

## **Adolescent Depression Screening and Initial Treatment Toolkit for Primary Care Clinicians**

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## INTRODUCTION

By the time children reach adulthood, 20% have had at least one episode of major depression.<sup>1</sup> Depression is a cause of significant disability, and major depressive disorder in children and adolescents is strongly associated with depression in adulthood, other mental health disorders, and suicide.<sup>2</sup>

The U.S. Preventive Services Task Force (USPSTF) advises primary care clinicians to screen adolescents, ages 12 years and older, for depression.<sup>2,3</sup> The Patient Health Questionnaire-9 (PHQ-9), which has been widely-used to screen adults for depression, has also been shown to be an effective screening tool in adolescent populations.<sup>4</sup> This tool has the advantage of being brief and easy to administer in the primary care setting, and it has a high sensitivity in adolescents 12 years of age and over.<sup>4,5</sup> A version of the PHQ-9 that has been slightly modified to make the questions more appropriate for adolescents (often called PHQ-A) has also been shown to be an effective tool for screening adolescent patients for depression in primary care settings.<sup>6</sup>

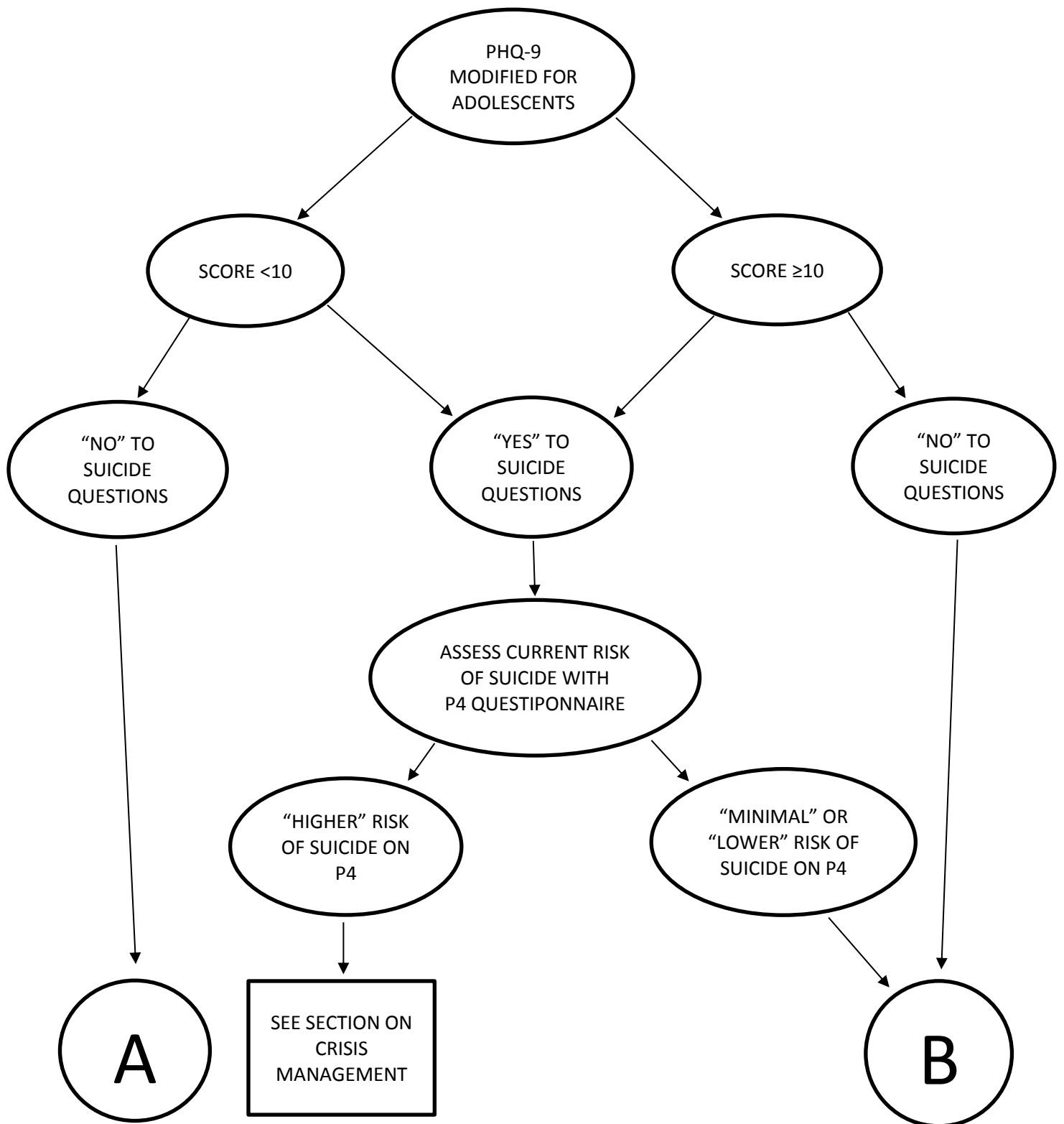
The PHQ-2 (two question screening tool) has also been recommended for use in adolescent populations, but it has been shown to have a somewhat lower sensitivity and specificity than the PHQ-9 in adolescents (sensitivity 74% and specificity 75% for the PHQ-2, and sensitivity 96% and specificity 82% for the PHQ-9).<sup>5</sup> The recommended use of the PHQ-2 generally involves confirmation of “positive” screens with the PHQ-9; because of this, because of the superior sensitivity of the PHQ-9, and because of the ease of administering the PHQ-9, we recommend the PHQ-9 (or the PHQ-9 modified for adolescents) as the initial screening tool.

