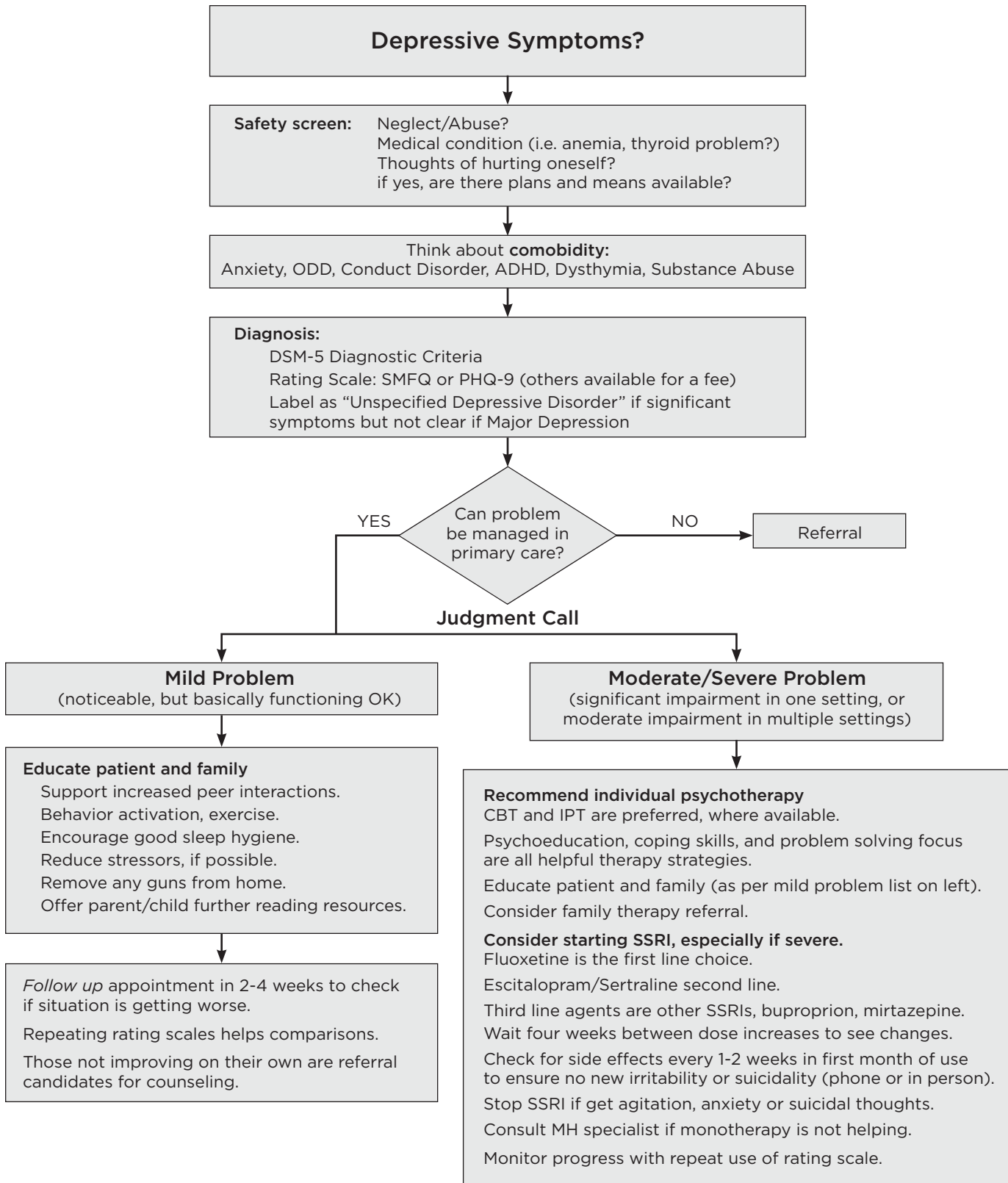




Depression

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Primary References:

Jellinek M, Patel BP, Froehle MC eds. (2002): Bright Futures in Practice: Mental Health-Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health: 203-211

Marek JS, Silva S, Vitiello B, TADS team (2006): "The treatment for adolescents with depression study (TADS): methods and message at 12 weeks." JAACAP 45:1393-1403

AACAP (in press): "Practice parameter for the assessment and treatment of children and adolescents with depressive disorders." Accessed 2/08 on www.aacap.org

Zuckerbrot R ed.: "Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit." Columbia University: Center for the Advancement of Children's Mental Health

Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks*.

