# Unmasking Depression

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# AMA Morning Rounds®

Good morning. Here are today's top stories.
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*in affiliation with* BulletinHealthcare

## Leading the News

### Study: More kids going to ED for suicidal thoughts, suicide attempts

**CNN** (4/8, Bracho-Sanchez) reports, "The number of children and teens in the United States who visited emergency" departments (EDs) "for suicidal thoughts and suicide attempts doubled between 2007 and 2015, according to a new analysis" of "publicly available data from the **National Hospital Ambulatory Medical Care Survey**, administered by the U.S. Centers for Disease Control and Prevention every year."

**HealthDay** (4/8, Reinberg) reports, "Among children aged five to 18, suicidal thoughts and attempts led to more than 1.1 million" visits to the emergency department (ED) "in 2015 – up from about 580,000 in 2007," investigators concluded after analyzing "data from the U.S. Centers for Disease Control and Prevention." The **findings** were published online April 8 in a research letter in JAMA Pediatrics.

From the AMA

# Suicide and Medical Settings

- 1 out 2 people who died by suicide had contact with a primary care provider in the month before the suicide
- 1 out 5 people who died by suicide were seen by a mental health provider in the month before the suicide
- 1 out of 10 people who died by suicide visited an ER in the 2 months before the suicide

Mental and Behavioural Disorders Department of Mental Health World Health Organization Geneva
2000

# The Scope of the Problem

Depression

- 20% of youth, ages 13 to 18, live with a mental health condition
- Major risk factor for suicide
- Associated with
  - Social and educational impairment
  - Increase rates of smoking, substance abuse and obesity

# The Scope of the Problem

*"Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated"*

Forman-Hoffman V, McClure E, McKeeman J, et al. Screening for Major Depressive Disorder in Children and Adolescents: A Systematic Review for the US Preventive Services Task Force. Evidence Synthesis No. 116. AHRQ Publication No. 13-05192-EF-1

# Bright Futures

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

## Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.