This tool may be used, quickly and effectively, during routine health maintenance visits (well visits), starting at age 12 years; it may also be used during other visits, if the clinician believes that administration would be appropriate (such as visits for ADD/ADHD, fatigue, or ongoing pain). A positive screen is defined as a score of  $\geq 10$ , but the questionnaire is most appropriately-used as a screening tool, not a tool for making a firm diagnosis; clinical validation by the primary care provider (PCP) is necessary to confirmation a diagnosis of major depression.<sup>7</sup> If the PCP believes that an adolescent with a score of 5-9 has symptoms that are concerning for depression, further assessment is warranted; the symptoms of depression in adolescents may be subtle and might even include symptoms that are not typically seen in adults, such as irritability or rebellious, high-risk behavior. The PCP must recognize that even the most effective screening tool is imperfect, so a high index of suspicion is necessary when screening adolescents. Furthermore, since the PHQ-9 has been shown to have a specificity of 82%,<sup>5</sup> the PCP must also realize that an adolescent with a PHQ-9 score of  $\geq 10$  may have a condition other than depression.

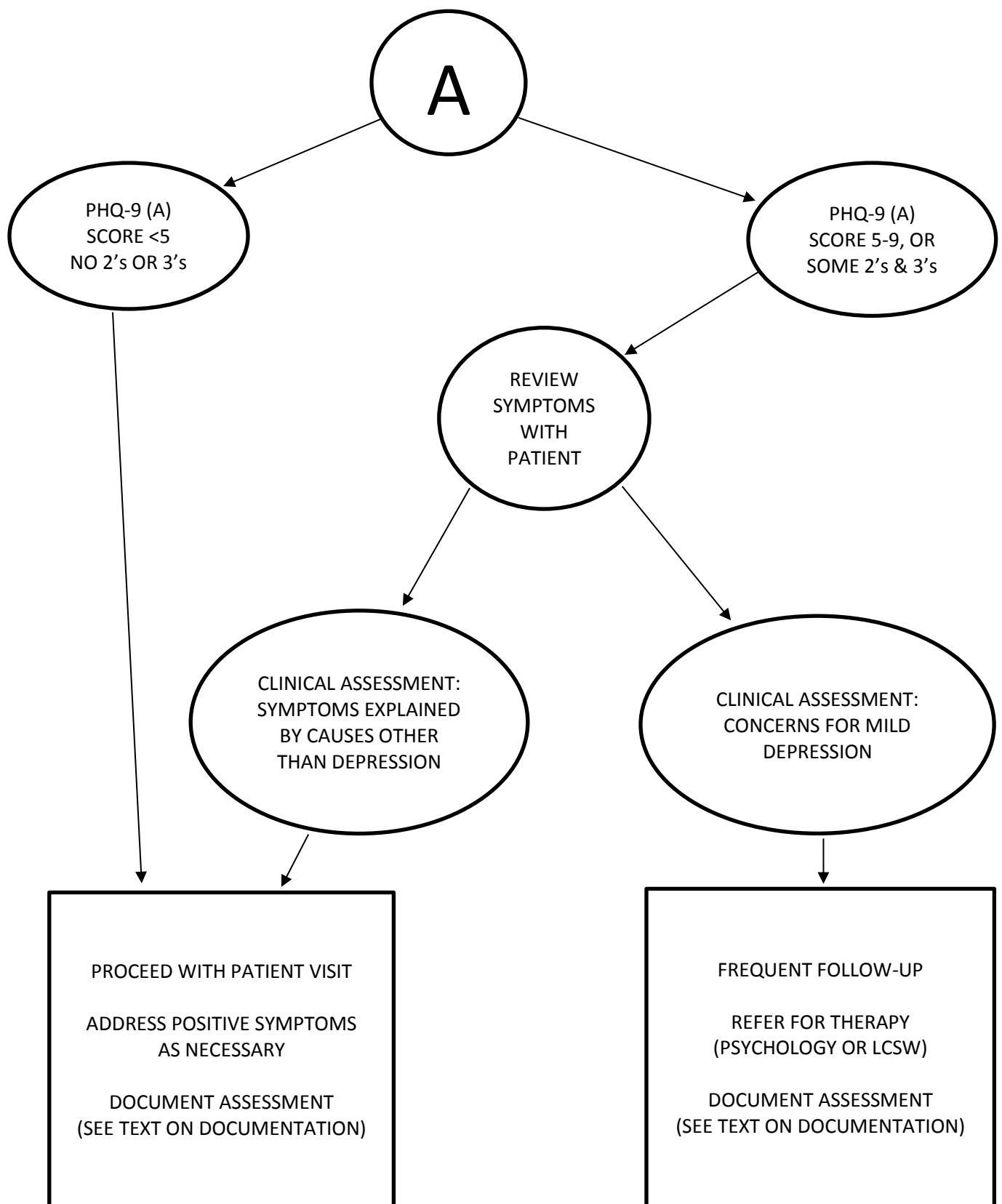
The P4 questionnaire is an effective screening tool to help clinicians determine a patient’s risk of suicide.<sup>8</sup> If a patient were to report suicidal ideation (such as with question 9 on the PHQ-9), the P4 questionnaire should then be used to inquire further about the likelihood of an actual suicide attempt.

The USPSTF recommends screening patients for depression only when adequate systems are in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.<sup>3</sup> The aim of this document is to provide PCP’s an aid to help them use the screening tools properly, document the encounter properly in the patient’s electronic medical record (EMR), make appropriate referrals, start the initial treatment, and manage crisis situations with suicidal patients.

