MCPAP Clinical Conversations: Depression Update: MCPAP Depression Algorithm

Bruce Waslick, MD
Western/Central MCPAP Medical Director
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Overview

- Introduction to MCPAP Clinical Algorithms
- Presentation of MCPAP Depression Clinical Algorithm
- Questions and Discussion

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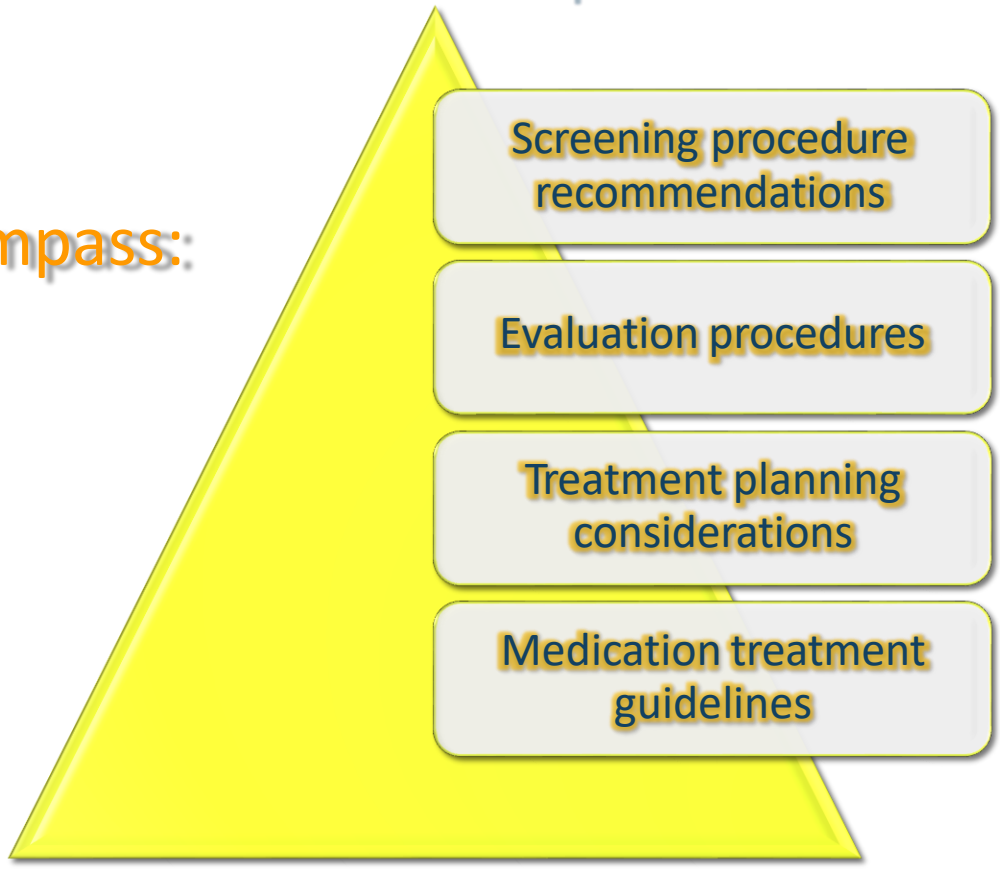
MCPAP Clinical Algorithms: Purpose

- Creation of practical clinical guidelines for PCP's when dealing with common mental health problems

➢ Guidelines encompass:



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MCPAP Clinical Algorithms: Content

1. Content is developed to be most helpful for PCP in regular primary care practice

2. Content includes procedures that can be performed in all algorithms in the context of regular primary care practice

3. Content recommends the use of standard well-validated clinical rating scales that can be used in primary care practice

4. Content recommends the use of medication guidelines suggesting evidence supported first-line medication treatment for mental health conditions commonly treated in primary care

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MCPAP Clinical Algorithms: Process

Conceptualization

- Content developed through clinical consensus process of MCPAP Medical Directors Leadership Team

Starting place

- Initial clinical guidelines for different conditions developed by H. Walter and colleagues for PPOC practices

First 3 MCPAP Clinical Algorithms

- Depression
- Anxiety
- ADHD

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MCPAP Clinical Algorithms: Applications

