Mental Health Care Guide

For Primary Care Clinicians

Depression

OPAL-K

Oregon Psychiatric Access Line about Kids

DOERNBECHER CHILDREN'S HOSPITAL
OHSU
Oregon Health & Science University

G. OPAL-K Depression Care Guide

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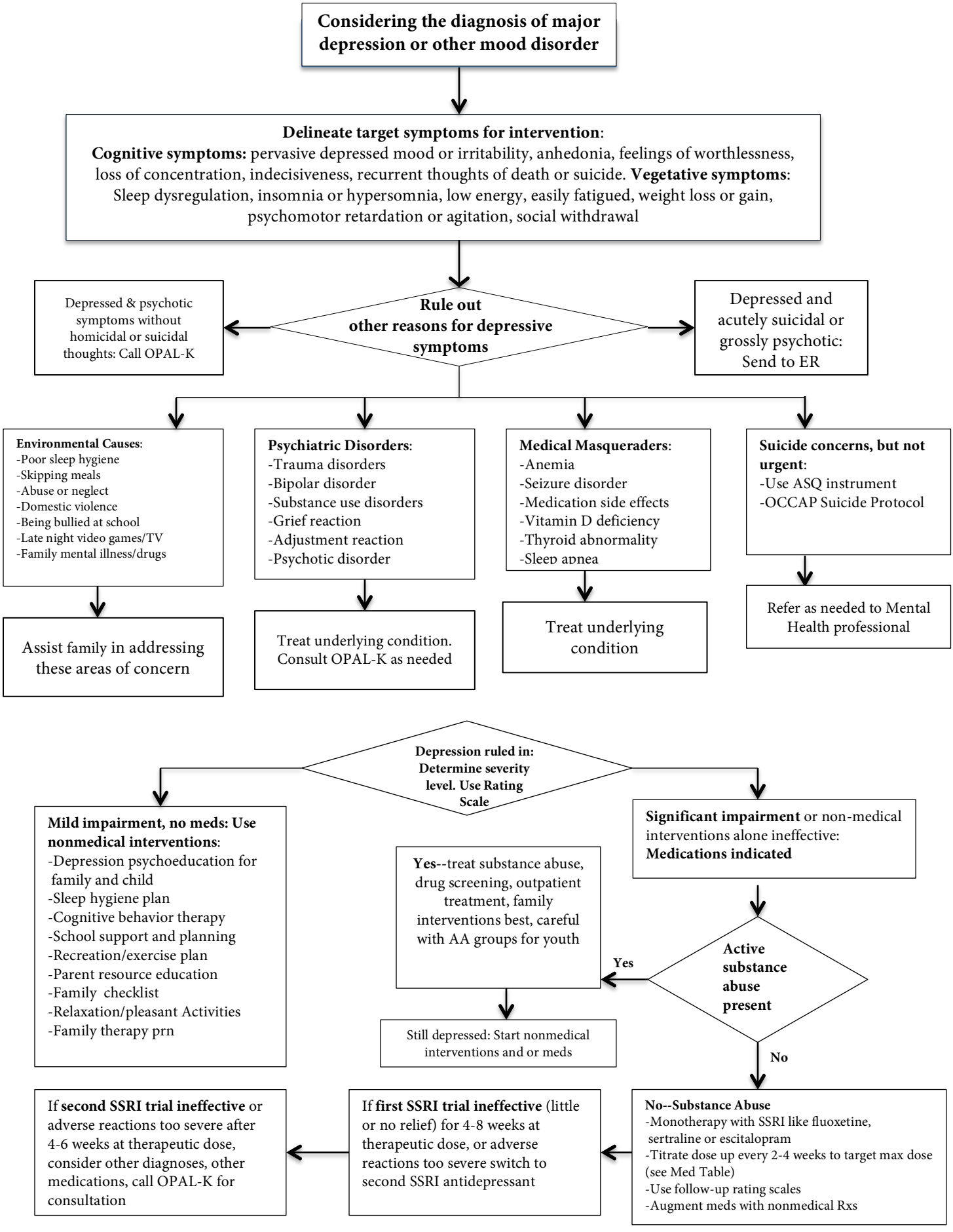
G1: OPAL-K Assessment & Treatment Flow Chart For Depression



G2: OPAL-K Assessment Guidelines For Depression

- The clinical interview remains the most accurate method for assessing the presence of depression.

