Welcome to UVM/AHEC ECHO: Children’s Mental Health

Date: 4/15/21

Facilitators:
Michael Hoffnung, DO
David Rettew, MD
Kathy Mariani, MD, MPH

Presenter: Sara Pawlowski, MD
• RECORDING OF SESSION TO BEGIN
Treatment-Resistant Depression in Children
Presenter: Sara Pawlowski, MD
Psychiatrist, Primary Care Mental Health Integration Program (PCMHI)
Agenda

• Introductions
• Objectives
• Didactic Presentation (15-20 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1.0 AMA PRA Category 1 Credits. Participants should claim only the credit commensurate with the extent of their participation in the activity.

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Series Objectives

• By the end of this series, the learners should be able to:

  • Feel more comfort and confidence in **identifying, treating, and referring** a variety of complex children's mental health presentations.
Session Objectives

• By the end of this activity, the learners should be able to:

• Understand the definition of treatment-resistant depression

• Understand the algorithm for treatment including medication and non-medication interventions for treatment-resistant depression

• Appreciate the limitations in medications and opportunities to think about non-medication interventions in children and families
Depression: General Definition

• “Spectrum Disorder”

• More somatic symptoms, atypical symptoms and irritability.

• Prevalence: 2% in children and 4% to 8% in adolescents.

• For MD diagnosis, a child must have > 2 weeks:
  • persistent change in mood (depressed or irritable mood and/or loss of interest and pleasure) and,
    • Thoughts of wishing to be dead, suicidal ideation or attempts
    • Increased or decreased appetite, weight, or sleep
    • Decreased activity, concentration, energy, or self-worth
    • This all represents a change from previous functioning and produces impairment in relationships or in performance of activities.
Treatment-Resistant Depression: Definition

The failure to respond to at least two antidepressant treatments of two different classes for an adequate dose and duration (SSRIs, SNRIs)

Estimates in a range from 10 - 33% of depressed patients
Consultation in Primary Care: What’s the next medication?
Pediatric Depression Algorithm: Part 1

1. Depressive Symptoms? Unexplained Somatic Complaints?
2. Safety screen:
   - Neglect/Abuse?
   - Medical condition (i.e., anemia, thyroid problem?)
   - Thoughts of hurting oneself?
   - If yes, are there plans and means available?
3. Think about comorbidity:
   - Anxiety, ODD, Conduct Disorder, ADHD, Dysthymia, Substance Abuse
4. Diagnosis:
   - DSM-5 Diagnostic Criteria
   - Rating Scale: SMFQ or PHQ-9 (others available for a fee)
   - Label as “Unspecified Depressive Disorder” if significant symptoms but not clear if Major Depression
5. Can problem be managed in primary care? 
   - YES
   - Judgment Call
     - Mild Problem (noticeable, but basically functioning OK)
       - Educate patient and family
       - Support increased peer interactions.
       - Behavior activation, exercise.
       - Encourage good sleep hygiene.
       - Reduce stressors, if possible.
       - Remove any guns from home.
       - Offer parent/child further reading resources.
     - Moderate/Severe Problem (significant impairment in one setting, or moderate impairment in multiple settings)
       - Recommend individual psychotherapy
       - CBT and IPT are preferred, where available.
       - Psychoeducation, coping skills, and problem solving focus are all helpful therapy strategies.
       - Educate patient and family (as per mild problem list on left).
       - Consider family therapy referral.
   - NO
     - Referral
Pediatric Depression Algorithm: Part 2

**Mild Problem**
(noticeable, but basically functioning OK)

- Educate patient and family
  - Support increased peer interactions.
  - Behavior activation, exercise.
  - Encourage good sleep hygiene.
  - Reduce stressors, if possible.
  - Remove any guns from home.
  - Offer parent/child further reading resources.

- Follow up appointment in 2-4 weeks to check if situation is getting worse.
  - Repeating rating scales helps comparisons.
  - Those not improving on their own are referral candidates for counseling.

