



Mood Disorders

Identification and management for Canadian primary care professionals

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Hamilton Family Health Team

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Mood Disorders

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Understanding Mood Disorders in Primary Care

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Epidemiology

- Rare in children
- Common in adolescents: 4-8% prevalence
- Male to female ratio 1:1 in childhood and 1:2 in adolescence
- 5-10% children and adolescents have subsyndromal MDD
- 20-40% will eventually be diagnosed with bipolar disorder

(Birmaher et al., 2007)

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Guidelines for Adolescent Depression – Primary Care (GLAD-PC)

Identification/Surveillance

- Recommendation I: Patients with depression risk factors (such as history of previous episodes, family history, other psychiatric disorders, substance abuse, trauma, psychosocial adversity, etc.) should be identified and systematically monitored over time for the development of a depressive disorder.

Assessment/Diagnosis

- Recommendation I: Primary care clinicians should evaluate for depression in high-risk adolescents as well as those who present with emotional problems as the chief complaint. Clinicians should assess for depressive symptoms based on diagnostic criteria established in the DSM IV or ICD 10 and should use standardized depression tools to aid in the assessment.
- Recommendation II: Assessment for depression should include direct interviews with the patients and families/caregivers and should include the assessment of functional impairment in different domains and other existing psychiatric conditions.

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Youth Depression

General Principles

- Youth depression is different than adult depression:
 - Reactive or irritable mood
 - Increased appetite more common
 - Cutting/self-harm
 - Ask about school, peers and home
(Cheung)
- How depression differs from normal teen moods:
 - Persistent changes in mood
 - Mood changes not precipitated by environment
 - Drastic changes in academics, friendships, temper, and involvement in activities
(Cheung)

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Bipolar Disorder

- Bipolar disorder is rare in children. Even in youth it is rare compared to depression. However, it is always important to screen for mania by asking about less need for sleep, grandiosity, etc. when meeting a child or youth with depression. The T-CAPS and Weiss Symptom Record have screening questions for mania.
- When teens present with manic episodes, there is often a history of previous depressive episodes.
- Children who are later diagnosed with bipolar disorder often have a history of ADHD.
- There is controversy surrounding the diagnosis of childhood bipolar disorder in those who do not meet full criteria for manic or hypomanic episodes but have severe mood dysregulation instead.

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Visit 1: History and Information Gathering

[Depression questions and screening tools](#)

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Depression Questions and Tools

[DSM-IV-TR criteria for depression](#) apply to children and youth.

Free domain screening tools (unlike CDI and other pay-per-use tools):

- Simple screen: “How is your mood?” “Have there been changes in your interests?” (Cheung, 2007)
- [6-item Kutcher Adolescent Depression Scale](#) (KADS-6) (available in 10 languages)
- [Patient Health Questionnaire 9-item](#) (PHQ-9) adolescent modification as per GLAD-PC
- **Whenever the issue of self-harm and suicide is on a self-report questionnaire, ensure youth fills out questionnaire in presence of qualified office staff**

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Assess functional impairment

- The degree of functional impairment along with the severity of symptoms will guide your management plan. Some free domain tools are listed below:
 - [Teen Functional Assessment \(TeFA\)](#) (self-report)
 - [Weiss Functional Impairment Scale \(Self-report\)](#)
 - [Weiss Functional Impairment Rating Scale \(parent report\)](#)

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Assess for co-morbidity

Screen for other mental health problems:

- Bipolar Disorder ([T-CAPS](#), [Weiss Symptom Record](#))
- Anxiety ([SCARED Child Self-Report](#), [SCARED Parent Report](#) or [K-GSADS-A](#))
- Substance use disorder ([CRAFFT Substance Use Screen](#))
- Trauma or bullying
- ADHD and learning problems ([SNAP-IV Long Version](#), [SNAP-IV Questionnaire Short Version](#))
- Eating disorder ([Eating disorder questions](#))
- Significant negative life events (e.g., death of loved one)

Free domain tools for assessing a number of co-morbid mental illnesses:

- [T-CAPS](#)
- [Weiss Symptom Record](#)
- **Whenever the issue of self harm and suicide is on a self-report questionnaire, ensure youth fills out questionnaire in presence of qualified office staff**

