
MANAGING ADOLESCENT DEPRESSION

The Complete Guide for Primary Care Clinicians

Edited by
Rachel A. Zuckerbrot, M.D.
Amy Cheung, M.D.
Ruth E. K. Stein, M.D.
Peter S. Jensen, M.D.



Civic Research Institute

4478 U.S. Route 27 • P.O. Box 585 • Kingston, NJ 08528

Copyright © 2012

By Civic Research Institute, Inc.
Kingston, New Jersey 08528

The information in this book is not intended to replace the services of professionals trained in law, psychiatry, psychology, or any other discipline discussed in this book. Civic Research Institute, Inc. provides this information without advocating the use of or endorsing the issues, theories, precedent, guidance, resources, or practical materials discussed herein. Any application of the issues, theories, precedent, guidance, resources, or practical materials set forth in this book is at the reader's sole discretion and risk. The authors, editors, and Civic Research Institute, Inc. specifically disclaim any liability, loss or risk, personal or otherwise, which is incurred as a consequence, directly or indirectly, of the use and application of any of the contents of this book.

All rights reserved. This book may not be reproduced in part or in whole by any process without written permission from the publisher.

This book is printed on acid free paper.

Printed in the United States of America

Library of Congress Cataloging in Publication Data
Managing Adolescent Depression: The Complete Guide
for Primary Care Clinicians
Rachel A. Zuckerbrot, M.D., Amy Cheung, M.D.,
Ruth E. K. Stein, M.D., and Peter S. Jensen, M.D.

ISBN 978-1-887554-81-7

Library of Congress Control Number: 2011937823

Table of Contents

Preface xiii
About the Editors and Authors xix

Chapter 1: Setting the Stage: Why Adolescent Depression Is an Issue for Primary Care Clinicians

Ruth E. K. Stein, M.D., F.A.A.P., and Peter S. Jensen, M.D.

What We Know 1-2
 Impact and Importance of Depression in Primary Care 1-2
 Why Primary Care Clinicians? 1-3
 Special Situations 1-4
 But What Can Primary Care Clinicians Actually Do? 1-4
How to Do It 1-5
 Assessing Severity and Doing a Comprehensive Evaluation 1-5
 Starting to Help 1-5
 Making a Plan 1-6
 Involving Others 1-8
 Education 1-8
 After Referral 1-8
Common Barriers and Obstacles and Practical Strategies
 for Overcoming Them 1-8
 Fear of Raising the Issue 1-9
 Time 1-9
 Helpful Tools 1-10
 Poor Reimbursement 1-10
 Unfamiliarity With Separating Adolescent and
 Parents During Visits 1-11
 Establishing Bounds of Confidentiality 1-11
 Lack of Skills and Confidence in Ability to Diagnose
 and Manage Adolescent Depression 1-11

Chapter 2: Depression: An Overview

*Bruce Waslick, M.D., M.P.H., Betsy Brooks, M.D., M.P.H., F.A.A.P.,
James J. Burns, M.D., M.P.H., F.A.A.P., and Barry Sarvet, M.D.*

Introduction 2-2
Depression in Adolescents as a Significant
 Public Health Problem 2-2
 Definition 2-2
 Epidemiology 2-3
 Comorbidity 2-3

Etiology	2-3
Natural History	2-4
Morbidity	2-4
Mortality	2-5
Recognizing Depression in Adolescents: The Basics	2-5
Common Presentations	2-5
Diagnostic Process	2-6
Diagnostic Criteria for Depressive Illnesses	2-6
Major Depressive Disorder	2-6
Dysthymic Disorder	2-8
Depressive Disorder Not Otherwise Specified	2-9
Other Types of Depressive Illness	2-9
Intervention	2-9
Pathways for Future Progress	2-10
Progress	2-10
Areas of Concern	2-10
Moving Forward	2-11

Chapter 3: Screening for Depression and Other Related Disorders

*Rachel A. Zuckerbrot, M.D., F.A.A.P., and
Evelyn Berger-Jenkins, M.D., M.P.H., F.A.A.P.*

What We Know	3-2
Importance of Screening	3-2
Feasibility of Screening	3-3
Meaning of Screening	3-3
Applying Screening Criteria to Depression	3-3
Deciding Whom to Screen	3-4
Screening for Depression (In General)	3-4
How to Do It	3-5
Parents, Adolescents, or Both?	3-6
Which Depression Screen?	3-6
When to Screen?	3-7
Whom to Screen?	3-7
What Should Be Explained?	3-8
Who Will Administer the Screen?	3-8
Where to Screen?	3-9
Who Will Score the Screen?	3-9
How Will We Use the Screen?	3-10
What Cutoffs Will We Use?	3-10
What Will We Do Once an Adolescent Is Identified?	3-11
What to Do With a Suicidal Adolescent?	3-11
Common Barriers and Obstacles and Practical Strategies for Overcoming Them	3-12

Chapter 4: Assessment and Diagnosis: Depression Instruments and Interviews, Identifying Comorbid Conditions

*Rachel A. Zuckerbrot, M.D., F.A.A.P., and
Deborah Steinbaum, M.D., M.P.H., F.A.A.P.*

What We Know	4-1
How to Do It	4-2
Initial Assessment	4-2
Comprehensive Evaluation	4-3
Preparation for the Visit—Visit Packets	4-6
Targeted History and Physical	4-6
Adolescent Interview	4-6
Parent Interview	4-14
Diagnostic Aids for Depression and Comorbidities	4-16
Medical Exam and Lab Tests	4-16
Collateral Information	4-17
Making the Diagnosis and Assessing for Impairment	4-17
Making It Brief	4-17
Common Barriers and Obstacles	4-18
Practical Strategies for Overcoming Barriers and Obstacles	4-18

Chapter 5: Assessing Suicide Risk and Handling Emergencies

*Kareem Ghalib, M.D., Carrie Bernstein, M.D., and
Karen Soren, M.D., F.A.A.P.*

Introduction	5-2
What We Know	5-2
Definitions and Epidemiology	5-2
Risk Factors	5-3
How to Do It	5-4
Approach to Assessment	5-5
Know the History	5-5
Evaluate Current Symptoms	5-5
Ask Directly About Suicide	5-6
Speak to Family Members	5-6
Assessing Risk and Managing Emergencies	5-7
Three Risk Categories	5-7
Taking Action	5-7
Completed Suicide	5-9
Common Barriers and Obstacles	5-10
Personal Obstacles	5-10
Perceived Incompetence	5-10
Difficulty Understanding the Limits of Confidentiality	5-10
Fear	5-10
Systemic Obstacles	5-10
Time	5-10
Money	5-11

Access to Mental Health Care	5-11
Practical Strategies for Overcoming Barriers and Obstacles	5-11
Overcoming Personal Obstacles	5-11
Gain Competence	5-11
Learn About the Laws and Limits to Adolescent	
Confidentiality in One's State	5-12
Combat Fear	5-13
Overcoming Systemic Obstacles	5-13
Save Time	5-13
Demonstrate Value	5-13
Obtain Access	5-14

Chapter 6: Issues of Confidentiality, Working With Parents, and Engaging Adolescents as Active Partners

Danielle Laraque, M.D., F.A.A.P., Hilary R. Hoagwood, M.A., and Kimberly E. Hoagwood, Ph.D.

