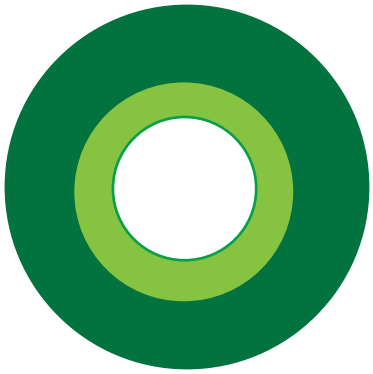

Identification, Diagnosis and Treatment of Adolescent Depression (Major Depressive Disorder)

A Package for First Contact Health Providers

www.teenmentalhealth.org

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For more information visit: **www.teenmentalhealth.org**

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A Package for First Contact Health Providers

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Introduction

This package is provided as a brief overview of clinical depression in adolescents and how first contact health providers can identify and address this issue in an effective, clinically relevant and best evidence-driven manner.

The package is divided into two parts:

1) An informational overview to help first contact health providers understand how to identify, diagnose and treat major depressive disorder in adolescents.
2) A toolkit for first contact health providers containing diagnostic tools and other useful resources for assessing major depressive disorder in adolescents

Throughout this package you will find text highlighted in **blue**. Clicking on the highlighted text will link you to either a resource within the package or to an external website.

This program offers the health care provider a comprehensive, sequential and rational framework for addressing adolescent depression. Each health care provider will be able to extract from this program those components that they can best apply in their own practice setting. By building on the information presented in this course and by utilizing those components of the toolkit that best meet the realities of their practice each health care provider can customize their approach to the treatment of the young person with depression.

For health care practices in which there exist family care teams, different component of the toolkit can be used by different providers with the team leader being responsible to ensure integrated monitoring of ongoing care.

Fast Facts about Adolescent Depression

- Adolescence comprises the years from puberty to the mid-twenties
- Major depressive disorder (MDD) affects 6-8% of adolescents
- Most people who develop MDD experience their first episode between the ages of 14-24 years of age
- Youth onset of MDD usually develops into a chronic condition with substantial morbidity, poor economic/vocational/interpersonal outcomes and increased morbidity (from suicide and, in the long term, from other chronic illness: diabetes, heart disease, etc.)
- Effective treatments that can be provided by first contact health providers are available
- Early identification and early effective treatment can decrease short-term morbidity and improve long-term outcomes (including decreased mortality)

Effective treatment for MDD can be appropriately delivered to adolescents by primary health care providers. Here's how…

Key Steps

1. **Identification of youth at risk for MDD**
2. **Useful methods for screening and diagnosis of MDD in the clinical setting**
3. **Treatment template**
4. **Suicide assessment**
5. **Safety/contingency planning**
6. **Referral flags**

Identification of Youth at Risk for MDD

First contact health providers are in an ideal position to identify youth who are at risk to develop depression. The following table has been compiled from the scientific literature and is presented in a format that can be efficiently used by a health provider to identify those young people who should be periodically monitored for onset of MDD.

MDD in Youth, Risk Identification Table

Well established and significant risk effect	Less well established risk effect	Possible "group" identifiers (these are not causal for MDD but may identify factors related to adolescent onset MDD)
1. Family history of MDD 2. Family history of suicide 3. Family history of a mental illness (especially a mood disorder, anxiety disorder, substance abuse disorder) 4. Childhood onset anxiety disorder	1. Childhood onset Attention Deficit Hyperactivity Disorder 2. Substance abuse 3. Severe and persistent environmental stressors (sexual abuse, physical abuse, neglect) in childhood	1. School failure 2. Gay, lesbian, bisexual, transsexual 3. Bullying (victim and/or perpetrator)

What to do if a youth is identified as high risk?

Educate about risk
MDD is not inevitable but it might occur. If it occurs, the sooner it is diagnosed and effectively treated, the better. It is better to check out the possibility that problems may be MDD than to ignore symptoms if they occur. Primary care health professionals who provide services to families are well placed to educate parents about potential risks for MDD in their children. Family members (youth included) should be made aware of their familial risk for mental disorders the same way they are made aware of their family risk for other disorders (eg: heart disease, breast cancer, etc.). **Click here to access resources for parents about adolescent depression.**

Obtain and record a family history of mental disorder
Primary health care providers should take and record a family history of mental disorders (including substance abuse) and their treatment (type, outcome) as part of their routine history for all patients. This will help identify young people at risk on the basis of family history.

Agree on a "clinical review" threshold
If the young person begins to feel low, sad, down, hopeless, unhappy or irritable or continuously bored and these symptoms last more than a few weeks, this should trigger an urgent clinical review. The onset of suicidal ideation, a suicide plan or acts of self-harm must trigger an emergency clinical review.

Arrange for a standing "mental health check-up"
These could be 15 minute office/clinical visits every 3 to 6 months during the teen years in which a clinical screening for MDD is applied. A recommended screening tool is the Kutcher Adolescent Depression Scale (KADS) which is found below.

One potentially useful approach is to ask the young person or parent to bring in the youth's school reports. Check for a pattern of declining grades, frequent lates or frequent absences. These patterns may indicate a mental health problem.

Confidentiality and understanding that treatment is by informed consent
Part of the education about risk should include a discussion about confidentiality and informed consent to treatment for both the young person and the parents. This information may make it easier for the young person to access care if they become depressed as they may be more comfortable in sharing their distress. For parents, knowing what they can expect in terms of being informed about their child may help them feel more comfortable about how treatment will occur if it becomes necessary.

Useful Methods for Screening and Diagnosis

As youth generally visit health care providers infrequently, screening should be applied to both high risk and usual risk youth at scheduled clinical contacts. Teen visits for contraception or sexual health issues provide an excellent opportunity to screen for depression.

A simple self-test with good sensitivity and specificity should be used. **The 6-item Kutcher Adolescent Depression Scale (6-KADS)** has been tested in population samples and demonstrated excellent sensitivity and specificity. It is recommended for use in both the NICE and GLAD-PC guidelines. It can be filled out by the young person prior to a face-to-face discussion with the health provider and is available in a number of different languages.

The 6 item KADS is available by clicking on the highlighted link above and in the toolkit below.

When the KADS is provided to the young person for the first time, the clinician should take time to ensure that the youth understands the purpose of using the tool and how the KADS should be

completed. When reviewing the KADS please ensure that you provide the young person with feedback on their results.

The 6 item KADS may be used by clinicians.

Clinicians who wish to use the KADS in their work are free to apply it using the directions accompanying the scale. Clinicians who would like training on the KADS and the tool for assessing teen suicide risk are encouraged to contact the office of the Sun Life Financial Chair in Adolescent Mental Health at (902) 470-6598.

Diagnosis of MDD in Adolescence

Mood states in young people may change rapidly and are often strongly influenced by their environment. It is important to distinguish a depressive disorder from depressive distress. The former is of long duration (usually lasting for many months) and will require health provider intervention, while the latter is usually of short duration (less than a couple of weeks) and is likely to resolve spontaneously or be substantially ameliorated by social support or environmental modification alone.

Diagnosis of MDD in adolescents is currently made using **DSM IV-TR criteria**.

Distress

- Always associated with a precipitating event
- Functional impairment is usually mild
- Transient – will usually ameliorate with change in environment or removal of stressor
- Professional intervention not usually necessary
- Can be a positive factor in life – person learns new ways to deal with adversity
- Social supports such as usual friendship and family networks help
- Counseling and other psychological interventions can help
- Medications should not usually be used

Disorder

- May be associated with a precipitating event or may onset spontaneously
- Functional impairment may range; mild – severe
- Long lasting or may be chronic, environment may modify but not ameliorate
- External validation (syndromal diagnosis: DSM*/ICD*)
- Professional intervention is usually necessary
- May increase adversity due to its effect on creation of negative life events (eg: low mood can lead to relationship loss)
- May lead to long term negative outcomes (substance abuse, job loss, etc.)
- Social supports and specific psychological interventions (counselling, psychotherapy)are often helpful
- Medications may be needed but must be used properly

* DSM- Diagnostic and Statistical Manual
* ICD – International Classification of Diseases

Diagnosis of MDD in Adolescence using the KADS

The KADS is a self-report instrument that can be helpful in the diagnosis and monitoring of depression in young people. Information on scoring of the KADS is found on the instrument itself.

A clinical depression in an adolescent should be **suspected** if a KADS score of 6 or higher is found at screening.

A high KADS score (6+) does not mean that a patient has a clinical depression; it simply suggests a possible diagnosis and the score/items can be used as a guide for further questioning.

If a KADS score of 6 or higher is found during screening the following is suggested:

- Discussion about important issues/problems in the youth's life/environment. Complete or use the **Teen Functional Activities Assessment (TeFA)** to assist in determining the impact of the depression on the teens functioning.
- Supportive, non-judgmental problem solving assistance – "supportive rapport" (use the **Psychotherapeutic Support for Teens (PST)** as a guide to this intervention) – strongly encourage and prescribe: exercise; regulated sleep; regulated eating; positive social activities
- Screen for suicide risk - use the **Tool for Assessment of Suicide Risk (TASR)**
- Telephone "check in" scheduled for 3 days from visit (3-5 minutes) – text message or email may be preferred by the adolescent. If a problem is identified ask the young person to come for an appointment as soon as possible.
- Mental health check-up with KADS completion 1 week from visit. This visit could also include the TeFA and PST so schedule about 15-20 minutes
- Another telephone "check in" at three days following the second visit (3-5 minutes)
- A third visit 1 week later during which the KADS & TeFA are completed.