- Physical examination, review of systems and laboratory testing are included to rule out possible medical etiologies including neurological, systemic and substance-induced disorders. Common medical conditions that produce symptoms similar to depression include anemia or disorders related to thyroid and hormone functioning.

- Evaluate the youth and family's history of previous treatment, including psychosocial and pharmacological intervention.

- A structured or semi-structured clinical interview involving both the youth and at least one parent facilitates proper diagnosis and case conceptualization, including making appropriate differential diagnoses, such as bipolar disorder, and identifying comorbid disorders such as an anxiety disorder.

- Ideally, the assessment should include time with the youth and parent together, as well as time with just the youth and just the parent(s) to ensure all parties have had sufficient opportunity to speak candidly about their concerns. With the youth alone, it is important to assess suicide risk, substance use, sexual behavior and other high-risk behaviors -- and also get online and social media activity.

- Gather information about the child's previous course of the depression including duration, prior episodes and age of onset.

- Assess key symptoms including suicidal ideation, psychotic symptoms and manic behaviors.

- Collect history of the youth's development, general medical history, family history of psychopathology and overall functioning across school, home and social domains.

- Assess significant stressors and traumas, including both episodic and ongoing stress. .

- Rating scales may be helpful for more information about the child or adolescent's symptoms, but should not be relied on to make a diagnosis.

- Both the parent and the youth should be asked about the presence of any suicide risk factors including the availability of guns, large quantities of medications or other potential methods of suicide.

- Assessment should also look for comorbid conditions such as anxiety disorders, substance abuse and disruptive disorders need should be.

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

G4: PHQ-A (continued)

Instructions to Clinicians

The Severity Measure for Depression—Child Age 11–17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a 9-item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11–17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score and should be interpreted using the table below:

Interpretation Table of Total Raw Score

Total Raw Score	Severity of depressive disorder or episode
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Note: If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)—Modified (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to Total Raw Score is:

$$\frac{(\text{Raw sum} \times 9)}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

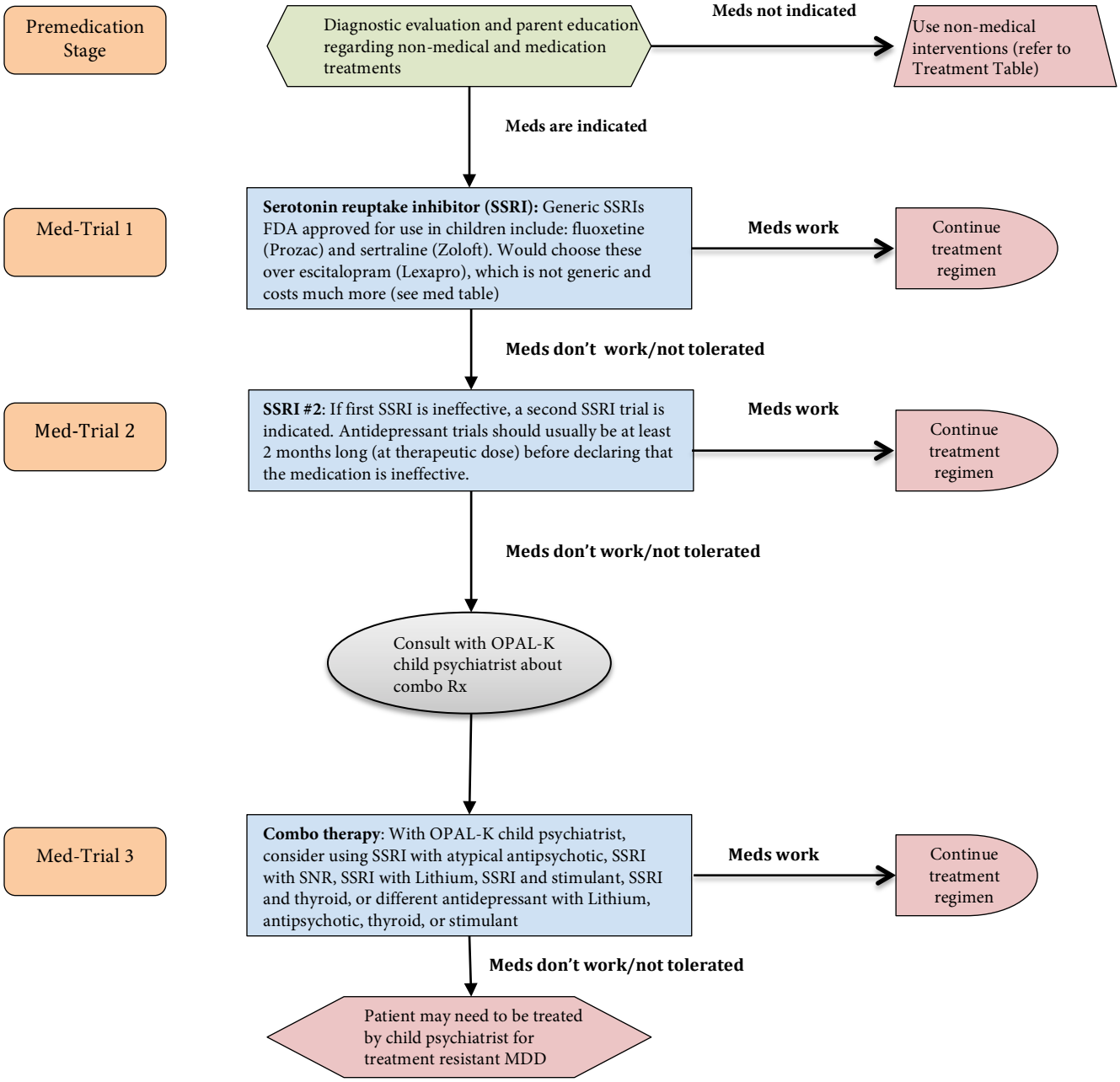
Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