Introduction	6-2
What We Know	6-2
Elements of a Therapeutic Alliance	6-2
Paying Attention to Changing Developmental	
Needs of the Adolescent	6-2
Understanding the Adolescent's View (Engagement)	6-3
Understanding the Parents' Views (Engagement)	6-4
Defining Roles in the Partnership (Treatment Planning)	6-4
How to Do It	6-5
Establish the Limits of Confidentiality	6-5
Establish Procedures for Communication	6-6
Establish a Protocol for Treatment	6-6
Integrate the Adolescent Perspective	6-7
Common Barriers and Obstacles and Practical Strategies	
for Overcoming Them	6-8
Establishing Trust	6-8
When Adolescents and Families Do Not Recognize	
the Symptoms of Depression	6-9
Discussing Treatment in a Sensitive Manner	6-10
Medication Side Effects and the Therapeutic Alliance	6-10
Adolescent's Reluctance to Disclose Suicidal Ideation	6-10
Reaching Adolescents Where They Are	6-11
Financial Barriers	6-11
Summary	6-11

Chapter 7: What the Primary Care Clinician Can Do

Ruth E. K. Stein, M.D., F.A.A.P., and Peter S. Jensen, M.D.

What We Know	7-1
How to Do It	7-2

Frequent Follow-Up	7-2
Monitoring Symptoms and Activities	7-3
Partnership	7-4
Therapeutic Techniques	7-5
Information From Others	7-6
Monitoring the Safety Plan	7-6
Educating the Adolescent and Family	7-6
Further Intervention	7-7
Caring for Adolescent Depression Over Time	7-7
Common Barriers and Obstacles and Practical Strategies for Overcoming Them	7-8
Concern About Adequacy of Skills	7-8
Lack of Time and Reimbursement:	7-8
Orientation	7-9
Summary	7-9

Chapter 8: Use of Antidepressants in Primary Care

Amy Cheung, M.D., MSc., and Diane Sacks, M.D., F.R.C.P. (C)

Introduction	8-2
What We Know	8-2
Management of Depression With Antidepressants	8-3
Selective Serotonin Reuptake Inhibitors	8-4
Fluoxetine	8-4
Sertraline	8-4
Citalopram	8-4
Escitalopram	8-4
Fluvoxamine	8-6
Paroxetine	8-6
Paroxetine Hydrochloride	8-6
Non-Selective Serotonin Reuptake Inhibitors	8-6
Bupropion	8-6
Venlafaxine	8-6
Desvenlafaxine	8-7
Mirtazapine	8-7
Duloxetine	8-7
Management of Discontinuation Symptoms	8-7
Managing Comorbid Conditions	8-8
Managing Interactions With Other Medications and Substances	8-8
Alcohol	8-9
Street Drugs	8-9
Over-the-Counter Medications	8-9
Herbal Remedies	8-9
Prescription Medications	8-9
Interactions in the Cytochrome P450	8-10
Risk of Seizures	8-10

Risk of Mania	8-10
How to Do It	8-11
Steps to Initiating Antidepressants	8-11
How Long Should Medications Be Continued?	8-14
Common Barriers and Obstacles and Practical Strategies for Overcoming Them	8-14
Overcoming Myths About Antidepressants	8-15
Providing Education About Antidepressant Treatment	8-15
Increasing Adherence	8-15
Summary	8-16
Exhibit 8.1: Antidepressants and Risk of Suicide	8-18
Exhibit 8.2: Serotonin Syndrome	8-19

Chapter 9: Psychotherapies

Amy Cheung, M.D., MSc., and Joan Rosenbaum Asarnow, Ph.D.

Introduction	9-1
What We Know	9-2
Cognitive Behavioral Therapy	9-2
Interpersonal Therapy for Adolescents	9-4
Other Therapies	9-4
How to Do It	9-6
Assessing for Suitability for Psychotherapy	9-6
Cognitive Behavioral Therapy	9-7
Interpersonal Therapy for Adolescents	9-7
Implementing Brief Cognitive Behavioral Management Strategies	9-8
Identifying and Referring to Mental Health Services in the Community	9-9
Compile List of Available Therapists	9-9
Ensure Appropriateness of Therapist	9-9
Make the Referral	9-10
Ensure Appropriate Follow-Up	9-10
Management of Nonresponse	9-11
Common Barriers and Obstacles and Practical Strategies for Overcoming Them	9-11
Identifying Appropriate Resources in the Community	9-11
No Cognitive Behavioral Therapy or Interpersonal Therapy for Adolescent Therapists	9-11
No Child or Adolescent Therapists	9-12
No Therapist Under Insurance Coverage	9-12
Stigma	9-12
Poor Treatment Compliance Due to Low Motivation	9-12
Summary	9-13
Exhibit 9.1: Sample Cognitive Behavioral Therapy Exercise	9-15

Chapter 10: How to Make an Effective Referral: From Finding the Elusive Referral to Overcoming Family Resistance

Peter S. Jensen, M.D., and Ruth E. K. Stein, M.D., F.A.A.P.

What We Know10-2

How to Do It10-2

 Recognizing the Need and Making the Mental Health Referral10-2

 Gathering the Facts10-2

 Finding Competent Referral Resources10-3

 Learning From Successes and Failures10-3

 Remembering That a Successful Referral Is Not a One-Time Event10-4

 Being Candid and Straightforward10-4

 Helping the Family Put Cost Concerns Into Perspective10-4

 Supporting the Family Through the Referral and Treatment Process10-5

 Assisting in Making the Appointment10-5

 Overcoming Family Members' Resistance10-5

 Receiving Feedback10-5

 Considering the Overall Approach10-6

Common Barriers and Obstacles and Practical Strategies for Overcoming Them10-6

 Finding a Mental Health Provider10-6

 Attitudes, Beliefs, Stigma, and Fear10-8

 Staff Resources and Creating a Virtual Team10-8

 Family Financial Resources10-9

Summary10-9

Chapter 11: Collaborative Care: How Primary Care Clinicians Can Work With Mental Health Providers

