Collaborative Care and the Treatment of Pediatric Depression

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Key points for today:

- Examine the prevalence and impact of depression and the role that Primary Care will increasingly play (for adults and kids)
- Explore the evidence base for a Collaborative Care Model for depression treatment in Primary Care
- Consider the impact of race and ethnicity on diagnosis and treatment of depression in Primary Care, and ways to address it
- Understand the benefits of a team-based approach in treating depression in the PC setting
- Learn ways to identify pediatric patients who are candidates for antidepressant treatment in Primary Care
- Review the treatment of pediatric depression, including safe psychopharmacological management in Primary Care
A 13yo AA girl with mild cognitive delay is complaining of feeling very sad for past month or two, not interested in school anymore, crying more often, and wanting to withdraw from activities. She is usually talkative but is quieter and less engaged today. She says that she doesn’t have much hope that things will get better. She remains socially active, but her friends are “also depressed and they talk together about suicide.” She says she doesn’t have any plans to do that. She denies worrying much, and says that she isn’t being bullied at school. She has an IEP and is getting weekly therapy at school and feels ok about her classes, but her grades are slipping.
You have been treating her and her mother for many years. She has been prone to feeling sad at different times, but you feel that her symptoms now are a notable change from baseline, and her mother agrees. Her mother has been very consistent with appointments and has engaged in parenting groups and other opportunities through the clinic in the past. Her mother also has a history of depression and is being treated with citalopram 30mg qd with moderate benefit, although some symptoms remain.

What do you do?
Depression Prevalence (CDC)

• During 2013–2016, **8.1%** of American adults aged 20 and over had depression in a given 2-week period (CDC)

• Overall, **15.8%** of adults from families living below the federal poverty level (FPL) had depression. The prevalence of depression decreased to **3.5%** among adults at or above 400% of the FPL

• Among **children living below 100% of the federal poverty level**, more than **1 in 5 (22%)** had a mental, behavioral, or developmental disorder
Financial Impact

• Depression increases the cost of health care up to 100%, particularly for patients with multiple chronic illnesses

• Behavioral health disorders account for half of all disability days

• Depression is ranked as one of the top five conditions driving overall health care costs (work related productivity + medical + pharmacy cost)
Ethnicity and Race in Depression Treatment

“Ethnicity and race, even after adjustment for social class-related variables, such as poverty, insurance coverage, and education, still had an independent effect on access to depression treatment…”

“Current approaches that rely on providers to detect depression to facilitate its care may have limited effectiveness,…”

**Question**: Will Universal Depression Screening help with this?

Depression Treatment in Primary Care

• 80% of people with a behavioral health disorder will visit a Primary Care provider at least once a year

• 50-60% of all behavioral health disorders are treated in Primary Care

• PCPs cited shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage as critical barriers to mental healthcare access
Evidence Base for Treating Depression in Primary Care (IMPACT model, Univ of WA)

- Universal Screening for Depression (eg BHVS)
- Care teams and roles (PCP, “BHC”, psychiatrist)
- Stepped care for depression
- Use data to drive changes in treatment (PHQ-9)
- Registry used to track all pts who screen positive
- Financial incentives for this model
Evidence base for Collaborative Care

Meta-analysis of 69 RCTs (2000-2009) showed robust evidence for...

...improving depression symptoms
...adherence to treatment
...response to treatment
...remission of symptoms
...recovery from symptoms
...quality of life/functional status
...satisfaction with care for patients diagnosed with depression

Evidence Base: *Compliance is key*

- 37 randomized studies including 12,355 patients with depression receiving primary care: “When exploring determinants of effectiveness, *effect size was directly related to medication compliance*…” in addition to other factors

Evidence for **Team-based Approach**

Preliminary data from Lisa Ochoa-Frongia, MD, Assistant Professor of Medicine, UCSF, and Interim Co-Medical Director, Richard Fine People’s Clinic:

- Depression Remission Pilot treatment arm includes *f/u phone call to pt one week after antidepressant prescription written*...

- 50-60% of pts had not filled their prescription at one week (N=15)

- PHQ-9 scores and remission rates improved in treatment group
Diabetes, Hypertension, Depression

• For major chronic diseases, Primary Care has long history of stressing compliance in diabetes and HTN management, with good results

• In context of depression prevalence, morbidity, and cost, consider the eventual goal of addressing depression med compliance with equal f/u to get better results (measurable by PHQ-9, or PHQ-9A for adolescents)

• When it comes to healing, a phone call can do a lot.
"You can't begin to imagine how embarrassing it is to be seen with you."
Pediatric Depression

• 3.2% of children aged 3-17 years are diagnosed with depression, and many have co-morbidities (commonly ADHD +/- anxiety). Risk increases with age.