G5: OPAL-K Treatment Guidelines For Depression

- Treatment of depression is generally most effective when multimodal.
- Treatment planning should be guided by the severity of disorder, comorbid psychiatric and medical conditions and the motivation of the youth and family. In developing a treatment plan, the clinician must also treat any comorbid conditions, especially addressing substance abuse that may be contributing to the depression and also increases the risk of suicide.
- Early intervention is important in order to limit the duration of a depressive episode and to potentially curtail recurrence of symptoms given its significant impact on youth academic, social and familial functioning.
- Mild depression is often effectively treated with evidence-based psychosocial interventions, including either cognitive behavioral therapy or interpersonal therapy.
- Psychotherapy is an important part of treatment for youth who have severe psychosocial stressors, poor medication compliance or refusal to take medications, suicidality or poor or limited response to pharmacotherapy alone.
- For moderate to severe depression, combined treatment involving both psychosocial and pharmacotherapeutic intervention is recommended. Consider higher levels of care when patient is suicidal or psychotic.
- Pharmacotherapy is an important treatment choice when there is a positive family history of a mood disorder, a family history for a good response to antidepressant medications, the presence of neuro-vegetative signs and symptoms, severe, chronic or recurrent depression and/or a poor or limited response to psychotherapy alone or limited resources.
- Providers should continually monitor the status and/or emergence of suicidality, manic and psychotic symptoms.
- Ongoing collaboration with the school should focus on education about depression, development of an appropriate Individualized Education Plan and assistance with behavioral management planning. Treatment begins with psychoeducation about depression as a disease, the nature of the treatment available, the prognosis and, ultimately, how depression has affected or can affect the life of the patient and the family.
- Medication is rarely, if ever, indicated as the sole treatment strategy in isolation of psychosocial interventions.
- In general, antidepressant improvement occurs in 4-6 weeks if it is going to work. After 4-8 weeks, consider dose change if no improvement. Most common reason antidepressants are ineffective is that the dose is too low.
- The FDA has given all antidepressants a Black Box Warning for possible increased risk for suicidal thinking and behavior. Use balancing test with wary families. (Subsequent studies show increased suicide rates with lower prescription rates.)
- All the antidepressants listed are rated Class C for pregnancy.
- All antidepressants can increase the risk of aggravating or inducing mania/hypomania.
- Given the lack of data on antidepressant medication use in preschool children, psychosocial interventions, including parent guidance and therapy, are the treatment of choice. Call OPAL-K.
- There is no evidence that "no-harm" contracts protect against suicide. See handout for protocol to decrease medical legal risk at http://www.aacap.org/AACAP/Regional_Organizations/OCCAP/Suicide_Prevention_Communication_Checklist.aspx.
- The treatment plan should address safety issues and provide a level of intensity to ensure the patient's safety.
- It is important to target not only depressive symptoms, but also associated problems in functioning that may persist after core symptoms are resolved.
- Family intervention is important to ameliorate difficulties in family functioning and to increase available psychosocial support

