Children First Medical Group

Depression in Children and Adolescents
Clinical Practice Guidelines

Acknowledgments

Children First Medical Group would like to thank the following individuals for their contribution in developing the Depression in Children and Adolescents Clinical Practice Guideline.

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Depression in Children and Adolescents

Despite what many have believed in the past, today's pediatrician is aware that depression does exist in children and adolescents. While it is more common in adolescents than in young children, the consequences of untreated depression for both groups can have dangerous and sometimes deadly outcomes. From the milder cases, where a child fails to reach full potential and may become derailed from appropriate development, to more severe cases that may result in self injury or death and/or harm to others, it is a condition that can be diagnosed, and treated safely and effectively.

Keys to effective treatment include the following:

1. Appropriate **Diagnosis** – establishing a diagnosis of depression and differentiating it from bipolar disorder, other psychiatric disorders, and physical disorders.
2. Appropriate **Screening Criteria** – after a thorough clinical interview of the patient, family members and others involved in the youth's care (possibly including teachers, coaches, mentors, other health professionals), applying objective screening tools can be useful in the initial diagnosis and follow-up treatment of depression (see Page 26, **RESOURCES**).
3. Appropriate **Management** (includes nonpharmacologic/cognitive) – after accurate diagnosis, developing a comprehensive treatment plan that includes non-pharmacologic and pharmacologic treatments is the key to a good prognosis. Understanding the risks of medications (including the "Black Box" warning carried by most psychotropic agents) and the risks of not medicating are important factors.
4. Criteria for **Consultation** – knowing when to refer for a routine outpatient consultation and when to refer to the Emergency Department.
5. Knowing how to handle an **Emergency Situation**
6. Providing reference materials for patients and families and developing a knowledge of professional resources and referrals.

While this clinical practice guideline is intended as a concise synopsis rather than a comprehensive overview of the topic of depression, we hope it will offer an informative and useful approach to the diagnosis and treatment of depression in children and adolescents.

Diagnosis and Screening Criteria

The diagnosis of depression in children and adolescents has received media attention and created controversy for decades. Yet the psychiatric and pediatric communities did not even recognize childhood depression until the mid 1970's. Children and adolescents were seen as having "phases" or "stages" to their mood swings that they would "grow out of." When this proved not to be the case, and suicide rates for adolescents continued to rise to alarming levels, the medical community began to consider whether the presenting signs and symptoms of adult depression were similar to those in children and adolescents. While written for adults, the Diagnostic and Statistical Manual of Mental Disorders (DSM), currently in its 4th edition (DSM-IV) has attempted to incorporate criteria to help diagnose major depressive disorder in children and adolescents. It is important to be familiar with the DSM-IV criteria, currently the standard for identifying the symptom clusters for depressive disorders.

The DSM-IV criteria posit that five (or more) of the following symptoms must have been present for a ***two week*** period and represent a change from previous functioning:

- depressed mood (or irritable mood in children)
- loss of interest or pleasure in activities (a.k.a. anhedonia)
- significant change in weight (loss or gain) or appetite over past month
- psychomotor agitation or retardation
- fatigue or loss of energy
- any change in sleep pattern
- feelings of worthlessness or guilt
- diminished ability to think or concentrate
- recurrent thoughts of death; suicidal ideation, attempt or formal plan

These symptoms must not only be present but ***cause distress or impairment in social/occupational/educational or other functioning***.

The DSM-IV further explains that manic episode, psychosis, substance abuse and general medical conditions have all been ruled out and are not better accounted for by bereavement.

It is important to not use the DSM-IV criteria as a “cookbook” to diagnose depression in children and adolescents, i.e. merely checking off symptoms without understanding the environmental context and the meaning of the symptoms to the child and family. While the above criteria focus mainly on the neurovegetative symptoms, the last symptom listed above, *recurrent thoughts of death, suicidal ideation, attempt or formal plan,* is a key distinguishing factor in making the diagnosis. Any child or adolescent of any age presenting with this symptom has crossed over from ruling out a mood disorder to being diagnosed with one. While it is often developmentally appropriate for adolescents to struggle with the existential questions of life and death, moving from thinking about these issues in general to questioning the worth of their own life, is very different and places these young people in a risk category.