**Moderate/Severe Problem**
(significant impairment in one setting, or moderate impairment in multiple settings)

- Recommend individual psychotherapy
  - CBT and IPT are preferred, where available.
  - Psychoeducation, coping skills, and problem solving focus are all helpful therapy strategies.
  - Educate patient and family (as per mild problem list on left). Consider family therapy referral.

- Consider starting SSRI, especially if severe.
  - Fluoxetine is the first line choice.
  - Escitalopram/Sertaline second line.
  - Third line agents are other SSRIs, bupropion, mirtazapine.
  - Wait four weeks between dose increases to see changes.
  - Check for side effects every 1-2 weeks in first month of use to ensure no new irritability or suicidality (phone or in person).
  - Stop SSRI if got agitation, anxiety or suicidal thoughts.
  - Consult MH specialist if mono therapy is not helping.
  - Monitor progress with repeat use of rating scale.

Primary References:
Arlington, VA: National Center for Education in Maternal and Child Health; 203-21
AACAP (in press); “Practice parameter for the assessment and treatment of children and adolescents with depressive disorders.”
Accessed 2/08 on www.aacap.org

Zuckerbrot R ed. “Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit.”
Columbia University; Center for the Advancement of Children's Mental Health

58 PRIMARY CARE PRINCIPLES FOR CHILD MENTAL HEALTH
Antidepressant Medications: State of the Evidence

Depression Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage Form</th>
<th>Usual starting dose for adolescent</th>
<th>Increase Increment after 4 weeks</th>
<th>RCT evidence in kids</th>
<th>FDA depression approved for children?</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>10, 20, 40mg</td>
<td>10 mg/day (60mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>Yes (Age ≥8)</td>
<td>Long 1/2 life, no side effect from a missed dose</td>
</tr>
<tr>
<td>(Prozac)</td>
<td>20mg/5ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sertraline</td>
<td>25, 50, 100mg</td>
<td>25 mg/day (20mg max)*</td>
<td>25-50mg**</td>
<td>Yes</td>
<td>No</td>
<td>May be prone to side effects when stopping</td>
</tr>
<tr>
<td>(Zoloft)</td>
<td>20mg/ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escitalopram</td>
<td>5, 10, 20mg</td>
<td>5 mg/day (20mg max)*</td>
<td>5-10mg**</td>
<td>Yes</td>
<td>Yes (Age ≥12)</td>
<td>The active isomer of citalopram</td>
</tr>
<tr>
<td>(Lexapro)</td>
<td>5mg/5ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>10, 20, 40mg</td>
<td>10 mg/day (40mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>No</td>
<td>Few drug interactions, dose maximum 40mg/day due to risk of QT prolongation</td>
</tr>
<tr>
<td>(Celexa)</td>
<td>10mg/5ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bupropion</td>
<td>75, 100mg</td>
<td>75 mg/day (later close this BID)</td>
<td>75-100mg**</td>
<td>No</td>
<td>No</td>
<td>Can have more agitation risk. Avoid if eat c/o. Also has use for ADHD treatment. Seizure risk limits dose.</td>
</tr>
<tr>
<td>(Wellbutrin)</td>
<td>100, 150mg, 200mg SR forms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mirazapine</td>
<td>15, 30, 45mg</td>
<td>15mg/24hr (45mg max)*</td>
<td>15mg**</td>
<td>No</td>
<td>No</td>
<td>Sedating, increases appetite</td>
</tr>
<tr>
<td>(Remeron)</td>
<td>15, 30, 45mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>25, 37.5, 50, 75, 100mg</td>
<td></td>
<td>37.5 mg/day (225mg max)*</td>
<td>37.5 to 75mg**</td>
<td>No</td>
<td>Only recommended for older adolescents. Withdrawal symptoms can be severe.</td>
</tr>
<tr>
<td>(Effexor)</td>
<td>37.5, 75, 150mg ER forms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duloxetine</td>
<td>20, 30, 40, 60mg</td>
<td></td>
<td>30 mg/day (120mg max)*</td>
<td>30mg</td>
<td>No</td>
<td>May cause nausea. May help with somatic symptoms.</td>
</tr>
<tr>
<td>(Cymbalta)</td>
<td>20, 30, 40, 60mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Citalopram, bupropion, mirazapine, venlafaxine, and duloxetine considered.
Short Mood and Feelings Questionnaire (SMFQ)

Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way in the past two weeks.