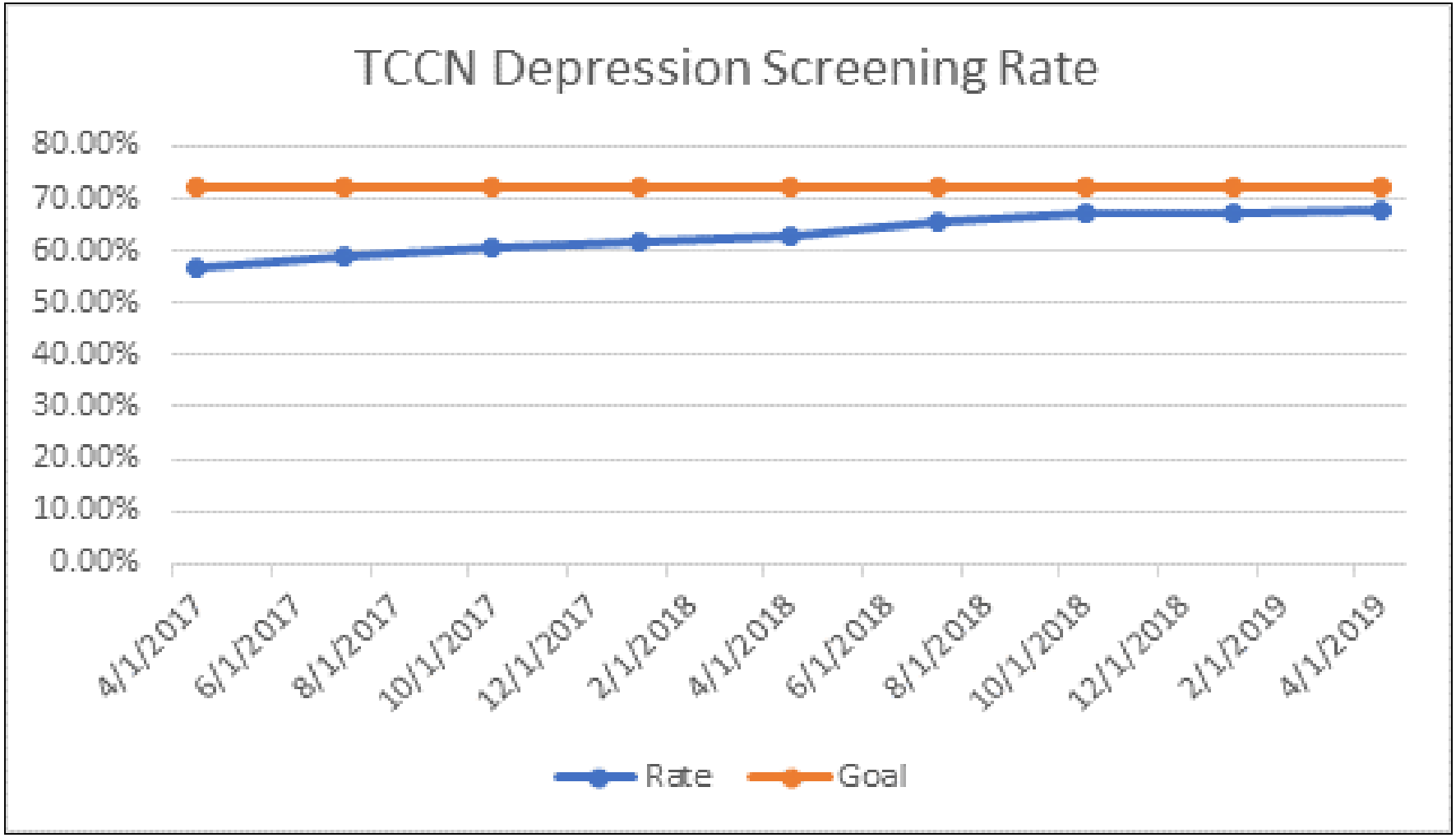
| | INFANCY | | | | | | | | EARLY CHILDHOOD | | | | | | | MIDDLE CHILDHOOD | | | | | | ADOLESCENCE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **AGE**[1] | Prenatal[2] | Newborn[3] | 3-5 d[4] | By 1 mo | 2 mo | 4 mo | 6 mo | 9 mo | 12 mo | 15 mo | 18 mo | 24 mo | 30 mo | 3 y | 4 y | 5 y | 6 y | 7 y | 8 y | 9 y | 10 y | 11 y | 12 y | 13 y | 14 y | 15 y | 16 y | 17 y | 18 y | 19 y | 20 y | 21 y |
| **HISTORY** Initial/Interval | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **MEASUREMENTS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Length/Height and Weight | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Head Circumference | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | | | | | | | | | | | | | | | | | | | | |
| Weight for Length | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | | | | | | | | | | | | | | | | | | | | | |
| Body Mass Index[4] | | | | | | | | | | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Blood Pressure[6] | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **SENSORY SCREENING** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vision[7] | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ● | ● | ● | ● | ★ | ● | ★ | ● | ★ | ● | ★ | ★ | ● | ★ | ★ | ★ | ★ | ★ | ★ |
| Hearing | | ●[8] | ●[9] → | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ● | ● | ● | ★ | ● | ★ | ● | ← | | | ●[12] → | | ← | ● → | | ← | | ● → | |
| **DEVELOPMENTAL/BEHAVIORAL HEALTH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Developmental Screening[11] | | | | | | | | ● | | | ● | | ● | | | | | | | | | | | | | | | | | | | |
| Autism Spectrum Disorder Screening[12] | | | | | | | | | | | ● | ● | | | | | | | | | | | | | | | | | | | | |
