Management and Treatment of Depression

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FAMILIES THRIVE WITH GOOD MENTAL HEALTH



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NEW YORK STATE | Office of Mental Health

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Disclosures

"My spouse/partner and I have the following relevant financial relationship with a commercial interest to disclose:

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POLL

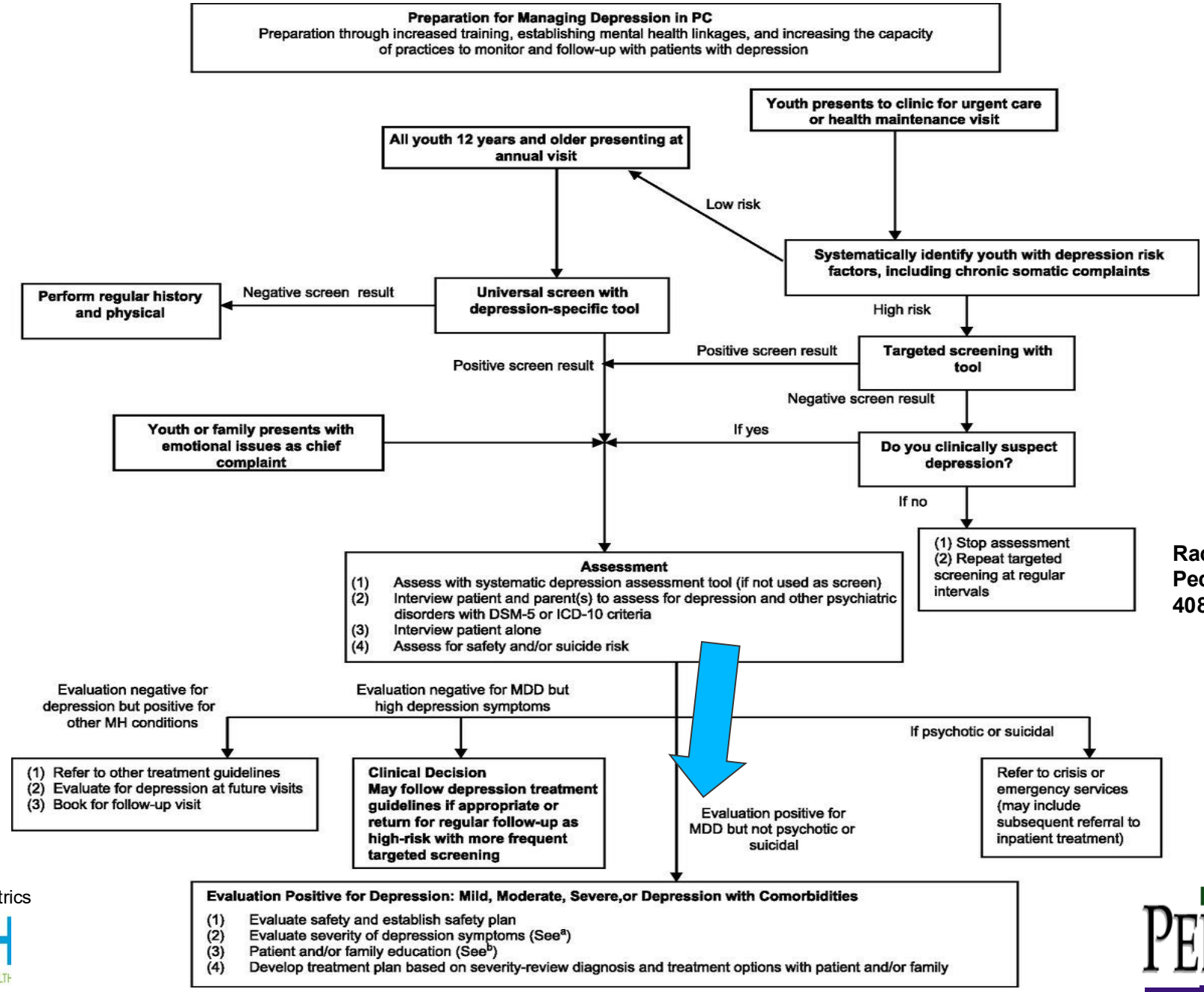
Should Pediatric Primary Care Providers treat major depressive disorder in teens?

- 1. Yes. Always.
- 2. No. Never.
- 3. Yes but only for mild depression.
- 4. Yes but only to bridge care while patients wait for a psychiatrist.



Let’s continue where we left off…

Clinical Assessment Flowchart.



Rachel A. Zuckerbrot et al. Pediatrics doi:10.1542/peds.2017-4081

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PEDIATRICS

Initial Management

A. Decide if Mild, Moderate or Severe
B. Establish a Safety Plan
C. Educate Patient and Family
D. Develop a treatment plan based on severity

A. How to Decide?

MILD **MODERATE** **SEVERE**

- Clinical impressions from interview
- Standardized rating scales scores
- Number of DSM-5 criteria
- Degree of impairment from baseline
- Safety issues (suicidality, self-injury)

B. Safety Planning

- Assess current risk – ASQ screen
- If safe to go home, have parents “sanitize” the home
- Make a written plan
  - NOT A PROMISE TO NOT HARM
  - Hierarchy of support system
    - comforting activities: music, art, sports, etc.
    - support systems: when to contact…. friends, parents, PCP, 911

