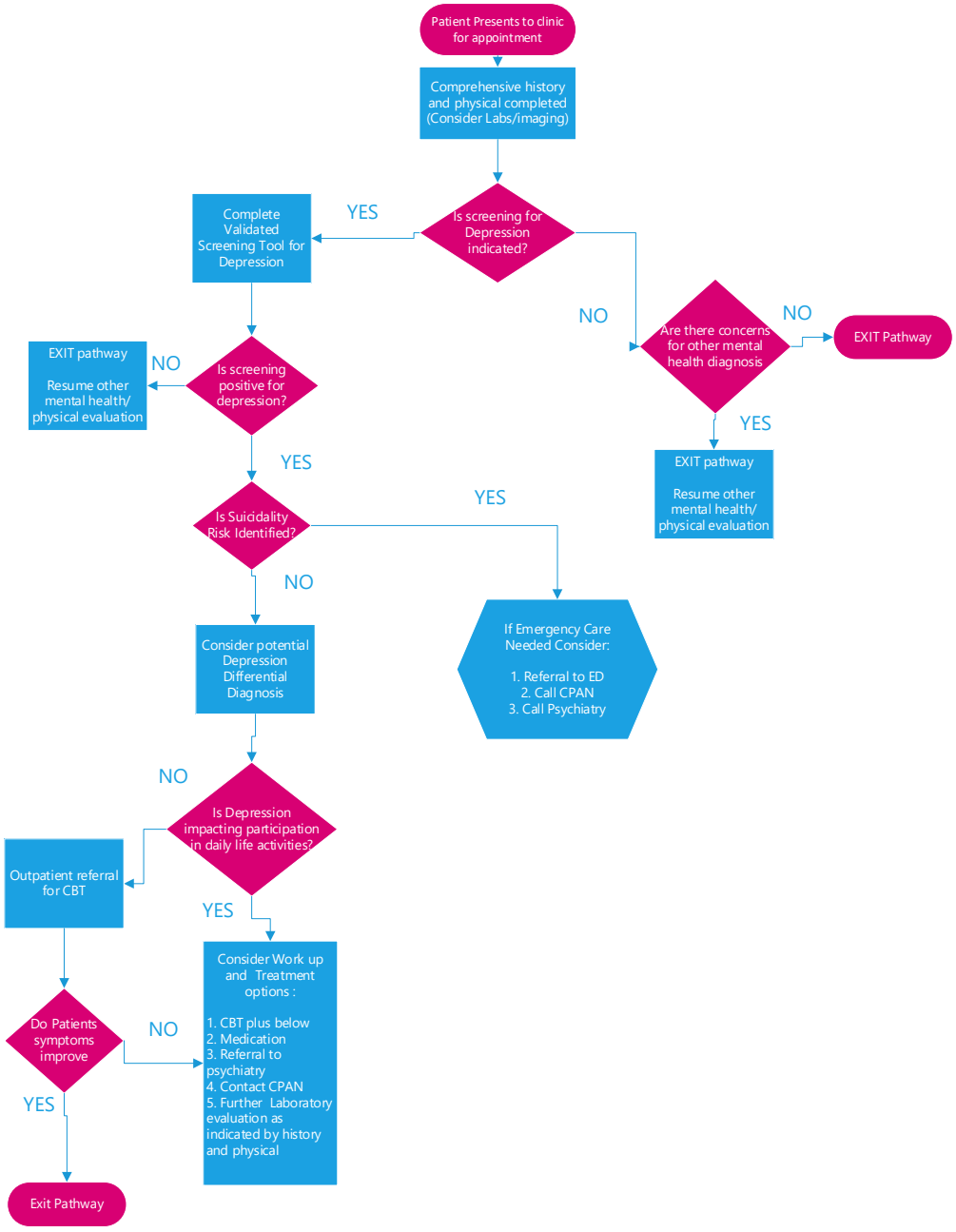
Clinical Pathway for the Diagnosis and Management of Depression in the Primary Care Medical Home

Depression in the Primary Care Medical Home Clinical Pathway Team:

Alice Phillips, MD, MPH, MSHQS– Medical Director Ambulatory Quality/Safety
Matthew Carroll, MD, MHA, MSHQS – VP, Associate Chief Quality Officer, Hospitalist
Kristen Pyrc, MD – Co-Medical Director Psychiatry
Daphne Shaw, MD – Primary Care

NOTE: This guideline is intended to assist providers in decision making by providing the current state of evidence and recommendations. This guideline is not meant to replace clinical judgement and may not be appropriate for all cases

CLINICAL PATHWAY FOR THE MANAGEMENT OF DEPRESSION IN THE PRIMARY CARE MEDICAL HOME



CLINICAL PATHWAY FOR THE MANAGEMENT OF DEPRESSION IN THE PRIMARY CARE MEDICAL HOME

I. Inclusion Criteria

a) Children ages 5 and over
b) Depression care manageable within the primary care medical home

II. Exclusion Criteria

a) Children less than 5 years of age
b) Children with multiple significant psychiatric co-morbidities and/or complex medical history with the exception of concurrent anxiety and/or ADHD
c) Patients with active suicidal ideation. Please refer to suicide Clinical Pathway for guidance of these cases: Suicide Screening and Care Clinical Pathway

III. Metrics

a) Percent of patients ages 12 and up screened annually for depression utilizing the recommended validated screening tool at Cook Children's, the PHQ 9M for teens
b) Number of patients with behavioral health referrals
c) Number of patients with referrals to the BH-ABC
d) Number of patients receiving prescriptions for depression within the primary care medical home

IV. Definitions (1, 4, 5)

a) ***Depressive Disorders –*** common features as identified in DSM-5 include sad, empty, or irritable mood found in combination with somatic or cognitive changes which negatively impact daily life functioning. (1)
b) ***Adverse Childhood Experiences –*** first described through a Kaiser/CDC study in 1998, ACES are increasingly identified as risk factors for future health issues including mental health conditions. ACES represent experiences in a child's life that lead to stress, trauma and chronic health problems and stress responses. (4)
c) ***Neuroticism –*** the degree to which the individual experiences the world as distressing, threatening, and unsafe.
d) ***Disruptive Mood Dysregulation Disorder –*** included in DSM 5 under Depressive Disorders. Children, up to age 12, with persistent irritability and frequent episodes of extreme behavioral dyscontrol. (1)
e) ***Major Depressive Disorder –*** episodes of at least 2 weeks with clear changes in affect, cognition, and neurovegetative functions. (1)
f) ***Persistent Depressive Disorder (Dysthymia) –*** persistence of mood disorder for at least 1 year in children or 2 years in adults. (1)
g) ***Trauma informed care*** shifts the focus of care from "what is wrong with you" to "what happened to you". Trauma-informed care provides a therapeutic assessment and treatment approach in which the practitioner recognizes the impact of life circumstances, adversities, or other stressful events that trigger mental health symptoms. (5)

