (i.e. Conduct Disorder, Oppositional Defiant Disorder)
Y-PSC-37 Teen Screen

A Survey From Your Healthcare Provider — PSC-Y

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>ID</th>
</tr>
</thead>
</table>

Please mark under the heading that best fits you or circle Yes or No

- 1. Complain of aches or pains
- 2. Spend more time alone
- 3. Tire easily, little energy
- 4. Fidgety, unable to sit still
- 5. Have trouble with teacher
- 6. Less interested in school
- 7. Act as if driven by motor

- □ 36. During the past three months, have you thought of killing yourself? Yes □ No
- □ 37. Have you ever tried to kill yourself? Yes □ No

Note — the sub scores do not impact the overall score; they are for interpretation purposes only.

FOR OFFICE USE ONLY

Plan for Follow-up
- □ Annual screening
- □ Return visit w/ PCP
- □ Parent declined
- □ Already in treatment
- □ Referred to counselor
- □ Referred to other professional

Q 36 or Q 37 = Y □ TS ≥ 30

Source: Pediatric Symptom Checklist — Youth Report (PSC-Y)
BEST PRACTICE: Questions, Screening, and Risk Assessment Tools to Assess Depression in Youth (Secondary Screenings)

### Severity Measure for Depression—Child Age 11-17

PHQ-9 modified for Adolescents (PHQ-A)—Adapted

<table>
<thead>
<tr>
<th>Item</th>
<th>Clinician Use</th>
<th>Item Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling down, depressed, irritable, or hopeless?</td>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>2. Little interest or pleasure in doing things?</td>
<td>Several days</td>
<td>1</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much?</td>
<td>More than half the days</td>
<td>2</td>
</tr>
<tr>
<td>4. Poor appetite, weight loss, or overeating?</td>
<td>Nearly every day</td>
<td>3</td>
</tr>
<tr>
<td>5. Feeling tired, or having little energy?</td>
<td></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things like school work, reading, or watching TV?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Total/Partial Raw Score: (If 1-2 items left unanswered)*

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Secondary (optional) Screening Tools to Monitor Patients

### Ask Suicide-Screening Questions

1. In the past few weeks, have you wished you were dead? **Yes** / **No**
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? **Yes** / **No**
3. In the past week, have you been having thoughts about killing yourself? **Yes** / **No**
4. Have you ever tried to kill yourself? **Yes** / **No**

If yes, describe:

### Next steps:

- Patient requires a STAT safety/mental health evaluation.
- Keep patient rights. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
- Patient requires an ID & suicide risk assessment to determine if a full mental health evaluation is needed. Patient cannot be admitted without evaluation for safety.

### Provide resources to all patients:

- 847 National Suicide Prevention Lifeline 1-800-273-TALK (82555) En Español 888-628-9459
- 1-800-Crisis Text Line: Text "HOME" to 741741

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American Academy of Pediatrics
New Jersey Chapter
BEST PRACTICE: Questions, Screening, and Risk Assessment Tools to Assess Depression in Youth

Asking questions to assess:
- Stressors/precipitants
- Context in which symptoms are occurring
- Duration
- Level of functioning

Physical Exam:
- Ex: cuts or weight(loss/gain)

<table>
<thead>
<tr>
<th>Domains</th>
<th>Crisis</th>
<th>Just surviving</th>
<th>Doing OK</th>
<th>Doing good</th>
<th>Doing great</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* Adapted from Wellbeing Indicator Tool for Youth
## Epidemiology of Depression

<table>
<thead>
<tr>
<th></th>
<th>Children/Adolescents</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td>2% in children; 6% in adolescents</td>
<td>20%</td>
</tr>
<tr>
<td>Male to Female ratio</td>
<td>1:1 in children; 1:2 in adolescents</td>
<td>1:2</td>
</tr>
</tbody>
</table>
## Diagnostic Criteria

### Symptoms:
- Depressed mood
- Sleep
- Interest
- Guilt
- Energy
- Cognition
- Appetite
- Psychomotor
- Suicide/Preoccupation

### Specifiers:
- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With psychotic features
- With catatonia
- With seasonal pattern
- In partial/full remission
### Adjustment Disorder with Depressed Mood:
- Specific event/incident
- Symptoms present for 6 months
- Level of functioning in different domains