Assessment of Depression

Presenting symptoms of depression can range from neurovegetative (fatigue, poor concentration and insomnia) to a notably withdrawn, irritable or depressed mood. In general, patients are not likely to lead off an interview with mood symptoms, so an ear for possible depressive symptoms is critical. Additionally, many physical medical illnesses can masquerade as depression, for example, anemia, allergy, Crohn’s disease, lupus, celiac disease, Addison’s disease and cancer. Keeping in mind that it is important to allow time to interview the youth separately, the following is a possible approach to the clinical interview:

- *History*: premorbid history, HPI (are DSM IV criteria present?) Do the symptoms come and go or are they constant? Is the mood state constant or does it vary amongst extremes? Are the symptoms only present in one area (school, for example) or are they present in others (relationships, extracurricular activities)?
- *Family History*: physical as well as psychiatric disorders. The family may be reluctant or embarrassed to share certain things. They may fail to see how other problems can be related to the child’s mental health.
- *School Functioning/Neuropsychiatric*: It is especially important to screen for Learning Disabilities.
- *Social History*: Have there been major life changes (moves, death, divorce) or other stressors? Are there any firearms/dangerous substances in the home?

- *History of Medication/Substance Use/Other*: Be sure to screen for drug/ETOH use and signs of use, such as mood shifts, or recent use of over-the-counter drugs, pain relievers, and herbal or caffeine products.
- *Objective Measures*: Beck Depression Scale (BDS), Child Depression Inventory (CDI), Hamilton Depression Checklist - Children (HDCL-C). Be aware that the HDCL-C is heavily weighted on somatic issues. For more information on obtaining and administering screening tools, see Appendix.
- *Physical Examination*
- *Labs/Diagnostic Studies*: Screen for other medical conditions. CBC with Differential, Serology-Electrolytes, Ca, Mg, ESR, Bun/Cr, Glucose, LFT's, Serum B12, Folate, and Thyroid Function Tests (TSH and FT4) are appropriate baseline labs; Toxicology Screen (specific, as needed: alcohol, cocaine, opiates, marijuana), Pregnancy Test

At the conclusion of this assessment, one should be able to develop a differential that includes physical and/or mental etiologies. Additionally, one should be able to determine whether the symptoms are consistent with a mood disorder (being careful to also screen for bipolar disorder if an agitated mood predominates with overactive physical activity) or other psychiatric disorder. Other relevant psychiatric disorders include anxiety disorders, especially Post Traumatic Stress Disorder (PTSD) and Attention Deficit Disorder (ADD).

Management of Depression

Keys in the management of children and adolescents with depression in the primary care setting are compassion, communication and collaboration amongst the primary care provider, patient, family, school and mental health professionals. Initial and ongoing assessment of the effectiveness of treatment by means of interview and available depression screening tools (see **SCREENING SECTION**) provide important information about the patient's ability to function and take pleasure in daily activities and relationships. While a multi-modal approach (patient/family education and support, therapy and medication) is necessary for some, a simpler approach may be sufficient for others. Additionally, in a pediatric practice with many providers, the preferred arrangement is one that allows for the patient/family to see the same provider at every visit.

<u>Guidelines for management</u>

The following is a guide for management of the patient who fits criteria for a diagnosis of depression (see **DIAGNOSIS AND SCREENING SECTION**), beginning with the simplest interventions:

1. <u>Primary Care Provider (PCP) support</u>
   - See weekly in the office.
   - Educate patient and family about depression (risk factors for suicide), treatment, resources (Parent Hotline, local emergency rooms and after hours assistance suicide hotline). It may be helpful to have this information in printed form.
   - Encourage exercise, healthy diet, adequate sleep, participation in enjoyable activities.
   - Assess for and address stressors – school situation (academic, social), work relations (adolescents), family and life transitions, changes with physical or mental health issues in other family members, peer relationships, alcohol and/or drug use, suicidality.

If no improvement after *four to six weeks*, then proceed to 2. **For acute crisis (possible expulsion from school, for example), requiring symptom relief within 2-4 weeks rather than 8 weeks, begin medication treatment first and then concurrently refer for therapy.**

2. Refer for therapy

- See weekly in office until therapy is in place, then *every one to three months* for maintenance.
- Types of therapies that may be considered – individual (Cognitive Behavioral Therapy, inter-personal, play), group/social skills, family.
- Maintenance: In addition to monitoring for stressors noted above, assess and monitor for compliance with therapy appointments. Regular communication should be established between the therapist and the treating physician, e.g. phone messages, email (confidentiality), faxed note, etc. You will need signed consent from patient/family.

If no improvement after *at least two months* of therapy, then proceed to 3.

3. Add medication

- The different medication choices can seem bewildering at first, so it is important to begin developing expertise with one or two agents to gain a level of comfort in prescribing. Please see **MEDICATION SECTION** for additional information on medication choices and types.
- See weekly for four weeks, then every two weeks for two months.
- Maintenance: See every three months with interim phone calls and/or appointments on a prn basis (as needed). In addition to assessing for stressors and compliance with therapy appointments noted above, monitor for compliance with medication recommendations.
- If no improvement after 6 weeks, then consider changing to another agent and reconfirming the diagnosis.