If a sentence was true about you most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about you, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. I felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt so tired I just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I felt I was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I hated myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I thought nobody really loved me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I thought I could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Short Mood and Feelings Questionnaire

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks*.

If a sentence was true about your child most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about your child, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. S/he didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. S/he felt so tired that s/he just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. S/he was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. S/he felt s/he was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. S/he cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. S/he found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. S/he hated him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. S/he felt s/he was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. S/he felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. S/he thought nobody really loved him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. S/he thought s/he could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. S/he felt s/he did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Scoring the SMFQ

Note: the SMFQ has been validated for use in children age 6 years and up.

The SMFQ should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child's symptom severity and treatment response over time.

Scoring:

Assign a numerical value to each answer as follows:

Not true = 0

Sometimes = 1

True = 2

Add up the assigned values for all 13 questions. Record the total score.

A total score on the child version of the SMFQ of 8 or more is considered significant.

Sensitivity of 60% and specificity of 85% for major depression at a cut off score of 8 or higher. Source is Angold A, Costello EJ, Messer SC. "Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents." *International Journal of Methods in Psychiatric Research* (1995), 5:237-249.

Sensitivity/specificity statistics of the parent version is not reported in the literature. If your patient does not complete the child version of SMFQ, repeated administration of the parent version over time should still be useful for symptom tracking.

Patient Health Questionnaire (PHQ-9)

NAME..... DATE.....

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer).

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns		[] +	[] +	[]
<i>(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).</i>		TOTAL: []		

10. If you checked off <i>any</i> problems, how <i>difficult</i> 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

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Scoring the PHQ-9

Note: this scale has not been evaluated for use with pre-pubertal children.
A number of studies have used this scale for adolescent patients.

The PHQ-9 should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child's symptom severity and treatment response over time.

Any positive response to question 9 should be followed up with questions about the child's current safety.

Any immediate plans for suicide require an emergent response.

Question 10 should be noted as at least "somewhat difficult" to be consistent with a diagnosis of depression.

A depression diagnosis requires a functional impairment to be present.

Add up the total number from items 1-9

Estimated depression severity:

- 0-4 None
- 5-9 Minimal symptoms
- 10-14 Possible dysthymia, or mild Major Depression
- 15-19 Consistent with Major Depression
- ≥ 20 Consistent with severe Major Depression

* As recommended by Macarthur Foundation and Pfizer, Inc.