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

<table>
<thead>
<tr>
<th></th>
<th>NOT TRUE</th>
<th>SOMETIMES</th>
<th>TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt miserable or unhappy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I didn't enjoy anything at all</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I felt so tired I just sat around and did nothing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I was very restless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I felt I was no good any more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I cried a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I found it hard to think properly or concentrate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I hated myself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I was a bad person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I felt lonely</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I thought nobody really loved me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I thought I could never be as good as other kids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I did everything wrong</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Short Mood and Feelings Questionnaire (Parent Report)

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way in the past two weeks.

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE.

<table>
<thead>
<tr>
<th></th>
<th>NOT TRUE</th>
<th>SOMETIMES</th>
<th>TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. S/he felt miserable or unhappy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. S/he didn't enjoy anything at all</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. S/he felt so tired that s/he just sat around and did nothing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. S/he was very restless</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. S/he felt s/he was no good any more</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. S/he cried a lot</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. S/he found it hard to think properly or concentrate</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. S/he hated him/herself</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. S/he felt s/he was a bad person</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. S/he felt lonely</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. S/he thought nobody really loved him/her</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12. S/he thought s/he could never be as good as other kids</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13. S/he felt s/he did everything wrong</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Scoring the SMFQ

Note: the SMFQ has been validated for use in children age 6 years and up.

The SMFQ should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child’s symptom severity and treatment response over time.

**Scoring:**

Assign a numerical value to each answer as follows:

Not true = 0
Sometimes = 1
True = 2

Add up the assigned values for all 13 questions. Record the total score.

A total score on the child version of the SMFQ of 8 or more is considered significant.


Sensitivity/specificity statistics of the parent version is not reported in the literature. If your patient does not complete the child version of SMFQ, repeated administration of the parent version over time should still be useful for symptom tracking.
Depression Resources

Information for Families

Books families may find helpful:
The Childhood Depression Sourcebook (1998), by Jeffery Miller
The Depressed Child: Overcoming Teen Depression (2001), by Mariam Kaufman
The Explosive Child (2003), by Ross Greene

Books children may find helpful:
Taking Depression to School (2002), by Kathy Khalsa (for young children)
Where's Your Smile, Crocodile? (2001), by Clair Freedman (for young children)
Feeling Good: The New Mood Therapy (1999), by David Burns (for adolescents)
My Feeling Better Workbook: Help for Kids Who Are Sad and Depressed (2008), by Sara Hami (for elementary school students)

Crisis Hotlines:
National Suicide Prevention Lifeline
1-800-273-8255
Text HOME to 741741
www.crisistextline.org

Websites families may find helpful:
Guide to depression medications from APA and AACAP professional societies
www.parentsmedguide.org
National Institute of Mental Health
www.nimh.nih.gov/health/topics/depression/index.shtml
National Alliance for Mental Illness
https://www.nami.org/Your-Journey/Teens-Young-Adults
American Foundation for Suicide Prevention
https://afsp.org
American Academy of Child and Adolescent Psychiatry
www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx
Youth Suicide Prevention Program
https://suicidepreventionlifeline.org/
• RECORDING TO BE STOPPED FOR CASE PRESENTATION
Cases/HIPAA

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.
Case
Questions and Concerns/Discussion
Conclusion

• Volunteers to present cases (this is key to the Project ECHO model)
  • Please submit cases to Michael.Hoffnung@uvmhealth.org

• Please complete evaluation survey after each session

• Claim your CME at www.highmarksce.com/uvmmmed

• Please contact us with any questions, concerns, or suggestions
  • Michael.Hoffnung@uvmhealth.org
  • Elizabeth.Cote@uvm.edu
  • ahec@uvm.edu