Special situations

Patient presenting in your practice on medications:

Review psychiatric history, current treatment plan and collaborate with existing treatment team. Schedule follow-ups as appropriate per existing treatment team.

Discontinuing medications:

Always taper medications over a 2 week period and monitor carefully for a change in mental status. Often a medication that seemed to be "ineffective" is shown to have been "effective" as it is withdrawn.

Non-traditional remedies:

Advise their cautious use; try to choose between nontraditional remedies or traditional remedies. Many psychotropic agents do not mix well with nontraditional herbal remedies and their interaction is difficult to monitor at best.

Developmentally delayed child with possible depression:

For children with developmental disabilities, always assess whether the current mental status is developmentally appropriate. If not, proceed carefully with psychotropic medications (many can have paradoxical reactions) and maintain close contact with other members of the treatment team and with school personnel in order to monitor effects.

Dual Diagnosed:

For those with alcohol or substance abuse problems, encourage sobriety and again proceed cautiously with psychotropic medications. Substance abuse is a powerful confounding variable during assessment of mood and of psychotropic efficacy.

Criteria for Consultation

Despite a careful assessment and appropriate treatment plan, there are ***times when consultation is required*****.**

Examples include:

1. Past history of suicidal thinking or behavior including previous gestures, attempts, or homicidal thoughts
2. Presence of self-induced cutting or mutilation
3. Comorbid disorders coexisting with the depression such as anxiety, Attention Deficit Hyperactive Disorder (ADHD), conduct disorder, and substance abuse
4. Possibility of bipolar disorder
5. Patient is not improving clinically or even worsening despite accepted treatment approaches
6. Worsening clinical presentation with agitation, hallucinatory thoughts, increasingly morose behavior
7. Adverse response to medication especially if there is a family psychiatric history
8. Pediatrician discomfort in diagnosing or treating the child/adolescent; need for ongoing consultation with a psychiatrist
9. Operational barriers to treatment and monitoring in the pediatrician's office, including time and economic considerations
10. Failure to respond to treatment in the pediatrician's office.

Additionally, there are ***times when referral to the Emergency Department (ED) is more appropriate than referral to an outpatient mental health specialist.***

Examples include:

1. Suicidal attempt/gesture
2. Imminent suicidal attempt such as an organized or semi-organized plan for suicide or homicide
3. Clinical decompensation which may include agitation, decreased functioning, increased vegetative signs and the emergence of psychotic features including hallucinations or paranoia
4. Lack of stable family/environmental support for the child or adolescent.

Medications

The age of the child that the primary care physician starts on medication will vary depending on the comfort level of the pediatrician. Based on target symptoms, physical conditions, any comorbid conditions, previous medication trials (of the patient or other family members), and provider comfort level, an initial medication trial can be started.

<u>Starting an Antidepressant Medication</u>

For a treatment-naïve patient needing an antidepressant, a Selective Serotonin Reuptake Inhibitor (SSRI) is typically the first line of therapy. If the patient has a family member who has had a good response to a particular antidepressant, that also may be helpful in selecting a medication.

Start at a low dose which is approximately 50% of the target or recommended dose. This will improve patient acceptability, tolerance of side effects, and compliance. By 2-4 weeks, if the patient is showing marginal benefit but no adverse effects, it is reasonable to advance the dose. At 4 weeks, if again there is no appreciable benefit or adverse effects, it is advanced further. At this point the patient should have reached the target or recommended dose. As it may take 4-6 weeks to reach maximum efficacy, it is important to encourage the patient and family to be patient and to acknowledge the presence of any side effects. By 6 weeks, if the patient still has only marginal benefit, consider a different antidepressant. If you change antidepressant medications, first consider a 2nd SSRI, as many patients who do not respond to one will respond to another.

Patients should be encouraged to take the medication at approximately the same time each day, to continue taking the medication after feeling better, and not to stop taking it without checking with their physician, given the possibility of withdrawal effects. Fluoxetine (Prozac) is the only formally FDA approved antidepressant in pediatric patients. Fluoxetine, Sertraline (Zoloft), Fluvoxamine (Luvox) and Clomipramine (Anafranil) have FDA approval for treatment of Obsessive Compulsive Disorder in children and adolescents. It is important to discuss the "Black Box" label of these medications with your patients and their families (see page 14).

MEDICATION CLASSES FOR DEPRESSION

1. Selective Serotonin Reuptake Inhibitors (SSRIs)

- Act by increasing serotonin in the synapse as a result of blocking its uptake at the presynaptic nerve.
- Side effects include nausea, lack of appetite, weight loss, GI upset, typically nausea and cramping, excessive sweating, nervousness, insomnia, sexual dysfunction (anorgasmia – there are no effects on reproduction itself), sedation, fatigue, headache and dizziness. Less common side effects include dry mouth, constipation, bleeding difficulties, nocturnal bruxism, and hair loss.
- Most side effects tend to subside after a few weeks, so encouraging compliance during the initial weeks in important.
- Relatively safe in overdose.
- Be aware that ***dextromethorphan and grapefruit can increase levels of serotonin*** and precipitate serotonin crisis.

