Depression in Children and Adolescents

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Depression in Children and Adolescents

Prevalence

It's more common than you think. Rates of major depressive disorder (MDD) are estimated at 2 percent in childhood and 4 – 8 percent in adolescence. Rates are equal in males and females until puberty, when the ratio increases in females by 2:1, which is more in line with adult ratios. The cumulative incidence by age 18 years is approximately 20 percent of community samples. Additionally, 5 – 10 percent of children and adolescents have subsyndromal symptoms of MDD – these youth may have considerable psychosocial impairment and an increased risk of suicide despite not meeting diagnostic criteria of MDD.

The complications associated with MDD are significant. Of greatest concern is the relationship between MDD and suicide, with approximately 60 percent reporting having thought about suicide and 30 percent actually attempting suicide. Pediatric patients with MDD are also at higher risk of substance abuse; legal problems; physical illness; early pregnancy; exposure to adverse life events; and poor work, academic and psychosocial functioning.

Symptoms

The DSM defines MDD as at least two weeks of persistent change in mood, manifested by either depressed or irritable mood, or loss of interest or pleasure. The person must also have at least four of the following during the same time period: changes in sleep, changes in appetite, decreased concentration, decreased energy, feelings of worthlessness/guilt/hopelessness, decrease in interest, anhedonia, psychomotor agitation or retardation, and suicidality.

These symptoms must represent a change from previous functioning and produce impairment in social, occupational or other important areas of functioning.

While some of these symptoms are seen in the pediatric population, there are differences that are attributable to children's physical, emotional, cognitive and social developmental stages. Common symptoms in depressed children are:

- Mood lability
- Irritability
- Low frustration tolerance
- Temper tantrums
- Aggression
- Decline in school performance
- School refusal
- Somatic complaints
- Social withdrawal
- Low self-esteem

Children have fewer melancholic and psychotic symptoms than adults do. Also, while children and adolescents can suffer from seasonal affective disorder (SAD), it is important to differentiate this from depression triggered by school stress, as both coincide with the school calendar.

Finally, comorbidity is frequent in psychiatric conditions. Of youths with depressive disorder, 40 – 90 percent have other psychiatric disorders, most often anxiety, but also disruptive disorders and attention deficit hyperactivity disorder (ADHD). Due to this, any patient suspected of having depression should be screened for other psychiatric conditions.

Differential Diagnosis

The differential diagnosis of depressive symptoms includes both psychiatric and medical disorders, and these may co-occur as well as mimic MDD. Other mental health issues that may be considered in a youth with changes in mood include the following:

- Normal moodiness of adolescents (generally not associated with changes in functioning)

- Dysthymic disorder
- Substance-induced mood disorder
- Adjustment disorder with depressed mood
- Adjustment disorder with depressed mood and anxiety
- Anxiety disorders
- Post-traumatic stress disorder (PTSD)
- Depressive episode of bipolar disorder*
- Eating disorders
- ADHD
- Oppositional defiant disorder (ODD)

Because some patients may have a medical etiology for their symptoms, it is imperative to rule out medical causes of depressive symptoms prior to any mental health treatment or referral. No imaging or lab tests are routinely required; however, the medical work-up should be guided by history and a physical. The differential diagnosis of depressive symptoms in children and adolescents includes the following medical conditions:

- Thyroid disorders
- Autoimmune disorders
- Premenstrual dysphoric disorder
- Anemia
- Mononucleosis
- Medication side effects (steroids, oral contraceptive pills, etc.)

***A special note about bipolar disorder:** Because most youths presenting to treatment are experiencing their first episode of depression, it is difficult to differentiate whether their depression is part of unipolar major depression or the depressive phase of bipolar disorder. Bipolar disorder is less common in children and adolescents than in adults. However, because pediatric patients with bipolar disorder can have significant adverse effects when treated with antidepressants, it is critical to obtain any history of past or current mania symptoms, such as elevated mood (happy, irritable or both), decreased need for sleep, high energy, increased speech, increased thoughts, grandiosity, acting silly or inappropriate, and poor judgment, all lasting for at least several days. These symptoms often are overlooked, and these children and adolescents may be more likely to become manic when treated with antidepressant medications. Other factors such as high family loading for bipolar disorder, psychosis, and history of pharmacologically induced mania or hypomania indicate a higher risk for bipolar disorder. It is also important to note that not all children who become activated or hypomanic while receiving antidepressants have bipolar disorder.

