ADOLESCENT DEPRESSION –
ENHANCING OUTCOMES IN PRIMARY CARE
A Resource from the American College of Preventive Medicine

A Time Tool for Clinicians
ACPM’s Time Tools provide an executive summary of the most up-to-date information on delivering preventive services to patients in the context of a clinical visit. Information presented is based on evidence presented in peer-reviewed journals. Please refer to the Adolescent Depression Clinical Reference for more information.

This Time Tool presents important elements from the 2010 Guidelines for Adolescent Depression in Primary Care (GLAD-PC) for the identification, assessment, and treatment of adolescent depression in the office setting.

Every year about two million adolescents (1 in every 12) suffer an episode of depression; 1 in 5 adolescents experience depression before they reach adulthood. It is a common and serious problem.

- It increases the risk for suicide, the third leading cause of death in this age group.
- Often leads to poorer academic achievement, greater absenteeism, strained relationships with family and friends, interference with extracurricular activities, and substance abuse.

The importance of detecting and treating depression in adolescents is being increasingly recognized.

- The U.S. Preventive Services Task Force (USPSTF) now recommends screening adolescents (12 to 18 years) for major depressive disorder (MDD) when systems are in place to assure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
- The American Academy of Pediatrics (AAP) also strengthened their recommendations for mental health screening and counseling in the latest Bright Futures Guidelines.
- The Guidelines for Adolescent Depression in Primary Care (GLAD-PC) were published in 2007 and have been updated in 2010. GLAD-PC provides a roadmap for enhancing care.
- Bottom line: Systems must be in place to allow effective triage (safety/placement) for:
  - Identification of high risk cases,
  - Screening,
  - Assessment and intervention, and
  - A predetermined ‘go-to’ list of providers and facilities to refer for care when indicated.

The Good News

- Screening is simple, effective and well received by patients, parents and providers.
- A two-question screening can identify the need for more in depth screening.
- Adolescents prefer to have their depression addressed in primary care.
- Most adolescents see their primary doctor at least annually; an estimated 45% of suicide victims reportedly saw their primary doctor in the month prior to the suicide.
- Most depressed adolescents can be treated in primary care.
- There are effective treatments, and guidelines for using them in primary care.

The Bad News

- Only about 1 of 3 adolescents with depression is identified.
• Fewer than half of primary care clinicians inquire about depression with adolescents; fewer yet use a standardized instrument to assess depression.
• Fewer than half of adolescents who are diagnosed are treated appropriately.
• Severe cases should be treated by mental health specialists but there is a severe shortage of child psychiatrists – few of these severe cases are seen by specialists.
• Reimbursement policies are often a disincentive to treating depression in primary care.
• Little coordination typically occurs between primary care and mental health specialties.

**The Challenge**
The burden of adolescent depression prevention and management falls squarely on primary care.
• Most pediatricians and family practitioners believe it is their responsibility to identify depression, but relatively few believe it is their responsibility to treat it.
• Most do not feel equipped to manage adolescent depression, and their office systems are not set up to handle it.
• Adolescent depression is different than adult depression due to developmental issues, responses to treatment, issues in psychotherapy, risks of medications, family dynamics.

**PREPARE THE PRACTICE**
This part is the key to success; the physician must be able to see him/herself as competent to handle this problem within the timeframe of a normal visit. While appropriately triaged mild depression might be managed in primary care, more severe cases of depression or those with additional psychiatric diagnoses will probably need quick referral to mental health specialists or higher levels of care.

Steps to integrate care:
• Assess the practice: adolescent patient load, prevalence of mental health issues.
• Determine the role you want to play and services to provide for adolescent depression.
• Build a network of local resources – therapists, peer counseling, group programs, etc.
• Determine relation with mental health resources – consultation, co-location, collaboration.
• Provide training where needed – screening/assessing, record keeping, confidentiality (state law), staff roles, insurance coverage including pre-approvals or pre-authorizations for referrals; counseling/psychotherapy training for designated staff.
• Assure systems are in place to allow effective triage (safety/placement) that includes a ‘go-to’ list of providers and facilities to send patients as needed.
• Follow guideline recommendations.

**GUIDE TO THE OFFICE VISIT**
Mental health or emotional issues as chief complaint, OR positive screen on Patient Health Questionnaire (PHQ-2)

**STAFF:** Preparation for Visit

1. **IDENTIFY risk status**
   • Assistant: Perform Chart Review to ensure:
     o Forms/assessments to be completed by patient in chart, AND
     o Score instrument in chart for clinician.
   • Receptionist: Provide questionnaire to assess depression-related symptoms using
     o Patient Health Questionnaire-9 (PHQ-9) OR
     o Beck Depression Index II (BDI II): Questionnaire needs to be purchased in advance.
     o Both are available with other screening tests in the Guidelines for Adolescent Depression – Primary Care Toolkit (GLAD-PC Toolkit pages 66-93).

