Curbside Consult with a CAP: Depression

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Disclosures

None
LEARNING OBJECTIVES

- Explain what depression is and the various differentials
- Describe how depression may present differently in children and adolescents
- Understand how to approach depression treatment in children and adolescents
- Identify when consulting psychiatry is recommended
- Discuss when to seek emergency assessment and treatment for a patient
WHAT IS DEPRESSION?

- Major Depressive Disorder (MDD)
- Unspecified Depressive Disorder
- Adjustment Disorder
- Persistent Depressive Disorder (previously dysthymia)
- Bipolar disorder, Most Recent Episode Depression
- Substance/Medication/Medical Condition Induced Depressive Disorder
WHAT IS DEPRESSION?

- Major Depressive Disorder (MDD)
- Unspecified Depressive Disorder
- Adjustment Disorder
- Persistent Depressive Disorder (previously dysthymia)
- Bipolar disorder, Depressive Episode
- Substance/Medication/Medical Condition Induced Depressive Disorder
A. 5 or + for the same 2-week period (change from previous functioning). At least 1 includes depressed mood or loss of interest/pleasure:

- Depressed mood most of the day, nearly every day (in kids this can be irritable mood)
- Markedly diminished interest or pleasure in all/most activities most of the day/nearly every day
- Significant weight lost or weight gain or decrease/increase in appetite nearly every day (in kids, can be failure to make expected weight gain)
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive/inappropriate guilt nearly every day
- Diminished ability to think or concentrate, or indecisiveness, nearly every day
- Recurrent thoughts of death or suicidal ideation/attempts/plans
DSM 5 CRITERIA for MDD

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (in kids, likely school/friends/home)

C. The episode is not attributable to the physiological effects of a substance or to another medical condition

D. The occurrence is not better explained by another psychiatric disorder

E. There has never been a manic or hypomanic episode

*Can be in partial or full remission; specify recurrent, single episode AND mild, moderate, severe (+/- psychotic features)
Symptoms may differ depending on age and developmental level:

**Children**
- Anxiety
- Somatic complaints
- Irritability
- Temper tantrums
- Behavioral problems

**Adolescents**
- Irritable mood
- Sleep change
- Appetite disturbance
- Behavior disturbance
- Suicidal ideation/attempts
- School changes
- Somatic complaints

Compared to adults, younger patients may show more behavioral and fewer neurovegetative symptoms!
DIFFERENTIAL DIAGNOSIS

- Substance use or use disorders
- Other depressive disorders
- Medical illness
- Medication related effects
- Lab derangements
Generally:

- Substance related disorders
- Panic disorder
- Obsessive-compulsive disorder
- Eating disorders
- Borderline personality disorders

Specific to Youth:

- Persistent depressive disorder
- Anxiety disorders:
  - Separation → children
  - Social anxiety/general → adolescents
- Disruptive behavior → adolescents
- Substance use disorders → adolescents
Prevalence ranges from 2.1% to 8.1% in youth

According to the National Survey on Drug Use and Health (2017):

- 13.3% adolescents had at least one episode of MDD
- 20% adolescent females > 6.8% males
- ~70% of those with an episode had an episode with severe impairment
- 19.6% received care by a health professional alone
- 17.9% received care by a health professional and medication
- ~60.1% of adolescents with an episode did not receive treatment
STATISTICS FOR THE NJ AREA

- One MDD episode in past year: 11.95%
- Severe MDD episode: 8.1%
- Received some treatment for severe MDD episode: 32.5%
- Received no treatment for severe MDD episode: 55.7%
RISKS

- Neuroticism (highly genetic)
- Adverse childhood experiences (particularly multiple)
- Stressful life events
- First degree family member with MDD (2-4 x higher risk)
- Other psychiatric diagnoses (substance, anxiety, borderline personality disorder)
- Medical illness (including chronic)
Presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet full criteria for any of the disorders in the depressive disorders diagnostic class.

May include situations where a more specific diagnosis cannot be made.