NOTE: If concerns exist for crossover symptoms of anxiety or suicide, please refer to the appropriate Clinical Care Pathway
Anxiety primary care: Lucidchart
Primary Care Suicide Screening: Lucidchart

V. Prevalence of Major Depressive Disorder (see also Appendix G – L for details on Additional Depression Disorders)

a) 12 month prevalence of 7 % for all ages in United States (1)
    a. Children 2 % with 1:1 M to F (6)
    b. During August 2021- August 2023, the prevalence of depression in the past two weeks was 13.1% in adolescents and adults age 12 and older (24)
b) Peak prevalence in all ages is 12 – 19 years

VI. Diagnostic Criteria

a) One or two of the following symptoms must be present:
    a. Depressed mood
    b. Loss of interest or pleasure in most or all activities
b) At least 3 – 4 of the following symptoms must also be present:
    a. Weight Change
    b. Sleep disturbance
    c. Psychomotor changes – sense of moving too fast/restless or slow
    d. Fatigue or loss of energy
    e. Feeling worthless or guilty
    f. Unable to concentrate
    g. Recurrent thoughts of suicide, death or self-harm
c) Symptoms present for at least 2 weeks
d) Symptoms cause impairment in activities of daily life including social, academic or occupational
e) Symptoms not due to effects of a substance or due to another medical condition
f) No history of previous manic episode as this may create possible diagnosis of Bipolar not included in this pathway

VII. Clinical Presentation: History/Physical Examination

a) Depression Mnemonic SIGECAPS (10)
    i. S – Sleep disruption
    ii. I – Interest in activities of daily life diminished
    iii. G – Guilt or feeling worthless
    iv. E – Energy loss
    v. C – Concentration difficulties
    vi. A – Appetite abnormality or weight change
    vii. P – Psychomotor retardation or agitation
    viii. S – Suicide or thoughts of death
b) Physical symptoms
    a. As outlined above could include: sleep disruption, low energy
    b. Acute weight loss or gain
    c. Acute or chronic pain such as headaches, back pain, or joint pain
    d. Stomach issues
    e. Irritability can be a primary presenting symptom in children and adolescents
c) Physical Examination
    a. Often normal
    b. Careful evaluation of growth parameters and vital signs
    c. Thorough physical examination to rule out potential medical causes and to visualize skin for any signs of self injury

IX. Differential Diagnosis/Laboratory Examination

a) Consider differential diagnosis including physical conditions that mimic depression:
    a. Attention deficit/hyperactivity disorder (restlessness or inattention)

b. Psychotic disorders (restlessness or socially withdrawn)
c. Pervasive Developmental Disorder (socially awkward, **withdrawn**, poor social skills, adherence to routines)
d. Learning disabilities
e. Other mental health disorders such as bipolar or anxiety
f. Hypothyroidism
g. Illicit drug effects, consider urine drug screen
h. Migraine presentation
i. Seizure or sleep disorder
j. Anemia
k. Mononucleosis
l. Vitamin D Deficiency

b) No routine labs recommended unless guided by history. Considerations could include thyroid labs or urine drug screen.

- **Clearly document somatic complaints prior to starting medication to avoid mistaking baseline symptoms as side effects of medication**

X. Screening

- The United States Preventative Task Force currently recommends the screening of all adolescents ages 12 – 18 for Major Depression Disorder utilizing a validated screening tool
- Estimated that 50% of youth with depression not detected in primary care settings
- Obtain information from multiple sources including: parents, teachers, and patients utilizing validated tools and screens or any additional communications
- Child's desire to please may alter responses to interviewer
- Utilize validated screening tools including:

a. ***PHQ 9 Modified for teens considered best practice for 11+***
   - Completed by patients, themselves, ages 11+
   - Along with clinical judgment and patient/family discussion this tool divides major depressive disorder into the following categories based on scoring:
     - Score 0-4 – no or minimal depression
     - Score 5-9 – mild depression
     - Score 10-14 – moderate depression
     - Score 15-19 – moderately severe depression
     - Score 20-27 – severe depression
   - With a cut off score of 11 PHQ-9 has a sensitivity of 89.5% and a specificity of 77.5%
   - In contrast the PHQ-2 with a cut score of 3 had a sensitivity of 73.7% and a specificity of 75.2%
   - ***19% of teenagers who did endorse suicidality did not screen positive on the PHQ-2***
   - See Appendix D
   - Available in EPIC or print here: Cook Branded PHQ 9M

b. PSC 17 for ages 4-11
   - A tool for screening a younger age group than is covered by PHQ
   - Newer, shorter version of older PSC -34
   - This is not just a screen for depression but for wider issues, among which are depressive symptoms
   - PSC-17 Parent version for ages 4-8, completed by parent
   - PSC-17 Y Youth version completed by patient for ages 9+

- Scoring is same for parent and youth scales
- Available in EPIC or print here: PSC-17.pdf
- Questions relating to 17 symptoms, with answers of frequency including never, sometimes, often (0,1, 2)
- Screen is concerning for issues for which you should delve further if total score is greater than or equal to 15
- There are also 3 sub scale scores:
    1. Attention issues (positive score 7+)
    2. Externalizing symptoms: acting out/behavior issues (positive is 7+)
    3. Internalizing symptoms: quiet sad/anxious symptoms (positive is 5+)

c. Additional screening tools include:

- Columbia Depression Scale: Guidelines TOOLKIT DEP.qxd (columbia.edu)
    - For age 11YO+, there are teen and parent versions based on who is completing
    - 22 questions, including questions about suicidal ideation
    - Rates a patient's chance of having depression:
        - 1-4 Very unlikely
        - 5-9 Moderately likely
        - 10-12 Likely
        - 13+ Highly likely
    - Not available in EPIC
- Adolescent Suicide Questionnaire: (12) screening_tool_asq_nimh_toolkit.pdf (nih.gov)
    - Secondary screening tool if depression screen or discussion creates need to further investigate suicidal ideation
    - Five questions about suicidal thinking, planning, and prior attempts
    - Includes a worksheet to guide the clinician
- Daily Rating of Severity of Problems for Premenstrual Mood Symptoms (13): Daily-Record-of-Severity-of-Problems-PMDD.pdf

XI. Suicide and Self-Harm

NOTE: Any patient with active suicidal ideation in which they do not wish to be alive and have a plan to do it requires emergent referral psychiatric evaluation and inpatient admission. For additional detail on Suicide, refer to Clinical Pathway: Primary Care Suicide Screening: Lucidchart

- Suicidal Ideation is common in teens
- Always inquire about suicidal ideation in a setting of mental health issues including depression and anxiety
- Second leading cause of death for ages 5 – 24 years
- 6,417 kids ages 10 – 24 died by suicide in 2023
- In younger children often related to impulsivity or ADHD
- Adolescents more commonly planned, related to anxiety or depression with an acute stressor

