Depression in Youths: Strategies for Improving Treatment & Patient Outcomes

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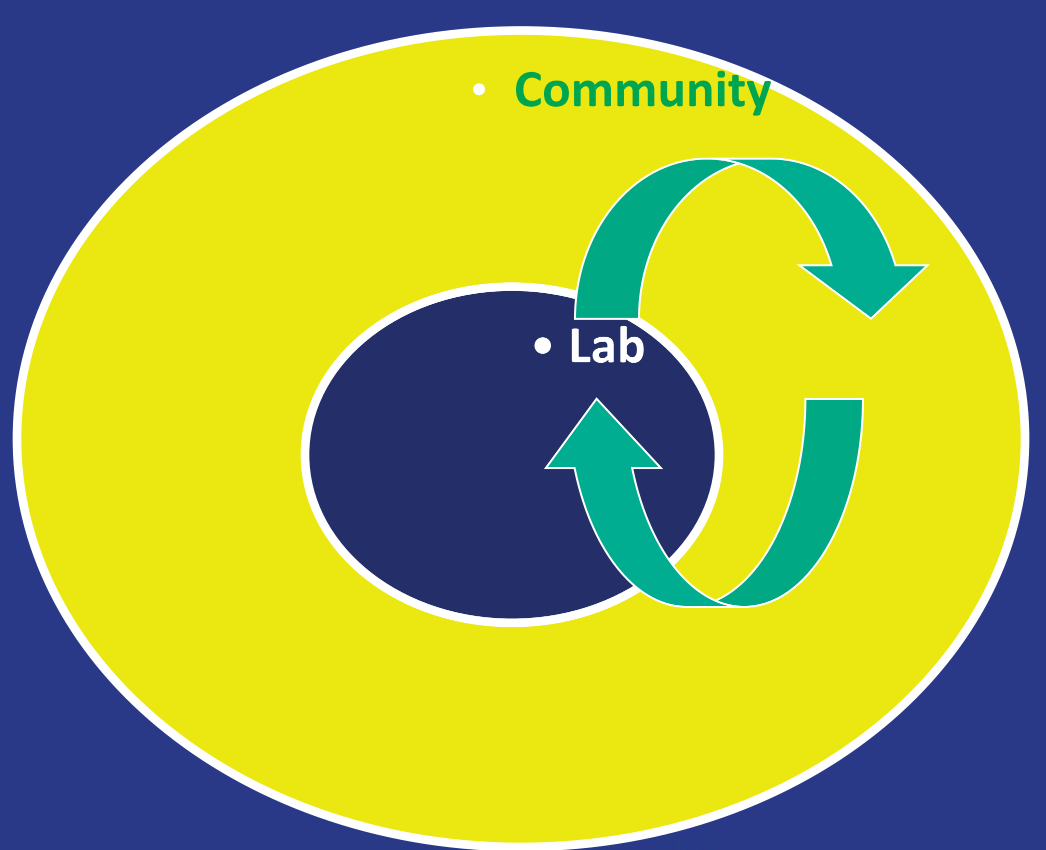
YSAM: 310 794-4962

www.semel.ucla.edu/mood/youth-stress

Youth Stress & Mood Program
YSAM
Working with Youths, Families, & Community Partners to Improve Care for Depression & Suicide Self-Harm Prevention



DTQI: Partnerships with Community Providers for Evidence-Based Depression Care

Michigan- Depression Treatment Quality Improvement Project

Joan Rosenbaum Asarnow
Kay Hodges
Margaret Rea
Jim Wotring

California Depression Treatment Quality Improvement Project DTQI

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National Registry of Evidence-Based Practices (NREPP), SAMHSA

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YSAM Program
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Presentation Goals

- Overview of what we know about depression in children and adolescents
- Treatments that work- demonstrated efficacy
- Strategies for bringing evidence-based treatments into community settings and improving youth outcomes

MAJOR DEPRESSION- DSM V-YOUTHS

DURATION	**≥two weeks**
# OF S/XS	5/9 symptoms, including depressed/irritable mood in youths or loss of interest/pleasure
CORE SYMPTOMS	Depressed/irritable mood Loss of interest/pleasure
OTHER SYMPTOMS	Weight/ Appetite Insomnia/Hypersopmnia Agitation/Retardation Fatigue Worthlessness/Guilt Concentration/Indecisiveness Thoughts Death/Suicidalit
SEVERITY	Distress or Functional Impairment
EXCLUSION	Not due to drugs, medical condition, shizophrenia spectrum or other psychotic disorder. No history of mania or hypomania.