Generic Name	Brand Name	Tablets/ Liquid	Daily Dose Range	Other info
Citalopram	Celexa	Tablet 10, 20, 40 mg Liquid soln 10 mg/ml	20-60 mg	
Escitalopram	Lexapro	Tablet 10, 20 mg Liquid soln 5mg/5ml	10-20mg	Similar to Celexa.
Fluoxetine	Prozac	Tablet 10, 20 mg Liquid soln 20mg/5ml 90 mg weekly tablet	10-80 mg	Generic available, generally more activating. Prozac also available weekly - equivalent to 20 mg daily.
Fluvoxamine	Luvox	Tablet 25, 50, 100 mg	50-250mg	May use BID dosing.
Paroxetine Paroxetine CR	Paxil	Tablet 10, 20, 30, 40 mg 12.5 and 25mg Liquid soln 10mg/5ml	10-50 mg 12.5-25 mg CR	Strongly associated with withdrawal. Mild anticholinergic side effects.
Sertraline	Zoloft	Tablet 50, 100 mg Liquid soln 20mg/ml	25-200 mg	May have more GI side effects.

2. Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)

- Inhibit the uptake of both serotonin and norepinephrine
- Can be effective for treatment of physical/somatic treatment of depression
- Most common side effects are nausea, lack of appetite, weight loss, excessive sweating, nervousness, insomnia, sexual dysfunction, sedation, fatigue, headache and dizziness

Generic Name	Brand Name	Tablets	Daily Dose Range	Other info
Venlafaxine	Effexor Effexor XR	25, 37.5, 50, 75. 100 mg	37.5–150 mg bid or 75-300 mg XR qd	May cause or aggravate hypertension and may cause nausea.
Duloxetine	Cymbalta	20, 30, 60 mg	30-120 mg qd	Approved for diabetic neuropathy.

3. Atypical Antidepressants

- Chemical structures different from Tricyclic Antidepressants (TCAs) and SSRIs and have variable side effects
- Relatively safe in overdose

Generic Name	Brand Name	Tablets	Daily Dose Range	Other info
Buproprion	Wellbutrin Wellbutrin XL Wellbutrin SR	75, 100, 150, 250, or 300 mg	75 mg bid-150 tid or 150-450 mg qd	Can induce seizures. Contraindicated in eating disorders. May aggravate arrhythmias.
Mirtazapine	Remeron	15, 30, 45 mg	15- 45 mg qhs	SE include sedation and weight gain. Lack of significant interactions with other drugs.
Trazodone	Desyrel	50, 100, 150, 300 mg	50 mg – 100mg qhs for sleep 50-600 mg qhs for depression	Popular use as a sleep aid (at lower doses). SEs include sedation, orthostasis, risk of priapism.

4. Tricyclic Antidepressants (TCAs)

- Cause cardiotoxicity and lethal in overdose
- Block cholinergic muscarinic receptors, so common side effects are dry mouth, constipation, urinary retention, sinus tachycardia, blurred vision and memory dysfunction
- Block histamine H1 receptors and may cause sedation, increased appetite, and weight gain
- Block alpha-1 adrenergic receptors and may cause postural hypotension, dizziness, and potentiation of antihypertensive effects of other drugs.
- EKG recommended before and 4 weeks into TCA treatment

Generic Name	Brand Name	Tablets/ Liquid	Daily Dose Range	Other info
Amitryptiline	Elavil	Tablets 10, 25, 50, 75, 100, 150 mg Liquid soln 10mg/5ml	25 mg -300 mg qhs	
Nortriptyline	Pamelor	Tablets 10, 25, 50, 75 mg	10 mg-150 mg qhs	
Desipramine	Norpramin	Tablets 10, 25, 50, 75, 100, 150	25 mg qhs or qam to 300 mg qhs or in divided doses	
Clomipramine	Anafranil	Tablets 25, 50, 75 mg	25 mg-200mg qhs	
Imipramine	Tofranil	Tablets 10, 25, 50 mg	25-100 mg qd	

Other TCA's include:

Doxepin (Adapin)

Protriptyline (Vivactil)

Trimipramine (Surmontil)

Black Box Warning

When starting children and adolescents on antidepressants, it is important to discuss with patients and family the 2004 FDA "Black Box" warning label on antidepressant medications. This warning states that an increased risk of suicidal thinking and behavior in children and adolescents while on these medications is possible, especially at the beginning of treatment. It is important to discuss this warning with patients and their families. It is also important to discuss warning signs of suicidality with patients and their families; consider giving patient and family a handout or something else in writing. See the **REFERENCE SECTION** for handouts from the American Academy of Child and Adolescent Psychiatry (AACAP). Early side effects consistent with an inappropriate response to antidepressants include activation/agitation, akathisia (abnormal involuntary movements), hypomania and mood irritability. Of note, recent studies now highlight a link between the "Black Box" warning, decreased use of antidepressants and an increase in adolescent suicide rates. The bottom line is that antidepressants remain useful treatments for depression but need to be used judiciously and with careful monitoring.