L. Read Sulik, M.D., and Jon Dennis, M.D., M.P.H., F.A.A.P.

Introduction11-2

What We Know11-2

 Collaborative Care11-4

 Shared Care11-4

 Colocation11-5

 Linking to Mental Health Providers11-6

 Comanagement With a Therapist11-6

 Use of Care Managers11-7

 Other Stages of Collaborative Care11-7

 Primarily Primary Care11-7

 Primary Care and Consultation11-8

 Shared Care and Higher Levels of Care11-9

 Primarily Mental Health Specialty Care11-9

Model of Integrative Care	11-10
How to Do It	11-10
Components of Collaborative Care	11-10
Funding the Consultation	11-10
Triage	11-11
Documentation	11-12
Communication	11-12
Follow-Up	11-13
Common Barriers and Obstacles and Practical Strategies for Overcoming Them	11-14
No Shows	11-14
Request for Psychotropic Medication Prescribed by Different Provider	11-14
Failure to Communicate With Other Providers Regarding Advice Given to Adolescent	11-15
Summary	11-15

Chapter 12: Managing Comorbid and Complicating Conditions

L. Read Sulik, M.D., and Jon Dennis, M.D., M.P.H., F.A.A.P.

Introduction	12-1
Overall Management	12-2
Anxiety Disorders	12-2
Traumatic Stress	12-4
Attention Deficit Hyperactivity Disorder	12-4
Learning Disabilities	12-5
Substance Abuse	12-6
Medical Conditions	12-7
Other Complicating Issues	12-7
Truancy/School Refusal	12-7
Sleep Disturbance	12-8
Summary	12-8
Exhibit 12.1: Overlap Between Manic and Attention Deficit Hyperactivity Disorder Symptoms	12-10

Chapter 13: Redesigning the Primary Care Practice to Incorporate Evidence-Based Treatments: Building Quality Treatments for Depression in the Practice Setting

John V. Campo, M.D., Darryl A. Robbins, D.O., F.A.A.P., and Peter S. Jensen, M.D.

What We Know	13-2
How to Do It	13-3
Redesigning Expectations	13-3

Creating a Medical Home for Depressed Adolescents	13-3
Leadership	13-4
Identifying Mental Health Resources	13-6
Decision Support: Educating the Primary Care Practice	13-6
Moving Ahead Into Practice Redesign	13-6
Common Barriers and Obstacles	13-10
No “Buy-In” From Others	13-10
Does the Primary Care Clinician Really Have a “Team?”	13-10
Too Much Too Soon?	13-11
Failing to Pick Targets Carefully	13-11
Time and Expense of Training	13-12
Practical Strategies for Overcoming Barriers and Obstacles	13-13
Care Management	13-13
Standardized Care Protocols	13-13
Buy or Build Clinical Information Systems	13-14
Summary	13-15

Chapter 14: Describing the Services to Pay the Bills: Correct Use of Procedural and Diagnostic Codes

Lynn M. Wegner, M.D., F.A.A.P., and Michael Houston, M.D.

Introduction	14-1
Face-to-Face Services	14-2
Coding for the Initial Visit, With and Without Screening	14-2
Request for Consultation by Another Physician or Professional	14-6
Follow-Up Visits After Either a Positive Screen or a First-Time Identification of Adolescent Depression	14-6
Non-Physician-Administered Depression Services	14-8
Non-Face-to-Face Services as Part of Case Management	14-9
Care Plan Oversight	14-9
Telephone Care	14-9
Electronic Communications: Online Evaluation and Management Service	14-10
Team Conferences	14-11
Special Reports/Form Completion	14-11
<i>International Classification of Diseases—Ninth Revision—Clinical Modification Coding</i>	<i>14-12</i>
Reasons for Denial of Coverage Despite Proper Documentation	14-13
What to Do When the Third-Party Payer Denies Coverage	14-13
Summary	14-14
Exhibit 14.1: Example of Service and Time Log for Care Management	14-15

Appendixes

Appendix 1: Recommendations for Guidelines for Adolescent Depression in Primary Care (GLAD-PC)	App. 1-1
Appendix 2a: Clinical Assessment Flowchart	App. 2-1
Appendix 2b: Clinical Management Flowchart	App. 2-3
Appendix 3: Childhood Depression	App. 3-1
Appendix 4: National Alliance on Mental Illness Family Guide	App. 4-1
Appendix 5: Suicide: What Should I Know?	App. 5-1
Appendix 6a: Patient Health Questionnaire-9: Modified for Teens	App. 6-1
Appendix 6b: Columbia Depression Scale—English	App. 6-5
Appendix 6c: Columbia Depression Scale—Spanish	App. 6-11
Appendix 7a: Screen for Child Anxiety Related Disorders (SCARED)—Child Version	App. 7-1
Appendix 7b: Screen for Child Anxiety Related Disorders (SCARED)—Parent Version	App. 7-5
Appendix 8a: Vanderbilt ADHD Diagnostic Rating Scale—Parents	App. 8-1
Appendix 8b: Vanderbilt ADHD Diagnostic Rating Scale—Teachers	App. 8-5
Appendix 9: A Children’s Global Assessment Scale (CGAS)	App. 9-1
Appendix 10: <i>DSM-IV-TR</i> Mood Disorder Checklists	App. 10-1
Appendix 11: SAD PERSONS Mnemonic	App. 11-1
Appendix 12: Some Ways to Help Prevent Suicide in Depressed Adolescents	App. 12-1
Appendix 13: Self-Care Success! Things You Can Do to Help Yourself	App. 13-1
Appendix 14: Family Support Action Plan: What a Family Can Do to Help Its Child/Adolescent	App. 14-1
Appendix 15: How Can You Help With Sleep Problems	App. 15-1
Appendix 16: Mood Monitoring Sheet for Depression	App. 16-1
Appendix 17: Depression Monitoring Flowsheet	App. 17-1
Appendix 18: Monitoring Depression Medications and Side Effects	App. 18-1
Appendix 19a: Antidepressant Medication and You—For Younger Children	App. 19-1
Appendix 19b: Antidepressant Medication and You—For Adolescents	App. 19-3
Appendix 20: Patient Handout: Psychological Counseling for Depression	App. 20-1
Appendix 21: Primary Care Clinician Guide to Mental Health Referrals	App. 21-1
Appendix 22: Depression Coding Fact Sheet for Primary Care Pediatricians	App. 22-1
Appendix 23: List of Abbreviations and Acronyms	App. 23-1
Index	I-1

Preface

If you are a primary care clinician (PCC), you probably already know that during the last thirty years there has been a dramatic decrease in many of the most common problems of childhood, ranging from otitis media and meningitis to even dental caries. Increasingly, as a PCC, you are finding that much of your day's work is involved with children and youth with chronic health problems, many of which are behaviorally based, and/or with children and youth who have mental health problems. In the landmark Global Burden of Disease study, Murray and Lopez (1996) determined that seven out of the top ten problems contributing to the overall global burden of disease were related to behavior, mental health, and lifestyle. These findings applied not only to adults, but also to those between 5 and 18 years of age. Among persons ages 15 to 44, depressive disorders and acquired immune deficiency syndrome (AIDS) accounted for the top two causes of "disease burden" both currently and projected forward to the year 2020. These original findings have been confirmed by the *World Health Report* (World Health Organization, 2001).