## ALGORITHM FOR DEPRESSION SCREENING AND INITIAL TREATMENT IN ADOLESCENTS

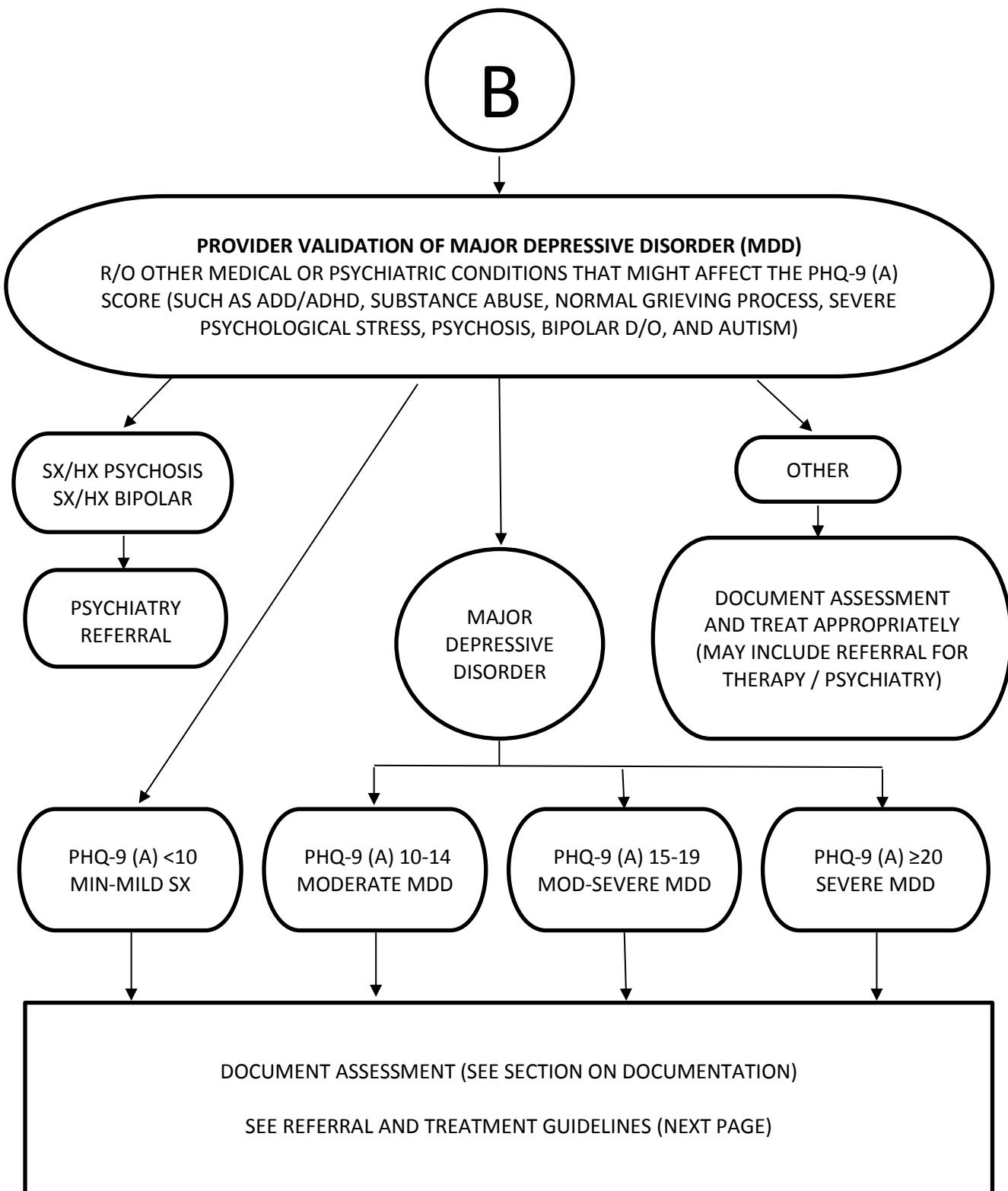


## ALGORITHM CONTINUATION FOR PHQ-9 (A) <10 WITHOUT SUICIDAL IDEATION



**ALGORITHM CONTINUATION FOR THE FOLLOWING:**

- 1) PHQ-9 (A)  $\geq 10$  WITHOUT SUICIDAL IDEATION
- 2) PHQ-9 (A)  $< 10$  WITH "MINIMAL" OR "LOWER" RISK ON P4 QUESTIONNAIRE
- 3) PHQ-9 (A)  $\geq 10$  WITH "MINIMAL" OR "LOWER" RISK ON P4 QUESTIONNAIRE



# REFERRAL AND TREATMENT GUIDELINES

## RECOMMENDATIONS BASED ON PHQ-9 SCORES

	<b>Score &lt;10</b>	<b>Score 10-14</b>	<b>Score 15-19</b>	<b>Score 20-27</b>
<b>PCP call / increase visit frequency</b>	Consider	All patients	All patients	All patients
<b>Referral: Therapy</b>	Consider	All patients	All patients	All patients
<b>Referral: Psychiatry *</b>		Consider	Consider	All patients
<b>Co-management</b>		All patients	All patients	All patients
<b>Medication **</b>	N/A	Consider	All patients	All patients

\* The decision to refer to psychiatry is affected by the availability of psychiatrists in the local area, the willingness of the patient/parents to pursue a referral to psychiatry, and the PCP's level of comfort when managing medications for depression. In many cases, medication management of depression is accomplished without a referral to psychiatry, depending upon the scope of the PCP's practice. PCP's may also refer to UNC Adolescent Medicine for evaluation and medication management of depression (984-974-6669).

\*\* Primary Care Provider should start medications (SSRI), even when planning to make a referral.

### Recommended Initial Follow-up Plans (Primary Care Provider)

- When starting or adjusting medications:
  - Telephone follow-up in one week (or sooner, if necessary)
  - Follow-up appointment (face-to-face) in two weeks and four weeks (additional appointments as necessary)
  - Follow-up plans, at that point, will be based on:
    - Response to treatment
    - Whether or not therapy has begun
    - Whether or not a psychiatry appointment has been planned (or has been made)
- If a medication has not been started:
  - Telephone follow-up in one week
  - Follow-up appointment (face-to-face) in four weeks (sooner, if symptoms are worsening)
  - Follow-up plans, at that point, will be based on whether or not therapy has been planned (or has begun)

### Psychiatry Referral Criteria

- Moderately-severe or severe depression
- Co-morbid substance abuse

- Co-occurring autism
- Psychotic or bipolar symptoms
- Severe psychosocial impact
- Previous episodes
- Prior suicide attempt
- Strong family history of depression that is refractory to treatment, or of bipolar disorder
- 2 failed SSRI trials
- Primary care clinician or parent discomfort with primary care clinician managing alone (eg, moderate depression).