**CLINICIAN:**

2. **ASSESS for Depression**
   • Review symptom assessment and scoring
   • Interview with patient and family/caregiver to identify contributing factors – school failure, family conflict, social problems, alcohol/drug use, other warning signs.
• Collect collateral information and family history to help distinguish adjustment disorders and family relationship issues; also family members currently or previously treated for depression -- if a family member is (was) effectively treated with a serotonin reuptake inhibitor (SSRI), it might be a reasonable first choice given the number of options available.
• Assess for safety/suicide risk and appropriate level of care.
• Refer to Crisis or Emergency Services if necessary.

3. DIAGNOSE and Rate Severity
• Provide diagnosis; rate severity: mild, moderate or severe [based on number of symptoms present].

4. EDUCATE – Key messages
• Depression is an illness, not a weakness; very common, no one’s fault, usually involves genetic and environmental factors.
• Functional impairment in various domains can be manifestations of the illness.
• Depression can be a recurrent illness – recovery may take a while.
• Key to overcoming depression is staying with the treatment plan long term.
• Stress in the parent-child relationship, if present, may be part of the problem.
• Ask adolescent about future goals – if none, be wary of suicidal ideation.

5. INITIAL MANAGEMENT
• Discuss limits of confidentiality, state laws
• Emphasize monitoring symptoms, especially changes reflecting increasing suicidal ideation. For guidelines, see the algorithms on page 16-17 of the Guidelines for Adolescent Depression in Primary Care.
• Offer referral for peer/family support, community resources, etc.
• Facilitate parental and patient self-management; provide written materials and websites for more information.

6. CONSIDER CONSULTATION with mental health specialist – Recommended for severe or complicated depressions, or for interventions not within scope of the pediatric practice
• Decide to treat in practice OR refer to trusted network of mental health providers.
• If referred, designate case coordination responsibilities; follow-up plan.
• Maintain contact with mental health specialist as long as such treatment continues.

7. TREATMENT PLAN if treating in practice
• Include family -- set specific goals for key areas of functioning -- home, peer relationships, school, and work.
• MILD Depression:
  a. Active support and monitoring for 6-8 weeks – contact every 1-2 weeks.
• MODERATE OR SEVERE:
  a. Initiate shared decision discussion about therapy
     i. Psychotherapy and/or anti-depressants, and
     ii. Review benefits and risks of each option including the Black Box warning regarding SSRIs and suicide risk.
  b. Discuss preferences and plan for chosen treatment
     i. Emphasize importance of finding a therapist you feel comfortable with for psychotherapy.
  c. Discuss common medication side effects
     i. Emphasizing temporary nature and importance of not stopping medication without calling first.
     ii. Discuss more serious adverse effects, especially suicidal ideation; emphasize careful monitoring due to increased risk earlier in treatment.
  d. Develop safety plan for acute crisis, deterioration of symptoms.
  e. Consider ongoing mental health consultation.
  f. Evaluate response at 6-8 weeks.
8. FOLLOW-UP MANAGEMENT at 6-8 week visit

- MILD Depression:
  - If persistent: Institute treatment as moderate cases OR refer to mental health.
  - If improved: Continue monitoring monthly for 6 months, regular follow-up for 2 years after resolution of symptoms.

- MODERATE or SEVERE:
  - If not improved:
    a. Reassess the diagnosis.
    b. Consider adding a medication, increasing the dosage, or changing medications if already on maximum dosage; Guidelines for SSRIs management in GLAD-PC Toolkit, pages 86-93.
    c. Add psychotherapy if not already using, or intensifying current therapy.
    d. Consider referral to mental health.
    e. Provide further education, review safety plan, continue ongoing monitoring.
    f. Evaluate response again at 6-8 weeks.
  - If partially improved:
    a. Consider adding a medication or increasing the dosage.
    b. Add psychotherapy if not already using, or intensifying current therapy.
    c. Consider referral to mental health.
    d. Provide further education, review safety plan, continue ongoing monitoring.
    e. Evaluate response again at 6-8 weeks.
  - If improved:
    f. Continue prescribed medication for 1 year after symptom resolution.
    g. Continue monthly monitoring for 6 months.
    h. Provide regular follow-up for 2 years after resolution of symptoms.

Final Thoughts
Adolescent depression challenges everyone – from the affected young person to the parents and providers, and the entire health care system. The fragmented care and lack of support for primary care undermines early identification and timely treatment.

But, there is plenty that can still be done:
1. Increase the rate of identifying depression in adolescents with systematic screening.
2. It is imperative to assess the symptoms at every visit because depression is so closely associated with suicidal thoughts and behavior.
3. Provide empathy, support, and education to all diagnosed with depression – may be all that is needed for half.
4. Facilitate psychotherapy; it is preferred by most adolescents and is effective if they are comfortable with the therapist.
5. Prescribe proven anti-depressant medication for those who prefer it, but monitor carefully for suicidal ideation, especially early in treatment; use the “start low, go slow” approach.
6. The most effective medical management plan also includes psychotherapy with Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (IPT).
7. Involve parents; educate and stress that it is virtually impossible to successfully adolescent depression without the parents being involved. Parents must pay attention to how their children are doing.
8. Advocate for changes in health care systems that will integrate mental health services, and promote the medical home model for primary care

For other information and useful links, visit the American College of Preventive Medicine website at www.acpm.org.