DYSTHYMIA- PERSISTENT DEPRESSIVE DISORDER-DSM-V YOUTHS

DURATION	**≥ 1 year, Never without symptoms for > 2 months**
# OF S/XS	2/5 symptoms, while depressed
CORE SYMPTOMS	Depressed/irritable mood most of day, more days than not By either self report or observation of others
OTHER SYMPTOMS	Weight/ Appetite Insomnia/Hypersopmnia Fatigue/Low energy Low Self Esteem Concentration/Indecisiveness Hopelessness
SEVERITY	Distress or Functional Impairment
EXCLUSION	Not due to drugs, medical condition, shizophrenia spectrum or other psychotic disorder. No history of mania, hypomania, cyclothymia.

Pediatric Depression is a Prevalent Condition

- Rates increase with age
  - <13 yrs. ~2-3 %
  - 13-18 yrs. ~5-6%
- Rates approach adult prevalence by end of adolescence
- Prior to adolescence roughly 1:1 sex ratio
- Increased frequency in girls during adolescence

Recovery is Goal

- Most youth with MDD recover within one to two years.
- Remission (minimal to no symptoms): the desired outcome of treatments

Pediatric Depression Not Benign Condition

- Episodes are lengthy: MDD (7-9 mos) in clinical cases; DD (~3yrs)
- Associated with significant impairment in school, with family, and peers
- Depression frequently recurrent
  - One year recurrence greater than adults (40% vs. 24%)
  - 20% have persistence >2yrs
- Suicide risk in adults with history of adolescent MDD is 5x adults with late onset

Asarnow et al., 1994; Kovacs et al., 1984a, 1994,1997; Lewinson et al., 1994; McCauley et al., 1993; Puig-Antich et al., 1989; Rao et al., 1995; Weissman et al., 1999 a,b

Burden of Pediatric Depression: Additional Consequences

- Eventual substance use/abuse disorders: 15% to 45%[a]
- Persistence of functional impairment in many youths: social dysfunction, work difficulties, low employment rate[b]
- Depressive episode recurrence of ~60%-69% into young adulthood[c]

a)Geller et al., 2001; Harrington et al., 1990; Rao et al., 1995; Weissman et al., 1999
b) Fergusson & Woodward, 2002; Fombonne et al., 2001; Garber et al., 1988; Geller et al., 2001;Harrington et al., 1991; Rao et al., 1995; Weissman et al., 1999 a,b; c)Harrington et al., 1990; Weissman et al., 1999 b; Rao et al., 1995

Comorbidity/Co-Occurring Disorders: High Across Range of Disorders

- Anxiety Disorders. ~ A third (30-50%), often precede the onset of depressive disorders. Separation anxiety most frequent in children; social phobia in teens. Common with PTSD & OCD.
- Double depression (DD/MDD) . ~ A third (20-30%) DD/MDD, associated with recurrent depression; associated with peer problems
- ADHD
- Conduct disorder
- Increased risk for bipolar disorder
- Comorbidity predicts more severe, longer depressions, more suicidality, more substance abuse

Baji et al., in press; Biederman et al., 1995; Carlson & Kashani, 1988; Ferro et al., 1994; Fombonne et al., 2001; Geller et al., 2001; Goodyer et al., 1997; Kovacs et al., 1988/89, 1994, 1997 and Unpub; McCauley et al., 1993; Mitchell et al., 1988; Rao et al., 1995; Ryan et al., 1987; Shain et al., 1991; Strober & Carlson, 1982; Strober et al., 1993; Weiss & Garber, 2003; Weissman et al., 1999a,b