Depression Medications

Drug Name	Dosage Form	Usual starting dose for adolescent	Increase increment (after ~4 weeks)	RCT evidence in kids	FDA depression approved for children?	Editorial Comments
Fluoxetine (Prozac)	10, 20, 40mg 20mg/5ml	10 mg/day (60mg max)*	10-20mg**	Yes	Yes (Age ≥8)	Long 1/2 life, no side effect from a missed dose
<i>Fluoxetine considered first line per the evidence base in children</i>						
Sertraline (Zoloft)	25, 50, 100mg 20mg/ml	25 mg/day (200mg max)*	25-50mg**	Yes	No	May be prone to side effects when stopping
Escitalopram (Lexapro)	5, 10, 20mg 5mg/5ml	5 mg/day (20mg max)*	5-10mg**	Yes	Yes (Age ≥12)	The active isomer of citalopram.
<i>Escitalopram and Sertraline considered second line per the evidence base in children</i>						
Citalopram (Celexa)	10, 20, 40mg 10mg/5ml	10 mg/day (40mg max)*	10-20mg**	Yes	No	Few drug interactions, dose maximum 40mg/day due to risk of QT prolongation
Bupropion (Wellbutrin)	75, 100mg 100, 150, 200mg SR forms 150, 300mg XL forms	75 mg/day (later dose this BID) (400mg max)*	75-100mg**	No	No	Can have more agitation risk. Avoid if eat d/o. Also has use for ADHD treatment. Seizure risk limits dose.
Mirtazapine (Remeron)	15, 30, 45mg	15 mg/day (45mg max)*	15mg**	No	No	Sedating, increases appetite
Venlafaxine (Effexor)	25, 37.5, 50, 75, 100mg 37.5, 75, 150 mg ER forms	37.5 mg/day (225mg max)*	37.5 to 75mg**	No (May have higher SI risk than others for children)	No	Only recommended for older adolescents. Withdrawal symptoms can be severe.
Duloxetine (Cymbalta)	20, 30, 40, 60mg	30 mg/day (120mg max)*	30mg	No	No	May cause nausea. May help with somatic symptoms.
<i>Citalopram, bupropion, mirtazapine, venlafaxine, and duloxetine considered third line treatments per the evidence base in children</i>						

Starting doses in children less than 13 may need to be lowered using liquid forms

Successful medication trials should continue for 6 to 12 months

* Recommend decrease maximum dosage by around 1/3 for pre-pubertal children

** Recommend using the lower dose increase increments for younger children.

Crisis Prevention Plan Aid

A parent's guide to creating a crisis prevention plan

Crisis Prevention Plans (CPP) are intended to help children/adolescents and their caregivers prevent minor problems from escalating into crisis events. CPPs provide an opportunity for the child/adolescent and the caregiver to logically think through situations by identifying the cause of distress, understanding and discussing options for minimizing difficult situations, and encouraging coping skills to help decrease the distress. Key components of a CPP include understanding triggers, identifying warning signs, and helping to facilitate interactions that will decrease the possibility of further difficulties. A thoughtful and carefully constructed CPP can help families make choices and take actions to diffuse difficult situations.

Steps for creating your own Crisis Prevention Plan:

- **Discuss triggers** — Triggers are things that cause distress for the child/adolescent. Common triggers include peer conflict, homework, chores, feeling sad or angry, and being told “no” or being unable to get their way. The child/adolescent and caregiver should be honest and explicit about the triggers for what is currently causing them the most difficulty.
- **Identify early warning signs** — Warning signs are physical clues the child/adolescent does (sometimes without their knowledge) that show others that they are upset or distressed. Common warning signs include blushing/flushed face, clenching fists, pacing, yelling, or withdrawing/becoming quiet.
- **List interventions the caregiver can do to help the child/adolescent calm down** — Discuss what the child/adolescent would want, and how the caregiver could provide that for them. Examples include giving the child/adolescent space to calm down, reminding them to use a coping skill, talking with them, or offering a hug.
- **List things the child/adolescent can do to help calm themselves** — This typically includes coping skills such as listening to music, talking a walk, doing deep breathing exercises, taking time to themselves (include a mention of how long to let the child/adolescent “cool off” before being expected to reengage with the family), writing, drawing/coloring, or other relaxation techniques.
- **Identify other supports if the above interventions aren't helpful or are unavailable** — for instance, list three people the child/adolescent can contact, beside the caregiver, when distressed. Examples include peers who would have a positive influence, relatives, older siblings, therapists, or teachers/coaches. The child/adolescent and caregiver should agree who are a good resource. Also identify and list the crisis line where you live. A hotline such as the Suicide Prevention Lifeline (800-273-8255) or <https://suicidepreventionlifeline.org> is also helpful.