Risk Factors for Suicide

- History of prior attempts
- Family history of suicidal behavior
- Mood disorders
- Particularly early-onset Major Depression
- Anxiety Disorders
- Substance abuse
- Irritability & agitation
- Availability of lethal means

- Runaway behavior
- LGBTQ+
- Victims of childhood sexual or physical abuse

SAFETY PLAN: All patients considered high risk for suicide but not having active suicidal ideation or suicide plan should complete a safety plan and have increased frequency of follow up or referral to appropriate mental health provider (Psychiatry or BHAC if available). See Appendix E for sample COOK CHILDRENS SAFETY PLAN

XII. SPECIAL CARE: Cutting

- Symptom of a larger problem
- Review Medical history with review of Tdap status
- Cutting releases endorphins, serotonin, and dopamine
    - Powerful biochemical response – produces calming
    - Makes cutting hard to stop
        - "When you feel like cutting, is there something you can do instead?"
- Relief from negative emotion (anxiety, numbness)
- Self-hatred typically present
- Action represents a cry for help
- Must evaluate: Do they need a higher level of care?
    - "What were you hoping would happen when you cut?"
        - Trying to kill self → Cook Children's Emergency Department
        - Relief + passive suicidal ideation → Partial Hospitalization Program
- Safety plan to include: Lock up sharps, search room, monitor social media
- Refer for therapy
    - Dialectical Behavioral Therapy (DBT) – excellent for this but hard to find
    - Cognitive Behavioral Therapy (CBT)
- Refer to psychiatry
    - No medications for self-injury but it rarely occurs without other psychiatric symptoms

XIII. Trauma Informed Care

Trauma informed care serves as an overarching framework stressing the effect of trauma and the importance of its recognition in working with patients and their families.

The 4 Rs of trauma informed care include:

R – REALIZING the broad impact of trauma and paths for recovery

R – RECOGNIZING the signs and symptoms

R – RESPONDING and caring for the victim of trauma, and integrating identification and care for trauma into all policies, procedures and practices

R – RESISTING RE-TRAUMATIZATION by using best practice interventions to actively treat and prevent unnecessary re-traumatization

Once trauma is recognized providers should strive to provide education and support to families on the creation of safe, stable and nurturing relationships.

Additionally, if available in your area:

- Trauma specific services should be employed through consultation with mental health specialists
- Trauma-focused cognitive behavior therapy – proven through 6 randomized control trials to be superior to other commonly used treatments in management of PTSD, depression, shame and behavioral problems in children related to past trauma
- Child-parent psychotherapy – designed for treatment of young children ages infancy to 6 years to heal the effect of trauma on small children and improve parent/child interactions
- Child and family traumatic stress interventions
- Cognitive behavioral interventions for trauma in schools

XIV. Treatment

a) General:

- Treatment involves 3 modalities with choice dependent on severity of illness and comfort of patient/family
    - Cognitive Behavioral Therapy
    - Medication
    - Combination of both of the above
- Mild to moderate: start with counseling
- Moderate to severe: use a combination
- Persistent school refusal may warrant partial hospitalization
- If treatment failure occurs, consider what else may be happening in patient's life, trauma, etc.
- **Treatment for Adolescent Depression Study: TADS**
    - 3 treatment arms: fluoxetine, Cognitive Behavioral Therapy (CBT), and the combination of both
    - "In adolescents with moderate to severe depression, treatment with fluoxetine alone or in combination with CBT accelerates the response. Adding CBT to medication enhances the safety of medication. Taking benefits and harms into account, combined treatment appears superior to either monotherapy as a treatment for major depression in adolescents

b) Cognitive Behavioral Therapy (CBT)

- Focuses on the interplay between cognitions, behaviors, and emotions
- Goal to assist patients in recognizing maladaptive thoughts and change patterns of avoidance
- CBT beneficial in ages 7 years and older
- Other children may benefit from play therapy or talk therapy
- Key treatment components include:
    - Psychoeducation – normalizing symptoms of depression
    - Somatic management skills – diaphragmatic breathing and muscle relaxation
    - Cognitive restructuring – identifying and challenging maladaptive thoughts
    - Exposure – gradual and supported exposure to the feared situation
    - Relapse prevention – establish a contingency plan if symptoms return

c) Medication management

a) General

- Selective Serotonin Reuptake Inhibitors represent first line treatment due to lower incidence of side effects and long clinical experience
- Dosage change interval every 1 month if limited improvement
- Always begin at the lowest recommended dose for children

b) Side Effects

- Most common side effects include headaches, gastric distress and sleep disturbances
- Weight change is unusual with SSRI but can occur

- Agitation possible especially if family history of Bipolar Disorder
- Diarrhea and dulled emotions more common with Sertraline
- Rare side effects include menorrhagia, increased bruising, or alterations in blood glucose
- Sexual dysfunction symptoms can occur with SSRIs including difficulty achieving or sustaining arousal/orgasm

XV. Black Box Warning

- All SSRIs contain a black box warning regarding increased risk for suicidal ideation in adolescents and should be discussed with families
- Warning added based on data showing patients with 2 % suicidal ideation prior to starting meds and 4 % after
- **Careful weighing of risk and benefit must be undertaken and discussed in detail with family. Follow up within 4 – 6 weeks of medication initiation is considered best practice.**

Medication	Starting dosage	Max dose	Other Uses/age limits
Sertraline (SSRI)	**25 mg PO Daily**	**150 mg PO Daily**	**Depression and OCD** **Ages > 6**
Fluoxetine (SSRI)	**Children: 5 to 10 mg PO Daily** **Adolescents: 10 mg PO Daily**	**60 mg PO Daily**	**Depression, OCD, selective mutism** **Ages > 7**
Escitalopram (SSRI)	**5 mg PO Daily**	**20 mg PO Daily**	**Depression** **Ages 12-17**
Citalopram (SSRI)	**10 mg PO Daily**	**40 mg PO Daily**	**Depression** **Ages 18 and older**

CROSS TAPER GUIDANCE PROVIDED IN APPENDIX G or use:
SwitchRx: Switching Medications

XVI. Treatment Pearls from Cook Children's Psychiatry

- **These medications represent standard of care for treatment of depression by COOK Children's Psychiatry**
- Set expectations: some benefit in first 3-5 days but takes 4-6 weeks to see full effect
- Because of black box warning, make sure the patient knows to tell a parent if they have suicidal ideation
- Fluoxetine has a half-life of 60 hours, no need to taper, good for teens
- Usually start sertraline at night because it can make some patients sleepy

