DEPRESSION "CLINICAL PEARLS" FOR PRIMARY CARE PROVIDERS

I. CLINICAL HISTORY	
Recommended Procedure	**Clinical Pearls**
Assess current symptom severity, ideally using a standardized symptom rating scale	**Pearl**: Symptom severity will suggest appropriate level and type of treatment. Primary Screen: Patient Health Questionnaire-9 (PHQ-9), self-report for ages 12 and older (score of 5-9 mild, 10-15 moderate, 16-27 severe)
Assess current functioning in different areas (family, peers, school, community)	**Pearl**: Usually depression affects youth across most or all areas of their life. If the youth is functioning highly in some areas but is compromised in only one area, consider other explanations apart from mood disorder.
Assess for acute stressors, life events, or traumatic exposures which may be contributing to presentation	**Pearl**: Stressors or traumas can become important targets for intervention via psychoeducation; consider NJPPC consultation or specialty care.
Assess for prior episodes of treated or untreated depression or mania	**Pearl**: Multiple prior episodes of depression or mania increase the complexity of the presentation; consider NJPPC consultation or referral to specialty care.
Assess for presence of other psychiatric symptoms and/or substance use and abuse	**Pearl**: The presence of other psychiatric symptoms including ADHD and anxiety and/or active substance abuse or dependence may complicate assessment and treatment planning; consider NJPPC consultation or referral to specialty care.
Assess for current or previous nonsuicidal and suicidal thinking and behavior (self-harm, suicide attempts) and previous suicidal crises	**Pearl**: Active suicidal planning, intent, or recent suicidal behavior increases safety risk; consider Psychiatric Crisis referral or NJPPC phone consultation. If there is a current active suicidal intent or plan, refer for immediate mental health assessment at a Crisis Center or equivalent.
Assess for current or previous episodes of mental health care and providers	**Pearl**: Prior history of specialized mental health care may indicate that the youth is presenting with complex or treatment-resistant depression; consider NJPPC consultation or referral to specialty care. Collaboration and information-sharing with current mental health providers is essential to quality care.

II. MEDICAL WORKUP	
Recommended Procedure	**Clinical Pearls**
Perform general standard medical assessment	**Pearl**: General medical assessment is part of good medical care for youth presenting with concerning mood symptoms.
Assessment of medical conditions that can present with depressive symptoms (i.e., thyroid abnormalities, chronic fatigue, chronic infections, etc.)	**Pearl**: Identification and intervention for general medical problems presenting with psychiatric symptoms may help with assessment and treatment planning; consider NJPPC phone consultation to discuss complex situations.
Assessment of medical treatments that can present with depressive symptoms as untoward reactions (i.e., steroid treatments, betablockers, anti-convulsants, etc.)	**Pearl**: Identification and intervention for medical treatments presenting with psychiatric symptoms may help with assessment and treatment planning; consider NJPPC phone consultation to discuss complex situations.

Assessment of medical conditions and concurrent medical treatments that may affect treatment planning	**Pearl**: Identify medical conditions that could impact antidepressant treatment (i.e., liver disease, renal problems) or medications with significant drug-drug interaction potential; consider NJPPC phone consultation for complicated situations.

III. Mental Status Examination	
Recommended Procedure	**Clinical Pearls**
SIGEHUB CAPS assessment (Sleep changes, loss of Interest, Guilt, loss of Energy, reduced Concentration/Cognition, Appetite changes, Psychomotor changes, Suicidality)	**Pearl**: General assessment of depressive symptoms can identify targets of treatment, and change over time may indicate positive or negative effect of treatment efforts.
Suicidality: suicidal thoughts, degree of planning, degree of intent, sense of control, ability to communicate with others and reach out for help, reasons for living	**Pearl**: Reports of active suicidal planning, intent, or recent suicidal behavior increases safety risk; consider Psychiatric Crisis referral or NJPPC phone consultation.
Psychosis: hallucinations, delusions, abnormalities of thought processes or content	**Pearl**: Active symptoms of psychosis increase safety risk; consider Psychiatric Crisis referral for further assessment or NJPPC phone consultation.

IV. DIFFERENTIAL DIAGNOSIS	
Recommended Procedure	**Clinical Pearls**
Adjustment reactions to acute stressors (symptoms clearly correlated to recent and likely time limited negative life event)	**Pearl**: Adjustment reactions rarely or ever require pharmacological intervention; consider general health education, health maintenance strategies, or referral for psychotherapy as first-line intervention. Consider NJPPC phone consultation for complex situations.
Bipolar disorders	**Pearl**: Bipolar disorders in youth can be complicated in terms of assessment; consider NJPPC phone or face-to-face consultation prior to initiating treatment if youth is presenting with signs of bipolar disorder.
Depressive disorder due to another medical condition	**Pearl**: First-line treatment would be intervention for the medical problem; consider interventions for depression as indicated. Consider NJPPC consultation in complex situations.
Substance/medication-induced depressive disorder	**Pearl**: First-line treatment would be removal of substance or medication causing symptoms; consider interventions for depression as indicated. Consider NJPPC consultation in complex situations.
Post-Traumatic Stress Disorder (PTSD)	**Pearl**: PTSD can present with prominent mood symptoms and emotional distress and also can co-occur with depression. Consider NJPPC phone or face-to-face consultation for diagnostic clarification in confusing situations.
Disruptive Mood Dysregulation Disorder (DMDD)	**Pearl**: DMDD can present with prominent irritability that may be difficult to distinguish from depressed mood with prominent irritability. Consider NJPPC phone or face-to-face consultation for diagnostic clarification in confusing situations.

