

Primary Care of Mental Health Issues in Teens

Mental health issues in teens are common

Depression: 20% incidence before adulthood, 10-15% at any given time, 5% have major depressive disorder
Anxiety
Bipolar
Schizophrenia

Screening Tools

HEADSS: Home environment, Education/Employment/Eating/Exercise, Activities & Peer Relationships, Drugs/Tobacco/Alcohol, Depression/Mood, Sexuality, Suicide, Safety, Spirituality

PHQ 9 Modified for Teens for depression addresses the following issues: depressed mood/irritability, anhedonia, sleep issues, appetite or wt change, tired, feeling bad about self, trouble concentrating, slowed down or agitated, thoughts of being dead or hurting self, suicidal thoughts, prior suicide attempts

PSC for Youth & Parent: 37 questions addressing the following issues: depression, anxiety, suicide, conduct, attention

Depression Diagnosis and Severity Grading

Major Depressive Disorder Dx:

5 of 9 sx for > 2 wks, must include mood issue and functional impairment:

- **Mood: irritable or depressed plus:**
- Sleep: increased or insomnia
- Interest: markedly decreased in activities
- Guilt: feeling worthless, inappropriate guilt
- Energy: fatigue or loss of energy
- Concentration: hard to think/concentrate
- Appetite: significant wt loss / gain (~ 5% change)
- Activity: physically slowed or agitated
- Suicide: thoughts, attempts, death thoughts

Depression Severity Grading:

Mild: 5-6 sx of mild severity (including mood) and function mildly impaired or nl but w/ substantial and unusual effort

Moderate in between mild and severe

Severe: most sx present and severe and function disabled or psychotic features are present

Domains of Function to assess: family, school, peer, stress/anxiety, self harm/risk taking

Screen for Co Morbidities

Physical illness

Substance / alcohol use (common, up to 20 – 30% and usually follows depression onset by ~ 5 years)

Psychiatric disorders: Anxiety, ADD, Bipolar, Conduct Disorders, Eating Disorders, PDD

Psychotic sx: hallucinations, paranoia

Abuse: physical / emotional / sexual

Assess Safety: 1) access to means of harm, 2) suicide risks (stresses, hopelessness, impulsivity), 3) protective factors (religious belief, wish not to harm family & friends).

Refer to Psychiatrist: anyone who requests this; or depression assoc w/ substance abuse, eating disorder or other complications: severe depression, suicidal pt

Suicide Risk Assessment and Management

Assessment: inquire about suicide plans, thoughts, access to means of harm

Management: Seek immediate consultation; don't leave pt alone.

- If pt is not of imminent danger to self or others and does not need emergency medical attention, call:
EMQ: 877-412-7474 or Peninsula Hospital Psych Intake: 650-696-5909
- If pt not of imminent danger but needs medical clearance before possible psych hospitalization, call:
Peninsula Hospital Pediatric PES: 650-696-5915
- If pt needs restraint or emergency medical care, call **911**

Initial Management of Depression in Primary Care

General Principles

- Form an alliance w/ the teen and affirm hope
- Educate, counsel pt and family about depression, tx options, limits of confidentiality
- Establish a safety plan: restrict access to lethal means, engage 3rd party to monitor, develop emergency communication plan to use if needed
- Develop a specific tx plan and goals re function in home, school and peer relationships
- Encourage adequate exercise and sleep
- Share resources: phone numbers, websites, handouts
- Refer pt and family to mental health providers
- Ease means for teen to contact provider
- Arrange follow up visit within one week
- Have family sign Release of Information form to allow communication w/ school staff and health care providers
- Obtain information from and communicate w/ school staff, other health care providers

Initial Treatment of MILD, Uncomplicated Depression:

- See pt weekly or biweekly for first 6 – 8 wks
- “Active support” in primary care: this is as effective as formal psychotherapy for mild depression
- Monitor depressive symptoms and function (school, home, peer, extracurricular activities)
- If sx persist > 4 – 8 wks, offer psychotherapy and / or antidepressants

Initial Treatment of MODERATE, Uncomplicated Depression

- Recommend psychotherapy and consider SSRI after discussion w/ psychiatrist or refer to psychiatrist
- If teen / family decline psychotherapy or psychiatry and if pt not on SSRI: provide active support, seeing pt weekly or every other week x 6 – 8 wks

Medication Management

Before starting SSRI:

- Rule out Bipolar Disorder: severe mood changes, unrealistic high self – esteem, great in energy/little sleep, increased talking, distractible, repeated high risk behavior
- Review black box warning
- Establish safety plan, close f/u
- Review medication side effects, warning signs requiring immediate attention (suicidality, sx suggesting mania).

If on SSRI, establish schedule for regular follow up:

- First follow up should be a face to face meeting with physician 1 week after starting medication. After that, if pt is doing well, follow up schedule:
 - 1st month: Every week w/ MD or therapist
 - 2nd month: Every other week
 - After 2nd month: Monthly thereafter
- If dose is changed, see pt within 1 week
- If any concerns, see pt sooner and/or consult with or refer to psychiatrist.

Continued Management of Depression in Primary Care

If only partially improved, change treatment:

- If not on SSRI consider adding one
- If on SSRI, consider increasing dose
- If not getting psychotherapy, recommend this
- Consult with or refer to psychiatrist
- Review safety plan
- Provide further teen/family education

If not improved: reassess dx and if depression confirmed, do all the above