Children's Hospital of Philadelphia PolicyLab

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

Behavioral Health

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In response to increases in adolescent depression and suicide over the past decade, providers, health systems and professional societies are urgently developing strategies to combat this epidemic. Last month, the American Academy of Pediatrics (AAP) issued updated Guidelines for Adolescent Depression in Primary Care (GLAD-PC) that offer recommendations for primary care providers (PCPs) on how to screen, treat and manage depression. In the first blog post in our series on these updated guidelines, we focused on the recommendation to screen for depression at all well visits starting at age 12. In this post, we focus on what happens after that screening takes place and strategies to ensure successful treatment and management of adolescent depression in primary care.

GLAD-PC emphasizes the need to support patients in accessing evidence-based treatments for depression, including medication and psychotherapy. In order for PCPs to do that effectively, it is important that practices are prepared not only to identify adolescent depression, but to manage it in primary care. This may occur though trainings on specific topics such as how to evaluate for depression following a positive screen or how to start a patient on an antidepressant and monitor them for side effects. For instance here at Children's Hospital of Philadelphia (CHOP), providers from the Department of Child and Adolescent Psychiatry and Behavioral Sciences offer free educational programs to PCPs about behavioral health issues, including depression.

While we agree with the guidelines that these types of trainings can help prepare PCPs to identify and manage depression, there are a number of barriers to implementing trainings, including a lack of time, availability and funds. In addition, the evidence suggests that one-time trainings, in the absence of ongoing feedback and support, do not lead to meaningful changes in practice. For these reasons, we think that training alone is likely an insufficient solution for PCPs to effectively treat and manage adolescent depression in primary care.

Given these known barriers to providing trainings, professionals and policymakers are increasingly recognizing the value of specialty consultation to help PCPs treat depression and other behavioral health issues in primary care. Following Massachusetts' lead, many states have implemented telephone consultation services for PCPs to seek guidance from child psychiatrists. Here in Pennsylvania, PCPs have access to the Telephonic Psychiatric Consultation Service Program (TiPS), a program for children covered by Medicaid that was informed, in part, by work from PolicyLab. CHOP's TiPS team covers the Southeast Zone of Pennsylvania. This excellent resource supports PCPs who prescribe medication for a variety of behavioral health problems, including depression. Efforts are underway to expand these services for more children and adolescents.

In addition to consultation models, integrated behavioral health care models have emerged to help address children's behavioral health needs. Most of these models emphasize multidisciplinary care through which children receive treatment for physical and behavioral health problems in the same location. Within CHOP's integrated care initiative, Healthy Minds Healthy Kids (HMHK), behavioral health providers deliver brief, evidence-based interventions to children and families in collaboration with their PCPs. So far, five primary care practices have rolled out HMHK, and CHOP plans to expand it into other sites over the next several years. Preliminary data indicate that families and providers are very satisfied with HMHK, noting that it reduces delays in accessing treatment, allows families to be seen in a familiar setting, and promotes opportunities for collaboration between PCPs and behavioral health providers.

A few studies have examined integrated care for adolescent depression specifically and have found positive outcomes, including improvements in patients' depression and functioning and high patient satisfaction. These models are particularly important if the goal is to offer depressed adolescents evidence-based psychotherapy, one of the GLAD-PC recommendations. As PCPs often do not have the time or training to deliver psychotherapy, these integrated models require a behavioral health provider to deliver these treatments in primary care. In collaboration with primary care sites at CHOP, we plan to examine the feasibility, acceptability and effectiveness of a brief version of interpersonal psychotherapy, an evidence-based treatment for depression that has been tested in primary care practices in New York. We also plan to offer an evidence-based depression prevention program to intervene before adolescents develop more significant depression.

As the AAP calls for increased screening for adolescent depression, it is important to make sure that there are systems in place to ensure that these adolescents receive timely and effective services. We are hopeful that these initiatives – availability of telephone consultation, integrated behavioral health care, and the delivery of evidence-based interventions for depression in primary care – can support PCPs in their efforts to treat and manage depression in primary care.

Jennifer Mautone, PhD, is a psychologist in the Department of Child and Adolescent Psychiatry and Behavioral Sciences and the Center for Management of ADHD at CHOP.

Jami Young
Jami Young
PhD
Faculty Member
Jennifer Mautone
Jennifer Mautone
PhD, ABPP
Faculty Member