Don't get overwhelmed!

Yes there are a number of clinical tools and they address important issues in diagnosis and treatment of adolescent major depressive disorder. However a full assessment of MDD can be completed in three 15 minute office visits using the suggested framework above. Some clinicians may prefer to integrate the details found in the tools into their assessment interviews rather than using the tools separately. However, the KADS should be routinely utilized at every visit as a symptom monitoring strategy.

MDD Diagnosis is highly probable if:

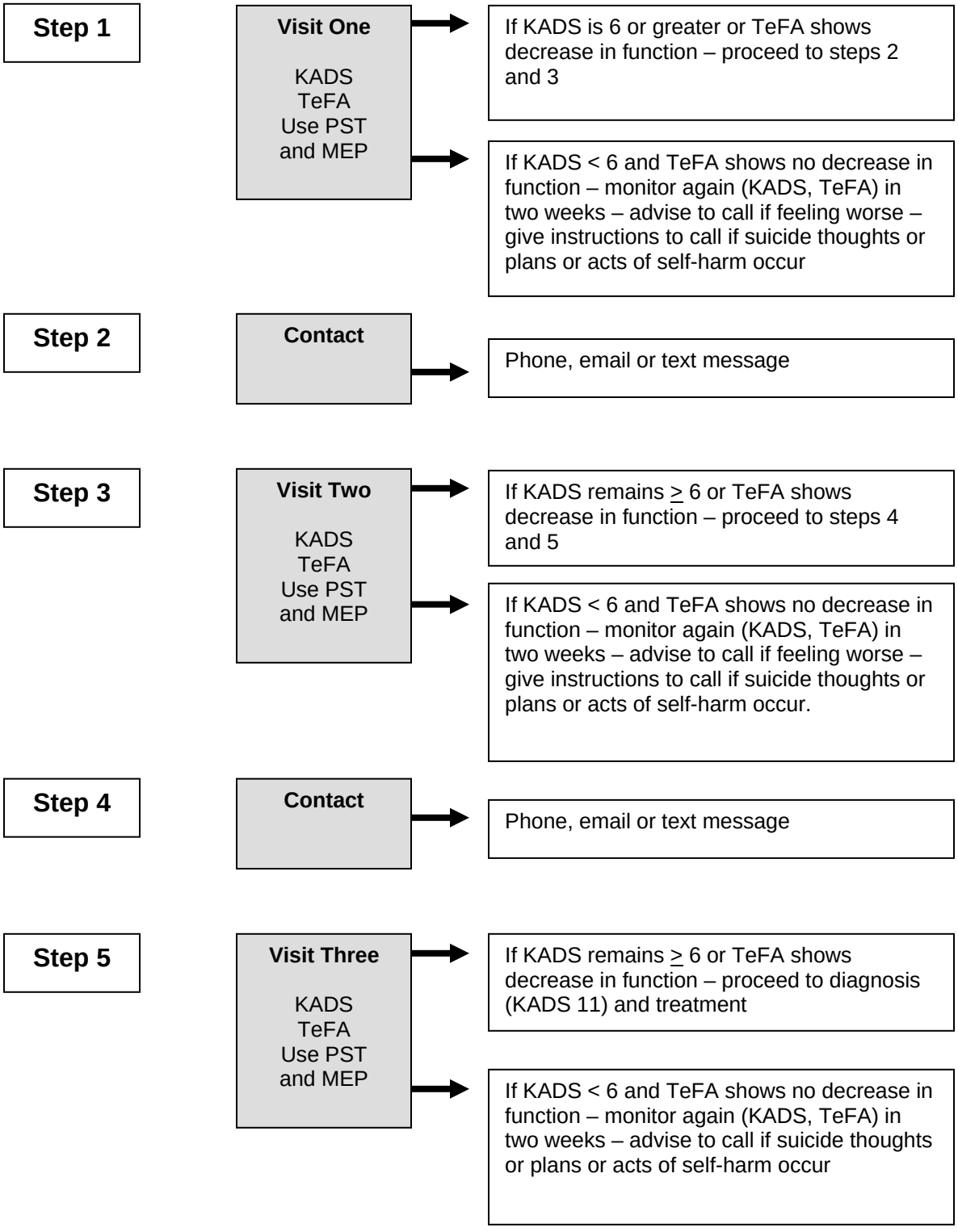
1. KADS scores remain at 6 or greater over the two week period (at each of the three assessment points)
2. Persistent suicidal thoughts or self-harm behaviours occur
3. School, family or interpersonal functioning declines (this can be assessed by using the TeFA)

If this occurs, the KADS-11 item should be completed at the third visit. If five or more items are scored as a 2 or greater using this tool, a diagnosis of MDD can be made and treatment planning initiated.

The 11 item KADS may be used at no cost to clinicians

Note that the KADS-11 is a clinician administered and not a patient completed tool. The clinician must ask the teen questions pertaining to the scale item and come to a best consideration of the score for each item on the basis of those questions.

Clinical Approach to Possible Adolescent MDD in Primary Care*



* Alternatively, some health care providers may choose to "flush out" the patient's entrance complaint, determine if any safety or immediate referral issues are present (for example: suicidal; psychotic – see below for more details), provide the KADS to the patient to complete and then schedule a longer visit in the near future to complete the assessment. The key issue here is to ensure patient safety while providing a long enough assessment period to allow for distress to be better differentiated from disorder.

Treatment Template – Adolescent MDD

Treatment of adolescent depression includes both specific and non-specific factors. Specific factors are: medications; structured psychotherapies (eg: Cognitive Behaviour Therapy (CBT); Interpersonal Therapy (IPT)). Non-specific factors include those activities, which improve mood and general well-being PLUS supportive psychological interventions (use the PST in the toolkit to guide you) given by the health provider.

When initiating treatment it is necessary to start by educating the patient/caregiver about the disorder and about the treatment. We suggest that this be done over two visits 3-5 days apart with the time between visits spent by the patient and parent/care provider in self study/research. You can direct them to websites provided below – but please also encourage them to search wherever they want - to "google it" and to bring a list of the questions and concerns to discuss with you at the next visit.

When Providing Information about A Mental Disorder:

1) Determine what the youth and caregivers know already – about the disorder and the treatment
2) Identify areas of misinformation and provide correct information
3) Identify gaps in knowledge and provide information
4) Be knowledgeable, realistic, clear and helpful
5) Provide written materials to take away. **Useful resources for GPs.**
6) Ask about the issue of **addiction**. Many teens/parents think that taking medicines will lead to addiction. They will often not bring this up spontaneously – so you need to bring this up with them. **Useful information about addiction and medications (link to NIDA website)**
7) Discuss anticipated duration of medication use. For a first episode this will be for 6-9 months after they get well.
8) Discuss how taking medicine will impact their lifestyle (eg: light alcohol use is usually ok; no limits to driving with an SSRI)

Check out MedEd ©

MedEd © is a novel interactive manual that has been designed to optimize psychopharmalogic treatment in young people

Non-specific Interventions

Recent neuro-biological research has provided more clues about how a variety of environmental manipulations may change brain functioning in those domains known to be associated with control of mood, such as: serotonin systems; dopamine systems; neurotropic factors (particularly brain derived neurotropic factor (BDNF)); and endorphin systems.

For a recent review (albeit using mostly adult data) please see: Young, Simon N. *How to increase serotonin in the human brain without drugs*. Journal of Psychiatry and Neuroscience. 2007: 32; 394-399.

These non-specific interventions include:

1) **Exercise** – particularly a minimum of 30 minutes of vigorous aerobic exercise daily.

2) **Bright Light** – particularly early morning (between 6 and 9 am) and early evening (between 6 and 9 pm) exposure to 2,000 lux or more. This should be the amount of outdoor light available during the summer months (in Canada). In the winter, a lamp of equivalent lux could be used.

3) **Social Support** – peer and family interactions - particularly associated with pleasurable activities (even in the face of not going to work or declining grades).

4) **Nutrition** – particularly foods rich in tryptophan – such as chickpeas – or serotonin – such as chocolate – (unfortunately it seems that eating turkey and bananas does not help). Overall, a balanced diet with no or else light alcohol intake and avoidance of drugs. Recent research is suggesting that there may be a therapeutic role of omega 3 in depression but the evidence at this point is still limited.

5) **Music and Movement** – particularly rhythmic "upbeat" music and dance

While it is unlikely that application of the above strategies in the absence of medication or psychotherapy will "treat" a major depressive disorder (there is some evidence that bright light applied twice daily, morning and evening, for a period of ½ hours each time – especially for seasonal depression might be helpful) there is no reason not to "prescribe" a wellness strategy that incorporates most or all of these interventions. At the very least the tendency for depressed youth to self isolate, listen to dreary music, read mood lowering literature/poetry and spend time in dark rooms should be actively discouraged.