Other specified depressive disorders: when do not meet time criteria, do not meet 5/7 symptom criteria.
A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset

B. These symptoms or behaviors are clinically significant with 1 or more of the following:
   1. Marked distress that is out of proportion to the severity or intensity of the stressor
   2. Significant impairment in social, occupational, or other important areas of functioning

C. The stress-related disturbance does not meet criteria for another mental disorder and is not an exacerbation of a pre-existing mental disorder

D. The symptoms are not normal bereavement

E. Once the stressor or consequences terminated, symptoms do not persist for more than an additional 6 months
<table>
<thead>
<tr>
<th>Differential Diagnosis</th>
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<tbody>
<tr>
<td>MDD</td>
</tr>
<tr>
<td>PTSD or Acute stress disorder</td>
</tr>
<tr>
<td>Personality disorder</td>
</tr>
<tr>
<td>Issues related to medical condition</td>
</tr>
<tr>
<td>Normative stress reaction</td>
</tr>
</tbody>
</table>
COMORBIDITIES

Any mental or medical disorder
In general, estimated to be 5-20% of patients in outpatient mental health treatment

Most common psychiatric diagnosis in the hospital consultation setting at ~50%
Life stressors are main risk

Adjustment disorders are associated with increased risk of suicide attempt/completion!
ASSESSING FOR DEPRESSION

Clinical interview and exam, collateral from parents, collateral from other providers/school/therapists

US Preventive Services Task Force recommends screening for depression in adolescents 12-18

SCALES for depression

American Academy of Pediatrics (AAP) recommends questions about risk factors for suicide including mood, sexual orientation, suicidal thoughts, and other risk factors during routine health visits
ASSESSING FOR SUICIDE & SAFETY!

Suicide is the 2nd leading cause of death between 14–18-year-olds

Majority of children/adolescents who attempt suicide have a mental health disorder

Suicidal thoughts in adolescence significantly increase risk of adult psychiatric problems and suicide

Prior suicidal behavior and depression increase risk for repeat behaviors and completion
## Suicide Risk Factors!

<table>
<thead>
<tr>
<th>Psychiatric history</th>
<th>Clinical factors</th>
<th>Environmental factors</th>
<th>Psychosocial factors</th>
<th>Personal factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Previous history of suicide attempts</td>
<td>• Impulsivity</td>
<td>• Violence exposure</td>
<td>• Bullying</td>
<td>• Sexual minority youth</td>
</tr>
<tr>
<td>• Family history of suicide attempts/suicide</td>
<td>• Aggressive or disruptive behavior</td>
<td>• Access to firearms</td>
<td>• Acute loss or rejection</td>
<td>• Adopted youth</td>
</tr>
<tr>
<td></td>
<td>• Non-suicidal self-injurious behaviors</td>
<td>• Living outside the home</td>
<td>• Argument with parent</td>
<td>• Internet use</td>
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<tr>
<td></td>
<td>• Feeling hopeless or helpless</td>
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<td>• Impaired parent/child</td>
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<td></td>
<td>• Intoxication</td>
<td></td>
<td>relationship</td>
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<td></td>
<td></td>
<td></td>
<td>• Social isolation</td>
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<td></td>
<td></td>
<td></td>
<td>• Struggling at school or not</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>attending</td>
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New Jersey Chapter

Hackensack Meridian Children's Health at K. Hovnanian Children's Hospital

American Academy of Pediatrics

INcorporated in New Jersey

Dedicated to the Health of All Children
TREATMENT - THERAPY

Initial treatment can be therapy for mild-moderate depression or adjustment reactions

- Cognitive Behavioral Therapy (CBT)
- Family therapy
- Interpersonal therapy
- Psychodynamic therapy
<table>
<thead>
<tr>
<th>TREATMENT – THERAPY?</th>
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</thead>
<tbody>
<tr>
<td>Younger age of onset</td>
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<tr>
<td>Other co-morbid disorders</td>
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<tr>
<td>Lack of support social/family support</td>
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<tr>
<td>Parental psychopathology</td>
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<tr>
<td>Stressful life events</td>
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<tr>
<td>Quality of treatment</td>
</tr>
<tr>
<td>Motivation/engagement in treatment</td>
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</table>
TREATMENT – MEDICATIONS?

- Typically indicated
  - Depression is severe
  - Inadequate response to adequate trial of therapy
  - Complicating factors
MEDICATIONS?