### Dysthymia (Persistent Depressive Disorder):
- 1 year of symptoms
- Level of functioning in different domains

### Disruptive Mood Dysregulation Disorder (DMDD):
- New diagnosis (severe recurrent temper outbursts)
- Symptoms for 1 year or more
- Age of onset is before <10 years of age (not dx before 6yo or after 18yo)

### Substance Use
Screening for Substance Abuse in Depressed Adolescents

CRAFFT 2.1 Screening Tool:

- Screening for use with adolescents age 12 and older to assess substance use
- Series of 6 questions developed to screen adolescents for high risk alcohol and other drug use disorders
- Short, effective screening tool
Formulating a Diagnosis

**Major Depressive Disorder (MDD)**
- 5 out of 9 Criteria
  - 1 symptom should be depressed mood or loss of interest
- 2 weeks
- Level of functioning in different domains

**SIG-E-CAPS for Major Depressive Disorder (pneumonic 😊):**
- Sleep
- Interest
- Guilt
- Energy
- Cognition
- Appetite
- Psychomotor
- Suicide/Preoccupation
Psychoeducation of Patient and Parent

• Diagnosis
• Risk Factors
• Discuss risk of treatment with medication vs. risk of not treating with medication
• Importance of compliance with follow up visits, therapy, and medication (if applicable)
Comprehensive Treatment Planning

Non-pharmacological
- Therapy (Individual, group, family)
- Exercise, Nutrition, Exposure to daylight
- Sleep routine/hygiene
- Limiting screen time and social media

School/environmental support
- School accommodations (504 plan)
- Family success centers

Community Resources
- Mobile Response – 1877-652-7624
- 2nd Floor Hotline – 1888-222-2228
- Crisis Center

Pharmacology
- Starting an SSRI is not an emergency
- 4-6 weeks for antidepressants to start working

- In mild to moderate depression, therapy should be the first treatment option
- Research shows that a combination of medication and therapy is most effective
- In children younger than 16y.o, medication may not be as effective
- Patient and parent preferences should be considered in the treatment planning process
When to Start Medication

- Consider chronicity of symptoms
- Consider depth of the depression
- Consider level of functioning (severity/impact on daily functioning)
- Did not respond (effectively) to psychotherapy treatment
# Depression Management in Primary Care Using PHQ-9

## Table 1. Applying Patient Health Questionnaire-9 (PHQ-9) Scores to Practice

<table>
<thead>
<tr>
<th>PHQ-9 score</th>
<th>Severity/provisional diagnosis</th>
<th>Treatment recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>Community norm</td>
<td>No action recommended</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild symptoms</td>
<td>Watchful waiting, self-management education, periodic rescreening</td>
</tr>
<tr>
<td>10-14</td>
<td>Major depression, mild</td>
<td>Pharmacotherapy or psychotherapy, creation of a treatment and follow-up plan, education, reevaluation</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Immediate institution of treatment (pharmacotherapy and/or psychotherapy)</td>
</tr>
<tr>
<td>≥20</td>
<td>Major depression, severe</td>
<td>Pharmacotherapy AND psychotherapy, referral</td>
</tr>
</tbody>
</table>

Adapted from MacArthur Initiative on Depression and Primary Care, with permission.
How to Start and Follow Up with Medication Initiation

- Consider age of the patient
- Consider previous trials with medication
- Start low, go slow with dosage
- Establish baseline PHQ-9 score before starting medication (depth of depression)
- Follow up phone call by clinical office staff one week after starting medication; suggested
- Follow up office visit with doctor 2 weeks after starting medication and re-administer PHQ-9
- Follow up office visit with doctor every 2 weeks, while dose is being adjusted (use PHQ-9 to track progress)
- Follow up once a month, after dose is optimized- until patient transitions to community CAP
  - Co-manage and maintain communication with community CAP by using rating tools (PHQ-9 during sick and well visits)
Pharmacological Treatment: Which medication to start?

