From Meh to Mayday: Decoding Depression in Pediatrics

Recognizing Severity, Responding to Risk, and Making the Right Call in Real-Time Clinical Scenarios

Children's National Hospital
Pediatric Health Network

Faith R. Kelley, MD

Erin M. Sadler, PsyD

Children's National

Introduction and Welcome

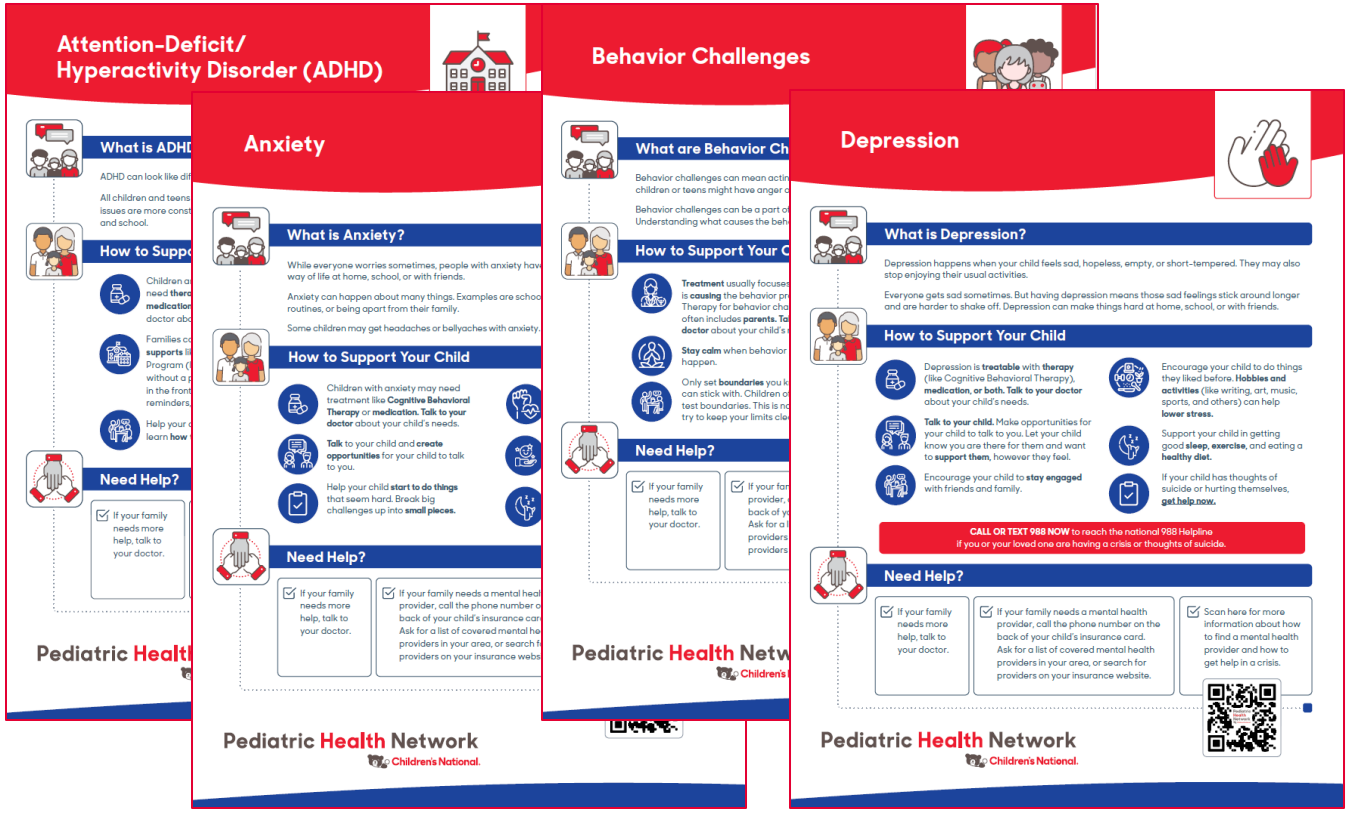
PHN Behavioral Health Initiative Upcoming Trainings

Activity	Speaker	Date/Time	Format
Diagnosis of Young Children with Autism in the Primary Care Setting	Kelly Register-Brown, MD and Annie Inge, PhD	January 8, 2026, 8:30am-12:30pm *Includes optional follow-up cohort	Half day online workshop

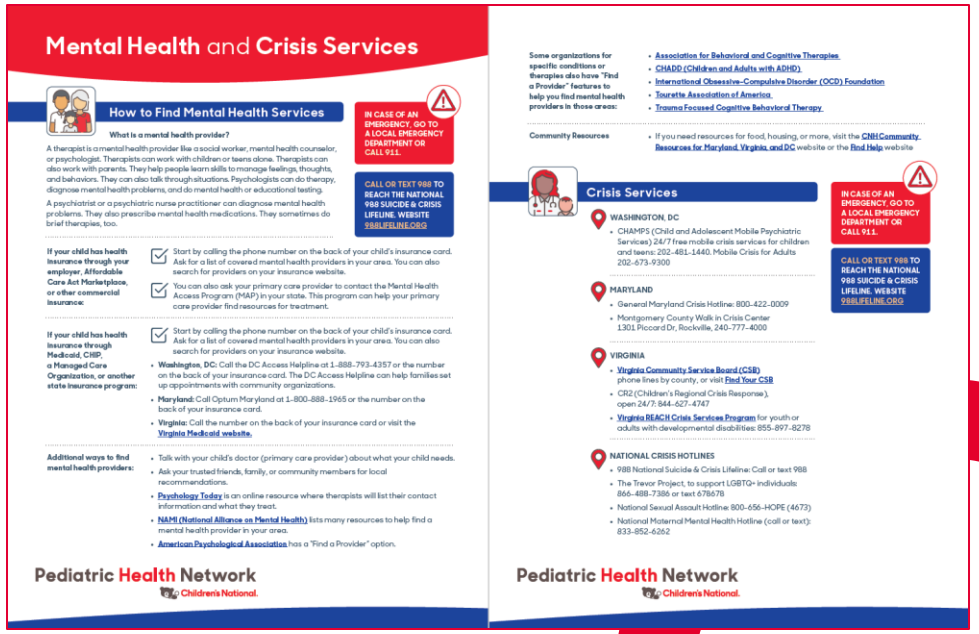
PLUS: Two additional webinars in early 2026
Wednesdays at 12:00pm
Content TBD

https://pediatrichealthnetwork.org/behavioral-health-initiative/

Handouts for Patients & Families



- ADHD
- Anxiety
- Depression
- Eating Disorders
- Autism
- Behavior Challenges
- Sleep Habits
- Mealtimes & Picky Eating
- Reducing Screen Time



All handouts are freely available online

https://pediatrichealthnetwork.org/clinical-support-tools-for-providers/

NEW: Behavioral Health Peer Network
Support for PHN Integrated Behavioral Health Providers

- What: Virtual support space to connect behavioral health colleagues in primary care settings
  - Case-based discussion
  - Shared problem-solving
  - Peer support
- Who: **PHN integrated BH providers** like social workers, therapists, counselors, psychologists, PMHNPs, psychiatric nurse practitioners, psychiatrists, etc.
- When: First Wednesday of each month from 12-1pm starting **Wednesday, September 3**
- Note: Does not constitute supervision; no CEs

To receive calendar invites, complete the brief form below:
https://forms.office.com/r/TE6fVALEEH

Notes About Today's Webinar

All lines are muted throughout the presentation.

Please use the Q&A to ask questions or make comments.

We will be recording the session.

Today's recording and materials will be posted to the PHN website following the presentation:

https://pediatrichealthnetwork.org/

Continuing Education Learner Notification

Notice of Requirement for successful completion

Participants may obtain CE Contact Hours for this session if you attend the entire session and complete an evaluation within 60 days of the event. A code and link/text number will be provided at the end of the session to complete the evaluation and claim CE credit.

Credit Designation Statement

- **ACCME:** Children's National Hospital designates this live/enduring activity for a maximum of **1 AMA PRA Category 1 Credits™** for physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- **ANCC:** Children's National Hospital designates this activity for **01 Live ANCC contact hours**.
- **Psychology:** Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs. All confirmed participants will earn 1 CE credits (Instructional Level, Intermediate Learning) upon successful completion of the learning event and evaluation.
- **Social Work Credit Designation Statement:** As a Jointly Accredited Organization, Children's National Hospital is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course receive **1** continuing education credits.

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INTERPROFESSIONAL CONTINUING EDUCATION

Learner Notification

Disclosure of Conflict of Interest

The planning committee and presenters have no relevant financial relationships with ineligible companies

Acknowledgement of Commercial Support

No financial nor in-kind commercial support was received for this education activity.

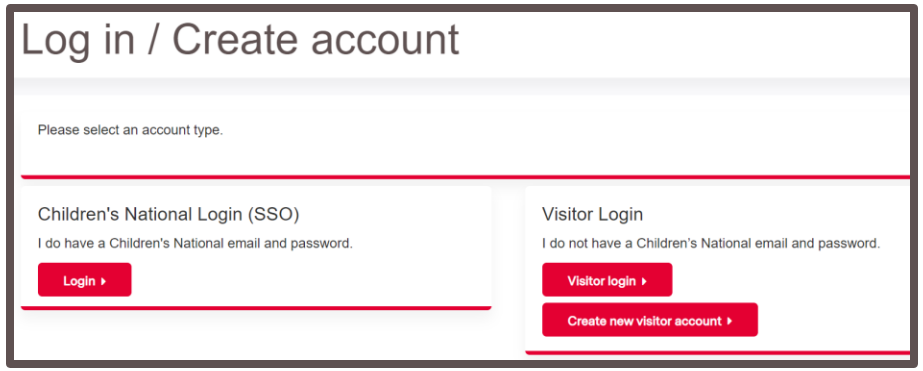
Instructions to claim CE will be provided at the end of the course.

CE Profile Set Up Instructions

You must create an account on the Continuing Education webpage to claim credit. If you are not yet registered, you will be prompted to do so when claiming credit.

To create an account:

1. Go to https://ce.childrensnational.org
2. Click Register on the top right corner on the webpage.
3. **Be sure to enter your profession and mobile phone number where prompted.**



For participants with *@childrensnational.org* emails, use Children's National Login (SSO)

All other participants, use Create new visitor account

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INTERPROFESSIONAL CONTINUING EDUCATION

Today's Speakers

Faith Kelley, MD

Erin M. Sadler, PsyD

Learning Objectives

Review recent trends and factors in depression and suicide in youth

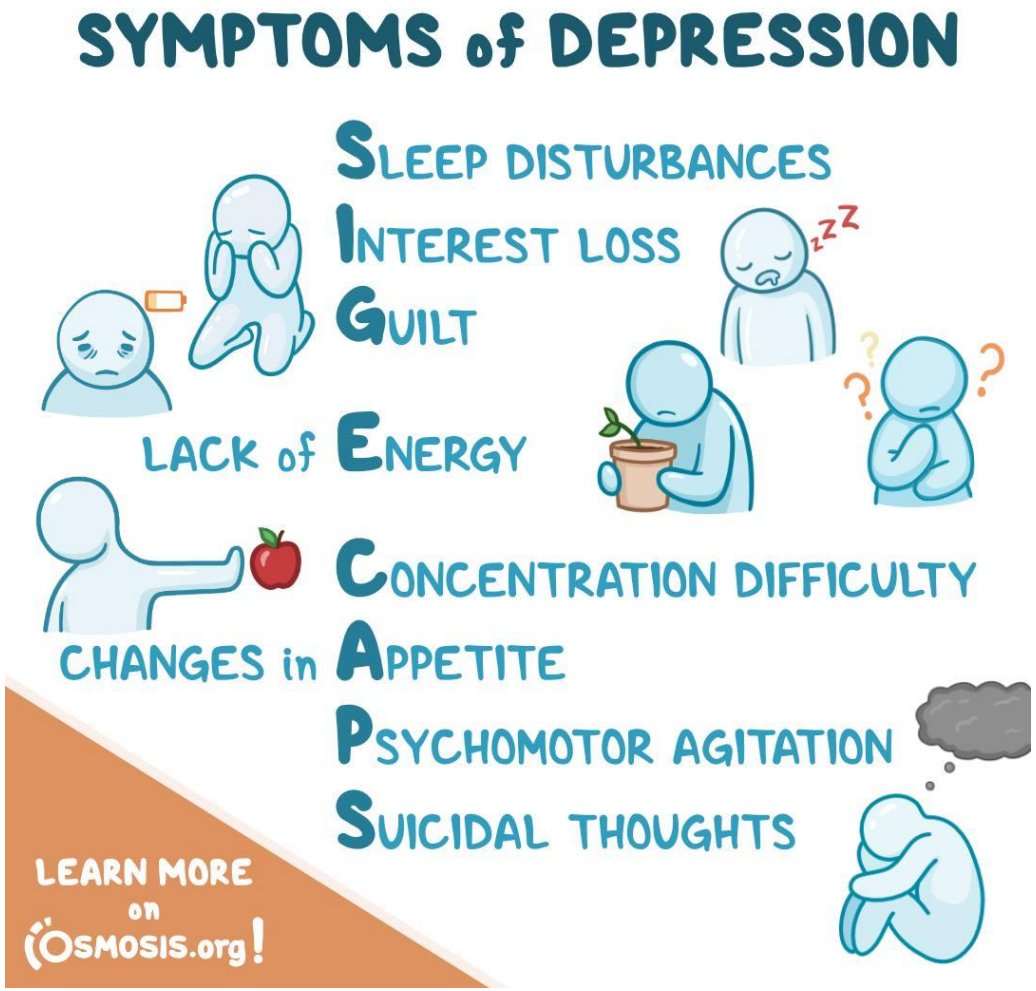
Provide practical language and easy tools to screen for depression and safety risk in the pediatric office