Follow Up

According to the FDA "Black Box" label, a child or adolescent starting on antidepressant medication should be seen by the prescribing medical doctor weekly for the first four weeks, then every 2 weeks for the second month, and then at the end of the 3rd month (12th week) on medication.

The AACAP and American Psychiatric Association (APA) recommend that the frequency of monitoring should be individualized to the needs of children and family. Patients and families should know how to contact the provider if any suicidal thoughts emerge, or if a patient becomes agitated.

Physicians and parents should be monitoring the patient for any suicidal thoughts, increased anxiety, agitation, aggressiveness, impulsivity or unwarranted elation or energy (signs of mania).

How to Handle an Emergency Situation

While suicide attempts and completed suicide are fairly uncommon in children, they are more common in adolescents and very common in young adults. Completed suicide is six times as common among teens as children and greater in males compared to females across all ages. Additionally, there are risk factors which increase the incidence of a suicide attempt:

- Precipitants: often occur after an acute stressful event or as an outcome from chronic stressors.
- Methods: firearms common among males, ingestions among females
- Previous psychiatric history: psychiatric diagnosis is present in 90% of completed suicides; history of substance abuse, previous suicide attempt
- Familial history: poor parent child communication; history of suicide in family/friends; reduced support network
- Community factors: imitation/suicide pacts

A child who admits to an acute suicide attempt or gesture must be immediately referred to an emergency department (ED). If the child is in your office, and there is any imminent physical risk to that child, it is appropriate to call "911". If the child is medically stable, and accompanied by a dependable parent or guardian, that person may transport the child to the appropriate emergency department. Be absolutely certain that the child will not be left unattended and that the driver will go directly to the ED. If there is any doubt regarding any of these issues, call 911. Also, if there is any concern that the child will not cooperate with transportation to the emergency room or is physically resistant to this action, call 911.

As a side note, paramedics in Alameda County will generally refuse to transport uninjured suicidal patients without a 5150 determination by the police or sheriff's department (refer to Appendix, page 22, for information about obtaining a 5150 determination). The 911 call, in the absence of physical findings or ingestion, may initially have to be answered by the local Police Department (PD).

If you have been notified of a suicide attempt, and the patient is not in your office, the caller should be instructed to call 911. Be certain to obtain a telephone number for the caller, as well as the location of the child and the caller, before ending the conversation. Call back after giving the caller time to carry out your instructions to be sure help has been summoned. Be available on the phone for emergency responders. If the caller refuses your instructions, you may have to call the PD. Be sure to call the jurisdiction for the current location of the child.

If the caller is the child, every attempt should be made to find the current location and phone number of the child. If the child is unable to give the phone to a responsible person, attempt to get your office personnel to make the emergency call while you continue to talk to the child.

In Alameda County: Children with suicidal thoughts/ideation under the age of 12 years should be directed to Children's Hospital and Research Center Oakland (CHRCO) ED **(510) 428-3240**. Older patients must be directed to the ED at Alta Bates Hospital in Berkeley **(510) 204-4444**. Psychiatric evaluation will be obtained in that setting. Again, transport to those facilities must be certain and direct, either by ambulance after 5150, or by a guardian who agrees to drive directly to the ED. See Appendix for a list of other emergency phone numbers.

Outside Alameda County: Children and teens should be directed to the closest ER in their area. Local hospitals with inpatient psychiatric wards include:
Mount Diablo Pavilion **(925) 674-4140** and St. Helena Hospital **(707) 649-4040**. See Appendix for a list of other emergency phone numbers.

After arranging for assessment and appropriate treatment, review a plan for additional follow-up. This follow-up may include contacting the emergency room to provide additional information as well as follow-up with the family to determine the final disposition of the child. Children and teens who are not admitted may not be given extensive referrals

for follow-up care. In this case, initial follow-up care should be provided by the primary care provider. Unless further care is not warranted, referral should be given to a mental health provider.

An additional note: Often following inpatient discharge, the outpatient follow-up plan may not be fully determined. Again, the primary care provider should act as the first outpatient provider of care with additional follow-up with mental health providers (i.e. therapists or psychiatric services).

Documentation

A visit sequence for patients with possible depression (sample):

Phone call is made to advice nurse. Next day appointment is made for a medical concern; for example, "fatigue".