| Developmental Surveillance | | ● | ● | ● | ● | ● | ● | | ● | ● | | ● | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Psychosocial/Behavioral Assessment[13] | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Tobacco, Alcohol, or Drug Use Assessment[14] | | | | | | | | | | | | | | | | | | | | | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Depression Screening[15] | | | | | | | | | | | | | | | | | | | | | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Maternal Depression Screening[16] | | | | ● | ● | ● | ● | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHYSICAL EXAMINATION**[17] | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **PROCEDURES**[18] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Newborn Blood | | ●[10] | ●[10] → | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Newborn Bilirubin[21] | | ● | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Critical Congenital Heart Defect[22] | | ● | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immunization[23] | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Anemia[24] | | | | | | ★ | | | ● | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Lead[25] | | | | | | | ★ | ★ | ● or ★[26] | | ★ | ● or ★[26] | | ★ | ★ | ★ | ★ | | | | | | | | | | | | | | | |
| Tuberculosis[27] | | | | ★ | | | ★ | | ★ | | | ★ | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Dyslipidemia[28] | | | | | | | | | | | | ★ | | | ★ | | ★ | | ★ | ← | ● → | | ★ | ★ | ★ | ★ | ★ | ← | | ● → | | |
| Sexually Transmitted Infections[29] | | | | | | | | | | | | | | | | | | | | | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| HIV[30] | | | | | | | | | | | | | | | | | | | | | | ★ | ★ | ★ | ★ | ← | | ● → | | ★ | ★ | ★ |
| Cervical Dysplasia[31] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ● |
| **ORAL HEALTH**[32] | | | | | | | ●[33] | ●[33] | ★ | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | | | | | | | | | | | | | | | |
| Fluoride Varnish[34] | | | | | | | ← | | | | ● → | | | | → | | | | | | | | | | | | | | | | | |
| Fluoride Supplementation[35] | | | | | | | ★ | ★ | ★ | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | | | | |
| **ANTICIPATORY GUIDANCE** | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/Index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