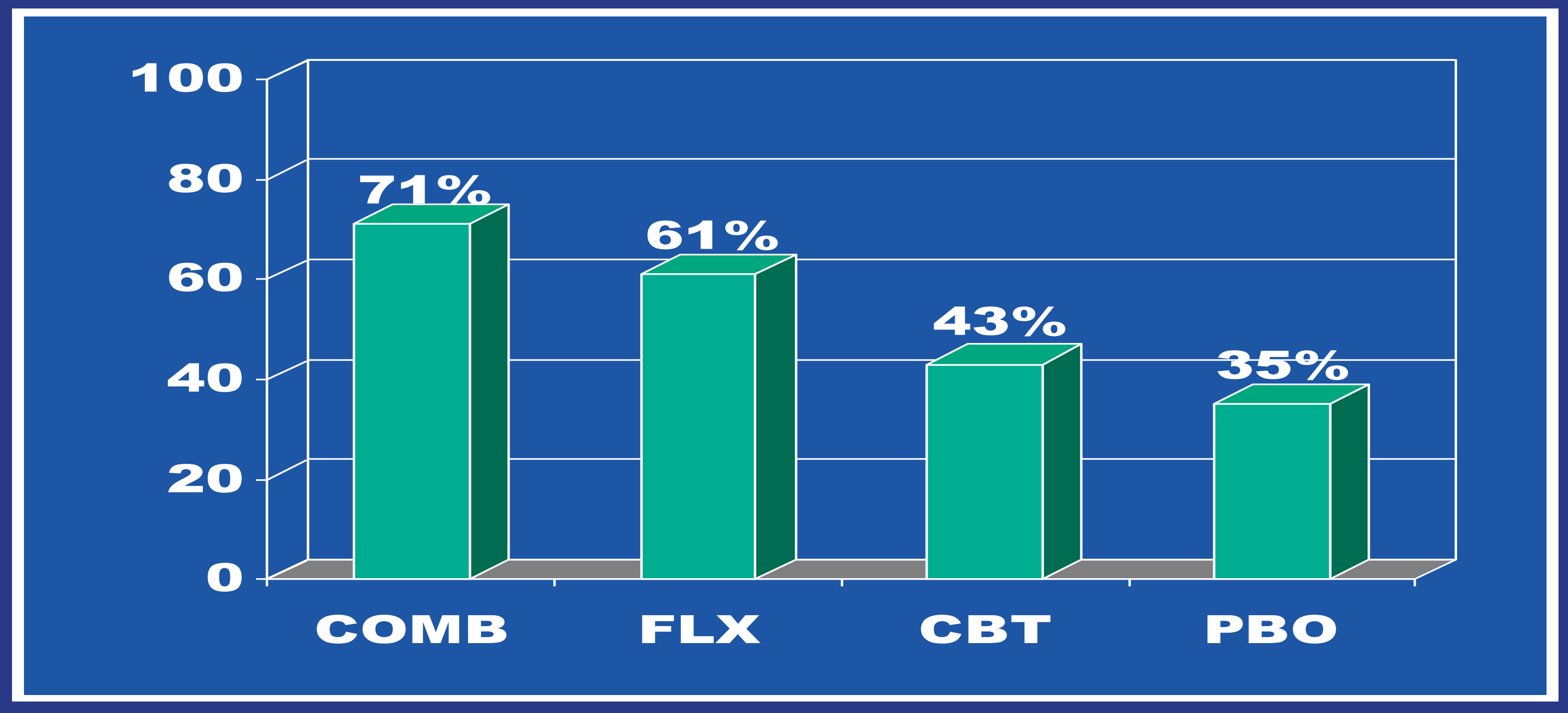
TREATMENT

Do we have effective treatments?