Teen depression appears to be on the rise. More adolescents are affected by it than during previous decades, and when they are affected, they tend to get it at younger ages. Thus, psychological and behavioral disabilities—whether depression or attention deficit hyperactivity disorder (ADHD)—appear to have taken the place of infectious diseases as the most important and common problems among adolescents in PCCs' practices. Among youth, it is now known that depression occurs in rates similar to that of adults, and almost half of adults who suffer from depression throughout their lives experience their first episode during their youth (Kessler, Avenevoli, & Ries Merikangas, 2001). As a practicing PCC, you probably know that just like rates of depression, rates of youth suicide have risen in recent years; and as in adults, depression in teens is intimately linked to youth suicide. But you may be surprised to learn that the yearly number of deaths due to youth suicide equals all biomedical causes of youth death combined and is second only to auto accidents as a cause of death among 14- to 21-year-old youth.

To cap it all off, clinicians are now understanding that a host of stressful childhood problems (adverse childhood experiences, or ACEs) are linked to long-term poorer health outcomes in later life, from depression and suicide to diabetes and heart disease (Dube et al., 2001; Felitti et al., 1998; Felitti, 2009). Because the foundations of lifelong physical and emotional health are laid down in childhood and adolescence, twenty-first century pediatrics must now come fully forward to confront these too-long overlooked problems previously placed in mental health specialty silos (Shonkoff, Boyce, & McEwen, 2009).

For all of these reasons, in 2000 the Surgeon General (Office of the Surgeon General, 2000) warned that adolescent depression was now a major public health crisis and argued for the need for increased mental health services for this group, beginning first in primary care. Not surprisingly, the U.S. Preventive Services Task Force (Agency for Healthcare Research and Quality, 2009) recommended screening of adolescents for major depressive disorder (MDD), when systems are in place to ensure accurate diagnosis, appropriate treatment, and follow-up—hence the need for this book.

In 2007-2008, the coeditors of this book published the results of an extensive consensus process related to optimal treatments of adolescent depression, "Guidelines for Adolescent Depression in Primary Care" (GLAD-PC; Cheung et al., 2007, 2008;

Zuckerbrot et al., 2007). This consensus process and the resulting GLAD-PC were developed because, across North America, shortages of child and adolescent psychiatrists and other mental health specialists have been keenly felt, particularly by PCCs who have been unable to obtain specialty treatment for depressed youth in their practices. As a result, much of the public health demand for assistance has fallen to PCCs, yet specific guidance and support, including assessment and treatment guidelines, have been unavailable for managing teens with MDD.

What is known about teen depression? What causes it? How do you screen for it? What is an adequate depression diagnostic assessment? What are the risks associated with depression, such as teen suicide? Are there effective treatments, and, if so, what are they? Concerning treatments, which of them might be delivered within primary care? What treatments must be provided by specialists? What are the appropriate responsibilities of the PCC when dealing with such an adolescent? What is your role with respect to the mental health specialist, and how should the two disciplines communicate and work together on behalf of a depressed youth? What should the PCC do if few or no specialty mental health services are available?

Thinking beyond these immediate clinical duties, how might you, as a PCC, effectively organize the primary care office setting to respond to depression and related problems that affect as many as 50 percent of youth over the adolescent years? And perhaps lastly, but critically, how do you pay the bills, particularly in the United States, where mental health care is often not supported to the same extent as other health care needs? While scarcities for mental health services exist both in the United States and Canada, there is an underlying assumption within Canada that mental health care—when provided—is provided at no cost to the patient. Because this same provision does not yet apply in the United States, attention to cost issues is quite critical.

This book addresses all of these issues. In Chapter 1, two of the coeditors address why, as a PCC, you are ideally situated to address MDD in youth. This chapter, as do all the chapters throughout the book, models “primary care-mental health collaborative relationships” ensuring that both an expert PCC (Stein) and a mental health specialist (Jensen) worked together to craft the content, so that it is not only applicable within primary care, but also reflects the latest mental health science that the field has to offer. Together, Stein and Jensen describe the unique mental health issues in primary care and discuss why and how PCCs are uniquely poised to address depression in teens—sometimes, even more effectively than mental health specialists—given their special long-term family relationships.

Chapter 2 provides an overview of what is known about youth depression. Fortunately, coincident with the rising rates of youth depression, there are now many new research findings. One of the key architects of the single most important study examining treatments of depression is Bruce Waslick. He and his primary care (Brooks and Burns) and mental health (Sarvet) coauthors provide an overview of what is known about youth depression, its causes, correlates, and consequences.

The two additional chapters (Chapters 3 and 4) that follow discuss optimum methods for screening of depression in primary care (Zuckerbrot and Berger-Jenkins) and how to employ appropriate strategies for assessing and diagnosing depression and comorbid conditions (Zuckerbrot and Steinbaum).

Additional information is provided in Chapter 5 (Ghalib, Bernstein, and Soren) concerning assessment and management of suicide risk and how PCCs, such as yourselves, can effectively handle such emergency situations.

One particularly thorny issue that all PCCs must confront when dealing with teens is that the nature of the child-PCC relationship changes once the teenager begins to

take increasing responsibility for his or her own health care actions. During these years, issues of confidentiality become quite critical, and the teen's ability to have an effective therapeutic relationship with a doctor—apart from his or her parents—becomes paramount. These issues are addressed by Laraque and colleagues (Hoagwood and Hoagwood) in Chapter 6. This important chapter outlines the key principles for working with parents and youth as active partners in managing teen depression.

Given the shortage of mental health specialists, it seems highly likely that treatments for depression will increasingly rest upon your shoulders. So what kind of useful psychological support can you actually offer? Or when a long wait for a mental health referral is needed, what can or should you do in the meantime? Can you assist? Stein and Jensen review the evidence in Chapter 7, as well as offer practical strategies about what you, as the PCC, can do, even when not employing formal "psychotherapy."