A Diet Suggestion

Although not completely established, recent evidence suggests that a diet rich in omega-3 may be helpful. Here's a recipe for a breakfast "smoothie" contributed by Dr. Jane Garland.

- Yogurt plus fruit (berries, bananas, peach etc)
- 1 tsp Nutra-Sea liquid omega-3 supplement (1000 mg mixed omega 3/6 small wild cold water rich source with good ratio and no fishy flavour)

You can replace the yogurt with soymilk or regular milk if you prefer. Extra protein powder can be included if the child needs the nutrition. There are also "smoothie" powders containing omega-3 essential fatty acids plus other nutrients (e.g. Learning Factors brand) that can be added as an alternative.

Mood Enhancing Prescription (MEP)

It is useful to provide the young person with a simple outline developed collaboratively with them (and caregiver if appropriate) that clearly specifies what self-regulatory activities they should pursue during the diagnostic and treatment phases of their contact with their health provider. The **Mood Enhancing Prescription** is a useful and time efficient tool that can be used to help the young person identify and plan their daily activities. It is embedded below and provided in the Clinician's Toolkit as well. Practically, the clinician can review the MEP with the patient, complete the form and then review it at the next office visit.

Mood Enhancing Prescription

There are many things that you can do to help your mood. Sometimes these activities by themselves will help you feel better. Sometime additional help (such as psychotherapy or medications) may be needed. This is your prescription for what you can do to help your mood. For each activity write in your plan (include what you will do, how often and with whom).

Activity	Plan (what, how often, and with whom)
Exercise	
Eating Well	
Problem Solving	
Being Socially Active	

Enrolling the Help of Others

If the young person has a supportive family, then family members could be involved in the MEP. Other significant persons in the young person's life may also be able to play a role (eg: teacher, school counsellor, coach, neighbour, etc.) It's a good idea to ask the young person about who else can help out and whenever possible get the family involved. Always inquire about school performance. Many young people with MDD may need extra educational interventions or a modified academic load. Discussion with a school counsellor (with permission from the patient) is recommended.

Psychotherapy

Various guidelines suggest the use of specific manual driven psychotherapies as “first-line” interventions for adolescents with mild to moderate MDD. In many locations, these interventions are not easily available, or the teen/caregiver may choose not to accept a recommendation for this treatment. For some, cost may be an important factor.

If CBT or IPT is available in your community it is good practice to provide that intervention as part of the treatment of depression in young people. However, if waiting lists for these therapies are long or these psychotherapies are not available, treatment should be implemented with medications, wellness enhancing activities and supportive rapport. Remember that suicide ideation and suicide attempts are common in MDD and may occur during treatment with CBT or IPT. Therefore patients (even those not taking medications) should be closely monitored for suicide ideation and suicide plans throughout the treatment period.

Additionally, some evidence suggests that CBT may have additional positive effects when combined with a medication treatment. For example, the addition of CBT to the SSRI fluoxetine has been demonstrated to decrease the likelihood of suicidal ideation when compared to fluoxetine alone.

Regardless of whether the adolescent with MDD receives CBT or IPT as part of their treatment, we recommend that they receive fluoxetine treatment as it is the one intervention with the best scientific evidence for efficacy in this condition. However, as noted previously, we also strongly advise that fluoxetine treatment not be provided without regular follow-up and outside the entire envelope of care (face to face visits, electronic contact, PST – supportive rapport, suicide risk assessment, etc.) that is described in this section.

An Important Clinical Point:

Medications should not be used to treat young people who have mild symptoms of depression, dysphoria, demoralization or distress. They should be used only for treating major depressive disorder. If you are not sure if it is a depression or not it is reasonable to institute wellness enhancing activities and supportive rapport and monitor carefully for symptom change and suicide risk. Do not rush into medication prescribing, but use the medications for which there is good scientific evidence when indicated.

Psychotherapeutic Support for Teens: Practical Pointers for Primary Care Health Providers Treating Adolescent Depression (PST) – Supportive Rapport

This tool provides clinicians with guidelines/suggestions that they can use to direct their clinical interactions with the teen.

Approach	• Be friendly but not a friend • Create a supportive space • Establish confidentiality and limits of confidentiality (self-harm, danger to others, etc) and be very CLEAR about these
Be Present-Focused	• Help identify the most important problems occurring now
Be Problem-Oriented	• Help develop and apply practical solutions to ongoing problems
Provide Education	• Provide education about depression and education about the treatment (complete KADS, TeFA)
Be Responsive	• Be available for urgent matters by phone, email or text messaging within office hours. • Schedule frequent brief face to face visits at times that do not conflict with school (15-20 minutes) • Monitor and support teen wellness activities (exercise, sleep, healthy diet, etc.) • Ensure access to professional care during the off hours for emergencies

Further guidelines to create a supportive environment

Remember to embed these guidelines/suggestions within a supportive, active listening environment. This includes the following:

- Compassionate and non-judgmental attitude, but be real
- Active listening: eye contact, verbal (“ah hum”, “go on”), and non-verbal (head nod) clues to listening engagement
- Clarification (“help me understand”, “could you explain what you were thinking about that”, etc.)
- Emotional identification (“seems as if you are feeling frustrated”, etc.)
- Do not understand the young person too quickly – you are likely to be wrong
- If you do not know what they are talking about – ask
- If you do not know an answer to a question – admit it and tell them how you will find out

Remember that parental or caretaker involvement is often necessary during the assessment and treatment of depression in an adolescent. Whenever possible, information about the young person's emotional state and function should be obtained from the parent or caretaker. It is not uncommon for teens and parents/caretakers to have different opinions about the mental state and activities of the young person. When this occurs, joint discussion of the issue will be necessary for clarification and optimal intervention planning. However, it is essential to ensure that appropriate confidentiality is being maintained during this process.

Confidentiality is important but it has its limits. Abuse, suicide intent, harm of others need to be identified as issues that can not be kept confidential. Drug use must be discussed with the youth and an appropriate decision pertaining to the degree of drug involvement must be clarified in terms of at what point does drug use become drug misuse/ abuse that requires informing others.

Antidepressants in Adolescent MDD

The best level one evidence for medication treatment of adolescent MDD is for fluoxetine. We recommend that this be the first line medication treatment for adolescent MDD in primary care and that other medication treatments be reserved for use by secondary/tertiary mental health services for those youth who do not respond or who cannot tolerate fluoxetine.

However we also strongly recommend that fluoxetine is not used alone. Ideally it should be combined with CBT, wellness enhancement activities and supportive rapport. Alternatively it could be combined with IPT, wellness enhancement activities and supportive rapport. If neither CBT nor IPT is available fluoxetine could be combined with wellness enhancement activities and supportive rapport.

Fluoxetine treatment significantly improves depressive symptoms and decreases suicidal ideation. However, some young people may experience suicidal ideation and self-harm attempts or have these increased when treated with fluoxetine. Therefore systematic assessment of suicide risk must be completed as part of the ongoing treatment with fluoxetine (**see Health Canada Advisory for Fluoxetine**).

Further information on SSRI use and youth suicide can be accessed below. We suggest that if fluoxetine is used, the following 12 steps of treatment be considered, customized and integrated into a practical approach that is feasible in your practice.

Issues To Consider When Monitoring SSRI Treatment

The following 12 steps appear in Kutcher, S., Gardner, D. & Virani, A. (2004) *A Suggested Careful Monitoring to SSRI Treatment.* Child and Adolescent Psychopharmacology News, 9 (4): 3-4.

CAPN is published by **Guilford Press** and edited by Dr. Stan Kutcher.

First
Do no harm. This does not mean—do not treat. This means do a proper risk benefit relationship analysis of the situation. And make sure that your evaluation of these risks and benefits has been fully discussed with your patient/ family.
Second
Make sure the patient has a major depressive disorder. This means that the diagnostic criteria are clearly met and that there is clear-cut functional impairment. Medications should not be used to treat depressive symptoms, they should be reserved for the treatment of major depressive disorder. Remember that threshold for diagnosis is not only within the total number of criteria met in the syndrome, but also within each criterion. For example, I would not call 20 to 30 minutes of sleeplessness one or two times per week "difficulty falling asleep".
Third
Check carefully for other psychiatric symptoms that might suggest a different disorder. For example, does the patient have a psychotic prodromal state that looks like major depression. Remember, depressive symptoms do not a depression make.
Fourth
Check for symptoms of anxiety (especially panic) and impulsivity. If the patient has these symptoms they may be at greater risk for the behavioral adverse effects of an SSRI.
Fifth
Check for a past history of mania and for a family history of bipolar disorder.. Remember that up to two-thirds of teen onset bipolar disorders present to a mental health professional first with depression. Young people with this background may be more at risk for the behavioral activation effects of SSRIs.
Sixth
Measure the patient's current somatic symptoms, paying careful attention to such items as restlessness, agitation, irritability and the like—before you begin treatment. A side effects scale (see below for an example) can be used to address this issue.
Seventh
Measure the symptoms of depression and pay special attention to suicidality. The KADS, which is a self report scale (see below) is easy to use, validated in this population and can provide not only baseline but also treatment outcome information. Remember that SSRI's may occasionally increase suicidal ideation so it is very important for your risk–benefit analysis to determine if

there is suicidal ideation is there at baseline.