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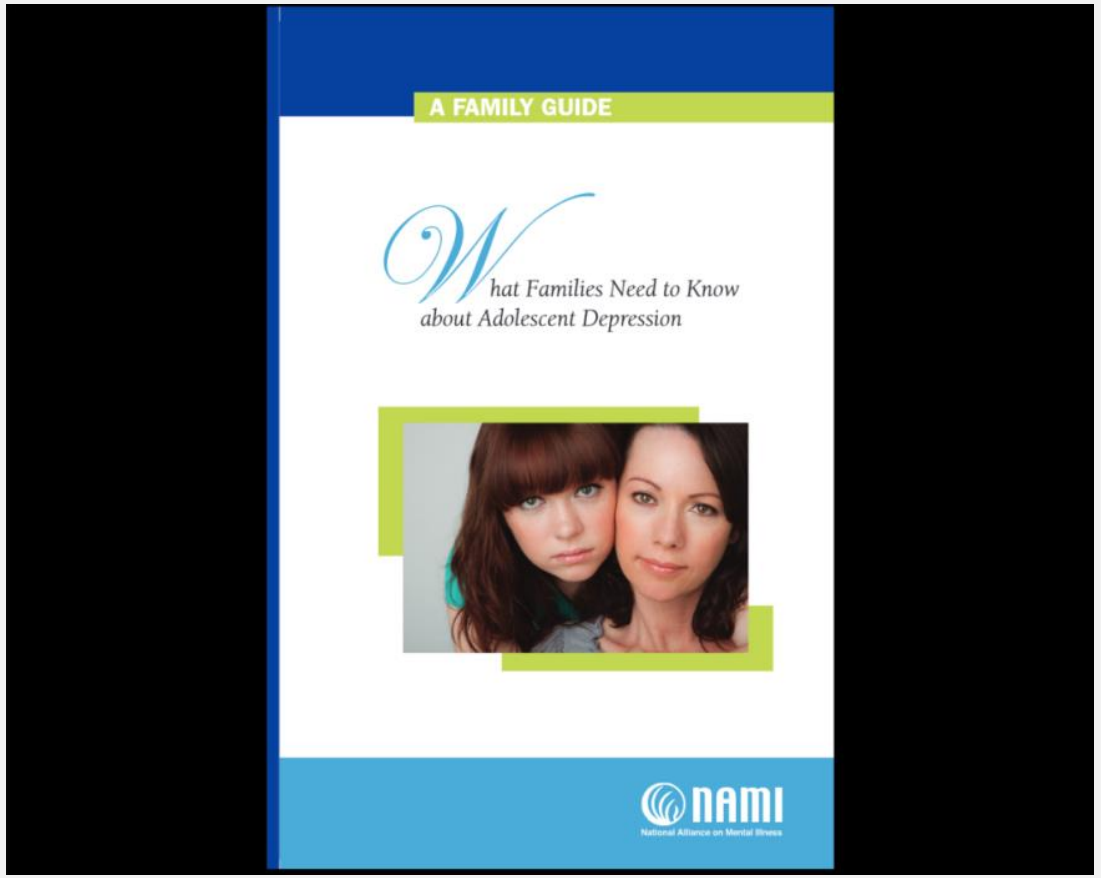
C. Patient and Family Education

- Explaining depression as a common and treatable condition is one of the most important steps to be done in primary care
- Written materials can go a long way in helping to keep them engaged in the mental health process
  - NAMI FAMILY GUIDE
  - GLAD-PC Toolkit Handouts



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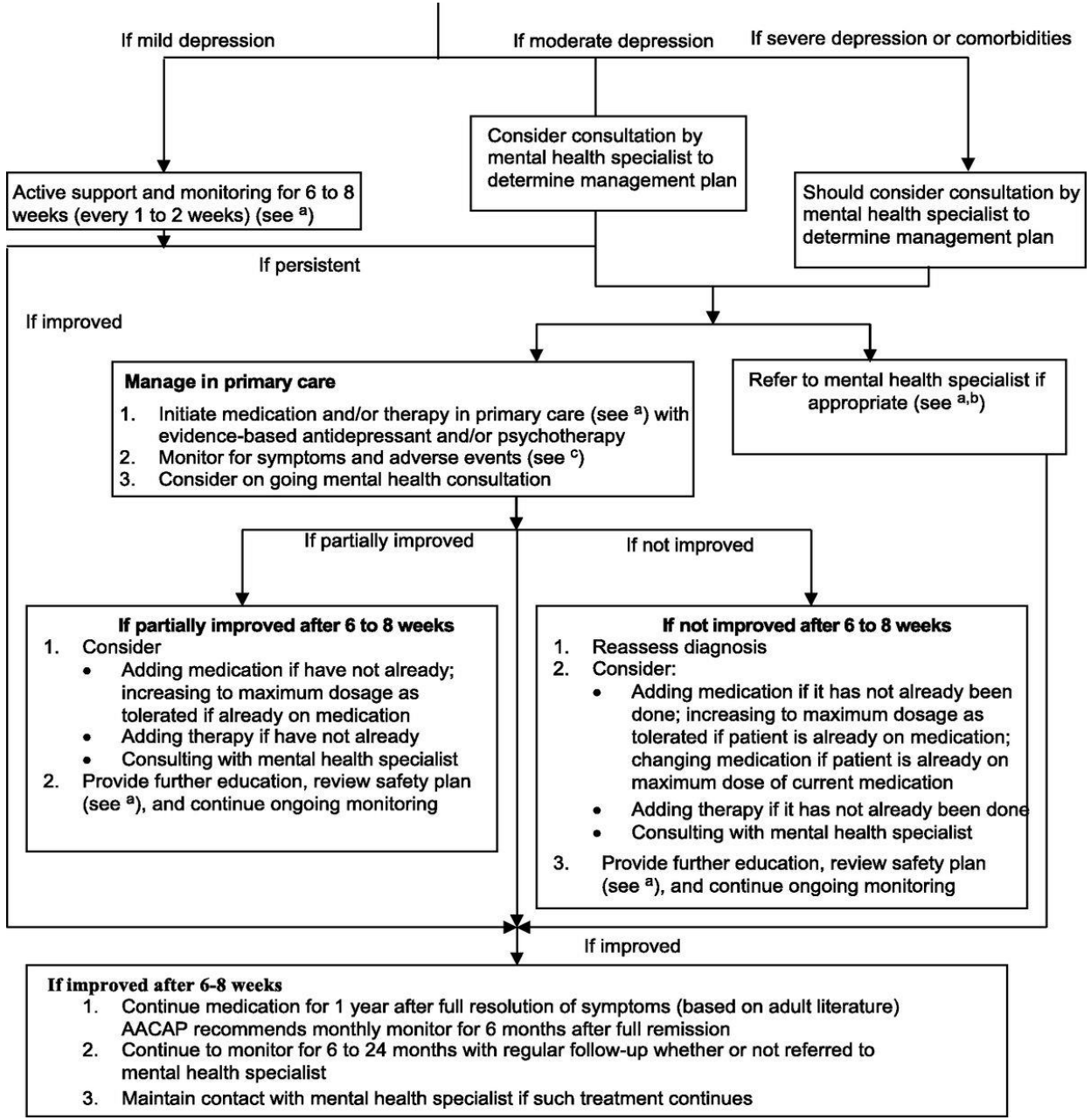
C. Patient and Family Education: Basic Interventions