Cheung, also a coeditor, along with Sacks, reviews the role of medication treatments for depression in Chapter 8, including strategies for initiating, titrating, monitoring, and eventually tapering the most common medications for depression (selective serotonin reuptake inhibitors; SSRIs). While still controversial in the public eye, the evidence has become increasingly clear that at least some SSRIs are safe and effective, *if* appropriately monitored by the adolescent's prescriber. In fact, since the SSRI concerns raised in the media between 2004 and 2006, and the Food and Drug Administration's (FDA's) actions in black-boxing all of the SSRIs as possible contributors to increased suicidal ideation in some youth, SSRI prescription rates among youth have dropped as much as 20 percent. This was followed by the largest year-to-year increase in youth suicide rates during the same period, according to recent Centers for Disease Control reports.

In Chapter 9, Cheung and Asarnow review the formal psychotherapies for depression, including Cognitive Behavioral Therapy—both group and individual—as well as Interpersonal Psychotherapy for adolescents. While many studies of adolescent depression have now been conducted and several forms of therapy have been shown to be effective, the problem is that—even now—most psychotherapists are not specifically trained in either of these two forms of psychotherapy. It is essential for you to be aware of what these therapies are, what they have to offer your patients, and then become sufficiently knowledgeable to assist the family in getting those effective forms of psychotherapy whenever possible.

All of this of course presumes that you, as the PCC, are able to make a referral and that the family actually follows through with the referral. In Chapter 10, Jensen and Stein discuss the challenges in making an effective referral. Tackling the obstacles of getting a family to follow through with a referral, they discuss what you can do when it seems like there is no one to whom you can refer.

So now that you have actually connected your adolescent and family with a mental health provider, what do you do? What are your various roles and responsibilities, and how might these functions differ, depending on the type of collaborative model that best fits you and your practice? Sulik and Dennis address these issues in Chapter 11, and then, in Chapter 12, describe how to apply these collaborative approaches for complex, comorbid patients.

In Chapter 13, Campo, Robbins, and Jensen discuss how you might usefully redesign and reorganize your primary care practice setting to incorporate the latest proven methods for identifying, assessing, diagnosing, and treating youth with depression. Of course, the actual effectiveness and extent of the deployment of these strategies within primary care will depend on the degree to which you, as the PCC, can adjust your practice model to accommodate chronic illnesses rather than short-term acute

illnesses. These steps entail learning about, and then jointly putting into place, many of the strategies noted above in the previous chapters. These include setting up an ongoing database to monitor and track patients, effective screening procedures, involving and activating families as key partners in the health care process, long-term maintenance strategies, and the use of decision tools to assist the physician in making critical determinations about optimal care at critical decision points.

And last but not least, Wegner and Houston describe, in Chapter 14, how you, as a busy PCC, at least within the United States, can take advantage of appropriate billing codes and reimbursement procedures to ensure that you can be compensated for rendering crucial assessment and treatment services for depressed youth in primary care settings. While variations in reimbursement procedures exist from state to state and from insurance plan to insurance plan, efficient office managers and well-organized primary care practices can take these issues into account to manage the chronic behavioral health problems effectively, including adolescent depression, and, yes, even be compensated appropriately!

Fittingly, almost all of the contributors to this volume were key participants in the development of GLAD-PC. The recommendations and algorithm from GLAD-PC are included in the appendixes (Appendixes 1 and 2) and are available on line at <http://www.glad-pc.org>. For the full set of guidelines, see Zuckerbrot et al. (2007) and Cheung et al. (2007). As you will see by perusing them, GLAD-PC attempts to take into account the necessary strategies that you will need to employ to effectively identify, diagnose, and manage depression in your practice setting. GLAD-PC was developed for those in the age range of 10 to 21 (preteens, adolescents, and young adults), who are assessed by you to be developmentally "adolescent." Use this book in the same way, including the younger and older age ranges when pubertal status and level of functioning fit those of a teen.

No guideline is complete without a user-friendly toolkit. Having at your fingertips readily applicable tools and efficient algorithms that you can use despite many other pressures is critical, if a guideline is to achieve its intended purpose. While a robust set of GLAD-PC tools are provided in the appendixes in this volume, we have provided them with the assumption that while they will help you, you will succeed best if you obtain additional training and take the critical steps to redesign the practice setting to better manage chronic illness. For information about how you can get additional training in managing teen depression, see the Web site of the nonprofit REACH Institute (<http://www.thereachinstitute.org>).

The challenges of teen depression are going to be here for the foreseeable future. As a consequence, all PCCs, including pediatricians, family practitioners, nurse practitioners, and physicians' assistants will be central to effective national strategies for managing teen depression. Hopefully, this handbook makes it possible for you, the primary care community, to do just that.

Peter S. Jensen, M.D.
Ruth E. K. Stein, M.D.
Amy Cheung, M.D.
Rachel A. Zuckerbrot, M.D.
2011

About the Editors and Authors

Rachel A. Zuckerbrot, M.D., F.A.A.P., is an assistant professor of clinical psychiatry at Columbia University and is on the medical staff at New York Presbyterian Hospital and New York State Psychiatric Institute. She is currently the acting assistant residency director for the child psychiatry residency program at Columbia University Medical Center and the Columbia site leader for the New York State Office of Mental Health (OMH)–funded multisite pilot program called CAP-PC, Child and Adolescent Psychiatry for Primary Care. CAP-PC is a new and innovative program designed to combine training of primary care providers in mental health with direct consultation with child psychiatrists. Dr. Zuckerbrot also serves as a consultant for the New York collaborative office rounds with pediatricians, a program funded by the U.S. Health Resources & Services Administration's (HRSA) Maternal and Child Health Bureau.

Dr. Zuckerbrot completed the combined residency in pediatrics/general psychiatry/child and adolescent psychiatry at Mount Sinai School of Medicine and then completed a three-year T-32 research fellowship at Columbia University, studying ways to integrate mental health into primary care. She is one of the lead authors of GLAD-PC (Guidelines for Adolescent Depression in Primary Care) and is often consulted on mental health screening in primary care. She has been involved in several national projects integrating mental health into primary care and has been involved with both the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry on collaborative projects. Dr. Zuckerbrot also maintains a private practice in Manhattan.

Amy Cheung, M.D., MSc., is an associate professor in the Department of Psychiatry, University of Toronto. She is a staff psychiatrist in the Division of Youth Psychiatry at Sunnybrook Health Sciences Centre and is an associate scientist at the Sunnybrook Research Institute. She is also an adjunct scientist in the Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health, University of Toronto. Dr. Cheung holds a Career Scientist Award from the Ministry of Health and Long Term Care, Ontario. Her research focus includes the management of mood disorders in adolescents and young adults by primary care providers and the adverse effects of pharmacological treatments for mood disorders. She was one of the lead authors of GLAD-PC (Guidelines for Adolescent Depression in Primary Care).