### **While Awaiting a Referral**

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

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

- Established referral relationships
- Provide a “warm hand off” to both therapist and psychiatrist
- Standardized exchange of information with both therapist and psychiatrist.
  - See AAP-AACAP joint HIPAA statement on communication between PCP and MHP: [www.aap.org/mentalhealth](http://www.aap.org/mentalhealth)
  - Click on “Key Resources”, then “HIPAA Privacy Rule” and “Provider to Provider Communication”
- Shared record if integrated or co-located
- **Medication management of stable patients may be transitioned from psychiatry back to the PCP**

### **Referring Patients with Medicaid**

- North Carolina Medicaid Outpatient Mental Health Services Directory: <https://www.ncdhhs.gov/providers/lme-mco-directory>
- Outpatient Behavioral Health services include:
  - Assessment
  - Treatment (individual medical evaluation and management) including
    - Medication management
    - Individual and group therapy
    - Behavioral health counseling
  - Family therapy
  - Psychological testing

# PSYCHOPHARMACOLOGY 7, 9, 10

## **Medications for Use in Adolescents**

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

## **Fluoxetine**

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

## **Fluoxetine Pearls**

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

## **Sertraline**

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

## **Sertraline Pearls**

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

## **Escitalopram**

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

## SSRI Information for Patients and Families

- How SSRI's Can Help
  - Decrease overall depression and enable patients to be happy again
  - Decrease overall feelings of anger and irritability
  - Decrease feelings of hopelessness and worthlessness
  - Improve energy level
  - Improve concentration and memory
  - Stabilize appetite and sleep
  - Decrease getting "stuck" on certain worries / concerns / memories
- Expectations (When Starting an SSRI)
  - SSRI's can take 2-6 weeks to start working
  - SSRI's have to be taken every day to be most effective
- Short Term Side Effects
  - Stomach upset
  - Increased anxiety / jittery feelings / moodiness
  - Trouble with sleep (too tired or not able to sleep)
  - For patients under 26 years of age, possible increase in suicidal thinking (see Black Box Warning)
- Long Term Side Effects
  - May decrease interest in (or pleasure with) sex. This occurs in 20-30% of patients.
  - May cause weight gain (average 5 pounds in a year for adults)

### **Black Box Warning for Antidepressants (See Package Inserts for Complete Warnings)**

Suicidality and Antidepressant Drugs – Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. The average risk of events representative of suicidality was 4% in drug-treated patients, compared with 2% in placebo-treated patients during the initial few months of treatment. Prescribers are advised to observe patients closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers are advised of the need for close observation and communication with the prescriber.<sup>11</sup>

## **CRISIS MANAGEMENT PATIENT AT HIGH RISK FOR SUICIDE**

Patients who are “higher” risk for suicide (identified by P4 Questionnaire assessment or through patient’s stated plan/intent) should have an **immediate evaluation** from a psychiatrist or therapist trained in crisis management. This may be available through mental health providers in the practice (if one is immediately available), through the local Emergency Department, or through other resources in the outpatient setting (listed below).

It is important to differentiate between suicidal ideation and non-suicidal self-injury (NSSI), such as cutting. Adolescents who engage in NSSI are at greater risk of suicide (and suicide attempts), but evidence of NSSI does not always indicate that the adolescent has suicidal ideation. See **APPENDIX A** for a discussion of NSSI.

### **CRISIS MANAGEMENT RESOURCES:**

#### **1. Crisis Solutions North Carolina**

[www.crisissolutionsnc.org](http://www.crisissolutionsnc.org)

Crisis management information for **ALL NORTH CAROLINA COUNTIES**, including information about local 24 hour **WALK-IN CRISIS CENTERS** and contact information for 24 hour **MOBILE CRISIS TEAMS**. Mobile Crisis Teams provide on-site counselors for all crisis situations, including threatened suicide, regardless of age or insurance status (average response time of 2 hours). North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

#### **Frequently-used Crisis Management / Mobile Crisis Team Numbers:**

- Alamance (336) 538-1220
- Alexander (800) 849-6127
- Ashe (800) 849-6127
- Buncombe (800) 849-6127
- Caldwell (800) 849-6127
- Clay (800) 849-6127
- Chatham (877) 626-1772
- Cherokee (800) 849-6127
- Durham (919) 797-1865
- Forsyth (888) 581-9988
- Graham (800) 849-6127
- Guilford (877) 626-1772
- Haywood (800) 849-6127
- Henderson (800) 849-6127
- Jackson (800) 849-6127
- Johnston (877) 626-1772
- Lee (877) 626-1772
- Macon (800) 849-6127
- Madison (800) 849-6127
- McDowell (800) 849-6127
- Mitchell (800) 849-6127

- Moore (877) 626-1772
- Nash (800) 893-8640
- Orange (919) 967-8844
- Person (919) 967-8844
- Polk (800) 849-6127
- Randolph (877) 626-1772
- Rutherford (800) 849-6127
- Swain (800) 849-6127
- Transylvania (800) 849-6127
- Wake (877) 626-1772
- Watauga (800) 849-6127
- Wayne (800) 913-6109
- Wilkes (800) 849-6127
- Yancey (800) 849-6127

## **2. National Suicide Prevention Resource Center**

[www.sprc.org](http://www.sprc.org)

24 Hour Hotline (800) 273-8255

## **3. Hopeline NC**

[www.hopeline-nc.org](http://www.hopeline-nc.org)

24 Hour Hotline (919) 231-4525 or (877) 235-4525

## **4. Police**

If the police (or EMS) are needed (eg, if the patient is violent or in immediate danger), call 911 and specify the need for a **CRISIS INTERVENTION TEAM (CIT) OFFICER**.