- Behavioral Activation
- Exercise
- Nutrition
- Spend time outside (commune with nature)
- Hang out with supportive friends
- Spiritual or other supportive community
- Altruism (volunteer opportunities)
- Sleep
- Limit screen time/ social media

D. Develop a Treatment Plan Based on Severity

- Now we go to Part II of the guidelines and the second flowchart

D. Develop a Treatment Plan Based on Severity



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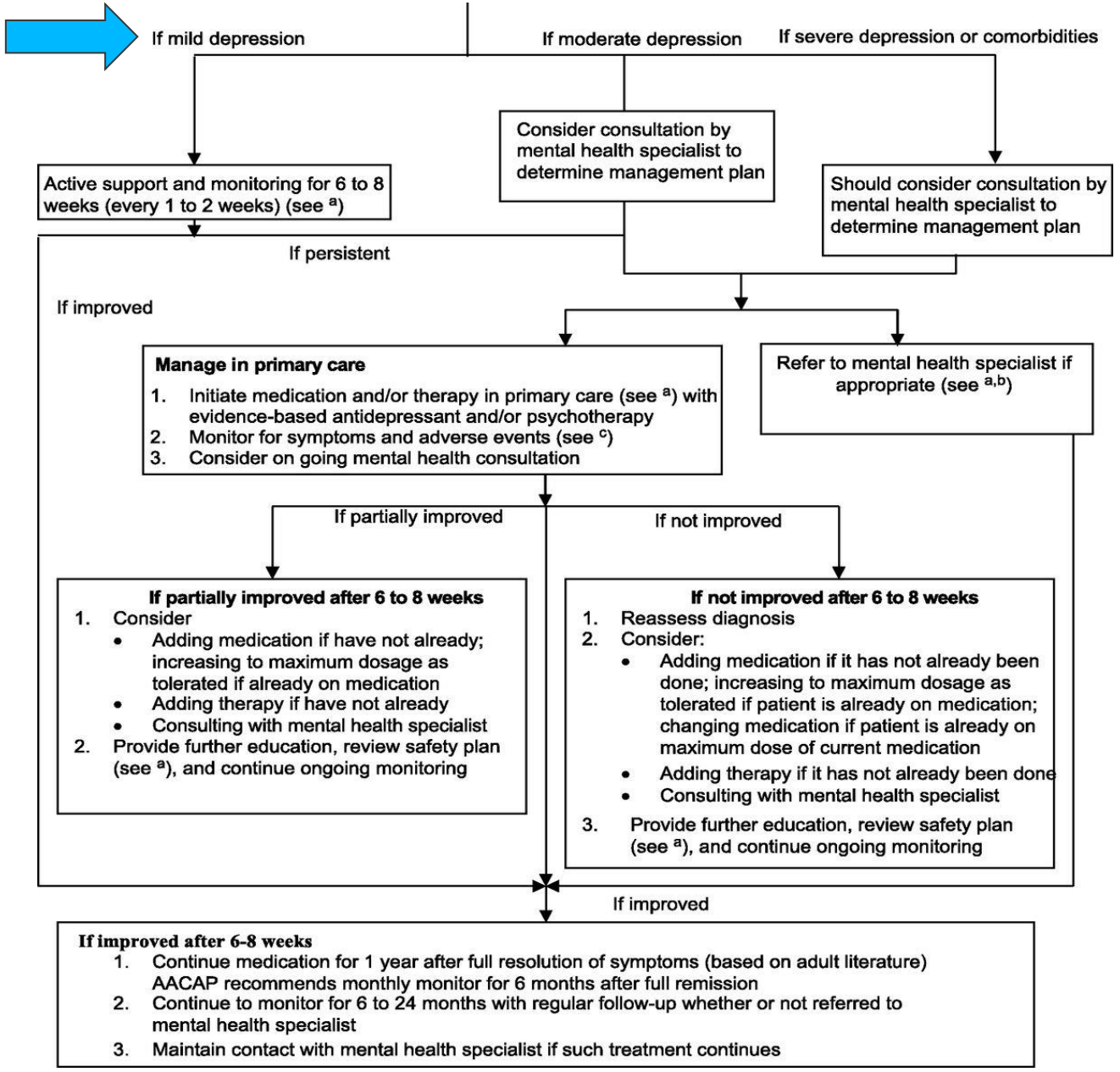
PEDIATRICS

Managing Mild Depression

Clinical Assessment Flowchart



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Active Monitoring & Close Follow-Up

Self-Care Success!

Things you can do to help yourself.

Name:_____ Date: _____

Instructions: When people are depressed they often forget to take care of themselves. By setting self-care goals you can take an active role in helping yourself feel better more quickly. Choose one or two of the areas below and set a goal. Make sure the goal is clear and reasonable. In the space below the boxes rate how likely you are to follow through on the goal(s) you set. If you are not very sure you can follow through on your goal you may want to find alternatives or make some adjustments.



Stay Physically Active

Each week during the next month I will spend at least _____ days doing the following physical activity for _____ minutes.

_____

_____

(Pick a specific date and time and make it reasonable!)



Schedule Pleasant Activities

Even though I may not feel motivated I will commit to scheduling ____fun activities each week for the next month. They are_____

_____

_____

(Specify when and with whom.)