Ruth E. K. Stein, M.D., F.A.A.P., is a tenured professor of pediatrics at the Albert Einstein College of Medicine. She served as vice chair of the Department of Pediatrics at Einstein and the Children's Hospital at Montefiore for ten years and as director of the Divisions of General and Ambulatory Pediatrics for twenty years. For over a decade, she was director and principal investigator of the National Institute of Mental Health–supported Preventive Intervention Research Center for Child Health at Einstein/Montefiore. Her research on child physical and mental health and child health policy has been funded by a number of federal and private sources, and she

was a recipient (with Laurie Bauman, Ph.D.) of a prestigious Robert Wood Johnson Investigator Award in Health Policy.

Nationally, Dr. Stein served as president of the Academic (previously Ambulatory) Pediatric Association and is a recipient of the Academic Pediatric Association Research Award. She has been a member of a number of advisory boards, including the Board of Children, Youth, and Families (National Research Council and the Institute of Medicine). She was cochair of the board's congressionally mandated Committee on the Evaluation of Child Health, which published *Children's Health, The Nation's Wealth: Assessing and Improving Child Health*. She was a member of the Executive Committee of the Board of the Center for Child Health Research of the American Academy of Pediatrics and served on the Scientific Advisory Board of the National Institutes of Health (NIH) Roadmap project on patient-reported outcomes measurement information system and the Board of Scientific Counselors of the National Center for Health Statistics. As chair of the New York Academy of Medicine Forum on Child Health she participated actively in developing the Guidelines for Adolescent Depression in Primary Care (GLAD-PC). She has published extensively on the topics of children with chronic conditions, measurement of child health, and mental health issues in primary care.

Peter S. Jensen, M.D., is Vice-Chair, Research, for the Department of Psychiatry and Psychology at the Mayo Clinic. Concurrent with this position, Dr. Jensen serves as president and chief executive officer of the REACH Institute (REsource for Advancing Children's Health), a federally chartered 501(c)(3) nonprofit organization dedicated to helping primary care practitioners apply evidence-based interventions for child and adolescent mental health. Prior to these current duties, Dr. Jensen was the Ruane Professor of Psychiatry at Columbia University and founding director of the Center for the Advancement of Children's Mental Health at Columbia University in New York (1999-2007), and associate director for Child and Adolescent Mental Disorders Research, National Institute of Mental Health (1989-99).

Dr. Jensen is the author of nearly 300 peer-reviewed articles and chapters and twenty books, and has received awards for his teaching and research from many national organizations, including the American Psychological Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the Society for Child Psychiatric Nursing, National Alliance on Mental Illness (NAMI), and Children With Attention Deficit Disorder (CHADD).

Joan Rosenbaum Asarnow, Ph.D., is professor of psychiatry and biobehavioral sciences at the UCLA David Geffen School of Medicine and a clinical psychologist. Dr. Asarnow's current work focuses on interventions and service delivery strategies for improving health and mental health in youth, with an emphasis on depression and suicide prevention. She has led efforts to disseminate evidence-based treatments for child and adolescent depression and suicide prevention. Dr. Asarnow has received grants from the National Institute of Mental Health, Centers for Disease Control, Agency for Healthcare Research and Quality, American Foundation for Suicide Prevention, and MacArthur Foundation. At the UCLA Semel Institute for Neuroscience & Human Behavior, Dr. Asarnow directs the Youth Stress and Mood Program, a depression and suicide prevention program. This program provides

clinical care for youth depression and suicidality, with an emphasis on cognitive behavioral treatments, work with families, and community-based treatment and service strategies.

Evelyn Berger-Jenkins, M.D., M.P.H., F.A.A.P., is a member of the Division of General Pediatrics at the Columbia Presbyterian Children's Hospital of New York where she cares for patients in the primary care setting, teaches pediatric trainees, and is pursuing implementation and evaluation of community-based health promotion programs. After attending Columbia University's College of Physicians and Surgeons and completing her pediatric residency at Columbia University Medical Center's Children's Hospital of New York, she completed a general academic pediatric fellowship at Mount Sinai Medical Center in order to pursue her goal of implementing and evaluating community-based projects in underserved communities. During the fellowship she completed two research projects: one on the sources of health disparities in the treatment of childhood attention deficit hyperactivity disorder (ADHD) and the other on the evaluation of school-based health promotion programs.

Carrie Bernstein, M.D., is an adolescent medicine fellow at the Columbia University Medical Center. She graduated from Emory University with a B.A. in chemistry in 2000 and received her medical degree at Albert Einstein College of Medicine in 2005. In June 2008, she completed her pediatric internship and residency at the Columbia University Medical Center at the Morgan-Stanley Children's Hospital of New York Presbyterian.

Betsy Brooks, M.D., M.P.H., F.A.A.P., is an assistant clinical professor of pediatrics at Tufts Medical School. After receiving her B.A. from Harvard College and her M.D. from Harvard Medical School, she completed an internship at Johns Hopkins and a residency at the University of Massachusetts Medical School. She completed her M.P.H. at the Columbia University Mailman School of Public Health. She has worked for more than twenty-five years as a primary care pediatrician at Holyoke Pediatric Associates, a large independent private practice serving a diverse population in Western Massachusetts.

Dr. Brooks is interested in primary care approaches to improving health care quality for common pediatric conditions including obesity and mental health problems. She heads her practice's quality improvement committee and has implemented several projects in improving primary care delivery of behavioral health services, including practice-wide projects in depression screening, evaluation, and treatment and improvement of attention deficit hyperactivity disorder (ADHD) services. She served as a consultant on the implementation of systematic behavioral health screening for the Massachusetts Children's Behavioral Health Initiative and is serving as clinical faculty for the revision of the National Initiative for Child Health Quality/American Academy of Pediatrics ADHD toolkit.

James J. Burns, M.D., M.P.H., F.A.A.P., is now a clinical professor of Pediatrics at Florida State University College of Medicine and practices in Pensacola, Florida. He is a graduate of the United States Naval Academy and the Pennsylvania State University School of Medicine. Dr. Burns did his internship, residency, and fellowship at the Naval Hospital San Diego. He is board certified in both pediatrics and adolescent medicine, and has taught medical students and residents for twenty-four years. After a career as an academic pediatrician in the United States Navy, Dr. Burns was associate

professor at West Virginia University School of Medicine. He then served as director of the Division of General Pediatrics at Baystate Children's Hospital and was an associate clinical professor of pediatrics at Tufts University. While in Massachusetts, Dr. Burns received his M.P.H. from the University of Massachusetts. He is the author and coauthor of numerous publications.

