Body System: Pediatrics		
Session Topic: Adolescent Depression Management and Bullying Mitigation		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Adolescents are underdiagnosed and undertreated for depression • There have been significant changes between the DSM-IV and the DSM-V with regard to the diagnosis of depressive disorders • Physicians frequently face many barriers to depression guideline implementation • Electronic Health Records (EHR) and PHQ data are frequently not used to optimize depression management, or to document suicidal ideation • There is often a lack of knowledge about medication-related side effects of antidepressants, contributing to patient non-adherence • Several antidepressants have FDA-required Risk	1. Utilize appropriate diagnostic criteria to evaluate and screen adolescent patients for depression, bullying, mood disorders, and suicide risk. 2. Counsel parents and adolescent patents regarding bullying prevention and intervention. 3. Devise collaborative treatment plans, including appropriate psychotherapy and pharmacotherapy (or a combination), that take into account the risks and benefits of various interventions. 4. Coordinate care for adolescent patients who require referral to sub-specialists or admission to hospitals for suicide prevention.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

Evaluation and Mitigation Strategies (REMS) • Suboptimal levels of recognition and treatment are due to a variety of physician, health system, and patient factors • Physicians often lack training and confidence in behavior counseling with adolescents • Access to psychiatry is limited in many communities and diagnosis and treatment of depression often falls to family physicians		

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide strategies for to recognize risk factors for depression in adolescent patients.
- Provide recommendations to utilize appropriate diagnostic criteria to evaluate and screen adolescent patients for depression, mood disorders, and suicide risk.
- Provide recommendations and resources for counseling parents and adolescent patents regarding bullying prevention and intervention.
- Provide strategies and resources to coordinate care for adolescent patients who require referral to sub-specialists or admission to hospitals for suicide prevention.

- Provide recommendations to devise collaborative treatment plans for depression that take into account severity, suicidality, developmental stage, and environmental and social factors.
- Provide an overview of relevant changes is diagnosis between the DSM-IV and the DSM-V.
- Provide an overview of current guidelines for treatment, including updates on the safety and efficacy of pharmacologic therapies; also, including strategies for implementing cognitive behavioral concepts.
- Provide recommendations to maximize office efficiency and guideline adherence to the diagnosis and management of adolescent depression and bullying.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.

Needs Assessment

In the United States, it is estimated that up to 3 percent of children and up to 8 percent of adolescents suffer from depression. Estimates of lifetime prevalence are significantly higher at 18-20%.[1] Reports from the Centers for Disease Control and Prevention (CDC) and the National Institute of Mental Health (NIMH) estimate that 1 in 10 U.S. adults report depression, and approximately 11 percent of adolescents have a depressive disorder by age 18.[2,3] There are approximately 8 million ambulatory office visits per year where the primary diagnosis is depression, and 395,000 discharges from hospital inpatient care per year.[4] Many depressive disorders co-occur with anxiety disorders (such as panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder) and substance abuse. The burden of mental illness is significant for many Americans; it is estimated that nearly 45% of those who have a diagnosable mental disorder meet the criteria for two of more disorders.[5] Depression is the most common mental disorder in adolescence, affecting school performance and personal relationships; which unfortunately sometimes ends with suicide, the third leading cause of death for youth between the ages of 10 and 24, and approximately 157,000 of youth between the ages of 10 and 24 receive medical care for self-inflicted injuries at Emergency Departments each year in the U.S.[6-8] Pediatric depression typically presents in primary care and is undertreated.[9]

Children who are bullied often suffer from depression, and are at greater risk of suicide.[10] Bullying behavior and suicide-related behavior are closely related. This means youth who report any involvement with bullying behavior are more likely to report high levels of suicide-related behavior than youth who do not report any involvement with bullying behavior. It is not known if bullying directly causes suicide-related behavior; most youth who are involved in bullying do not engage in suicide-related behavior. Bullying, along with other risk factors, increases the chance that a young person will engage in suicide related behaviors.[11] Victims of bullying are more likely than those who are not bullied to report feelings of low self-esteem and isolation, to perform poorly in school, not to have a lot friends at school, have a negative view of school, experience psychosomatic problems (e.g., headache, stomachache, or sleeping problems), and to report mental health problems (depression, suicidal thoughts, and anxiety).[12]