Eat Balanced Meals

Even if I don't feel like it, I will eat _____ balanced meals per day to include

_____

_____

_____

_____

(Choose healthy foods.)



Spend Time With People Who Can Support You

During the next month I will spend at least ____ days for at least ___ minutes at a time with:

_____ doing:_____

_____ doing_____

_____ doing:_____

(Who?) (What?)

(e.g. talking, eating, playing)



Spend Time Relaxing

Each week I will spend at least _____ days relaxing for ____ minutes by participating in the following activities: _____

_____

_____

(e.g. reading, writing in a journal, deep breathing, muscle relaxation)



Small Goals & Simple Steps

The problem is:_____

_____

My goal is:_____

_____

Step 1:_____

_____

Step 2:_____

_____

Step 3:_____

How likely are you to follow through with these activities prior to your next visit?

Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

What might get in the way of your completing these activities prior to your next visit?

_____

Solution(s) to the above barriers

_____

_____

_____

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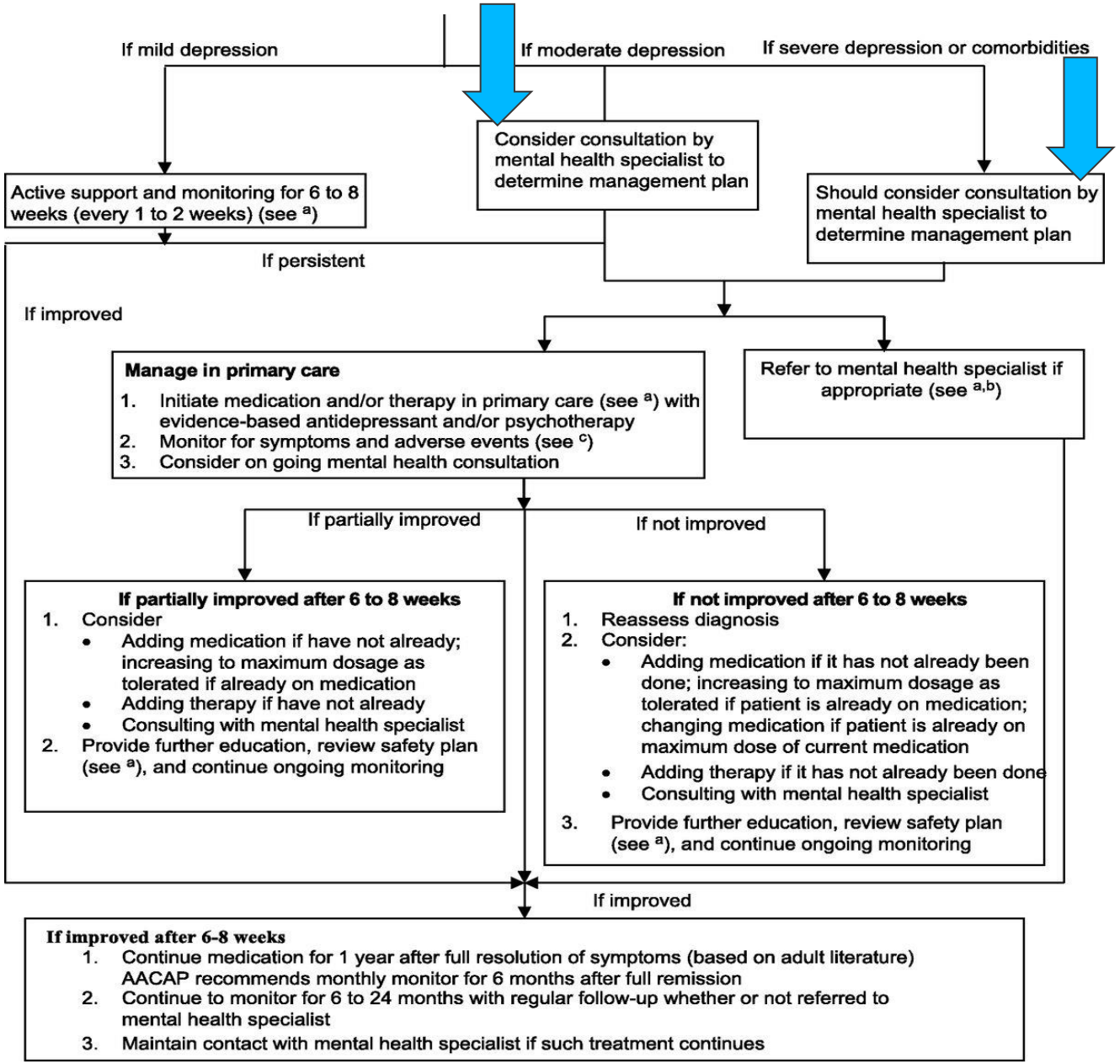
Managing Moderate to Severe Depression

Clinical Assessment Flowchart



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PEDIATRICS®

Referral for Evidence-based Therapy

- Explain to the family why you are referring them.
- Explain what the provider will do, use names and describe office if possible.
- Explain your continued role in their care.
- Communicate with referral provider.
- Establish roles and responsibilities with mental health provider.

Psychotherapy for Depression

- Cognitive Behavioral Therapy (CBT)
- Interpersonal psychotherapy- Adolescent (IPT-A)
- Other therapies are difficult to manualize and test in a RCT (does not mean that they are ineffective)

POLL

If your patient has been referred to specialty mental health, should you make a depression follow-up appointment in primary care?

- 1. Yes. Always.
- 2. No. Never.
- 3. Yes, just to make sure they are engaged in treatment, and then no need to follow-up after that.