Describe algorithms for addressing positive depression and/or safety screens in youth

Review in-office therapeutic and pharmacologic interventions to treat depression in youth

Depression

Major Depression



*(5+ for 2 weeks)

Major Depressive Disorder*
Seasonal Affective Disorder
Persistent Depressive Disorder (Dysthymia)
Pediatric Bipolar Disorder
Disruptive Mood Dysregulation Disorder
Premenstrual Dysphoric Disorder
Depressive Disorder Due to Another Medical Condition
Substance/Medication-Induced Depressive Disorder

A day in the life of Dr. Bear…

Chart Review

Reason for Visit:	• Natalie is an AAF returning for 15yo WCC
Past Medical History:	• Seasonal allergies; on cetirizine. NKDA. Immunizations UTD.
Past Psychiatric Hx:	• None
Social Hx:	• Strong student – Has friends; involved in sports • Some arguing with brother. Overall good family relationships
Interim Hx:	• Family called in for refills and notified the office the family recently moved.

Depression trends to keep in mind…

- **Prevalence** is high and is on the rise…
  - 1:5 (20%) teens experience at least 1 MDE → ***so, in an 8-hour workday…***
    - <50% of those with MDE receive treatment (~40-44%)
  - Teen rates > school age rates
    - Child rates are increasing exponentially
- **Risk** Factors
  - Marginalized groups are at higher risk
    - Race, gender, sexuality, SES
  - Girls > boys
    - Lethality stronger for boys
  - 2/3 school aged youth are missed at peds visits
  - Physical health concerns
  - Poor family functioning

Depression trends to keep in mind…

Protective Factors

Having…

- Sense of belonging/connectedness
- Community/social network
- Academic success/ accomplishment
- Positive self-esteem and self-efficacy

  Effective coping and regulation skills
- Positive peer and parent-child relationship
- Clear expectations for behaviors and Values

No history of (or minimal)…

- Mental health concerns
- Physical health concerns (obesity, chronic illnesses)
- Interpersonal challenges
- ACEs/Trauma
- Family mental health concerns (particularly depression and anxiety)
- Family conflict or negative family environment

Chart Review

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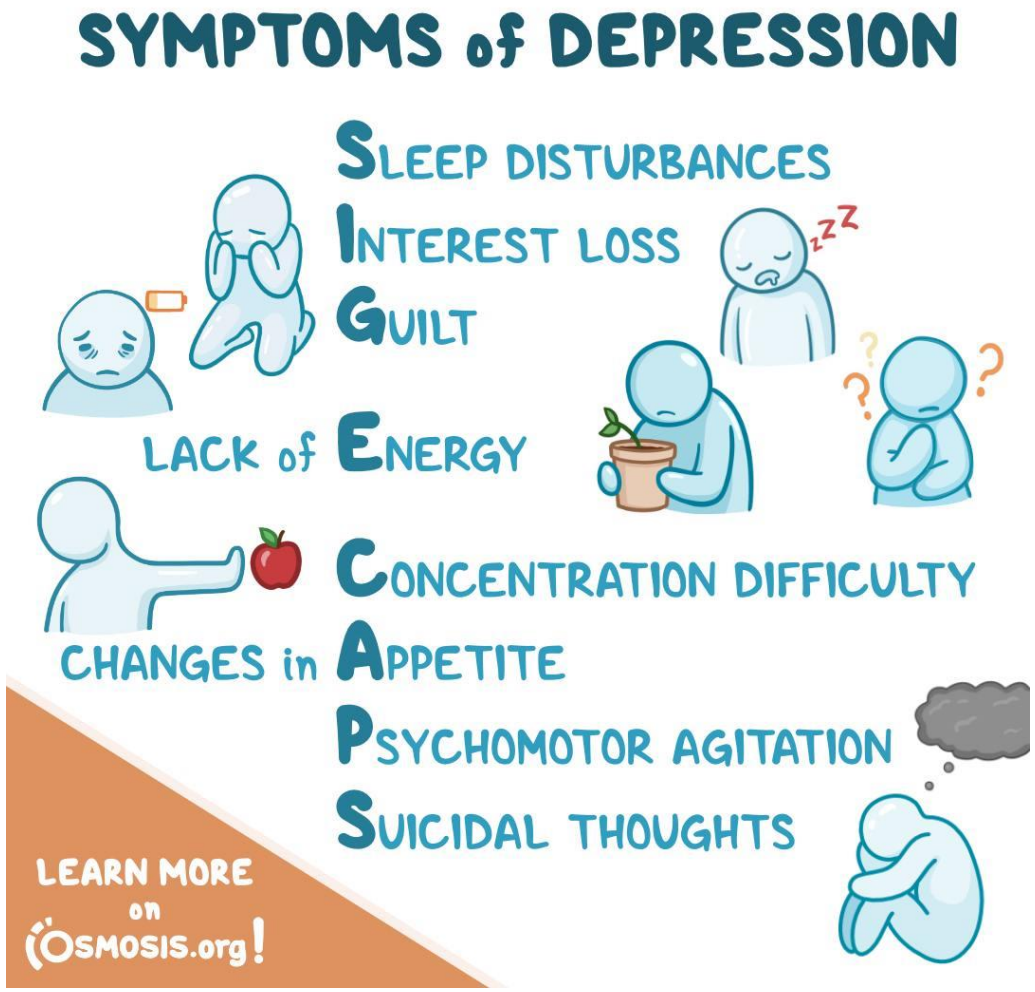
Past Psychiatric Hx:	• None
Social Hx:	• Strong student – Has friends; involved in sports • Some arguing with brother. Overall good family relationships
Interim Hx:	• Family called in for refills and notified the office the **family recently moved**.

Initial Assessment – Visit Notes

Subjective/HPI	• Move was stressful; feeling "meh"
Interval history	• Family moved -> new school -> trying to make new friends
Nutrition	• No changes in diet, but appetite waxing and waning
Sleep	• Some nights it's hard to stay asleep. Feels tired, so no issues going to sleep
Education	• Started 9th grade at new school. • Grades are slightly lower (A's and B's) than previous (All A's)
Activities	• Played final game with soccer team. Decided not to try out for new school team
Physical Exam	• Slightly tired appearing, affect dysthymic but brightens when talking about upcoming trip to see an old friend
Screeners	• SDOH • PHQ2 → PHQ9

Major Depression

(5+ for 2 weeks)



Initial Assessment – Visit Notes

Subjective/HPI	• "The move was **stressful**, but I'm getting used to my new school"; feeling "***meh***"
Interval history	• **Family moved** -> new school -> **trying to make new friends**
Nutrition	• No changes in diet, but **appetite waxing and waning**
Sleep	• Some nights it's **hard to stay asleep**. Feels tired, so no issues going to sleep
Education	• Started 9th grade at new school. • **Grades are slightly lower** (A's and B's) than previous (All A's)
Activities	• Played final game with soccer team. **Decided not to try out for new school team**
Physical Exam	• Slightly tired appearing, **affect dysthymic** but brightens when talking about upcoming trip to see an old friend
Screeners	• SDOH, GAD7, PHQ2 → PHQ9

Introducing Depression Screening – PHQ2

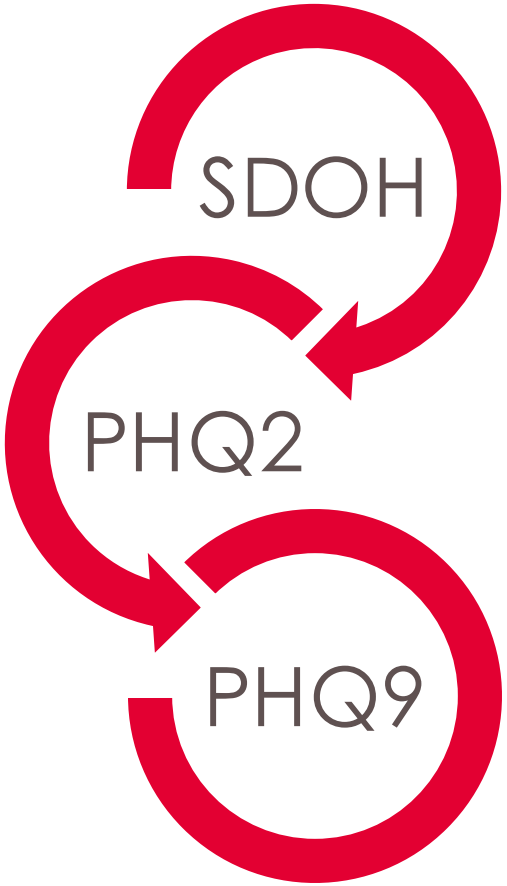
*PHQ-2 can be done as a prescreen before the visit.

- *Mental & physical health are both important parts of development.*
- *We've spoken about your physical health, now it's time to check-in on your mental and emotional health.*
- *We'll start with this survey. There are no right or wrong answers. Just mark what is true for you over the last two weeks (so going back to Halloween)*

***Encouraged to inform the family at the start of the visit how time will be split.*

ex: "We'll spend the first portion of our time all together, and then I'll meet with Natalie for a few minutes individually."

Psychosocial & Mental Health Assessment



SDOH

No concerns – Natalie has access to quality social, economic, and environmental resources

PHQ-2: Over the last 2 weeks, how often have you felt…

…Little interest or pleasure in doing things?
More than half the days (2)

…down, depressed, or hopeless?
Several days (1)

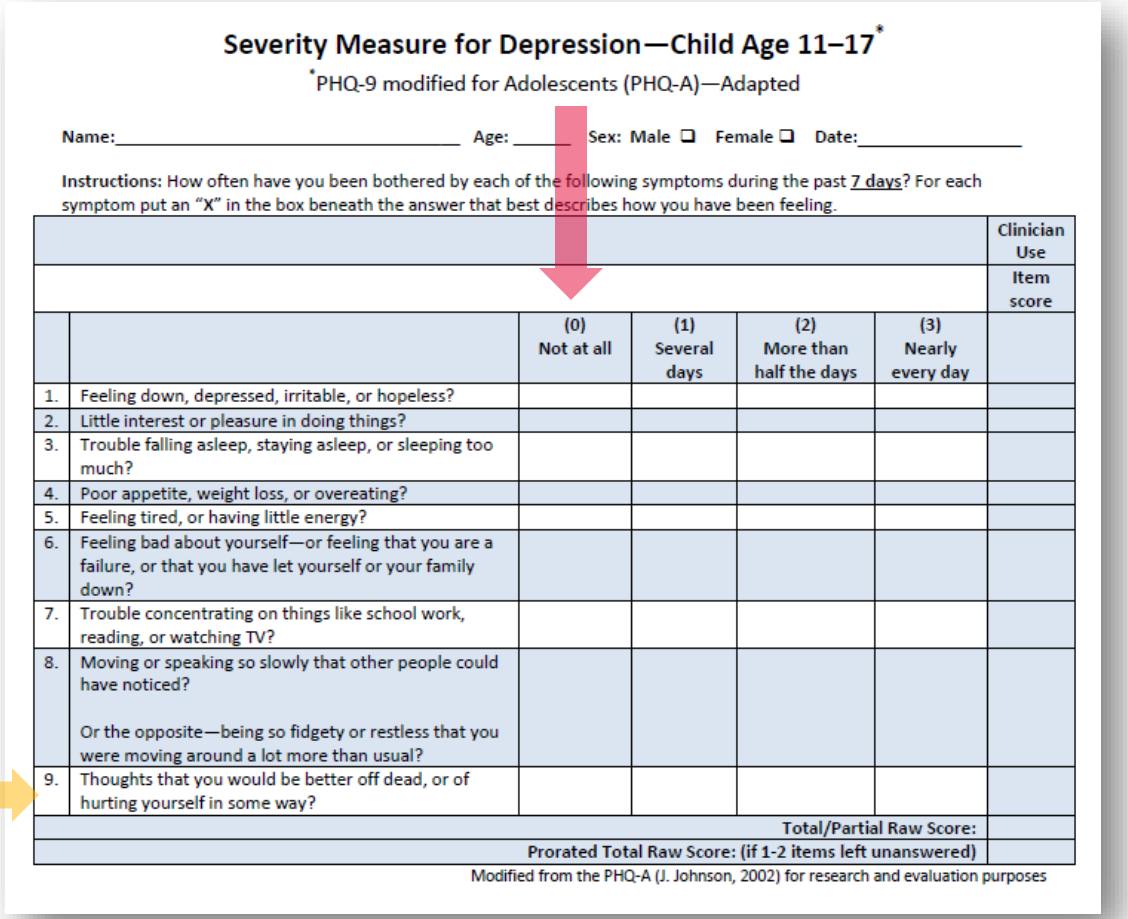
Positive Score (3)

Introducing PHQ-9 Severity Screening

- *Thank you for answering these questions. Everyone feels down (low) sometimes…*
- *This next form will take a look at other experiences some children/teens notice.*
- *Again, there are no right or wrong answers. Check what feels true for you…*
- *(So, out of the 14 days- zero days, 1-7days, 8-10 days, 11-14 days)*

It's not recommended to give the full PHQ-9 prior to the visit due to SI question (#9). Instead, consider the PHQ-8.