• Among children aged 2-8 years, boys were more likely than girls to have a mental, behavioral, or developmental disorder

• Age and poverty level affected the likelihood of children receiving treatment for anxiety, depression, or behavior problems
Depression, Anxiety, Behavior Disorders, by Age

Depressive symptoms in kids

• Irritability or anger
• Continuous feelings of sadness and hopelessness
• Social withdrawal
• Increased sensitivity to rejection, “being misunderstood”, sulking
• Changes in appetite -- either increased or decreased
• Changes in sleep-- sleeplessness or excessive sleep
• Vocal outbursts or crying

• Difficulty concentrating
• Fatigue and low energy
• Physical complaints (such as stomachaches, headaches) that don't respond to treatment
• Reduced ability to function during events and activities at home or with friends, in school, extracurricular activities, and in other hobbies or interests
• Feelings of worthlessness or guilt
• SI
The “ideal” pediatric patient for antidepressant treatment in Primary Care

- Known to PCP and treatment team members
- Medical causes ruled out (TSH, B12?, fatigue: anemia?)
- Invested and reliable in following recommendations and med regimen
- Able to verbally articulate feelings
- Depression is moderate to severe after not improving with weekly therapy for >6 weeks
- Adequate psychosocial supports to help monitor response
- Not endorsing active suicidal ideation with plan and no h/o serious self-injurious Bx
- Family h/o depression responsive to medication (which one?)
- No definite family history of bipolar disorder
- Substances being used? Consider case-by-case.
Cultural and Racial Considerations

• B/AA pts may have suspicion of MDs in light of Medicine’s history in treatment of B/AA people. Establishing trust requires nurturing the relationship, *patience*, and honesty. It is sometimes helpful to acknowledge that it may be frightening or difficult to trust an MD, but that you sincerely believe medication may be a helpful option.

• Asian pts may find it more difficult to admit their concerns and to give negative feedback because of wanting to “tell you what you want to hear”. Emphasizing the importance of understanding whether a med is helpful is important. Also, there may be concomitant use of “herbal medicines”. It’s a good idea to emphasize that that is fine, but that you need to be aware of this to safely avoid interactions.

• Nonjudgmental listening, humility, and curiosity go a long way.
What to do?

• **Collaborate.** It’s important that we use a team-based approach to treatment and that therapy is co-occurring. **Involve the BHC.** Child psychiatry is highly subjective so collaboration is *always* key.

• **Confirm** the diagnosis of depression after ruling out medical causes, interviewing the pt, caregiver(s), and, ideally, teacher or school counselor. **PHQ-9-A can be used in adolescents.**

• **Consider** severity and length of depressive episode. Recent stressors (social media, bullying, school performance), impact on pt *functioning*, risks/benefits of antidepressant treatment

• **Caution** in pts with suicidal ideation, especially with history of impulsivity and/or self injury

• **Convey** risks/benefits to pt and/or caregiver, including monitoring closely for SI, *and document this discussion*
What to do, cont...

• **Conservative** dosing. Reassure family that you want to use the lowest dose possible that will still be helpful.

• **Contact** pt/family weekly to assess response to medication. *BHC can also do this.* If pt is stable one month after last med change, may decrease frequency to qmonth.

• **Check** for SE, including suicidal thinking or behavior, nervousness, agitation, irritability, mood instability, or sleeplessness. Document clinical status, including no SI (done by either PCP or BHC).

• **Change** doses slowly, every 1-2 weeks, as tolerated and indicated

• **Continue** at therapeutic dose for at least six months.

• **Consult** psychiatry anytime!!!
I CAN'T DO THIS
I CAN'T DO THIS
I CAN'T DO THIS
I CAN'T DO THIS
I CAN'T DO THIS
I CAN'T DO THIS
I CAN'T DO THIS

(BUT I'M DOING IT ANYWAY.)
Depression Treatment Guideline--PHQ-9(A)

- **PHQ-9(A)<5**: Reassess prn, at least once a year
- **PHQ-9(A) 5-8**: Supportive care and psycho-ed re: depression
- **PHQ-9(A)=9**: Consider referral to BHC
- **PHQ-9(A) 10-14**: Collaborate with BHC for mgmt
- **PHQ-9(A) 15-20**: Therapy w/BHC, medication, or both
- **PHQ-9(A) 20-27**: Medication likely indicated, collaborate w/BHC and consult psychiatry as needed
Questions to anticipate

Q: *Is it addictive?* “Not in the way you think about some drugs or alcohol, where you have a craving and want to keep taking more, but you do need to go down on them slowly if you decide you want to stop to avoid your mood getting worse or otherwise feeling bad. The symptoms sometimes return for some people when they stop taking it. That’s not always the case, but it can happen.”