- Liquid sertraline should be diluted in 4 oz of fluids and has a strong metallic taste which makes compliance difficult, consider Fluoxetine if liquid needed
- **Refer to psychiatry if failure to control symptoms at maximum dosage, multiple comorbidities or patient/provider request**

XVI. Serotonin Syndrome

- Presentation can range from mild symptoms to potentially life threatening
- Symptoms usually present within 24 hours of increase in dosage or addition of another serotonergic agent
- Mild presentations typically include features of mild hypertension and tachycardia, mydriasis, diaphoresis, shivering, tremor, myoclonus, and hyperreflexia
- Moderate to severe presentations include fever as a hallmark presenting symptom
- Most presentations are mild and will self-resolve with removal of medication
- Symptoms of serotonin syndrome with one SSRI do not exclude future uses of others

Symptom Cluster	Symptomatology
Altered Mental Status	**Agitation** **Anxiety** **Disorientation** **Restlessness** **Excitement**
Neuromuscular Abnormalities	**Tremors** **Clonus** **Hyperreflexia** **Muscle rigidity** **Bilateral Babinski sign** **Akathisia**
Autonomic Hyperactivity	**Hypertension** **Tachycardia** **Tachypnea** **Hyperthermia** **Mydriasis** **Diaphoresis** **Dry mucous membranes** **Flushed skin** **Shivering** **Diarrhea** **Vomiting** **Hyperactive bowel sounds** **Arrhythmias**

XVII. Resources for Providers

Resource	What is it helpful for?	Contact Info
Behavioral Health Intake	Community resources, navigating levels of care	682-885-3917
Cook Outpatient Psychiatrist On Call	Medication questions	682-885-1050 and ask to leave a message for the psychiatrist on call or use the On-Call Finder in Epic and Epic Chat to message them
BH-ABC (Behavioral Health Assessment and Bridge Clinic)	Rapid behavioral health assessment with 3 medication management appointments and/or crisis therapy	Mark the patient's Behavioral Health Resource order as 'Urgent' to refer to this clinic
Child Psychiatry Access Network (CPAN)	A Texas legislature funded access point for mental health care	**Providers can call** 888-901-CPAN (2726) to connect with a pediatric psychiatrist or mental health clinician

- Community Behavioral Health Resources available on COOKNET Clinical Guidelines
  - http://intranet.cookchildrens.org/departments/HealthCareSystem/cg/Documents/Community%20Behavioral%20Health%20Resources/Behavioral%20Health%20Community%20Resources.pdf
- Online Resources
  - Behavior and Emotion Resources | Cook Children's
  - Parents' Medication Guides

XVIII. Coding Guidance for Providers

CLINICAL PATHWAY FOR THE MANAGEMENT OF DEPRESSION IN THE PRIMARY CARE MEDICAL HOME

Initial Consult		
Patient Scenario	**MDM**	**E&M Level**
Patient presents with mild exacerbation of anxiety w/ depression. Physician evaluates & discusses management options: referral for counseling, observation, prescription management. Caregiver would like to seek counseling and trial prescription management.	• Chronic w/ mild exacerbation • Prescription drug management	Level 4
Patient presents with severe exacerbation of anxiety w/ depression. Physician evaluates & discusses management options: prescription management/ counseling. Due to the severity of presentation physician also discusses recommendation to elevate care to PHP. Caregiver would like to trial prescription management & seek counseling first. Will closely follow.	• Chronic w/ severe exacerbation • Decision for hospitalization*** ○ ****2021 E&M guidelines give credit for management options considered. If decision for hospitalization was considered but not elected this needs to be documented and the highest risk will go to this option.*	Level 5
Follow-up Visits		
Patient returns for follow-up of anxiety with depression. Prescription medication began during initial consult. Patient has been responding well. Will continue to follow.	• Stable Chronic • Prescription drug management	Level 3
Patient returns for follow-up. Prescription medication began during initial consult. Patient still reporting bothersome signs/ symptoms. Will increase dose and see the patient back in 3-4 weeks.	• Chronic w/ mild exacerbation ○ E.g. chronic condition 'not at treatment goal' • Prescription drug management	Level 4
Patient returns for follow-up. Prescription medication began during initial consult. Patient reports signs/ symptoms have intensified. Caregiver has become concerned. Due to severity physician discusses management options: increase prescription dose vs. seeking elevation of care via PHP. Caregiver would like to seek elevation of care via PHP.	• Chronic w/ severe exacerbation • Decision for hospitalization*** ○ ***2021 E&M guidelines give credit for management options considered. In this case hospitalization was selected. However, whether it was selected or only considered this would still have been the same RISK	Level 5

Appendix A – Depression Quick Reference from Cook Psychiatry

Major Depressive Disorder[1]:

- **5 or more of the following, for 2 weeks, & represents a change from baseline**
  - **Depressed mood or irritability**
  - **Decreased interest or pleasure in activities**
  - Change in appetite
  - Change in sleep
  - Agitation/psychomotor retardation
  - Fatigue
  - Worthlessness/guilt
  - Difficulty concentrating
  - Recurrent thoughts of death

CookChildren's

Treatment approach: Counseling & medication are equally efficacious; combination therapy typically produces faster & safer improvement in pediatric patients.

FDA-Approved Medications for the Treatment of Depression in Pediatric Patients:

Medication	Starting Dose	Titration	Max Dose
Escitalopram	5 mg	5 mg every 4 weeks until effective	20 mg
Fluoxetine	10 mg	10 mg every 4 weeks until effective	60 mg