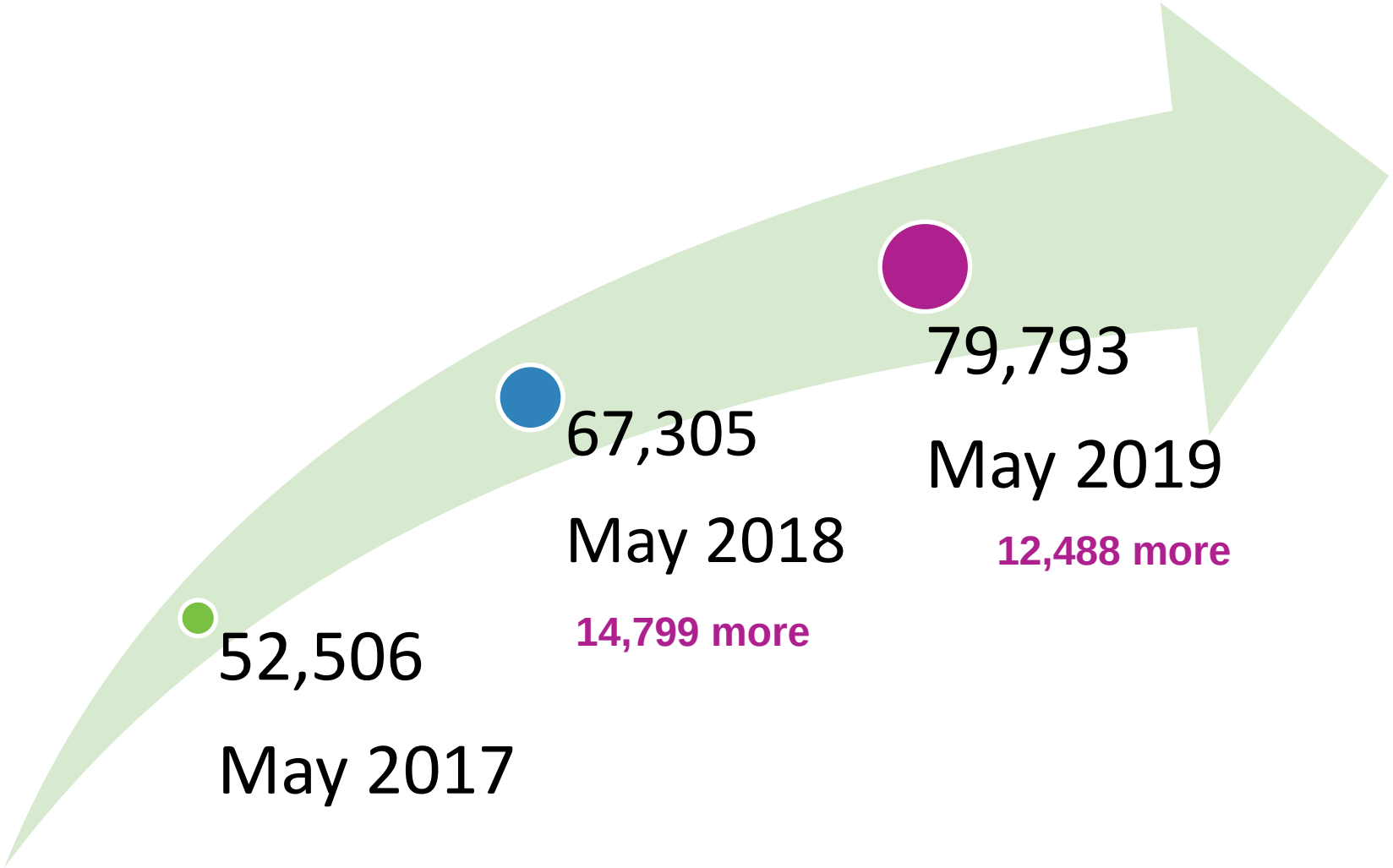
*(continued)*

**KEY:** ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←—●—→ = range during which a service may be provided

# TCCN Depression Screening Rates



# Increasing the Number of Screens Each Year



# Depression Screening Rates as of 4/28/19

Total number of eligible adolescents - **356,809**

Total number of adolescent well child visits - **156,495**

Total number of screenings at a well child visit - **90,709**

# SMART Aim

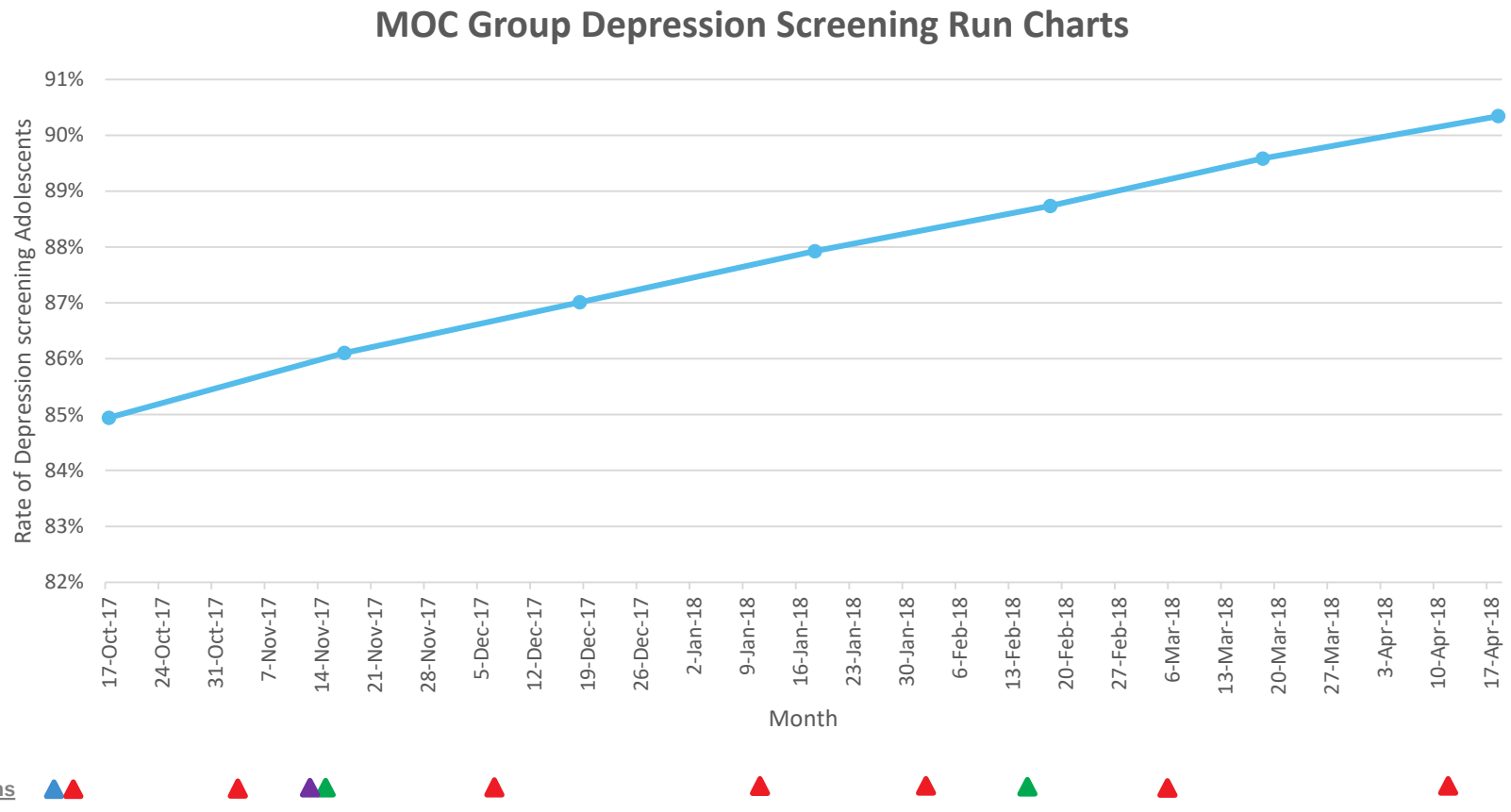
- Our project SMART AIM

  We will increase the rate of adolescent depression screenings by 5% at well encounters for established adolescents 12-18 y.o. by December 2019

# What Are We Asking TCCN Practices To Do?

- If you are not actively screening for depression…
  - Adopt a screen, integrate it into your practice and code using 96127
  - Barriers and other concerns will be addressed in this presentation
- If you are actively screening for depression…
  - Utilize your adolescent list to pro-actively reach out to adolescents in need of services and schedule appointments
    - First adolescent recall list started going out on 3/25
    - Second recall list scheduled for 7/15
  - Use the opportunity to fill all adolescent care gaps

# Entire Group Performance Over Project Course



# What is Depression?

- Major Depressive Disorder:
  - Debilitating mental health condition that affects a child or teen's daily functioning
  - Impacts their involvement with family, friends, and school
  - Affects over 25% of high schoolers and up to 5% of all children and teens
- Depressed mood is not the same as a depressive episode
- Depressed mood is a symptom that can be expressed in a number of mental and physical illnesses