Eighth

Provide comprehensive information about the illness and the various treatment options to the patient and family. Appropriate literature should be available in your office and you should have a list of good websites to which you can direct their attention. Remember, the pharmacotherapy of depression is not emergency medical treatment. There is time for substantial research followed by frank and open discussion with the patient and family.

Ninth

If an SSRI is chosen make sure that you provide the patient and family with appropriate information about possible side effects (both behavioral and somatic) and the expected timelines to improvement. Ideally this should be in written form and if you are concerned about litigation have the patient and family sign one form and keep it in the patient record. Also make a note in the record as to the discussions and decision.

Tenth

After doing the necessary laboratory workup (for an SSRI the only one that I would consider totally necessary is a pregnancy test for females), start with a small test dose of the medication, preferably given at a time when the teen is with a responsible adult who knows about the test dose and who can contact you if there is a problem. Following that begin treatment with a very low dose (often you can cut the smallest dose pill in half or you can have the patient separate a capsule's contents) and ask the patient and parent to monitor for adverse behavioral effects daily. Remember to provide a phone number where you (yes, *you*) can be reached if any problems develop and arrange to see the patient within 3—4 days of initiating treatment.

Eleventh

Increase the dose slowly at no more than 3—5 day intervals until your initial therapeutic dose is reached (the expected minimally effective daily dose), then wait for the required 6—8 weeks at this dose to determine efficacy. Never prescribe medication without at least offering supportive psychotherapy using cognitive or interpersonal techniques of support. See the patient **weekly** and allow for telephone check–in whenever the dose is increased or between visits if concerns arise. Always check for and record possible adverse events at each visit (use the form that you used at baseline so that you can compare symptom changes over time) and assess improvement at Weeks 2, 4, 5 and 6.

Twelfth

Take advantage of the placebo response (found to be high in most adolescent depression trials) That is, invoke a similar approach to patient care as done in studies including frequent face–to–face contact early in the course of therapy, the development of a trusting and supportive relationship, efforts to measure response objectively and subjectively, and careful elicitation of side effects, overall tolerance, ongoing concerns, and satisfaction with treatment.

This approach represents good clinical care that is consistent with the "careful monitoring" advocated by the FDA and other organizations. This approach will not necessarily totally ameliorate the occurrence of behavioral side effects but it may cut down their prevalence and will help you quickly identify when they occur so that you can intervene appropriately.

Initiating and Continuing Fluoxetine Treatment *

- Start low and go slow
- Begin at 10 mg daily (if significant anxiety symptoms are present start with 5 mg)
- Continue 10 mg for one to two weeks then increase to 20 mg
- Continue 20 mg for a minimum of 8 weeks
- If side effects are a problem with the increase to 20 mg – decrease the dose to 15 mg daily for 1 week and then increase to 20 mg. If substantial side effects occur again continue the dose at 15 mg for a minimum of 8 weeks.

*** The PST based supportive rapport model should be used at every visit as a framework within which you can structure your interaction with your teenage patient.**

Referral – Red Flag

If the youth presents with a severed depression with active suicide intent immediate referral to specialty mental health services is warranted. The presentation of a depression with psychosis or the presence of a suicide plan necessitates emergency referral.

Assessment and Monitoring of Functioning

Functional impairment is an essential component of an MDD diagnosis. In young people, a functional assessment across four domains is an essential component of treatment monitoring. Functional recovery is a necessary target for treatment outcome.

The four functional domains that need to be addressed are:

1.	**School**	Grades, teacher relationships, attendance
2.	**Home**	Parental/sibling relationships, home activities
3.	**Work**	Job performance, job relationships
4.	**Friends**	Peers, intimate relationships, sexual activity

The **Teen Functional Assessment (TeFA)** has been developed to assist the primary care provider in her/his evaluation of each of these components. Clinicians can copy and use the TeFA without written permission from the author. Some clinicians may choose to incorporate the essential features of the TeFA into their standard patient monitoring interviews rather than using the tool itself.

Monitoring Treatment

Outcomes and side effects should be monitored regularly during treatment*. The following chart is suggested as a guideline. For treatment outcome evaluation use the KADS and the TeFA. For side effects assessment use the **Short Chehil-Kutcher Side Effects Scale (sCKS)** as illustrated on the next page.

Tool	Baseline	Day 1	Day 5	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
KADS	✓				✓		✓		✓	✓	✓
TeFA	✓				✓		✓		✓	✓	✓
sCKS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

*** The PST based supportive rapport model should be used at every visit as a framework within which you can structure your interaction with your teenage patient.**

Side Effects

Treatment emergent adverse effects (side effects) are those problems that arise during medication treatment and are caused by the medication. Side effects can include physical, emotional or behavioural problems. In order to best evaluate side effects a systematic baseline assessment of common problems should be conducted using a combination of structured and semi-structured evaluations.

Semi-structured: A useful question that may elicit side effects is *"Have there been changes in your body that you think may be a side effect?"*

Structured: A useful side effects scale that could be used at every clinic visit is found below.

Short Chehil-Kutcher Side Effects Scale (sCKS)*

Item	None	Mild	Moderate	Severe
Headache				
Irritability/Anger				
Restlessness				
Diarrhea				
Sexual Problems				
Suicidal Thoughts				
Self Harm Attempt	☐ No ☐ Yes If yes describe: Was this a suicide attempt (intent to die) ☐ No ☐ Yes			
Any other problem?	1. 2.			

Clinicians who would like to use the short Chehil Kutcher Side Effects Scale in their individuals or group practice may do so without obtaining written permission from the authors. The short Chehil Kutcher Side Effects Scale may not be used for any other purpose (including publication) without expressed written consent of the authors.

Clinicians working in specialty mental health settings may wish to use the long version of the Chehil Kutcher Side Effects Scale (CKS). The CKS may be used under similar circumstances and with similar condistions as outlined for the sCKS.

Click here to access the full Chehil Kutcher Side Effects Scale.

Hypomania

One rare side effect of medication treatment is the induction of hypomania. This presents symptomatically as:

1) Decreased need for sleep – subjective feeling that sleep is not needed
2) Increase in goal directed activity (may be idiosyncratic or inappropriate
3) Increase in motor behaviour (including restlessness), verbal productivity, and social intrusiveness

If hypomania is suspected the medication should be discontinued and urgent mental health referral initiated. Remember that a family history of bipolar disorder increases the risk for hypomania.

I have finished 8 weeks at 20 mg/day – now what?

There will be three possible outcomes – each with a different intervention strategy.

ALWAYS CHECK ADHERENCE TO MEDICATION TREATMENT!!

One	Outcome	Strategy
	Patient not better or only minimally improved. KADS score 6 or more and little or no functional improvement.	• Increase fluoxetine gradually to 30 mg and refer to specialty child/adolescent mental health services • Continue weekly monitoring and all other interventions until consultation occurs
Two	**Outcome**	**Strategy**
	Patient moderately improved. KADS score (4 or 5). Some functional improvement (50-60% as determined from the TeFA)	• If medication is well tolerated, increase to 30 mg daily and continue monitoring and interventions for two to four weeks then reassess. If no substantial improvement then refer. • If medication is not well tolerated continue 20 mg daily plus monitoring and intervention for two more weeks then reassess. If no substantial improvement then refer for specialty mental health treatment.
Three	**Outcome**	**Strategy**
	Patient substantially improved. KADS score below 6 and major functional improvement.	• Continue fluoxetine at 20 mg daily • Gradually decrease monitoring and interventions visits to once every two weeks for two months and then monthly thereafter • Educate patients/caregivers about need to continue medications and how to identify relapse if it occurs • If first episode continue medications for 9-12 months before jointly deciding to discontinue. If discontinuing choose a suitable window (low stress period) and decrease gradually (over a period of four to six weeks) monitoring every two weeks. • Agree on “well checks” (for example, once every three months) and how to identify relapse if it occurs • If second or further episode obtain mental health consultation on treatment duration

Fluoxetine doses used in specialty mental health services may occasionally exceed those usually found in primary care. Physicians monitoring youth who have been treated by specialists should discuss medication dose requirements prior to initiating dose changes.

Checking Adherence to Medication Treatment

Determining medication adherence can be difficult. It may be useful to predict the likelihood of medication non-compliance in advance. Openly recognizing that it is probable that the patient may miss one or more doses of medications is not only consistent with reality, but it allows the patient to miss the occasional dose without guilt, and to return to medication use without seeking permission to do so. Pharmacologically, if this happens occasionally there will be little if any substantive change in fluoxetine serum levels due to the long half-life of fluoxetine and its major metabolite (5 to 7 days).

There are three methods that can be used to monitor and assess treatment adherence.