Treatment course and monitoring

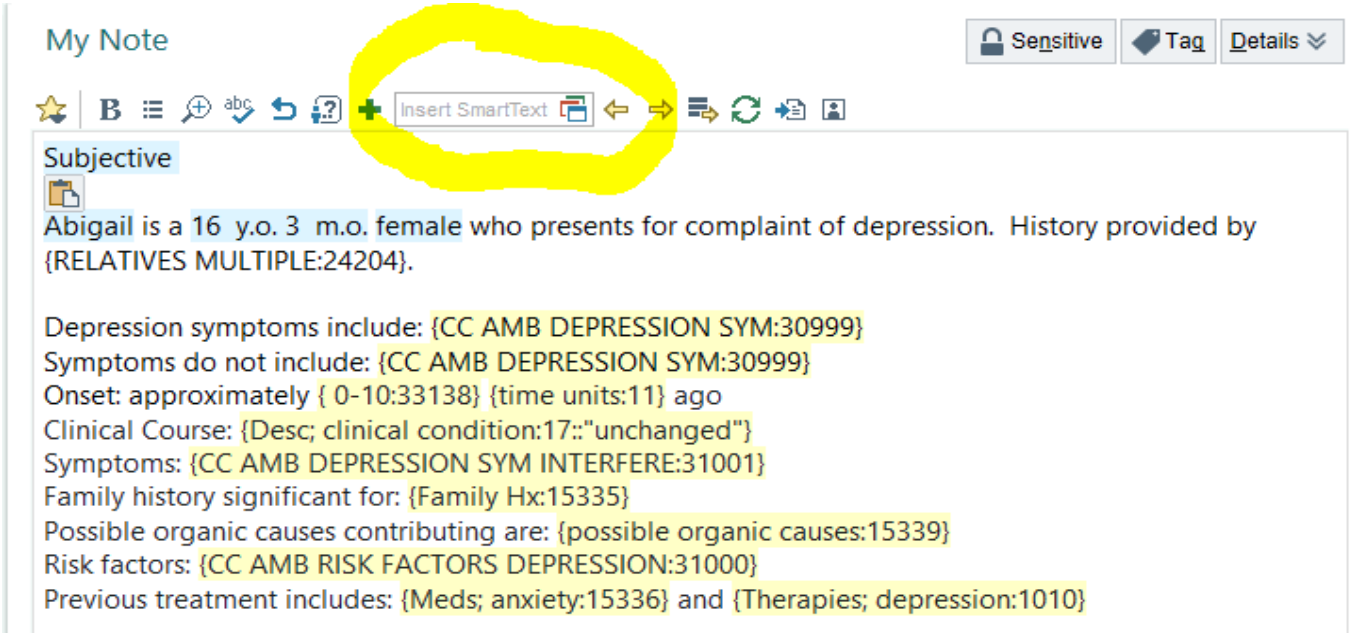
- **Initial follow-up:** Approximately 4 weeks after SSRI initiation.
- **Ongoing follow-up:** Every 1–2 months thereafter while adjusting or stabilizing treatment.
- **Time to effect:** Expect up to 4–6 weeks to see full therapeutic benefit.
- **Duration of therapy:** Continue SSRI treatment for **6–12 months** after mood stabilization to reduce risk of relapse.

Quick reminders for clinicians

- Combine psychotherapy with medication when possible for faster, safer improvement.
- Individualize dosing and monitoring based on clinical response and tolerability.
- Document follow-up plans and safety monitoring (including suicidality risk) at each visit.

Appendix B – Documentation of Depression in EPIC

Documentation Smart Phrase: CC AMB Gen Depression



Appendix C – PHQ 9 Modified

CookChildren's

PHQ-9: Modified

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? 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
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 schoolwork, 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?				
In the past year, have you felt depressed or sad most days, even if you felt okay sometimes? ○ Yes ○ No				
If you're 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				

**If you've had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your health care clinician, go to a hospital emergency room, or call 911.*

Office use only:
Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Use with permission. Guidelines for Adolescent Depression in Primary Care. Version 2, 2010.

Appendix C – PHQ 9 Modified (continued)

Scoring the PHQ-9 Modified

Scoring the PHQ-9 Modified is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for major depressive disorder:
- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need 5 or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult.....) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:
- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score > 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:
- The dysthymia question (In the past year....) should be endorsed as "yes."

To use the PHQ-9 to screen for suicide risk:
- All positive answers to question 9 as well as the two additional suicide items MUST be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:
- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See table below.

Total score	Depression severity
0-4	No or minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

CookChildren's.

09.2025

APPENDIX D – PSC-17 – Parent Report

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

13

APPENDIX D – PSC-17 – Youth Self-Report

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still ◆	0	1	2
✻	Feel sad, unhappy ✻	0	1	2
◆	Daydream too much ◆	0	1	2
❑	Refuse to share ❑	0	1	2
❑	Do not understand other people's feelings ❑	0	1	2
✻	Feel hopeless ✻	0	1	2
◆	Have trouble concentrating ◆	0	1	2
❑	Fight with other children ❑	0	1	2
✻	Down on yourself ✻	0	1	2
❑	Blame others for your troubles ❑	0	1	2
✻	Seem to be having less fun ✻	0	1	2
❑	Do not listen to rules ❑	0	1	2
◆	Act as if driven by a motor ◆	0	1	2
❑	Tease others ❑	0	1	2
✻	Worry a lot ✻	0	1	2
❑	Take things that do not belong to you ❑	0	1	2
◆	Distract easily ◆	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total ❑ _____ Total ✻ _____ Grand Total ◆+❑+✻ _____

APPENDIX E – SAFETY PLAN

SAFETY/SUPPORT PLAN FOR THE FOLLOWING PROBLEM:

☐ SELF-HARM ☐ SUICIDE ☐ AGGRESSION ☐ ALTERED THOUGHT PROCESSES ☐ OTHER _____

PROBLEM TRIGGERS:

1. _____

2. _____

3. _____

COPING SKILLS – THINGS I CAN DO TO DEAL WITH MY PROBLEM OR TAKE MY MIND OFF OF MY PROBLEM (EXAMPLES: LISTEN TO MUSIC, EXERCISE, READ, WATCH TV, JOURNAL, DO ARTWORK):

1. _____

2. _____

3. _____

PEOPLE I CAN TALK TO OR ASK FOR HELP WHEN I FEEL UPSET:

1. _____ **TELEPHONE NUMBER** _____

2. _____ **TELEPHONE NUMBER** _____

3. _____ **TELEPHONE NUMBER** _____

IMPORTANT TELEPHONE NUMBER FOR GETTING HELP

NAME OF AGENCY/PROFESSIONAL	TELEPHONE NUMBER
COOK CHILDREN'S MEDICAL CENTER PSYCHIATRY INTAKE	**682.885.3917** (press the emergency prompt)
TARRANT COUNTY MHMR CRISIS LINE	1.800.866.2465 (available 24 hours a day)
SUICIDE PREVENTION LIFELINE	1.800.273.TALK (8255)
OTHER:	
OTHER:	

_____ **I WILL CLOSELY MONITOR MY CHILD.**

_____ **I WILL REMOVE OR LOCK UP ALL SHARPS, WEAPONS, MEDICATIONS, CHEMICALS OR OTHER ITEMS THAT COULD BE USED TO HARM SELF OR OTHERS.**

_____ **I WILL** _____

_____

PERSON	SIGNATURE	DATE	TIME
PATIENT			
PARENT/LEGAL GUARDIAN			
STAFF WITNESS			

APPENDIX F – DEPRESSION FAQS/PEARLS from COOK PSYCHIATRY

Cross Tapers: This guidance results from Cook Psychiatry clinical practice and is not an evidence-based recommendation.