Diagnosis

The diagnosis of MDD is a clinical one, based on history and physical exam. However, several diagnostic tools have been developed based on the DSM 5 criteria and validated in pediatric populations. These can be helpful to conceptualize and quantify the experience related by patients and their families. This toolkit includes two of the most commonly used diagnostic tools, the Patient Health Questionnaire-9: Modified for Adolescents (PHQ-A) and the Center for Epidemiological Studies Depression Scale for Children (CES-DC). In addition, many health centers have begun incorporating brief depression screens at each office visit. The most commonly used screen is the PHQ-2, an abbreviated form of the PHQ-9, which has been validated in adolescents and consists of the following questions:

Over the past two weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Treatment

The mainstays of depression treatment are therapy and medications. For all children and adolescents with depression, psychoeducation, supportive management, psychotherapy, and family and school involvement are critical, regardless of severity. School assistance can be enlisted in the form of accommodations until recovery is achieved, up to and including an individualized education program (IEP) if needed.

Psychoeducation refers to education of family members and the patient about the causes, symptoms, course, and different treatments of depression and the associated risks with these treatments as well as no treatment at all. Depression is presented as an illness, not a weakness, and has genetic and environmental contributions. The difficulties that the patient experiences in function are not manipulation but manifestations of an illness.

Supportive management includes active listening and reflection, restoration of hope, problem-solving, coping skills and strategies for maintaining participation in treatment.

Family involvement is critical to the successful treatment of children and adolescents. Motivation for treatment often comes from the caregivers, such that treatment planning must involve them. Caregivers also observe aspects of the child's functioning or symptoms that the child may not be aware of or want to disclose, providing vital information for the development of an effective treatment plan. Also, it is critical that families secure all medications and any potential weapons to help prevent self-injury.

Lifestyle choices – family members are able to monitor the child's progress and implement behavioral and lifestyle strategies that are part of the treatment plan such as supporting diet and exercise recommendations, maintaining good sleep, hygiene, encouraging positive activities and pro-social behaviors by the child, and adjusting behavior management approaches until the child's depression improves.

Psychotherapy has been shown to be effective in treating young people with depression. Two types of therapy have been studied extensively and have a strong evidence base for use in pediatric populations:

1. Cognitive behavioral therapy (CBT) is based on the principal that one's thoughts, feelings and behaviors affect one another. The goal of treatment is to modify the negative thoughts and behaviors in the expectation that this will break the depressive cycle. This is done by cognitive restructuring, body awareness and the development of personal coping strategies.
2. Interpersonal therapy for adolescents (IPT-A) is based on the principal that depression occurs in an interpersonal context. The goal of treatment is to address the interpersonal problems that may be contributing to or resulting from the patient's depression.

Awareness that a patient's depression may often be, in part, a response to the caregiver's behavior due to his or her own mental illness is helpful, as referrals for caregivers to their own individual or family psychotherapy can be a significant part of a successful treatment plan.

Pharmacotherapy is for more complicated depression or mild disease that has not responded to psychotherapy, so a trial of antidepressants is indicated. The only U.S. Food and Drug Administration-approved antidepressants for pediatric patients are fluoxetine (8 years and older) and escitalopram (12 years and older). In practice, citalopram and sertraline have been used as well, especially if there is caregiver preference or a specific contraindication. The common adage in pediatric psychopharmacology holds here: start low, go slow. This is to avoid unwanted side effects and improve adherence.

The table on the back details the dosing of the most common selective serotonin reuptake inhibitors (SSRIs) used in children.

SSRIs can take four to six weeks at an adequate dose to produce improvement in symptoms. However, in practice, children will usually show improvement within two to three weeks at a therapeutic dose. Thus, if a patient's symptoms have not begun to improve after two to three weeks, the dose may be increased to the next increment and the child reassessed in another three to four weeks.

If an antidepressant dose has been maximized and maintained for at least four weeks but no improvement in symptoms is noted or major side effects are experienced, a different SSRI should be used. A **cross-titration approach** may be used in which the first SSRI is tapered by the following increments and intervals, and the second SSRI is titrated as in the table on the back page:

Medication	Tapering Increment	Time Interval
Fluoxetine	10 mg	1 – 2 weeks
Sertraline	25 mg	1 – 2 weeks
Citalopram	10 mg	1 – 2 weeks
Escitalopram	5 mg	1 – 2 weeks

If the child has reached maximum dosing on two separate SSRIs and failed to improve, referral to a child psychiatrist is indicated for further care.

Some common side effects of SSRIs include the following:

- Dry mouth
- Constipation
- Diarrhea
- Sweating
- Sleep disturbance
- Sexual dysfunction
- Irritability
- Disinhibition (risk-taking behaviors, increased impulsivity or doing things that the youth might not otherwise do)
- Agitation or jitteriness
- Headache
- Appetite changes
- Rashes

Some other, more serious side effects include the following:

- Serotonin syndrome (fever, hyperthermia, restlessness, confusion, etc.)

