Collaborative Treatment of Depression in Adolescence

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There Are No Disclosures –
Case Presentation

- 19 yo Hispanic female here for WCC, first time I am meeting her
- Chart review: hx depression, suicide attempt 2015
Initial Impression

- Upon entering room she is obese, well groomed, organized and normal affect
- Type A personality - double major, has a job, goal to have graduate degree
- Stressors: school work and extracurriculars, commutes from home; pet passed away, Grandmother in Mexico with Alzheimer's (has not seen her in 7 years), friend recently admitted to a psych ward

Audience Participation/Discussion:
Depression History Taking “SIG-E-CAPS”

- Sleep changes: increase during day or decreased sleep at night
- Interest (loss): of interest in activities that used to interest them
- Guilt (worthless): depressed elderly tend to devalue themselves
- Energy (lack): common presenting symptom (fatigue)
- Cognition/Concentration: reduced cognition &/or difficulty concentrating
- Appetite (wt. loss); usually declined, occasionally increased
- Psychomotor Agitation (anxiety) or Retardations (lethargic)
- Suicide/death preoccupation
Signs and Symptoms of Depression

Major Depressive Disorder: DSM-5

- A. 5 (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- Note: do not include symptoms that are clearly attributable to another medical condition
- (1) Depressed mood most of the day, nearly every day
- (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
- (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
- (4) Insomnia or Hypersomnia nearly every day
- (5) Psychomotor agitation or retardation nearly every day
- (6) Fatigue or loss of energy nearly every day
- (7) Feelings of worthlessness, or guilt, or inappropriate guilt nearly every day
- (8) Diminished ability to think or concentrate, or indecisiveness, nearly every day
- (9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- 8. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- 9. The episode is not attributable to the physiological effects of a substance or another medical condition
- 10. There has never been a manic episode or a hypomanic episode
- 11. This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition. The symptoms are not better accounted for by Bereavement

CRAFFT 2.1 and Y-PSC
After the PSC, if you suspect depression, this will give you a lot more information:

- **Quick Inventory of Depressive Symptomatology** - 17 item questionnaire in AACAP Toolbox for Clinical Practice & Outcomes

- **PHQ-9 A** - adapted for adolescents - available in the public domain

### Self Care

- **Psych:**
  - Group and individual therapy at school
  - Mother has been against medications, but patient open to it

- **Physical:**
  - No exercise but started to buy soups/salads rather than burgers/fries
  - Sleep could improve
  - Taking VitD
Referral to PPC Hub

Pediatric Psychiatry Collaborative

Regional Hubs

- Atlantic Health Hub @ Newton Medical Center
- Atlantic Health Hub @ Goryeb Children's Hospital
- Hackensack Meridian Hub @ Hackensack University Medical Center
- Hackensack Meridian Hub @ Palisades Medical Center
- Hackensack Meridian Hub @ Saint Peter's Family Health Center
- Hackensack Meridian Hub @ Jersey Shore University Medical Center
- Cooper Hub @ Cooper University Medical Center
- Cooper Hub @ Pennsville

Essex County served by Rutgers University Behavioral Health Care. New Jersey Center on the Future of Child Health: https://www.njfuture.org/
Collaborative Hub Procedure

- Referring to the Hub: After required routine screening and/or based on clinical judgement following the exam, providers can fax the PPC Hub. Providers should send a complete referral form, screening tools, and any other clinically relevant information.

- What Does the Hub Staff Need? All of the information the PPC Hub staff needs is on the referral form, including relevant background information, current clinical picture, demographic information, and reason for referral. Some providers may choose to send notes from previous visits as well, which can be very helpful, but is not required.

- Communicating with the Family: Please be sure you have discussed the PPC Hub with the patient and family prior to faxing a referral to the PPC Hub, so that the family is aware that a Hub staff psychologist/LCSW/other mental health specialist will be contacting them to discuss current concerns and suggestions for support/treatment.

Collaborative PPC Hub Procedure

(Continued)

What will the PPC Hub Staff Do?

