MCPAP Clinical Conversations:
Depression Update: Rollout of New MCPAP Depression Algorithm

Bruce Waslick, MD
Medical Director UMass / Baystate MCPAP Team
January 23, 2018
Overview

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

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

Guidelines encompass:

- Screening procedure recommendations
- Evaluation procedures
- Treatment planning considerations
- Medication treatment guidelines
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
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
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.
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
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, provides 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 8-16 (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; if 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, reassess 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; if 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 6-12-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.

HJ Walker, Department of Psychiatry, Boston Children’s Hospital (adapted by MCPAP with permission)
Revised 1/1/19
Funding provided by the Massachusetts Department of Mental Health, Boston Children’s Hospital, and Sidney A. Swann Foundation
MCPAP Depression Guidelines for PCPs

PCP visit:
- Screen for behavioral health problems
  - Pediatric Symptom Checklist: 17 (cut-points: 15 total, 6 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
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- Monitor for several months after discontinuation for symptom recurrence.

Acknowledgement, Origins and Process of Development

HJ Weber, Department of Psychiatry, Boston Children’s Hospital (adapted by MCPAP with permission)
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Funding provided by the Massachusetts Department of Mental Health, Boston Children's Hospital, and Siddhartha D. Swarup Foundation
MCPAP Depression Guidelines for PCPs

PCP visit:
- Screen for behavioral health problems
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  - Patient Health Questionnaire, ages 12+ (cut-points: 10 [PHQ-10] 13 [PHQ-9])
- If screen is positive, conduct brief interview focusing on distress, impairment, danger
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  - 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+);
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Acknowledgement, Origins and Process of Development

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Screening and Evaluation Procedures

**PCP visit:**

- **Screen for Behavioral Health problems**
  - Patient Health Questionnaire (PHQ), ages 12+ (cut-points: 3 [PHQ-2], 10[PHQ-9])
  - Pediatric Symptom Checklist (PSC)-17 (cut-points: 15 total, 5 internalizing, individual depression items)

- **If concern for subclinical 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 screen is positive, conduct brief interview focusing on distress, impairment, danger

- **Consult with MCPAP CAP as needed**

- **If concern for imminent danger, refer to hospital or crisis team for emergency psychiatric assessment**
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

### Pediatric Symptom Checklist-17 (PSC-17)

**Caregiver Completing this Form:** ____________  **Date:** ____________

**Name of Child:** ____________

**For Office Use**

<table>
<thead>
<tr>
<th>Please mark under the heading that best fits your child</th>
<th>NEVER</th>
<th>SOME-TIMES</th>
<th>OFTEN</th>
<th>I</th>
<th>A</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fidgety, unable to sit still</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>2. Feels sad, unhappy</td>
<td></td>
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<tr>
<td>3. Daydreams too much</td>
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<td>4. Refuses to share</td>
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<tr>
<td>5. Does not understand other people’s feelings</td>
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<td>6. Feels hopeless</td>
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<tr>
<td>7. Has trouble concentrating</td>
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<tr>
<td>8. Fights with other children</td>
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<tr>
<td>11. Seems to be having less fun</td>
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<tr>
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**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.

**PSC-17 may be freely reproduced.**
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**(scoring totals)**

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

**PSC-17 may be freely reproduced.**
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

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

### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

*Use √ to indicate your answer*

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)*

**NAME:** ___________________________  **DATE:** ___________________________  **TOTAL:** ___________________________  **13. 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
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.
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

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)

<table>
<thead>
<tr>
<th></th>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minimal depression</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mild depression</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Moderate depression</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Moderately severe depression</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Severe depression</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total Score: ____________________________

(add columns)

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

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

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Massachusetts Child Psychiatry Access Program
Clinical Decision-Making Procedures II

**Treatment planning**

**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 & medication management until stable
FDA-approved medications for depression:

- **Fluoxetine**: age 8+
- **Escitalopram**: age 12+

Start daily **test dose for 1-2 weeks**

- **Fluoxetine**: 5mg if < age 12, fluoxetine 10mg if age 12+
- **Escitalopram**: 5mg for age 12+
- **Sertraline**: 12.5mg if < age 12, or sertraline 25mg if age 12+

If test dose tolerated, **increase daily dose**

- **Fluoxetine**: 10mg < age 12, fluoxetine 20mg age 12+
- **Escitalopram**: 10mg age 12+
- **Sertraline**: 25mg < age 12, or sertraline 50mg age 12+

Evidence-based medication for depression:

- **Sertraline**

Monitor weekly for agitation, suicidality & 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
Follow-up and Monitoring Support

- At 4 weeks, re-assess symptom severity with MFQ/PHQ-9
  - If score > cut-point & impairment persists, consult MCPAP CAP for next steps
  - If 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, & 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 score < cut-point without impairment, decrease daily dose by 25-50% every 2-4 weeks to starting dose, then discontinue medication; consult with MCPAP CAP as needed
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.
Thank you for your attendance and attention!

Questions and Comments invited and appreciated!