# DSM V: Major Depressive Disorder

- Criteria A: 5 symptoms (SIGECAPS), during same 2 week period, representing a change from usual functioning. Symptom of depressed mood OR loss of interest/pleasure (anhedonia) has to be present
- Criteria B: the symptoms cause significant distress
- Criteria C: not due to a substance or a GMC
- Criteria D: not better explained by a primary psychotic disorder
- Criteria E: no history of mania or hypomania

# Screening Tools for Depression

- Find what works for your clinic
- Want effective tools that guide towards diagnosis, can be monitored over time
- ECHO project – use of PHQ 2 and PHQ 9
- Need to be validated for reimbursement

# PHQ2 – Initial Step

## The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

| Over the past 2 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 |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

# PHQ-9

- More detailed review
- Each question addresses one of the core symptoms of depression

| | (0) Not At All | (1) Several Days | (2) More Than Half the Days | (3) Nearly Every Day |
|---|---|---|---|---|
| 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?<br><br>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? | | | | |

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** 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 have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

# PHQ 9 Score Interpretation

| SCORE | Interpretation | Interventions |
|---|---|---|
| 5-9 | Minimal to Mild Depressive Symptoms | Support<br>Psychoeducation |
| 10-14 | Moderate Depressive Symptoms | Refer to Psychotherapy<br>Consider Psychiatry Referral<br>Consider SSRI |
| 15-19 | Moderately Severe Depressive Symptoms | Refer to Psychotherapy<br>Refer to Psychiatry<br>SSRI Recommended<br>Establish Safety |
| >20 | Severe Depressive Symptoms | Refer to Psychotherapy<br>Refer to Psychiatry<br>SSRI Strongly Recommended<br>Safety Plan |