V. ASSESSMENT OF RISK	
Recommended Procedure	**Clinical Pearls**
Assess youth comprehensively using the Ask Suicide-Screening Questions (ASQ) or the Columbia-Suicide Severity Rating Scale (C-SSRS) for suicidal thinking or behavior as main short-term concern is risk of self-harm, suicidal behavior, or completed suicide	**Pearl**: Refer for immediate and emergent Crisis Assessment with Emergency Psychiatric Service providers in the following situations: ● Any evidence of recent suicidal behavior ● Current active intent to engage in suicidal behavior ● Current significant planning for suicidal behavior ● Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified ● Evidence that youth or family will not or cannot access Emergency Psychiatric Service providers in times of worsening risk ● Consider NJPPC phone consultation for complex or confusing situations

VI. TREATMENT PLANNING	
Recommended Procedure	**Clinical Pearls**
Present to family clinical impressions and recommendations regarding the need for treatment	**Pearl**: Consult with NJPPC by phone as needed regarding developing an appropriate treatment plan.
Using NJPPC guidelines, discuss treatment options with family, including Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT), medication, and school-based accommodations. Ascertain family preferences for treatment.	**Pearl**: Family preferences regarding treatment choices can be considered along with many other factors in determining initial treatment plan in many situations; consider NJPPC phone or face-to-face consultation for complicated situations.
With medication treatment, discuss with parent/guardian/child potential benefits of treatment, potential side effects, alternatives to medication treatment, and prognosis with and without medication treatment; include discussion of “black box” warning regarding treatment emergent suicidality associated with all anti-depressants for patients ages 25 and younger. Document this discussion in clinical record. Although only fluoxetine (ages 8 and older) and escitalopram (ages 12 and older) are FDA-approved for the treatment of depression, other SSRIs (especially sertraline) have proven safety and effectiveness in research studies.	**Pearl**: Consult with NJPPC Hub CAP as needed regarding any concerns about informed consent as it applies to treatment planning.
Discuss plan for medication monitoring, dosage adjustment, and discontinuation	**Pearl**: Monitoring response to treatment, ideally with a standardized symptom rating scale, and adjusting medication dose as indicated may lead to an improved outcome; the plan for medication discontinuation after symptom remission should be discussed.

NJPPC currently does NOT recommend the use of routine pharmacogenetic testing for initial medication selection strategies in primary care for youth with depression	**Pearl**: Pharmacogenetic testing is considered experimental and is not incorporated at this time into any standard practice guidelines for youth with depression. There may be specialized situations where pharmacogenetic testing is appropriate in specialty care. Consider phone consultation with NJPPC Hub CAP to discuss further as warranted.

VII. MEDICATION MANAGEMENT (Refer to MEDICATIONS TO TREAT DEPRESSION IN CHILDREN & ADOLESCENTS)	
Recommended Procedure	**Clinical Pearls**
Acute Treatment Phase	**Pearl**: Goals - remission and/or reduction of symptoms, improvement in function ● Initiation and close monitoring of medication treatment response and tolerance ● Weekly to bi-weekly check-ins with youth and/or family ● Monitor medication adherence and tolerance ● If youth experiencing side effects from medication, do not advance dose until side effect remits fully ● Re-assessment of depressive symptoms at 4 weeks using PHQ-9 ● Follow guidelines and consult with NJPPC Hub CAP as needed
Maintenance Phase	**Pearl**: Goals - youth will continue to demonstrate reduction and/or remission of symptoms and improvement in function after positive acute treatment response ● Maintain active treatment plan (medication, psychotherapy) during this period ● Monitoring generally less involved or intensive assuming ongoing symptom improvement ● Monitor medication adherence and tolerance ● Ongoing collaboration with therapist if present ● Consult with NJPPC Hub CAP as needed ● If symptoms and functioning improve for 6-12 months, reassess with PHQ-9 ● Discussion with NJPPC Hub CAP of treatment discontinuation phase if response has been sustained for 6-12 months
Treatment Discontinuation Phase	**Pearl**: Goals - safely and thoughtfully withdrawn treatment and monitor for symptom recurrence ● Informed consent with family: potential benefits of withdrawing treatment, potential risks of withdrawing treatment, plan to deal with problems or recurrence if needed ● Discuss medication strategies with family (consult with NJPPC Hub CAP as needed) ● Active monitoring for several months during this phase ● Re-assessment of depressive symptoms at monthly to bi-monthly intervals using PHQ-9 -> re-evaluate need for resuming medication if assessment scales suggest episode relapse or recurrence

	● Ongoing collaboration with therapist if present ● Consult with NJPPC Hub CAP as needed