PHQ-9 Depression Severity Screening



Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

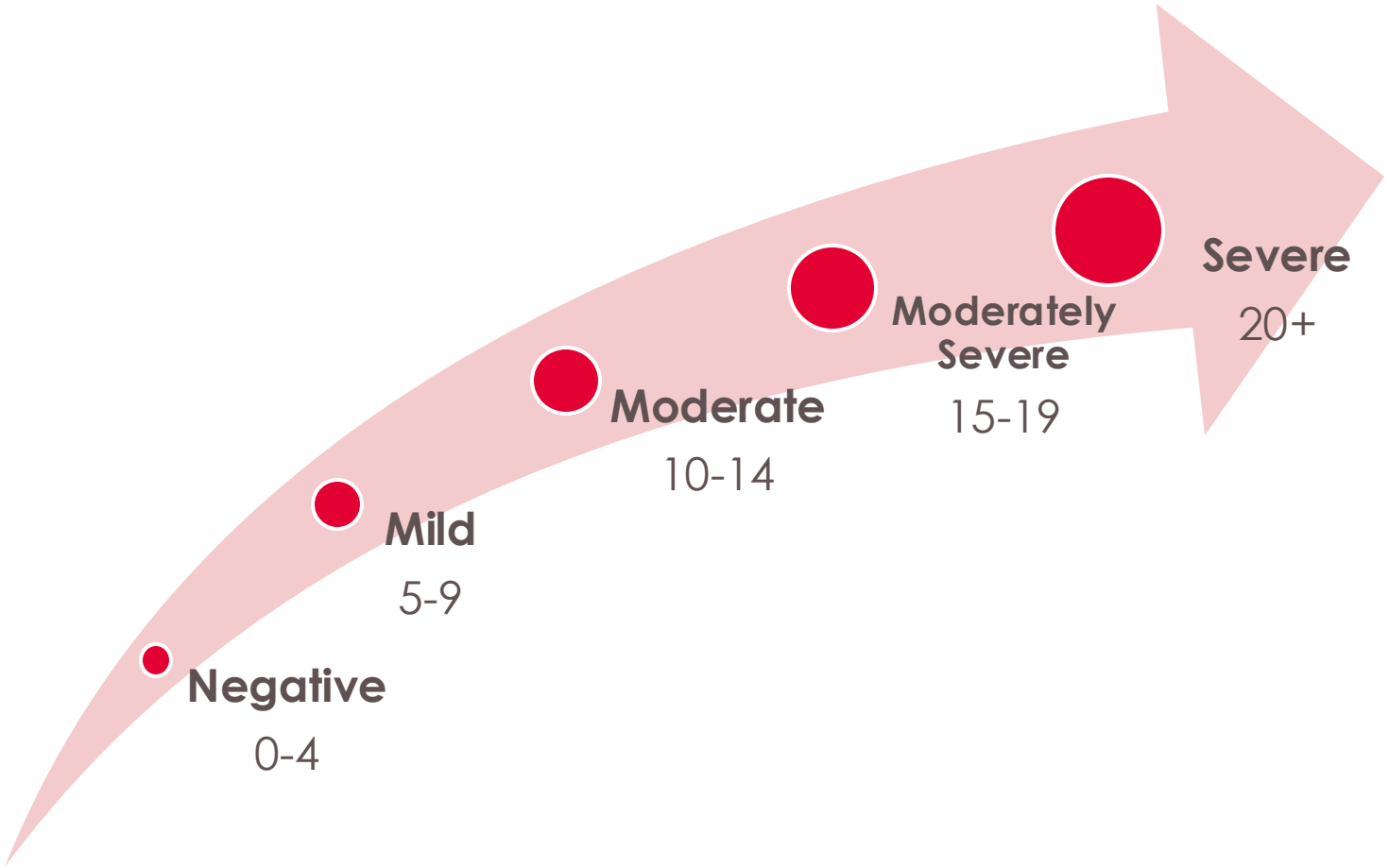
Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

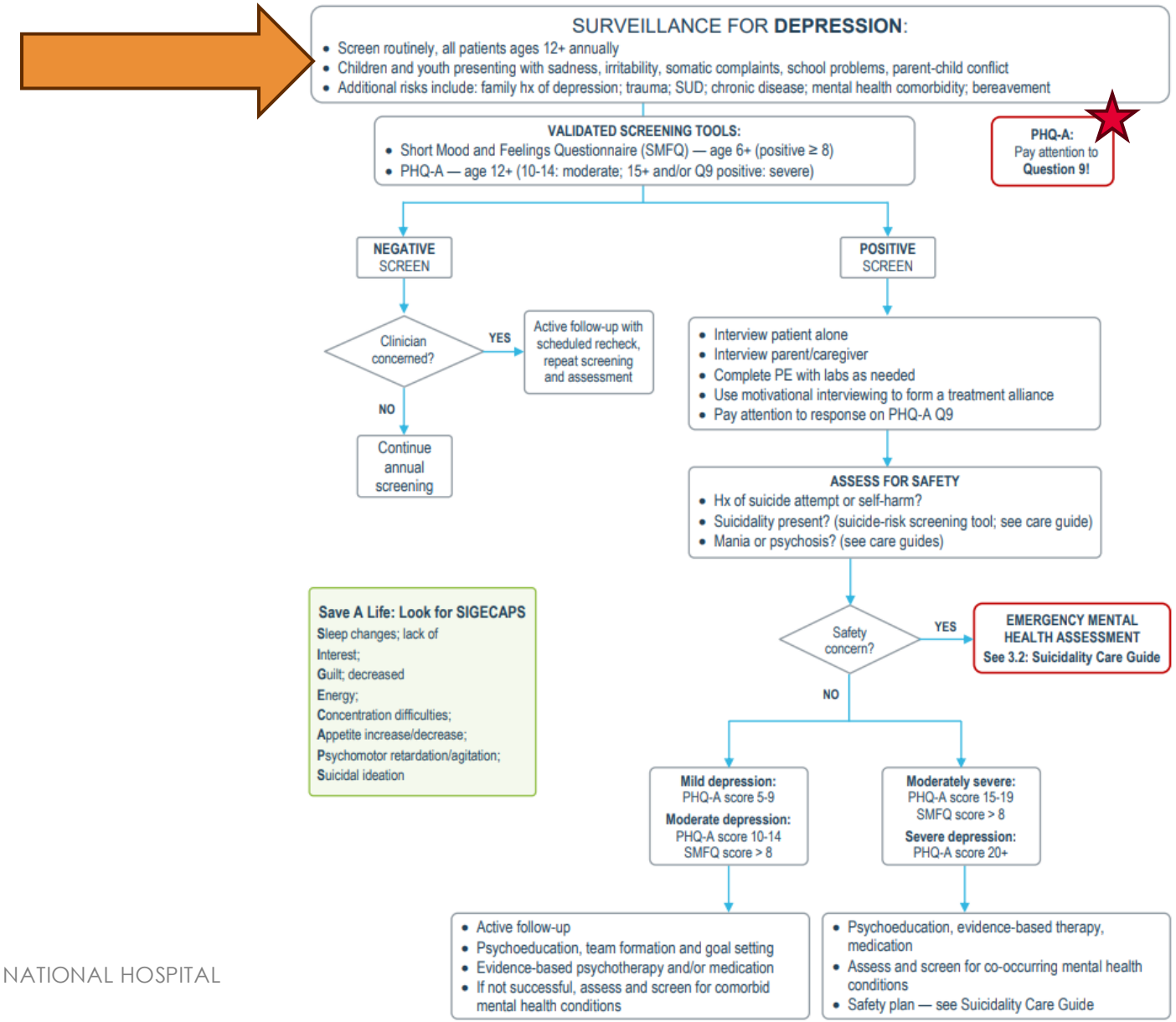
						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor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

