Q&A Summary

Adolescent Depression: Diagnosis, Management and Suicide Risk

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Available On Demand:
optumhealtheducation.com/adolescent-depression-2019

Screening tools

Some clients have stated that depression screenings are not covered under annual wellness exams. How do we overcome that and make them mandatory, so they are part of the routine screening?

Make sure you are linking your screening to Z13.31 (screening for depression). If you are using this, but still being told it is not covered, check the CPT code. Some payors are asking for the following (screening only, never for diagnostic), G0444-annual depression screening. Check that it is on your fee schedule with your payer as well. If you have additional questions on billing and coding, feel free to reach out to the American Academy of Pediatrics coding hotline if you are a member of the Academy.

Do the screening tools include trauma-informed care questions?

The development of screeners is often done with one condition in mind. Therefore, there are specific trauma questionnaires. However, there are some screeners that examine the cross-section of trauma with depression and other psychosocial factors, including the Trauma Symptom Checklist for Children (TSCC) and Strengths and Difficulties Questionnaire (SDQ) available here: https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews.

Can you provide more information on the Patient Health Questionnaire for Adolescents (PHQ-A) questionnaire?

Here is a link to the screener with scoring:
http://contentmanager.med.uvm.edu/docs/yhii_chapter_9_mental_health/vchip-documents/yhii_chapter_9_mental_health.pdf?sfvrsn=2.

This screener was shown to have the highest predictive value. See this review from the US Preventative Task Force:
https://pediatrics.aappublications.org/content/pediatrics/137/3/e20154467.full.pdf.

Here is the paper from Richardson, et al. about the PHQ-A:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217785/.

Teen resistance

What does a clinician do if a parent reports that an adolescent has refused to see a therapist or go to a therapy appointment?

It is important to work with the teen by using motivational interviewing techniques. Explore reasons for not wanting to go or refusal, including beliefs about therapy and what the purpose is from the adolescent's perspective. Try to find the "why" that will motivate them, and explore their ambivalence by asking them their reasons for wanting a change or concerns about the work to make the change. It is important not to give advice and to listen and reflect back the teens' values, reasons and thoughts.

Here is some information about the basics of motivational interviewing: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/motivational-interviewing.aspx.

Consider going to this website for more information on using motivational interviewing with teens: https://www.newportacademy.com/resources/empowering-teens/how-motivational-interviewing-helps-teens/.

How do you manage/motivate a teen who does not want to go to therapy and is non-compliant with medications?

Again, it is important to use motivational interviewing plus psychoeducation. Luckily for those of you in primary care practice, you have rapport with the family. Acknowledge the reasons the teen supplies you. Reflect back their words. Use the Ask-Tell-Ask framework so that you don't lecture the teen but invite them to be a part of the conversation. Ask the teen what they know about the medication and what they know about how it works. Explore what reservations they have, including side effects or any misconceptions that they may have. Many children and teens do not want to be on medicine unless they have to be—including citing that they don't want to be different than their peers.

Here are some strategies to improve medication adherence with youth: https://www.psychiatrictimes.com/child-adolescent-psychiatry/strategies-improve-medication-adherence-youths.

Guidance on the Ask-Tell-Ask framework: http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/ConnieDavis-WhatIsAskTellAsk.aspx.

More information on depression: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/depression.aspx.

Puberty/hormones

At the beginning of the training it was said that "being female has a likelihood of recurrent depression." Do studies indicate that this could be due to hormonal imbalances? How much of a role does that play?

There was an interesting study that concluded: “especially the effect of sex steroids on the maturing HPA [hippocampus-pituitary-adrenal] axis makes girls more sensitive to the effects of stress, whereas androgens appear to play a protective role in boys. Together with a genetic predisposition and/or psychosocial factors, this may trigger an easier onset of depression in girls. Thus the greater prevalence of depression in adolescent girls likely results from a combination of profound hormonal changes, fluctuations in hormone levels and psychosocial factors.”

For more, see “Sex Differences in Adolescent Depression: Do Sex Hormones Determine Vulnerability” by Naninck, Lucassen, & Bakker: https://orbi.uliege.be//bitstream/2268/93102/1/jne_2125.pdf.

How do you differentiate "normal teen” behavior from major depressive disorder (MDD), (ie, teens staying in their rooms and just being moody; hormones vs MDD)?

This can be tricky, but the key is to look for clues that the teen is having prolonged symptoms that impair function in multiple settings and across interpersonal relationships for more than just a few hours or days. MDD has to be at least 2 weeks in length. However, you need to rule out additional possibilities such as substance use/abuse. Look at severity and duration as well. https://www.health.harvard.edu/blog/distinguishing-depression-from-normal-adolescent-mood-swings-20100913335.