To help train primary care providers in basic evidence-supported tools and procedures for mild-to-moderate, relatively uncomplicated forms of mental health problems that can reasonably be handled in primary care practice

To help MCPAP consulting teams provide consistent training and guidance to primary care providers during phone and face-to-face consultations across the state

Algorithms will likely not be the best starting point for severely ill, treatment-resistant or highly complicated presentations of mental illness in primary care

Primary care providers are encouraged to make liberal use of MCPAP phone consultation and face-to-face consultations for complicated, treatment-resistant or severely ill presentations rather than relying on MCPAP Clinical Algorithms

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MCPAP Depression Clinical Algorithm

- First clinical algorithm "rolled out" by MCPAP teams

- Provides clinical guidance for the PCP in terms of:
  - Screening for depressive illness in children and teens
  - Diagnostic evaluation procedures
  - Treatment planning considerations
  - Initial medication selection and management procedures

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MCPAP Depression Guidelines for PCPs

PCP visit:

- Screen for behavioral health problems
  - Pediatric Symptom Checklist-17 (cut-points: 15 total, 5 internalizing, individual depression items)
  - Patient Health Questionnaire, ages 12+ (cut-points: 3 [PHQ-2], 10 [PHQ-9])
- If screen is positive, conduct brief interview focusing on distress, impairment, danger
  - If concern for sub-clinical depression, provide guided self-management with follow-up
  - If concern for clinical depression, conduct focused assessment including precipitating factors, symptom rating scales, family history of mood disorders, and "red flags" for medication use
  - If concern for imminent danger, refer to hospital or crisis team for emergency psychiatric assessment
  - Consult with MCPAP CAP as needed

Symptom rating scales for depression:
Mood and Feelings Questionnaire – Long: ages 8-18 (cut-point: 27 parent, 29 youth) OR
Patient Health Questionnaire – 9: ages 12+ (cut-point: 10 moderate, 20 severe)

Sub-clinical to mild depression:
Guided self-management with follow-up

Moderate depression (or self-management unsuccessful):
Refer for therapy; consider medication

Severe depression:
Refer to specialty care for therapy and medication management until stable

FDA-approved medications for depression:
Fluoxetine: age 8+; Escitalopram: age 12+
Evidence-based medication for depression:
Sertraline

- Start daily test dose for 1-2 weeks (e.g., fluoxetine 5mg < age 12, fluoxetine 10mg age 12+, escitalopram 5mg age 12+, sertraline 12.5mg < age 12, or sertraline 25mg age 12+)
- If test dose tolerated, increase daily dose (e.g., fluoxetine 10mg < age 12, fluoxetine 20mg age 12+, escitalopram 10mg age 12+, sertraline 25mg < age 12, or sertraline 50mg age 12+)
- Monitor weekly for agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency evaluation; consult with MCPAP CAP as needed

- At 4 weeks, re-assess symptom severity with **MFQ/PHQ-9.**
- If the score > cut-point and impairment persists, consult MCPAP CAP for next steps.
- If the score < cut-point with mild to no impairment, remain at current dose for 6-12 months.
- Monitor bi-monthly during the second four weeks and monthly thereafter for maintenance of remission, agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency evaluation; consult with MCPAP CAP as needed.
- After 6-12 months of successful treatment, re-assess symptom severity with **MFQ/PHQ-9.**
- If the score < cut-point without impairment, then consider tapering antidepressant medication according to the following schedule: decrease daily dose by 25-50% every 2-4 weeks to starting dose, then discontinue medication; consult with MCPAP CAP as needed. Tapering should ideally occur during a time of relatively low stress. Maintenance of antidepressant medication may be considered beyond the 6- to 12-month period of successful treatment in cases of high severity/risk, recurrent pattern, and/or long duration of illness. Consider consulting with MCPAP CAP regarding decision to taper.
- Monitor for several months after discontinuation for symptom recurrence.