DOSING OF THE MOST COMMON SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs) USED IN CHILDREN					
Medication	Starting Dose (daily)	Increments	Effective Dose (daily)	Maximum Dose	Pearls
Fluoxetine (Prozac®)	5 – 10 mg	5 – 20 mg	20 – 40 mg	80 mg	» Dose in the AM, as tends to be activating » Half-life is 2 – 5 days, so consider for patients with suboptimal compliance » Potent CYP2D6 inhibitor
Escitalopram (Lexapro®)	2.5 – 5 mg	2.5 – 5 mg	10 – 20 mg	20 mg	» May dose in PM if sedating
Sertraline (Zoloft®)	12.5 – 25 mg	12.5 – 5 mg	50 – 100 mg	200 mg	» May be divided BID due to more rapid metabolism in prepubertal patients » May be activating or sedating for some patients – time dose accordingly
Citalopram (Celexa®)	5 – 10 mg	5 – 10 mg	20 – 40 mg	40 mg	» Cardiac arrhythmias associated with higher doses

- Akathisia
- Hypomania
- Discontinuation syndrome (dizziness, drowsiness, nausea, lethargy, headache)

Most importantly, when discussing the risks, benefits and side effects with patients and parents, **DO NOT FORGET THE BLACKBOX WARNING** regarding increased suicidality in adolescents on SSRIs.

Acute phase treatment should continue until symptoms resolve, not just improve. Because the typical course of depression is nine months, medication should continue for six to 12 months *after* resolution of symptoms. Once stabilized, follow-up appointments should occur monthly to check efficacy of medication, evaluate target symptoms, and monitor for adverse reactions and medication compliance.

Because relapse rates are 20 – 40 percent within two years and 70 percent in adulthood, some depressed youth may need two years or more of maintenance to prevent relapse.

When discontinuing medication, taper off by decreasing medication by similar increments of titration every one to two weeks.

SOURCES

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Suicide Risk Assessment in Children and Adolescents

Suicide Risk Assessment

- Standard of care exists not to predict suicide, but to perform an adequate risk assessment and to take necessary measures to address or mitigate that risk.
- Suicide risk assessment takes into account risk factors for suicide, severity/imminence of intent to harm self and any protective factors.
- It will identify any **modifiable risk factors** for acute and long-term intervention and will help assess the patient's **immediate** safety and determine the most appropriate setting for treatment (inpatient vs. outpatient).
- Risk may **fluctuate** depending on a variety of chronic and acute factors.

Unique Factors to the Pediatric Population

- Social media
- Bullying/cyberbullying
- Pacts/promises with other peers
- Impulsive gesture in response to acute precipitant or trigger
- Threatening to harm self/others when limits are placed or privileges are lost
- Threatening to harm self in order to avoid going to school or facing legal consequences

Assessing for Suicidal Ideation and Intent in Children and Adolescents

Consider the child's level of cognitive development.

- What is his or her understanding of the finality of death?
- Does he or she want to die, or does he or she want a negative feeling to go away/end?
- Is reporting suicidal ideation his or her way of expressing feelings of sadness or avoiding something unfavorable?
- Use concrete questions with younger children.

Dangerous/risk-taking behavior may not be a result of suicidal intent, but rather impulsivity/poor judgment.

- Examples: Running into traffic, jumping off roofs, etc.
- Elicit the motivation for this behavior.
  - » Is this something that he or she can control, or does it feel out of his or her control?

Examples of questions to ask:

- "Do you wish you were dead?"
- "How long have you been feeling this way?"
- "How often do you have thoughts of hurting yourself?"
- "What makes the thoughts worse/better?"
- "Are there things/people in your life that you feel are worth living for?" or "Who would miss you if you were dead?"
- "What would stop you or what stops you from hurting yourself?"
- "Did you wake up today with suicidal thoughts?"
- "What did you think/hope would happen when you (cut yourself/took pills/harmed yourself)?"
- "What steps have you taken to attempt suicide?"
- "Do you have access to firearms?" or "Are there guns in your home?"

Risk Assessment

- Acute and chronic risk
- Level of severity: minimal/moderate/severe
- Document risk assessment and steps taken to address the risk including any appropriate follow-up plans

Suggestions for Documenting Suicidal Ideation in the Pediatric Population

Step 1: Define and document the situation.

Example: John is an 11-year-old who reported having suicidal thoughts after he got in trouble at school for being disrespectful to his peer. He reported that he just made that statement because he was angry at his teacher for sending him to the principal's office. He denied having a plan or any intent to act on his thoughts and has no history of suicidal behavior.

