March 16, 2023, TMIN Team HOPEFUL Treating Depression in Adolescents and Children- A Guide for Pediatrics and Family Medicine	
Question	**Answer**
What is the best way for us as PCPs to advocate for patients who have those severe features/histories to be seen ASAP by psychiatry? I think some would warrant ED evaluation, but that may not always be the best next step.	MCPAP can be a good path. I agree ED is not the best answer because kids tend to usually just get sent back. I think another alternative is a referral for a partial program if the symptoms are escalating but have not reached a level of acuity where ED would be appropriate. If you would like to email me for more information on this question, you can!
Does routine CBC for anemia have role in w/u for Depression with bHCG, TFTs & UrTox?	Absolutely, especially when it's a young person who has reached her menarche. TFT and U.tox should always be done prior to diagnosing depression. For young girls, mood diary could be helpful to ascertain between depression and PMDD.
Regarding SSRI- my understanding fluoxetine was better studied? Any reason sertraline instead?	Sertraline as well has been well studied like fluoxetine. Fluoxetine has been studied earlier. Both are equally well used for depression.
I think it's such a great idea to talk about lifestyle - have you ever written out a "prescription" for sleep, nutrition and screens - if so could you share it?	I do write prescription for sleep, nutrition and screens. I don't write it literally, most parents accept it when I just say it. I then follow up on it. I don't treat depression right away, I usually recommend lifestyle change and then assess the response.
How do you address adolescent's concern about weight gain they experience on the meds?	I acknowledge that there is a real possibility of weight gain from the meds but not all meds result in weight gain. It's a trial and error process to see which medication causes weight gain. Paxil has fallen out of the favor for this reason. If they are gaining weight on the medication, I will try to switch the medication. Wellbutrin is more weight neutral so if possible and there is no comorbidities of anxiety I will try to use that. Wellbutrin is also contraindicated for eating disorders
What is the specific interaction between cannabis and antidepressants? Is it at the P450 level?	I don't believe it is at the P450 level, I believe it's more about the cognitive slowing on a neurological level in terms of reflexes and responsivity that gets in the way of treating depression. There is no direct interaction with antidepressants, there is just no way of antidepressants treating depression well

	because the symptoms of depression are being perpetuated by cannabis. It is hard to self-right them.
I feel like most of us are pretty comfortable with the basic SSRI's - do you feel like we're at a point where PCP's should be considering second medications like Wellbutrin and Abilify?	I do believe that. I would also say after two trails of SSRI's it would be fair to actually consider SNRI's such as Effexor. I think before going to Abilify maybe trying Effexor or Wellbutrin will be a good choice. A lot of the pediatricians I come across have become very comfortable with SSRI that I think it is okay to try the next level. Also, if the two SSRIs have been ineffective, it may be worth re-evaluating the diagnosis. ADHD, inattentive type, PTSD, and substance use can also present like depression
How to get pediatrics into psychiatry sooner rather than going through BH referral?	I think this is the million dollar question! We need more child psychiatry, I wish I had a better answer.
AT what age can I start meds?	It variables in the sense that I usually don't try medication for anyone younger than 7 or 8. I would try lifestyle modification, support for the parents, parent management guidance to help support the child through depression. If all of this has been tried, and not effective, I would consider SSRI for an 8 year old. Side note the FDA approval for some of these medications are 12 and up.
How do you sort out ADHD as comorbidity vs. poor focus/ organization due to depression and anxiety? Many of my teens with depression and anxiety also think they have ADHD.	ADHD is a developmental disorder and has been present for their whole life. I try to get more historical detail. I ask for report cards from when the kids were younger, I send Vanderbilt screen to the schools to better assess for ADHD. I also do a deep dive on family history. Depression and ADHD both have a genetic predisposition. Depression has multifactorial reasons to present where ADHD is predominantly genetic besides exposure to substances. So, I get deeper into details because ADHD is a developmental disorder and should have persistent symptoms that have been lasting for a long time whereas depression is episodic.
I have found MCPAP and MCPAP for Moms very helpful https://www.mcpap.com/Provider/McPAPservice.aspx	MCPAP is a great resource and I highly recommend people to use it.