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Acknowledgement, Origins and Process of Development

Clinical Decision-Making Procedures

Screening and Evaluation Procedures

Medication Selection Support

Follow-up and Monitoring Support

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Screening and Evaluation Procedures

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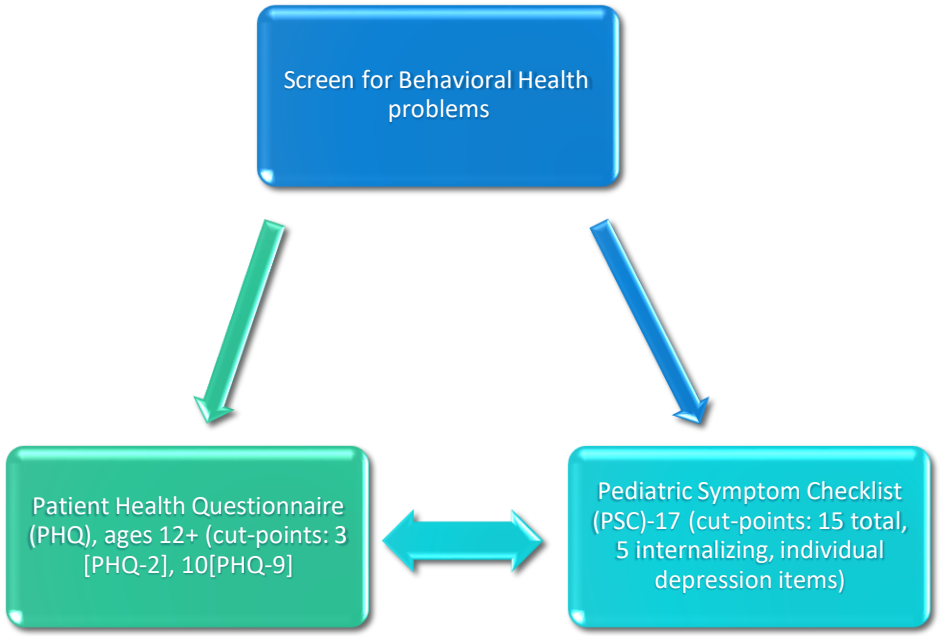

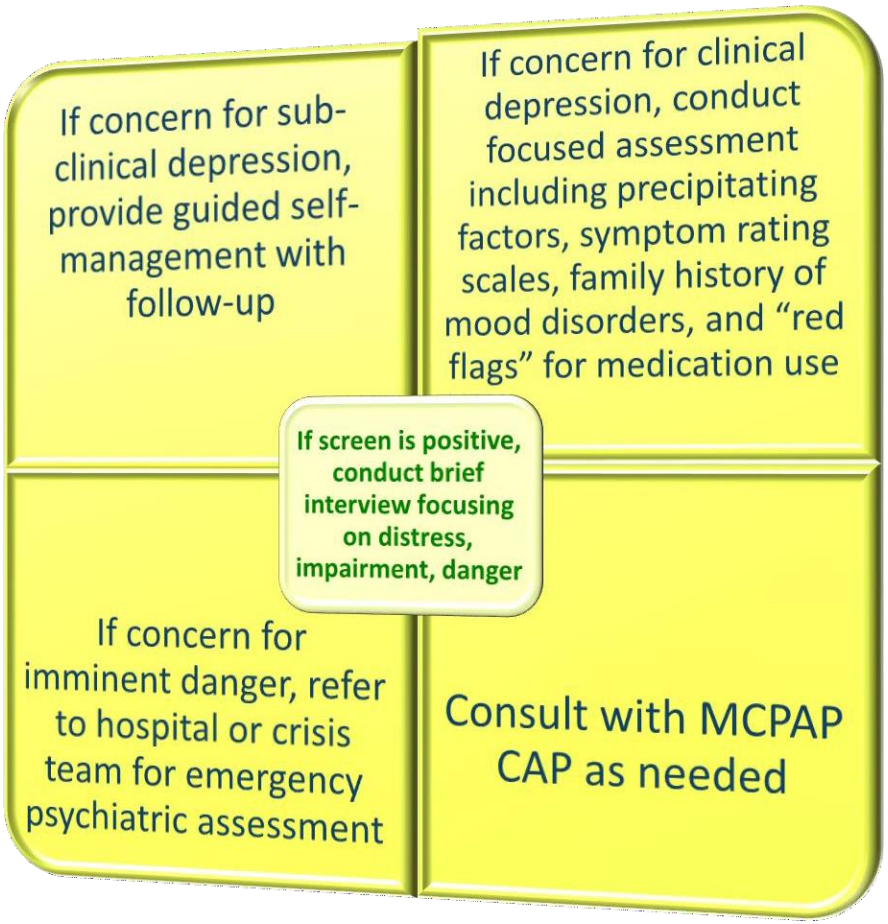

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At screening:

PSC-17-I subscale ≥ 5 is considered positive for internalizing symptoms

PSC-17-A subscale ≥ 7 is considered positive for ADHD symptoms

PSC-17-E subscale ≥ 7 is considered positive for externalizing symptoms

PSC-17 total ≥ 15 is considered positive for total problems

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Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:
- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

At screening:

PSC-17-I subscale ≥ 5 is considered positive for internalizing symptoms

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Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

For initial diagnosis:

Consider MDD: if 5 √'s in shaded boxes with Q1 or Q2 positive

Consider Other Depressive Disorder: if 4 √'s in shaded boxes with Q1 or Q2 positive

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

All responses should be verified by a clinician and a definitive diagnosis is made on clinical grounds

Diagnoses of Major Depression and other Depressive Disorder require impairment in functioning (Q. 10)

Important "rule outs" :

- ✓ Normal Bereavement
- ✓ Bipolar Disorder
- ✓ Medical Disorders
- ✓ Reactions to medications
- ✓ Illicit substance use

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "√" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Clinical Decision-Making Procedures I

Diagnostic Evaluation

- Symptom rating scales for assessment of **depression severity**:
  - **Mood & Feelings Questionnaire (MFQ)-Long** ages 8-18 (cut-point: 27 parent, 29 youth) OR
  - **Patient Health Questionnaire (PHQ)-9** ages 12+ (cut-point: 10 moderate, 20 severe)

- Assessment for "red flags" and diagnostic "rule-outs" that would be expected to affect treatment planning

Red Flags
- Suicidality
- Psychosis
- Trauma
- Substance Abuse

Diagnostic Rule-Outs
- Normal Bereavement / Adjustment Disorders
- Bipolar Disorder
- Medical Disorders
- Reactions to medications
- Illicit substance use

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MOOD AND FEELINGS QUESTIONNAIRE: Long Version

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

For each question, please check (✓) how you have been feeling or acting ***in the past two weeks***.

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

Score the MFQ as follows:
NOT TRUE = 0
SOMETIMES = 1
TRUE = 2

To code, please use a checkmark (✓) for each statement.	NOT TRUE	SOME TIMES	TRUE
1. I felt miserable or unhappy.			
2. I didn't enjoy anything at all.			
3. I was less hungry than usual.			
4. I ate more than usual.			
5. I felt so tired I just sat around and did nothing.			
6. I was moving and walking more slowly than usual.			
7. I was very restless.			
8. I felt I was no good anymore.			
9. I blamed myself for things that weren't my fault.			
10. It was hard for me to make up my mind.			
11. I felt grumpy and cross with my parents.			
12. I felt like talking less than usual.			
13. I was talking more slowly than usual.			
14. I cried a lot.			

Child Self-Report

15. I thought there was nothing good for me in the future.			
16. I thought that life wasn't worth living.			
17. I thought about death or dying.			
18. I thought my family would be better off without me.			
19. I thought about killing myself.			
20. I didn't want to see my friends.			
21. I found it hard to think properly or concentrate.			
22. I thought bad things would happen to me.			
23. I hated myself.			
24. I felt I was a bad person.			
25. I thought I looked ugly.			
26. I worried about aches and pains.			
27. I felt lonely.			
28. I thought nobody really loved me.			
29. I didn't have any fun in school.			
30. I thought I could never be as good as other kids.			
31. I did everything wrong.			
32. I didn't sleep as well as I usually sleep.			
33. I slept a lot more than usual.			