1) Enquire about medication use from the adolescent patient. Using such prompts as: "How have things been going with taking the medicine?" or "As we talked before, it is not uncommon to forget to take your medicine sometimes. How many times since we last talked do you think you may have not taken your medicine?" It is important not to admonish the adolescent who self-identifies occasional medication non-adherence. Simply acknowledge the difficulty in remembering and ask if there is anything you can help him/her with to improve their remembering. If the compliance with medications is poor it is important to address the issue openly, trying to understand what the reasons for the adherence difficulties may be. Once these have been identified they can be collaboratively addressed.

2) Enquire about medication use from the teen's parents. Some teens and parents may choose to have the parents dispense the medication. However, dispensing is not the same as taking. So even if the parents are dispensing the medication it is important to ask the young person about medication use as described in method one above.

3) A pill count may sometimes be useful. Simply ask the young person or parent to bring the pill bottle to each appointment. However, an empty pill bottle does not equal treatment adherence. So, even in this situation it is important to ask the teen about medication use as described in method one above.

Duration of Treatment

Once substantial improvement or recovery has occurred, the issue of duration of continued treatment arises. Maintaining treatment for a defined length of time is undertaken for the following reasons:

1. To allow for further, perhaps longer to develop, improvements in symptoms and functioning to take place
2. To allow for additional or alternative therapeutic interventions to occur: for example the addition of cognitive behavioural therapy to a initial treatment with medication alone
3. To decrease the risk of relapse
4. To decrease the risk of developing a co-morbid mental disorder (for example: substance abuse or social anxiety disorder)

Currently, there exists insufficient substantive research to allow for good evidence driven guidelines for the duration of ongoing treatment following recovery from the index depressive episode. Given the data (including clinical experience) currently available the following suggestions can be reasonably made:

1. Continue with the same dose of medication that was used to achieve recovery
2. Continue with the same treatment that was used to achieve recovery for a minimum of six to nine months
3. Educate the patient about signs and symptoms that may suggest relapse and encourage immediate clinical review should these occur

4. Encourage scheduled mental health monitoring visits ("check up from the neck up")
5. If a decision to discontinue medication is made, do not discontinue medication during times of increased stress (such as examinations at school or moving to a new city)
6. If a decision to discontinue medication is made, decrease dose gradually over a substantial period of time (for example: three months) and monitor closely for signs or symptoms of relapse
7. Advise adherence to mental wellness activities that include appropriate diet, exercise, and sleep hygiene; limit use of alcohol (no binge drinking); avoid illicit drug use

If a patient relapses while on an adequate treatment regime evaluate the following:

1. Compliance with treatment
2. Onset of recent substance abuse
3. Onset of recent stressors that challenge the patient's ability to adapt
4. Emergence of an alternative diagnostic possibility (such as: schizophrenia, bipolar disorder)

Referral to a mental health specialist is indicated if relapse occurs despite adequate ongoing treatment.

Suicide Assessment

In young people, unrecognized and untreated mental illness, especially depression – is the single strongest risk factor for suicide. Suicide risk is increased if the following factors are additionally present.

- Family history of suicide
- Substance abuse
- History of impulsivity
- Hopelessness
- Legal difficulties
- A previous suicide attempt
- Access to lethal means (such as firearms)

Suicide is more common in males, while self harm attempts are more common in females.

Suicide assessment should occur whenever a depression is suspected and at specific points during treatment. While use of the KADS at treatments visits will allow for self-reported suicide ideation, plans or acts, particular attention to suicide risk during treatment and monitoring of depression should occur if:

- A major life stressor occurs
- A friend or acquaintance commits suicide
- A public figure commits suicide
- The media reports on a successful suicide

In these situations, exploration of the impact of the occurrences on suicide risk in your patient must be part of the monitoring and intervention visit.

Tool for Assessment of Suicide Risk in Adolescents (TASR-A)

Dr. Kutcher and Dr. Chehil have developed a clinically useful tool that can assist the health provider in the evaluation of suicide risk. The **Tool for Assessment of Suicide Risk in Adolescents (TASR-A)** is available in pdf format and may be reproduced by clinicians treating depressed youth with the written permission of the authors. Information on how to use the TASR –A is also found in the appended toolkit.

The TASR-A has been developed for use by physicians and health providers with expertise in assessment and treatment of young people with depressive disorder. The TASR-A is copy written and can not be used for any other purposes other than that noted above without the expressed written consent of the authors.

Health providers who would like to attend a training session on the clinical use of the TASR-A and suicide assessment in young people can contact the Office of the Chair at (902) 470-6598 for further information.

Assessing Suicide Risk

Suicide risk should be assessed at baseline and throughout the treatment period. Particular attention to suicide risk should be paid if any of the items identified as risk enhancers noted above occur. Not all young people who have decided to commit suicide will admit to their plan when asked so no suicide assessment is completely preventive of suicide. However, the assessment of suicide ideation and suicide plans will often identify young people who are at increased suicide risk and appropriate interventions (including hospitalization if suicide plans are in place) can be instituted.

Suicide ideation

- Ask about ideas of dying, not living and of committing suicide
- Ask about feeling hopeless – A DEPRESSED YOUNG PERSON WHO FEELS HOPELESS IS AT INCREASED RISK – remember not everyone who has a diagnosis of MDD feels hopeless.

Suicide plan

- If the youth admits to suicide ideation or hopelessness ALWAYS ask about suicide plan

If in your clinical judgement the young person is at high risk for suicide, this is a medical emergency. In such a case the young person must be taken by a responsible adult for immediate psychiatric assessment. Please ensure that a copy of your assessment plus information on how to contact you is made available for the mental health specialist conducting the emergency consultation. Many clinicians find that personal contact of the assessing clinician prior to the assessment will facilitate a more useful consultation.

Young people with persistent suicidal ideation and frequent self-harm attempts should be referred to specialty mental health services for ongoing treatment.

Safety and Contingency Planning

The patient's safety is of paramount importance. Safety concerns trump all other considerations. Here are some suggestions for helping the teen being treated for MDD to stay safe. If the first contact health care provider is concerned about safety, mental health consultation should be obtained (see below).

Emergency Contact Cards – this consists of emergency contact numbers (for example: mental health services, emergency youth mental health services, emergency room service, etc.). Often this is written on a "wallet card" that can be carried by the young person at all times. Other methods such as electronically saved messages can also be used.

Rapid Health Provider Availability – often suicide and other safety issues arise in the context of stressful events. Allowing the young person or their caregiver to have easy access to a first contact health care provider (for example: by phone; by email) can be a useful strategy. Clinical experience suggests that most young people or their caregivers rarely overuse this access.

Help Phone – while crisis telephone "hot-lines" have not been demonstrated to reduce suicide rates, they can be a valuable resource for young people in crisis. The young person should be provided with the phone number for the appropriate service in their area.

No Suicide Contract – this intervention although popular amongst some clinicians has not demonstrated effect on suicide rates. Its use is not recommended.

Referral Flags

Referral of the teen with MDD to specialty mental health services can occur at three different points. The following referral points are suggestions only. Each first contact care provider must identify their own comfort level with treatment and management of adolescent MDD and act accordingly. These suggestions are:

Emergency Referral (prior to treatment initiation by first contact care provider):

- Suicidal ideation with intent or suicide plan
- MDD with psychosis (presence of delusions and/or hallucinations)

Urgent Referral (treatment may be initiated but referral should be made concurrently):

- Relapse from previous positive treatment response
- Persistent suicidal ideation with no intent or suicide plan
- Family History of Bipolar Disorder
- History of suicide attempts
- Hypomania

Usual Referral:

- MDD not responding to adequate first contact treatment trial

Suggested Websites

- Resources for families and health providers can be found on GLAD PC website – **www.gladpc.org**
- Texas TMAP website, and the Families for Depression awareness has a toolkit for families and patients at **www.familyaware.org/parentandteenguide.php**
- American Academy of Child and Adolescent Psychiatry - **www.aacap.org**
- Sun Life Financial Chair in Adolescent Mental Health – **www.teenmentalhealth.org**

Suggested Readings

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Appendix I: Case Study

April 15, 2006

MJ is a 16-year-old girl who presents seeking advice about birth control. She admits to being sexually active for about one month and her boy friend has been using a condom but has suggested she go on the pill. Her past medical history is unremarkable apart from multiple somatic complaints (such as stomach aches and headaches) and two short-term episodes of school refusal (in grade one and in grade three). She has always been a shy and somewhat anxious child but has not been diagnosed with any anxiety disorder. You have successfully treated her mother for a major depressive episode about 11 years ago with fluoxetine. Her father has had difficulties with alcohol miss-use but in your opinion does not meet criteria for alcohol abuse or dependence.

Issues: This teenage girl is at higher risk for a major depression due to the history of MDD in the mother, her noticeable anxiety symptoms as a child and possibly her paternal history of alcohol miss-use. Although she comes to see you asking for birth control, because of your knowledge of her family history you are ideally placed to inform her and her family of her higher risk status (see the Risk Identification Table) and to provide health promotion interventions that include the mental wellness activities found in the "Mood Enhancing Prescription" component of this program. Additionally, you can provide her and her family with information about resources (see the websites section of the program) that they can access and discuss. Ideally they may want to make an appointment with you in the future to review the issue of what to look for in terms of early identification of depression and what to do if they suspect MJ may be becoming depressed and you may want to proactively arrange for a "check up from the neck up" visit every 4 – 6 months.

