Implications of AAP's New Guidelines for Adolescent Depression: Part One

Behavioral Health

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Depression is an important issue facing America's teenagers that often begins in adolescence and continues into adulthood. It leads to a number of adverse outcomes across an individual's life, including strained relationships and decreased productivity in school and at work. Depression impacts not only the individual, but also their family, social network, and broader society. Therefore, the importance of identifying and treating depression during adolescence cannot be overstated.

While there are effective preventive interventions and treatments for adolescent depression, access to mental health care remains low due to barriers including lack of identification, stigma around mental health, a national shortage of child mental health providers and limited insurance coverage. For these reasons, expert panels have promoted primary care as an essential setting to identify and manage adolescent depression. However, surveys conducted by the National Center for Health Statistics indicated that, from 2005 to 2010, **screening for adolescent depression was documented in less than one percent of ambulatory care visits**.

Last month, the American Academy of Pediatrics (AAP) issued updated Guidelines for Adolescent Depression in Primary Care (GLAD-PC). These clinical practice guidelines aim to assist primary care providers (PCPs) in the screening, assessment, treatment and ongoing management of adolescent depression. Since these updated guidelines have the potential to impact so many of our patients as well as adolescents nationwide, we thought it was important to dedicate two posts to the implications of these recommendations and the challenges they pose for both patients and the providers who will implement them. This first blog post will focus on screening for adolescent depression.

So what do these guidelines say? GLAD-PC now recommends depression screening at all well visits starting at age 12 – an update from their previous screening guidelines, which focused on youth who present to PCPs with an emotional problem. This modification puts the AAP in line with recommendations from other organizations, including the United States Preventive Services Task Force (USPSTF).

We commend the AAP, whose voice is invaluable in pediatrics, for modifying the screening recommendations even as we acknowledge that not everyone agrees with these recommendations. There are people in the behavioral health community who are concerned about the accuracy of depression screening tools and who worry that depression screening may lead to the over-identification of adolescents when there are limited health care resources available to treat them. Moreover, PCPs across the country report a number of barriers to screening, including a lack of time and challenges in facilitating care when depression is identified. These are all issues that need to be addressed if we expect PCPs to adhere to these new guidelines.

As a start to addressing these challenges, many health care organizations have integrated depression screens into their electronic health records (EHRs), which has resulted in increased screening rates. As part of

Pennsylvania's Quality Demonstration Grant for the Children's Health Insurance Program Reauthorization Act (CHIPRA), primary care offices at Children's Hospital of Philadelphia (CHOP) transitioned to a fully-automated electronic screening system between 2011 and 2014. Guided by researchers at PolicyLab, CHOP issued an organizational recommendation to use these electronic screens for developmental and behavioral issues at key time points, including for depression at adolescents' age-16 well visits.

We are now analyzing the depression screening data that CHOP has gathered and are very encouraged by what we have found. At CHOP primary care sites that chose to implement the Patient Health Questionnaire (PHQ-9), a tool to screen for depression, providers screened more than 75 percent of adolescents who attended their age-16 well visit. This is a massive increase from the rates seen in national surveys and demonstrates that screening is feasible to implement in primary care. Furthermore, about one-quarter of these screened patients reported elevated depressive symptoms, the majority of whom (78 percent) were not already receiving behavioral health care, suggesting that screening helps PCPs flag previously unidentified concerns in many adolescents.

Recently, CHOP expanded its organizational recommendation to include screening for depression at all well visits for adolescents ages 12 and up. In the months to come, it will be interesting to see how the combination of these modified organizational recommendations and the new AAP guidelines will impact the rates of screening across adolescence at CHOP and across the country. The next crucial step will be figuring out how we can support PCPs in caring for youth identified with depression to ensure that these adolescents receive appropriate and effective care. Stay tuned for the second post in this series, which will dive deeper into that topic.

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