Treatment of Depression

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Disclosures

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Managing Adolescent Depression
The Complete Guide for Primary Care Clinicians
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Guidelines for Adolescent Depression in Primary Care

GLAD - PC
Part I

- *Pediatrics*. 2018;141(3):e20174081
  
  [http://pediatrics.aappublications.org/content/141/3/e20174081](http://pediatrics.aappublications.org/content/141/3/e20174081)

- Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Practice Preparation, Identification, Assessment, and Initial Management

- Zuckerbrot RA, Cheung AH, Jensen PS, Stein REK, Laraque D; GLAD-PC Steering Group
Part II

- *Pediatrics*. 2018;141(3):e20174082
  http://pediatrics.aappublications.org/content/141/3/e20174082

- Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management

- Cheung AH, Zuckerbrot RA, Jensen PS, Laraque D, Stein REK; GLAD-PC Steering Group
Guidelines for Adolescent Depression in Primary Care

GLAD - PC

Toolkit
Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit

The GLAD-PC Toolkit helps primary care providers to put the GLAD-PC guidelines into effect. This toolkit was developed with the input of experts from the areas of adolescent depression, primary care behavioral medicine, parent and family advocacy, guideline development, and quality improvement.

Whenever possible, we have adapted or borrowed generously (and with permission) from those pioneers who had already developed such materials for their own populations and settings. We especially want to thank our partners in depression care improvement from the Texas State Department of Health Services, Columbia University’s Treatment Guidelines Project, Intermountain Health Care, American Medical Association, Western Psychiatric Institute and Clinic, the National Alliance for the Mentally Ill, the Depression & Bipolar Support Alliance, and many others too numerous to mention who have shared time, expertise, and toolkit content.

On behalf of the GLAD-PC Steering Committee, organization liaison representatives, and the many expert clinicians who contributed to this process to improve adolescent depression management in primary care, we thank you for your service and efforts for depressed teens.

Downloads:

Download the updated GLAD-PC Toolkit here
GLAD-PC Toolkit: www.gladpc.org

Guidelines for Adolescent Depression in Primary Care

GLAD - PC

Toolkit
Let’s continue where we left off…
Clinical assessment flowchart.

Preparation for Managing Depression in PC
Preparation through increased training, establishing mental health linkages, and increasing the capacity of practices to monitor and follow-up with patients with depression

All youth 12 years and older presenting at annual visit

Low risk

Youth presents to clinic for urgent care or health maintenance visit

Systematically identify youth with depression risk factors, including chronic somatic complaints

High risk

Targeted screening with tool

Positive screen result

Do you clinically suspect depression?

If yes

Assessment

(1) Assess with systematic depression assessment tool (if not used as screen)
(2) Interview patient and parent(s) to assess for depression and other psychiatric disorders with DSM-5 or ICD-10 criteria
(3) Interview patient alone
(4) Assess for safety and/or suicide risk

Positive screen result

If yes

(1) Stop assessment
(2) Repeat targeted screening at regular intervals

Negative screen result

If no

Perform regular history and physical

Negativescreen result

Universal screen with depression-specific tool

Positive screen result

Evaluation negative for depression but positive for other MH conditions

Evaluation negative for MDD but high depression symptoms

Evaluation Positive for Depression: Mild, Moderate, Severe, or Depression with Comorbidities

(1) Evaluate safety and establish safety plan
(2) Evaluate severity of depression symptoms (See*)
(3) Patient and/or family education (See*)
(4) Develop treatment plan based on severity-review diagnosis and treatment options with patient and/or family

(1) Refer to other treatment guidelines
(2) Evaluate for depression at future visits
(3) Book for follow-up visit

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

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

MILD

MODERATE

SEVERE

Clinical impressions from interview
Standardized rating scales
Number of DSM-5 criteria
Level of impairment, Safety issues
Severity Determination

Framework for Grading Severity of Depressive Episodes

In both the DSM-5 and the ICD-10, severity of depressive episodes is based on the number, type, and severity of symptoms, as well as the degree of functional impairment. The DSM-5 guidelines are summarized in the table below.

### DSM-5 Guidelines for Grading Severity Depression

<table>
<thead>
<tr>
<th>Category</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of symptoms</td>
<td>Closer to 5</td>
<td>-</td>
<td>Closer to 9</td>
</tr>
<tr>
<td>Severity of symptoms</td>
<td>Distressing but manageable</td>
<td>-</td>
<td>Seriously distressing and unmanageable</td>
</tr>
<tr>
<td>Degree of functional impairment</td>
<td>Minor impairment</td>
<td>-</td>
<td>Symptoms markedly interfere</td>
</tr>
</tbody>
</table>

* According to the DSM-5, in “moderate” episodes of depression, “the number of symptoms, the intensity of symptoms, and/or the functional impairment are between those specified for ‘mild’ and ‘severe.’”