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Safety Assessment and Planning

- **Check in about safety at each visit.**
- **Develop and implement a safety plan when there is a risk of self-harm or suicide.** [Click here](#) for a guide on developing and implementing a safety plan from “Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth, 2nd edition, a Desk Reference”.
- **If there are any safety concerns, you can arrange to have the person assessed in the closest emergency department. The options available to have someone assessed vary from province to province. Common options include (1) a physician certifying a patient in their office, (2) the police bringing a patient into hospital, or (3) the family seeking an order from a Justice of the Peace to have an assessment completed. Please check your provincial Mental Health Act to determine what options are available in your province.**

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- 15-20% of teenagers report suicidal ideation
- 5% attempt suicide
- More attempts in females and more completions in males
- Asking about suicidal ideation does not increase suicidal ideation or suicides
- Free domain suicide risk screening tool: [TASR-A](#)
- [Click here](#) for a handout for youth about suicide from the GLAD-PC (Guidelines for Adolescent Depression – Primary Care) toolkit
- For more information on SSRIs and suicidal ideation, see [treatment](#) section

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Visit 2: Medical and Physical Exam

- As with any mental health presentation, perform **review of systems, complete physical exam, and screening bloodwork if indicated.** Consider:
 - Anemia (CBC and differential)
 - Infection (CBC and differential, monospot, STIs)
 - Thyroid problems (TSH)
 - Chronic illness (liver tests, electrolytes, kidney tests)
 - Medications (over the counter, alternative, and prescribed)
 - Pregnancy
 - Malnutrition (Vitamin B12, Folate, Vitamin D)
 - Less frequent conditions like cancer

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Visit 3: Education

- GLAD-PC Guidelines: Initial Management: Education:
 - *Recommendation 1: Primary care clinicians should educate and counsel families and patients about depression and options for the management of the disorder. Clinicians should also discuss limits of confidentiality with the adolescent and family.*

Sample Patient Handouts:

- [Common Signs of Depression](#)
- [NAMI Family Guide](#)

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Visit 4: Treatment Plan

- [GLAD-PC Guidelines: Initial Management](#)
- [GLAD-PC Guidelines: Treatment](#)
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GLAD-PC Guidelines: Initial Management

- Recommendation II: Primary care clinicians should develop a treatment plan with patients and families and set specific treatment goals in key areas of functioning including home, peer and school settings
- Recommendation III: The primary care clinician should establish relevant links/ collaboration with mental health resources in the community, which may include patients and families who have dealt with adolescent depression and are willing to serve as resources to other affected adolescents and their family members.
- Recommendation IV: All management must include the establishment of a safety plan, an emergency communication mechanism should the patient deteriorate, become actively suicidal or dangerous to others, or experience an acute crisis associated with psychosocial stressors especially during period of initial treatment when safety concerns are highest.

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GLAD-PC Guidelines: Treatment

- Recommendation I: After initial diagnosis, in cases of mild depression, clinicians should consider a period of active support and monitoring before starting other evidence-based treatment.
- Recommendation II: If a primary care clinician identifies an adolescent with moderate or severe depression or complicating factors/conditions such as co-existing substance abuse or psychosis, consultation with a mental health specialist is recommended. Appropriate roles and responsibilities for ongoing management by the primary care and mental health clinicians should be negotiated. The patient and family should be consulted and approve the roles of the primary care and mental health professionals.
- Recommendation III: Primary care clinicians should recommend scientifically-tested and proven treatments (i.e., psychotherapies such as cognitive behavioural therapy or

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interpersonal therapy, and/or antidepressant treatment such as SSRIs) whenever possible and appropriate to achieve the goals of the treatment plan

- Recommendation IV: Primary care clinicians should monitor for the emergence of adverse events during antidepressant treatment (SSRIs).

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Non-medication strategies

Lifestyle:

- Sleep: see sleep hygiene handout from the GLAD-PC toolkit, p. 111, or [click here](#).
- Diet
- Exercise
- [Relaxation](#) and socialization
- Curtailing the use of alcohol and substances

Active Support & Monitoring:

- Provide the patient with education on depression and recommended websites
- In cases where the depression is mild, make bi-weekly “check-in” phone calls to the patient to monitor – can also have patient use a [mood tracker](#)

Self-Help Resources:

Online resources available for youth include:

- “[Dealing with Depression: Antidepressant Skills for Teens](#)” is a workbook for teens that explains depression and teaches three main antidepressant skills you can use to help

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overcome or prevent it. The authors are Drs. Dan Bilsker, Merv Gilbert, David Worling, & E. Jane Garland.