# Evidence Based Treatment Options

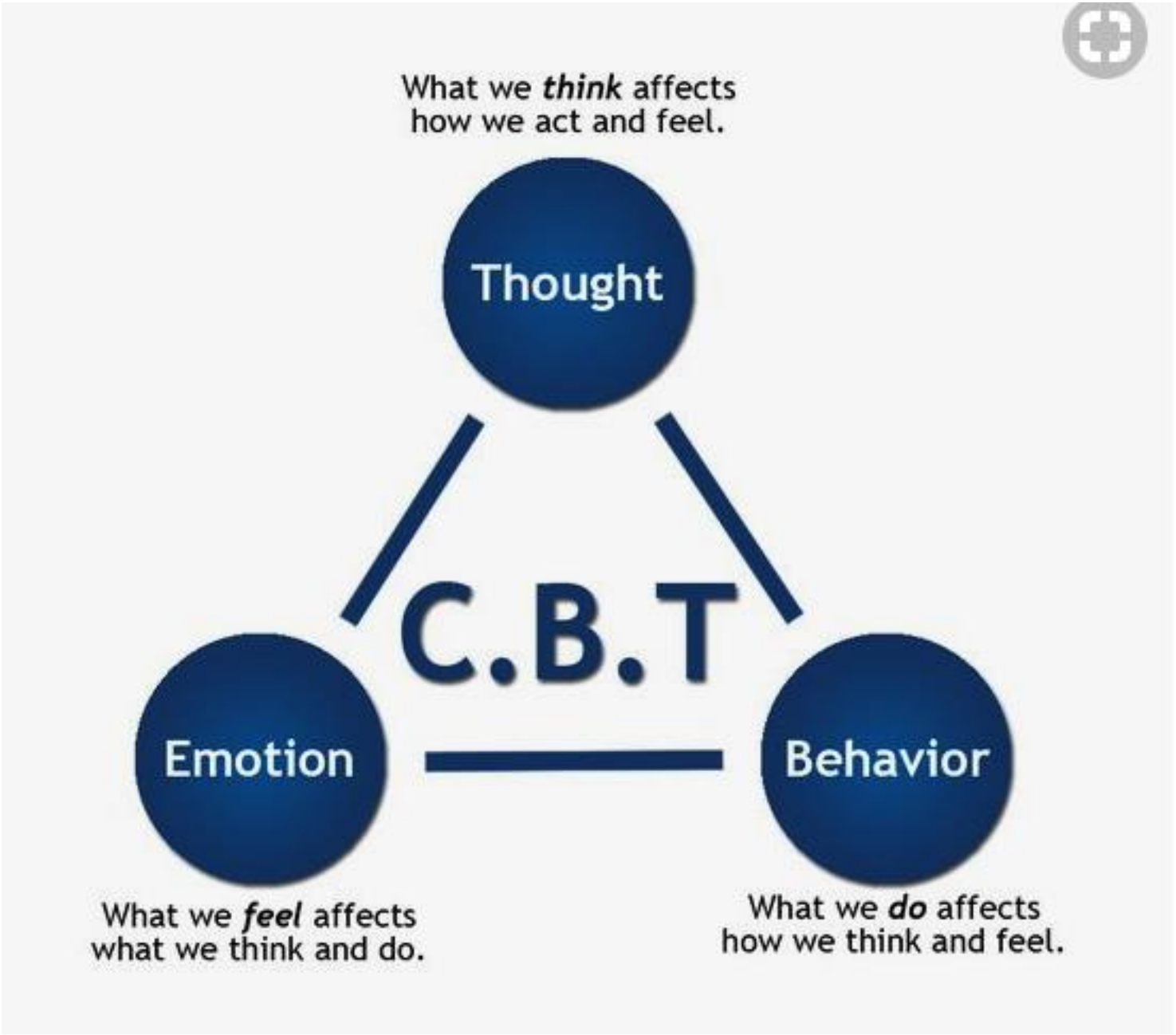
- Psychotherapy alone: Cognitive Behavioral Therapy or Interpersonal Psychotherapy
- Psychotherapy + medication: CBT or IPT + SSRI. Reduces risks of medications, higher rates of response to treatment over time
- Medication alone: SSRI (fluoxetine, escitalopram, sertraline***). Higher risk
- Supportive care: psychoeducation, serial monitoring of scores, etc. Only recommended for mild depression