First Visit: This is one way to approach a child who may have mild to moderate depression.

Office Visit, 15-20 minutes

- **S** history of present illness, duration, severity, interfering with function, review of systems
- **O** exam
- **A** depression suspected, begin to R/O medical causes
- **P** lab tests ordered, CBC, chem 20, TSH, ESR, EBV titer, calendar of symptoms (code 99214 for visit)*

Visit #2: Having determined the severity of the depression at the first visit, this is a way to continue your assessment.

Physical Exam (if none within the last year). Discussion of labs and calendar (add modifier for illness)*. Depression Assessment tool; at the beginning of the visit, please have the patient complete the Children's Depression Inventory (CDI). Inform the patient and family that they need to arrive 15 minutes before their appointment to complete it. The CDI is quick and provides a useful way to gather and quantify qualitative data about depression.

- Review Depression Assessment tool.
- Family/child conference (conference code for TIME.)* If depression is strongly considered, then proceed to 1 below.

Further Actions:

1. Refer to therapist - phone call, letter of referral (if same day as conference, bill for TIME)*. Communication with patient to make sure appointment is made.
2. Review therapist's recommendations.

3. Follow up to discuss therapist's recommendation (conference). Code for TIME*.

   If therapy is needed:

   a) Discuss roles of pediatrician, therapist, and psychiatrist if needed.
   b) Expectations.
   c) Evaluation tools, side effects, progress, warnings for suicidal behavior. Discuss need for information sharing with teachers/ coaches.
   d) Prescribe medication. Visit weekly X 4 (If talking time is most of visit be sure to code for TIME)*.
   e) Make sure patient is relating to therapist.
   f) Check for side effects/suicidal thoughts.
   g) **Communicate each time with therapist.**
4. Frequency of additional visits as determined by team

**** See "Proper Use of Coordination of Care Visits" in the APPENDIX SECTION.***

Concluding Pearls

1. **1.** Family psychiatric history is helpful, but is not diagnostic of a child or adolescent having unipolar depression or bipolar disorder. Early data suggest that children of parents with bipolar disorder are at higher overall risk of having mental health disorders in general, but not specifically bipolar disorder.
2. **2.** Careful screening should be done for other disorders that affect cognitive functioning. Such disorders include Attention Deficit Hyperactive Disorder (ADHD) and Bipolar Disorder (BPD). For ADHD, there should be additional symptoms of impulsivity and/or hyperactivity that should be constant. For BPD, there should be additional symptoms of irritability, mood swings, and interspersed periods of normal functioning.
3. **3.** Scheduling a patient at the end of the morning or the last visit of the day may be helpful if one suspects that the presenting concerns may be related to a possible depressive disorder. This will allow the necessary time to address concerns.
4. **4.** It may also be helpful to divide the visits into several based on the presenting medical problem, to get to know the patient better and to build rapport. See the **DOCUMENTATION SECTION** for a possible visit sequence.
5. **5.** Note whether a family member has had positive or adverse effects with a psychotropic medication.
6. **6.** While SSRI medications have been shown to reduce sexual interest and to cause anorgasmia, they do not have any effect on conception or reproductive maturation.
7. **7.** Be alert to the need to use medications <u>only</u> as the prescription is written. Do <u>not</u> freely substitute a generic if a brand name is prescribed. Generics may not have the same effectiveness.
8. **8.** Some medications may impact weight, causing either gain or loss.

Appendix Containing the Following PCP Tools

Emergency Telephone Numbers

Referral Telephone Numbers

Proper Use of Coordination of Care Codes

Resources*

References

Emergency Telephone Numbers

Child Protective Services

Alameda County Hotline:	510-259-1800
Contra Costa County Hotline:	925-646-1680

Oakland Police Department *

Non-emergency Number:	510-777-3333
Cell Phone Direct Access Emergency Number:	510-777-3211

Berkeley Police Department *

Non-emergency Number:	510-981-5900
Cell Phone Direct Access Emergency Number:	510-981-5911

Child Youth Crisis Team: 510-618-3432

Contra Costa Mental Health Crisis Services: 888-678-7277

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Outside Alameda County: Children and teens should be directed to the closest ER in their area. Local hospitals with inpatient psychiatric wards include Mt. Diablo Pavilion **(925) 674-4140** and St. Helena Hospital **(707) 649-4040**.