Treatment for Depression in Children and Adolescents

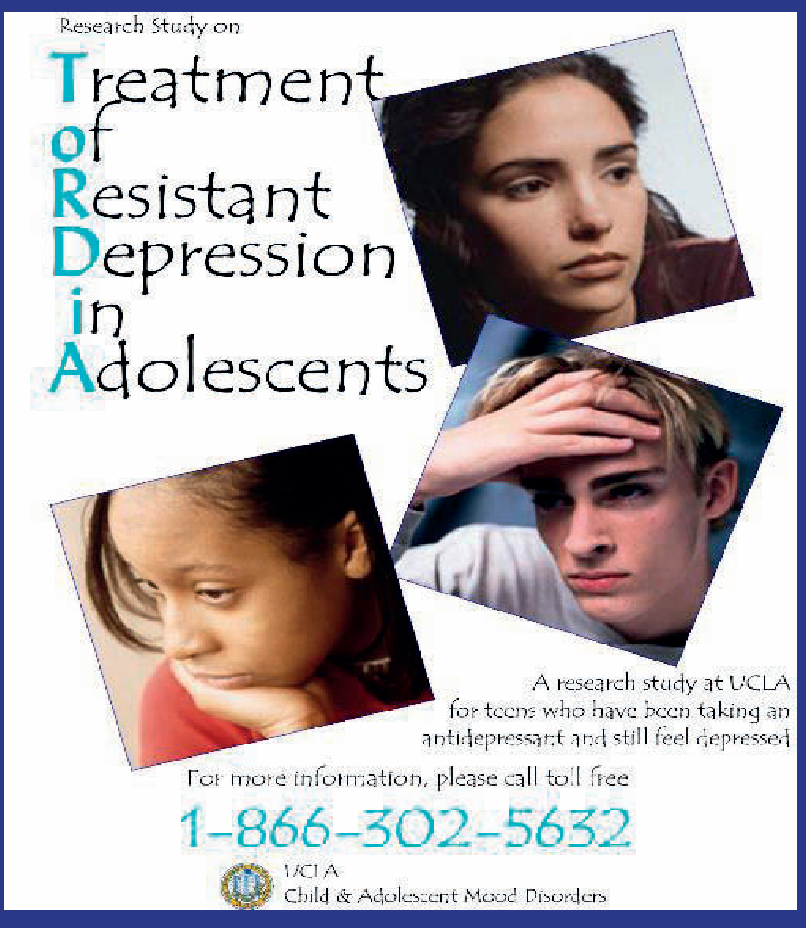
- Psychotherapy
- Pharmacotherapy
- Combination psychotherapy and pharmacotherapy

Adolescent Depression
Combined CBT + Medication Treatment of Choice for Moderate to Severe Major Depression



N=439, Treatment of Adolescent Depression Study (TADS); Week 12 Acute Treatment Response.

March J, Silva S, Petrycki S, Curry J, Wells K, Fairbank J, Burns B, Domino M, McNulty S, Vitiello B, Severe J; Treatment for Adolescents With Depression Study (TADS) Team. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. JAMA. 2004 Aug 18;292(7):807-20.



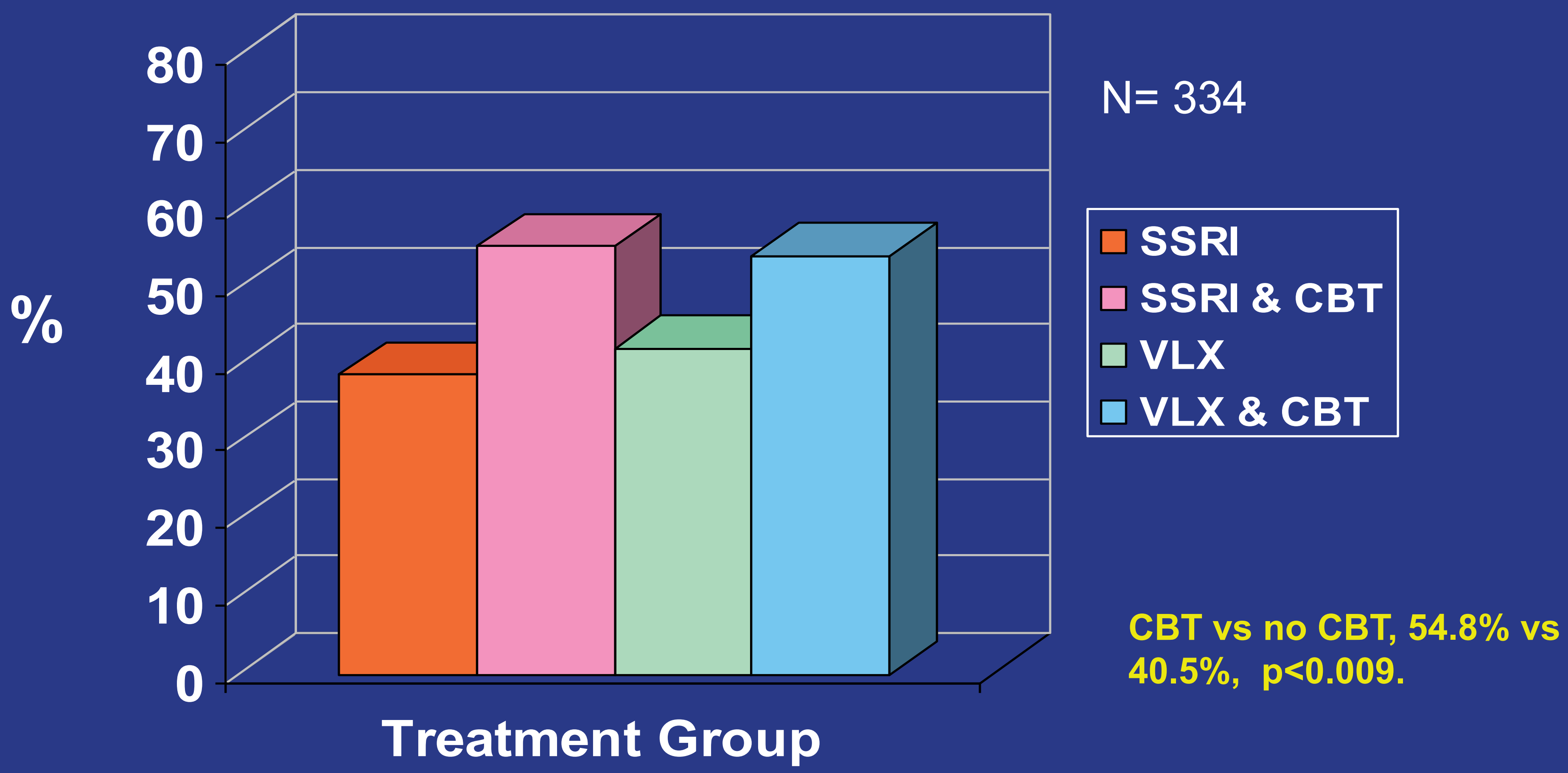
6-Site NIMH Study
MH61835 Pittsburgh, Brent
MH61864 UCLA, Asarnow
MH61856 Galveston, Wagner
MH61869 Portland, Clarke
MH61958 Dallas, Emslie
MH62014 Brown, Keller