<table>
<thead>
<tr>
<th>SSRI</th>
<th>FDA approved age</th>
<th>Formulation</th>
<th>Dose</th>
<th>Half Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>8</td>
<td>Solution</td>
<td>20mg/5ml</td>
<td>2-4 days *(Metabolite norfluoxetine 7-15 days)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tablet</td>
<td>10mg, 20mg, 60mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capsule</td>
<td>10mg, 20mg, 40mg</td>
<td></td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>12</td>
<td>Solution</td>
<td>1mg/ml</td>
<td>27-32 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tablet</td>
<td>5mg, 10mg, 20mg</td>
<td></td>
</tr>
</tbody>
</table>

(Mayo Clinic, 2019)
Prozac can be initiated at 5mg first dose
• Titration: in 5mg increments
• Maximum dose: 60mg/day

Lexapro can be initiated at 2.5mg first dose
• Titration: in 5mg increments
• Maximum dose: 20mg/day
### Pharmacological Treatment (continued)

**Other uses for antidepressants in youth (currently not FDA approved for depression)**

<table>
<thead>
<tr>
<th>Medication*</th>
<th>Age (in years)</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sertraline (Zoloft)</td>
<td>6 and older (Solution - 20mg/ml; Tablet – 25mg, 50mg, 100mg; Half-life 22-36 hours)</td>
<td>OCD</td>
</tr>
<tr>
<td>Clomipramine (Anafranil)</td>
<td>10 and older</td>
<td>Obsessive-compulsive disorder (OCD)</td>
</tr>
<tr>
<td>Duloxetine (Cymbalta)</td>
<td>7 and older</td>
<td>Generalized anxiety disorder</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>8 and older</td>
<td>OCD</td>
</tr>
<tr>
<td>Olanzapine and fluoxetine, combination drug (Symbyax)</td>
<td>10 and older</td>
<td>Bipolar depression</td>
</tr>
</tbody>
</table>

*Many of these drugs are also available in generic form. Recommended initial dose and maximum dose vary by age.*
Black Box warning &
Off-Label Use of Antidepressant Medication In Youth
Monitor for Potential Side Effects

- Agitation
- Suicidality through screening tools (*even for patients who did not initially screen positively for SI)
- Activation syndrome – serotonergic effect
  - Akathisia
  - Mania-like symptoms (medication induced v. primary bipolar)
  - Suicidality
Defining Stability

Determined through discussion with child, parent, and screening tools:

- Reduction/remission of depressive symptoms
- PHQ-9 score is decreasing to safe zone
- Functioning well academically and socially
- Sleep and appetite are good
How Long to Continue and When to Stop Medication

- 6 months after stability is reached if this was the first episode of depression of moderate degree
- \( \geq 12 \) months after stability is reached if episode(s) are severe, illness is chronic or long in duration, illness is recurrent
- If side effects occur
Safety Planning (with patient and parent)

- Remove lethal means
- Recognize warning signs of suicidal crisis
- Discuss/identify personal coping strategies
- Reach out to social supports
- Contact a professional for help

- Resources:
  - Mobile Response – 1877-652-7624
  - 2nd Floor Hotline – 1888-222-2228
  - Hospital crisis center/ER
INITIATION ➔ COLLABORATION ➔ WARM HANDOFF

Collaborate with HUB CAP
Initiate medication
**Start low**
Check if therapy started
Encourage establishing community CAP appointment

Follow up with patient during office visit
Assess symptoms (+/-) PHQ-9/ASQ
Side effects
**Go slow --> Increase medication dosage in small increments**
Collaborate with HUB CAP as needed

Repeat process

Confirm appointment with community CAP
Hand off to community CAP
Collaborate/co-manage/communicate with community CAP
Encourage compliance with therapy and medication regimen
Collaborate with HUB CAP as needed

*If youth destabilizes contact HUB staff/CAP
*If imminent danger refer to ER/Crisis
Case presentation 1

- Patient is a 13 year old female, with depressive mood and suicidal ideation. At the time of intake, patient denied active SI and reported thoughts of worthlessness. Patient experienced bullying in school related to sexuality and appearance. Significant weight-loss and insomnia reported. Patient and mother reported loss of interest in activities.
- PSC-Y score – 14 (primary)
  - Indicated in the last three months she has attempted to kill herself
- CRAFFT score – 0 (primary)
- PHQ score- 16 (secondary)
  - Indicated previous suicide attempt and suicidal ideation
- Received short term (5-6 session) counseling with a psychologist following incidents of bullying
Case presentation 1 (continued)