# Match the Treatment to the Individual

- There are no set in stone guidelines for when to use which treatments, but my approach is to start with psychotherapy, and to use the least amount and lowest doses of medications necessary
- Determine your own comfort level before stepping into the treatment discussion
- Availability of resources can change the treatment and many providers feel a pressure to prescribe when there are limited resources

# Cognitive Behavioral Therapy

- CBT
- Centered on the theory of depression that depressed individuals have distorted thinking patterns and information processing that lays more importance on the negative, and underemphasizes the positive
- The goal of treatment is to interrupt the cycle of negative thinking, depressed mood, and maladaptive behaviors
- Key components: cognitive restructuring and behavioral activation
- Also works on skill building, problem solving, relaxation, emotional regulation, social skills training


What we *think* affects how we act and feel.
Thought
C.B.T
Emotion
Behavior
What we *feel* affects what we think and do.
What we *do* affects how we think and feel.

# Interpersonal Therapy

- IPT
- Conceptualizes depression as occurring within an interpersonal matrix, focuses on the impact of depressive symptoms on relationships
- Targets interpersonal stress: Loss; Role disputes; Role transitions; Interpersonal Skills Deficits
- Goal – replace conflict-ridden, unfulfilling relationships with meaningful, lower conflict ones

# Selective Serotonin Reuptake Inhibitors (SSRI'S)

- Block presynaptic serotonin reuptake – decreases degradation of serotonin, and increases post-synaptic availability
- Can take 4-6 weeks to have their full effect – not rapid acting medications
- Very little cardio-toxicity in overdose (unlike older antidepressants)
- Need monitoring, especially when starting and stopping
- Consider prior medication trials when choosing an SSRI
- Discontinuation trial should be in low stress, 6 months-year after stabilized for depression
- FDA approved in children (varies per specific medication)

# Medications:
# 1st Line – SSRIs

## Positive Effects

- Relief of depressed mood
- Increased enjoyment
- Decrease in physical symptoms
- Decreased anxiety
- Feel more like their natural self
- Raises the floor – not a "happy pill"

## Potential Side Effects

- Common: HA, nausea, weight gain, GI dysfunction, sexual dysfunction, changes in sleep
- Not as common: mania/hypomania, SSRI induced apathy, serotonin syndrome, vivid dreams, disinhibition, bruising, akathisia, bruxism
- Big, Scary Black Box Warning!

# Black Box Warning

- Overall number needed to harm to see one patient with significant suicidal ideation due to medication (according to FDA definition): NNH= 125
- Overall number needed to treat to see one response for treatment of Depression: NNT = 10
- NNT for anxiety disorders = 4
- Unclear mechanism of action to explain this relationship between SSRI use and suicidality. Possibilities: Rapid metabolism? Non compliance? Mixed state? Disinhibition?

# SSRI's

- **Fluoxetine/Prozac – FDA approved for 8+ for MDD**
- **Sertraline/Zoloft – FDA approved for OCD ages 6+,** but used often in children for depression
- **Escitalopram/Lexapro – FDA approved 12+ for MDD**, mixed evidence in studies. More potent serotenergic activity than celexa
- **Citalopram/Celexa** – Not FDA approved in children for MDD or anxiety, but FDA approved in adults. Some additional cardiac warnings. Studied in TORDIA
- **Paroxetine/Paxil – no promising studies in kids**

# Fluoxetine – Prozac

- **FDA Approved  for MDD ages 8 and older and OCD ages 7 and older**
- **Most clinical data**
- **First choice**
- SSRI with longest half life (4-6 days for the prodrug, 4-16 days for metabolite)
  - No discontinuation syndrome
  - Long wash out period
- Usually weight neutral and not sedating
- Starting dose 5-10 mg QD, usual dose 10-20mg po QD
- Recent Lancet article, August 2016