Step 2: Assess and document the current suicide risk.

Example: Sue is a 16-year-old white female with a history of depression and chronic pain from juvenile rheumatoid arthritis who presents today with cutting herself to relieve her pain. Given patient's static and modifiable risk factors (female, 16 years old, chronic illness, no previous suicide attempt or behavior, currently free from suicidal thoughts) and protective factors (good social support, fear of suicide), her acute risk of harm is low.

Step 3: Document how dynamic or protective factors have been modified or addressed in current (and prior) treatment.

Example: Jim is a 17-year-old male with a history of mood disorder who presented to the ER making statements that he wished he was dead after he smoked cannabis and ETOH intoxication. Jim has been observed to be sober in the ER, and he is currently denying any suicidal thoughts and doesn't recall saying he was suicidal. Jim has a long-standing history of cannabis and ETOH use. It has been recommended to Jim's parents several times that they engage in an adolescent detox program, but his family refuses recommended interventions to address his substance use or his mental health. His family is aware that not addressing his modifiable risk factors could increase his risk of suicide.

Step 4: Document your discussion of the treatment rationale with the patient's guardian and the guardian's understanding of the discussion. This is especially important if the family is disagreeing with the recommendation.

Example: John is an 8-year-old autistic male who presents today for ongoing behavior issues and a history of self-injurious behavior. John's mom is seeking admission for John to an inpatient child psychiatric unit. At this time, there does not appear to be an acute psychiatric issue that would require emergent interventions. The patient is safe to go home and follow up with his outpatient providers. John's mom became angry and did not want to engage in productive discussion around this issue. I believe John's mom has a good understanding of treatment recommendations and John is appropriate to be discharged back home under the supervision of the mom.

Step 5: Seek consultation from a child psychiatrist if you are uncertain how to document appropriately.

Reference: Bundy, C, Schreiber, M, & Pascualy, M. Discharging your patient who displays contingency-based suicidality: 6 steps. Current Psychiatry. 2014;13(1).

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Center for Epidemiological Studies
Depression Scale for Children (CES-DC) - Age 6 - 17 Instructions

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20-item self-report depression inventory with possible scores ranging from 0 to 60. Each response to an item is scored as follows:

0 = "Not at All"
1 = "A Little"
2 = "Some"
3 = "A Lot"

However, items 4, 8, 12 and 16 are phrased positively, and thus are scored in the opposite order:

3 = "Not at All"
2 = "A Little"
1 = "Some"
0 = "A Lot"

Higher CES-DC scores indicate increasing levels of depression. Weissman et al. (1980), the developers of the CES-DC, have used the cutoff score of 15 as being suggestive of depressive symptoms in children and adolescents.

REFERENCES

Weissman MM, Orvaschel H, Padian N: Children's symptom and social functioning self-report scales: Comparison of mothers' and children's reports. Journal of Nervous Mental Disorders 168(12):736–740; 1980.

Faulstich ME, Carey MP, Ruggiero L, et al.: Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC). American Journal of Psychiatry 143(8):1024–1027; 1986.

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Center for Epidemiological Studies
Depression Scale for Children (CES-DC) - Age 6 to 17

Name: _____ Age: _____ Sex: Male ☐ Female ☐ Date: _____

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

During the past week	Not at All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating or I wasn't very hungry.				
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.				
4. I felt like I was just as good as other kids.				
5. I felt like I couldn't pay attention to what I was doing.				

During the past week	Not at All	A Little	Some	A Lot
6. I felt down and unhappy.				
7. I felt like I was too tired to do things.				
8. I felt like something good was going to happen.				
9. I felt like things I did before didn't work out right.				
10. I felt scared.				

During the past week	Not at All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.				
12. I was happy.				
13. I was more quiet than usual.				
14. I felt lonely, like I didn't have any friends.				
15. I felt like kids I know were not friendly or that they didn't want to be with me.				

During the past week	Not at All	A Little	Some	A Lot
16. I had a good time.				
17. I felt like crying.				
18. I felt sad.				
19. I felt people didn't like me.				
20. It was hard to get started doing things.				

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For office use only

Score: _____

Severity Measure for Depression – Age 11 – 17*

*PHQ-9 Modified for Adolescents (PHQ-A) – Adapted

Name: _____ Age: _____ Sex: Male ☐ Female ☐ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past seven days? For each symptom, put an "X" in the box beneath the answer that best describes how you have been feeling.