John V. Campo, M.D., is chief of Child and Adolescent Psychiatry, medical director of Pediatric Behavioral Health, and professor of clinical psychiatry and pediatrics at the Ohio State University and Nationwide Children's Hospital. A graduate of Lafayette College and the University of Pennsylvania School of Medicine, he completed pediatric training at the Children's Hospital of Philadelphia, followed by residency in general and child and adolescent psychiatry at the Western Psychiatric Institute and Clinic and the University of Pittsburgh Medical Center. Dr. Campo is board certified in pediatrics, psychiatry, and child and adolescent psychiatry, and has been honored by inclusion in Best Doctors in America and America's Top Doctors, as a National Alliance on Mental Illness (NAMI) exemplary psychiatrist and as recipient of the American Academy of Child and Adolescent Psychiatry's Simon Wile Leadership in Consultation Award. The beneficiary of federal funding, Dr. Campo's clinical and research interests include the integration of mental health services into primary care, psychopharmacologic safety, suicide prevention, and the relationship between pediatric functional abdominal pain, anxiety, and depression.

Jon Dennis, M.D., M.P.H., F.A.A.P., is currently senior physician in practice in adolescent medicine and pediatrics at Centracare Health System in St. Cloud, Minnesota, where he participates in and helped form the integrative behavioral pediatric system. He is coauthor with Dr. L. Read Sulik on a recent chapter on collaborating with primary care in the *Textbook of Child and Adolescent Psychiatry*.

Kareem Ghalib, M.D., is the director and chief of service of Child Psychiatry at Harlem Hospital and an assistant clinical professor of psychiatry in the Division of Child and Adolescent Psychiatry at Columbia University. He completed his general psychiatry residency at the New York State Psychiatric Institute/Columbia University and his child and adolescent psychiatry fellowship at New York Presbyterian Hospital. His research interests include treatment-resistant mood and anxiety disorders, and the safety and efficacy of newer antidepressant medications.

Hilary R. Hoagwood, M.A., received her degree in psychology at the Catholic University of America in Washington, DC, in 2007, with a concentration on children, families, and culture. She has assisted with several research projects in the areas of children's cognitive development, children's theory of mind, the impact of marital conflict on children's emotional well-being, and the impact on children and families of attention deficit hyperactivity disorder (ADHD) and autism spectrum disorders. Ms. Hoagwood currently works as a clinic coordinator in the Department of Pediatrics at the University of Maryland Medical School and works with families of children with diabetes and other chronic illnesses to assure continuous coverage and quality care. She provides support to families as well as coordination of care.

Ms. Hoagwood is also a liver transplant recipient and athlete in the U.S. and World Transplant Games where she has won nine medals in swimming, tennis, and skiing competitions. She is a member of speaker's bureaus with the National

Kidney Foundation, Washington Regional Transplant Community, and Living Legacy Foundation of Maryland. She talks with adolescents, families, and community members about organ donation, transplantation, and health.

Kimberly E. Hoagwood, Ph.D., is professor of clinical psychology in psychiatry at Columbia University and director of the Bureau of Youth Services Research in the Office of Performance Measurement and Evaluation within the New York State Office of Mental Health (NYSOMH). She directs the Child and Family Services Research Unit within the Division of Mental Health Services and Policy Research at the New York State Psychiatric Institute. Dr. Hoagwood has been a scientific investigator on several large, multisite studies on community-based services for children with serious psychiatric disorders and is currently the principal investigator (PI) for a National Institute of Mental Health (NIMH)-funded Developing Center for Implementing Evidence-Based Practices (EBPs) for Children. She is the author of over 100 papers and numerous book chapters, and is coeditor of five books on topics relevant to community-based services for children and families.

Before joining NYSOMH and Columbia University, Dr. Hoagwood was associate director for child and adolescent mental health research with the NIMH and oversaw the entire portfolio of research on child and adolescent mental health. At NIMH, she was also chair of the Child and Adolescent Research Consortium, an interdisciplinary forum of scientists across the National Institutes of Health (NIH). From 2000-2001 she served as scientific editor for the Office of the Surgeon General's National Action Agenda on Children's Mental Health. Among Dr. Hoagwood's awards and honors are the Outstanding Scholar in Education Award from the University of Maryland and the American Psychiatric Association's Distinguished Contribution Award in School Psychology.

Michael Houston, M.D., is a child, adolescent, and adult psychiatrist. He is an associate clinical professor of psychiatry and pediatrics at the George Washington University Medical Center where he is actively involved in the education of medical students and resident physicians. Dr. Houston is an active member of the American Academy of Child and Adolescent Psychiatry and is the chair of their Committee on Healthcare Access and Economics. He is also chair of the Council on Children, Adolescents, and Their Families for the American Psychiatric Association. Dr. Houston is in private practice in Washington, DC.

Danielle Laraque, M.D., F.A.A.P., is the chair of the Department of Pediatrics and vice president of the Maimonides Infant and Children's Hospital in Brooklyn, New York. Prior to this role, she was professor of pediatrics and professor of preventive and community medicine, and the endowed Debra and Leon Black Professor of Pediatrics, as well as the chief of the Division of General Pediatrics, vice chair for public policy and advocacy in the Department of Pediatrics (2000-10), at the Mount Sinai School of Medicine. She is a nationally and internationally recognized expert in injury prevention, child abuse, adolescent health risk behaviors, and in the issues critical to health care delivery in underserved communities. In the past decade, she has focused her attention on defining systems' changes that will facilitate the integration of the identification, diagnosis, and treatment of children's mental health problems in primary care settings. She has authored over 100 peer-reviewed publications and chapters, hundreds of presentations, and is the recipient of numerous awards, most recently the American

Academy of Pediatrics (AAP) Job Lewis Smith Award for outstanding service in community pediatrics (2010).

Dr. Laraque completed her medical studies at the University of California at Los Angeles where she received the Roy Markus Scholarship (1977-81). Her internship and residency were completed at the Children's Hospital of Philadelphia where she was also a Robert Wood Johnson Fellow in General Academic Pediatrics (1984-86). She is the immediate past-president of the Academic Pediatric Association (APA, 2010). She is also the American Academy of Pediatrics (AAP) District II (NYS) Vice Chair (2004-10). She was appointed to the AAP National Mental Health Task Force (MHTF, 2005-10) and chairs its Decision Support Committee. She was a member of the Maternal and Child Health Bureau, Bright Futures National Health Promotion Workgroup (1998-2004) and the national AAP Bright Futures Project Advisory Committee (2004-07). She was the 2001 United States Public Health Service Primary Care Policy Fellow and a member of the National Institute of Mental Health Standing Committee on Interventions for Disorders Involving Children and Their Families (2006-10).

