MANAGING ADOLESCENT DEPRESSION

The Complete Guide for Primary Care Clinicians

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Preface

If you are a primary care clinician (PCC), you probably already know that during the last thirty years there has been a dramatic decrease in many of the most common problems of childhood, ranging from otitis media and meningitis to even dental caries. Increasingly, as a PCC, you are finding that much of your day's work is involved with children and youth with chronic health problems, many of which are behaviorally based, and/or with children and youth who have mental health problems. In the landmark Global Burden of Disease study, Murray and Lopez (1996) determined that seven out of the top ten problems contributing to the overall global burden of disease were related to behavior, mental health, and lifestyle. These findings applied not only to adults, but also to those between 5 and 18 years of age. Among persons ages 15 to 44, depressive disorders and acquired immune deficiency syndrome (AIDS) accounted for the top two causes of "disease burden" both currently and projected forward to the year 2020. These original findings have been confirmed by the *World Health Report* (World Health Organization, 2001).

Teen depression appears to be on the rise. More adolescents are affected by it than during previous decades, and when they are affected, they tend to get it at younger ages. Thus, psychological and behavioral disabilities—whether depression or attention deficit hyperactivity disorder (ADHD)—appear to have taken the place of infectious diseases as the most important and common problems among adolescents in PCCs' practices. Among youth, it is now known that depression occurs in rates similar to that of adults, and almost half of adults who suffer from depression throughout their lives experience their first episode during their youth (Kessler, Avenevoli, & Ries Merikangas, 2001). As a practicing PCC, you probably know that just like rates of depression, rates of youth suicide have risen in recent years; and as in adults, depression in teens is intimately linked to youth suicide. But you may be surprised to learn that the yearly number of deaths due to youth suicide equals all biomedical causes of youth death combined and is second only to auto accidents as a cause of death among 14- to 21-year-old youth.

To cap it all off, clinicians are now understanding that a host of stressful childhood problems (adverse childhood experiences, or ACEs) are linked to long-term poorer health outcomes in later life, from depression and suicide to diabetes and heart disease (Dube et al., 2001; Felitti et al., 1998; Felitti, 2009). Because the foundations of lifelong physical and emotional health are laid down in childhood and adolescence, twenty-first century pediatrics must now come fully forward to confront these too-long overlooked problems previously placed in mental health specialty silos (Shonkoff, Boyce, & McEwen, 2009).

For all of these reasons, in 2000 the Surgeon General (Office of the Surgeon General, 2000) warned that adolescent depression was now a major public health crisis and argued for the need for increased mental health services for this group, beginning first in primary care. Not surprisingly, the U.S. Preventive Services Task Force (Agency for Healthcare Research and Quality, 2009) recommended screening of adolescents for major depressive disorder (MDD), when systems are in place to ensure accurate diagnosis, appropriate treatment, and follow-up—hence the need for this book.

In 2007-2008, the coeditors of this book published the results of an extensive consensus process related to optimal treatments of adolescent depression, "Guidelines for Adolescent Depression in Primary Care" (GLAD-PC; Cheung et al., 2007, 2008;

Zuckerbrot et al., 2007). This consensus process and the resulting GLAD-PC were developed because, across North America, shortages of child and adolescent psychiatrists and other mental health specialists have been keenly felt, particularly by PCCs who have been unable to obtain specialty treatment for depressed youth in their practices. As a result, much of the public health demand for assistance has fallen to PCCs, yet specific guidance and support, including assessment and treatment guidelines, have been unavailable for managing teens with MDD.

What is known about teen depression? What causes it? How do you screen for it? What is an adequate depression diagnostic assessment? What are the risks associated with depression, such as teen suicide? Are there effective treatments, and, if so, what are they? Concerning treatments, which of them might be delivered within primary care? What treatments must be provided by specialists? What are the appropriate responsibilities of the PCC when dealing with such an adolescent? What is your role with respect to the mental health specialist, and how should the two disciplines communicate and work together on behalf of a depressed youth? What should the PCC do if few or no specialty mental health services are available?

Thinking beyond these immediate clinical duties, how might you, as a PCC, effectively organize the primary care office setting to respond to depression and related problems that affect as many as 50 percent of youth over the adolescent years? And perhaps lastly, but critically, how do you pay the bills, particularly in the United States, where mental health care is often not supported to the same extent as other health care needs? While scarcities for mental health services exist both in the United States and Canada, there is an underlying assumption within Canada that mental health care—when provided—is provided at no cost to the patient. Because this same provision does not yet apply in the United States, attention to cost issues is quite critical.