- 334 outpatient adolescents, ages 12-17 years, with diagnosis of major depression
- Depression persists despite at least 6 weeks of SSRI treatment
- Acute phase 12-week trial

JAMA Feb 27, 2008

Asarnow J.R., APA, 2009, Toronto

TORDIA Supports Value of CBT-Clinical Response by Treatment Group



Brent D, Emslie G, Clarke G, Wagner KD, Asarnow JR, Keller M, Vitiello B, Ritz L, Iyengar S, Abebe K, Birmaher B, Ryan N, Kennard B, Hughes C, DeBar L, McCracken J, Strober M, Suddath R, Spirito A, Leonard H, Melhem N, Porta G, Onorato M, Zelazny J. Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the TORDIA randomized controlled trial. JAMA. 2008 Feb 27;299(8):901-13.

Developing Relapse Prevention CBT for Youth with Major Depressive Disorder

NIMH R34 MH72737; PI: Kennard

Kennard, B.D., Emslie, G.J., Mayes, T.L., Nightingale-Teresi, J., Nakonezny, P.A., Hughes, J.L., Jones, J.M., Tao, R., Stewart, S.M., & Jarrett, R.B. Cognitive behavioral therapy to prevent relapse in pediatric responders to pharmacotherapy. Journal of the American Academy of Child & Adolescent Psychiatry, 47, 1395-1404.

Interpersonal Psychotherapy: MDD Response

Mufson L, Weissman MM, Moreau D, Garfinkel R. Arch Gen Psychiatry. 1999(Jun);56(6):573-579

Youth Partners in Care: An Effectiveness Trial of Quality Improvement for Adolescent Depression in Primary Care

Joan Asarnow, Ph.D. , Lisa Jaycox, Ph.D., Naihua Duan, Ph.D., Anne LaBorde, Ph.D. , Kenneth Wells, M.D., M.P.H., and colleagues

- Sponsored by the Agency for Healthcare Research and Quality (AHRQ; Joan Asarnow, PI). Additional support from UCLA- RAND Health Services Research Center (NIMH, Ken Wells, PI)
- Builds on Partners in Care Study (Ken Wells, PI)

YPIC Goal

- **To test an innovative model for delivering evidence based treatments for depression through primary care**
- **Builds on research with adults showing that similar intervention models with adults led to improved outcomes, with some gains maintained 5 years after program implementation** (Wells et al., Partners in Care Study)