Case: July 24, 2006

MJ's mother calls to say that her daughter has not been herself – she has been moping around the house, has lost her appetite and seems to be unhappy. She attributes this to MJ breaking up with her boyfriend. You arrange to see MJ in your office. Her 6-item KADS score is 8 and her TASR-A review does not identify any urgent issues pertaining to suicide or safety. MJ spends her visit with you talking about how awful she feels about her breakup and one small panic episode she had when she saw her ex-boyfriend in the shopping mall.

Issues: The question here is whether MJ has become depressed at this time or is demonstrating distress in reaction to the breakup of her relationship. An appropriate clinical response is to initiate the diagnostic monitoring schedule using the KADS as found in the "Clinical Approach to Possible Adolescent MDD in Primary Care". At the same time you may schedule a visit to provide a brief psychotherapeutic intervention based on the PST model and endorse application of the "Mood Enhancing Prescription". This will provide both a useful monitoring of her mood over time and will allow you to get to know her a bit better thus establishing a therapeutic alliance that may come in handy in the future. This would also be a good time to discuss the issue of confidentiality with her and her parents – making it clear what information would be considered to be confidential and what would require parental involvement. Arranging to see her in a week following this appointment would be a good idea with the invitation to call you if she becomes worse.

Case: August 4, 2006

MJ comes in for her follow-up appointment today. Her KADS score is 3 and she is eagerly anticipating her family holiday to the cottage.

Issue: Clearly this was an episode of distress and not the onset of a disorder. No additional intervention is needed apart from reviewing with her what she should do in the future if she feels she is becoming depressed.

Case: November 13, 2007

MJ's mother calls you concerned that her daughter has been doing poorly for the last month or so. MJ had gone away to university and they thought all was going well but last week her student advisor had called to say that MJ was missing most of her classes and that one of MJ's friends had come to voice her concern that MJ was staying away from friends and seemed to be drinking in her room much of the time. You arrange a time to see MJ.

When you see MJ she gives a 6 week history of increasingly depressed mood accompanied by sleep difficulties, loss of appetite, fatigue and loss of interest in school and social activities. She has missed most of her classes over the last 2 weeks and admits to drinking "lots of beers" every day – "to make me feel better". Her KADS score is 12 and she endorses number of items on the TASR-A (including occasional thoughts that life is not worth living) that make you concerned about her wellbeing but you do not think that she is actively suicidal. Using the TeFA as a guide you establish that she has developed significant functional problems in a variety of domains. She is not psychotic and denies any other drug use. You review with her concerns about her possibly becoming depressed and arrange to see her for a longer assessment in three days time. You impress on her the need to call if things get worse and discuss the situation with her parents who feel that they can provide the necessary monitoring at home. Your once again provide them with sources of information (see websites listed in this program) and ask them to read about depression and its treatment.

Issues: It seems as if MJ is developing a major depressive episode. You have conducted a safety and urgent referral assessment and have established a time course for the problem and have initiated a measure of symptom severity and conducted a functional assessment. Furthermore you have engaged both MJ and her mother in a collaborative relationship with you to address her problems and they have agreed to initiate an educational exercise that will bring them to the next appointment with more information, questions to ask you about and perhaps ready to begin a course of treatment.

Since your practice has access to the services of a social worker you discuss MJ with her and arrange for her to attend the next consultation.

Case: November 16, 2008

MJ's score on the KADS today is 14 and she is having more frequent thoughts about dying but no suicidal ideas or plans. The TASR-A is unchanged from the previous visit. Given the history you have obtained to date and the persistently elevated KADS scores you decide that she likely has a major depressive disorder and apply the 11 item KADS as the baseline symptom evaluation. You discuss treatment options and MJ agrees to ongoing counseling with the social worker and prescription of fluoxetine at your recommendation because she has read about the disorder and its treatment. She has questions about the use of the medication – in particular the possibility that she may become addicted to the medicine – which you are able to answer to her satisfaction. You complete your assessment using the TeFA and the Short Side Effects Check List and use the fluoxetine medication using the "Initiating and Continuing Fluoxetine Treatment" as outlined in the program. You review the anticipated time lines for improvement and arrange to see her next week with the social worker using the PST framework agreeing with MJ to begin counseling during that time. You arrange to see her again in one weeks time and advise her to call you or the social worker if things get worse or if she become suicidal during that time.

Issues: Although you did not follow exactly the 3 KADS points in time scores suggestions in the program your modification was reasonable given MJ's history and the persistently elevated

scores. Your use of the TASR-A gave you a comprehensive overview of the factors that you could use to make a reasonable assessment of her suicide risk and your preparation of MJ and her parents for the possibility of her experiencing a depressive episode (visit of April 15, 2006) most likely contributed to its early identification and thus your early intervention. This was also likely helped by the fact that you had established a positive therapeutic relationship with MJ and her mother prior to her becoming depressed so that she would be more likely to accept your assistance than if this relationship was not in place. Your involvement of the social worker was appropriate as was your suggestion that MJ and her mother re-educate themselves about depression and its treatment prior to this appointment. This probably made it easier to prescribe an appropriate intervention to an informed patient and parent. Your evaluation of "side effects" gives you a good base-line by which to monitor the possible onset of treatment emergent adverse events and also provides further education and collaboration in care with MJ. The social workers use of the PST framework will allow for a counseling intervention that will complement the medication treatment you have prescribed.

Case: November 24, 2008

MJ presents to your office for follow-up. Her KADS score is 14 and there is no difference in your assessment of her suicide risk using the TASR-A guideline. You review the side effects scale and notice that while she has complained of having headaches her score is the same as it was before the treatment was started. You use the PST framework to guide your discussions with her and address her concerns about side effects using the data from the side effects checklist. You review the expected time-lines for symptom improvement and arrange to see her in a week's time. She tells you that she found the counseling session with the social worker helpful. You encourage her to use the "Mood Enhancing Prescription" as much as possible and arrange to see her again in a week's time with the usual proviso for her to call if things get worse or if she becomes suicidal.

Issues: The value of the pre-prescription side effects check-list is illustrated here. This has allowed you and MJ to jointly determine that her headaches are likely not due to the medication, thus encouraging compliance to a treatment that may be useful but would not be if it had been stopped at this time. It is important to frequently review the expected time-line to improvement as it does take a number of weeks for the interventions to take effect. During this time weekly visits to you by MJ and continued counseling from the social worker can be guided by the "Monitoring Treatment" chart found in this program. This allows you to track her progress not only in terms of symptoms but also in terms of functioning and also to track potential treatment emergent events. Essentially, for the primary care practitioner, this is a period of ongoing support, availability for emergency situations, appropriate monitoring of suicide risk and structured (weekly) assessment points. Because teenagers frequently take longer that adults to begin recovery (4 – 6 weeks) and because symptomatic improvement may take up toe 12 weeks this type of ongoing supportive intervention is necessary to maintain therapeutic compliance.

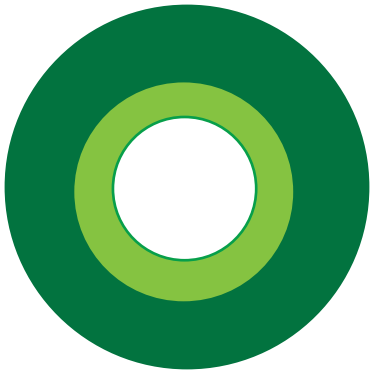
Case January 12, 2009

You see MJ today. Her KADS score is 3 and has been 5 or less for 3 weeks. She reports that she can concentrate much better and is interested in getting back to school. She is taking fluoxetine 20 mg. daily and is tolerating it well. She continues to see the social worker but has now decided to attend counseling sessions every two weeks instead of weekly. Her functioning (which you have monitored using the TeFA) has improved substantially as well apart from the fact that she is not in school. She wants to go back to school and asks your advice on how to proceed and how long she will need to take the medications.

Issues: Duration of medication treatment following recovery or remission is an important issue. There is a dearth of research data in teenagers to guide us in this. Best estimates suggest a period of 6 – 9 months on the same dose to protect against relapse. Studies have demonstrated that the risk of a second episode of depression within five years is as high as 70% so a period of

prophylactic medication continuation is strongly advised. As well, if CBT is available (in this scenario it was not) it would be useful to have MJ initiate it even though she is getting well. This would provide her with an additional prophylactic intervention against a further episode. This phase of treatment is all about preventing another episode and maximizing recovery. It may be necessary for you to advocate on her behalf with the university or college that she is attending to adjust her course of study so as to not overload her with additional stresses at this vulnerable time. When she returns to school it would be important for her to be followed at the school – perhaps at the student health center or by the schools counseling service so that a relapse prevention strategy can be put into place and actively advanced. Once again, mental health promotion activities may be helpful and once again attention to early signs of relapse will be important. You may want to review the process of onset of the first episode to better characterize the depression onset process and to help MJ better identify and more quickly seek professional intervention than she did previously should the disorder return. She had been depressed for over a month and did not self-refer for care during the first episode in spite of your early identification discussions with her.