## **RECOMMENDATIONS:**

**If the patient is experiencing suicidal ideation, has a plan and intent, and legal guardians/patient agree to seek further treatment:**

1. Transportation: Have the guardian or their designee transport to ED or crisis center.
2. Inform guardian that 911 and DSS will be called if they are not at the ED/crisis center within two hours.
3. Call ahead to where the patient is going to provide clinical information.
4. Document the encounter in the patient's electronic medical record in Epic (see section on "Documentation").
5. After two hours, call the receiving facility to ensure arrival (or if they are going to a UNC facility, look in Epic to confirm that they have arrived).
  - If they have not arrived, **call 911** and request a welfare check by law enforcement.
  - If they have not arrived, DSS for the County of the patient's residence should also be contacted.
  - If the two-hour mark is after hours and the provider who saw the patient is not available, the on-call provider assumes responsibility for the follow up.

**If the patient is experiencing suicidal ideation and has a plan, but no intent or immediate threat:**

1. Make an urgent referral to LCSW and/or external psychiatry practice/department.
2. The PCP or designee will conduct a follow up by phone with the guardian and/or patient within 2-3 business days.
3. Discuss with parents the importance of removing all potential weapons from the home (guns, kitchen knives, etc).
4. Plan for the patient to return to the office within two weeks for a follow up with the PCP or LCSW (if LCSW is available in the practice).
5. Document the encounter in the patient's electronic medical record in Epic (see section on "Documentation").
6. If the follow up appointment is missed and the patient/guardian has been unreachable by phone since their last visit, **call 911** and request a welfare check through the sheriff's department.
7. Consider DSS referral if concern for medical neglect.

**If the patient is experiencing suicidal ideation, has a plan and intent, but legal guardians/patient do NOT agree to seek further treatment:**

1. If the patient is violent or in immediate danger, call 911 and request a CIT (Crisis Intervention Team) officer.
2. Consider DSS referral for medical neglect (based on parents not consenting to psychiatric treatment for suicidal child). However, this is not lead to rapid resolution of the problem.
3. Involuntary commitment requires completion and notarization of the following form:  
<http://www.nccourts.org/Forms/Documents/661.pdf>
  - The form must be completed, notarized, and faxed to the office of the County Magistrate. The magistrate will fax back a commitment order.
  - Notaries Public are not always available in clinic. If this is the case, it will be necessary for someone to actually go to the magistrate's office to complete the form, in person.
  - Law enforcement personnel can refuse to transport a suicidal patient (adult or minor) until the involuntary commitment process has been completed (unless the patient is under arrest). However, if they are aware that the involuntary commitment process is underway (either via fax or in person at the magistrate's office), they will be able to stay with the patient (and keep them from leaving) until the process has been completed.
  - If the PCP is unsure about his/her assessment or uncomfortable with the process, Mobile Crisis Teams may be utilized (but the involuntary commitment form must be signed by a provider or therapist who has made an on-site assessment, **in person**).
4. Document the encounter in the patient's electronic medical record in Epic (see section on "Documentation").

## DOCUMENTATION

For patients seen within the UNC Healthcare System, the results for both the PHQ-9 (A) and P4 suicidality screener should be documented in the patient's EMR, within the Flowsheet tab in Epic. If these two questionnaires are not already present in the provider's Flowsheet toolbar, they may be added by clicking on the "wrench" icon in the upper right corner of the Flowsheet tab and then searching for either "PHQ-9" or "P4" in the Facility Preference List.

When data is entered into the PHQ-9 (A) flowsheet, results will be given as both numeric scores and as a description of the severity of symptoms. A score  $\geq 10$  suggests Major Depressive Disorder (MDD), but requires validation by the primary care clinician.<sup>7</sup>

- 0 (none)
- 1-4 (minimal)
- 5-9 (mild)
- 10-14 (moderate)
- 15-19 (moderately-severe)
- 20-27 (severe)

If the patient answers 1, 2, or 3 to question 9 of the PHQ-9 (A) questionnaire, the clinician will be directed to have the patient complete the P4 questionnaire. The P4 results will be given as one of three levels of risk for suicide.

- Minimal
- Lower
- Higher

The PHQ-9 (A) results can be pulled into the clinic note with the following dot phrase: ".PHQ9"

The P4 results can be pulled into the clinic note with the following dot phrase: ".P4"

## PHQ-9 (A) IN EPIC (FLOWSHEET):

Flowsheets

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Vital Signs Ambulatory Falls Risk... Domestic Abuse PHQ-2 Depression Screen PHQ-9 Depression Scale GAD-7 ANXIETY SCALE P4 Sui...

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**PHQ-9: Over the last 2 weeks, how often have you been bothered by any of the following problems?**

Little interest or pleasure in doing things	1
Feeling down, depressed, or hopeless; (age 12-17)	1
Feeling down, depressed, irritable, or hopeless	1
Trouble falling or staying asleep, or sleeping too much	2
Feeling tired or having little energy	3
Poor appetite or overeating; (age 12-17)	3
Poor appetite, weight loss or overeating	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down; (age 12-17)	3
Trouble concentrating on things, such as reading the newspaper or watching television; (age 12-17)	1
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or	1
Thoughts that you would be better off dead, or of hurting yourself in some way	2
Clinic Collected PHQ-9 Total Score	17
Have you had thoughts of actually hurting yourself?	

**PHQ-9 Total Score Depression Severity:**

PHQ-9 Total Score Depression Severity: Moderately ...