G6: OPAL-K Medication Treatment Algorithm For Depression



G7 - G11: OPAL-K Antidepressants Table: SSRIs & Other Antidepressants

(Medication information based on www.epocrates.com)

Drug/Category - **SSRIs**	Dosing/Half-life	FDA Approval	Comments/Monitoring	Warnings/Precautions	Cost for Monthly Supply
Fluoxetine (Prozac) Forms available: tablets, pulvules and liquid Selective serotonin reuptake inhibiter (SSRI)	Initial dosing:10-20 mg/day Maximum dosing: 30-60 mg/day Half-life: 48-72 hrs, active metabolites 2 weeks	Approved for treatment of depression in youth ages 8 years and older	·Weight gain unusual ·Sedation gain unusual ·Sexual dysfunction not unusual ·Higher rates of drug-drug interactions ·Rarely lethal in monotherapy overdose	· Increase birth defects if given during 3rd trimester · Higher rates of drug-drug interactions than other SSRIs	Generic 10 mg - $$ 20 mg - $$ 40 mg - $$$ Prozac 10 mg - $$ 20 mg - $$ 40 mg - $$$
Sertraline (Zoloft) Forms available: tablets and liquid (SSRI)	Initial dosing: 12.5-25 mg/day Maximum dosing: 200 mg/day Half-life: 22-36 hrs, active metabolites 62-104 hrs	Approved for treatment of OCD in youth ages 6 years and older	· Higher rates of diarrhea than other SSRIs. · Sexual dysfunction not uncommon · Rarely lethal in monotherapy overdose · Weight gain and sedation uncommon	Rare/mild dopamine reuptake blocking activity could contribute to agitation, anxiety and agitation early in dosing	Generic 25 mg - $$ 50 mg - $$ 100 mg - $$ Zoloft 25 mg- $$$$ 50 mg - $$$$ 100 mg - $$$$
Citalopram (Celexa) Forms available: tablets and liquid (SSRI)	Initial dosing10-20 mg/day Maximum dosing: 40 mg/day Half-life: 23-45 hrs	Not FDA approved for youth under age 18 years	· May have less sexual side effects than other SSRIs · Weight gain unusual · Sedation not uncommon	· Monitor for QT prolongation in doses over 40mg/day. · This dose is associated with prolonged QT interval	Generic 10 mg - $$ 20 mg - $$ 40 mg - $$ Celexa 10 mg - $$$$ 20 mg - $$$$ 40 mg - $$$$

Drug/Category – **SSRIs**	Dosing/Half-life	FDA Approval	Comments/Monitoring	Warnings/Precautions	Cost for Monthly Supply
Escitalopram (Lexapro) Forms available: tablets and liquid (SSRI)	Initial dosing: 5 – 10 mg/day Maximum dosing; 20 mg/day Half-life: 27-32 hrs	Approved for treatment of depression in youth 12 years and older	· May have faster onset than Citalopram because of higher potency. · May be better tolerated than Citalopram. · Fewer drug-drug interactions than other SSRIs		<u>Lexapro</u> 5 mg - $$$$ 10 mg - $$$$ 20 mg - $$$$
Fluvoxamine (Luvox) Forms available: tablets, liquid and continuous release (SSRI)	Initial dosing: 25 mg/day Maximum dosing: 200-300 mg/day Half-life: 9-28 hrs	Approved for treatment of OCD in youth ages 8 years and older	· Higher rate of side effects and drug-drug interactions · May also have a higher side effect profile than other SSRIs · Short half-life for regular release. Can be fairly sedating	Fluvoxamine has been reported to slow the metabolism of acetaminophen, caffeine, propranolol and theophylline.	<u>Generic</u> 50 mg - $$$ 100mg - $$$ <u>Luvox CR</u> 100 mg - $$$$ 150 mg - $$$$