Current Presentation
- Interferes with functioning/safety
- Timeline
- Psychotic symptoms
- Manic symptoms

Past Psychiatric History
- Number of prior episodes
- Previous response to treatments
- Bipolar illness

Other Factors
- Psychosocial stressors
- Home environment
- Compliance
1st line are selective-serotonin reuptake inhibitors (SSRIs)

If no improvement, should increase at 4-weeks and re-assess at 6 weeks

If no improvement at 6 weeks, trial alternate SSRI

Once stability is achieved, continue for 6-12 months
TREATMENT – MEDICATIONS

- **Fluoxetine**
  - MDD: 8+
  - OCD: 7+
  - Bipolar depression: 10+ (fluoxetine/olanzapine)

- **Escitalopram**
  - MDD: 12+

- **Sertraline***
  - OCD: 6+
# TREATMENT – MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Initiation Dose</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sertraline</td>
<td>25mg-50mg (6-12/13+)</td>
<td>Varies; up to 200mg</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>10-20mg</td>
<td>Varies; 10-20mg for depression; up to 60mg for anxiety*</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>10mg</td>
<td>10-20mg</td>
</tr>
</tbody>
</table>
## SIDE EFFECTS?

<table>
<thead>
<tr>
<th>Common side effects</th>
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<tbody>
<tr>
<td>Nausea</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
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<tr>
<td>Sexual, sweating, fatigue, dry mouth, appetite loss</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric side effects</th>
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<tbody>
<tr>
<td>Mood changes</td>
<td></td>
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<tr>
<td>Activation</td>
<td></td>
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<tr>
<td>Hypomania</td>
<td></td>
</tr>
<tr>
<td>Mania</td>
<td></td>
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<tr>
<td>Suicidal thoughts (new onset or increased)</td>
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</tbody>
</table>
Side effects with SSRIs and polypharmacy/underlying medical conditions:

- QTc prolongation
- Abnormal bleeding
- Lower seizure threshold
- Serotonin syndrome
- Hyponatremia

Interactions

- Cytochrome P450
- Serotonergic Norepinephrine Reuptake Inhibitors (SNRIs)
- Tricyclic Antidepressants (TCAs)
- NSAIDS, Aspirin, Anticoagulants?
- St. John’s Wort and other herbals

Contraindications

- Monoamine oxidase inhibitors (MAOIs) → washout necessary!
- Pimozide, thioridazine (fluoxetine), disulfiram (liquid sertraline)
- Known hypersensitivity to active/inactive ingredients
Antidepressants increase risk of suicidal thinking and behavior in children and adolescents with MDD and other psychiatric disorders.

Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increased suicidality with clinical need.

Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.

Families and caregivers should be advised to closely observe the patient and to communicate with the prescriber.
All pediatric patients being treated with antidepressants for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases!
BLACK BOX WARNING – DATA

Increased rates of suicidal thinking or behaviors significantly higher in patients on antidepressants up to 25 years old

- FDA found 1.4% increase in <18 and 0.5% in 18-24
- Average risk was 4% (meds) vs 2% (placebo)
- Highest risk is 1-9 days after initiation
- No suicides occurred in trials
- Precursor behaviors identified but ? causal link
A study by Gibbons et al found that the year after the black box warning → 22% decrease in prescribing and 14% increase in suicide rates in U.S.

A review by Dudley et al (2010) identified that recent exposure to an SSRI was rare (1.6%) for young people who died by suicide.
MONITORING GUIDELINES

- Initiation
  - Weekly face to face visits for first 4 weeks
- Biweekly visits for next 4 weeks
- Continue with a monitoring visit 4 weeks later
- Monthly for 6-12 months after full resolution of symptoms
If episode is a recurrence, monitor for up to 2 years

After discontinuation, closely monitor for at least 2-3 months
<table>
<thead>
<tr>
<th>MONITORING GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss BLACK BOX WARNING!</td>
</tr>
<tr>
<td>Provide printed materials</td>
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<tr>
<td>Discuss risks/benefits of medications</td>
</tr>
<tr>
<td>Discuss whether approved for any pediatric indications, and if so, which ones</td>
</tr>
</tbody>
</table>
Best evidence for combination (if meds + therapy)

About 60% of adolescents with an initial episode respond to some form of treatment or remit clinically by 6 months

Education is important!
DISCONTINUATION

Abrupt discontinuation → worse symptoms
• Dysphoric, irritable, or labile mood
• Insomnia
• Agitation
• Dizziness
• Sensory disturbance (electric shocks)
• Anxiety
• Headache
• Lethargy

Abrupt discontinuation → relapse

TAPER over 1-2 weeks by increments

If significant discontinuation, restart at previously prescribed dose and/or more gradual taper!
GLAD-PC GUIDELINES

Literature is emerging about greater effectiveness of shared care models

Shared management of depressed adolescents with mental health professionals should be considered where possible