This book addresses all of these issues. In Chapter 1, two of the coeditors address why, as a PCC, you are ideally situated to address MDD in youth. This chapter, as do all the chapters throughout the book, models "primary care-mental health collaborative relationships" ensuring that both an expert PCC (Stein) and a mental health specialist (Jensen) worked together to craft the content, so that it is not only applicable within primary care, but also reflects the latest mental health science that the field has to offer. Together, Stein and Jensen describe the unique mental health issues in primary care and discuss why and how PCCs are uniquely poised to address depression in teens—sometimes, even more effectively than mental health specialists—given their special long-term family relationships.

Chapter 2 provides an overview of what is known about youth depression. Fortunately, coincident with the rising rates of youth depression, there are now many new research findings. One of the key architects of the single most important study examining treatments of depression is Bruce Waslick. He and his primary care (Brooks and Burns) and mental health (Sarvet) coauthors provide an overview of what is known about youth depression, its causes, correlates, and consequences.

The two additional chapters (Chapters 3 and 4) that follow discuss optimum methods for screening of depression in primary care (Zuckerbrot and Berger-Jenkins) and how to employ appropriate strategies for assessing and diagnosing depression and comorbid conditions (Zuckerbrot and Steinbaum).

Additional information is provided in Chapter 5 (Ghalib, Bernstein, and Soren) concerning assessment and management of suicide risk and how PCCs, such as yourselves, can effectively handle such emergency situations.

One particularly thorny issue that all PCCs must confront when dealing with teens is that the nature of the child-PCC relationship changes once the teenager begins to

take increasing responsibility for his or her own health care actions. During these years, issues of confidentiality become quite critical, and the teen's ability to have an effective therapeutic relationship with a doctor—apart from his or her parents—becomes paramount. These issues are addressed by Laraque and colleagues (Hoagwood and Hoagwood) in Chapter 6. This important chapter outlines the key principles for working with parents and youth as active partners in managing teen depression.

Given the shortage of mental health specialists, it seems highly likely that treatments for depression will increasingly rest upon your shoulders. So what kind of useful psychological support can you actually offer? Or when a long wait for a mental health referral is needed, what can or should you do in the meantime? Can you assist? Stein and Jensen review the evidence in Chapter 7, as well as offer practical strategies about what you, as the PCC, can do, even when not employing formal "psychotherapy."

Cheung, also a coeditor, along with Sacks, reviews the role of medication treatments for depression in Chapter 8, including strategies for initiating, titrating, monitoring, and eventually tapering the most common medications for depression (selective serotonin reuptake inhibitors; SSRIs). While still controversial in the public eye, the evidence has become increasingly clear that at least some SSRIs are safe and effective, *if* appropriately monitored by the adolescent's prescriber. In fact, since the SSRI concerns raised in the media between 2004 and 2006, and the Food and Drug Administration's (FDA's) actions in black-boxing all of the SSRIs as possible contributors to increased suidical ideation in some youth, SSRI prescription rates among youth have dropped as much as 20 percent. This was followed by the largest year-to-year increase in youth suicide rates during the same period, according to recent Centers for Disease Control reports.

In Chapter 9, Cheung and Asarnow review the formal psychotherapies for depression, including Cognitive Behavioral Therapy—both group and individual—as well as Interpersonal Psychotherapy for adolescents. While many studies of adolescent depression have now been conducted and several forms of therapy have been shown to be effective, the problem is that—even now—most psychotherapists are not specifically trained in either of these two forms of psychotherapy. It is essential for you to be aware of what these therapies are, what they have to offer your patients, and then become sufficiently knowledgeable to assist the family in getting those effective forms of psychotherapy whenever possible.

All of this of course presumes that you, as the PCC, are able to make a referral and that the family actually follows through with the referral. In Chapter 10, Jensen and Stein discuss the challenges in making an effective referral. Tackling the obstacles of getting a family to follow through with a referral, they discuss what you can do when it seems like there is no one to whom you can refer.

So now that you have actually connected your adolescent and family with a mental health provider, what do you do? What are your various roles and responsibilities, and how might these functions differ, depending on the type of collaborative model that best fits you and your practice? Sulik and Dennis address these issues in Chapter 11, and then, in Chapter 12, describe how to apply these collaborative approaches for complex, comorbid patients.