Drug/Category – **Other Antidepressants**	Dosing	FDA Approval	Comments/Monitoring	Warning/Precautions	Cost for Monthly Supply
Venlafaxine (Effexor) Available forms: immediate release capsules and extended release tablets	No clear guidelines for dosing in children and adolescents. TORDIA study used initial dosing at 37.5 mg/day and increase to 150 mg/day in 4 weeks. Maximum dose used was 225mg/day. Average dose at end of titration 205 mg/day	Not FDA approved for youth under 18 years	·Primarily serotonergic in lower doses. In higher doses both serotonergic and noradrenergic ·Most side effects increase at higher does, but often go away with time ·Nausea and vomiting very common up to 25% of patients experience this adverse reaction ·Weight gain and sedation are uncommon ·Monitor BP especially in higher doses	Can be lethal in overdose. In higher doses is associated with hypertension and requires BP monitoring and; ECGs should be considered if the patient has any cardiac risk factors	<u>Generic</u> 25 mg - $$ 37.5 mg - $$ 50 mg - $$ 75 mg - $$ 100 mg - $$$ <u>Effexor</u> 37.5 mg - $$$ 75 mg - $$$

Venlafaxine (Effexor) - **Continued** Serotonin and norepinephrine reuptake inhibitor (SNRI)	Half-life: 3-7 hrs, active metabolites 9-13 hrs				<u>Generic Sustained Release</u> 37.5 mg - $$$$ 75 mg - $$$$ 150 mg - $$$$
Bupropion (Wellbutrin, Budeprion) Available forms: immediate release (IR) tablets sustained and extended release tablets Norepinephrine and dopamine reuptake inhibitor (NDRI)	No clear guidelines for dosing in children and adolescents. Half-life: 10-14 hrs, active metabolites 20-27 hrs Conners et al (1996) used the following dosing guidelines: 3 mg/kg to start and 6 mg/kg for maximum dose	Not FDA approved for youth under 18 years	·May have lowest risk of sexual side effects of antidepressants ·Indicated for smoking cessation in adults ·Some RCT studies show efficacy in treatment of ADHD in youth. ·Weight gain and sedation are uncommon side effects ·Most common side effect in children nausea and vomiting	Reported to increase risk of seizures (though rare 0.1%-0.4%) is more common in higher doses and bulimic patients. The combination of lithium and bupropion in case reports resulted in changes in lithium levels and three cases of seizures.	<u>Generic IR</u> 75 mg - $$ 100 mg - $$ <u>Generic SR</u> 100 mg - $$ 150 mg - $$$``

Bupropion (Wellbutrin, Budeprion) **(Continued)** Norepinephrine and dopamine reuptake inhibitor (NDRI)					<u>Wellbutrin SR</u> 100mg - $$$$ 150 mg - $$$$ <u>Generic XL</u> 150 mg - $$$$ 300 mg - $$$$ <u>Wellbutrin XL</u> 150 mg - $$$$ 300 mg - $$$$
Mirtazapine (Remeron) Available in tablets and disintegrating tablets Noradrenaline and specific serotonergic agent (NaSSA)	No clear guidelines for dosing in children and adolescents Initial suggested dosing: 15 mg/day Maximum suggested dosing: 30 mg/day Half-life: 10-12 hrs	Sedation common Weight gain common Not FDA approved for youth under 18 years	Sedation greater at lower doses, so 7.5 mg may be more sedating than 15 mg dose. Used in youth with insomnia Weight gain common side effect	May increase cholesterol Drug may lower white cell count in rare instances Can cause fatal serotonin syndrome if combined with MAOI Case reports of transient increases in liver enzymes	<u>Generic</u> 7.5 mg - $$$ 15 mg - $$ 30 mg - $$ <u>Remeron</u> 15 mg - $$$$ 30 mg - $$$$ 45 mg - $$$$