Summary of current statistics on bullying and suicide:[13-15]

- Suicide is the third leading cause of death among young people, resulting in about 4,400 deaths per year, according to the CDC. For every suicide among young people, there are at least 100 suicide attempts. Over 14 percent of high school students have considered suicide, and almost 7 percent have attempted it.
- Bully victims are between 2 to 9 times more likely to consider suicide than non-victims, according to studies by Yale University
- A study in Britain found that at least half of suicides among young people are related to bullying
    - 10 to 14-year-old girls, who are bullied, may be at even higher risk for suicide
- In a 2013 nationwide survey, 20% of high school students reported being bullied on school property in the 12 months preceding the survey.
- An estimated 15% of high school students reported in 2013 that they were bullied electronically in the 12 months before the survey.
- During the 2012-2013 school year, 8% of public school students ages 12-18 reported being bullied on a weekly basis.

As such, the scope of this education will encompass child and adolescent depression, suicide prevention, and how to help families cope with bullying. Physicians may want to consider the Olweus Bullying Prevention Program as a resource to help them develop effective programs for reducing bullying among elementary and junior high school aged patients.[10]

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful gaps in the medical skill necessary to provide optimal care and management of depression and suicide.[16] More specifically, CME outcomes data from 2012-2015 AAFP FMX (formerly Assembly) sessions on *Mood Disorders, Depression, and Bipolar Disorders* sessions suggest that physicians have knowledge and practice gaps with regard to standardized clinical monitoring and follow-up; consistent use of patient health questionnaire (PHQ) and other screening tools; screening for comorbid conditions; awareness of current screening guidelines; appropriate use of pharmacologic treatments; being aware that depression is underdiagnosed; and efficiently managing depression within the time frame of a typical office visit.[17-20]

A review of the literature validates these and other practice gaps with regard to diagnosing and managing depression, summarized as follows:[6,21-32]

- Adolescents are underdiagnosed and undertreated for depression
- There is a shortage of providers dedicated to child and adolescent mental health, and limited coverage for mental health services
- Most adolescents do not report depressive symptoms and do not seek treatment
- Long-term depression in adolescence is a predictor of continued mental health problems in adulthood; therefore, it is imperative that depression is recognized and treated early
- There have been significant changes between the DSM-IV and the DSM-V with regard to the diagnosis of depressive disorders
- Physicians frequently face many barriers to depression guideline implementation
- Electronic Health Records (EHR) and PHQ data are frequently not used to optimize depression management, or to document suicidal ideation

- There is often a lack of knowledge about medication-related side effects of antidepressants, contributing to patient non-adherence
- Several antidepressants have FDA-required Risk Evaluation and Mitigation Strategies (REMS)
- Suboptimal levels of recognition and treatment are due to a variety of physician, health system, and patient factors
- Physicians often lack training and confidence in behavior counseling with adolescents
- U.S. Food and Drug Administration boxed warning has been issued because of increased risk of suicidality in adolescents and young adults in the early months after starting SSRI therapy

Physicians may improve their care of adolescent patients with depression by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[30,33-42]