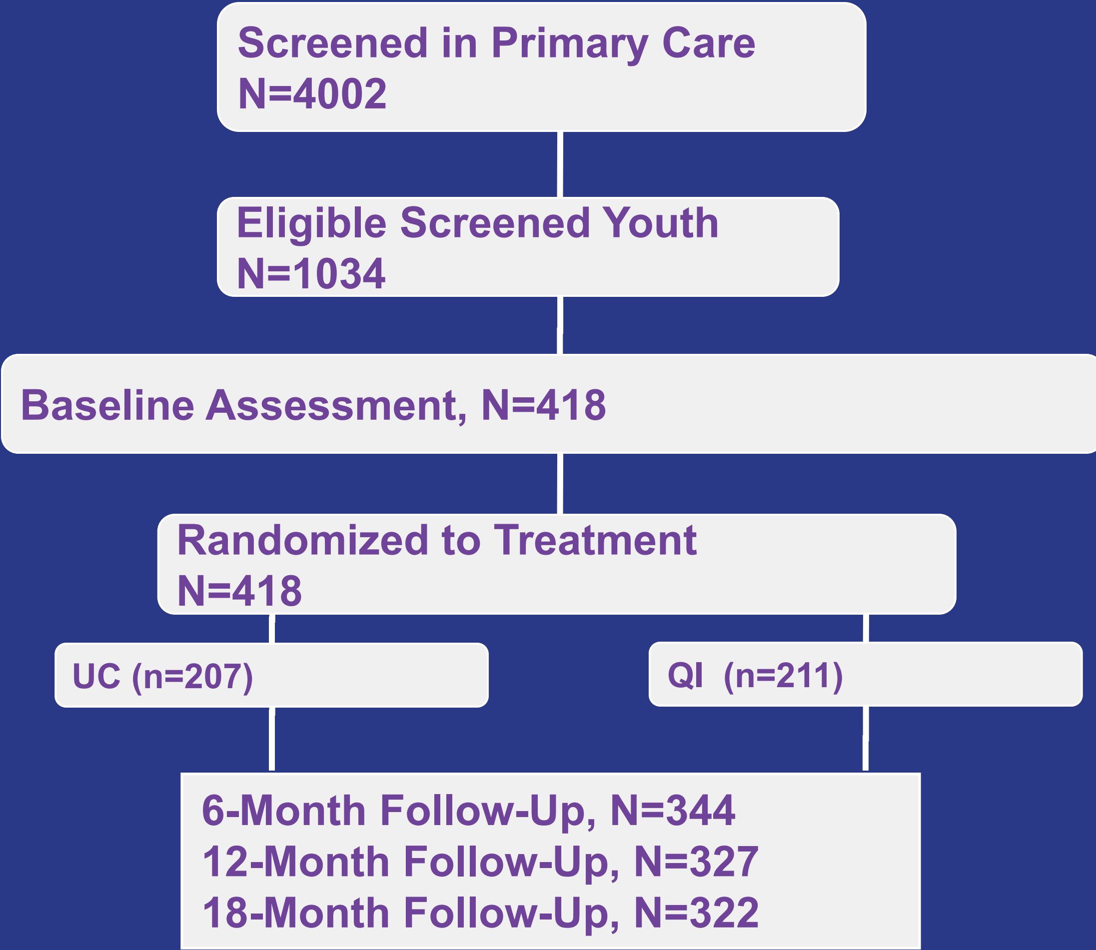
Why Primary Care?

- Most children and adolescents have some contact with a primary care provider each year (Horwitz et al., 1982; Kramer & Garralda, 1998; Stiffman et al., 1997)
- Screening for mental health needs at the time of a primary care visit offers a window of opportunity to detect mental health problems and provide effective treatment.

YPIC: Participating Sites

- Academic Medical Centers
  - UCLA Mattell Children's Hospital & Satellite Clinics
  - University of Pittsburgh Children's Hospital
- Managed Care Clinics
  - Kaiser Permanente Los Angeles Medical Center
  - Family Practice & Pediatric Departments
  - Sunset & East LA Sites
- Public Sector Clinics
  - Ventura County Medical Center-Family Practice & Pediatrics
  - Venice Family Clinic

YPIC Design



Asarnow, J.R., Jaycox, LJ, Duan, N., et al. (2005). JAMA, 2005, 293, 311-319.