Doxepin (Silenor, Sinequan, Adapin) Available forms: capsules and liquid Tricyclic antidepressant (TCA)	Initial dosing: 25-50 mg/day Maximum dosing: 100 mg/day Half-life: 8-24 hrs	FDA approved for the treatment of depression in youth 12 years and older	Very antihistaminic so good for depression with insomnia Sedation and weight gain common	Lethal in OD Prolonged QT risk like other TCAs	<u>Generic</u> 10 mg - $$ (90 tabs) 25 mg - $$ (60 tabs) 50 mg - $$ (60 tabs) 75 mg - $$ 100 mg - $$ 150 mg - $$ 10 mg/cc - $$ (120 cc)

<u>For all antidepressants</u>:

In general, antidepressant improvement occurs in 2-4 weeks if they are going to work. After 8 weeks, consider dose change if no improvement.

The FDA has given all antidepressants a Black Box Warning for possible increase in risk for suicidal thinking and behavior.

All the antidepressants listed are rated Class C for pregnancy.

All antidepressants can increase the risk of aggravating or inducing mania/hypomania.

<u>Cost Code:</u>

$ -- $10 or less $$ -- $11 to $49 $$$ -- $50 to $99 $$$$ -- $100 to $499 $$$$$ -- $500 or more

G12: Depression Intervention Checklist for Families and their Depressed Child

Living with a child who has depression can be confusing, frustrating and at times scary. The following checklist can help families become more effective in managing the behavior issues associated with depressed children and adolescents.

Checklist for parents:

- ☐ All guns and weapons should be removed from the house or secured
- ☐ Other potentially harmful items such as ropes, cords, sharp knives, alcohol, prescription drugs, and poisons should be removed
- ☐ Eliminate any negative statements or scolding (try to stay positive)
- ☐ Help your child set up a written schedule for home and activities in the community
- ☐ Ask about suicide. Parents should ask regularly about thoughts of death or suicide. Providers should remind parents that making these inquires will not increase suicide risk
- ☐ Watch for signs of drinking or use of other drugs. Use of substances increase suicide risk
- ☐ Develop a suicide emergency plan. Parents and their depressed child should decide how to proceed if a child feels suicidal. Be specific with your plan and provide youth with accurate names, phone numbers and addresses for crisis resources

Checklist for siblings:

- ☐ Make sure you understand what clinical depression is and what to expect from your depressed sibling
- ☐ Don't feel responsible for your sibling's behavior
- ☐ Don't hesitate to communicate worries to your parents about your siblings depression or suicide risk
- ☐ Don't hesitate to ask your parents for attention when you need it
- ☐ Do be patient if they are unable to meet your needs immediately
- ☐ Have a plan of how to handle negative and apathetic behaviors from your depressed sibling

Checklist for schools:

- ☐ Check in with student about work load and adjust as needed (late arrival or early dismissal, decreased number of classes and assignment requirements)
- ☐ Be aware of multiple truancies or absences and communicate this to parents
- ☐ Report excessive irritability or social crises to parents
- ☐ Assist in evaluation for individualized education program (IEP) or 504 accommodations when indicated

Checklist for child:

- ☐ Stay physically active. This can help decrease depression
- ☐ Schedule pleasant activities
- ☐ Eat balanced meals. Keep away from caffeine and other foods that can result in sleep problems
- ☐ Make sure to tell your doctor if your medicine is bothering you
- ☐ Spend time with people who can support you
- ☐ Schedule time for relaxation and rest
- ☐ Tell your parents if your depression is becoming overwhelming

G13: Depression Resources For Patients, Families And Teachers

"The Use of Medication in Treating Childhood and Adolescent Depression: Information for Patients and Families." American Academy of Child and Adolescent Psychiatry (2010). This informative guide is not just about medications. It is also a good overview about what clinical depression looks like in youth in addition to providing easy to understand information about antidepressant medications.
http://www.parentsmedguide.org/parentsmedguide.pdf

"Raising a Moody Child: How to Cope With Depression and Bipolar Disorder" by Mary A. Fristad, Ph.D., Jill S. Goldberg, PhD. (2004). Written by a well-known researcher, this book provides a very clear overview of mood disorders—including bipolar disorder—and a helpful toolkit of coping strategies for parents and youth coping with mood difficulties.

