Body System: Psychogenic		
Session Topic: Depressive Disorder Updates		
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 • 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	1. Recognize the risks associated with certain drugs used to treat depression and mood disorders, and know which carry REMS and black box warnings about suicide. 2. Utilize appropriate diagnostic criteria to evaluate and screen patients for depression, mood disorders, and suicide risk. 3. Coordinate care for patients who require referral to sub-specialists or admission to hospitals for suicide prevention. 4. Devise collaborative treatment plans for depression that take into account severity, suicidality, developmental stage, and environmental and social factors.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

are due to a variety of physician, health system, and patient factors • Physicians often lack training and confidence in behavior counseling with adolescents		

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 patients for depression, mood disorders, and suicide risk.
- Provide strategies and resources to coordinate care for 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.

Needs Assessment

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.[1,2] 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.[3] In a given year, nearly 21 million U.S. adults (about 9.5% of the population) have a mood disorder, which includes major depressive disorder, dysthymic disorder and bipolar disorder. 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.[4] 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.[5-7] As such, the scope of this education will encompass child and adolescent depression and suicide prevention.

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.[8] More specifically, CME outcomes data from 2012-2014 AAFP 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; appropriate use of pharmacologic treatments; being aware that depression is underdiagnosed; and efficiently managing depression within the time frame of a typical office visit.[9-11]

A review of the literature validates these and other practice gaps with regard to diagnosing and managing depression, summarized as follows:[5,12-21]

- 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 is 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
- 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 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:[21-30]

- Selective serotonin reuptake inhibitors are more likely than placebo to produce depression remission in the primary care population.
- Serotonin-norepinephrine reuptake inhibitors are slightly more likely than selective serotonin reuptake inhibitors to improve depression symptoms, but they are associated with higher rates of adverse effects such as nausea and vomiting.
- For treatment-naive patients, all second-generation antidepressants are equally effective. Medication choice should be based on patient preferences, with adverse effect profiles, cost, and dosing frequency taken into consideration.
- Antidepressants are most effective in patients with severe depression.
- Preferred agents for older patients with depression include citalopram (Celexa), escitalopram (Lexapro), sertraline (Zoloft), mirtazapine (Remeron), venlafaxine, and bupropion (Wellbutrin). Because of higher rates of adverse effects in older adults, paroxetine (Paxil) and fluoxetine (Prozac) should generally be avoided.
- Treatment for a first episode of major depression should last at least four months. Patients with recurrent depression may benefit from prolonged treatment.
- 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. (2009)
- 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). (2009)
- 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.
- Depression screening in older adults can be accomplished with multiple instruments, including the PHQ-2, PHQ-9, and various Geriatric Depression Scales.

- 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.
- Current evidence does not support the routine use of vortioxetine in the treatment of depression.

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.[31,32]

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.

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.[33,34]

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

- Common Questions About the Pharmacologic Management of Depression in Adults[23]
- Childhood and adolescent depression[25]
- Screening for depression[27]
- Treatment of childhood and adolescent depression[26]
- Evaluation and treatment of the suicidal patient[24]
- Adolescent health screening and counseling[21]
- AAFP Depression. Clinical Preventive Service Recommendation[28]
- AAFP Suicide Screening. *Clinical Preventive Service Recommendation*[29]
- APA Guidelines for Adolescent Depression in Primary Care[31,32]
- Adding health education specialists to your practice[35]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[36]
- The benefits of using care coordinators in primary care: a case study[37]
- Engaging Patients in Collaborative Care Plans[38]
- Medication adherence: we didn't ask and they didn't tell[39]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[40]
- Integrating a behavioral health specialist into your practice[41]
- Simple tools to increase patient satisfaction with the referral process[33]
- Coding for depression without getting depressed[42]
- FamilyDoctor.org. Depression (patient education)[43]
- FamilyDoctor.org. Suicide (patient education)[44]

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