**PHQ-9(A) Additional Questions - age 12-17**

In the past year, have you felt depressed or sad most days, even if you felt OK sometimes?	No
If you are experiencing any of the problems on this form, how difficult have these problems made it for you	Somewhat di...
Has there been a time in the past month, when you have had serious thoughts of ending your life?	No
Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?	No

If the patient gives a positive answer (1, 2, or 3) to the 9<sup>th</sup> question ("Thoughts that you would be better off dead"), and additional 10<sup>th</sup> question will appear: "Have you had thoughts of actually hurting yourself?" If the patient answers "yes" to this question, the provider will be prompted to complete the P4 Questionnaire.

Thoughts that you would be better off dead, or of hurting yourself in some way	1
Clinic Collected PHQ-9 Total Score	19
Have you had thoughts of actually hurting yourself?	Y
<b>PHQ-9 Total Score Depression Severity:</b>	Moderately Sev
*****PHQ-9, Q10 is positive. Complete P4 suicide assessment to finish suicide screen*****	

Likewise, if the patient answers “yes” to the third “additional question” (“Has there been a time in the past month when you have had serious thoughts of ending your life?”), the provider will be prompted to complete the P4 Questionnaire.

Has there been a time in the past month, when you have had serious thoughts of ending your life?	<input type="checkbox"/> Yes
Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?	<input type="checkbox"/> No
*****Thoughts of self-harm. Complete P4 suicide assessment to finish suicide screen.*****	

## P4 QUESTIONNAIRE IN EPIC (FLOWSCHEET):

Flowsheets

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PHQ-9 Depression Scale GAD-7 ANXIETY SCALE P4 Suicidality Screener

Mode: Accordion Expanded View All

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5/24/17  
**1300**

**Initial Suicide Screening Question: active vs. passive thoughts**

Have you had thoughts of actually hurting yourself?

**P4 Suicidality Screener**

1 - Have you ever attempted to harm yourself in the past?  
2 - Have you thought about how you might actually hurt yourself? If  
3 - There's a big difference between having a thought and acting on a  
4 - Is there anything that would prevent or keep you from harming

**Suicide Risk Summary**

P4 - Acute Suicide Risk Level

**Clarifying questions: if unclear if patient has a plan**

Do you live alone?  
Have you thought about taking an overdose of medication, driving  
Do you own a gun?  
Have you been stockpiling (saving up) medications?  
Do you feel hopeless about the future?  
Do you feel you can resist your impulses to harm yourself?  
Right now, how strong is your wish to die?

**DOCUMENTING THE PATIENT ENCOUNTER IN THE CLINIC NOTE (PROVIDERS ARE ENCOURAGED TO MAKE THEIR OWN “DOT PHRASES” IN EPIC, TO ENSURE THAT DOCUMENTATION IS CONSISTENT, ADEQUATE, AND APPROPRIATE):**

**Documentation of PHQ-9 results in the clinic note should include the following:**

- Numeric score – The dot phrase “PHQ9” (or “@FLOW(2100100060)@” added to a note template) may be used to bring the numeric score from the flowsheet section of Epic into the clinic note.
- Clinical assessment or diagnosis, if made (such as “symptoms of mild depression”, “moderate major depressive disorder”, “moderately-severe major depressive disorder”, or “severe major depressive disorder”)
- If a diagnosis of “depression” is made (including “depression”, “depressed mood”, or “major depressive disorder”), a statement of suicide/self-harm risk assessment should be included (such as “no suicidal ideation”, “minimal risk of suicide on P4 Questionnaire”, or “lower risk of suicide on P4 Questionnaire”)
- Plan for referrals (therapy or psychiatry), including specific information about receiving therapists/psychiatrists and appointment dates/times, if that information is available.
- Plan for follow-up (including telephone and in-person follow-up)
- If the assessment is that an elevated PHQ-9 score is due to factors other than depression, discuss the reasoning behind this assessment:
  - Other psychiatric/psychological diagnoses
    - For instance: “The patient has ADD. The insomnia and anorexia reported on the PHQ-9 are most likely side effects of methylphenidate (and these symptoms are not present when she does not take this medication). We discussed the results of the PHQ-9, and she did not report any other symptoms of depression.”
  - Symptoms are not due to a specific diagnosis
    - For instance: “The patient reported significant problems with inadequate sleep (score of 3) on the PHQ-9. We discussed this problem; he has been voluntarily staying up late at night for the past two weeks to study for upcoming exams. This is a temporary problem, and although he reports feeling somewhat sleep-deprived, he says that he is coping with the added stress. We discussed the importance of adequate sleep, especially when trying to do well on exams, and we discussed a plan for him to get to bed by 11:00 pm, even when studying for exams.”
- If other conditions are identified, document the plan for further assessment, follow-up, and treatment as above.

**When starting/continuing an SSRI to treat depression, the clinic note should include documentation of the following:**

- The medication and dose
- Follow-up plan, including the plan for dose escalation (if applicable) and plan for transferring medication management to a psychiatrist (if applicable)
- Discussion about expectations for treatment, including the fact that it might take 2-6 weeks for the effects of an SSRI to become apparent (when starting/adjusting the dose)

- Discussion about possible side-effects when starting an SSRI
- Discussion of the BLACK BOX WARNING for increased risk of suicidal thoughts when starting an SSRI (and that they should return immediately for an assessment if this were to happen)

**Patients with “HIGHER” risk of suicide (based on P4 Questionnaire or patient’s stated plan/intent) should have the following documented in the encounter note:**

- Statement of suicide risk assessment (“Higher risk of suicide on P4 Questionnaire”)
- Associated risk factors (such as a stated plan or access to a weapon)
- Protective factors (in place to prevent a suicide attempt, such as supervision by a competent parent or law enforcement personnel)
- Plan for further assessment or treatment (including facility, receiving therapist/provider, and time the patient left your care)
- Whether continued care is voluntary or involuntary (and if the plan includes involuntary commitment, documentation of how the order was obtained)
- Documentation of patient arrival at the receiving facility

**Additions to the patient’s After Visit Summary (AVS) – The following phrases (or similar phrases) may be incorporated into dot phrases and added to the patients AVS:**

**Medications for Depression:**

The medication that has been prescribed is generally safe, and dangerous side effects are rare. Common side effects include upset stomach (or even constipation or diarrhea), changes in appetite, problems sleeping (or being too tired), headache, dry mouth, and sexual dysfunction. If your child develops a rash, contact your doctor immediately. If your child becomes agitated, silly, speaks too fast, or seems over-energetic, call your doctor immediately – it could mean that the medication dose is too high, or that a different medication would be a better choice.