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

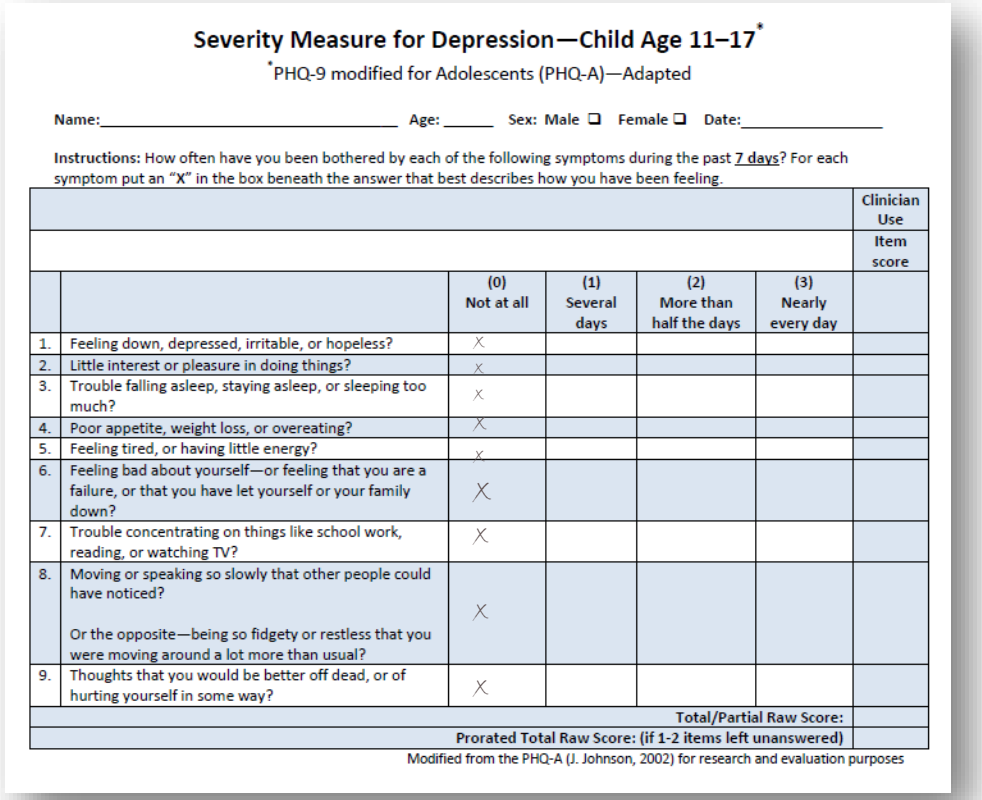
PHQ-9 Depression **Severity Scores**



3.1 Depression



Negative Screen



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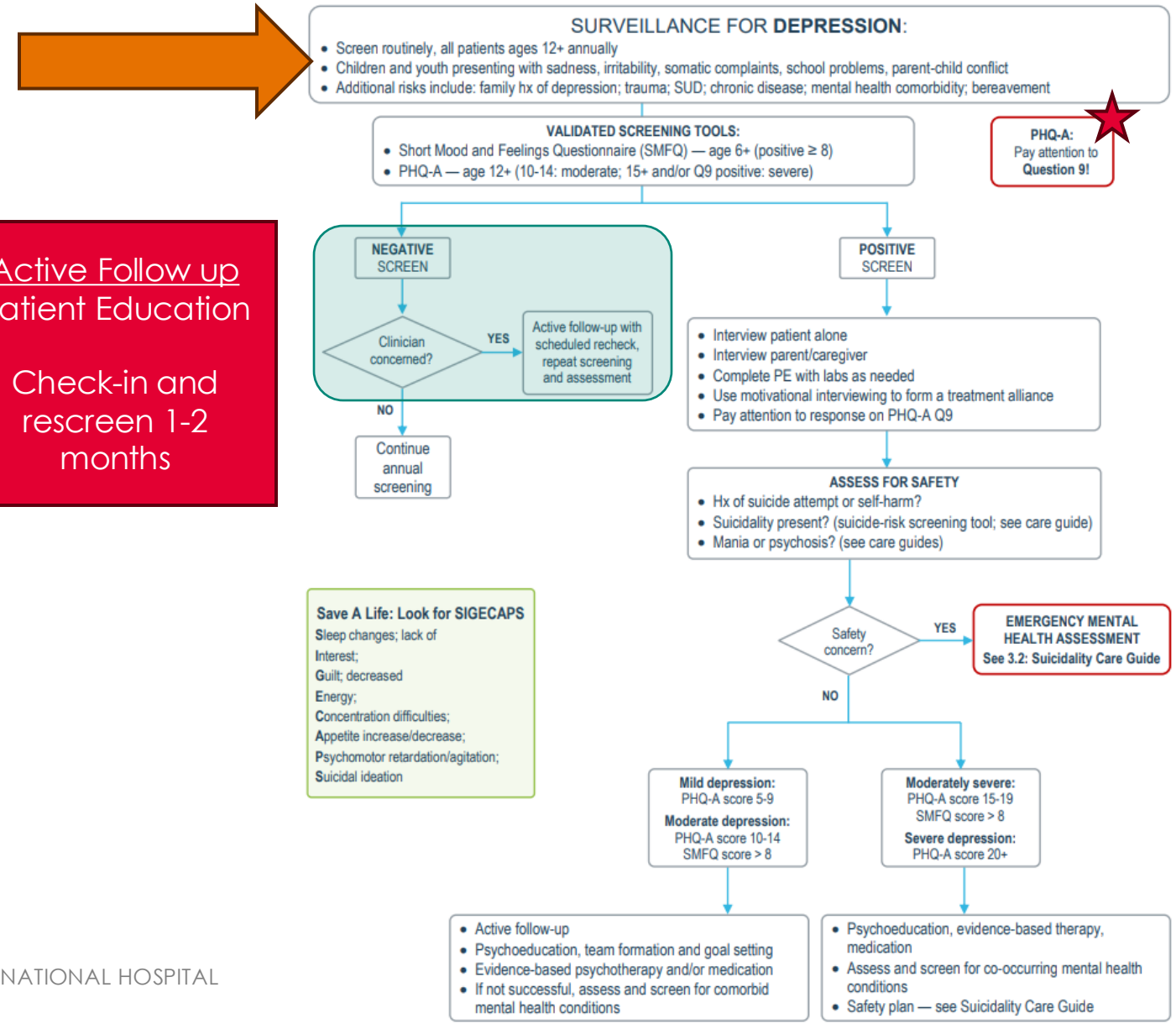
- **Anticipatory Guidance**
  - *Our bodies and brains are connected together, making both mental health and physical health development important.*
  - ***Routine check-ups** on mental health are just as necessary as coming to see me each year (or scheduling another appointment when a new concern comes up).*
  - ***Everyone feels down sometimes**.*
  - *If you ever notice feeling down, **cranky/irritable**, or uninterested having fun and these issues stick around for most days in a couple of weeks, **I want to hear from you**. We'll go over what's going on and work together to work on a plan to help you feel better.*

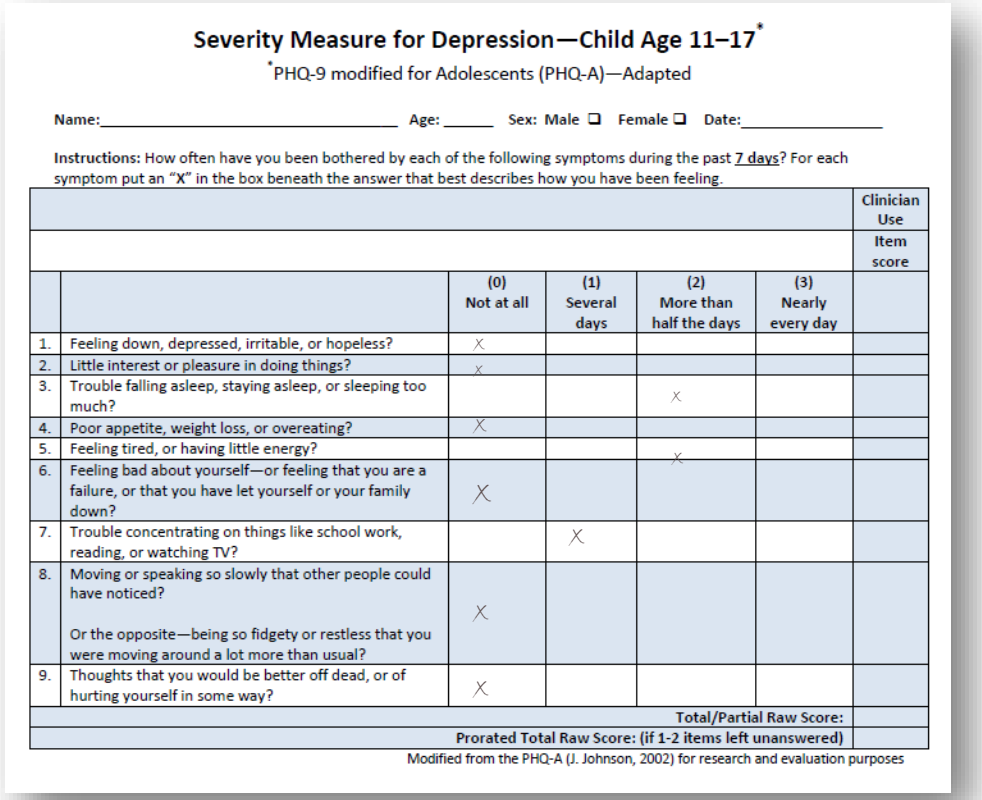
3.1 Depression



Active Follow up
Patient Education

Check-in and rescreen 1-2 months

Mild to Moderate Severity



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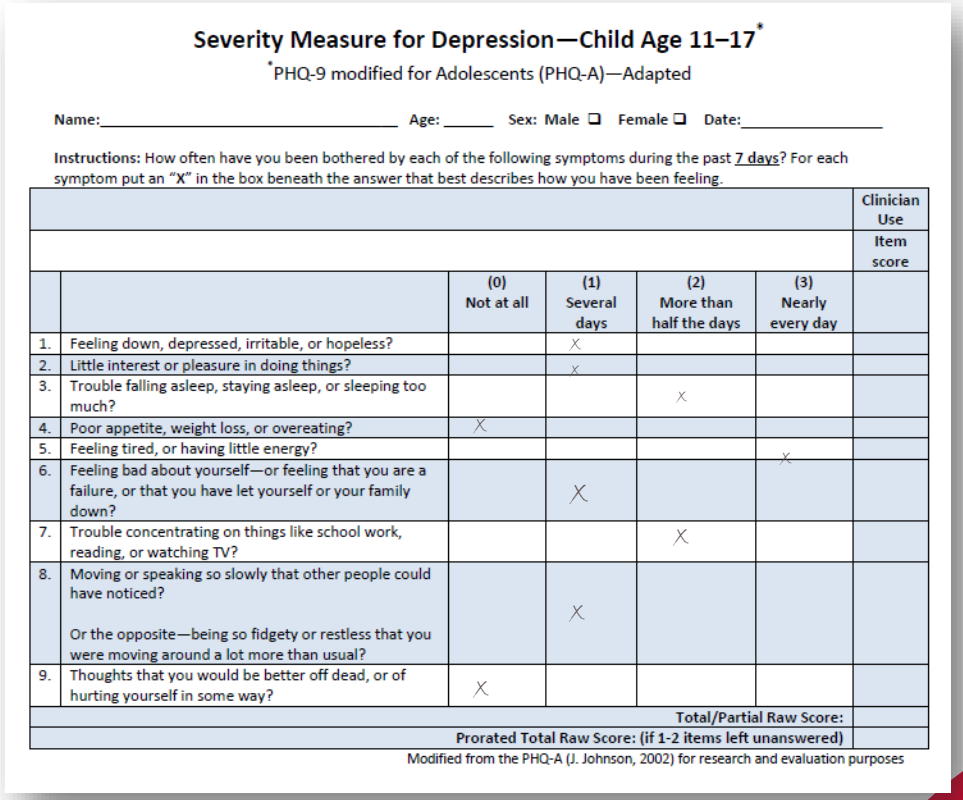

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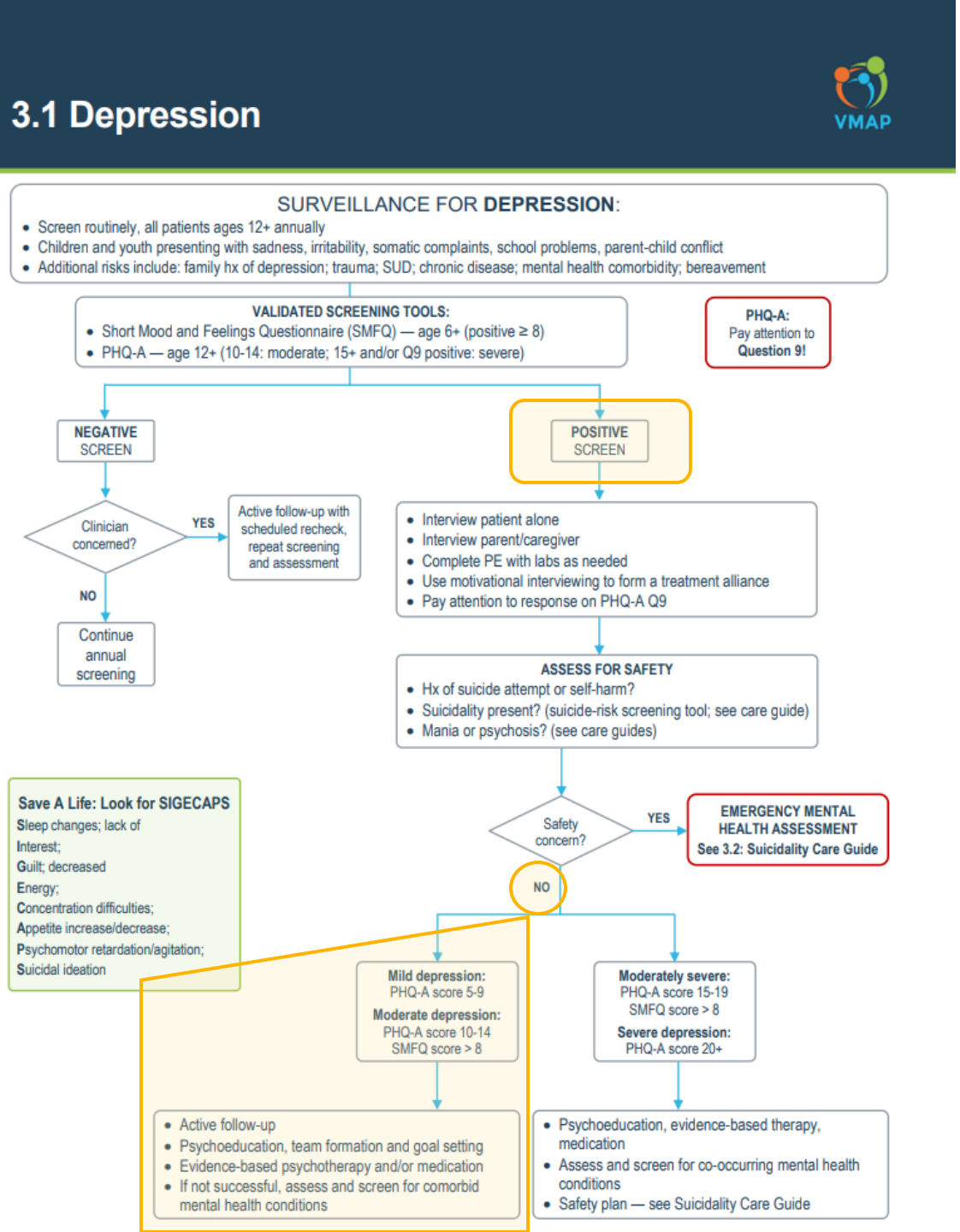
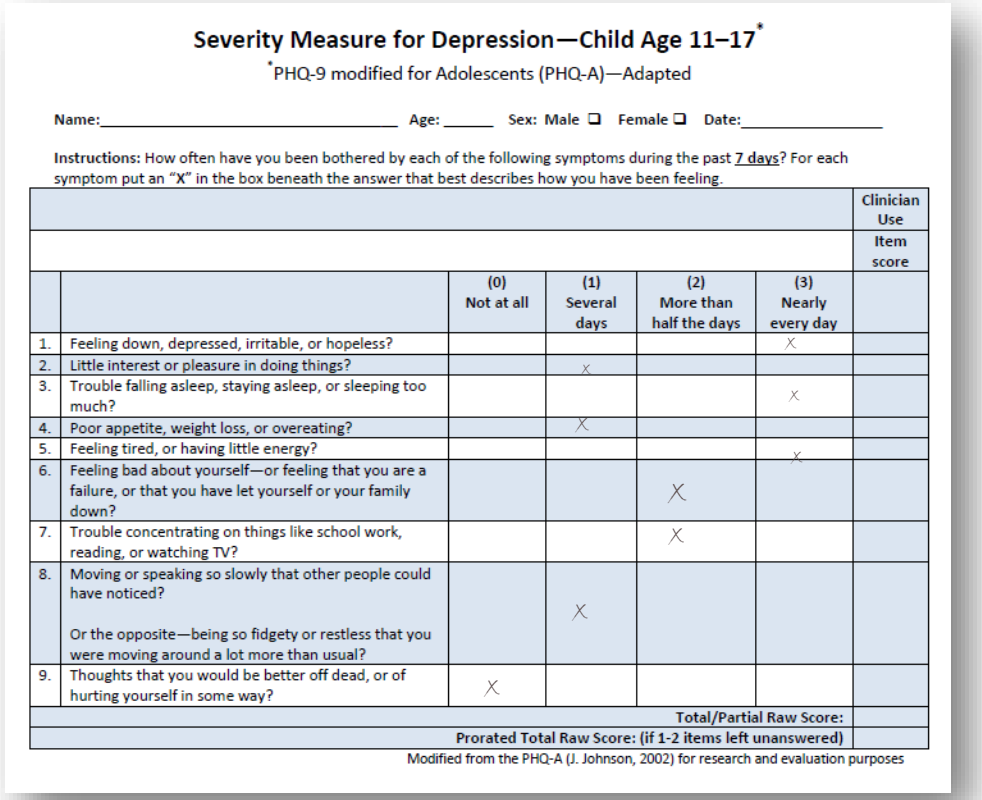
Assessment & Plan



