Depression—Management

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.

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**FAST FACT**

**Teens with high scores**

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

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**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

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For urgent questions, call 24/7 Cincinnati Children’s PIRC 513-636-4124.
Depression—Management

Inclusion Criteria
Patients with diagnosed Major Depressive Disorder

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

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

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

Psychotherapy
- Cognitive behavioral therapy
- Interpersonal therapy for adolescents

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
  - Medication, THEN
  - Consult/refer to psychiatry

FDA Approved

<table>
<thead>
<tr>
<th>Medication</th>
<th>Starting and monthly titration dosing (ages in yrs)</th>
<th>Therapeutic dose range</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLUOXETINE (Prozac) liq, tab, cap</td>
<td>2.5–5 mg (8-10) 5–10 mg (&gt;10)</td>
<td>20 mg &lt;12yo 40 mg &gt;12 yo</td>
<td>No withdrawal 2D6, 2C19 interactions may be strong w/other medications</td>
</tr>
<tr>
<td>ESCITALOPRAM (Lexapro) liq, tab [MDD ages 12+]</td>
<td>2.5–5 mg + 5–10 mg</td>
<td>20 mg</td>
<td>Abrupt Discontinuation &quot;flu-like&quot; syndrome</td>
</tr>
<tr>
<td>SERTRALINE (Zoloft) Liq, tab</td>
<td>12.5–25 mg (&lt;12) 25–50 mg (&gt;12)</td>
<td>75–200 mg</td>
<td>Abrupt Discontinuation &quot;flu-like&quot; syndrome</td>
</tr>
</tbody>
</table>

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—Physician Priority Link (same-day response) or EPIClink (within 72 hours)

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.