- The AAFP *concludes that the current evidence is insufficient* to assess the balance of benefits and harms of screening for suicide risk in **adolescents**, adults, and older adults in primary care.
- The AAFP *recommends* screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. (2016)
- The USPSTF *recommends* screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation.)
- The AAFP *concludes that the current evidence is insufficient* to assess the balance of benefits and harms of screening of children (7-11 years of age). (2016)
- Don't prescribe antipsychotic medications to patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring.
- Don't routinely prescribe two or more antipsychotic medications concurrently.
- Don't routinely prescribe an antipsychotic medication to treat behavioral and emotional symptoms of childhood mental disorders in the absence of approved or evidence supported indications.
- Because there is no significant difference in performance among the different depression screening instruments, the most practical tool for the clinical setting should be used.
- The PHQ-2 is accurate for depression screening in **adolescents**, adults, and older adults.
- The PHQ-9 is a valid, quick screening instrument for depression that also can be used as a follow-up to a positive PHQ-2 result and to monitor treatment response.
- Physicians should ask about bullying when children and adolescents present with unexplained psychosomatic and behavior symptoms; when they experience problems at school or with friends; if they begin to use tobacco, alcohol, and other drugs; and if they express thoughts of self-harm or suicide.
- Patients identified as bullies should be screened for conduct disorder and other psychiatric comorbidities.

- Cognitive behavior therapy and interpersonal therapy should be used for the treatment of mild depression. Psychotherapy should be used in combination with medication for the treatment of moderate to severe depression in children and adolescents.
- Tricyclic antidepressants should not be used in the treatment of childhood and adolescent depression.
- Fluoxetine, citalopram, and sertraline are recommended as first-line treatments for childhood and adolescent depression.
- Treatment of major depression in children and adolescents should continue for at least six months.
- Children and adolescents taking antidepressants should be monitored closely for suicidal thoughts and behavior.
- Direct inquiry concerning suicidal ideation in patients with risk factors is associated with more effective treatment and management.
- Screening for depression, anxiety, and alcohol use helps to determine symptom severity in a patient with possible suicidal ideation.
- Use of suicide prevention contracts should generally be avoided.
- Treatment of suicidal ideation should include medications and psychological interventions.
- CBT is an effective treatment for mild to moderate depression, anxiety disorders, posttraumatic stress disorder, obsessive-compulsive and tic disorders, autism, eating disorders, personality disorders, insomnia, and attention-deficit/hyperactivity disorder.
- For many psychiatric conditions, CBT provides similar outcomes or additional benefits compared with psychiatric medications alone.

Additionally, family physicians should be familiar with the American Academy of Pediatrics (AAP) guidelines for adolescent depression in primary care and integrate key principles into general practice.[43,44]

The USPSTF recommends screening adolescents 12 to 18 years of age for depression in clinical practices that have systems (or referral systems) in place to ensure accurate diagnosis, psychotherapy (cognitive behavioral or interpersonal therapy), and follow-up; often, physician require guidance toward establishing effective protocols for referral management. Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.[45,46]

Clinical guidelines will often recommend behavioral counseling; however, many practices are not structured to offer these services effectively.[47,48] Physicians should consider how to integrate behavioral health and psychiatry specialists into their practices.[49,50] Physicians should also receive training to appropriately code for offering depression-related services.[51]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference

resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Childhood and adolescent depression[37]
- Screening for depression[39]
- Treatment of childhood and adolescent depression[38]
- Evaluation and treatment of the suicidal patient[36]
- Adolescent health screening and counseling[30]
- Common Questions About Cognitive Behavior Therapy for Psychiatric Disorders[33]
- AAFP Depression. Clinical Preventive Service Recommendation[40]
- AAFP Suicide Screening. *Clinical Preventive Service Recommendation*[41]
- APA Guidelines for Adolescent Depression in Primary Care[43,44]
- Adding health education specialists to your practice[52]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[53]
- The benefits of using care coordinators in primary care: a case study[54]
- Engaging Patients in Collaborative Care Plans[55]
- Medication adherence: we didn't ask and they didn't tell[56]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[57]
- Integrating a behavioral health specialist into your practice[50]
- Managing Behavioral Health Issues in Primary Care: Six Five-Minute Tools[48]
- Simple tools to increase patient satisfaction with the referral process[45]
- Coding for depression without getting depressed[51]
- FamilyDoctor.org. Depression (patient education)[58]
- FamilyDoctor.org. Suicide (patient education)[59]

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