Depression Management and Treatment

Objectives:

1. Assess severity of depression.
2. Evaluate suicidality and establish safety plan if indicated.
3. Provide psychoeducation about depression.
4. Discuss evidence-based treatment options for mild, moderate, and severe depression and collaboratively implement treatment plan

SUMMARY:

Inclusion Criteria:

All children and adolescents 11 years old and older who meet DSM-5 criteria for major depression

Exclusion Criteria:

Medical or psychiatric diagnosis that better explains depressive symptoms
NOTE: refer to Depression Screening/Diagnosis Guidelines for depression differential diagnosis

Significant Developmental delay
Mania
Psychosis
Active Substance Use Disorder

Management and Treatment:

1. Evaluate severity of depression symptoms. Consider use of rating scales (PHQ9) which can help guide severity of symptoms and functional impairment.
   a. Mild
      i. Number of DSM-5 criteria symptoms 5-6
      ii. Severity of symptoms mild
      iii. Degree of impairment mild or normal functioning with substantial and unusual effort
   b. Moderate
      i. Moderate episodes of depression have a severity that is intermediate between mild and severe
   c. Severe
      i. Number of DSM-5 criteria symptoms 8-9
         1. Note: Can have severe depression with less than 8 symptoms IF significant severity of symptoms
      ii. Severity of symptoms severe
iii. Degree of functional impairment is clear-cut, observable disability

2. **Evaluate for suicidal ideation, violent ideation, and psychosis.**
   a. If psychotic or suicidal (wanting to harm themselves today with a plan) or having plan to hurt others refer to crisis or emergency services
   b. If suicidal thoughts but not wanting to harm themselves today, consider safety plan with parental involvement
      i. Restricting lethal means (parents need to be involved to do this)
      ii. Engaging concerned third party
      iii. Provide crisis numbers

3. **Patient and family psychoeducation**
   a. Educate and counsel patient and family about depression
      i. Ex. Depression is an illness, not a weakness. Depression is no one person’s fault. There are genetic and environmental factors that contribute. Depression is usually a chronic illness with periods of recovery and recurrent episodes.
   b. Educate and counsel patient and family about options for management of depression
   c. Discuss limits of confidentiality with adolescent and family
   d. Provide supportive counseling
   e. Facilitate parental and patient self management (motivation for treatment often starts with parents)

4. **Develop treatment plan based on severity**
   a. **Mild Depression**
      i. Active support and monitoring every 2 weeks for 6-8 weeks
      ii. If improved, continue to monitor every 3 months for 6-24 months
      iii. If depression persists:
         1. Consider consultation by mental health professional to determine management plan
         2. Does the patient now meet criteria for moderate depression?
            a. If yes, see instructions for moderate depression
            b. If no, consider referral for individual therapy (CBT or IPT) and continue active monitoring.
   b. **Moderate Depression**
      i. Consider consultation by mental health to determine management plan
      ii. Initiate SSRI in primary care AND refer for individual therapy in the community
      iii. Start low, and gradually increase dose weekly until in target range
      iv. Monitor for symptoms and adverse events
         1. Increased suicidal ideation
         2. Increased agitation
         3. Change in sleep patterns
      v. If improved after 6-8 weeks
         1. Continue medication for 6 months to 1 year after full resolution of symptoms
2. Continue to monitor for 6-24 months with regular follow-up
   vi. If partially improved after 6-8 weeks
      1. Consider ongoing mental health consultation
      2. Consider adding medication if have not already; increasing to maximum dosage as tolerated if already on medication
      3. Consider adding therapy if have not already
      4. Provide further education, review safety plan and provide handouts on CBT and mood monitoring. Continue ongoing monitoring every 2-3 weeks.
   vii. If NOT improved after 6-8 weeks
      1. Reassess diagnosis
         a. consider TSH, hemoglobin
         b. consider urine toxicology
      2. Consider formal consult with mental health
      3. Negotiate roles/responsibilities between primary care and mental health
      4. Consider:
         a. Adding medication if have not already
         b. Increasing to maximum dosage as tolerated if already on medication
         c. Changing medication if already on maximum dose of current medication
         d. Adding individual therapy if have not already
      5. Provide further education, review safety plan and provide handouts on CBT and mood monitoring. Continue ongoing monitoring every 2 weeks.

c. Severe Depression
   i. Consult with mental health professional to determine management plan
   ii. Combined treatment recommended including SSRI + evidence based therapy.
   iii. Make a safety plan and restrict access to lethal means
   iv. Refer to mental health
      1. Negotiate roles/responsibilities between primary care and mental health
      2. Continue to monitor in primary care after referral
   v. Maintain contact with mental health

Definitions:

Active Monitoring

- Schedule frequent visits
- Prescribe regular exercise and leisure activities
- Recommend practice of mindfulness which is a state of active, open attention on the present
- Recommend a peer support group
Depression Outpatient Guidelines

- Review self-management goals
- Follow-up with patients via telephone
- Provide patients and families with educational materials

Supportive Counseling

- Provide supportive counseling in the primary care setting
- Encourage use of effective coping strategies by depressed adolescents
- Meet with patients in brief, but regular, intervals with focus on finding solutions to youth-identified problems
- Empathize with adolescent patient while helping them to formulate clear, simple and specific behavioral change plans

Problem Solving Treatments for Primary Care (PST-PC)

- Psychological treatment for depression tested in adult population
- Based on finding that depression is associated with life problems
- Meet with patient for 4-6 30 minute sessions over a 6-10 week period
- Identify and clarify problems
- Set realistic goals and generating solutions
- Evaluate progress and renew problem-solving efforts when indicated

Evidence-based Psychotherapy

1. **Behavioral Activation (BA)**
   a. An “outside in” treatment that focuses on helping people with depression to change the way they act.
   b. Goal of treatment is to help people make the link between their behavior and their mood.