- <http://moodgym.anu.edu.au> (click "new users"): A free self-help program to teach cognitive behaviour therapy skills to people vulnerable to depression and anxiety
- <http://www.thelowdown.co.nz>: Get all the facts and treatment information from this youth depression website.

Therapy:

- CBT is an evidence-based practice for the treatment of depression in children and adolescents.
- Practice elements of CBT include:
 - Cognitive restructuring ([Checklist of Cognitive Distortions](#))
 - Coping skills
 - Behaviour Activation
 - Problem-solving skills
 - Relaxation
- Creating a safe, supportive environment for teens is important. [Click here](#) for tips on developing a therapeutic alliance with teens (Kutcher and Chehil, 2009).

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Medications

- SSRIs are first line
 - [CANMAT](#) guidelines conclude that fluoxetine (Prozac) and citalopram (Celexa) are first-line agents with moderate effect size in moderate to severe depression.
 - None are officially indicated in those under 18 in Canada.
- TCAs not found to be effective for depression.
- Black Box warning for increased suicidal ideation and behavior
 - Number needed to harm 50-143.
- No increased rate of completed suicides observed and, in fact, suicide rate has started to rise again since warning released and prescription rates have fallen.
- For brief review of use of antidepressants in children and youth including SSRIs and suicidal ideation [click here](#) (Lam et al., 2009)

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Self-Help Resources

Youth:

“Think Good, Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People” by Paul Stallard

<http://moodgym.anu.edu.au> (click “new users): A free self-help program to teach cognitive behaviour therapy skills to people vulnerable to depression and anxiety

<http://www.mindyourmind.ca>: Youth information, resources and tools to help you manage stress, crisis and mental health problems.

<http://www.thelowdown.co.nz>: Youth depression website. Get all the facts and treatment information. Talk to a trained counsellor and hear other people’s personal stories.

www.kidshelpphone.ca or call 1-800-668-6868: Kids Help Phone.

Parents:

“Overcoming Teen Depression: A Guide for Parents” by Miriam Kaufman

“Helping Your Teenager Beat Depression: A Problem-Solving Approach for Families” by Katharina Manassis

“Mind Over Mood” by Dennis Greenberger and Christine Padesky

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Follow-up and referral

- Depending on the severity/situation, follow-up might be required as frequently as weekly
- There is agreement on close follow-up when antidepressants are started. The guidelines below are copied from the National Alliance on Mental Illness (NAMI):
 - First four weeks seen at least once a week with family contact
 - Weeks five through eight, seen every other week by the treating provider
 - See again at week 12
 - See as clinically indicated after this
 - Face-to-face contact as well as family contact are emphasized as important
- Urgent/emergent referral is required for significant/acute suicidality, homicidality, or psychosis.
- Uncertainty of diagnosis or treatment plan or lack of improvement are some other reasons to consider referring a patient.
- [Click here](#) for a guide to making referrals from the GLAD-PC Guidelines.

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Freely available comprehensive guides

- For a comprehensive guide to depression in children and youth in primary care, see the [GLAD-PC toolkit](#) (Cheung et al., 2007).
- For a comprehensive guide to depression in children and youth in primary care, please download ["Identification, Diagnosis and Treatment of Adolescent Depression \(Major Depressive Disorder\)"](#) (Kutcher and Chehil, 2009) or visit <http://www.teenmentalhealth.org>.
- For a comprehensive guide to depression in children and youth in primary care, see the American Academy of Child and Adolescent Psychiatry Practice Parameter (Birmaher et al., 2007).
- For a comprehensive guide to child and youth mental health in primary care by Dr. Harold Lipton, see ["Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth, 2nd edition, a Desk Reference"](#) by Healthy Minds/Healthy Children and the Southern Alberta Child & Youth Health Network, or visit the [Healthy Minds Healthy Children](#) website.

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