**Risk of suicide:**

Patients with depression are at an increased risk for suicide. To minimize the risks of a suicide attempt, it is important for you to remove or lock up guns, razors, sharp knives, ropes, alcohol, and medications. Talk with your child about suicide – it is important to know if your child is having suicidal thoughts. Asking about suicide does NOT promote suicide, but it does help prevent suicide.

It is possible for children, adolescents, and young adults to develop suicidal thoughts while on medications for depression. We will monitor your child very closely in the first few weeks of medical treatment, to ensure that side effects are tolerable and that suicidal thoughts are not present. Please call your doctor right away if your child develops suicidal thoughts, unusual changes in behavior, or other intolerable side effects.

## LEGAL CONSIDERATIONS

### **1. Can minors provide their own consent for the treatment of depression, or for referrals for psychotherapy or psychiatry (without the knowledge of their parent/guardian)?**

Yes. North Carolina General Statute (NCGS) 90-21.5 states that a minor may provide their own consent for “medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance.”<sup>12</sup> Note that this does not include admission to an inpatient psychiatric facility, unless it is an emergency.

If the minor is being seen within the UNC system (by a PCP, therapist, or psychiatrist) and is giving consent for their own treatment, they will need to sign a new patient consent to treat form before treatment can begin; this is especially important if the minor is an established patient and the parent/guardian has previously signed the consent to treat form for the minor’s treatment – consent forms signed by the minor will cover only the conditions listed in NCGS 90-21.5 (including the treatment of depression), but consent forms signed by the parent/guardian will cover all other areas of the minor’s medical care. The minor’s health insurance (through his/her parents) may be used, but the minor should be told that the parent/guardian will become aware of the appointments when the insurance EOB and/or the bill arrive in the mail. If this is unacceptable to the minor and they still want to have treatment for depression without the knowledge or consent of the parent/guardian, the minor would be responsible for the cost of treatment (and insurance should not be filed).

### **2. Can minors consent to treatment for depression with medications (even without the knowledge of their parent/guardian)?**

Yes. However, the patient should be reminded that the parent/guardian will become aware that a medication has been prescribed if the insurance is filed (an EOB will arrive in the mail); the minor should be prepared to pay out-of-pocket for the medication and tell the pharmacist not to file the insurance. Also, if the provider is prescribing a medication that has a black box warning (or a risk of significant side effects), the provider must decide whether or not they feel comfortable doing so without involving the parent/guardian in the treatment plan. The provider should assess the minor’s capacity to understand the risks associated with the medication before prescribing it, and if the provider believes that the minor does not understand the risk (or that the risk is unacceptable without adult supervision), the minor should be encouraged to inform the parent/guardian of the diagnosis and treatment plan. In this instance, the parent/guardian may be informed of the plan while the minor still provides the consent for treatment. If the minor still refuses to inform the parent/guardian, the provider can decide to go against the wishes of the minor and notify the parent/guardian if the provider determines that notification of the parent/guardian “is essential to the life or health of the minor”, according to NCGS 90-21.4.<sup>13</sup>

### **3. Can minors consent to inpatient hospitalization?**

No.

#### **4. How is HIPAA applied, particularly when it relates to parents/guardians, when treating minors for depression in primary care?**

##### **Release of information to the parent/guardian, if the minor is consenting to treatment:**

Under NC law, NCGS 90-21.4<sup>13</sup> and 90-21.5<sup>12</sup>, if the minor is consenting to the treatment on his/her own, then the provider cannot disclose information to the parent/guardian about the minor's treatment unless:

- (1) The minor signs an authorization to release copies of records to the parent or the minor gives permission (documented in the medical record by the provider) to release oral information to the parent/guardian;
- (2) In the opinion of the provider, notification of the parent/guardian about the minor's treatment is essential to the life or health of the minor (documented in the medical record by the provider); or
- (3) The parent/guardian contacts the provider to enquire about the minor's treatment (the parent/guardian, not the provider, must initiate the contact); in this case, the provider may voluntarily discuss the diagnosis and treatment plan with the parent/guardian, although the provider is not obligated to do so. While it would be "legal" for the provider to discuss the minor's medical information with the parent/guardian in this instance, the impact on the therapeutic relationship with the minor must be considered, especially if the provider has promised the minor that information would not be shared. This would cover the release of oral information, but the provider should document the conversation in the medical record (including the reasons why the provider chose to share the information).

##### **Release of information to a party other than the parent/guardian, if the minor is consenting to treatment:**

If the minor is consenting to the treatment, they would need to sign the appropriate UNC Health Information Management (HIM) forms to release medical information (i.e., to a new medical provider).

##### **Release of information to the parent/guardian, if the parent/guardian is consenting to treatment:**

If the parent/guardian is consenting to treatment, then they have access to the patient's records upon request (without consent from the minor); UNC HIM procedure must be followed to release copies of the records. To deny a written request from a parent/guardian for records, the appropriate UNC HIM procedure must also be followed.

Consult your local legal/risk management department with specific questions about minors consenting to treatment or patient privacy.