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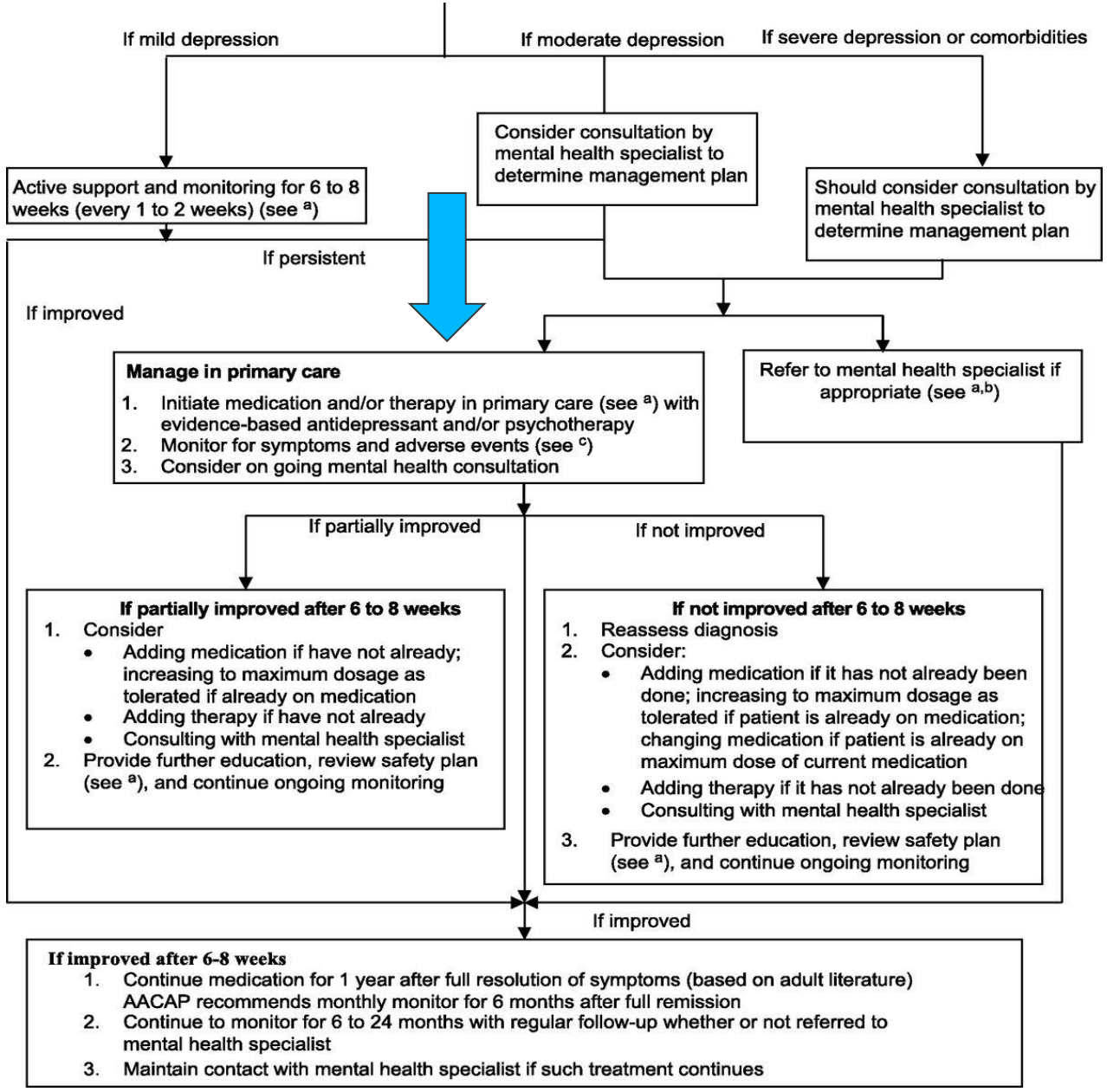
Clinical Assessment Flowchart



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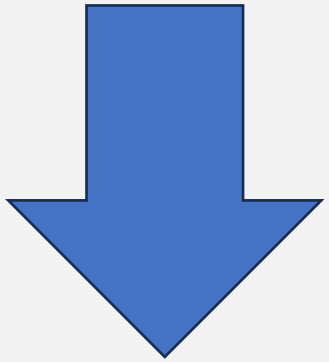
Cognitive Behavioral Therapy

GETS KIDS MOVING and BUILDS SKILLS

- Behavioral Activation (Go watch the other kids play basketball even if you are too tired and not interested).
- Cognitive restructuring (The world is not out to get you. That is the depression talking.)
- Coping skills training (What can you do next time when you get into a fight instead of trying to hurt yourself?)
- Stress management (Deep breathing, listening to music, etc).

Psychopharmacotherapy for Depression

SSRIs (Selective Serotonin Reuptake Inhibitors)



First-line Treatment in Adolescent Depression

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Choosing an SSRI

FDA Approval for MDD in Teens?

- Fluoxetine
- Escitalopram

RCT Evidence for MDD in Teens?

- Fluoxetine
- Escitalopram
- Sertraline
- Citalopram

FDA Approval for other Disorders in Teens?

- Fluoxetine
- Sertraline
- Fluvoxamine

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Other Considerations

- Prior treatment history
- Family member response
- Family preference
- Clinical experience

Treatment of Adolescent Depression Study (TADS)