**Collaboration/Disposition/Outcome:**

- Referred to Children’s Mobile Crisis
- Mother initially declined HUB consultation
- CM provided outpatient counseling referrals
- Pediatrician was contacted regarding treatment and follow up plan
- Patient re-referred by pediatrician a few weeks later (concern with weight loss and ongoing depression)
- HUB CAP assessed the patient and initiated Zoloft 12.5mg in AM
- Patient seen again at the HUB 2 weeks later, patient found to be still depressed. Pediatrician agreed to increase the Zoloft dose.
- During this time, patient started and maintained in-home therapy treatment
- Pediatrician in consultation with HUB CAP titrated dose up to 50mg in AM (in 12.5mg increments over two week period)
- Referred for parent coaching, family support, community CAP, and nutritionist
- Two months later, mother reported noticeable decrease in depressive symptoms and medication continued at 50mg daily
  - Two close family members whose depression was successfully treated with Zoloft. Mother preferred that Zoloft be tried initially
Case presentation 2

- 9 year old male irritable; selectively mute (school); angry outbursts (‘I hope you die, go kill yourself. I wish I would die’); in school would put his head down on the desk with hood covering his face; difficulty concentrating; mother reported child had low self-worth
- Family history (father) of depression with psychotic features, learning disabilities
- PSC-35 score – 0 (primary)
- SCARED score (parent) – (secondary)
  - Highest scores in separation and social anxiety
Collaboration/Disposition/Outcome:

- Pediatrician contacted regarding treatment recommendations and follow up plan
- School in the process of reviewing IEP to work on further accommodations to support child in school
- After consultation child started on Prozac solution (20mg/5ml) 5mgs once daily in AM for two weeks by the HUB CAP
- Follow-up HUB visit: Prozac increased to 10mgs once daily in AM
- Referred to community CAP (pediatrician informed)
- Mother called Hub 4 months later because she had run out of medication. By then, child had been off medication for 4 months
- Pediatrician restarted medication after consulting with HUB CAP
Opportunities for Quality Improvement

• Depression is a chronic condition making follow up visits essential to management of the disease
• Utilizing community resources (mobile response, family success centers)
• Collaboration with community CAP should be ongoing (opportunity during sick and well visits)
• Collaboration between physicians when patient is admitted to inpatient unit (pediatrician and inpatient CAP)
Takeaway: There is always hope, and an opportunity to do something more...

"It never hurts to keep looking for sunshine."

Eeyore
Poll (Post)

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True or False: If a patient with past history of Suicidal Ideation/attempt/psychiatric hospitalizations, comes in for a sick visit, you should use it as an opportunity to follow up with the patient regarding depressive symptoms and suicidality:
- True
- False
Pediatric Psychiatry Collaborative

Regional Hubs

- Atlantic Health Hub @ Newton Medical Center
- Atlantic Health Hub @ Goryeb Children’s Hospital
- Hackensack Meridian Hub @ Hackensack University Medical Center
- Hackensack Meridian Hub @ Palisades Medical Center
- Hackensack Meridian Hub @ Saint Peter’s Family Health Center
- Hackensack Meridian Hub @ Jersey Shore University Medical Center
- Cooper Hub @ Cooper University Medical Center
- Cooper Hub @ Pennsville

Essex County served by Rutgers University Behavioral Health Care.

More information on the Essex Hub can be found here:
http://ubahc.rutgers.edu/services/children_family/EssexHub.html
A child and adolescent psychiatrist available for consultative support through the Child Psych. consult line

A psychologist/social worker available to:

- Assist the pediatrician with diagnostic clarification and medication consultation,
- Speak with a referred child’s family regarding the child’s mental health concerns and to assist in providing diagnostic clarification.

One-time evaluation by a child and adolescent psychiatrist (CAP) at no charge to the patient when appropriate.

- Based on the recommendation of the CAP, the PPC Hub staff will work with the family to develop the treatment and care coordination plan.

Continuous education opportunities in care management and treatment in the primary care office for the common child mental health issues: ADHD, depression, anxiety, etc.
References

• https://www.mayoclinic.org/diseases-conditions/teen-depression/in-depth/antidepressants/art-20047502

Thank you! Questions?

Please contact:
NJAAP
Mental Health Collaborative
609-842-0014
mhc@njaap.org

To Register to Participate:
http://njaap.org/programs/mental-health/ppc/