# Escitalopram – Lexapro

- **FDA approved for MDD ages 12+**
- Usual starting dose 5-10 mg po QD, max dose 20 mg po QD.
- Not as activating as fluoxetine
- Not usually sedating or activating
- Usually given in AM

# Sertraline – Zoloft

- **FDA approved  for OCD in children ages 6+**
- Most serotonergic – potent, moderate-severe nausea
- In adults, MDD, social phobia, panic disorder, PTSD, PMDD in adults
- In studies using sertraline for depression, response (reduction of baseline symptoms ≥40 percent) occurred in more patients who received sertraline than placebo (69 versus 59 percent)
- Usually weight neutral and non sedating
- Take in the AM usually, can be activating
- Starting dose 12.5 mg vs 25 mg po QD, typical range 25-150 mg po qday

# Suicidal Patients: Emergency Resources

- **GCAL- 1-800-715-4225**
- **Psychiatry Receiving Facilities:** able to provide emergency psychiatric evaluations and hospitalize patients if needed for stabilization. Can also assess for lower levels of care, such as Partial Hospitalization Programs (PHP) or Intensive Outpatient Programs (IOP). Able to do basic bloodwork and labs (ex those required for admission to a psych facility).
- **Medical Emergency Rooms:** limited psychiatric services available, but can evaluate immediate safety and/or need for 1013. Able to perform medical screens for pt's with concerns of physical causes of psych symptoms. Any pt with suspected ingestion should be referred to medical hospital ED for eval.

# Some Nearby Psychiatric Hospitals…

- Ridgeview – Smyrna, Monroe
- Peachford – Dunwoody
- Summit Ridge – Lawrenceville
- Anchor – Southwest Atlanta
- Tanner/Willowbrooke – Cartersville
- Crescent Pines – Stockbridge
- Lakeview – Norcross
- Viewpoint – Lawrenceville
- Laurel Heights – Druid Hills (Atlanta), mostly Autism

# Limitations and Difficulties in Screening

- Can be difficult to connect patients to mental health providers outside of Atlanta
- Coordinating care with multiple providers
- Limited follow through from patients and parents
- Limited resources available
- HIPPA concerns: link to information will be included in a post webinar resources document
- Billing: scenarios will be included in a post webinar resources document

# Resources:
# For Patients and Families

- **GCAL 1-800-715-4225**
  - 24-hour phone line that offers crisis assistance and connection with services
  - Patients can call to talk to a crisis counselor, parents can call for list of low-cost providers
  - Most evaluations are conducted over the phone and patients are guided to the appropriate emergency resources
  - Can even send a crisis counselor to the home in certain situations for in-person assessment
- **www.georgiacollaborative.com**: List of low cost clinics and state funded providers
- **National Suicide Prevention Hotline** 1-800-273-TALK

# Resources:
# For Providers

- **American Academy of Child and Adolescent Psychiatry**: www.aacap.org
- Program through **AACAP** for collaboration of care: http://integratedcareforkids.org/
- **NAMI (National Alliance on Mental Illness):** Georgia Behavioral Health Resource Pocket Guide for Assisting Children and Youth: www.namiga.org; 770-234-0855

# Friends Physician Advice Line Expanded Coverage

- Call **404-785-DOCS** and ask for the Behavioral Advice Line
- **Monday-Friday from 12pm – 4pm**
- Be connected immediately to one of our psychiatry providers
  - If helping other clinicians, leave a voicemail and our provider will contact you same day or within 24 hours

# Again, What Are We Asking TCCN Practices To Do?

- If you are not actively screening for depression…
  - Adopt a screen, integrate it into your practice and code using 96127
  - Barriers and other concerns will be addressed in this presentation
- If you are actively screening for depression…
  - Utilize your adolescent list to pro-actively reach out to adolescents in need of services and schedule appointments
    - First adolescent recall list started going out on 3/25
    - Second recall list scheduled for 7/15
  - Use the opportunity to fill all adolescent care gaps