- PPC Hub staff will call the patient’s family and complete a clinical intake. The family will discuss their main concerns. Case managers will evaluate for severity and level of care. Depending on the patient’s needs, PPC Hub staff will:

  - Recommend an appropriate level of care (inpatient, PHP, IOP, or outpatient) - family is sent list of referrals for therapy services to address current MH concerns.
  - Match the patient with therapist based on insurance and geographic location - referrals are researched by staff psychologists/LCSWs, and most often accept patient insurance.

- “Closing” the Loop: PPC Hub staff will communicate with you, sending you notes on what occurred with the family. They will also encourage the family to call them back if they need another resource. PPC Hub staff will also follow-up with referred families 3 and 9 months after initial referral.
Initial Hub Intake

- PPC Hub staff received the referral and called the patient directly (19 years old)
- PPC Hub staff notes to pediatrician after intake:
  Patient discussed history of depression:
   - Last year her therapist suggested medication
   - Patient interested in second opinion by psychiatrist to see if medication warranted
   - She’s open to medication due to how hard it’s been to keep her depression at bay while engaging in therapy alone

Psychiatric Assessment

- Patient presents with symptoms of significant mood impairment. She reports feeling depressed over the last year with disturbances in sleep ranging from insomnia to hypersomnia. She reports overeating with weight gain. Her energy and concentration are low. She reports low self esteem. She reports associated spike in anxiety - always worrying about her family and having frequent headaches. She denies any associated self injurious behavior, mania, psychosis or suicidal thinking.

- She reports that she has experienced multiple psychosocial stresses including death of pet, friend’s mental illness and grandmother’s dementia as well as worries about immigration related issues.
Psychiatric Assessment (continued)

- She denies significant substance use
- She denies significant medical issues at this time
- Medications: OCPs
- Mental Status Exam significant for a depressed mood and affect and negative for suicidal ideations
- Assessment: Major Depressive Episode

Treatment

- Coordination with Dr. Shafi following my evaluation.
- Continue school group therapy and referred to individual therapist
- Lexapro 2.5 mg x 5 days, 5 mg x 1 week, 10 mg x 1 month
AACAP Toolbox for Clinical Practice & Outcomes:

1. Medication for Depression or Anxiety consent form; Lists common side effects of SSRIs and SNRIs

2. British Columbia Children’s Hospital Antidepressant Monitoring Form

Risk Factors for Adolescent Depression

- 2:1 female to male ratio after puberty
- Positive family history: if a parent has Major Depression teen is 3-4 times as likely as teen from unaffected parents. In particular the effect of maternal depression increases the risk. Role of paternal depression is less well understood.
- Early life Adversity
- Exposures to stressful events including maltreatment, bullying, poverty, physical illness and negative family relationships.
- Other psychiatric disorders in childhood including anxiety and disruptive behavior disorders
Epidemiology of Major Depression among Adolescents

Among U.S. adolescents in 2016:

- An estimated 3.1 million adolescents aged 12 to 17 in the United States had at least one major depressive episode. This number represented 12.8% of the U.S. population aged 12 to 17.
- The prevalence of major depressive episode was higher among adolescent females (19.4%) compared to males (6.4%).
- The prevalence of major depressive episode was highest among adolescents reporting two or more races (13.8%).

Importance of Adolescent Depression as a Public Health Issue

1. Prevalence
2. It confers profound morbidity
3. The national shortage of child and adolescent psychiatrists necessitates a more efficient and innovative model of care
Assessing Suicidality

- The most important thing is to take a good history. There is no evidence that asking patients about suicidal thoughts “puts these ideas in their heads.”
- Important considerations: age of child, level of maturity, overall presentation.
- One of the easiest ways to assess is using the Columbia-Suicide Severity Rating Scale. It is designed for use in a primary care setting. It assesses thoughts, intentions, plans and steps youth has taken to carry this out.

Patient Outcome

- Seen initially in primary care on 6/1
- Phone intake with PPC Hub on 6/15
- Saw Hub psychiatrist on 6/22; Prescribed medication after a few collaborative conversations
- Dr. Shafi checked in with patient on 7/2, 8/10, and 11/7 Decide to increase amount of medication
- Last spoke Nov 7th: patient doing well Feels more motivated at school, not procrastinating
- Still going to group therapy at school
- Started new weekly individual therapy with therapist recommendation from PPC Hub
- Dr. Shafi stays in touch with patient monthly
Questions?

Please contact:
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