Christina Clark, MD

Crisis Prevention Plan

My triggers are:

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

My early warning signs are:

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

When my parents/caregivers notice my early warning signs, they can:

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

Things I can do when I notice my early warning signs:

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

If I am unable to help myself I can call:

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

- State Mental Health Crisis Line
Careline Alaska 1-877-266-4357
<https://carelinealaska.com>
- Text HOME to 741741 or visit: <https://www.crisistextline.org>
- National Suicide Prevention Lifeline Phone Number: 1-800-273-8255

This Crisis Prevention Plan was created to give your family strategies you can use in your home to help calm your child during an escalation before they reach a crisis point. We do not advise using restraint, such as holding your child down, because you or your child could get hurt. Please call 911 if you or your child is in imminent danger.

General Home Safety Recommendations After a Child Crisis Event

The following safety tips may help to keep things safe right now after an escalated crisis event, and help to reduce further escalations/crises:

1. In the home environment, maintain a “low-key” atmosphere while maintaining regular routines
2. Follow your typical house rules, but pick your battles appropriately, for example:
 - immediately intervene with aggressive or dangerous behaviors
 - if your child is just using oppositional words, it may be wise to ignore those behaviors
3. Provide appropriate supervision until the child's crisis is resolved
4. Make a crisis prevention plan by identifying likely triggers for a crisis (such as an argument), and **plan with your child** what the preferred actions would be for the next time the triggers occur (such as calling a friend, engaging in a distracting activity or going to a personal space)
5. Encourage your child to attend school, unless otherwise directed by your provider
6. Make sure that you and your child attend the next scheduled appointment with their provider
7. Administer medications as directed by your child's medical or psychiatric provider
8. Go into each day/evening with a plan for how time will be spent — this should help prevent boredom and arguments in the moment
9. Secure and lock up all medications and objects your child could use to hurt him/herself and/or use to attempt suicide. When locking up items, ensure your child does not have knowledge of their location, the location of the key, or the combination to any padlock used to secure them. This includes:
 - Sharp objects like knives and razors
 - Materials that can be used for strangulation attempts, such as belts, cords, ropes and sheets
 - Firearms and ammunition (locked and kept in separate/different locations from each other)
 - All medications of all family members, including all over the counter medicines. If your child takes medication of any type, you should administer it for the time being (unless instructed to stop it by your care provider)

In the event of another crisis, please do the following:

- If you believe that you, your child, or another person is no longer safe as a result of your child's behavior, call 911 to have your child transported to the emergency department closest to your home
- Consider calling your local crisis hotline: Careline Alaska 1-877-266-4357 <https://carelinealaska.com>
- Consider calling the National Suicide Prevention Lifeline: 1-800-273-8255

Depression Information for Teens and Parents/Caregivers

First Approach Skills Training for Depression (FAST-D)

QUICK SUMMARY

What is depression?

Depression is when normal feelings like being sad, down, grumpy or irritable are very intense, go on too long, and get in the way of normal life. About 1 in 5 teens have serious depression at some point. Here are the common signs:

- Easily irritated
- Sleeping problems
- Problems thinking clearly
- Sad, down, or hopeless
- Changes in how fast you move or speak
- Trouble making decisions or concentrating
- Less interest or enjoyment in things you used to enjoy
- Low energy/tiredness
- Thinking about death or hurting yourself
- Appetite or weight change
- Feeling worthless or guilty

What causes depression?

Many things can cause depression: losses, disappointments, stressful or traumatic events, social or family problems, medical problems, loneliness, changes in the family such as divorce, transitions like moving to a new school, or anxiety problems. Sometimes depression seems to come out of the blue. Depression can also run in families.

How can depression make you stuck?

Depression makes it hard to do things that might help you feel better. And problems can start to pile up, making you feel overwhelmed.

THINGS TEENS CAN DO

What can teens do to feel better?

Even small changes can make a big difference. Are there are 1 or 2 things below you could try this week? Consider talking with a family member, friend or counselor for support.

Sleep better: Aim for 8-10 hours. Avoid naps and caffeine, stick to regular sleep and wake times, no screens the hour before bed, keep phones out of the bedroom at night, and try to get outside during the day. These changes alone can have a huge impact.