In Chapter 13, Campo, Robbins, and Jensen discuss how you might usefully redesign and reorganize your primary care practice setting to incorporate the latest proven methods for identifying, assessing, diagnosing, and treating youth with depression. Of course, the actual effectiveness and extent of the deployment of these strategies within primary care will depend on the degree to which you, as the PCC, can adjust your practice model to accommodate chronic illnesses rather than short-term acute

illnesses. These steps entail learning about, and then jointly putting into place, many of the strategies noted above in the previous chapters. These include setting up an ongoing database to monitor and track patients, effective screening procedures, involving and activating families as key partners in the health care process, long-term maintenance strategies, and the use of decision tools to assist the physician in making critical determinations about optimal care at critical decision points.

And last but not least, Wegner and Houston describe, in Chapter 14, how you, as a busy PCC, at least within the United States, can take advantage of appropriate billing codes and reimbursement procedures to ensure that you can be compensated for rendering crucial assessment and treatment services for depressed youth in primary care settings. While variations in reimbursement procedures exist from state to state and from insurance plan to insurance plan, efficient office managers and well-organized primary care practices can take these issues into account to manage the chronic behavioral health problems effectively, including adolescent depression, and, yes, even be compensated appropriately!

Fittingly, almost all of the contributors to this volume were key participants in the development of GLAD-PC. The recommendations and algorithm from GLAD-PC are included in the appendixes (Appendixes 1 and 2) and are available on line at http://www.glad-pc.org. For the full set of guidelines, see Zuckerbrot et al. (2007) and Cheung et al. (2007). As you will see by perusing them, GLAD-PC attempts to take into account the necessary strategies that you will need to employ to effectively identify, diagnose, and manage depression in your practice setting. GLAD-PC was developed for those in the age range of 10 to 21 (preteens, adolescents, and young adults), who are assessed by you to be developmentally "adolescent." Use this book in the same way, including the younger and older age ranges when pubertal status and level of functioning fit those of a teen.

No guideline is complete without a user-friendly toolkit. Having at your fingertips readily applicable tools and efficient algorithms that you can use despite many other pressures is critical, if a guideline is to achieve its intended purpose. While a robust set of GLAD-PC tools are provided in the appendixes in this volume, we have provided them with the assumption that while they will help you, you will succeed best if you obtain additional training and take the critical steps to redesign the practice setting to better manage chronic illness. For information about how you can get additional training in managing teen depression, see the Web site of the nonprofit REACH Institute (http://www.thereachinstitute.org).

The challenges of teen depression are going to be here for the foreseeable future. As a consequence, all PCCs, including pediatricians, family practitioners, nurse practitioners, and physicians' assistants will be central to effective national strategies for managing teen depression. Hopefully, this handbook makes it possible for you, the primary care community, to do just that.

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About the Editors and Authors

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Dr. Zuckerbrot completed the combined residency in pediatrics/general psychiatry/child and adolescent psychiatry at Mount Sinai School of Medicine and then completed a three-year T-32 research fellowship at Columbia University, studying ways to integrate mental health into primary care. She is one of the lead authors of GLAD-PC (Guidelines for Adolescent Depression in Primary Care) and is often consulted on mental health screening in primary care. She has been involved in several national projects integrating mental health into primary care and has been involved with both the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry on collaborative projects. Dr. Zuckerbrot also maintains a private practice in Manhattan.

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was a recipient (with Laurie Bauman, Ph.D.) of a prestigious Robert Wood Johnson Investigator Award in Health Policy.

Nationally, Dr. Stein served as president of the Academic (previously Ambulatory) Pediatric Association and is a recipient of the Academic Pediatric Association Research Award. She has been a member of a number of advisory boards, including the Board of Children, Youth, and Families (National Research Council and the Institute of Medicine). She was cochair of the board's congressionally mandated Committee on the Evaluation of Child Health, which published *Children's Health, The Nation's Wealth: Assessing and Improving Child Health*. She was a member of the Executive Committee of the Board of the Center for Child Health Research of the American Academy of Pediatrics and served on the Scientific Advisory Board of the National Institutes of Health (NIH) Roadmap project on patient-reported outcomes measurement information system and the Board of Scientific Counselors of the National Center for Health Statistics. As chair of the New York Academy of Medicine Forum on Child Health she participated actively in developing the Guidelines for Adolescent Depression in Primary Care (GLAD-PC). She has published extensively on the topics of children with chronic conditions, measurement of child health, and mental health issues in primary care.