Mild to Moderate Depression Severity

Active follow-up	Check in within 1-2 months
Psychoeducation	Depression 101
	Evidence-based psychotherapies and medication options
Team formation	**Referral to therapists** (warm handoff to integrated behavioral health support when possible)
Goal setting	Review symptoms endorsed and provide general recommendations for improving symptoms.
If not successful…	*Assess and screen for comorbid mental health conditions*
Special Note:	Teen angst, late nights up on social media vs. depression
	Consider constellation of symptoms and personality

Moderately Severe to Severe



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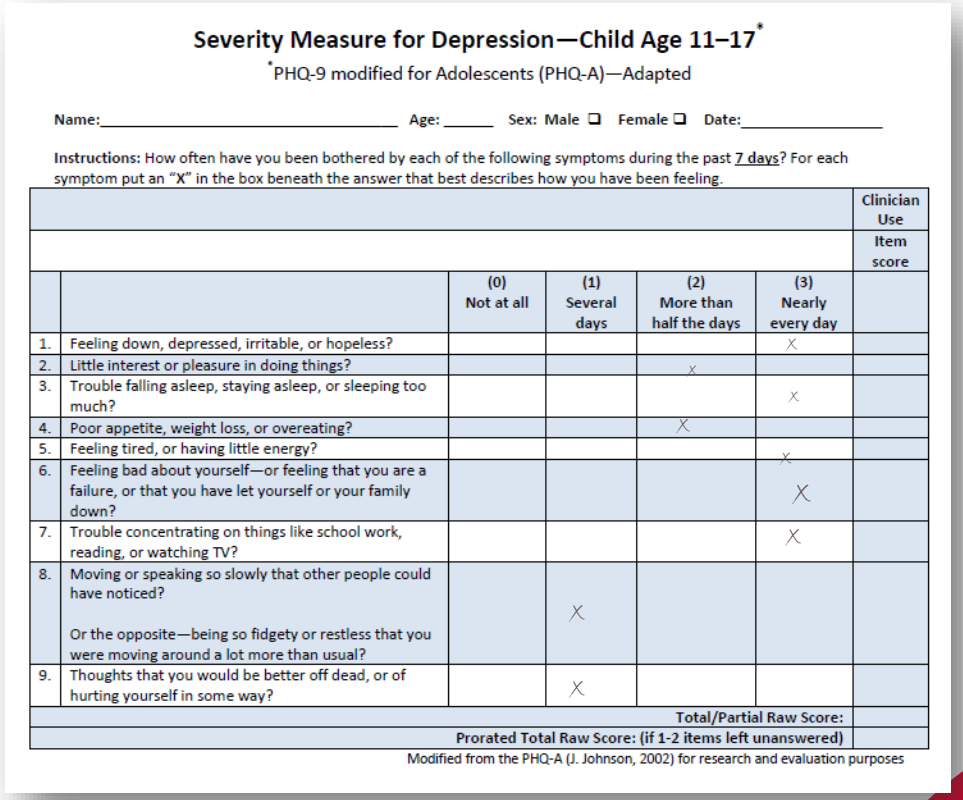

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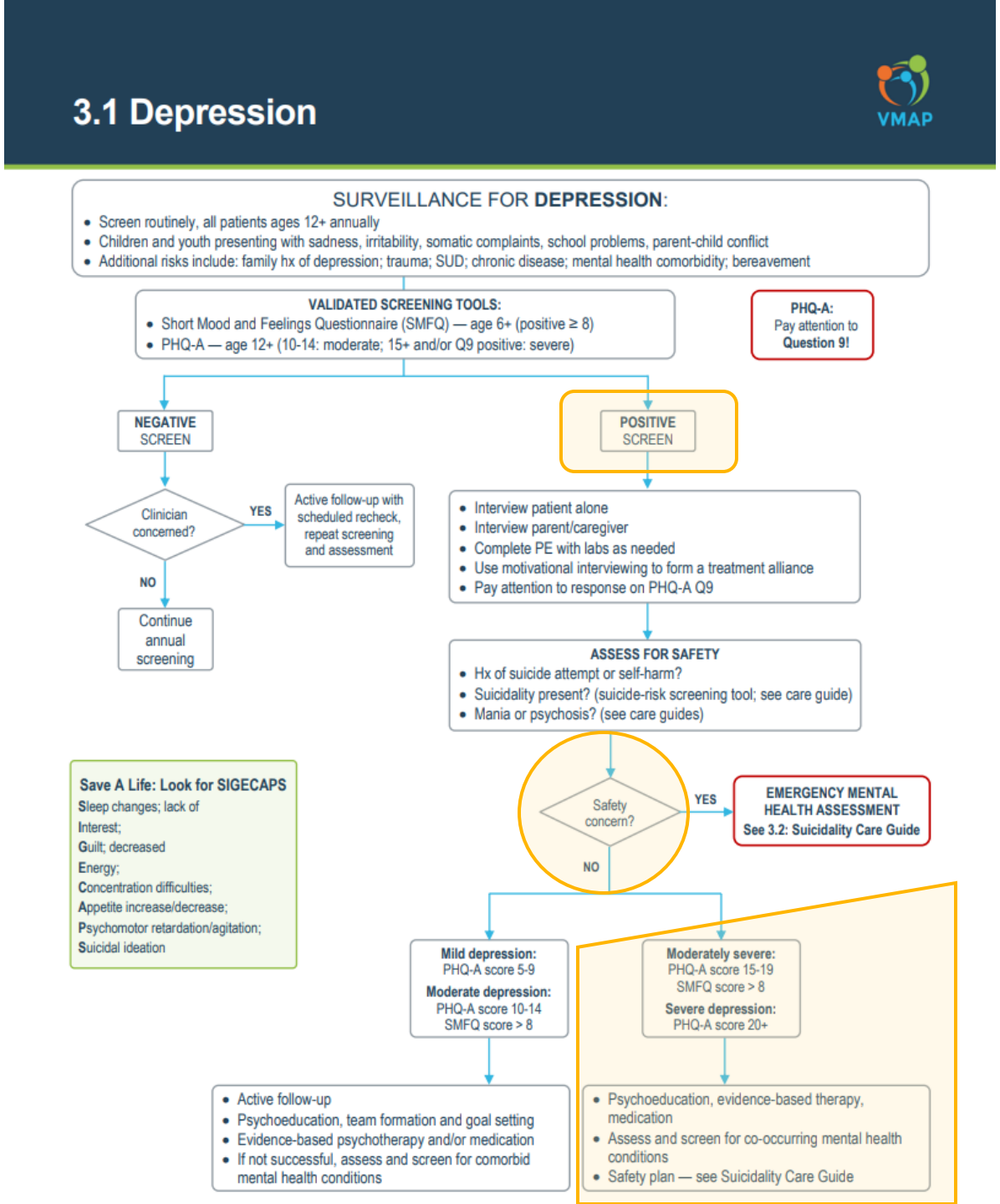


Moderately Severe to Severe Depression

Psychoeducation	Depression 101
	Evidence-based psychotherapies
	Medication options
	Assess and screen for comorbid mental health conditions
Evidence-Based Treatments	CBT, IPT, BA
	Consider levels of care and potential needs.
	Antidepressants
	Physical health recs (sleep hygiene, nutrition, ADLs)
	Improve coping, reduce safety/risk behaviors
Safety Planning	*PHN Suicidality Care Guide*
	Safe/Helpful people, places, activities
	Crisis lines
	ED Transfer

PHQ-9 Recommended Actions

PHQ9 Score	Depression Severity	Suggested Treatment Response
0 – 4	None to minimal	Anticipatory Guidance, Psychoeducation
5 – 9	Mild	Watchful waiting. Repeat PHQ9
10 – 14	Moderate	Treatment plan, and consider counseling, follow-up, and/or pharmacotherapy
15 – 19	Moderately Severe	Active Treatment with psychotherapy and/or pharmacotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy, and if severe impairment – initiate expedited referral to mental health specialist for psychotherapy and/or collaborative management *ED Referral pending SI assessment

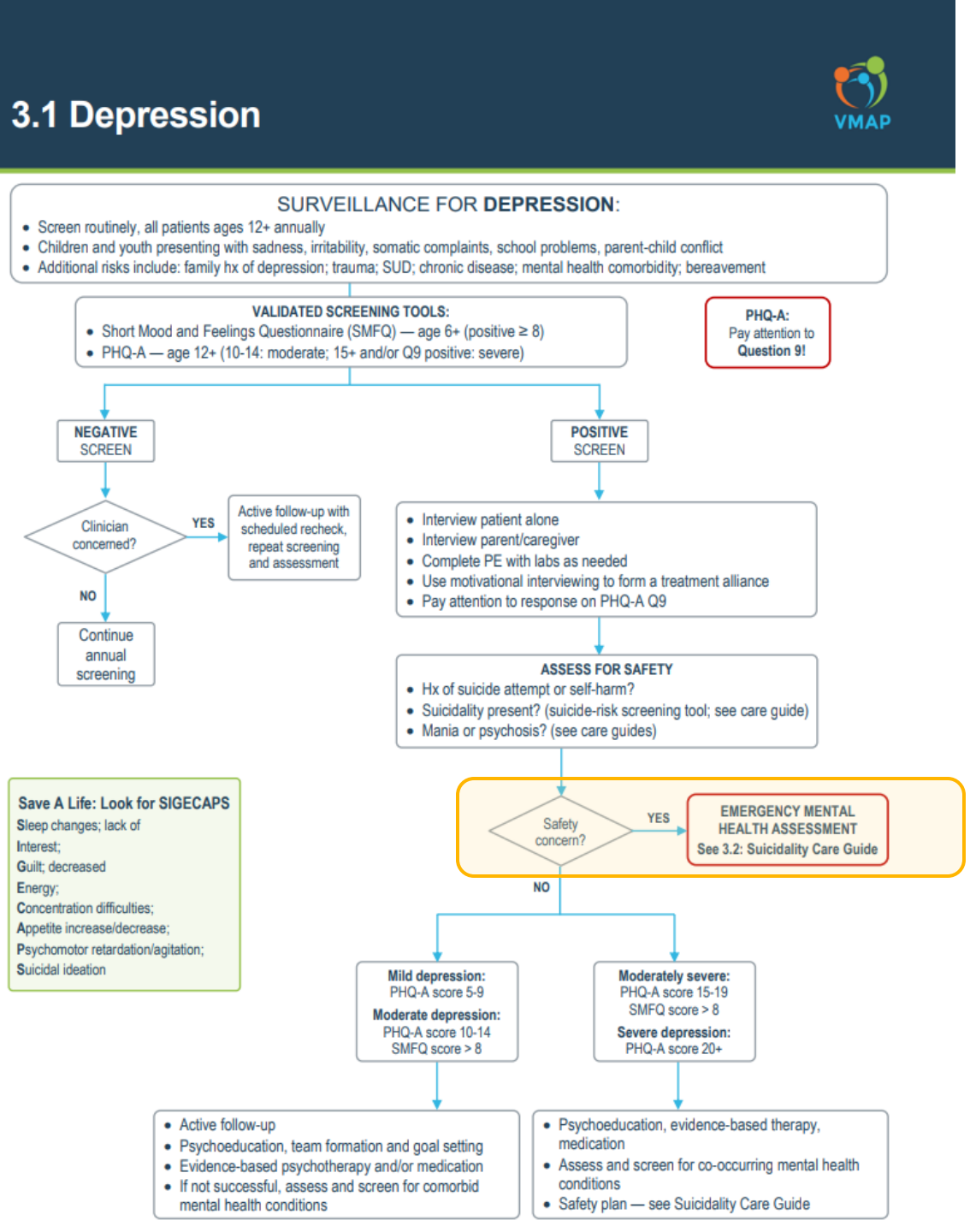
Clinical Presentation Across Childhood

Infancy/Early Childhood
- Prolonged sadness or irritability + disrupted sleep, poor appetite and little activity
- Limited or **low engagement, responsiveness** and reciprocity with caregivers/others
- Delays in achievement or regression of developmental milestones