In addition to the above framework, individual rating scales are associated with their own indicators of severity, as indicated elsewhere in this section.
B. Safety Planning

• Assess Current risk

• If safe to go home:
  • Encourage parents to “sanitize” the home
  • Make a written plan (or on the iphone, ipad, etc.) with steps agreed upon by all parties as to what to do at what point –NOT A PROMISE TO NOT HARM
  • Hierarchy of Support systems and comforting activities (music, art, sports, etc.)
    • When should friends be contacted
    • When should parents be contacted
    • When should the PCP be contacted
    • When should 911 be contacted
    • When should a suicide crisis line be contacted
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

• Giving written materials to your patients can go a long way in helping to keep them engaged in the mental health process
  • NAMI FAMILY GUIDE
  • GLAD-PC Toolkit Handouts
C. Patient and Family Education: Basic interventions to help oneself or one’s child

• Behavioral Activation
• Exercise
• Nutrition
• Spend time outside (commune with nature)
• Hang out with supportive friends
• Spiritual or other supportive community
• Altruism (volunteer opportunities)
D. Develop a Treatment Plan Based on Severity

• Part II of the Guidelines:
• *Pediatrics*. 2018 Feb
• Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and ongoing management.
• Cheung AH¹, Zuckerbrot RA, Jensen PS, Laraque D, Stein RE; GLAD-PC Steering Group.
Mild Depression
Clinical Assessment Flowchart

If mild depression

- Active support and monitoring for 6 to 8 weeks (every 1 to 2 weeks) (see *)

If moderate depression

- Consider consultation by mental health specialist to determine management plan

If severe depression or comorbidities

- Should consider consultation by mental health specialist to determine management plan

If persistent

Manage in primary care

1. Initiate medication and/or therapy in primary care (see *) with evidence-based antidepressant and/or psychotherapy
2. Monitor for symptoms and adverse events (see *³)
3. Consider on-going mental health consultation

Refer to mental health specialist if appropriate (see H²/³)

If partially improved

If partially improved after 6 to 8 weeks

1. Consider
   - Adding medication if not already; increasing to maximum dosage as tolerated if already on medication
   - Adding therapy if not already
   - Consulting with mental health specialist
2. Provide further education, review safety plan (see *), and continue ongoing monitoring

If not improved after 6 to 8 weeks

1. Reassess diagnosis
2. Consider:
   - Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
   - Adding therapy if it has not already been done
   - Consulting with mental health specialist
3. Provide further education, review safety plan (see *), and continue ongoing monitoring

If improved after 6-8 weeks

1. Continue medication for 1 year after full resolution of symptoms (based on adult literature)
2. AACEP recommends monthly monitor for 6 months after full remission
3. Continue to monitor for 6 to 24 months with regular follow-up whether or not referred to mental health specialist
4. Maintain contact with mental health specialist if such treatment continues
Chapter IV.
Treatment Information for Providers
Guide to the “Treatment Information for Providers” Section
Active Monitoring
Treatment Choices: Supportive Counseling and Problem-Focused Treatment
  Treatment Choices: Evidence-based Psychotherapy
  Evidence-based Pharmacotherapy
  Depression Monitoring Flow Sheet
Suicidality in Adolescents and the Black Box Warning
  Safety Planning for Depressed Adolescents
  Assessment of High-Risk Teen Suicide Attempters
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 eating, 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:

(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
Moderate to Severe Depression
Clinical Assessment Flowchart

If mild depression
Active support and monitoring for 6 to 8 weeks (every 1 to 2 weeks) (see *)

If moderate depression
Consider consultation by mental health specialist to determine management plan

If severe depression or comorbidity
Should consider consultation by mental health specialist to determine management plan

If persistent

If partially improved
If partially improved after 6 to 8 weeks
1. Consider
   • Adding medication if have not already; increasing to maximum dosage as tolerated if already on medication
   • Adding therapy if have not already
   • Consulting with mental health specialist
2. Provide further education, review safety plan (see *), and continue ongoing monitoring

If not improved
If not improved after 6 to 8 weeks
1. Reassess diagnosis
2. Consider:
   • Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
   • Adding therapy if it has not already been done
   • Consulting with mental health specialist
3. Provide further education, review safety plan (see *), and continue ongoing monitoring

If improved after 6-8 weeks
1. Continue medication for 1 year after full resolution of symptoms (based on adult literature)
2. AACAP recommends monthly monitor for 6 months after full remission
3. Continue to monitor for 6 to 24 months with regular follow-up whether or not referred to mental health specialist
4. Maintain contact with mental health specialist if such treatment continues
Making the Most of Your Referral

• Explain to the family why you are referring them somewhere.
• Explain to the family what the referral provider will do.
• Explain to the family your continued role in their care for this issue.
• 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)
CBT