March et al, 2004

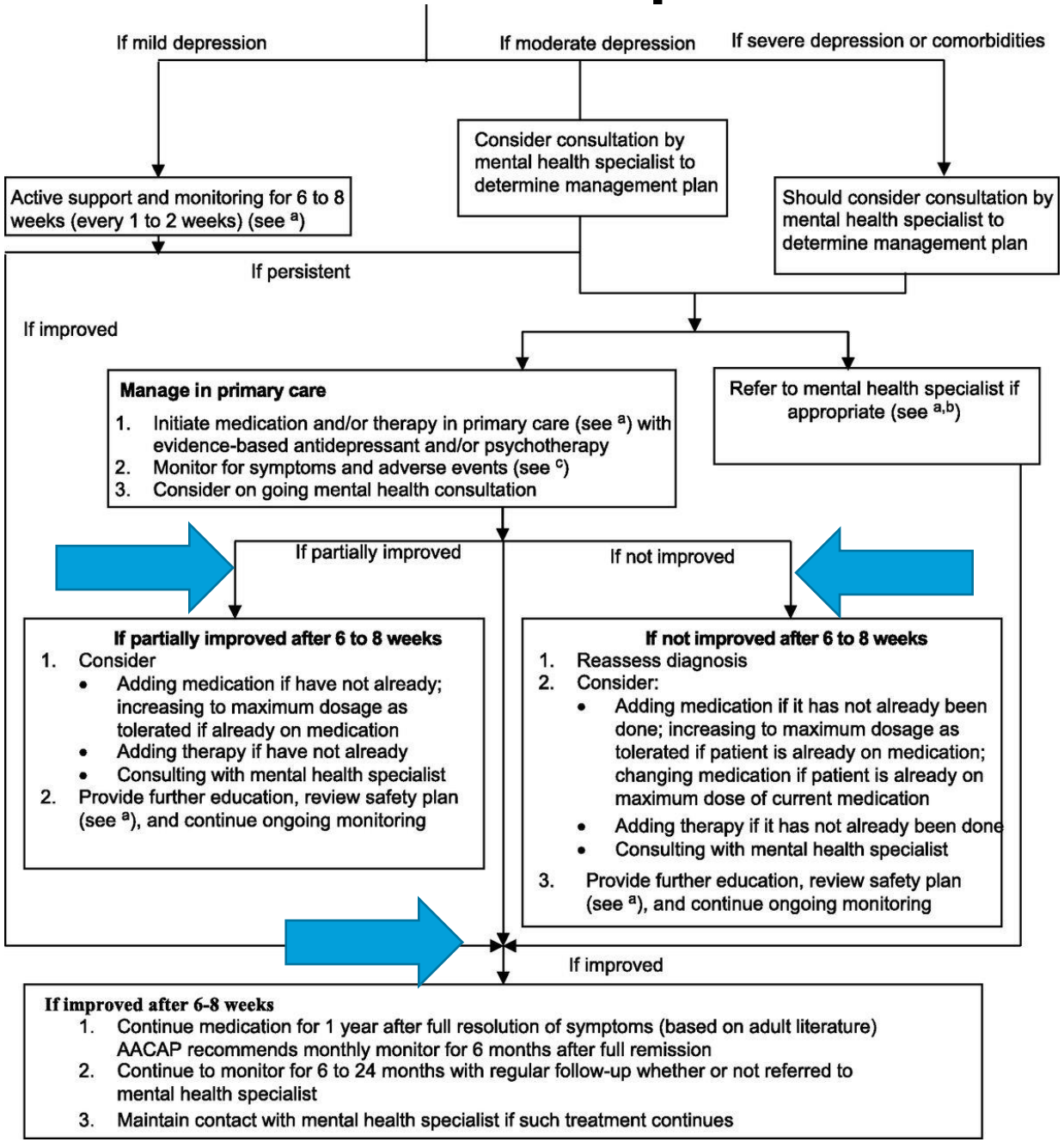
- 439 adolescents, 12-17 years old, 13 sites, 12 weeks
- Study groups:
  - Medication (fluoxetine) alone: 60.6%
  - Cognitive Behavioral Therapy alone: 43.2%
    (not statistically different from placebo at 12 weeks)
  - CBT + fluoxetine: 71%
  - Placebo: 34.8%

CBT for Relapse Prevention

- Adding CBT after initial response to meds will keep improvement for longer (increase time to relapse)

- CBT booster sessions also help prevent relapse and deterioration of CBT skills

Follow-Up



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PEDIATRICS

FOLLOW UP

- Doing well = full remission! → Educate about the natural history of depression, the goal is treatment for ~12 months after improvement before taper and D/C
- Partial response → increase dose for full trial, consider augmentation if at maximum dose or add CBT
- Doing poorly → Reassess diagnosis, change dose or medicine, add evidence-based psychotherapy
- Call the Project TEACH Hotline for consultation and/or referral to Mental Health

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SSRI How-To: Part I

- Try to start with a first-line medication (FDA approved) unless other considerations take precedence
- Start at a dose lower than the expected therapeutic dose (e.g fluoxetine 5 or 10 mg instead of 20 mg or escitalopram 5 mg instead of 10 mg)
- If there are no side effects, go up in a week.
- Warn families that the early doses are to acclimate and test the waters.
- Get to a therapeutic dose in 2-4 weeks (clinical judgement).
- Patients should respond somewhat to therapeutic dose in 2-3 weeks.
- If no response, increase dose.
- If some response, wait 4-6 weeks (for full response to take effect) to decide if dose should be increased.

SSRI How-To: Part II

- Fluoxetine (longest acting)
  - Start at 10mg (can even start at 5mg)
  - Increase by 10mg increments (can go by 5mg)
  - Therapeutic range: 20-60mg, can go up to 80mg
- Escitalopram
  - Start at 5mg
  - Increase by 5mg increments
  - Therapeutic range: 10-20mg
- Sertraline
  - Start at 25mg (can even start at 12.5mg)
  - Increase by 25mg increments (can increase by 12.5mg)
  - Therapeutic range: 25-200mg

SSRI How-To: Part III

- Monitor for side effects
- Monitor for suicidality
- Monitor for improvement in symptoms and functioning
- If patient does not respond at higher doses of SSRI, consider change of medication
- Next step in medication is to try a different SSRI (not to switch classes)
- How to switch from one medication to another (cross-tapering vs. stopping and starting, cross-tapering slowly vs cross-tapering quickly, etc.) depends on many factors including but not limited to which specific SSRIs, the side effects, the response, and the clinical picture→ CALL PROJECT TEACH

What Could Go Wrong: Side Effects

- GI symptoms: resolve in a few weeks
- Serotonin syndrome: Start low and titrate up
- Sexual: discuss at onset and at follow up visits
- Suicidality: Medication-induced versus medication undertreatment?
- Activation and Mania

See Glad PC Toolkit for complete list

SSRI Activation in Youth

- Activation represents a hyperarousal event: increase in activity, impulsivity, disinhibition, restlessness and insomnia.
- Antidepressant-related activation emerges early in treatment or following an increase in dose, and symptoms resolve when the antidepressant dose is decreased or when the antidepressant is discontinued
- Some evidence suggests slower titrations and lower doses can help
- Hypomania and mania are rare but some activation symptoms in youth treated for MDD is not so rare

What else could go wrong

- Patients often stop meds for “side effects” that are actually part of the primary disorder – fatigue, appetite changes, etc.