Middle/Late Childhood
- Expressing guilt, low self-esteem, poor self-efficacy
- **Somatic complaints** (e.g., headaches, stomachaches or feeling ill)
- Irritability, tantrums or other **behavior problems**

Adolescence
- **Withdrawal** from adults (though may still spend time with close friends)
- Emotional changes expressed via **irritability** or anger in lieu of sad or down mood
- Poor sleep hygiene (getting sleep, but at varied hours)

Assessment & Plan



Diagnostic Considerations:
Rule-Outs, Co-Occurring Conditions

Complete a ROS

1. To rule out medical causes or other psych explanations
2. To get a baseline of somatic sxs to monitor for med s/e's

Physical health

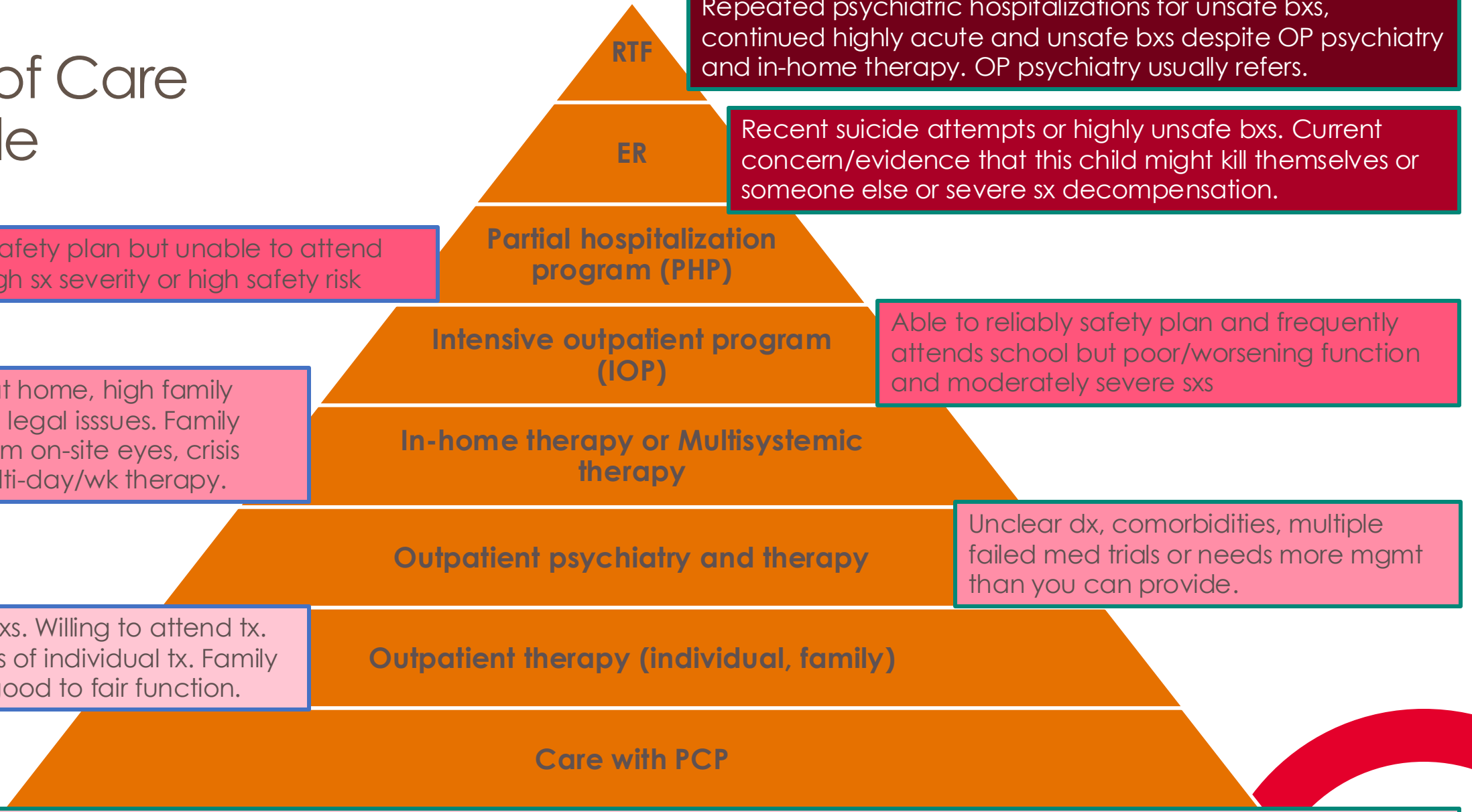
- Mononucleosis
- Hypothyroidism
- Anemia
- Autoimmune disease
- Chronic fatigue syndrome
- Migraine
- Epilepsy
- Asthma
- Inflammatory bowel disease
- Certain cancers
- Lead, Carbon monoxide exposure
- Substance use: Nicotine, alcohol, cannabis, opiates, cocaine, stimulants, sedatives, anabolic steroids

Mental health

- ADHD: distractibility
- Disruptive behavior disorders (ODD, DMDD): irritability
- Anxiety: irritability, distractibility, insomnia, somatic complaints
- PTSD: irritability, distractibility, insomnia,
- Bipolar disorder: irritability
- Psychotic disorders: agitation, social withdrawal, distractibility
- Autism spectrum disorders: irritability, social withdrawal, distractibility
- Learning disorders: sadness about school performance

Levels of Care for Mental Health Support

Level of Care Triangle



Repeated psychiatric hospitalizations for unsafe bxs, continued highly acute and unsafe bxs despite OP psychiatry and in-home therapy. OP psychiatry usually refers.

Recent suicide attempts or highly unsafe bxs. Current concern/evidence that this child might kill themselves or someone else or severe sx decompensation.

Able to reliably safety plan but unable to attend school due to high sx severity or high safety risk

Able to reliably safety plan and frequently attends school but poor/worsening function and moderately severe sxs

Frequent crises at home, high family stressors/conflict, legal isssues. Family could benefit from on-site eyes, crisis support, and multi-day/wk therapy.

Unclear dx, comorbidities, multiple failed med trials or needs more mgmt than you can provide.

Mild/moderate sxs. Willing to attend tx. No past 8wk trials of individual tx. Family conflict. Mostly good to fair function.

No acute safety issues that will keep you awake at night w/worry. Mild/moderate sxs. You/your practice/local resources can support the pt's needs.

Deciding the Right Level of Care in Clinic-

Ask yourself these no-judgment questions:

1. **Should I refer to ER or not?**
   - Send to the ER if you won't sleep because you're not sure how safe this child will be when they leave your office.
   - Consider sending if: Recent suicide attempt, SIB needing sutures, increased severity SIB with SI/severe depression, severe sxs with safety concerns, acute inability to care for self *(Consider calling ahead to the psych ER SW with a hx to ensure they get the full story.)*
2. **Should I provide crisis numbers or not?** Yes, to all
3. **Can I/my office provide meds or therapy right now?**
   - Schedule f/u for more info before prescribing or med f/u or to provide support.
4. **Does this patient ultimately need a higher level of care?**
   - See level of care chart and consider your comfort and office's resources. Reach out to MAP programs (DCMAP, BHIPP, VMAP) for resources. Call agency with collateral.
   - Consider interventions your office can provide as they are waiting for higher levels of care if needed (e.g. meds, therapy/behavior activation, school support letters for counselor check-ins/tutoring/breaks, recs for clubs or EC involvement).

Problem-solving barriers to family engagement with psych referrals

- **Explore potential barriers when making the recommendation.**
  - *"What questions do you have about this rec? What might get in the way of you being able to participate in X program?"*

- **Explain:**
  - The psych teams are partners in your care of the family.
  - Mental health is a part of their child's overall health and it's important to you to support them in feeling better.
  - What you can do and your limitations in managing the mental health concern, while letting them know you will walk through the journey with them.

Managing specific barriers to care

Missing school → Provide a 504-request letter asking for excused absences for mental health care if in OP. Encourage family to request school excuses for MH appts/programs.

School knowing child's dxs/treatment → Explore what the school should know to support the child and be discrete about non-essential information.

Missing fun/EC activities → Explore ways to minimize interruptions or other fun opportunities. Explore pt/family goals that might be more important to them than the missing opportunity or how MH treatment can help them engage and enjoy future fun activities.

Parent missing work → Offer to complete FMLA paperwork. Explore virtual options. Have parents explore child attending sessions alone (if appropriate).

Transportation → Explore transportation by other adult family/friends or insurance company. Explore virtual options, child attending sessions alone (if appropriate) with MH providers.

Outpatient Psychotherapy

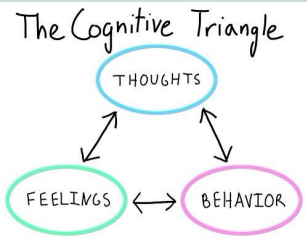
Evidence-Based Therapies for Depression

Cognitive Behavioral Therapy (CBT)

- Cognitive model: connection between thoughts, feelings, and behaviors
- ~12-20 sessions
- Negative/stressful events can exacerbate down moods that child is at risk for based their risk factors.

Behavioral Activation (BA)

- Focus is withdrawal & anhedonia
- Identify pleasant activities and intentionally engage in them
- ~8-14 sessions

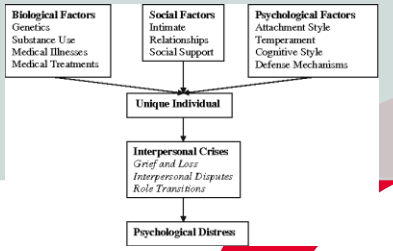


Dialectical Behavior Therapy (DBT)

- Based on cognitive model, slightly more intensive
- Appropriate for teens with more safety/risk behaviors
- Practical skills for emotion regulation, interpersonal effectiveness, distress tolerance and mindfulness.
- ~ 1 year of care