		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	**Item Score** *Clinician Use*
1	Feeling down, depressed, irritable or hopeless?					
2	Little interest or pleasure in doing things?					
3	Trouble falling asleep, staying asleep or sleeping too much?					
4	Poor appetite, weight loss or overeating?					
5	Feeling tired or having little energy?					
6	Feeling bad about yourself – or feeling that you are a failure or that you have let yourself or your family down?					
7	Trouble concentrating on things like school work, reading or watching TV?					
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?					
9	Thoughts that you would be better off dead or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if one to two items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes.

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PHQ - A Instructions for Clinicians - Age 11 - 17

The Severity Measure for Depression – Age 11 – 17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a nine-item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11 – 17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms during the past seven days.

Scoring and Interpretation

Each item on the measure is rated on a four-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with the higher score indicating greater severity of depression. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw score on the nine items should be summed to obtain a total raw sore and should be interpreted using the table below:

Interpretation Table of Total Raw Score	
Total Raw Score	Severity of depressive disorder or episode
0 – 4	None
5 – 9	Mild
10 – 14	Moderate
15 – 19	Moderately severe
20 – 27	Severe

Note: If three or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If one or two items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of the items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A) – Modified (i.e., nine) and divide the value by the number of items that were actually answered (i.e., seven or eight). The formula to prorate the partial raw score to total raw score is:

$$\frac{\text{(Raw sum x 9)}}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. A consistently high score on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment and follow-up. Your clinical judgment should guide your decision.

Suicide Risk Assessment in Children and Adolescents

Static Risk Factors	Dynamic Risk Factors	Protective Factors
Race White > Black/others	Current suicidal thoughts, intent, plans, behaviors	Social support, sense of responsibility to family
Sex Males more likely to complete suicide Females more likely to attempt suicide	**Current psychiatric illness** Majority of completed suicides occur in patients with a mood disorder (MDD)	Fear of suicide
Previous suicide attempt Greatest risk	Up to 50% of suicides among patients with schizophrenia occur during the first few weeks and months post-discharge	Fear of social disapproval
Age Bimodal distribution (ages 15 – 24 and > 65)	**Substance use** Approximately 15% of all alcohol-dependent persons commit suicide	Religious beliefs
Marital status Unmarried individuals more likely to commit suicide	Employment	Positive coping skills
Family history of suicide	Feelings of hopelessness	Positive therapeutic alliance
Chronic medical illness	Lack of or limited social support	
Other factors to take into account Living in a rural vs. urban area – limited resources	Life crisis that causes shame/despair	
	Access to means of harm (firearm, weapons/sharps, medications, etc.)	
	Severe anxiety/anxious ruminations	
	Global insomnia	
	Depression with delusions of poverty/doom	
	Other factors to take into account Impulsivity, hallucinations (command type), criminal behavior	

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SUICIDE ASSESSMENT FIVE-STEP EVALUATION AND TRIAGE

1	2	3	4	5
IDENTIFY RISK FACTORS	IDENTIFY PROTECTIVE FACTORS	CONDUCT SUICIDE INQUIRY	DETERMINE RISK LEVEL/INTERVENTION	DOCUMENT
Note those that can be modified to reduce risk	Note those that can be enhanced	Suicidal thoughts, plans, behavior and intent	Determine risk; choose appropriate intervention to address and reduce risk	Assessment of risk, rationale, intervention and follow-up

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

1. Risk Factors

- **Current/past psychiatric diagnoses:** especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. *Comorbidity and recent onset of illness increase risk.*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Family history:** of suicide, attempts or Axis 1 psychiatric diagnoses requiring hospitalization
- **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status – real or anticipated); ongoing medical illness (esp. CNS disorders, pain); history of abuse or neglect; intoxication
- Access to firearms

2. Protective Factors

Protective factors, even if present, may not counteract significant acute risk

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

3. Suicide Inquiry

Specific questioning about thoughts, plans, behaviors, intent

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

Homicide inquiry: *when indicated, esp. postpartum, and in character disordered or paranoid males dealing with loss or humiliation; inquire in four areas listed above*

4. Risk Level/Intervention

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

5. Document

- **Document:** rationale for risk level, the treatment plan to address/reduce the current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation) and firearm instructions, if relevant

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide http://www.stopasuicide.org/professional.aspx
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors
- www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx

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DEVELOPED BY DOUGLAS JACOBS, MD

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RISK LEVEL	RISK/PROTECTIVE FACTORS	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk; suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors; develop crisis plan; give local/national emergency info*
Low	Modifiable risk factors, strong protective factors	Thoughts of death, but no plan, intent or behavior	Outpatient referral, symptom reduction; give local/nat'l emergency info*