Medication

You spoke of lower doses of medication in adolescents; however, many adolescents have weights comparable to adults. Should this impact dosing?

In pre-pubertal children, I always start a little lower than the recommended dose as a “test” dose, especially if the child has never taken any medications before. This is because they are more sensitive and can experience insomnia, restlessness and hyperkinesis. A rule of thumb is to start low and go up as needed. In this way you can end on the lowest dose possible with optimal effect. As long as no or minimal adverse effects occur you can continue to titrate while monitoring response to medication (positive and negative).

What medication would you initiate when a teen presents with MDD symptoms but the family history is significant for bipolar disorder in first-degree relatives?

My personal opinion would be to go with fluoxetine or sertraline regardless. I keep pertinent family history in mind when monitoring the course of the adolescent’s symptoms. It is possible that treating with an antidepressant alone in adolescents with positive family history may increase the likelihood of mixed or manic episodes, so one should be mindful. Per this paper, in some cases it was the result of an increase in dose after previously tolerating lower doses, but cessation of antidepressant treatment led to resolution of symptoms: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2655139/.

What about Wellbutrin (bupropion) for adolescents?

Its safety for use in adolescents under 18 years of age has not been established given limited/few clinical trials in this population. However it may be used off label.

https://keltymentalhealth.ca/sites/default/files/documents/bupropion_medication_information_-_may_2013.pdf

Wellbutrin for attention-deficit/hyperactivity disorder (ADHD):
https://www.additudemag.com/medication/wellbutrin/

Can you prescribe an antidepressant for adolescents who are also on medication for ADHD?

Fluoxetine can be safely combined with stimulants. However, whenever there are two possible conditions, you need to determine which symptoms are dominant or more severe. Treat one first and utilize behavioral strategies, parent training and other supports as well. It is important to look at the whole picture when considering treatment. If family dysfunction or drug abuse is happening, you must address some of the root causes of the clinical presentation.

The Texas Children's Medication Algorithm Project: update from Texas Consensus Conference Panel on Medication Treatment of Childhood Major Depressive Disorder:
https://pdfs.semanticscholar.org/78bf/a876a25552e9856d942e89c9496f2a60551b.pdf.

Major Depression with ADHD in children and adolescents:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2990565/.

Vitamin D

Vitamin D deficiency played a major role in my family member's adolescent depression. What are your thoughts on this, particularly in darker-skinned individuals?

The mechanism by which vitamin D improves depressive symptoms is unclear. However, there are several promising studies of the use of vitamin D, including this one:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2908269/.

However, there is a need for more studies to establish causality between vitamin D deficiency and depression: http://www.jneuropsychiatry.org/peer-review/depression-and-vitamin-d-deficiency-causality-assessment-and-clinical-practice-implications-12051.html.

A rigorous, randomized, controlled trial specifically in adolescents is underway:
https://www.ncbi.nlm.nih.gov/pubmed/29490621.

As with other complementary therapies, I am not opposed to its use if it is safe, affordable and does not substitute for more intensive treatment in cases where the patient has moderate-severe depression and is suicidal. In cases where you have time to try this as one option, I think it is worth trying. It is worth evaluating for vitamin D deficiency when an adolescent patient presents with depressive symptoms. If found deficient, you should provide supplementation.

Complementary and alternative medicine (CAM)

How do you feel about using St. John's Wort and/or cannabidiol (CBD) oil in lieu of traditional medications?

I have not traditionally prescribed either St. John's Wort or CBD for my patients. As with any of the herbal supplements, I warn my families that over-the-counter supplements may have variable concentrations given the lack of regulation by the US Food and Drug Administration

(FDA). Moreover, there are no studies that have been done on the efficacy of CBD for children, and thus I always urge caution. I thank the families for being honest about telling me whether they have or are thinking about using alternative therapies, because it is important for medical professionals to know, especially if any medications are prescribed. https://childmind.org/article/cbd-what-parents-need-to-know/.

I've had my son on antidepressants at various times over several years. He never continues because he said he doesn't like the way they make him feel (or not feel). Have you ever tried treating with essential oils and/or herbal supplements? If so, have you had any success with these alternative treatments?

I personally have not tried alternative treatments for depression with consistency. It is hard when an adolescent does not adhere to medication for a variety of reasons. However, trying to find an alternate approach that is adolescent-friendly and acceptable is important.
There is some evidence of using folate for supplementation to improve response to SSRIs and SNRIs for depression. If we obtain a Genomind report (this company specifically has *MTHR* in their pharmacogenomic reports) that specifically states a patient has an *MTHR* mutation, we talk about the possibility of trying to supplement with folate. I have had a few patients state it has helped and again, it is worth a try. It is important to engage the adolescent in the discussion of ALL options, review risks and benefits and keep communication open. There should always be discussion about re-evaluation of symptoms and functioning and re-assessment of treatment with definable outcomes. https://onlinelibrary.wiley.com/doi/10.1002/wps.20672.