- Recurrence/relapse – more likely if you treat partially (too low a dose or too short a duration)

Danielle

How to Decide When to Use Any Medicine

- Severity of illness
- Patient preference
- Monitor the trajectory of the illness
- Remember the risks of NOT treating
- Assess the risk-benefit ratio with the family

Barriers to Success



Time:

- Schedule appropriately
- Bill for your valuable time

Parental Resistance:

- Bring up medication early
- Discussed risk of not treating
- Emphasize informed decision-making

Knowledge and Confidence:

- Start small and “easy”
- Use Project Teach

Provider Fatigue:

- Decompress, Discuss, Delegate

The Boxed Warning

Boxed Warnings

- FDA requires a boxed warning when a medication causes a serious undesirable effect
- Over 600 medications carry boxed warnings
- Over 40% patients in outpatient setting receive at least 1 medication with a boxed warning

Wagner 2006

Antidepressant Boxed Warning

2004

- Warning up to the age of 18
- Warned of increased suicidality
- Called for weekly visits for 4 weeks, every other week visits for another 8 weeks, and then monthly visits

2007

- Warning up to age 24
- Risk must be balanced with the clinical need.
- Risk of suicide from depression itself highlighted.
- Monitor patients closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.

FDA Boxed Warning on Antidepressants

- Prompted by warning of increased suicide risk in adolescents treated with ***paroxetine***, by British MHRA in June 2003

- FDA pooled data from 24 studies examining antidepressant use in children for depression and anxiety disorders

Limitations of the FDA review

- Limitations
  - Post-hoc analyses, multiple sub-analyses
    - none of original 24 studies were designed to evaluate this
  - Few events of “suicidality” (78/4400)
  - Substantial differences between studies in classification
  - Noncompliance not considered
  - Patients with severe pathology excluded

FDA Analysis Results

- September 2004,FDA reports increase in *suicidality* on medication
  - Suicidality defined as
    - new onset SI
    - worsening of SI
    - new or increased suicidal behaviors

3.8% on SSRIs vs 2.1% on placebo

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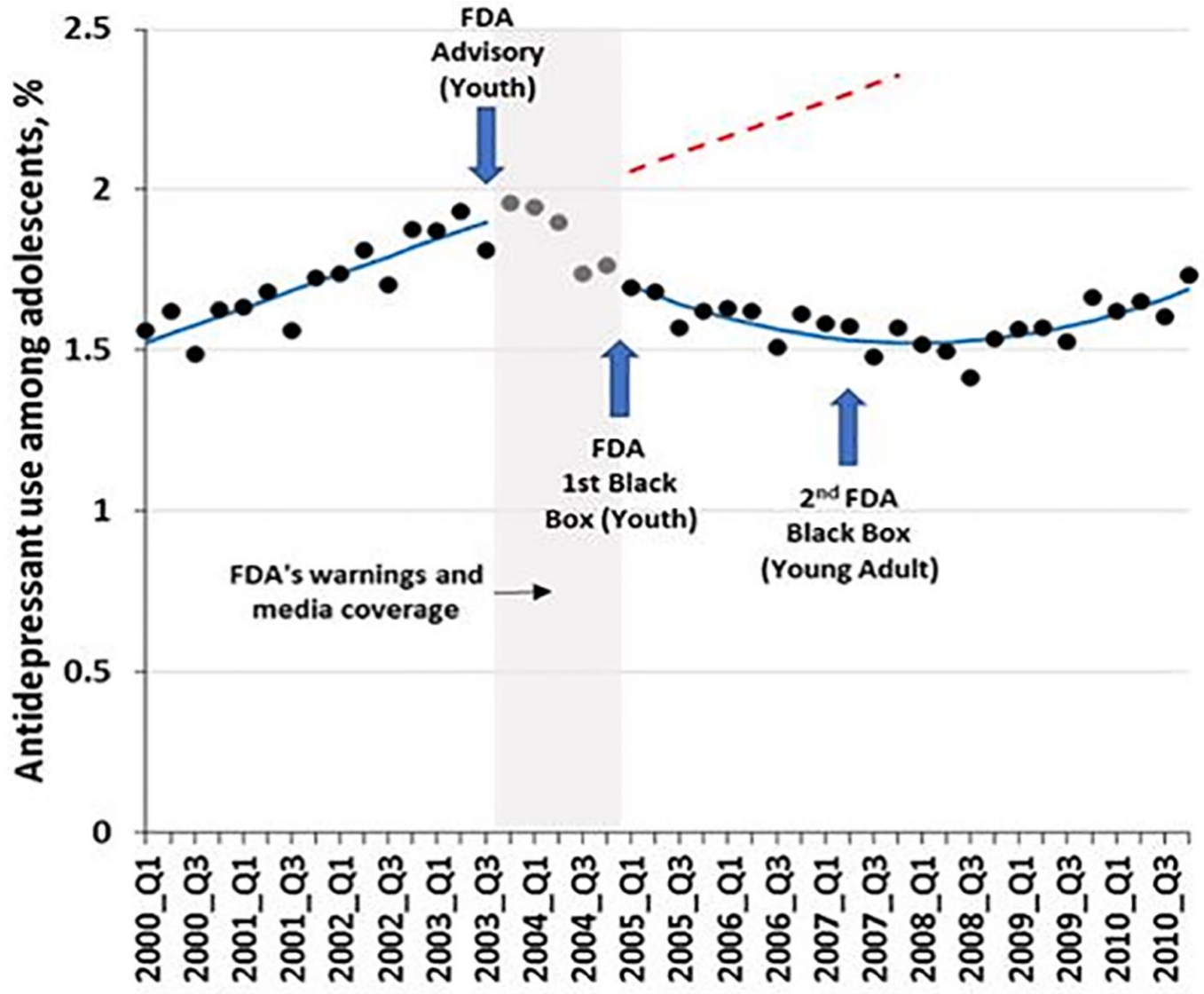
Unintended Consequences