Darryl A. Robbins, D.O., F.A.A.P., is a clinical assistant professor in pediatrics at The Ohio State University College of Medicine. He is a graduate of Dickinson College and Philadelphia College of Osteopathic Medicine, and completed his pediatric residency at Cincinnati Children's Hospital Medical Center, where he was the first recipient of the Samuel Dalinsky Memorial Award as outstanding graduating pediatric resident. Dr. Robbins is a recertified Diplomate of the American Board of Pediatrics. He has been in private practice for the past thirty-five years in addition to being actively involved at Nationwide Children's Hospital, where he is a past president of the medical staff. For the past decade, Dr. Robbins has been president of Children's Practicing Pediatricians, an umbrella organization for the primary care private practice pediatricians in central Ohio. He has received several honors including The Ohio State University College of Medicine Lifetime Achievement Award and the Nationwide Children's Hospital Career Contribution Award. He was named Teacher of the Year twice by the pediatric house staff at Nationwide Children's Hospital and has been included annually in Best Doctors in America.

Diane Sacks, M.D., F.R.C.P. (C), is assistant professor of pediatrics at the University of Toronto. Dr. Sacks received her training in pediatrics and adolescent medicine at the Children's Hospital of Pittsburgh and the Hospital for Sick Children, Toronto, Canada. She has worked in adolescent medicine in both academic and community settings for over thirty-five years. She served as liaison from the Canadian Pediatric Society (CPS) to the American Academy of Pediatrics Committee on Adolescence for many years. She was president of the Canadian Pediatric Society 2004-05 and chair of the CPS Committee on Adolescence. She served on the board of Canadian ADHD Research Alliance establishing guidelines for evaluation and treatment. Dr. Sacks writes a monthly pediatric column in a popular Canadian parenting magazine and was editor-in-chief of the CPS's *Guide for Caring for Your Child from Birth to Age 5* (2009). She currently advocates for children and youth mental health initiatives as a member of the Mental Health Commission of Canada and as chair of the Mental Health Section of the CPS.

Barry Sarvet, M.D., is chief of the Division of Child and Adolescent Psychiatry at Baystate Medical Center and associate clinical professor in the Department of

Psychiatry at Tufts Medical School. His special interest in access to care for children with mental health needs and collaborative models of working with primary care providers has been a focus of his clinical, administrative, and academic work, and has guided his role in the development of the Massachusetts Child Psychiatry Access Project, a state-wide, population-based program designed to help pediatricians and child psychiatry teams meet the needs of children with mental health problems and their families.

Karen Soren, M.D., F.A.A.P., is an associate clinical professor of pediatrics and public health at Columbia University, and the director of Adolescent Medicine at the Morgan Stanley Children's Hospital of New York Presbyterian. After receiving her B.A. from Harvard University and her M.D. from New York University School of Medicine, Dr. Soren trained in pediatrics at Children's Hospital National Medical Center in Washington, DC, and adolescent medicine at the University of Chicago Medical Center. An experienced clinician and educator, Dr. Soren is board certified in adolescent medicine and is a nationally recognized expert in the field. In addition to providing comprehensive care to adolescents at Columbia University Medical Center, she has developed and is the program director for the Adolescent Medicine Fellowship Training Program at the New York Presbyterian Hospital, Columbia University. Dr. Soren has received grants to fund clinical research in adolescent chronic illness, contraception, depression, obesity and diabetes prevention, and medical education. Her areas of expertise include adolescent reproductive health care, mental health issues in adolescents, and prevention of underage drinking.

Deborah Steinbaum, M.D., M.P.H., F.A.A.P., is a general pediatrician in private practice in Northern NJ. Prior to her current position, she was an assistant professor of pediatrics at the Mount Sinai Medical Center in New York City, where one of her primary focuses was the integration of mental health into primary care pediatrics. After receiving her B.A. from Harvard University and her M.D. from the Yale University School of Medicine, Dr. Steinbaum trained in general pediatrics at the Mount Sinai School of Medicine, where she remained to complete a fellowship in general academic pediatrics and to receive an M.P.H. from Mount Sinai/New York University. Subsequent to this, Dr. Steinbaum was an attending physician at Mount Sinai in both general pediatrics and child abuse pediatrics. Her research interests include mental health screening in primary care and the identification and management of trauma-related distress in school-aged children.

L. Read Sulik, M.D., is the senior vice president of mental health services for Sanford Health out of Sioux Falls, South Dakota, and Fargo, North Dakota. From November 2008 to January 2011, he was the assistant commissioner of the Chemical and Mental Health Services Administration of the Minnesota Department of Human Services. Prior to assuming that role, he was the medical director of Child and Adolescent Psychiatry at the St. Cloud Hospital/CentraCare Health System where he founded the integrated behavioral health care system. He attended medical school at the University of Minnesota Medical School and completed the triple board residency program in pediatrics, psychiatry, and child and adolescent psychiatry at the University of Kentucky.

Bruce Waslick, M.D., M.P.H., is a child psychiatrist at Baystate Medical Center in Springfield, Massachusetts, and an associate professor of psychiatry at Tufts University.

His academic interests include medical and psychosocial interventions for children and adolescents with psychiatric disorders, particularly adolescents with depression and other mood disorders. He has been the principal investigator and co-investigator on many research projects comparing medication treatment, psychotherapy, and combination treatments in mood and anxiety disorders in children and adolescents.

Lynn M. Wegner, M.D., F.A.A.P., a developmental/behavioral pediatrician, is associate clinical professor and director of the Developmental/Behavioral Pediatrics Division of the Pediatrics Department at the University of North Carolina School of Medicine. After receiving her B.A. from Mt. Holyoke College and her M.D. from the University of Oklahoma School of Medicine, Dr. Wegner trained in pediatrics at Children's Memorial Hospital, Oklahoma City, Oklahoma, and North Carolina Children's Hospital, Chapel Hill, North Carolina. She completed her developmental/behavioral pediatrics fellowship at the Center for Development and Learning, University of North Carolina under the directorship of Dr. Melvin Levine.

Dr. Wegner is the immediate past-chairperson of the American Academy of Pediatrics (AAP) Section on Developmental and Behavioral Pediatrics (SODBP) and was appointed in 2007 to the AAP Committee on Coding and Nomenclature. She is chairperson of the SDBP/SODBP Coding Committee—a combined effort of the AAP SODBP and the Society for Developmental and Behavioral Pediatrics (SDBP). She was a member of the AAP Task Force on Mental Health (2006-09), is the AAP liaison to the American Academy of Child and Adolescent Psychiatry's Committee on Health Care Access and Economics (2006-present), and represented both the AAP and the SDBP to the 2008 American Academy of Child and Adolescent Psychiatry (AACAP) Research Group Committee for developing the *Parent's Medication Guide for Pediatric Bipolar Disorder*. Dr. Wegner's areas of particular expertise are executive functions and emotional regulation in children and adolescents, specific learning disabilities, language development and disorders, and payment for mental health services in non-mental health care settings.