Guidelines for Adolescent Depression in Primary Care (GLAD-PC)
All youth 12+ → universal screen at annual visit

- Negative → repeat yearly
- Positive → assess with depression specific tool, interview child/obtain collateral from parent, assess for safety and suicide risk

- If psychotic/suicidal → refer to crisis or emergency services
- Otherwise, if + for depression → evaluate safety and establish safety plan, evaluate severity of depression symptoms, provide education, develop treatment plan based on severity
- If evaluation negative for MDD but high depression symptoms → follow depression guidelines or follow regularly with targeted screens
- If negative for depression but + for other mental health issues → treat other issue and re-assess for depression in future visits
GLAD-PC GUIDELINES

- For youth presenting for health maintenance visit at risk for depression
  - Low risk → screen at 12 years old
  - Higher risk → screen
    - Positive screen and/or suspected depression → do further assessment
    - Negative screen and/or clinician doesn’t suspect depression → repeat screening tools at regular intervals

Somatic complaints
- Previous episodes
- Family history
- Psychosocial stressors
- Substance use
- Trauma
MILD depression
- Monitor q 1-2 weeks for 6-8 weeks with active support
- If improved, monitor for 6-24 months
- If not improved, address like moderate depression

SEVERE depression or comorbidities
- Should consider consultation with mental health to develop treatment plan
- Can treat in primary care or refer out to mental health if appropriate
GLAD-PC GUIDELINES

MODERATE depression:
- Recommend treatment
- Crisis if necessary
- Consult with child & adolescent psychiatry*
- Services to family
- Refer to mental health OR manage in primary care
If improved after 6-8 weeks

- Continue medication for 1 year after full resolution
- Continue to monitor with regular follow-up x 6-24months
- Coordinate with mental health if involved

GLAD-PC GUIDELINES
WHEN TO INVOLVE PSYCHIATRY?

- Clinical presentation of the patient
- Complicating factors—suicidality, psychosis, psychiatry history, family history, medical problems, substance use, other co-morbidities
- Availability of a child & adolescent psychiatrist
- Moderate to severe depression
- Significant psychosocial stressors
- When 6-8 weeks of treatment has yet to show meaningful improvement
- Lack of diagnostic clarification
WHEN TO CHANGE LEVEL OF CARE?

- Threat to the safety of the patient/others
- Significant changes with no obvious trigger
- Caregiver cannot maintain safety
- Affect day to day functioning or medical treatment
REFERENCES


REFERENCES


14. AACAP. AACAP Recommendations for Pediatricians, Family Practitioners, Psychiatrists, and Non-mental Health Practitioners. AACAP.org. (2017). https://www.aacap.org/AACAP/Member_Resources/Practice_Information/When_to SEEK Referral_or Consultation_with_aCAP.asp

15. Label for PROZAC (fluoxetine) (fda.gov)

16. ZOLOFT (sertraline hydrochloride) Label (fda.gov)

17. Lexapro (escitalopram oxalate) (fda.gov)


New Jersey 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 @ Middlesex and Mercer
- 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.

More information on the Essex Hub can be found here: https://ubhc.rutgers.edu/clinical/community/collaborative-behavioral-health-care-project-essex-hub/collaborative-behavioral-health-care-project-essex-hub.xml
NJPPC Hub Benefits

▪ A child and adolescent psychiatrist available for consultative support through the Child Psych. consult line

▪ A psychologist/social worker available to:
  ▪ Assist the pediatrician with diagnostic clarification and medication consultation,
  ▪ Speak with a referred child’s family regarding the child’s mental health concerns and to assist in providing diagnostic clarification.

▪ One-time evaluation by a child and adolescent psychiatrist (CAP) at no charge to the patient when appropriate.
  ▪ Based on the recommendation of the CAP, the PPC Hub staff will work with the family to develop the treatment and care coordination plan.

▪ Continuous education opportunities in care management and treatment in the primary care office for the common child mental health issues: ADHD, depression, anxiety, etc.
NJPPC Hub Telepsychiatry Services

Implementation rolling out as an expansion of the NJPPC

- Three platforms to be utilized
  - Face to face
  - Telepyesch from home
  - Telepyesch from pediatric offices

- Notify your Regional Hub if interested
Thank you!

For more Information or to Register for the NJPPC

Visit:
https://njaap.org/programs/mental-health/ppc

Contact:
NJAAP
Mental Health Collaborative
609-842-0014
mhc@njaap.org