Exercise: Even a little daily exercise can boost mood and help with sleep and energy.

Connect: Find ways to be social. Reconnect with old friends or try make new ones. Try to have fun with relatives.

Have fun: Even if you don't feel like it, set a time for activities you would normally enjoy.

Solve problems: Are you stressed by problems in your life? Talk with a trusted person about what is going on, or write in a journal, and figure out a plan that might help.

Move toward goals: Figure out a small step you can take toward a goal you care about.

Deal with anxiety: Lots of anxiety (feeling too worried or nervous) can lead to depression. Ask your primary care provider or counselor about how to overcome anxiety problems.

Deal with trauma: Traumatic events (like abuse or violence) can cause depression. Consider getting support from a counselor or talking to someone you trust about what happened.

Avoid alcohol or drugs: These make depression worse. Look for other ways to cope.

— Nathaniel Jungbluth, PhD

Try these strategies to help your teen

Support sleep: Encourage healthy sleep habits (see page 1). Consider having a device curfew so screens and technology do not interfere with sleep. Having devices like cell phones charge overnight where you can monitor them, and setting up parental controls (check with your cell carrier) can sometimes help.

Support socializing and getting active: If there are ways you can help your teen get out of the house, get physical activity, or connect with healthy peers, do it! If your teen is depressed, try to avoid using punishments like grounding them at home.

Spend quality time: Spend one-on-one time with your teen at least a few times each week. Do something they like and follow their lead. Avoid lectures or criticism. Ask them about things they are into and show interest. Consider asking them to teach you about something they know more about (like their favorite music or hobby).

Hold your criticism: It is easy to find things to criticize when your teen is depressed. Often they are avoiding important tasks (like schoolwork or chores) and they might be grumpy and withdrawn. If you do have to give your teen negative feedback, try not to criticize their personality (don't call them lazy or selfish) but instead focus on the behaviors you don't like.

Comment on positive steps: Try to find examples of small positive steps or healthy choices and comment on those. Look for one or two each day. Keep it totally positive! (Don't add on comments like "I wish you would do that more often.")

Be a good listener: Ask your teen about their life and their interests. When they do open up, don't punish their openness by giving lectures, telling them what to do, or criticizing. Don't give advice unless they want it. Tell them you understand what they are feeling even if you don't totally agree.

Deal with screen problems: If your teen is using screens or technology in an unhealthy way, and it is getting in the way of their relationships or responsibilities, consider putting limits on it. Parental control apps (like Circle, or cell carrier parental controls) can help you block off times of the day for school, homework, and sleep. Parental controls can also turn devices off until teens have met daily responsibilities.

Tell them you believe in them: Let your teen know they are strong and you know they can get through this hard time.

Safety: *If you have a depressed teen in your house, remove any guns from the home. If you think your teen might try to hurt themselves, seek professional support right away.*

Medication: *Some medications have been found to help with teen depression, especially when combined with effective therapy. Your primary care provider can tell you more.*

— Nathaniel Jungbluth, PhD

Depression Resources

Information for Families

Books families may find helpful:

The Childhood Depression Sourcebook (1998), by Jeffery Miller

The Depressed Child: Overcoming Teen Depression (2001), by Mariam Kaufman

The Explosive Child (2001), by Ross Greene

Helping Teens Who Cut: Understand and Ending Self-Injury (2008), by Michael Hollander

Books children may find helpful:

Taking Depression to School (2002), by Kathy Khalsa (for young children)

Where's Your Smile, Crocodile? (2001), by Clair Freedman (for young children)

Feeling Good: The New Mood Therapy (1999), by David Burns (for adolescents)

My Feeling Better Workbook: Help for Kids Who Are Sad and Depressed (2008),
by Sara Hamil (for elementary school students)

When Nothing Matters Anymore: A Survival Guide for Depressed Teens (2007),
by Bev Cobain and Elizabeth Verdick

Crisis Hotlines:

Careline Alaska
1-877-266-4357 (HELP)

National Suicide Prevention Lifeline
1-800-273-8255

Text HOME - 741741
www.crisistextline.org

Websites families may find helpful:

Guide to depression medications from APA and AACAP professional societies

www.parentsmedguide.org

National Institute of Mental Health

www.nimh.nih.gov/health/topics/depression/index.shtml

National Alliance for Mental Illness

<https://www.nami.org/Your-Journey/Teens-Young-Adults>

American Foundation for Suicide Prevention

<https://afsp.org>

American Academy of Child and Adolescent Psychiatry

www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx



PARTNERSHIP ACCESS LINE - ALASKA
Child and Adolescent Psychiatric Consultation



This resource page is now available in Spanish at www.seattlechildrens.org/pal

Peripartum Mood and Anxiety Disorders

Nearly 1 in 5 women experience a peripartum mood or anxiety disorder. Untreated peripartum mood or anxiety disorder presents serious risks.

- Risks to mothers: delayed or poor prenatal care, low birth weight, spontaneous abortion, impaired bonding with child, increased substance abuse (including nicotine), psychiatric hospitalization, postpartum psychosis, and suicide.
- Risks to offspring: decreased cognitive abilities, increased risk of affective, anxiety, and conduct disorders, increased risk of ADHD and learning disorders, increased risk of failure to thrive, delayed immunization, decreased car seat safety, and infanticide.

RISK FACTORS: history of traumatic birth, fussy baby, difficulty breastfeeding, unplanned C-section, stressful life events during peripartum period, financial hardship, NICU visit, or history of mental health difficulties in the mother.

SYMPTOMS:

- Sadness, hopelessness, emptiness
- Crying more often than usual for no apparent reason
- Increased worry, anxiety, panic or feeling overwhelmed
- Moodiness, irritability, restlessness, anger, rage
- Oversleeping, or being unable to sleep even when her baby is asleep
- Difficulty concentrating, remembering details, making decisions
- Losing interest in activities that are usually enjoyable
- Physical aches and pains, e.g., frequent headaches, stomach problems, and muscle pain.
- Increased or decreased appetite
- Social withdrawal or avoidance
- Difficulty emotionally attaching to her baby
- Persistently doubting ability to care for her baby
- Thinking about harming herself or her baby

SCREENING: The American Academy of Pediatrics recommends screening of mothers at 1, 2, 4, and 6 months well child visits. The PHQ-2, PHQ-9 and the Edinburgh Postnatal Depression Scale (EPDS) are free, brief rating scales. Patients who screen positive on the PHQ-2 (score ≥ 3) should be further evaluated with the PHQ-9. The EPDS removes some signs of depression that are difficult to distinguish from the average parenting experience, such as diminished sleep. To bill for screening, use the infant's MRN and CPT code 96161.

TREATMENT:

If screening is positive for mild symptoms (PHQ-9 10-14 or EPDS 9-13),

- a) Let the mother know that postpartum depression and anxiety are common, treatable, and not her fault.
- b) Support parenting through feeding support, sleep training support, etc.
- c) Enlist social and community support.
- d) Refer to a support group and/or for maternal or dyadic (mother/baby) therapy.
- e) Consider referral for medication.

If screening is positive for moderate symptoms (PHQ-9 15-19 or EPDS 14-18) or severe symptoms (PHQ-9 >20 or EPDS >19), in addition to above interventions for mild symptoms,

- a) Strongly consider medication intervention.
- b) Consider hospitalization when safety is a concern.

Kisha Clune, MD

References:

NIMH, "Postpartum depression facts," <https://www.nimh.nih.gov/health/publications/perinatal-depression/mcpap-for-moms>, "Assessment of Depression Severity And Treatment Options;" <https://www.mcpapformoms.org/Docs/Assessment%20of%20Depression%20Severity%20and%20Tx%20Options%2009.09.14.pdf>, Maternal depression and child development. Paediatrics & Child Health. 2004;9(8):575-583.