Q: *What are the side effects?* “Most people don’t notice many side effects, but sometimes kids have dry mouth, a stomach ache, or a headache. I recommend drinking more water each day, which will probably help with these if they happen.”
The **BLACK BOX WARNING**...

- **2004**: warning added after review of clinical trials suggested possibility of increased “suicidality” (not well-defined from trial to trial--ranged from passing thoughts to self-injurious behavior)
- Revised to include 18-25 year-olds
- **2007**: “results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that *the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders*” (NIMH)
- **Current**: Controversy persists. “Fluoxetine can be helpful in treating childhood depression, and can lead to significant improvement of depression overall. However, it may increase the risk for suicidal behaviors *in a small subset of adolescents*.” (NIMH)
Sample psycho-ed script for parents/kids

“In some cases, this medication can be really helpful in improving your (child’s) mood, where you feel less sad, and have fewer negative thoughts or constant worries. You may feel better about school and sometimes be less bothered by things that you normally wouldn’t consider to be a big deal. The medicine doesn’t always work, but it can sometimes make a big difference. It is really important that you take it every day.

I do want to let you know that in a small number of patients, this medication can make a you feel more irritable, have trouble sleeping, and even, for some kids, especially those who have had thoughts of hurting or killing themselves before, it can make those thoughts worse. If I thought that would happen here, I wouldn’t be prescribing this medicine. But if you’re having any thoughts about hurting yourself, it’s important that you let me or your [caregiver] know so that we can make sure that you’re safe, ok? To be really careful, I [or someone I work with] will check in with you more often after you start the medication or when we make any changes, ok?”

[Document conversation, including acknowledgement of risk of SI]
Antidepressant Use with Peds Pts

• The rule is “Start low, go slow”. Avoid SE!

• FDA approved: fluoxetine (8+) and escitalopram (12+)

• Commonly used in adolescents: sertraline (OCD), bupropion (smoker/vaper, low energy, ADHD sx, low anxiety), citalopram (no Peds-approved use but well-tolerated and easy to titrate). BEST TO INFORM AND DOCUMENT THAT NOT FDA-APPROVED AND USING OFF-LABEL.

• Avoid paroxetine and venlafaxine (no evidence of benefit and possibly increases SI)
Standard of Care for kids and antidepressants

• check in **WEEKLY** with the child/family for **four weeks after any dosage change**—may be done by phone and doesn’t need to be the prescriber
Antidepressant Treatment for Peds Patients

***CONSULT PSYCHIATRIST ANYTIME***

**STEP 1**
- Start and titrate*
- Fluoxetine (8+)
- or
- Escitalopram (12+)

**STEP 2**
- Step 1 med substitution
- OR
- Consider Specialty MH

**STEP 3**
- If step 2 med substitution ineffective, refer to Specialty

*Titrate*
**Titration schedules**

**Fluoxetine**

Start 5-10 mg qd (generally qam unless sedating)

May increase 5 mg q 5-7 days as tolerated

Max dose 30mg/day (child)
Max dose 40mg/day (adol)

**Escitalopram (age 12+)**

Start 2.5-5 mg qd

Increase by 2.5-5 mg q week as tolerated

Max 20mg/day
Discontinuation Syndrome (adolescent+adult)

• Advise pts about not stopping med suddenly to avoid discontinuation syndrome (flu-like symptoms, insomnia, nausea, imbalance, sensory disturbances, and hyperarousal)

• **fluoxetine**<**escitalopram**

• Taper fluoxetine by 5mg q 1-2 weeks, as tolerated
• Taper escitalopram by 2.5-5 mg q 1-2 weeks, as tolerated.
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What do you do?
Case study, cont.

- Any medical reasons? *No*
- Therapy co-occurring? *Yes*
- Contact with therapist made for collateral information (BHC)? *Not yet*
- Pt/ family well-known to provider? *Yes*
- Decline in functioning—grades, social engagement, family relationships? *Yes*
- Family history of depression? *Yes*
- Did medication work well for family member? *Yes, mostly*
- History of self-harm? *No*
- Current SI with plan? *No*
- PHQ-9(A)= 21

*What are the next steps?*
Case study, cont.

What to do?

1. Talk with the therapist. The BHC may do this. Collaborate with BHC as much as possible.
2. If therapy is happening regularly for 6-8 weeks or more, has it helped? Is the picture you’re hearing from pt, parent, and therapist consistent?
3. Talk with the parent and kid about possible benefit from antidepressant treatment. If they want to try medication, go by titration schedule and follow standard of care (weekly check-ins).
4. Consult with child psychiatrist for ANY questions ANY time.
Questions?