Practice Guidelines

Depression in Adolescents: AAP Updates Guidelines on Diagnosis and Treatment

Key Points for Practice

- After a patient is diagnosed with mild depression, physicians should consider active support and monitoring for six to eight weeks before initiating treatment.
- Only treatments that have been proven effective for depression, such as cognitive behavior therapy and SSRIs, should be recommended.
- Even after symptom resolution, patients being treated for depression should be monitored monthly for six to 12 months and up to two years for those being treated for a recurrence.

From the AFP *Editors*

Although depression is associated with short- and long-term morbidity in adolescents, only 50% are diagnosed before becoming adults, with many adolescents never receiving treatment. These updated recommendations from the American Academy of Pediatrics (AAP) aim to address the identification and diagnosis of all forms of depression in adolescents, defined in this guideline as those 10 to 21 years of age. Recommendations regarding treatment of major depressive disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-5), in this population also are provided.

Identification

Because of the high prevalence (20% by 20 years of age) and persistence of depression in adolescents and the importance of brain development in these patients, physicians should screen adolescents who are at least 12 years of age for depression annually via a formal self-report tool in an attempt to identify the condition early. Because evidence regarding the most effective initial screening tool is lacking, physicians should use what works best for their practices and patients. Identifying patients with risk factors for depression is important to allow for routine monitoring for a depressive disorder over time. These risk factors include a personal or family history of depression, bipolar disorder, suicide-related behavior, substance use, or other psychiatric illness; major psychosocial stressors, such as physical or sexual abuse; recurring somatic problems; and being in foster care or being adopted.

Diagnosis

An assessment using diagnostic criteria from the DSM-5 or the *International Classification of Diseases*, 10th revision, and standardized depression tools should be performed in patients who have positive results on initial screening, patients who present with a primary concern of emotional issues, and patients who screen negative on initial screening but in whom there is still a high suspicion of depression. This assessment should include interviews with the patient and his or her family or caregivers separately to identify symptoms and problems with functioning; an evaluation of functioning at home, school, and other peer settings; and a review for other possible psychiatric problems. To help in identifying depression, physicians should have knowledge of the common symptoms, such as irritability, fatigue, insomnia, excessive sleeping, weight loss or gain, decline in academic performance, and family problems.

Treatment

INITIAL THERAPY

Depression is best treated using a multidisciplinary approach. Physicians should collaborate with the administration at their facilities to help ensure their practices are organized based on integrated patient care best practices, including the ability to connect patients with therapists, psychiatrists, or case managers.

After a patient is diagnosed with mild depression, physicians should consider active support and monitoring for six to eight weeks before initiating treatment; however, if symptoms do not improve, antidepressants or psychotherapy

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CME **This clinical content** conforms to AAFP criteria for continuing medical education (CME). See CME Quiz on page 417.

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should be considered. After a patient is diagnosed with moderate to severe depression or other factors or conditions that can complicate depression (e.g., substance abuse), a mental health subspecialist may be consulted. Ongoing treatment in these patients can be managed by the physician and mental health subspecialist after discussing and agreeing on each person's responsibilities and after the patient and his or her family agree with the arrangement. Determining the need for consultation with a mental health subspecialist is based on the physician's clinical judgment and level of expertise, patient preference, and severity of the patient's depression.

If there is a long wait for the availability of mental health services, the physician should provide active support and treatment in the interim. Once the patient begins to receive mental health services, the physician should stay involved in the patient's care.

The patient and his or her family should be provided with support and education regarding the treatment options. Only treatments that have been proven effective for depression, such as cognitive behavior therapy and selective serotonin reuptake inhibitors (SSRIs), should be recommended, taking into account patient and family preferences and accessibility of services. The treatment should be individualized based on the severity of the patient's depression, risk of suicide, and comorbidities. If an SSRI is prescribed, the patient should be monitored for adverse effects.

ONGOING THERAPY

For any patient being treated for depression, outcomes should be tracked, including symptoms and functioning at home, school, and other peer settings. This ongoing assessment should include persistent symptoms, suicide risk, treatment adverse effects and compliance, and environmental stressors. Even after symptoms have resolved, patients should be monitored monthly for six to 12 months and up to two years for those being treated for a recurrence. Based on studies in adults, antidepressants should be continued for one year after remission.

If the patient does not improve after six to eight weeks of treatment (e.g., decreased symptoms, improved functioning), the initial diagnosis and treatment choice should be reevaluated, and consultation with a mental health subspecialist should be considered. Treatment compliance, comorbidities, and new stressors also should be evaluated.

If symptoms do not sufficiently improve with the maximal dosage of an SSRI, physicians may consider adding psychotherapy, switching medications, or adding another medication, preferably in consultation with a mental health subspecialist. If symptoms do not sufficiently improve after multiple treatment approaches have been tried and treatment compliance and comorbidities have been addressed, consultation with a mental health subspecialist is strongly recommended if one is not already involved. To help ensure appropriate ongoing management, the physician should provide active support for any patients referred to a mental health subspecialist, as well as consider establishing a comanagement strategy with any consulting subspecialists.

Editor's Note: The AAFP supports the U.S. Preventive Services Task Force recommendation on screening for depression in adolescents (https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-children-and-adolescents-screening1). Adolescents 12 to 18 years of age should be screened for major depressive disorder, although the evidence is insufficient to support or recommend against screening in those 11 years and younger. Appropriate screening warrants that adequate systems are in place for diagnosis, treatment, and monitoring.

Guideline source: American Academy of Pediatrics

Evidence rating system used? Yes

Systematic literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? Yes

Recommendations based on patient-oriented outcomes? Yes

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