"I Had a Black Dog" by Matthew Johnstone (2005). This is a short book that describes depression, and what helps, in cartoon format. It is an excellent introduction to depression for patients and families and should appeal to wide range of people.

"Journeys with the Black Dog: Inspirational Stories of Bringing Depression to Heel" edited by Tessa Wigney, Kerrie Eyers and Gordon Parker (2007). This book contains first-hand accounts from people who have suffered from depression.

Websites that provide information on depression, specifically for young people:

http://www.kidshealth.org/

http://www.thelowdown.co.nz/

http://www.sortoutstress.co.uk/

Websites that provide more general information on depression:

www.blackdoginstitute.org.au

http://www.helpguide.org/mental/depression_teen.htm

http://www.nasponline.org/publications/cq/cq354suicide.aspx

G14: Depression Resources for Clinicians

"Antidepressant Drug Therapy and Suicide in Severely Depressed Children and Adults: A Case Control Study" (2006) by Mark Olfson, M.D., M.P.H., Steven C. Marcus, Ph.D., David Shaffer, M.D.
http://archpsyc.jamanetwork.com/article.aspx?articleid=668199&resultClick=3

"Early Childhood Depression" (2009) by Joan L. Luby, M.D.
http://ajp.psychiatryonline.org/article.aspx?articleID=101100

GLAD-PC Toolkit (A detailed monograph on taking care of depressed youth that contains suicide screening instruments like the Columbia Depression Scale)
http://www.glad-pc.org

"Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management" (2007) by Rachel A. Zuckerbrot, M.D., Amy H. Cheung, M.D., Peter S. Jensen, M.D., Ruth E. K. Stern, M.D., Danielle Laraque, M.D. and the GLAD-PC Steering Group
http://pediatrics.aappublications.org/content/120/5/e1299.abstract

OCCAP Suicide Prevention in Youth and Young Adults: Communicating With Families Saves Lives (A protocol that helps families and clinicians provide care for suicidal youth.)
http://www.aacap.org/AACAP/Regional_Organizations/OCCAP/Suicide_Prevention_Communication_Checklist.aspx

"Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders" (2007) by Boris Birmaher, M.D., David Brent, M.D., principal authors et al.
http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/depressive_disorders_practice_parameter.pdf

"Treatment of Resistant Depression in Adolescents (TORDIA): Week 24 Outcomes (2010) by Graham J. Emslie, M.D., et al.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3257891/

"The Treatment for Adolescents With Depression Study (TADS): Long-term Effectiveness and Safety Outcomes (2007) by the TADS team
http://archpsyc.jamanetwork.com/article.aspx?articleid=210055

"Clinical Presentation and Course of Depression in Youth: Does Onset in Childhood Differ From Onset in Adolescence?" (2003) by Boris Birmaher, M.D., Douglas E. Williamson, Ph.D., Ronald E. Dahl, M.D., David A. Axelson, M.D., Joan Kaufman, Ph.D., Lorah D. Dorn, Ph.D., Neal D. Ryan, M.D.
http://adolescenthealthinstitute.com/download/15.%20Birmaher,%20Williamson,%20Dahl%20et%20al.,%202004%20-%20J%20Am%20Acad%20Child%20Adol%20Psychiatry.pdf

G15: Depression Resources for Professionals (continued)

"Irritable Mood as a Symptom of Depression in Youth: Prevalence, Developmental, and Clinical Correlates in the Great Smoky Mountains Study (2013) by Argyris Stringaris., M.D., Ph.D., M.R.C.Psych., Barbara Maugham, Ph.D., William S. Copeland, Ph.D., E. Jane Costello, Ph.D., Adrian Angold, M.R.C.Psych.
http://www.sciencedirect.com/science/article/pii/S0890856713003444

"Texas Medication Algorithm Project Procedural Manual (2008) by Brandon Suehs, Pharm.D.., Tami R. Argo, Pharm.D., M.S., BCPP, Sherrie D. Bendele, B.S., M. Lynn Crismon, PharmD, BCPP, Madhukar H. Trivedi, M.D., Benji Kurian, M.D., M.P.H.
http://www.cardinalinnovations.org/docs/TMAP%20Depression%202010.pdf

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