How do we refer to a partial program?	There are many different partial programs in the state. Someone will have to contact them and fill out their intake form/go over availability and openings. It is something you will need support from social worker or case manager at your clinic.
Do we have increased resources from Boston Children's hospital? Does Boston Children's have a Child Psychiatry and Counseling program we can refer to?	They do have Child Psychiatry, same as Tufts. You can try a referral, but as far as I know they have a two year back log at this moment. I am not sure how much more effective they are. They have MCPAP. They are doing the same thing as we are. There is no difference, everyone is full and backed up.
Link to the med lists? and good general resource to guide tapers?	Yes, we will post the medication charts on the TMIN website, on the TUSM eeds platform and we will send out to each TMIN LCO to distribute as well.
Can you please repeat why Bupropion should not be used in kids with ADHD?	What I am saying is that it should be used with kids with ADHD who has comborbidies of depression because Bupropion has dopaminergic activity that helps with ADHD. I was suggesting don't use Bupropion with people who have anxiety or eating disorder because dopaminergic increases anxiety and can lower threshold for seizures for people with eating disorders.
I am having trouble finding the depression medication chart on the TMIN website - not sure if someone can send a link of where that lives. I have an old NEQCA guide, so would love the most updated version! Thanks	Colleagues will share it shortly
List of good resources for eating disorders? therapists in particular, but partials as well?	Dr.Sharma will put something together and will put on the website as well!
What is a good way to screen for substance abuse versus experimentation versus sx of depression for adolescents? I feel like it is more unclear when we've crossed over to the substance being the primary issue.	It is challenging. When substance use concerns first present, refer for therapy. The therapist should be discussing the purpose of substance and if it is being used for an escape/ self-treatment for depression or just used for experiment. What is the function of the substance is the main question? It is hard to separate. Usually, when being used for experimentation, it is not a regular usage. Social context of the usage also helps differentiate SUD and depression. If obtaining the substances and usage is

	controlling their everyday decisions then, it is becoming problematic.
To the extent that there's a risk of an increase in suicidal ideation with SSRIs [which led to a black box warning but is not that common], it's most likely in young people, and should be mentioned.	Absolutely, it is mentioned in the medication chart. The black box warning is for suicidal increase of 2% of suicidal ideations between placebo group and group who received fluoxetine. The black box warning is a reaction to that 2% increase. This study was done by the FDA, there were no suicidal gestures/attempts. It was all based on suicide ideations. As long there is consistent contact, it seems to mediate that 2% risk. As long as child is seeking therapy and connecting with you then we are in a good zone! The other thing I would like to highlight is since the black box warning came up there has been another study that looked at the data, there has been an increase in suicidal behavior in teenagers since the black box warning, and adolescents have been undertreated. I provide this additional information with the parents so they can make informed decision.
If you are cross-tapering meds from a therapeutic dose (Zoloft 150 for ex) do you still go down by 25 mg or do you go down faster at first (by 50 mg) as you go up on Prozac from 5?	I would go down from by 50mg to expedite the process.
As a psychiatrist, I'd like to request our PCPs on this forum to PLEASE consider taking back patients when they are stable. It's OK to prescribe low dose SSRI or even benzodiazapines when Pt is taking them for years, seen psychiatrist and are stable. If you need curb-side, we are still here!!	Agreed. It is important to think of specialist as resources who are addressing acute care and not the ones to maintain the care when treatment is stable.
Would you consider patient's with chronic medical conditions such at Type 1 diabetes or struggling with gender identity as high risk worth referring to psychiatry?	Yes. Both have increased rare of depression, anxiety, and suicidal behavior.
Do you think there is a role for atypical medications such as buspar and seroquel in moderate depression as a second agent for teens or initial If there is significant self-harm?	Both Buspar and Seroquel are often used to treat anxiety but not depression among adults. Buspar has been noted to be mostly ineffective in treating anxiety except for a small population that may be neuro-atypical. Seroquel has been good in managing anxiety; however, if you are considering usage of atypical antipsychotics, the kid should be referred to a child psychiatrist at this point.

How do you address the black box warnings for SSRI's I have a spiel but I'd love to hear from you	This is what I usually say to the patients: "Black box warning came out of a study where there was 2% increase in suicidal ideations in the group receiving fluoxetine vs. placebo. Of note, the group that received placebo also had 2% SI. Neither group had suicidal attempt nor was anyone harmed in this study. There have been studies that show that this 2% risk can be mitigated with weekly contact with therapists, nurse, or PCP. " If needed, I also add that since the Black Box warning was released, the following 10 years showed increase in SI among teenagers due to untreated depression due to fear around black box warning." "Ultimately, there is a risk of not doing anything as much as there is risk of doing something."
If a parent takes a certain SSRI or depression med and do well on it, have you seen that perhaps genetically patients may do well on the same med?	I can't say that is statistically accurate since I have not studied this. However, I do take this in account and often prescribe the same meds that parents experienced success in.