Depression—Management

Cincinnati Children's
changing the outcome together

FAST FACT

teens with high scores

on depression screening tools, but no diagnosis of depression, may meet criteria within 6 months. Monitor frequently.

STEPPED CARE APPROACH TO TREATMENT PLAN

All Severity
- PCP brief office interventions (promote brain health, self-care, depression education)
- Start at appropriate level for your patient's PHQ9 score. Actively monitor. If no improvement, step up care to next level (regardless of score).

Mild (PHQ9 5-9)
- Active monitoring

Moderate (PHQ9 10-14)
- Psychotherapy; consider medication

Mod-Severe (PHQ9 15-19)
- Psychotherapy AND
- Recommend medication

Severe (PHQ9 >20)
- Begin medication AND psychotherapy
- Recommend consultation as needed OR
- Refer to psychiatry for medication management

For urgent questions, call 24/7 Cincinnati Children's PIRC 513-636-4124.

Rapid access to evidence-based interventions decreases morbidity associated with depression AND decreases a child's risk of depression recurrence into early adulthood. Patients with acute depression symptoms should be seen at least monthly by their primary care provider even after referral to therapist.

MANAGEMENT/TREATMENT

Evidence-Based Primary Care Interventions

Active monitoring—Review treatment plan elements every 1–2 weeks (phone ok); follow-up appointment monthly (office/telemedicine)

Psychotherapy—Cognitive behavioral therapy (CBT), or interpersonal therapy for adolescents (IPTa)
- CBT teaches skills and shows how thoughts, feelings, behavior and body signals relate. Also teaches how to stop depression/anxiety-causing unhelpful patterns.
- IPTa—Helps reframe when major life event is causing significant change (such as parent divorce, injured athlete)

Medication—SSRIs
- First line—Fluoxetine (8+ yo)
- Second line—Escitalopram (12+ yo)
- Good evidence, but not FDA-approved for major depressive disorder—Sertraline

Medical Monitoring

Monitor:
All patients with active depression symptoms (PHQ9>10) need at minimum monthly visits with PCP for medical monitoring and plan adjustments, unless care has been transferred to psychiatrist/psychiatric APRN who will make medical decisions.

- Assess response to current interventions—target symptoms, functioning, adherence
- Reassess PHQ9 score
- If not improving (PHQ9 score worse, same, or decreasing (less than 5 points), assess problem first:
  - Enhance current plan, remove obstacles, or adjust meds
  - Step up care to augment treatment plan

WHEN TO REFER

Psychiatric resources or rapid safety management support—Call PIRC 513-636-4124

Direct psychiatric physician consultation—Call Priority Link 24/7 (same day response) 513-636-7997 or 888-636-7997, or use EPIC-Link messaging (response up to 72 hrs)

Acute crisis support (URGENT psychiatry safety evaluation needed)—Call current treatment team, **OR** call PIRC to coordinate rapid evaluation.

Medical Emergency or concern for ingestion/mental status change—Send to nearest Emergency Room

Use Cincinnati Children's specialist referral form or Epic order to refer for specialty care. Therapy for depression, refer to psychiatry/psychology and maintain medical monitoring.

Diagnostic evaluation/medical management, refer to psychiatrist/psychiatric APN.

If you would like additional copies of this tool, or would like more information, please contact the Physician Outreach and Engagement team at Cincinnati Children's.

Tool developed by Cincinnati Children's physician-hospital organization (known as Tri-State Children's Health Services, Inc.) and staff in the James M. Anderson Center for Health Systems Excellence. Developed using expert consensus and informed by Best Evidence Statements, Care Practice Guidelines, and other evidence-based documents as available. For Evidence-Based Care Guidelines and references, see www.cincinnatichildrens.org/evidence.

Depression—Management

Inclusion Criteria

Patients with diagnosed Major Depressive Disorder

Patient Presents

Severity Guides Initial Recommendations

All Severity
- PCP brief office interventions (promote brain health, self-care, depression education)
- Start at appropriate level for your patient's PHQ9 score. Actively monitor. If no improvement, step up care to next level (regardless of score).

Mild (PHQ9 5-9)
- Active monitoring

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- Psychotherapy; consider medication

Mod-Severe (PHQ9 15-19)
- Psychotherapy AND
- Recommend medication

Severe (PHQ9 >20)
- Begin medication AND psychotherapy
- Recommend consultation as needed OR
- Refer to psychiatry for medication

Active Monitoring

- Review treatment plan every 1–2 weeks
- Follow-up appointment monthly (office/telemedicine)

Psychotherapy

- Cognitive behavioral therapy

OR

- Interpersonal therapy for adolescents

Medication

SSRI
- First line—Fluoxetine (8+ years old)
- Second line—Escitalopram (12+ years old)
- Consider Sertraline

Medical Monitoring

All patients PHQ9>10 (prior to treatment)
- Monitor at least MONTHLY (by either PCP or psychiatrist/psychiatric APRN for medical management (not a therapist alone)
- Reassess PHQ9 score
  - Assess response to current interventions
    - Target symptoms and new concerns
    - Functioning
    - Adherence
- If not improving (PHQ9 score worse, same, or decreasing (less than 5 points)
  - Active monitoring, THEN
  - Psychotherapy, THEN
  - Medication, THEN
  - Consult/refer to psychiatry

Referral

Acute crisis support or rapid safety management support—call current treatment team OR PIRC to coordination rapid evaluation

Medical emergency or concern for ingestion/mental status change—nearest emergency department

Psychiatric consultation—Physican Priority Link (same-day response) or EPIClink (within 72 hours)

FDA Approved	Medication	Starting and monthly titration dosing (ages in yrs)	Therapeutic dose range	Notes
First Line for MDD Ages 8+ [OCD ages 7+]	FLUOXETINE (Prozac) liq, tab, cap	2.5–5 mg (8-10) 5–10 mg (>10)	20 mg <12yo 40 mg >12 yo	No withdrawal 2D6, 2C19 interactions may be strong w/other medications
Second Line for MDD, Ages 12+	ESCITALOPRAM (Lexapro) liq, tab [MDD ages 12+]	2.5–5 mg + 5–10 mg	20 mg	Abrupt Discontinuation "flu-like" syndrome
Not Approved for MDD (Good evid) [OCD ages 6+]	SERTRALINE (Zoloft) Liq, tab	12.5–25 mg (<12) 25–50 mg (>12)	75–200 mg	Abrupt Discontinuation "flu-like" syndrome

NOT RECOMMENDED IN YOUTH = Desvenlafaxine (Pristique), Paroxetine (Paxil)
NOT RECOMMENDED for PCP to initiate without psychiatric consultation = mirtazapine (Remeron), bupropion (Wellbutrin).
- Venlafaxine (Effexor) has highest association with suicidal thinking—triggered Boxed Warning for Suicidality of all antidepressants.

For urgent issues, or to speak with the specialist on call 24/7, call the Physician Priority Link® at 1-888-987-7997.