Fluoxetine:

Fluoxetine → Escitalopram		
Week:	**Fluoxetine dose:**	**Escitalopram Dose:**
Week 1:	Stop fluoxetine because it self-tapers	5 mg
Week 3 or 4:	0 mg	10 mg if no improvement at 5 mg
Fluoxetine → Sertraline		
Week:	**Fluoxetine dose:**	**Sertraline Dose:**
Week 1:	Stop fluoxetine because it self-tapers	25 mg qhs
Week 3 or 4:	0 mg	50 mg qhs
Week 5 or 6:	0 mg	75 mg qhs (reassess symptoms before increasing)
Week 7 or 8:	0 mg	100 mg qhs (reassess symptoms before increasing)
Week 9 or 10:	0 mg	150 mg (reassess symptoms before increasing)

Escitalopram:

Escitalopram → Fluoxetine		
Week:	**Escitalopram dose: if starting at 20 mg**	**Fluoxetine Dose:**
Week 1:	15 mg	10 mg
Week 2:	10 mg	
Week 3:	5 mg	Increase to 20 mg if no improvement
Week 4:	stop	Continue 20 mg
Escitalopram → Sertraline		
Week:	**Escitalopram dose: if at 20 mg:**	**Sertraline Dose:**
Week 1:	15 mg	25 mg qhs
Week 2:	10 mg	25 mg qhs
Week 3:	5 mg	50 mg qhs
Week 4:	0 mg	50 mg qhs
Week 5:	0 mg	75 mg qhs

Sertraline:

Sertraline → Fluoxetine		
Week:	**Sertraline dose: if starting at 200 mg**	**Fluoxetine Dose:**
Week 1:	150 mg	10 mg
Week 2:	100 mg	
Week 3:	50 mg	Increase to 20 mg if no improvement
Week 4:	25 mg	Continue 20 mg
Week 5:	0 mg	Continue 20 mg
Sertraline → Escitalopram		
Week:	**Sertraline dose: if at 200 mg:**	**Escitalopram Dose:**
Week 1:	150 mg	5 mg
Week 2:	100 mg	5 mg
Week 3:	50 mg	10 mg
Week 4:	25 mg	10 mg
Week 5:	0 mg	Increase to 15 mg if no improvement

Antidepressant Discontinuation After 6-12 Months of Stability:

- Fluoxetine: decrease by 10 mg per month
- Escitalopram: decrease by 5 mg per month
- Monitoring: reassess symptoms with each dose reduction to monitor for recurrence of depression. Monthly visits are not required but caregivers should call monthly to report progress and receive updated instructions.
- There is no requirement to taper after 6-12 months of stability however it is important to discuss this option when the patient is doing well. Continuation is appropriate if the patient or family prefers. Long-term use is safe and does not pose additional risk.

Sleep aids:

Medication:	Starting Dose:	Max dose:	Side effects:
Melatonin	1-3 mg	5-6 mg	Vivid dreams
Benadryl	12.5 mg	50 mg	Constipation, don't give if kid has paradoxical reaction
Hydroxyzine	12.5 mg – 25 mg	50 mg	Slightly better for anxiety than benadryl
Trazodone	25 - 50 mg	100 -150 mg (weight dependent)	Orthostatic hypotension & priapism

- Consider advising parents to administer the first dose on a weekend or low-stress period. Avoid initiating treatment the night before significant events such as exams or performances to minimize the risk for side effects negatively affecting quality of life.

Pharmacogenetic Testing:

In general, this testing should be discouraged, as it is rarely helpful. There are 2 FDA-approved SSRIs for treating depression in kids, and it is best practice to recommend one of those regardless of what the testing says. Advise parents that the testing does not tell us **if** the medication will work or not. It only tells us how your body breaks it down. In general, experience has shown that it is not helpful.
https://www.fda.gov/news-events/press-announcements/fda-issues-warning-letter-genomics-lab-illegally-marketing-genetic-test-claims-predict-patients

Appendix G Major Depressive Disorder (1, 6)

Prevalence:

- 12 month prevalence of 7 % for all ages in United States (1)
  - Children 2 % with 1:1 M to F (6)
  - Adolescence 4-8 % with 1:2 M to F (6)
- Peak incidence in 20's

Diagnostic Criteria:

- Symptoms present daily for 2 weeks
- One or more of the following must be present:
  - Depressed mood, ***this may present as irritability in children***
  - Loss of interest or pleasure in activities
- In addition 3 (or more) of following for a total of 5 symptoms:
  - Unintentional weight loss
  - Sleep changes either insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Fatigue
  - Feelings of worthlessness
  - Loss of ability to concentrate
  - Recurrent thoughts of death or suicidal ideation
- Symptoms create distress or impairment in social, work, or school functioning
- No substance or medical conditions present to which symptoms can be attributed
- No history of a manic like or hypo-manic episode
- Symptoms must be present daily with exception of weight change and suicidal ideation

Clinical Presentation:

- Insomnia or fatigue is frequently the presenting symptom so must probe for depression in such cases
- Frequent somatic complaints, aches and pains, also a common presentation
- Irritability expressed as angry outbursts or blaming others
- Change in appetite

Additional Points:

- Likelihood of onset increases with puberty
- Remission defined as a period of 2 or more months with no symptoms
- Chronicity of symptoms increases likelihood of comorbid diagnosis
- Recovery typical within 3 months for 40% of individuals and within 1 year for 80% of individuals
- Substantial number of bipolar individuals will present initially with depressive symptoms
- Possibility of suicide behavior exists at all times
- Greatest risk factor for suicide completion is previous suicide attempt
- Females have higher rates of attempts but males have higher rates of completion

Risk Factors:

- Neuroticism or negative affectivity is well established risk factor
- Adverse childhood experiences
- First degree family members of individuals with major depressive disorder have a 2 to 4 fold higher risk
- All major non-mood disorders, substance use, anxiety or personality disorders increase likelihood of depression
- Risk of recurrence lower over time as duration of remission increases
- Risk of recurrence higher in severe depression, younger age of onset or history of multiple previous episodes

Differential Diagnosis:

- Manic episodes with irritable mood
- Mood disorder due to another medical condition (Multiple sclerosis, hypothyroidism, stroke)
- Substance or medication induced depression
- Bipolar disorder
- Attention Deficit/Hyperactivity Disorder
- Adjustment disorder
- Trauma-related Disorder
- Sadness in which periods last less than 2 weeks and do not meet additional diagnostic criteria

Comorbidity:

- Substance abuse disorders
- Panic disorders
- Obsessive-compulsive disorders
- Anorexia nervosa
- Bulimia nervosa
- Borderline personality disorder

Appendix H Disruptive Mood Dysregulation Disorder (1)

Prevalence:

- 6 month to 1 year prevalence of 2 – 5% (1)
- Higher rates in males and school aged children

Diagnostic Criteria:

- Severe recurrent temper outbursts, grossly out of proportion to situation or triggering event
- Outbursts occur on average 3 or more times per week
- Mood of child between outburst is described as irritable or angry
- Above symptoms have been present for more than 12 months with no periods of remission longer than 3 months
- Outbursts occur in at least 2 of 3 settings - home, school, or with peers
- Age of onset before age 10 and diagnosis not made before age 6 or after age 18
- Behaviors do not occur during an episode of major depressive disorder and are not explained by another mental disorder (e.g. autism spectrum, posttraumatic stress, separation anxiety, persistent depressive disorder)