Some patients find it helpful to check in with their primary care provider when the return home from school – just to review medication use and proactively monitor their mental health. If after 6 –9 months on the medication she decides to stop, she should be advised to taper it very slowly (over a period of 6-8 weeks) and to not stop the medication during periods of high stress (such as during examinations).



Identification, Diagnosis and Treatment of Adolescent Depression (Major Depressive Disorder)

A Clinician's Toolkit

1. MDD in Youth - Risk identification table
2. Six Item Kutcher Adolescent Depression Scale (6-KADS)
3. Psychotherapeutic Support for Teens (PST)
4. Mood Enhancing Prescription (MEP)
5. Teen Functional Activities Assessment (TeFA)
6. Tool for Assessment of Suicide Risk in Adolescents (TASR-A)

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IWK Health Centre

Sun Life Financial

MDD in Youth - Risk Identification Table

Well established and significant risk effect	Less well established risk effect	Possible "group" identifiers (these are not causal for MDD but may identify factors related to adolescent onset MDD)
1. Family history of MDD 2. Family history of suicide 3. Family history of a mental illness (especially a mood disorder, anxiety disorder, substance abuse disorder) 4. Childhood onset anxiety disorder	1. Childhood onset Attention Deficit Hyperactivity Disorder 2. Substance abuse 3. Severe and persistent environmental stressors (sexual abuse, physical abuse, neglect) in childhood	1. School failure 2. Gay, lesbian, bisexual, transsexual 3. Bullying (victim and/or perpetrator

Sun Life Financial Chair in Adolescent Mental Health

The Kutcher Adolescent Depression Scale (KADS): How to use the 6-item KADS

The KADS was developed to assist in the public health and clinical identification of young people at risk for depression. It was created by clinicians and researchers expert in the area of adolescent depression and the application of various scales and tools in clinical, research and institutional settings. Work on the KADS was conducted in samples of secondary school students, in clinical settings and in clinical research projects.

There are three different KADS scales: the 6-item, the 11-item and the 16 item. The 16 item is designed for clinical research purposes and is not available on the Sun Life Financial Chair in Adolescent Mental Health website.

The 11-item KADS has been incorporated into the Chehil-Kutcher Youth Depression Diagnosis and Monitoring Tool. This tool is designed for use in clinical settings in which health providers treat young people who have depression.

Researchers interested in using the KADS can contact the office of the Sun Life Chair at (902) 470- 6598 or Dr. Kutcher directly by email at **skutcher@dal.ca**.

The 6-item KADS is designed for use in institutional settings (such as schools or primary care settings) where it can be used as a screening tool to identify young people at risk for depression or by trained health care providers (such as public health nurses, primary care physicians) or educators (such as guidance counselors) to help evaluate young people who are in distress or who have been identified as possibly having a mental health problem.

The tool is a self-report scale and is meant to be completed by the young person following direction from the health provider, educator or other responsible person. The youth should be instructed that this tool will help the person conducting the assessment to better understand what difficulties they might be having and to assist the assessor in determining if the young person may have one of the more common emotional health problems found in adolescents – depression. The young person should be told that depending what the assessment of their problem identifies (the KADS plus the discussion with the assessor) the use of the KADS will help in the determination of next steps.

The KADS is written at approximately a grade six reading level and is useful in assessing young people ages 12 to 22. It has a sensitivity for depression of over 90 percent and a specificity for depression of over 70 percent – putting it into the top rank of self-report depression assessment tools currently available. It is also much shorter than other available tools and unlike many others, is free of charge. It has been recommended for use in a number of expert reports including the National Institute for Clinical Evaluation (UK) and the GLAD-PC Guidelines (USA and Canada). The KADS has been translated into many different languages and is used globally.

KADS Scoring

The KADS is scored using a zero to three system with “hardly ever” scored as a zero and “all of the time” scored as a three. A score of six or greater is consistent with a diagnosis of Major Depressive Disorder and should trigger a more comprehensive mental health assessment of the young person. The KADS will also often identify young people who suffer from substantial anxiety such as Panic Disorder and Social Anxiety Disorder but it has not been validated for that specific purpose.

Another use of the KADS is for monitoring of symptoms in the young person being treated for depression. This should ideally be done at each visit and the scores recorded and reviewed for evidence of improvement.

The last item on the KADS is very sensitive to suicide risk. Any young person scoring one or higher on the last item should have a more thorough suicide risk assessment. We suggest that this be conducted using the adolescent suicide risk assessment guide – the TASR – A. A copy of the TASR – A can be accessed on the **clinical tools section of our website.**

The KADS can be used by expert clinicians (such as child and adolescent mental health staff working in sub-specialty or academic settings) without additional training. Training in the use of the KADS for others is advised and can be arranged for groups of 10 or more by contacting the office of the Chair. Depending on the group, the duration of KADS training ranges from one to three hours.

Sun Life Financial Chair in Adolescent Mental Health

Permission to use the KADS

The KADS is available freely for use but may not be sold, copied or otherwise distributed without the express written consent of Dr. Stan Kutcher.

We appreciate any feedback on the use, outcome or suitability of the KADS from any individual or group who is using it. Feedback can be directed to Dr. Stan Kutcher by email at **skutcher@dal.ca**.

Clinicians, educators, youth workers and others interested in other training programs pertaining to youth depression and suicide offered by the Chair can find further information by visitng the **training programs section of our website.**

More Information

Further information about the KADS can be found in these sources:

Brooks, S. (2004) The Kutcher Adolescent Depression Scale (KADS). *Child & Adolescent Psychopharmacology News*, 9, 54, 4-6

Brooks, S.J.,& Kutcher, S. (2001). Diagnosis and measurement of adolescent depression: A review of commonly utilized instruments. *Journal of Child and Adolescent Psychopharmacology,* 11, 341–376.

Brooks, S.J., Krulewicz, S.,& Kutcher, S. (2003). The Kutcher Adolescent Depression Scale: Assessment of its evaluative properties over the course of an 8–week pediatric pharmacotherapy trial. *Journal of Child and Adolescent Psychopharmacology,* 13, 337–349.

Kutcher, S., Chehil, S. (2006) Suicide Risk Management: A Manual for Health Professionals. Wiley-Blackwell.

LeBlanc, J.C., Almudevar, A., Brooks, S.J., & Kutcher, S. (2002). Screening for adolescent depression: comparison of the Kutcher Adolescent Depression Scale with the Beck Depression Inventory. *Journal of Child and Adolescent Psychopharmacology*, 12, 113–126.

6-ITEM Kutcher Adolescent Depression Scale: KADS

NAME :_____ DATE :_____

OVER THE LAST WEEK, HOW HAVE YOU BEEN "ON AVERAGE" OR "USUALLY" REGARDING THE FOLLOWING

1. Low mood, sadness, feeling blah or down, depressed, just can't be bothered.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

2. Feelings of worthlessness, hopelessness, letting people down, not being a good person.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

3. Feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

4. Feeling that life is not very much fun, not feeling good when usually would feel good, not getting as much pleasure from fun things as usual.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

5. Feeling worried, nervous, panicky, tense, keyed up, anxious.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

6. Thoughts, plans or actions about suicide or self-harm.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

TOTAL SCORE: _____

6 - item KADS scoring:

In every item, score:

a) Hardly Ever = 0
b) Much of the time = 1
c) Most of the time = 2
d) All of the time = 3

then add all 6 item scores to form a single Total Score.

Interpretation of total scores:

Total scores at or above 6	Suggest 'possible depression' (and a need for more thorough assessment).
Total scores below 6	Indicate 'probably not depressed'.

Reference

- LeBlanc JC, Almudevar A, Brooks SJ, Kutcher S: Screening for Adolescent Depression: Comparison of the Kutcher Adolescent Depression Scale with the Beck Depression Inventory, Journal of Child and Adolescent Psychopharmacology, 2002 Summer; 12(2):113-26.

Self-report instruments commonly used to assess depression in adolescents have limited or unknown reliability and validity in this age group. We describe a new self-report scale, the Kutcher Adolescent Depression Scale (KADS), designed specifically to diagnose and assess the severity of adolescent depression. This report compares the diagnostic validity of the full 16-item instrument, brief versions of it, and the Beck Depression Inventory (BDI) against the criteria for major depressive episode (MDE) from the Mini International Neuropsychiatric Interview (MINI). Some 309 of 1,712 grade 7 to grade 12 students who completed the BDI had scores that exceeded 15. All were invited for further assessment, of whom 161 agreed to assessment by the KADS, the BDI again, and a MINI diagnostic interview for MDE. Receiver operating characteristic (ROC) curve analysis was used to determine which KADS items best identified subjects experiencing an MDE.