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

National Suicide Prevention Lifeline *1-800-273-TALK

Integrated Behavioral Health Services

Services Available

- Office-Based Psychiatric Social Worker Evaluation
- Referral for Behavioral Health Services

Clinical Concern(s) or Reason for Referral

- ADHD
- Aggression
- Abuse/trauma
- Adjustment disorder
- Anxiety
- Alcohol and/or drug use
- Autism spectrum disorder
- Behavioral problems
- Depression
- Family discord
- Maternal depression
- Neurological concerns
- Parenting
- Obsessive compulsive disorder
- Oppositional defiant disorder
- School concerns
- Social problems
- Suicidal concerns
- Other behavioral health problems

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To receive a restock of any of these materials, please call the UH Rainbow Care Connection office at 216-844-1509.

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Contents include:

- Provider Background – Depression
- Provider Background – Suicide
- Patient Education Handout – Depression
- Patient Education Handout – Suicide
- PHQ-A Instructions
- PHQ-A Depression Screening Tool
- Depression Scale for Children
- Community Resources

DEPRESSION TOOLKIT DEVELOPMENT COMMITTEE

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Depression in Children and Teens: What Parents Need to Know

Not only adults become depressed. Children and teenagers also may have depression. Childhood depression is diagnosed when a child's sadness interferes with that child's regular activities, schoolwork, friends and family life. The good news is that depression is treatable.

About one in 20 children and teens have depression at any one point in time. Children under stress, who experience loss, or who have problems with attention, learning, conduct or anxiety are at a higher risk for depression. Depression also often runs in families.

Depression in children often looks different from depression in adults. Seek help for your child if you notice that he or she has any of the following signs that last for two or more weeks:

- Frequent sadness, tearfulness or crying
- Less interest in activities, especially ones your child used to enjoy
- Little care about what happens in the future
- Low energy
- Low self-esteem or guilt
- Very afraid of failure or rejection
- More easily upset, angry or annoyed
- Not wanting to be with friends or family
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Missing many days from school or a drop in grades
- Problems concentrating
- A major change in eating and/or sleeping – either more or less
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self-harming behavior

A child who used to play with friends may now spend most of his or her time alone. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way of trying to feel better.

Children and adolescents who cause trouble at home or at school may also be depressed. Because a child may not always seem sad, parents and teachers may not realize that bad behavior can be a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

If you are worried that your child may be depressed, talk to your child. Ask your child about how he or she is feeling and about what may be bothering him or her at home or school. Bullying is a common cause of mental health problems in children. If your child is being bullied, involve the school and your child's doctor to get your child help. Depression can often occur after a loss. Loss and grief can affect both parents and children. If you are grieving as a parent, get help for yourself as well as your child.

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Depression is a real illness that needs help from your child's doctor or a mental health professional. Your child's doctor can help evaluate him or her for depression and get your child the help he or she needs.

The goals of treatment are to shorten the period of depression, help your child be more successful in school and at home, and prevent him or her from becoming depressed again. It can take time for your child to fully recover, so make sure to follow through with treatment plans.

Treatment may include counseling and/or medication. In addition, encourage your child to get enough sleep, exercise regularly, eat a healthy diet, and have strong connections with family and friends.

Counseling: Counseling often includes both individual and family therapy. For example, cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are types of individual therapy that can help treat depression.

Medication: Selective serotonin reuptake inhibitors (SSRIs) are often the first choice of medication for treatment of depression. SSRIs are used to treat depression as well as anxiety. Some common SSRIs used in children are fluoxetine (Prozac®), sertraline (Zoloft®), citalopram (Celexa®) and escitalopram (Lexapro®). Children often start to feel better two to four weeks after starting these medications. The dose will start low and go up slowly.

Common side effects include headaches, stomach pain, diarrhea, changes in sleep or eating, irritability, dry mouth, hyperactivity and difficulty sitting still. More serious side effects include increased risk for hurting oneself, mania and sexual side effects. If you think the medication is not working or you are concerned about side effects in your child, call his or her doctor. Do not just stop the medication, as this may cause worse side effects. Teenagers occasionally report an increase in suicidal thinking after they start one of these medications.

The following are RED FLAGS for suicide. If you hear your child say or do these things, your child requires immediate help:

- Complain of being a bad person or feeling rotten inside
- Give verbal hints with statements such as, "I won't be a problem for you much longer," "Nothing matters," "It's no use," and "I won't see you again"
- Make final arrangements such as giving away or throwing away favorite possessions or making a will
- Become *suddenly* cheerful after a period of depression
- Have signs of psychosis (hallucinations or bizarre thoughts)
- Make suicidal threats

If a child or adolescent says, "I want to kill myself," or "I'm going to commit suicide," always take his or her words seriously and immediately seek assistance from a qualified mental health professional.