Clinical Presentation:

- Chronic, severe persistent irritability
- Must be carefully distinguished from pediatric bipolar disorder
- Rare rates of conversion to bipolar
- Half of children with extreme irritability will continue to meet diagnosis 1 year later
- At risk to develop depression or anxiety disorders in adulthood
- May exhibit face emotion labeling deficits
- Disturbed decision making and cognitive control
- Difficulty succeeding in school

Additional Points:

- Suicidal behavior and aggression should be clearly noted and addressed
- Rates of dangerous behaviors, suicidal ideation or attempts, severe aggression and hospitalization are high
- Family life is severely disrupted
- Often have difficulty initiating and sustaining friendships

Risk Factors:

- Typically have complicated psychiatric histories
- May meet criteria for attention-deficit hyperactivity disorder, anxiety, or major depressive disorder
- Predominantly male

Differential Diagnosis:

- Bipolar disorders
- Oppositional defiant disorders
- Attention deficit/hyperactivity disorder
- Major depressive disorder
- Anxiety disorder
- Trauma-related Disorder
- Autism spectrum disorder
- Intermittent explosive disorder

Comorbidity:

- High rates of co-morbidity with strongest overlap with oppositional defiant disorder
- Disruptive behavior, mood, or anxiety
- Autism spectrum symptoms or diagnosis

Appendix I - Persistent Depressive Disorder (Dysthymia) (1)

Prevalence: 12 month prevalence in United States of 0.5%

Diagnostic Criteria:

- ***Depressed mood most of day for at least 2 years***
- Two or more of following symptoms
    - Appetite change
    - Sleep disturbance
    - Fatigue or low energy
    - Low self esteem
    - Poor concentration or difficulty making decisions
    - Feelings of hopelessness
- No period without symptoms of more than 2 months
- Never a manic episode
- Not better explained by other psychiatric condition
- Symptoms not due to substance or medical condition
- Symptoms cause impairment in social, occupational, or other areas of functioning

Clinical Presentation:

- In children or adolescents diagnosis applicable if depressed mood for 1 year
- Patients describe mood as sad or down in the dumps
- Onset before age 21 years carries a higher likelihood of comorbid personality disorder or substance use disorder

Risk Factors:

- High levels of neuroticism
- Poor global functioning
- Presence of anxiety or conduct disorder
- History of parental loss of separation
- First-degree relatives with persistent depressive disorder

Differential Diagnosis:

- Major depressive disorder
- Psychotic disorders
- Bipolar disorder
- Trauma-related Disorder
- Substance or medication induced depressive disorder
- Personality disorder

Comorbidity:

- High risk for psychiatric comorbidity
- Anxiety disorders
- Substance abuse disorders
- Personality disorders

Appendix J - Premenstrual Dysphoric Disorder (1)

Prevalence:

- 12 month prevalence of 1.8 to 5.8 %

Diagnostic Criteria:

- Symptoms must occur in majority of menstrual cycles
- Symptom timing includes:
  - Onset within week prior to onset of menses
  - Symptoms improve within a few days after onset of menses
  - Minimal or absent symptoms in week post menses
- One or more of following must be present:
  - Marked mood swings
  - Marked irritability
  - Marked depressed mood
  - Marked anxiety
- In addition one (or more) of following for a total of 5 symptoms:
  - Loss of interest in activities
  - Difficulty in concentration
  - Low energy or fatigue
  - Change in appetite
  - Sleep changes
  - Feeling overwhelmed or out of control
  - Physical symptoms including breast tenderness, joint pain, muscle pain, bloating, or weight gain
- Symptoms result in significant distress or functioning in school, work or social activities
- Not explained by exacerbation of another psychiatric disorder
- Not attributable to a substance, medication or other medical condition

Clinical Presentation:

- Frequency, intensity and expressivity of symptoms may be influenced by cultural factors
- Diagnosis is appropriately confirmed by 2 months of prospective ratings (see section on screening methods on page 16, the Daily Rating of Severity of Problems)
- Clinically meaningful distress resulting in poor school, family, and social functioning
- Oral contraceptives may modify course with fewer premenstrual complaints

Risk Factors:

- Stress
- History of interpersonal trauma
- Incidence of heritability estimated between 30 and 80%

Differential Diagnosis:

- Premenstrual syndrome – shares the symptoms but of less severity and impact
- Dysmenorrhea or syndrome of painful menses without affective changes
- Bipolar disorder
- Major depressive disorder
- Trauma-related Disorder
- Persistent depressive disorder
- Effect of hormonal treatments including contraceptives

Comorbidity:

- Major depressive episodes
- Worsening of other medical or mental disorders during the premenstrual phase including:
  - Migraine
  - Asthma/Allergies
  - Seizure disorders
  - Depressive. Anxiety, or bipolar disorders
  - Bulimia nervosa
  - Substance use disorders

Appendix K - Substance/Medication-Induced Depressive Disorder (1, 7)

Prevalence:

- Lifetime prevalence of 0.26%
- More likely to be male

Diagnostic Criteria:

- Persistently depressed mood with loss of interest or pleasure in activities
- Evidence of both:
    1. Symptoms developed soon after intoxication, withdrawal or exposure to substance or medication
    2. The involved substance is capable of producing symptoms
- Symptoms not better explained by depressive disorder not substance induced
- Not associated with course of delirium
- Causes significant social, occupational or other areas of functioning

Clinical Presentation:

- Features include the symptoms of depressive disorder
- Symptoms associated with ingestion, injection or inhalation of substance
- Depressive symptoms persist beyond length of physiologic effects of substance
- Distinguished through careful consideration of onset, course and other factors
- Onset typically during use of medication and/or withdrawal period

Substances which can Induce Depressive Symptoms: (7)

- Alcohol
- Opioids (especially heroin)
- Cocaine
- Hallucinogens
- Inhalants
- Amphetamines
- Stimulants (methylphenidate, dextroamphetamine)
- Steroids (i.e. high dose corticosteroids
- Hormones (i.e. high estrogen/progesterone oral contraceptives: thyroid medications)
- Other CNS drugs (i.e. neuroleptics such as carbamazepine, topiramate, gabapentin)
- L-dopa; anticholinergics such as dicyclomin, bentyl)
- Dermatologic agents (isoretinoin/Accutane)
- Chemotherapeutic agents
- Immunologic agents (interferon-alpha)
- Beta-blockers
- Statins
- Proton-pump inhibitors
- Singulair (black box warning)
-

Note that substances of abuse and medications which are not CNS depressants, and which in fact are CNS "uppers"/stimulants, can cause depression in withdrawal.