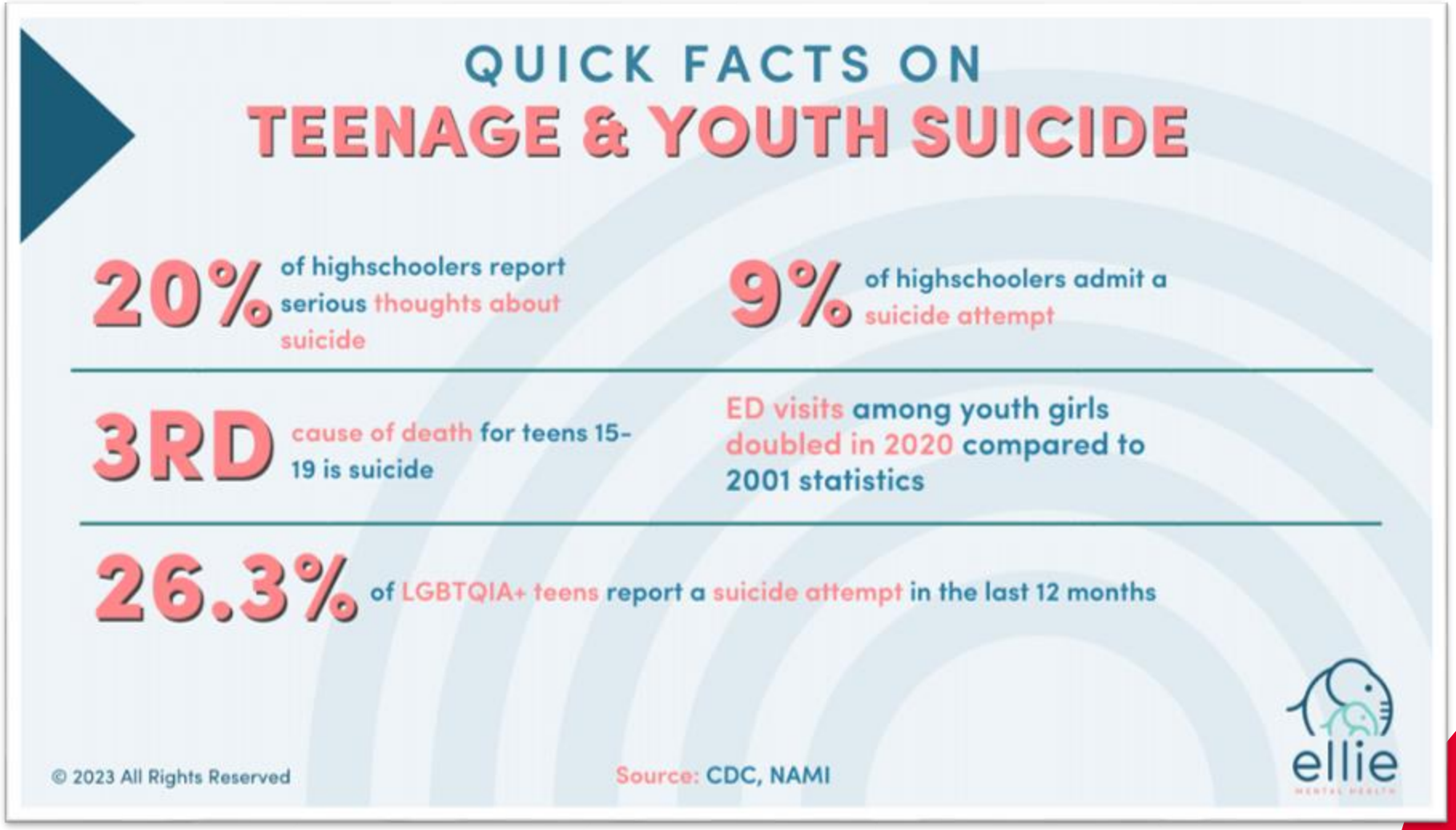
Interpersonal Psychotherapy for Adolescents (IPT-A)

- Biopsychosocial Model: Therapy focuses on improving problematic relationships and circumstances
- 12-16 weeks



Suicidality & Safety Planning

Quick Facts


QUICK FACTS ON
TEENAGE & YOUTH SUICIDE
20% of highschoolers report serious thoughts about suicide
9% of highschoolers admit a suicide attempt
3RD cause of death for teens 15-19 is suicide
ED visits among youth girls doubled in 2020 compared to 2001 statistics
26.3% of LGBTQIA+ teens report a suicide attempt in the last 12 months
© 2023 All Rights Reserved
Source: CDC, NAMI
ellie

Suicidality & Self Harm

- Problem solving solution
- Intentions are important, but not most important
- Can be chronic, fleeting
- Active vs. Passive

Suicidal Ideation (thoughts)

Thoughts about "***not being here***"

Thought about **death/dying**

Thoughts about **killing oneself**

Suicidal Ideation (actions/gestures)

Thinking about ***how*** one might kill themselves

Making **plans** or **preparations** to kill oneself

Acting on thoughts, plans, ideas…

Self Harm (NSSIB & SSIB)

Head-banging

Pinching

Biting

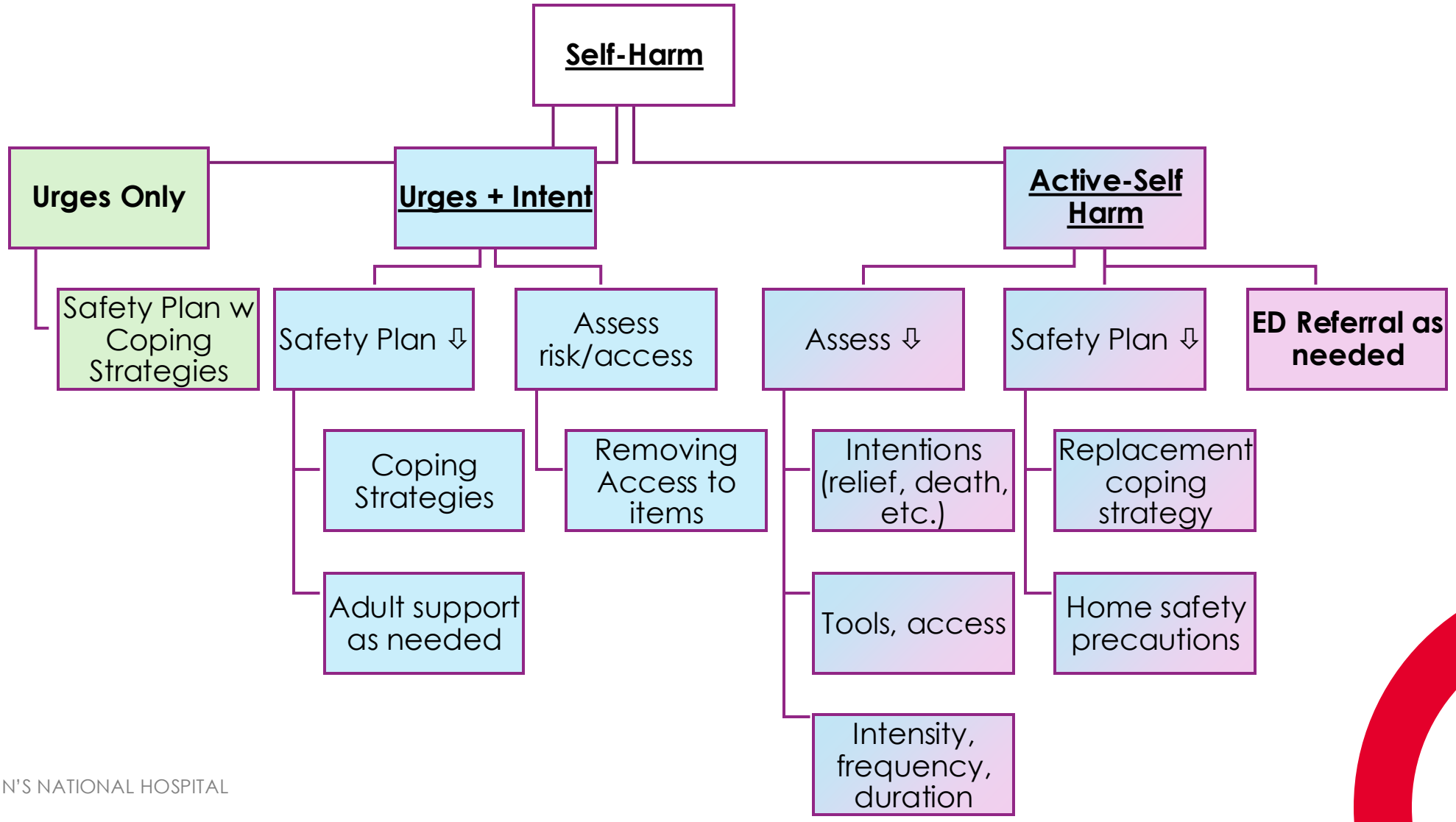
Burning

Cutting

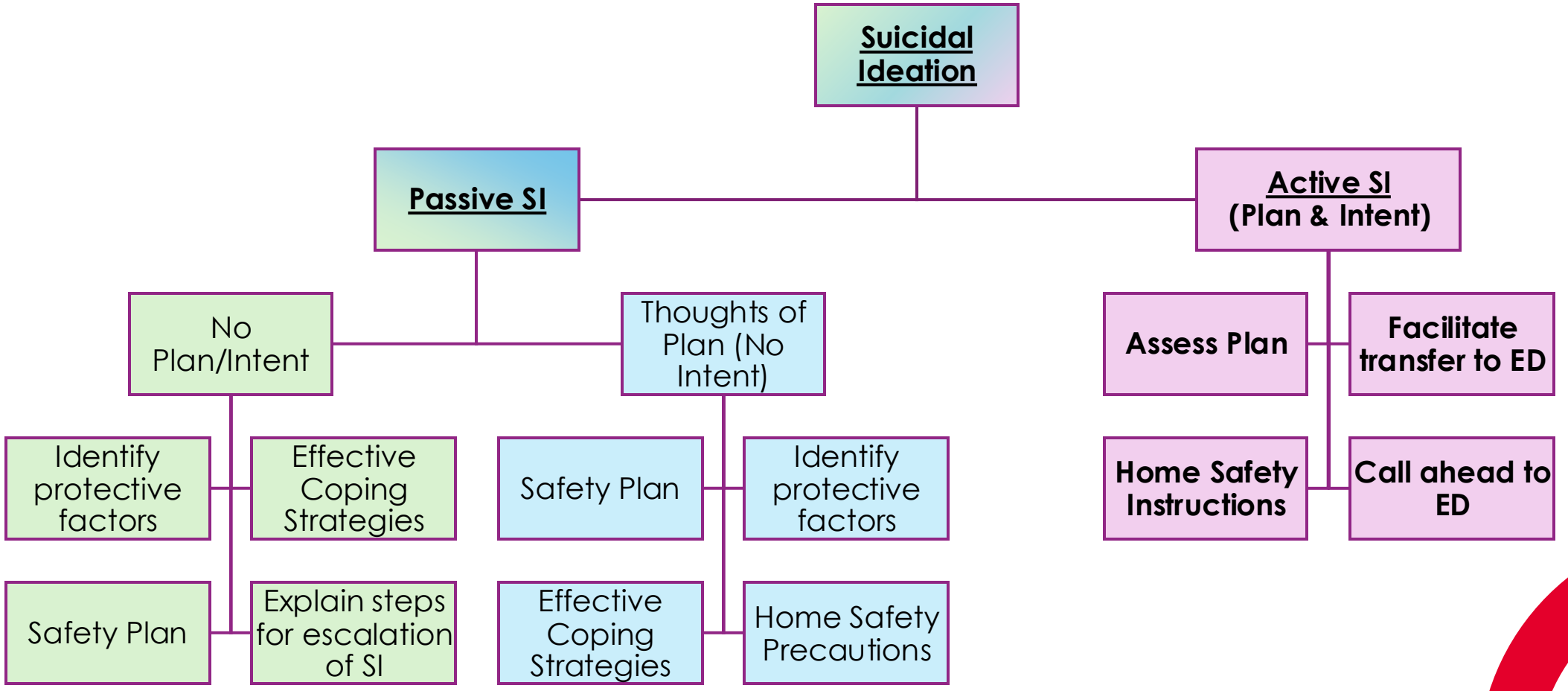
Safety Planning

Part 1:	Warning signs (thoughts, images, mood, situation, behavior) that a crises may be developing
Part 2:	Internal coping strategies - Things I can do to take my mind off my problems without contacting another person
Part 3:	Social settings that provide distraction
Part 4:	People that provide support/distraction
Part 5:	Professionals or agencies to contact during a crisis

Responding to Suicidality and Self-Harm



Responding to Suicidality and Self-Harm



Home Safety Proofing

Secure and lock up objects your child could use to hurt themselves or others, such as:

- **All medicines**, drugs, alcohol – including over-the-counter medicines
- **Toxic chemicals** – like bleach, cleaning products, yard products, and pest poisons
- **Sharps** – such as knives, razors, or other blades
- Items that could be used for **strangulation** – such as belts, cords, ropes and sheets
- **Firearms** and **ammunition** – be **triple safe** by keeping firearms unloaded and locked, and ammunition locked separately from firearms
- Items that may be **easily broken** or used as a weapon, if your child has destructive or aggressive behaviors

Make sure that your child does not know where the locked items are hidden.

Medications

Starting Medications

Mild Depression

- Therapy

Moderate Depression

- Therapy +/-
- Meds

Severe Depression

- Therapy and
- Meds

Consider starting an antidepressant if there is…

- High symptom severity
- Poor function
- Recurrent or chronic depression
- Poor availability/response/willingness to engage in therapy
- Presence of suicidality

Medications

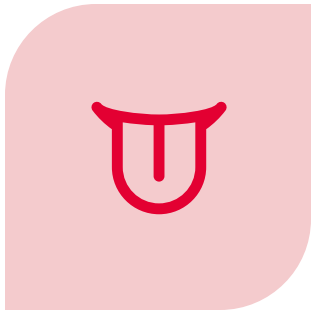
- Pooled data show that SSRIs reduce depression and improve function.
- FDA-approved meds: Fluoxetine (8yo+), Escitalopram (12yo+)
- Dosing: Qday, exc. Possibly BID for low dose sertraline
- Improvement seen by: 2-4wks (in 2/3 of pts)
- Tolerability: usually good

Establish your medication and side effect "soapbox": ***"No bothersome s/e's and it's got to work!"***

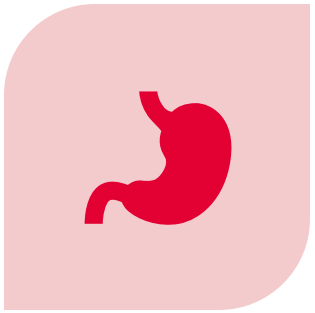
- "Our goal of using the medication is only to help the depression go away and help the child/teen feel better and not cause problems, so it's very important that you let your parents and me know if your body feels weird or different after you start the medicine.
- The only thing that should be annoying about taking the medicine should be remembering to take the medicine (and hopefully, we can help with a system that makes that a breeze).
- If we're using a medicine, it's got to do its job and work or it's gone. So, we're going to do check-ins and see how things are going. If the medicine is not helping yet but it's not causing problems- that's easy- we just increase the dose. If it's not helping AND it's causing problems that we can't fix, it's gone. … Is that okay with you?
- You get to tell me if the medicine is bothering you. I don't make that decision... so, I want to hear from you and so does your (parent)."