2. **Cognitive Behavioral Therapy (CBT)**
   a. An “inside out” treatment based on principle that one’s thoughts, feelings and behaviors affect one another. Certain negative thoughts evoke negative feelings that predispose to and/or are exacerbated in depression.
   b. Goal of treatment is to modify the negative thoughts and behaviors in order to improve mood and break the depression cycle.

3. **Interpersonal Therapy for Adolescents (IPT-A)**
   a. Based on the principle that depression occurs in an interpersonal context
   b. Goal of treatment is to address the interpersonal problems that may be contributing to or resulting from the patient’s depression

4. **Dialectical Behavior Therapy (DBT)**
   a. Intensive program designed to help people change patterns of behavior that are not helpful, such as self-harm and suicidality
b. Goal of treatment to help people increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and helping to assess which coping skills to apply

c. Consider for patients who do not respond to first line treatment and have persistent suicidality and emotion dysregulation

Evidence-based Pharmacotherapy

1. Prescribing Medication

Selective Serotonin Reuptake Inhibitors (SSRIs) are medication of choice for depressive disorders in children and adolescents.

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) and other classes of antidepressants are typically reserved for patients who fail first line SSRI therapy.

a. First-line Medication
   i. Fluoxetine (SSRI)

b. Second-line Medications
   i. Sertraline (SSRI)
   ii. Citalopram (SSRI)
   iii. Escitalopram (SSRI)

c. Third line Medications
   i. Fluvoxamine (SSRI)
   ii. Mirtazapine (tetracyclic antidepressant)
   iii. Venlafaxine (SNRI)
   iv. Wellbutrin (aminoketone class antidepressant)

2. Changing medication

a. Different SSRI should be used when maximum dose is reached and maintained for 4-6 weeks without response in target symptoms OR major side effects

b. Consider second-line medication if child fails fluoxetine and a course of CBT and IPT

c. Establish cross-taper from fluoxetine to new SSRI

d. Consider consulting mental health specialist regarding second-line medications

e. Physician should re-evaluate diagnosis and consider combination of medication if patient fails >2 medication trials

3. Maintaining medication

a. Continue on medication for 6-12 months following cessation of symptoms

b. Some depressed youth may need 2 or more years of maintenance to prevent relapse

c. Once stabilized, follow-up appointments should occur quarterly
d. Evaluate target symptoms, adverse reactions and medication compliance at each visit

4. Stopping medication
   a. Slowly taper medication when discontinuing, depending on half life of SSRI
   b. General rule: cut dose in half x 1 week, then in half again x 1 week, then discontinue.
   c. Take into consideration dose of medication and length of therapy when deciding on how fast or slow to taper medication. If patient has been stable on significant dose consider tapering over 1-2 months instead of 1-2 weeks.

Important medication concerns to cover with parents and children

- FDA’s review of the SSRI safety data, including suicidality, and document covering this in your chart note
- Common side effects associated with SSRIs: GI symptoms, headaches, restlessness, change in sleep patterns, sweating, sexual dysfunction
- Rare side effects: irritability, agitation, disinhibition, seizure (Wellbutrin), blood pressure changes (Venlafaxine)
- Even rarer: serotonin syndrome, increased bleeding, increased suicidality
- Common side effects are often dose dependent and can resolve with time
- Recommend supervision of medication administration and handling of medication by adults ONLY
- Likely duration of treatment (6 months to 1 year after cessation of symptoms)
- Possibility of withdrawal symptoms if medication is stopped without medical supervision (flu-like symptoms)
Addendum

Suicidality in Adolescents
(adapted from APA/AACAPs Physicians Med Guide)

Suicidal ideation and suicide attempts are common in adolescence. Youth Risk Behavior Study (CDC) reports 17% of adolescents think about suicide in a given year. Among high school students, 12% of girls and 5% of boys attempt suicide in a given year. Ultimately, 2 per 100,000 girls and 12 per 100,000 boys die as a result of suicide. Overall rate of suicide in 10-19 year olds has declined by 25% over the past decade.

The Black Box Warning

In 2004, the FDA reviewed detailed reports of 23 clinical trials involving more than 4,400 children and adolescents prescribed any of nine antidepressants for treatment of depression, anxiety or obsessive-compulsive disorder. FDA concluded that more of the children and teens who were receiving an antidepressant medication spontaneously reported that they thought about suicide or made a suicide attempt than did those who received placebo. The FDA’s analysis of these data found that medication did NOT increase suicidality that had been present at the start of the study and that it did NOT induce new suicidality in those without prior suicidal ideation. All studies showed a reduction in suicidality over the course of treatment.