• Most evidence for adolescent depression at this point

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).
Evidence-Based Psychotherapy: Information for PCPs

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Key Components</th>
<th>Manuals/Websites</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPT</td>
<td>Interpersonal problems may cause or exacerbate depression and that depression, in turn, may exacerbate interpersonal problems. Treatment targets patient's interpersonal problems to improve both interpersonal functioning and their mood. Essential elements of interpersonal therapy include identifying an interpersonal problem area, improving interpersonal problem-solving skills, and modifying communication patterns.</td>
<td>Interpersonal Psychotherapy for Depressed Adolescents, 2nd ed. Laura Malhan, Kristen Polack. Dotta, Donna Moreau, and Myna M. Wessman. New York, Guilford Press 2011 (paperback), 355 pp</td>
</tr>
</tbody>
</table>

CST=Cognitive Behavioral Therapy
IPT=Interpersonal Therapy

Table 1. Cognitive Behavioral Therapy and Interpersonal Therapy
Psychopharmacotherapy for Depression

• SSRIs (Selective Serotonin Reuptake Inhibitors) are first-line treatment in Adolescent Depression
WHICH SSRI?

FDA Approval for MDD in Teens?
• Fluoxetine
• Escitalopram

Evidence Base for MDD in Teens?
• Fluoxetine
• Escitalopram
• Sertraline
• Citalopram
WHICH SSRI?

FDA Approval for other disorders (safety established)?
- Fluoxetine
- Sertraline
- Fluvoxamine

Other Considerations?
- Prior treatment history
- Comorbidity
- Family member response
- Family preference
- Clinician 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-reduce time to relapse


Sequential treatment with fluoxetine and relapse--prevention CBT to improve outcomes in pediatric depression. 
*Kennard BD, Emslie GJ, Mayes TL, Nakonezny PA, Jones JM, Foxwell AA, King J.*
Follow-Up
Follow-Up

If mild depression
Active support and monitoring for 6 to 8 weeks (every 1 to 2 weeks) (see *)

If moderate depression
Consider consultation by mental health specialist to determine management plan

If severe depression or comorbidities
Should consider consultation by mental health specialist to determine management plan

If persistent

If improved
Manage in primary care
1. Initiate medication and/or therapy in primary care (see *) with evidence-based antidepressant and/or psychotherapy
2. Monitor for symptoms and adverse events (see *)
3. Consider ongoing mental health consultation

If partially improved
1. Consider
   a. Adding medication if not already; increasing to maximum dosage as tolerated if already on medication
   b. Adding therapy if not already
   c. Consulting with mental health specialist
2. Provide further education, review safety plan (see *), and continue ongoing monitoring

If not improved after 6 to 8 weeks
1. Reassess diagnosis
2. Consider:
   a. Adding medication if it has not already been done; increasing to maximum dosage as tolerated if patient is already on medication; changing medication if patient is already on maximum dose of current medication
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3. Provide further education, review safety plan (see *), and continue ongoing monitoring

If improved after 6-8 weeks
1. Continue medication for 1 year after full resolution of symptoms (based on adult literature)
   a. AACA recommends monthly monitor for 6 months after full remission
2. Continue to monitor for 6 to 24 months with regular follow-up whether or not referred to mental health specialist
3. Maintain contact with mental health specialist if such treatment continues
FOLLOW UP: How’s it going?

- Going well – full remission! >> Educate about the natural history of depression, goal of treatment for minimum 6-12 months after improvement

- Partial response – increase dose

- Doing poorly –
  - Reassess diagnosis
  - make a change in dose or medicine, add evidence based psychotherapy
  - Call the Project TEACH Hotline
  - Refer to Mental Health
SSRI How-Tos: 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 fluoxetine 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 and not to expect a sudden recovery.
- 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-Tos: Part II

✓ 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 – many are possible (see GLAD PC toolkit for list)
  
  * Suicidality: Medication-induced versus medication undertreatment?
  * GI / stomach upset: usually transient after a few weeks
  * Sexual: Must be discussed at onset alone with teens

  “Call if you notice any problems, any issues”

  Ask specifically at f/u visits as teens may be too embarrassed to bring it up

* Patients stopping med for “side effects” that are actually just part of the primary disorder – fatigue, appetite changes, etc

* Recurrence – more likely if you treat partially (too low a dose or too short a duration)
In Summary…

INITIAL MANAGEMENT IN PRIMARY CARE (safety planning, psychoeducation, and treatment planning based on severity) is a vital component

TAILOR THE TREATMENT (psychotherapy, SSRI, or both)

FOLLOW UP to see if adequate (see often and soon)

ADJUST (dosage, meds, therapy)

FOLLOW UP as story unfolds

STAY INVOLVED