#### **Useful Links:**

US Department of Health and Human Services: HIPAA Privacy Rule and Sharing Information Related to Mental Health:

<https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html>

American Academy of Child and Adolescent Psychiatry (AACAP) and the American Academy of Pediatrics (AAP) statement: HIPAA Privacy Rule and Provider to Provider Communication:

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/HIPAA-Privacy-Rule-and-Provider-to-Provider-Communication.aspx>

## SCREENING TOOLS

**Link to PHQ-9 Modified for Adolescents:**

[https://collab.unchealthcare.org/sites/etd/Population%20Health/Supporting%20Documents/Printable%20PHQ-9%20\(A\)%20for%20adolescents.pdf](https://collab.unchealthcare.org/sites/etd/Population%20Health/Supporting%20Documents/Printable%20PHQ-9%20(A)%20for%20adolescents.pdf)

This version includes four additional questions that are often included with the PHQ- 9 (A).

**Link to P4 Questionnaire:**

<http://gerocentral.org/wp-content/uploads/2013/04/P4-Suicide-Risk-Screener.pdf>

**Link to Mood Disorder Questionnaire (MDQ) – Screening Tool for Bipolar Disorder:**

<http://www.integration.samhsa.gov/images/res/MDQ.pdf>

## PHQ-9 modified for Adolescents (age 12-17)

**Over the last 2 weeks, how often have you been bothered by any of the following:**

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Feeling down, depressed, irritable or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Trouble falling asleep, staying asleep, or sleeping too much?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Feeling tired or having little energy?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Poor appetite, weight loss or overeating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Trouble concentrating on things like school work, reading or watching TV?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. Thoughts that you would be better off dead or of hurting yourself in some way?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

If response to question 9 is in shaded squares, answer question 10 below.

If response to question 9 is 0 → STOP.

10. Have you had thoughts of actually hurting yourself?	YES	NO
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**Staff:** Add score for 9 questions. Enter all information in PHQ-9 doc flowsheet.

If question 10 response if YES, a P4 ASSESSMENT IS NEEDED.

### Additional Questions

In the past year have you felt sad or depressed most days, even if you felt okay sometimes	YES	NO		
If you are experiencing any of the problems listed on this form, how <b>difficult</b> have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
Has there been a time in the past month when you had serious thoughts about ending your life?	YES	NO		
Have you <b>EVER</b> in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?	YES	NO		

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[http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter\\_90/GS\\_90-21.4.pdf](http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_90/GS_90-21.4.pdf)

## APPENDIX A:

### **Non-Suicidal Self-Injury (NSSI)**

Many adolescents who engage in self-harm do not intend to take their life; however, those engaging in repeated self-harm have a higher risk of suicide attempts and suicide. Thus, any adolescent who reports self-harm requires a safety assessment to determine their level of imminent danger. Adolescents intending to take their life and expressing active suicidality require immediate referral and crisis management. Studies assessing intervention to treat and/or prevent non-suicidal self-injury are limited; existing evidence suggests that Therapeutic Assessment, Dialectal Behavior Therapy, and Mentalisation may reduce recurrence of non-suicidal self-injury (NSSI). If possible, adolescents who report NSSI should be referred to a mental health provider who uses these interventions.

Adolescents use NSSI as a coping strategy for a variety of reasons, including to distract themselves from intense emotional pain or to help reconnect when they are feeling “numb” or “empty.” The most common types of NSSI are cutting, carving, scraping, scratching, banging/hitting and burning. Prevalence of NSSI ranges from approximately 18% in the general population to as high as 60% in psychiatric populations, peaking around mid-adolescence (age 15-16 years).

Before leaving the office, the patient engaging in NSSI requires guidance to reduce risk associated with the NSSI. Providers should consider asking about onset, frequency and methods of NSSI. While adolescents experience relief from NSSI they are often ashamed or afraid of “getting caught.” They may not reveal the extent of NSSI and thus having the patient change into a hospital gown allows all possible affected areas of injury to be assessed. Validate the relief adolescents experience with the use of NSSI and discuss dangers if they accidentally inflict too much injury as well as care needed to prevent complications. Discuss other possible means of stress relief (see below).

#### **Guidance for Parents/Caregivers:**

Parents should be given information and resources about NSSI. Often parents react with anger, frustration or extreme distress when they learn their adolescent is engaging in self-harm. Unfortunately, this generally does not stop adolescents from engaging in NSSI and leads to adolescents hiding their NSSI. Parent should try to remain calm, non-judgmental and compassionate when addressing NSSI with their teen. They should acknowledge/validate the difficult event or intense emotion that leads to the NSSI even if it seems trivial. Trying to convince adolescents that their intense emotions are not serious (or worth concern) typically only contributes to the adolescents’ sense of feeling isolated. To help adolescents better regulate these intense feelings, parents should seek help from their primary care provider or mental health provider.

#### **Immediate safety steps:**

- Clean the wounds and apply antiseptic
- Ensure tetanus vaccination is up to date
- Apply sunscreen to areas that are uncovered
- Remove/lock up all weapons in the home
- Consider referral to dermatology or plastic surgery for management of permanent scarring
- Identify safer means of stress-relief
  - Stress balls, homemade “play doh” or “slime”
  - Rubber band on wrist

- Spinners
- Pinch webbing between thumb & index
- Holding ice
- Journaling, drawing, coloring
- Listening to music, dancing
- Smart phone apps such as Mindshift, Calm, and Virtual Hopebox

**Resources:**

Book: *Helping Teens Who Cut*, by Michael Hollander (for parents)

Workbook: *Stopping the Pain: A Workbook for Teens Who Cut and Self Injure* (for adolescents)

**Websites:**

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/self-harm-and-suicide.aspx> (Video demonstration of motivational interviewing to address self-harm and suicide)

<http://www.therapistaid.com> (includes worksheets, handouts and other tools that can be printed and shared with adolescents and/or parents)

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