Telehealth

In telenursing, is the PHQ-A questionnaire applicable to ask the parent alone, or does the adolescent need to answer some of the questions through the parent, as we are not speaking to minors by phone?

The PHQ-A is meant to be administered to the adolescent directly. There are other screeners you can use if you want to obtain parent report of adolescent symptoms and functioning. One is the Strengths and Difficulties Questionnaire, and there are others as well. If you are talking to the parent during the telephonic appointment, you will need to educate the parent as to the importance of allowing the adolescent to complete the screening form on their own. The parent can and should be given time to discuss with you their observations, impressions and concerns. When it comes time to reviewing the screening result, it may be helpful to schedule the appointment when the adolescent can be available to join the call.

What is your experience with using child psychiatrists in a consultative capacity in the outpatient setting? Telephone consultation systems; you mentioned the MA telephonic consultation program. Formal arrangements as in regular meetings with child psychiatrists or something more informal (e.g., as needed curb consults).

I am lucky that currently I have partners who are psychiatrists so I will often go to them for additional guidance or to run cases. It is helpful to do so. During my training in San Diego, we had a monthly developmental behavioral pediatrics and joint child psychiatry seminar where we would run through challenging cases. I started something similar at Indiana University given the ability to promote co-learning and collaboration. I think it always helpful to have the ability to discuss with psychiatric colleagues, for personal learning but also to decide when a patient of mine needs to be transferred to a psychiatrist's care.

What was that program for remote treatment?

CATCH IT. It stands for Competent Adulthood Transition with Cognitive Behavioral Humanistic and Interpersonal Training:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418055/.

Stigma

How do you address the potential concern from parents or the adolescent regarding stigma for not only asking for help but actually seeking and obtaining help?

Here is another resource of Q&A for families developed by the AACAP:
http://www.parentsmedguide.org/parentsmedguide.pdf.

Any pointers on addressing family resistance to higher levels of care? Suppose a child/ adolescent needs a partial hospitalization program/intensive outpatient program (PHP/IOP) but families want to "stick it out" despite NOT making progress?

Again, I would set in motion a treatment plan and set the expectation of reviewing this at periodic intervals. We don't want to get to the point of prescribing a medication or treatment that is not adding value or helping to optimize the functioning of the adolescent. In saying this, I always layer treatments so that we can be clear what the purpose of each therapy/treatment is and what the desired outcome is.

However, sometimes there is need to step up care. I will often preface these discussions with first asking for the opinions of parents and adolescent on the adolescent's ability to manage day to day successfully. Are they able to do the things that they are supposed to do? If the answer is no, we need to re-evaluate how we are going to be addressing those activities of daily living and ensuring quality of life. We set up an agreed upon timeline for which, if we don't see improvement by a certain timepoint, we need to have an honest discussion of what other treatments may be needed. I provide guidance to the family about my own thresholds for stepping up treatment and make sure they understand from the onset that we will be having discussions about this with the adolescent present so that everyone is on the same page.

Resources/Definitions

What's a split visit?

A split visit is the practice of seeing the adolescent separately from the parent or guardian on the same day, during the visit time.

It is helpful to provide some introduction to this the visit before you begin (usually at the 11-year well-child visit—letting the family know that starting at age 12 you will begin to split the adolescent from the parent for a period to allow the adolescent time to talk to the doctor alone).

Dr. Bauer's website/blog

- https://www.letstalkkidshealth.org
- GLAD-PC (http://glad-pc.org/)
- A link to a PDF of the tool kit is located at the bottom of the homepage

Can you define the "CATCH-IT" acronym? What is the name of the online resiliency modules for adolescents?

The Competent Adulthood Transition with Cognitive Behavioral Humanistic and Interpersonal Training (CATCH-IT) was developed as a primary care, internet-based depression prevention intervention. It is a self-guided, online approach to depression prevention: https://clinicaltrials.gov/ct2/show/NCT00152529.

You can refer to the American Academy of Pediatrics (AAP) Mental Health Priorities in Practice videos that cover motivational interviewing and provide clinical scenarios on using this technique in the context of disruptive behavior and aggression, depression, inattention and impulsivity, substance use and self-harm and suicide: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/implementing_mental_health_priorities_in_practice.aspx.

The AAP Screening Technical Assistance and Resource (STAR) Center provides evidence-informed technical assistance and resources to assist practices in implementing effective screening, referral and follow-up for developmental milestones, maternal depression and social determinants of health. The screening widget is helpful to find screening tools for the above conditions plus social-emotional screening. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/default.aspx.

If you have questions regarding this document or the content herein, please contact: moreinfo@optumhealtheducation.com.