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Dr. Jensen is the author of nearly 300 peer-reviewed articles and chapters and twenty books, and has received awards for his teaching and research from many national organizations, including the American Psychological Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the Society for Child Psychiatric Nursing, National Alliance on Mental Illness (NAMI), and and Children With Attention Deficit Disorder (CHADD).

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clinical care for youth depression and suicidality, with an emphasis on cognitive behavioral treatments, work with families, and community-based treatment and service strategies.

Evelyn Berger-Jenkins, M.D., M.P.H., F.A.A.P., is a member of the Division of General Pediatrics at the Columbia Presbyterian Children's Hospital of New York where she cares for patients in the primary care setting, teaches pediatric trainees, and is pursuing implementation and evaluation of community-based health promotion programs. After attending Columbia University's College of Physicians and Surgeons and completing her pediatric residency at Columbia University Medical Center's Children's Hospital of New York, she completed a general academic pediatric fellowship at Mount Sinai Medical Center in order to pursue her goal of implementing and evaluating community-based projects in underserved communities. During the fellowship she completed two research projects: one on the sources of health disparities in the treatment of childhood attention deficit hyperactivity disorder (ADHD) and the other on the evaluation of school-based health promotion programs.

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Dr. Brooks is interested in primary care approaches to improving health care quality for common pediatric conditions including obesity and mental health problems. She heads her practice's quality improvement committee and has implemented several projects in improving primary care delivery of behavioral health services, including practice-wide projects in depression screening, evaluation, and treatment and improvement of attention deficit hyperactivity disorder (ADHD) services. She served as a consultant on the implementation of systematic behavioral health screening for the Massachusetts Children's Behavioral Health Initiative and is serving as clinical faculty for the revision of the National Initiative for Child Health Quality/American Academy of Pediatrics ADHD toolkit.

James J. Burns, M.D., M.P.H., F.A.A.P., is now a clinical professor of Pediatrics at Florida State University College of Medicine and practices in Pensacola, Florida. He is a graduate of the United States Naval Academy and the Pennsylvania State University School of Medicine. Dr. Burns did his internship, residency, and fellowship at the Naval Hospital San Diego. He is board certified in both pediatrics and adolescent medicine, and has taught medical students and residents for twenty-four years. After a career as an academic pediatrician in the United States Navy, Dr. Burns was associate

professor at West Virginia University School of Medicine. He then served as director of the Division of General Pediatrics at Baystate Children's Hospital and was an associate clinical professor of pediatrics at Tufts University. While in Massachusetts, Dr. Burns received his M.P.H. from the University of Massachusetts. He is the author and coauthor of numerous publications.

John V. Campo, M.D., is chief of Child and Adolescent Psychiatry, medical director of Pediatric Behavioral Health, and professor of clinical psychiatry and pediatrics at the Ohio State University and Nationwide Children's Hospital. A graduate of Lafayette College and the University of Pennsylvania School of Medicine, he completed pediatric training at the Children's Hospital of Philadelphia, followed by residency in general and child and adolescent psychiatry at the Western Psychiatric Institute and Clinic and the University of Pittsburgh Medical Center. Dr. Campo is board certified in pediatrics, psychiatry, and child and adolescent psychiatry, and has been honored by inclusion in Best Doctors in America and America's Top Doctors, as a National Alliance on Mental Illness (NAMI) exemplary psychiatrist and as recipient of the American Academy of Child and Adolescent Psychiatry's Simon Wile Leadership in Consultation Award. The beneficiary of federal funding, Dr. Campo's clinical and research interests include the integration of mental health services into primary care, psychopharmacologic safety, suicide prevention, and the relationship between pediatric functional abdominal pain, anxiety, and depression.

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Before joining NYSOMH and Columbia University, Dr. Hoagwood was associate director for child and adolescent mental health research with the NIMH and oversaw the entire portfolio of research on child and adolescent mental health. At NIMH, she was also chair of the Child and Adolescent Research Consortium, an interdisciplinary forum of scientists across the National Institutes of Health (NIH). From 2000-2001 she served as scientific editor for the Office of the Surgeon General's National Action Agenda on Children's Mental Health. Among Dr. Hoagwood's awards and honors are the Outstanding Scholar in Education Award from the University of Maryland and the American Psychiatric Association's Distinguished Contribution Award in School Psychology.