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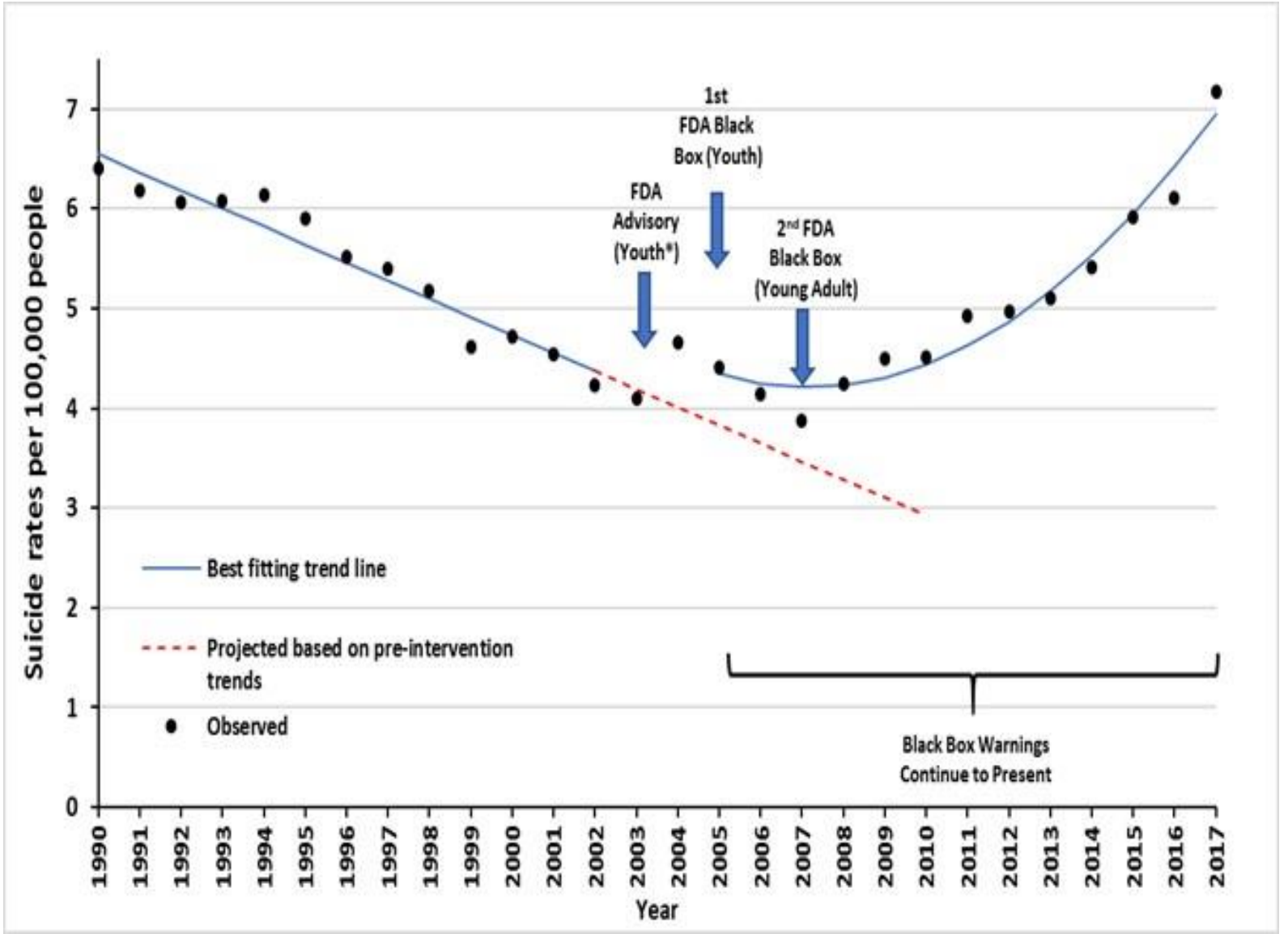

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Unintended Consequences

- Rates of antidepressant drug prescriptions declined by 50%
- Rate of diagnosis of MDD reduced by 40%
- Increase in psychotherapy did NOT occur as expected
- Increased utilization of Benzo and antipsychotic medications
- Studies suggested actual increased rate of suicide

Formaro 2019

TAKE HOME POINT #1:
SUICIDAL RISK ON ANTIDEPRESSENTS

- No deaths / no completed suicides
- Across ALL studies with 4400 children and adolescents

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TAKE HOME POINT #2:
SUICIDE RISK

- Increased risk of suicide with untreated depression

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In Summary: Management of Depression in Children and Adolescents

- Depression in children & adolescents is common, identifiable and treatable
- Psychotherapy is acceptable/emphasized as a first line in mild/moderate MDD
- Based on FDA meta-analysis, share with families:
  - There is a 2-4% RISK of SI on meds vs 1-2% on placebo

BUT

  - TADS study shows a 60-70% chance of improvement of MDD with medication treatment

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In Summary: Management of Depression in Children and Adolescents (continued)

- Fluoxetine and Escitalopram are FDA approved to treat depression in adolescents (although may have good reason to use others)
- Educate families to watch for and report :
  - Increase in agitation or uncharacteristic behavior change or suicidal/self-injurious thoughts/behaviors and how to get help
- Monitor closely for side effects and for improvement

The Take-Away…

- Depression can be managed in a Primary Care setting
- PCPs are the first line of defense: accessibility, trusted, established knowledge of the patient
- These are the most grateful of families
- The mental health crisis is our call to step up to the plate
- Do not make kids suffer!