**** A 5150 determination may be obtained by contacting the police department. In such cases, a person will be placed on police hold and detained for 72 hours for observation and treatment.***

Referral Telephone Numbers

Outpatient Mental Health Services available for MediCal Managed Care and Healthy Families/Healthy Kids Programs:

<u>Alameda Alliance for Health</u>

<u>MediCal Members</u>

Alameda County Behavioral Health Plan (ACCESS):	800-491-9099

<u>Healthy Families/Healthy Kids Program</u>

PacifiCare Behavioral Health, Inc:	800-999-9585

<u>Blue Cross of California</u>

<u>MediCal Members</u>

Alameda County Behavioral Health Plan (ACCESS):	800-491-9099
Contra Costa County Behavioral Health Plan (ACCESS):	888-678-7277

<u>Healthy Families Program</u>

Blue Cross Behavioral Health Program	
Alameda County:	800-399-2421
Contra Costa County:	925-957-5150

Inpatient Mental Health Service

Mount Diablo Pavilion:	925-674-4140
Herrick Behavioral Health (Alta Bates):	510-254-4405
St. Helena Hospital:	707-649-4040
The McAuley Institute at St. Mary's Center (San Francisco)	415-750-5649

Proper Use of Coordination of Care Codes

Billing for the *Coordination* of *Care* codes requires an understanding of the individual codes, proper documentation, and an easy to follow billing slip.

Coordination of Care Physician Management codes:

These codes are for *physician time only* and, ideally, should not be used until verifying that the patient's insurer will cover them and the diagnoses that the care was provided for. For example, Ohio only reimburses for these codes through their Title V Program (BCMH) and will not cover these services if they are provided for a developmental or mental health diagnosis.

Prolonged Services (with direct patient contact)

These are used when a physician provides prolonged service in an inpatient or outpatient setting that is beyond the usual service provided. They can be billed in addition to the Evaluation and Management (E/M) code.

Outpatient	99354	30-74 minutes (if less than 30 minutes, do not report)
	99355	each additional 30 minutes
Inpatient	99356	30-74 minutes (if less than 30 minutes, do not report)
	99357	each additional 30 minutes

Prolonged Services (without direct patient contact)

This refers to such services as reviewing records, communication with other providers or the patient and/or family.

99358	30-74 min (if less than 30 minutes, do not report)
99359	each additional 30 min

Case Management

This refers to *Team Conferences* needed to coordinate the activities of patient care. They may occur during a hospitalization or after discharge. The patient or family need not be present. Each physician present can bill this code separately.

99361	approximately 30 min
99362	approximately 60 min

There are additional codes for *phone calls* which involve active management of a problem over the phone, such as the after hours calls that prevent an ER visit. They can also be used when management or coordination involves phone communication with a pharmacy, lab, social worker, home care provider, therapist, or other physician.

99371	brief call ~10 min
99372	intermediate call, 10-20 min
99373	complex call ~ 20 min

To bill for *special reports* such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. This code is not an add-on code; it does not have to be reported in conjunction with a face-to-face E/M visit. It does not require face-to-face contact with the patient/parent. Medicare does not assign any relative value units to this code.

99080

Modifiers

The *-25 modifier* should be used when symptoms requiring significant amounts of physician work beyond preventive care are encountered during a preventive medicine visit (check-ups) of a child with special health care needs. This would be added to the end of E/M code and billed with the preventive medicine code. Thus, a 5yo with chronic lung disease, seizures, and feeding problems comes in for his yearly WCC and the physician spends additional time evaluating and treating his chronic problems. The physician can then bill:

99393	5yo preventive care visit
99214-25	E/M code for the add'l time spent on the child's special needs.

Be aware that while this is appropriate billing, many of these codes may not be reimbursed by health insurance companies.

Resources

The following web sites are provided
to assist you in your practice.

**** Note: These are provided as resources which may be helpful to you in the management of children or adolescents with depression, not as an endorsement of any specific resource.***

Selected Depression Resources for Families

Letter to Families:

American Academy of Child and Adolescent Psychiatry (2004). *Sample letter to families about antidepressant medication and the black box warning.* Retrieved June 5, 2007, from the American Academy of Child and Adolescent Psychiatry Web site: http://www.aacap.org/galleries/PsychiatricMedication/Sample%20Letter%20to%20Families%2010%2029%2004.pdf Also available in Spanish at: http://www.aacap.org/galleries/PsychiatricMedication/SpanishSSRISampleLetter.pdf
A copy of this letter is provided in the following pages.

Medication Information:

American Psychiatric Association and American Academy of Child and Adolescent Psychiatry (n.d.). *The use of medication in treating childhood and adolescent depression: Information for physicians*. Retrieved June 5, 2007, from the Parent's Med Guide Web site at: http://www.physiciansmedguide.org/parentsmedguide.htm

Facts for Families:

American Academy of Child and Adolescent Psychiatry (2006). *Facts for families*. Retrieved June 8, 2007, from http:www.aacap.org/page.ww?section=Facts+for+Families&name=Facts+for+Families
A listing and examples of this resource are provided in the following pages.