Risk Factors:

- Individuals with known alcohol or drug use disorders
- History of major depressive disorder
- History of drug induced depression
- Psychosocial stressors

Differential Diagnosis:

- Substance intoxication and withdrawal
- Primary depressive disorder
- Trauma-related Disorder
- Depressive disorder due to another medical condition

Appendix K (continued) - Substance/Medication-Induced Depressive Disorder (1, 7)

Comorbidity:

- Any DSM IV mental disorder
- Pathologic gambling
- Paranoid, histrionic and antisocial personality disorders
- Alcohol use disorder or substance use disorder
- Less likely to have persistent depressive disorder

Appendix L - Depressive Disorder Due to another Medical Condition (1)

Diagnostic Criteria:

- Persistent period of depressed mood
- Evidence from history, exam or laboratory findings that is direct consequence of another medical condition
- Not better explained by other mental disorder
- Does not occur in course of delirium
- Causes significant distress or impairment in social, occupational or other areas of functioning

Clinical Presentation:

- Clinician must first establish the presence of a general medical condition
- Mood disturbance is etiologically related to medical condition
- Temporal association between onset, exacerbation, and remission of general medical condition and mood disturbance
- Presence of features atypical to mood disorders including atypical age of onset or course or lack of family history
- Evidence in literature that suggests there can be direct association between the medical condition and development of depressive symptoms

Additional Points:

- Examples of medical conditions with clear associations include:
    - Stroke – symptoms can occur within 1 day
    - Huntington's
    - Parkinson's
    - Traumatic brain injury
    - Cushing's
    - Hypothyroidism

Differential Diagnosis:

- Depressive disorders not due to another medical condition
- Medication induced depressive disorder
- Adjustment disorder

References

1. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.)
2. American Academy of Pediatrics (10/19/21) *Pediatricians, Child and Adolescent Psychiatrists, and Children's Hospitals Declare National Emergency in Children's Mental Health*. Retrieved from: Pediatricians, Child and Adolescent Psychiatrists and Children's Hospitals Declare National Emergency in Children's Mental Health (aap.org)
3. Hills, S., et.al. (December, 2021) *Covid-19 Associated Orphanhood and Caregiver Death in the United States. Pediatrics*. 148(6): 31-43.
4. Boulier, M., Blair, M. (March 2018) *Adverse Childhood Experiences*. Pediatrics and Child Health. 28 (3): 132-137
5. Trauma Informed Care Implementation Resource Center (2021) *What is Trauma Informed Care?* Retrieved from: What is Trauma-Informed Care? - Trauma-Informed Care Implementation Resource Center (chcs.org)
6. GLAD-PC Toolkit found at: Guidelines for Adolescent Depression in PrimaryCare (thereachinsti.tute.org)
7. Qato, D., Ozenberger, K., Olfson, M. (June 2018) *Prevalence of Prescription Medications with Depression as a Potential Adverse Effect Among Adults in the United States*. JAMA. 319(22): 2289-22998
8. United States Preventative Task Force (2006) American Family Physician. Retrieved from: Screening for Depression in Children and Adolescents: Recommendation Statement (aafp.org)
9. Kramer T, Garralda ME. *Psychiatric disorders in adolescents in primary care*. Br J Psychiatry. 1998 Dec;173:508-13. doi: 10.1192/bjp.173.6.508. PMID: 9926080.
10. Abraham, P., Shirley, E. (2006) *New Mneumonic for Depression Symptoms* Retreived from: New Mnemonic for Depressive Symptoms | American Journal of Psychiatry (psychiatryonline.org)
11. https://www.nimh.nih.gov/health/statistics/suicide.shtml
12. Practice Parameter for the Assessment and Treatment for Children and Adolescents with Suicidal Behavior. AACAP. July 2001
13. Borenstein, J., Dean, B., Yonkers, K., Endicott, J. (2007) *Using the daily record of severity of problems as a screening instrument for premenstrual syndrome*. Retrieved from: Using the daily record of severity of problems as a screening instrument for premenstrual syndrome - PubMed (nih.gov)
14. March, J. S., Silva, S., Petrycki, S., Curry, J., Wells, K., Fairbank, J., Burns, B., Domino, M., McNulty, S., Vitiello, B., Severe, J., Casat, C., Kolker, J., Riedal, K., Feeny, N., Findling, R., Stull, S., Baab, S., Weller, E. B., ... Rochon, J. (2007). *The Treatment for Adolescents with Depression Study (TADS): Long-term effectiveness and safety outcomes*. Archives of general psychiatry, 64(10), 1132-1144. https://doi.org/10.1001/archpsyc.64.10.1132
15. PHQ – 9 Modified for teens: IHC MHI Depression Fact Sheet: Children and Adolescents (aacap.org)
16. PSC – 17 retreived here: PSC-17.pdf (drbelknap.com)
17. American Academy of Pediatrics (2014) *Addressing Adverse Childhood Experiences and other Types of Trauma in the Primary Care Setting*. Retrieved from: Addressing_ACEs_and_Other_Types_of_Trauma_in_Primary_Care-AAP-2014_508988_7.pdf (michigan.gov)
18. Cohen JA, Kelleher KJ, Mannarino AP. (May 2008) *Identifying, Treating, and Referring Traumatized Children: The Role of Pediatric Providers*. *Arch Pediatr Adolesc Med.* 2008;162(5):447–452. doi:10.1001/archpedi.162.5.447
19. Laskey, A., Sirotnak, A. (2020) *Child Abuse: Medical Diagnosis and Management. American Academy of Pediatrics*. Chapter 31/Trauma Informed Care and Treatment. Pgs 1059-1089
20. ACCAP Practice Parameter: Anxiety. https://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/JAACAP_Anxiety_2007.pdf

21. Leonte, Puilafico, Na, Rynn. (December 2020) *Pharmacotherapy for anxiety disorders in children and adolescents.* Retrieved from: Pharmacotherapy for anxiety disorders in children and adolescents - UpToDate
22. Alvarez, E, Puliafico, A, Leonte, K, Albano, A (2021) *Psychotherapy for anxiety in children and adolescents.* Retrieved from: Psychotherapy for anxiety disorders in children and adolescents - UpToDate
23. Volpie-Abadie, J, Kaye, AM, Kaye, AD (2013) *Serotonin Syndrome.* The Oschner Journal. 2013 Winter; 13(4): 533–540.
24. Brody, D., Hughes, J. (April 2025) Depression Prevalence in Adolescents and Adults: United States, August 2021 – 2023. Retrieved from: Products - Data Briefs - Number 527 - April 2025
25. Tejada-Vera B, Bastian BA, Curtin SC. Deaths: Leading causes for 2023. Natl Vital Stat Rep. 2025 Sep;74(10):1–115. DOI: https:// dx.doi.org/10.15620/cdc/174607.