Emergency resources include Mobile Crisis Hotline at 216-623-6888, National Suicide Prevention Lifeline at 1-800-273-TALK (8255) and your local emergency room. Always remove or lock up any weapons at home and keep medications locked and inaccessible.

Periods of depression most commonly last nine months or more. While depression is treatable, children who have gotten over a period of depression may have another episode of depression during their childhood. Seven out of 10 children with a history of depression will suffer from depression as an adult, making it even more important to get treatment as early as possible. With proper treatment, however, children and teenagers can feel better and lead healthy lives.

For more information, please visit:

cdc.gov/childrensmentalhealth/depression.html

healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Childhood-Depression-What-Parents-Can-Do-To-Help.aspx

Adapted from Facts for Families: Depression in Children and Teens. American Academy of Child and Adolescent Psychiatry, 2013; Bi-Ped Project, Emotional Health Committee, Maryland Chapter American Academy of Pediatrics.

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Suicide in Children and Teens: What Can Parents Do to Prevent Suicide?

Suicide among young people continues to be a serious problem. Each year in the United States, thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15- to 24-year-olds, and the sixth leading cause of death for 5- to 14-year-olds.

Teenagers often have strong feelings of stress, confusion, self-doubt, pressure to succeed, money worries and other fears while growing up. For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, moving to a new community, loss (break-up or death), uncertainty about one's sexual orientation, or getting in trouble at home, school or with the law can be extremely stressful and can cause a teen to question his or her value. For some teens, suicide may appear to be a way out of their problems and stress. Other risks factors for suicide are substance abuse, peer pressure, access to weapons, mental health problems, chronic illness and family history of suicide.

Depression and suicidal feelings are treatable. It is important to recognize, diagnose and treat depression in children and teens. If you have questions about whether your child is depressed or suicidal, call your doctor or get help from a mental health professional.

Being a good listener for your child, asking what's wrong if your child seems sad or has a change in personality, and offering to help your child are important first steps in suicide prevention.

Many of the signs and symptoms of suicidal feelings are similar to those of depression. Signs that your child might be suicidal may include:

- Change in eating and/or sleeping
- Loss of interest in friends, family and regular activities
- Isolating or withdrawing from others
- Violent actions, acting out or running away
- Drug and alcohol use
- Unusual neglect of personal appearance
- Marked personality change
- Persistent boredom, difficulty concentrating or a drop in school grades
- Lots of complaints about physical symptoms often related to emotions, such as stomachaches, headaches and fatigue

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The following are RED FLAGS for suicide. If you hear you child say or do these things, your child requires immediate help:

- Complain of being a bad person or feeling rotten inside
- Give verbal hints with statements such as, "I won't be a problem for you much longer," "Nothing matters," "It's no use" and "I won't see you again"
- Make final arrangements such as giving away or throwing away favorite possessions; making a will
- Become *suddenly* cheerful after a period of depression
- Have signs of psychosis (hallucinations or bizarre thoughts)
- Make suicidal threats

If a child or adolescent says, "I want to kill myself" or "I'm going to commit suicide," always take his or her words seriously and immediately seek assistance from a qualified mental health professional.

Emergency resources include Mobile Crisis Hotline at 216-623-6888, Suicide Prevention Lifeline at 1-800-273-TALK (8255), Trevor Lifeline at 1-866-488-7386 and your local emergency room.

People often feel uncomfortable talking about death. However, asking your child or teen whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, asking about suicide will let your child know that somebody cares and will give your child the chance to talk about his or her problems.

It is important to listen (not to judge), offer to help and let your child know that things will get better.

If you think that your child is suicidal, keep all guns, alcohol and medicines (over-the-counter and prescription) locked up. Encourage your child to get regular sleep, exercise and eat a healthy diet. It can take time for your child to get better – make sure to follow through with treatment plans.

With support from family and appropriate treatment, children and teens who are suicidal can heal and lead a healthy life.

For more information, please visit:

mentalhealthamerica.net/conditions/child-and-adolescent-suicide

helpguide.org/articles/depression/parents-guide-to-teen-depression.htm

suicidepreventionlifeline.org/

sptsusa.org/teens/

Adapted from Facts for Families: Teen Suicide. American Academy of Child and Adolescent Psychiatry, 2013.