Dear potential MFQ user: *The following publications present information pertinent to the selection of MFQ cut points for use in various circumstances. There is no single cut point that is best for use in all circumstances. This is true of all screening tests, whether psychiatric or general medical. As a result our group does not recommend any specific cut-points for use with the MFQ. Rather it is up to users to decide what will be most useful in their particular circumstances. Best wishes. Adrian Angold.*

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Clinical Decision-Making Procedures II

Treatment planning

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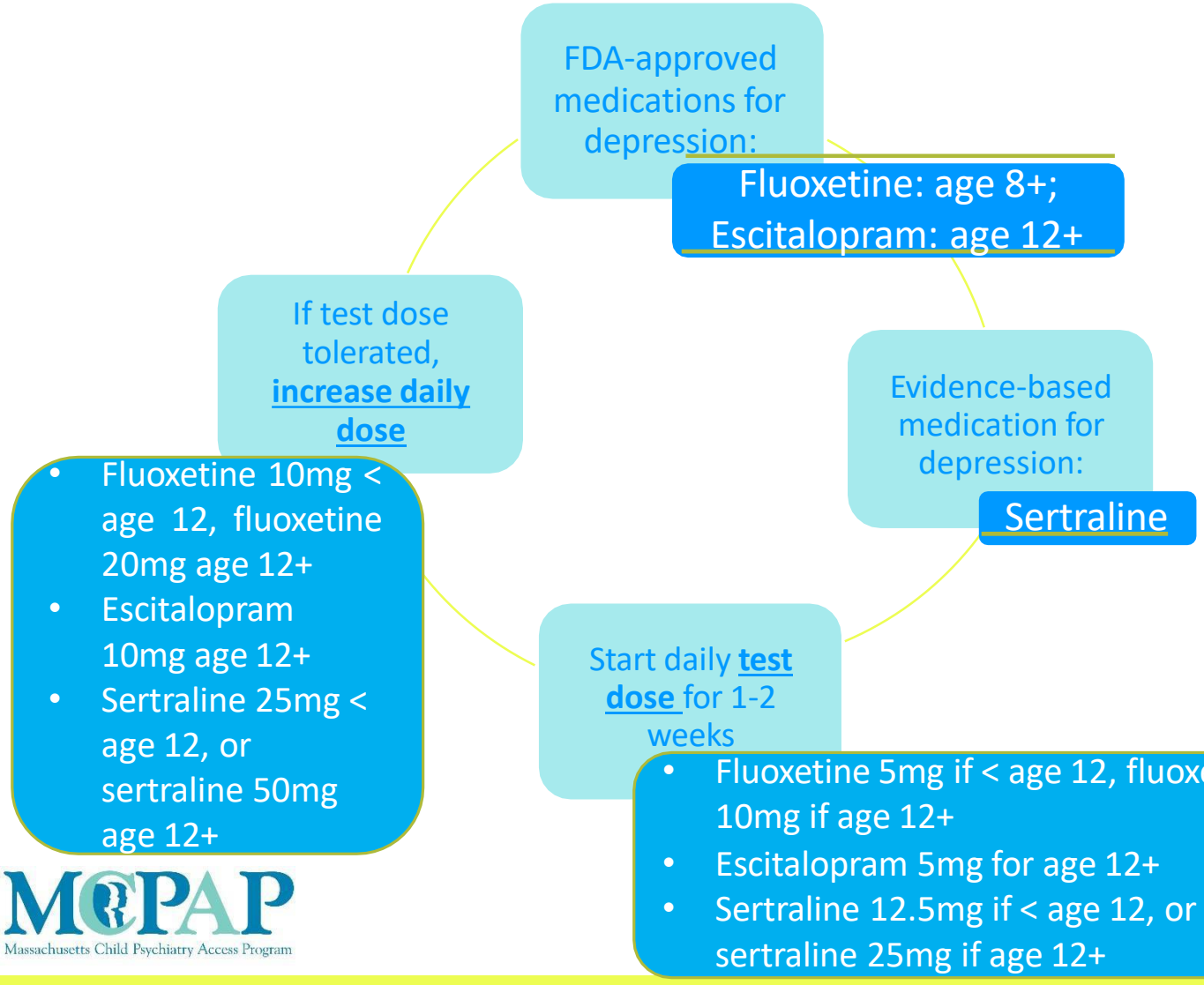
Medication Selection Support



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Follow-up and Monitoring Support

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Thank you for your attendance and attention!

Questions and Comments invited and appreciated!

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