Selected Depression Resources for Medical Practitioners

Web Links

American Academy of Pediatrics (2002). *Bright futures: tool for professionals*. Retrieved June 20, 2007, from:
http://brightfutures.aap.org/web/healthCareProfessionalstoolsAndResources.asp
Samples of this resource are provided in the following pages.

American Psychiatric Association and American Academy of Child and Adolescent Psychiatry (n.d.). *The use of medication in treating childhood and adolescent depression: Information for physicians*. Retrieved June 5, 2007, from the Parent's Med Guide Web site at: http://www.physiciansmedguide.org/parentsmedguide.htm

Beck, A., Steer, R., & Brown, G. (2007). Beck Depression Inventory II (BDI-II). Retrieved June 5, 2007, from
http://harcourtassessment.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8018-370
See pages 5 and 18 of the Clinical Practice Guideline. A sample from this web site is provided in the following pages.

Kovacs, M. (2007). The Children's Depression Inventory (CDI). Retrieved June 5, 2007, from http://www.pearsonassessments.com/tests/cdi.htm
See pages 5 and 18 of the Clinical Practice Guideline. A sample from this web site is provided in the following pages.

References

American Academy of Child and Adolescent Psychiatry (2006). *Facts for families*. Retrieved June 8, 2007, from http:www.aacap.org/page.ww?section=Facts+for+Families&name=Facts+for+Families

American Academy of Child and Adolescent Psychiatry (2004). *Sample letter to families about antidepressant medication and the black box warning.* Retrieved June 5, 2007, from http://www.aacap.org/galleries/PsychiatricMedication/Sample%20Letter%20to%20Families%2010%2029%2004.pdf Also available in Spanish at: http://www.aacap.org/galleries/PsychiatricMedication/SpanishSSRISampleLetter.pdf

American Academy of Child and Adolescent Psychiatry (1998). *Summary of the practice parameters for the assessment and treatment of children and adolescents with depressive disorders.* Retrieved August 24, 2006, from http://www.aacap.org/page.ww?section=Summaries&name=Summary+of+the+Practice+Parameters+for+the+Assessment+and+Treatment+of+Children+and+Adolescents+with+Depressive+Disorders

American Academy of Pediatrics (2002). *Bright futures: tool for professionals*. Retrieved June 20, 2007, from: http://brightfutures.aap.org/web/healthCareProfessionalstoolsAndResources.asp

American Psychiatric Association and American Academy of Child and Adolescent Psychiatry (n.d.). *The use of medication in treating childhood and adolescent depression: Information for physicians*. Retrieved June 5, 2007, from the Parent's Med Guide Web site at: http://www.physiciansmedguide.org/parentsmedguide.htm

Beck, A., Steer, R., & Brown, G. (2007). Beck Depression Inventory II (BDI-II). Retrieved June 5, 2007, from http://harcourtassessment.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8018-370

Bostic, J., et al. (2005). *Evaluation of medications side effects.* Retrieved June 5, 2007, from the Massachusetts General Web site: www.massgeneral.org/madiresourcecenter/pdfs/MADIResourceCenterGuide2005.pdf

Ferren, P. (2006, February). Demystifying the black box warning on antidepressants [Electronic version]. *Contemporary Pediatrics*, 23.
See details of this article at the back of the Appendix.

Food and Drug Administration (2007). *Antidepressant use in children, adolescents and adults.* Retrieved June 5, 2007, from http://www.fda.gov/cder/drug/antidepressants/default.htm

Food and Drug Administration (2005). *Medication guide: About using antidepressants in children and teenagers.* Retrieved June 5, 2007, from http://www.fda.gov/cder/drug/antidepressants/MG_template.pdf

Jellinek, M., Patel, B.P., Froehle, M.C., eds. (2002). *Bright futures in practice: Mental health (1). Practice guide. Chapter on mood disorders: Depressive and bipolar disorders*. Retrieved August 24, 2006, from http://www.brightfutures.org/mentalhealth/pdf/bridges/mood_dsrdr.pdf

Kovacs, M. (2007). The Children's Depression Inventory (CDI). Retrieved June 5, 2007, from http://www.pearsonassessments.com/tests/cdi.htm

Rakel, R. & Bope, E. (2006). Conn's current therapy 2006, (58th ed.). Philadelphia: Saunders.

Rappaport, N., et al. (2006). Treating pediatric depression in primary care: Coping with the patient's blue mood and the FDA's black box. *Journal of Pediatrics 148*, 567-568.

Shaffer, D. & Pfeffer, C. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 40.*

Solberg, L., Trangle, M., & Wineman, A. (2005). Follow-up and follow-through of depressed patients in primary care: The critical missing components of quality care. *Journal of the American Board of Family Practice, 18(6),* 520-527.
See details of this article at the back of the Appendix.