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Community Resources

Agency	Locations (City)	Services	Insurance(s)	Phone
Allied Behavioral Health	Fairview Park, Lorain	Behavioral Health Counseling	Medicaid: some plans provider dependent; Some commercial insurances	1-888-606-2247
Applewood	Cleveland, Elyria	Behavioral Health Counseling, Psychiatry	Medicaid: all plans; Some commercial insurance on limited basis, ADAMHS Board Assistance (Elyria)	216-696-5800 x1264, 216-521-6511 (ECMH), 440-324-1300 (Elyria)
Avenues of Counseling	Medina, Fairlawn	Behavioral Health Counseling, Psychiatry	Commercial only	330-723-7977
Beech Brook	Cleveland, Akron	Behavioral Health Counseling, Psychiatry	Medicaid: all plans; Some commercial insurance on limited basis	216-831-2255 (Cleveland), 234-678-7912 (Akron)
Bellefaire	Cleveland, Elyria, Akron	Behavioral Health Counseling, Psychiatry, Groups (Elyria)	Medicaid: all plans (Cleveland, Elyria); Some commercial insurance (Elyria), ADAMHS Board Assistance (Elyria)	216-932-2800 (Cleveland), 440-324-5701 x13 (Elyria), 1-800-879-2522 (Akron)
Center for Effective Living	Fairview Park	Behavioral Health Counseling, Psychiatry	Medicaid: all plans; Some commercial insurance	440-333-4949
Child Guidance & Family Solutions	Akron, Cuyahoga Falls, Twinsburg, Barberton	Behavioral Health Counseling, Psychiatry, Medication Consultation, Groups	Medicaid: all plans; Multiple commercial insurances	330-762-0591
Cleveland Regional Perinatal Network	Northeast Ohio	Facilitate access to children's mental health providers in the area	N/A	216-844-3391
Connections	Beachwood, Cleveland	Behavioral Health Counseling, Psychiatry	Medicaid: all plans; Some commercial insurances, Uninsured	216-453-2580 x786
Crossroads	Mentor, Painesville, Perry	Behavioral Health Counseling, Psychiatry, Multiple Levels of Care	Medicaid: all plans; Some commercial insurances	440-255-1700 (Mentor, Perry), 440-358-7370 (Painesville)
ECMH Coordinator – Cuyahoga County	Cleveland	Provide Early Childhood Mental Health Consultation and Referral for ECMH	N/A	216-881-4291

Agency	Locations (City)	Services	Insurance(s)	Phone
Guidestone	Cleveland, Lorain, Painesville, Fairlawn, Canton, Medina, Portage	Behavioral Health Counseling, ECM, Psychiatry (Cleveland, Lorain), In-home, ECMH (Painesville, Fairlawn, Canton, Medina, Portage)	Medicaid: all plans	440-260-8300
Humanistic Counseling Center	Avon, Beachwood, Bedford Heights, Brecksville, Brunswick, Chagrin Falls, Cleveland Heights, Euclid, Fairview Park, Hudson, Lyndhurst, Mentor, North Olmsted, Pepper Pike, Richfield, Rocky River, Stow, Warrensville Heights, West Park	ADHD Evaluation at Family Achievement Center with Dr. Dan, Behavioral Health Counseling	Providers independently paneled with commercial insurance and individual Medicaid plans, dependent on location; Website profiles indicate specialization of providers	216-839-2273
PsychBC	Beachwood, Brecksville, North Olmsted, Ashtabula, Willoughby, Avon	Behavioral Health Counseling, Psychiatry (limited locations only)	Commercial insurances, Some Medicaid plans provider dependent	216-831-6611
Ravenwood	Chardon	Behavioral Health Counseling, Psychiatry	Medicaid: all plans; Multiple commercial insurances	440-285-3568
Signature Health	Ashtabula, Garfield Heights, Willoughby	Behavioral Health Counseling, Psychiatry	Medicaid: all plans	440-992-8552 (Ashtabula), 216-663-6100 (Garfield Heights), 440-953-9999 (Willoughby)
Solutions Behavioral Health Care	Medina	Behavioral Health Counseling, Psychiatry	Medicaid only	330-723-9600
The Center for Families & Children	Parma, Rocky River	Behavioral Health Counseling, Psychiatry, Limited Access	Medicaid: all plans	216-325-9355
UH Rainbow Babies & Children's Child & Adolescent Psychiatry	Cleveland, Solon, Mayfield Heights, Westlake	Psychiatry and Medication Consultation	Medicaid: all plans; Self-pay and Commercial insurance with limited accessibility	216-844-3881
UH Rainbow Babies & Children's Developmental & Behavioral Pediatrics	Cleveland, Solon	ADHD Evaluation and Medication Consultation	Medicaid: all plans; Multiple commercial insurances	216-844-3230

University Hospitals does not endorse these specific behavioral health providers. This list is provided as a resource. Other providers may also be available.

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