Further ROC curve analyses established that the overall diagnostic ability of a six-item subscale of the KADS was at least as good as that of the BDI and was better than that of the full-length KADS. Used with a cut-off score of 6, the six-item KADS achieved sensitivity and specificity rates of 92% and 71%, respectively—a combination not achieved by other self-report instruments. The six-item KADS may prove to be an efficient and effective means of ruling out MDE in adolescents.

Psychotherapeutic Support for Teens (PST)

Practical Pointers for Primary Care Health Providers Treating Adolescent Depression – Supportive Rapport

This tool provides clinicians with guidelines/suggestions that they can use to direct their clinical interactions with the teen.

Checklist	Type of Support	Guidelines/Suggestions
☐	**Approach**	• Be friendly but not a friend • Create a supportive space • Establish confidentiality and limits of confidentiality (self-harm, danger to others, etc) and be very CLEAR about these
☐	**Be Present-Focused**	• Help identify the most important problems occurring now
☐	**Be Problem-Oriented**	• Help develop and apply practical solutions to ongoing problems
☐	**Provide Education**	• Provide education about depression and education about the treatment (complete KADS, TeFA)
☐	**Be Responsive**	• Be available for urgent matters by phone, email or text messaging within office hours. • Schedule frequent brief face to face visits at times that do not conflict with school (15-20 minutes) • Monitor and support teen wellness activities (exercise, sleep, healthy diet, etc.) • Ensure access to professional care during the off hours for emergencies

Further guidelines to create a supportive environment

Remember to embed these guidelines/suggestions within a supportive, active listening environment. This includes the following:

- ☑ Compassionate and non-judgmental attitude, but be real
- ☑ Active listening: eye contact, verbal ("ah hum", "go on"), and non-verbal (head nod) clues to listening engagement
- ☑ Clarification ("help me understand", "could you explain what you were thinking about that", etc.)
- ☑ Emotional identification ("seems as if you are feeling frustrated", etc.)
- ☑ Do not understand the young person too quickly – you are likely to be wrong
- ☑ If you do not know what they are talking about – ask
- ☑ If you do not know an answer to a question – admit it and tell them how you will find out.

Remember that parental or caretaker involvement is often necessary during the assessment and treatment of depression in an adolescent. Whenever possible information about the young person's emotional state and function should be obtained from the parent or caretaker. It is not uncommon for teens and parents/caretakers to have different opinions about the mental state and activities of the young person. When this occurs, joint discussion of the issue will be necessary for clarification and optimal intervention planning. However, it is essential to ensure that appropriate confidentiality is being maintained during this process.

Confidentiality is important but it has its limits. Abuse, suicide intent, harm of others need to be identified as issues that can not be kept confidential. Drug use must be discussed with the youth and an appropriate decision pertaining to the degree of drug involvement must be clarified in terms of at what point does drug use become drug misuse/ abuse that requires informing others.

Mood Enhancing Prescription (MEP)

It is useful to provide the young person with a simple outline developed collaboratively with them (and caregiver if appropriate) that clearly specifies what self-regulatory activities they should pursue during the diagnostic and treatment phases of their contact with their health provider. The Mood Enhancing Prescription is a useful and time efficient tool that can be used to help the young person identify and plan their daily activities. It is embedded below and provided in the Clinician's Toolkit as well. Practically, the clinician can review the MEP with the patient, complete the form and then review it at the next office visit.

Mood Enhancing Prescription

There are many things that you can do to help your mood. Sometimes these activities by themselves will help you feel better. Sometime additional help (such as psychotherapy or medications) may be needed. This is your prescription for what you can do to help your mood. For each activity write in your plan (include what you will do, how often and with whom)

Activity	Plan (what, how often, and with whom)
Exercise	
Eating Well	
Sleeping Well	
Problem Solving	
Being Socially Active	

Enrolling the Help of Others

If the young person has a supportive family, then family members could be involved in the MEP. Other significant persons in the young person's life may also be able to play a role (eg: teacher, school counsellor, coach, neighbour, etc.) It's a good idea to ask the young person about who else can help out and whenever possible get the family involved. Always inquire about school performance. Many young people with MDD may need extra educational interventions or a modified academic load. Discussion with a school counsellor (with permission from the patient) is recommended.

Teen Functional Assessment (TeFA)

The TeFA is a self-report tool. It is meant to be completed by the patient and should take no more than three minutes to complete for most adolescents. The health care provider can use the information obtained on the TeFA to probe for further information – especially in those areas where the young person noted worse or much worse than usual and in those domains that the teen identifies as either self or parental worry.

This form is meant to let your health provider know about how you are doing. All information you give is confidential. Please write your answers to the items on the form.

For each of the following categories, write down one of the following options in the space provided – much better than usual; better than usual; about the same as usual; worse then usual; much worse than usual.

Over the last week how have things been at:

School _____

Home _____

Work _____

Friends _____

Write down the two things in your life that either worry you the most or are causing you the most problems.

1) _____

2) _____

Write down the two things about you that cause your parents or other adults to be concerned about or that you think might concern them if they knew about these things.

1) _____

2) _____

Sun Life Financial Chair in Adolescent Mental Health

The Tool for Assessment of Suicide Risk for Adolescents (TASR-A): How to use the TASR - A

The TASR-A was developed to assist in the clinical evaluation of young people at imminent risk for suicide. It was created by clinicians with expertise in the area of adolescent suicide assessment and the development and application of various scales and tools in clinical, research and institutional settings. The TASR-A was derived from the Tool for Assessment of Suicide Risk (TASR) that was developed for clinical use in emergency room, hospital and outpatient settings in the assessment of imminent suicide risk in adults. The adult TASR is found in the book: Suicide Risk Management: A Manual for Health Professionals (Kutcher and Chehil; Wiley-Blackwell, 2007).

The TASR is intended for use as part of a comprehensive mental health assessment of a young person considered to be at risk for suicide. The clinician should conduct the assessment in her/his usual manner and then score the TASR–A. If sections of the TASR-A have not been addressed in the interview, then the clinician should then go back and address them with the patient. A notation of the presence or absence of each risk factor identified on the TASR-A should be made in the appropriate space provided. Once the TASR-A has been completed, the clinician comes to a clinical decision as to the level of risk for imminent suicide and notes that in the space provided on the TASR–A.

The TASR-A is not a diagnostic tool since suicide is a behaviour rather than a medical diagnosis. The TASR-A is also not a predictive tool since there is no tool that can be demonstrated to predict suicide. Rather, the TASR-A is a semi-structured instrument that the clinician can follow to ensure that the most common risk factors known to be associated with suicide in young people have been assessed. The tool also provides the clinician with a convenient overview of the entire risk factor assessment, thus allowing the clinician to make a best judgment call as to the level of risk for imminent suicide. Furthermore, the TASR-A provides an excellent documentation of the comprehensiveness of the suicide risk assessment conducted by the clinician and thus may be useful for both clinical record keeping and in medico-legal cases.

The TASR-A also includes a section in which the 6 item KADS score for depression can be recorded. This is important for a number of reasons. 1) Suicide, like behaviours, can often be the entry point for clinical assessment, and depression is a common risk factor for youth suicide. 2) The presence of a depressive disorder increases the probability of suicide in young people. 3) Treatment of depression has been demonstrated to decrease suicide attempts. The 6-item KADS can be accessed on the **professionals section of our website.**

The 6-item KADS is designed for use in institutional settings (such as schools or primary care settings) where it can be used as a screening tool to identify young people at risk for depression or by trained health care providers (such as public health nurses, primary care physicians) or educators (such as guidance counselors) to help evaluate young people who are in distress or who have been identified as possibly having a mental health problem.

Permission and Training

The TASR-A can be used by expert clinicians (such as child and adolescent mental health staff working in sub-specialty or academic settings) without additional training. Training in the use of the TASR-A for other health providers is advised and can be arranged for groups of 10 or more by contacting the office of the Chair. Depending on the group, the duration of TASR-A training ranges from one to three hours.

The TASR-A is available freely for use but may not be sold, copied or otherwise distributed without the express written consent of Dr. Stan Kutcher.

We appreciate any feedback on the use, outcome or suitability of the TASR-A from any individual or group who is using it. Feedback can be directed to Dr. Stan Kutcher by email at **skutcher@dal.ca.**

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Tool for Assessment of Suicide Risk: Adolescent Version (TASR-A)

Name: _____ Chart #: _____

Individual Risk Profile	**Yes**	**No**
Male		
Family History of Suicide		
Psychiatric Illness		
Substance Abuse		
Poor Social Supports/Problematic Environment		

Symptom Risk Profile	**Yes**	**No**
Depressive Symptoms		
Psychotic Symptoms		
Hoplessness/Worthlessness		
Anhedonia		
Anger/Impulsivity		

Interview Risk Profile	**Yes**	**No**
Suicidal Ideation		
Suicidal Intent		
Suicide Plan		
Access to Lethal Means		
Past Suicidal Behavior		
Current Problems Seem Unsolvable		
Command Hallucinations (Suicidal/ Homicidal)		
Recent Substance Use		

6 item KADS Score: _____

Level of Immediate Suicide Risk

High _____
Moderate _____
Low _____

Disposition: _____

Assessment Completed by: _____ Date: _____