Michael Houston, M.D., is a child, adolescent, and adult psychiatrist. He is an associate clinical professor of psychiatry and pediatrics at the George Washington University Medical Center where he is actively involved in the education of medical students and resident physicians. Dr. Houston is an active member of the American Academy of Child and Adolescent Psychiatry and is the chair of their Committee on Healthcare Access and Economics. He is also chair of the Council on Children, Adolescents, and Their Families for the American Psychiatric Association. Dr. Houston is in private practice in Washington, DC.

Danielle Laraque, M.D., F.A.A.P., is the chair of the Department of Pediatrics and vice president of the Maimonides Infant and Children's Hospital in Brooklyn, New York. Prior to this role, she was professor of pediatrics and professor of preventive and community medicine, and the endowed Debra and Leon Black Professor of Pediatrics, as well as the chief of the Division of General Pediatrics, vice chair for public policy and advocacy in the Department of Pediatrics (2000-10), at the Mount Sinai School of Medicine. She is a nationally and internationally recognized expert in injury prevention, child abuse, adolescent health risk behaviors, and in the issues critical to health care delivery in underserved communities. In the past decade, she has focused her attention on defining systems' changes that will facilitate the integration of the identification, diagnosis, and treatment of children's mental health problems in primary care settings. She has authored over 100 peer-reviewed publications and chapters, hundreds of presentations, and is the recipient of numerous awards, most recently the American

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Dr. Laraque completed her medical studies at the University of California at Los Angeles where she received the Roy Markus Scholarship (1977-81). Her internship and residency were completed at the Children's Hospital of Philadelphia where she was also a Robert Wood Johnson Fellow in General Academic Pediatrics (1984-86). She is the immediate past-president of the Academic Pediatric Association (APA, 2010). She is also the American Academy of Pediatrics (AAP) District II (NYS) Vice Chair (2004-10). She was appointed to the AAP National Mental Health Task Force (MHTF, 2005-10) and chairs its Decision Support Committee. She was a member of the Maternal and Child Health Bureau, Bright Futures National Health Promotion Workgroup (1998-2004) and the national AAP Bright Futures Project Advisory Committee (2004-07). She was the 2001 United States Public Health Service Primary Care Policy Fellow and a member of the National Institute of Mental Health Standing Committee on Interventions for Disorders Involving Children and Their Families (2006-10).

Darryl A. Robbins, D.O., F.A.A.P, is a clinical assistant professor in pediatrics at The Ohio State University College of Medicine. He is a graduate of Dickinson College and Philadelphia College of Osteopathic Medicine, and completed his pediatric residency at Cincinnati Children's Hospital Medical Center, where he was the first recipient of the Samuel Dalinsky Memorial Award as outstanding graduating pediatric resident. Dr. Robbins is a recertified Diplomat of the American Board of Pediatrics. He has been in private practice for the past thirty-five years in addition to being actively involved at Nationwide Children's Hospital, where he is a past president of the medical staff. For the past decade, Dr. Robbins has been president of Children's Practicing Pediatricians, an umbrella organization for the primary care private practice pediatricians in central Ohio. He has received several honors including The Ohio State University College of Medicine Lifetime Achievement Award and the Nationwide Children's Hospital Career Contribution Award. He was named Teacher of the Year twice by the pediatric house staff at Nationwide Children's Hospital and has been included annually in Best Doctors in America.

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Dr. Wegner is the immediate past-chairperson of the American Academy of Pediatrics (AAP) Section on Developmental and Behavioral Pediatrics (SODBP) and was appointed in 2007 to the AAP Committee on Coding and Nomenclature. She is chairperson of the SDBP/SODBP Coding Committee—a combined effort of the AAP SODBP and the Society for Developmental and Behavioral Pediatrics (SDBP). She was a member of the AAP Task Force on Mental Health (2006-09), is the AAP liaison to the American Academy of Child and Adolescent Psychiatry's Committee on Health Care Access and Economics (2006-present), and represented both the AAP and the SDBP to the 2008 American Academy of Child and Adolescent Psychiatry (AACAP) Research Group Committee for developing the *Parent's Medication Guide for Pediatric Bipolar Disorder.* Dr. Wegner's areas of particular expertise are executive functions and emotional regulation in children and adolescents, specific learning disabilities, language development and disorders, and payment for mental health services in non–mental health care settings.