Common side effects include…

USUALLY EVIDENT W/IN THE 1ST FEW WEEKS



ENT: DRY MOUTH, BRUXISM



GI: NAUSEA, DIARRHEA, HEARTBURN, APPT CHANGES, WT LOSS OR GAIN

NEURO: HA, SOMNOLENCE, INSOMNIA, DIZZINESS, VIVID DREAMS, FATIGUE, NERVOUSNESS, TREMOR, DIAPHORESIS

Serious Side Effects include...

Behavior activation/agitation
Hypomania/mania
Sexual dysfunction (ED, delayed ejaculation, anorgasmia)
Seizures (use with caution if h/o seizures)
Abnormal bleeding (esp. If NSAIDs/ASA use; possible surgical risk)
Serotonin syndrome
Suicidal thinking and behavior ("black" box warning)

Black Box Warning for Antidepressants

- The warning is for increased spontaneous reporting of suicidal thoughts and behavior in children, adolescents, and young adults (up to 25 y.o.) taking antidepressants (4% med vs. 2% on PBO; newer studies show 3% vs. 2%)

- No completed suicides
- No differences between antidepressants (exc. paroxetine which was higher)
- Follow-up: Noticeable increase in suicides in youth not treated with antidepressants with decreased SSRI prescribing after black box warning was issued (61%)

- Benefit of SSRIs likely outweighs the risks

Explaining the dreaded "black box"

(Warning:)

- When you get the medicine, it will have a black box that says that there may be an increased risk of suicidal thoughts and behaviors from taking antidepressants.

(Validate but qualify:)

- Some researchers looked back on old studies and reviewed how many youth spontaneously reported suicidal thoughts and behaviors. When they reviewed the differences, 4% of teens on antidepressants reported these thoughts compared to 2% of teens on the placebo (sugar pill), but there were no suicides in the study. So, the FDA put the box warning on all antidepressants to help providers consider the risks. As a result of the warning, many primary care providers stopped prescribing the medicine as often. We also saw a new increase in suicides at the same time. We can't say that lower prescriptions caused the increase in suicides, but it caused our field to think that the relationship between antidepressants and suicide was not as clear as they thought from these studies.

(Newer data:)

- Newer research intentionally studied rates of suicidal thinking and behaviors of teens on antidepressants and showed that the difference was 3% (among teens on meds) vs. 2% (among teens on placebo)- a significant risk when they run the numbers, but small and lower than previously thought.

Explaining the dreaded "black box" (cont'd)

(Risk of untreated depression:)

- We know that having untreated depression is a big risk factor for suicide and consider with the family who might benefit from using both medication and therapy.

(How we manage risk:)

- We know that sometimes suicidal thoughts go along with depression, so we look carefully at whether a teen is already having suicidal thoughts and make a safety plan together. We monitor for safety and I want you to take your child to the ER for an evaluation if they have new or worsening thoughts about killing themselves that are distressing or takes any action to try to kill themselves. If they just happen to notice these thoughts but do not have intent on acting on them, I want you to let me know and we'll decide what to do next.

(Check for understanding or concern:)

- How does that sound? What questions do you have about that?

MEDICATION GUIDANCE: COMMONLY PRESCRIBED ANTI-DEPRESSANTS (not an exhaustive list)

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
SSRI	fluoxetine	Prozac	• 20mg/5ml • Tabs 10/20/40/60mg	*Initial dose: 5-10mg Max dose: 60mg Typical effective dose: 20mg Duration: 24 hours	When switching meds tapering is not usually required due to very long half-life of active metabolite (avg 9.3 days) Common side effects and risk of serotonin syndrome ++	Common first line, FDA approved for MDD age 8+, OCD age 7+, PMDD
SSRI	escitalopram	Lexapro	• 5mg/5ml • Tabs 5/10/20mg	*Initial dose: 5mg Max dose: 20mg Typical effective dose: 10mg Duration: 24 hours	Contraindicated in known congenital long QT syndrome Common side effects and risk of serotonin syndrome ++	Common first line, FDA approved for MDD age 12+, GAD
SSRI	sertraline	Zoloft	• 20mg/ml • Tabs 25/50/100mg	Initial dose: 12.5mg Max dose: 200mg Typical effective dose: 100mg Duration: 24 hours	Drowsiness and sleep disturbance more common in adults than children Common side effects and risk of serotonin syndrome ++	Evidence based for MDD, OCD age 6+, PMDD, PTSD.
SSNRI	duloxetine	Cymbalta	• Caps 20/30/60mg • Sprinkle 20/30/40/60mg	Initial dose: 30mg for at least 2 weeks Max dose: 120mg Typical effective dose: 40-60mg for MDD, up to 120mg for GAD Duration: 24 hours	Common side effects: abd pain, dec appetite, nausea, vomiting, dry mouth, drowsiness, headache. Sexual side effects, sleep disturbance, and weight loss can be seen.	MDD; FDA approved GAD age 7+, consider after two SSRIs have been tried, juvenile fibromyalgia age 13+
NDRI	bupropion	Wellbutrin	Multiple forms Short and longer acting	Dosing depends upon the release of the med	NOT first line therapy for depression — may consider for refractory depression or co-occurring conditions; consider psychiatry consultation	Not first line for ADHD but may be considered for MDD with co-occurring ADHD

Note: all medication information should be verified using current PDR

SSRI = selective serotonin reuptake inhibitor, SNRI = selective serotonin-norepinephrine reuptake inhibitor, NDRI= norepinephrine and dopamine reuptake inhibitor

* Initial dose, max dose, typical effective dose are half for age 8-11.

++ Common SSRI side effects: nausea, diarrhea, dry mouth, drowsiness, insomnia, decreased libido, ejaculatory dysfunction. Serotonin syndrome is an emergency and is a clinical diagnosis. KNOW all of patient's medications (rx, other substances and supplements) and symptoms of serotonin syndrome: tachycardia, hypertension, hyperthermia, agitation, ocular clonus, dilated pupils, tremor, akathisia, hyperreflexia, clonus, flushed skin, diaphoresis.

Consider switchrx.com for guidance on medication switch

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Outpatient Follow-Up

FDA rec for depression: Weekly x 4wks then Every other week

- Practically, f/u in 2wks for safety and s/e eval, then q2-4wks until sxs improve.

Typically, if SSRI is started:

- **Week 0**: Start SSRI at ½ effective dose for age x 1wk.
- **Week 1** (on effective dose): If lower dose is tolerated, increase to effective dose.
- **Week 4/5**: F/u in clinic (wk 3/4 of the med). Check for sx improvement and side effects. Increase dose if only getting a partial response but med is tolerated. If not tolerated, adjust OR decrease and switch to SSRI #2 (or SNRI if 2 SSRIs previously failed). Family should call in interim if there are problems and use safety plan.
- **Week 8/9**: F/u in clinic. Same tasks as wk 4/5. Continue med if positive response (Goal: ALL SXS GONE)
- **Goal= week 12- symptom remission + return of function**. If no remission, consider med change to 2nd SSRI, switch to SNRI (if failed 2 SSRIs) or add therapy.
- Monitor esp. for affective blunting, akathisia, mania/agitation, worsening/new SI
- **Some studies have reported that the half-lives of sertraline (at low doses) and bupropion SR are much shorter than reported in adults and may benefit from BID dosing in some youth.*

Resources

- Pediatric Health Network Resource Page for Depression (screening tools, therapy tools, patient handouts, treatment protocols, billing/coding, webinars): Depression - Pediatric Health Network
- AACAP Medication Guide for Antidepressants: DepressionGuide-web.pdf

"Black Box" Antidepressant Warning Resources

- Bridge JA, Iyengar S, Salary CB, Barbe RP, Birmaher B, Pincus HA, Ren L, Brent DA. Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment: a meta-analysis of randomized controlled trials. JAMA. 2007 Apr 18;297(15):1683-96. doi: 10.1001/jama.297.15.1683. PMID: 17440145.
- AAP Antidepressants Side Effects: Pediatric Mental Health Minute Series https://www.aap.org/en/patient-care/mental-health-minute/antidepressants-side-effects/?srsltid=AfmBOorCDeum3r6qr1VpKYrGz27ai2YxbrbmMb69GcBnb-6GHA7vl9so
- Michigan Clinical Consultation & Care (MC3; mental health access program) PCP info sheet on the box warning for antidepressants: https://mc3michigan.org/clinical-pearls-faqs-ssri-black-box-warnings/
- Mayo Clinic family information sheet on antidepressants: https://www.mayoclinic.org/diseases-conditions/teen-depression/in-depth/antidepressants/art-20047502
- Stanford Medicine: Antidepressants for kids and teens: What the science says: https://med.stanford.edu/news/insights/2025/07/antidepressants-for-kids-and-teens--what-the-science-says.html

Inpatient Psychiatry at Children's National

- Located at the Main Hospital (111 Michigan Ave NW)
- **CPU: Ages 4-13; 12 bed unit** **APU: Ages 14-17; 13 bed unit**
- ~1,000 patients treated per year across both units.
- Average LOS is **5-7 days** (often there are outliers).
- Most common presentation is for a **suicide attempt** or **serious suicidal ideation** with plan.
- **Multidisciplinary team-** Child and adolescent psychiatrists, nurses, child psychiatric unit specialists, child life specialists, social workers, expressive arts therapist, therapy dog, and chaplain services.
- Each patient is assigned a **primary clinician** (resident, psychiatry fellow, psychology intern/extern, or psychologist).
- Each patient has a **family meeting(s)** with our family therapist (social worker).
- Patients participate in community meetings, unit school, art therapy, skills groups, and group recreational activities.
- **NEW**: Reinforcement/incentive system; DBT Caregiver Group

For patient admission and availability information and to give sign out on a patient you are sending, call the ED Psychiatry Team at **202-476-2479.**

CNH inpatient psychiatry unit video

Mood & Trauma Disorders Program

Individual Therapy
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT-A)
- Trauma-Focused CBT (TF-CBT)

Group Therapy
- Parent & Teen CBT Group for Depression
- Multi-Family DBT Skills Group

Family Support
- Family support sessions as indicated
- Caregiver tips and strategies
- Referral resources for community Family Therapists

Pharmacological Therapy
- Medication management with Child/Adolescent Psychiatry specialists

Faith Kelley, MD

- **Psychiatrist**
- Medical Director
- Medication Management

Erin Sadler, PsyD

- **Psychologist**
- Clinical Director
- CBT, DBT, TF-CBT
- Individual & Group Therapy

Komal Sharma-Patel, PhD

- **Psychologist**
- Director of Research
- TF-CBT, DBT, CBT
- Individual & Group Therapy

Michael Sexton, MB BCh

Children's National

- **Psychiatrist**
- Medication Management

Josh Golt, PhD

- **Postdoctoral Fellow**
- DBT, CBT, TF-CBT
- Individual & Group Therapy

Judy McDonald, MA

Children's National

- **Psychology Extern**
- CBT, DBT
- Individual & Group Therapy

Abby Fry, MS

- **Psychology Extern**
- CBT, DBT
- Individual & Group Therapy

Claim CE Credit

Please ensure your profile is set up first and you have selected your "profession" so that the applicable CEs will generate for you to select.

Required Steps:

1. **Text Attendance Code: BAGZOS** to 301-273-7643 *or* **go to:** https://ce.childrensnational.org/code and enter **BAGZOS**
   - Ensure you complete all the steps to claim CE
   - If an evaluation is required, you will receive an email with instructions.
   - Credit can be claimed up to expiration date (60 days from live event) whether you attend in person or watch the recording.
   - The texting option has a time limit of less than 1 hour after the event has started, then the website link will have to be used.
2. **To claim credit**, ensure you complete all steps including click **Take Course/ Resume Course** and then Complete the evaluation and **Submit**, then **click Next** until you see "**You were awarded Credit.**"

Children's National®

Thank you!