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Intervention Components

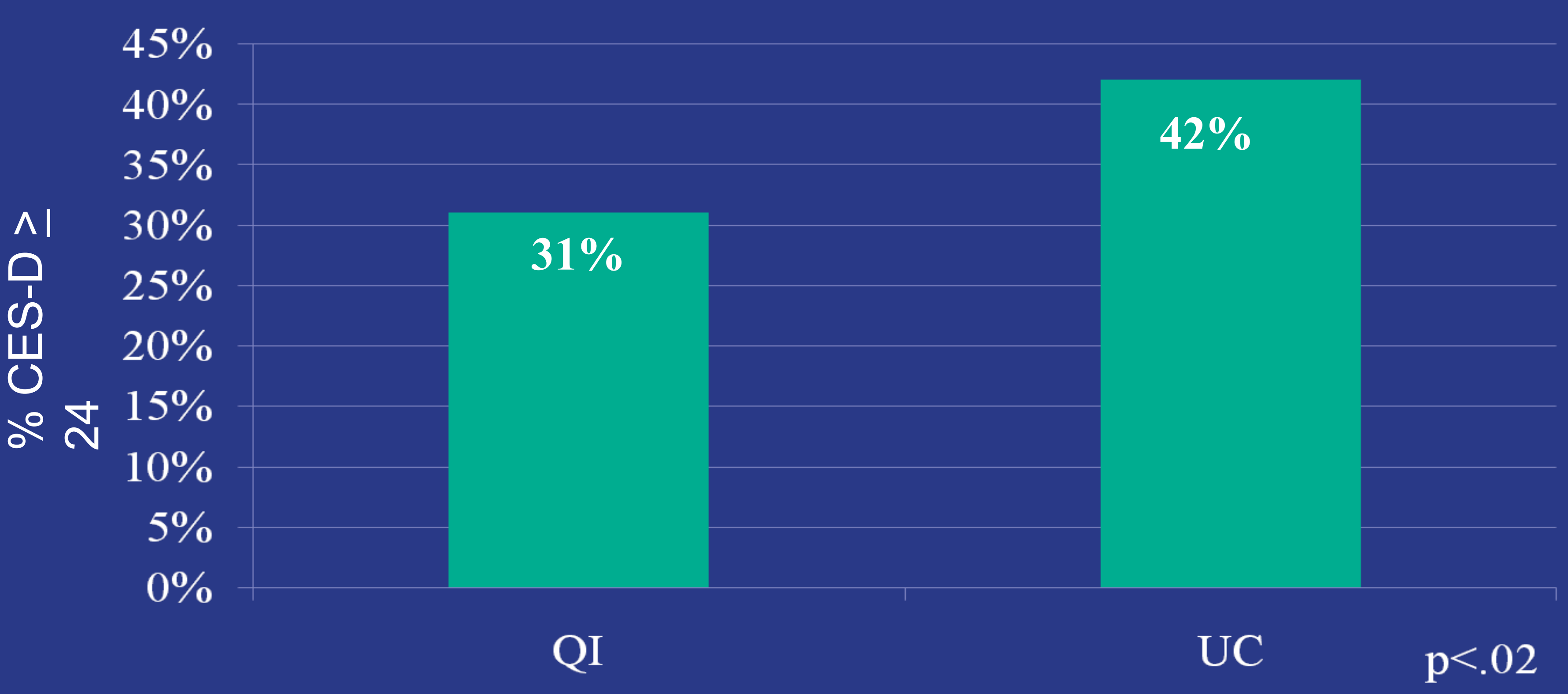
- Provider education
- Care managers to support primary care clinicians and provide cognitive-behavior therapy in primary care clinics
- Patient & family education
- Emphasis on patient, parent and provider choice
- Local expert teams to tailor the depression management model to each system

Effectiveness of a Quality Improvement Intervention for Adolescent Depression in Primary Care Clinics: *A Randomized Controlled Trial*

Asarnow JR, Jaycox LH, Duan N, LaBorde AP, Rea MM, Murray P, Anderson M, Landon C, Tang L, Wells KB.

Journal of the American Medical Association
2005 Jan 19; 293 (3):311-319.

Depression Outcomes: Lower Rates of Severe Depression in QI vs. UC Group

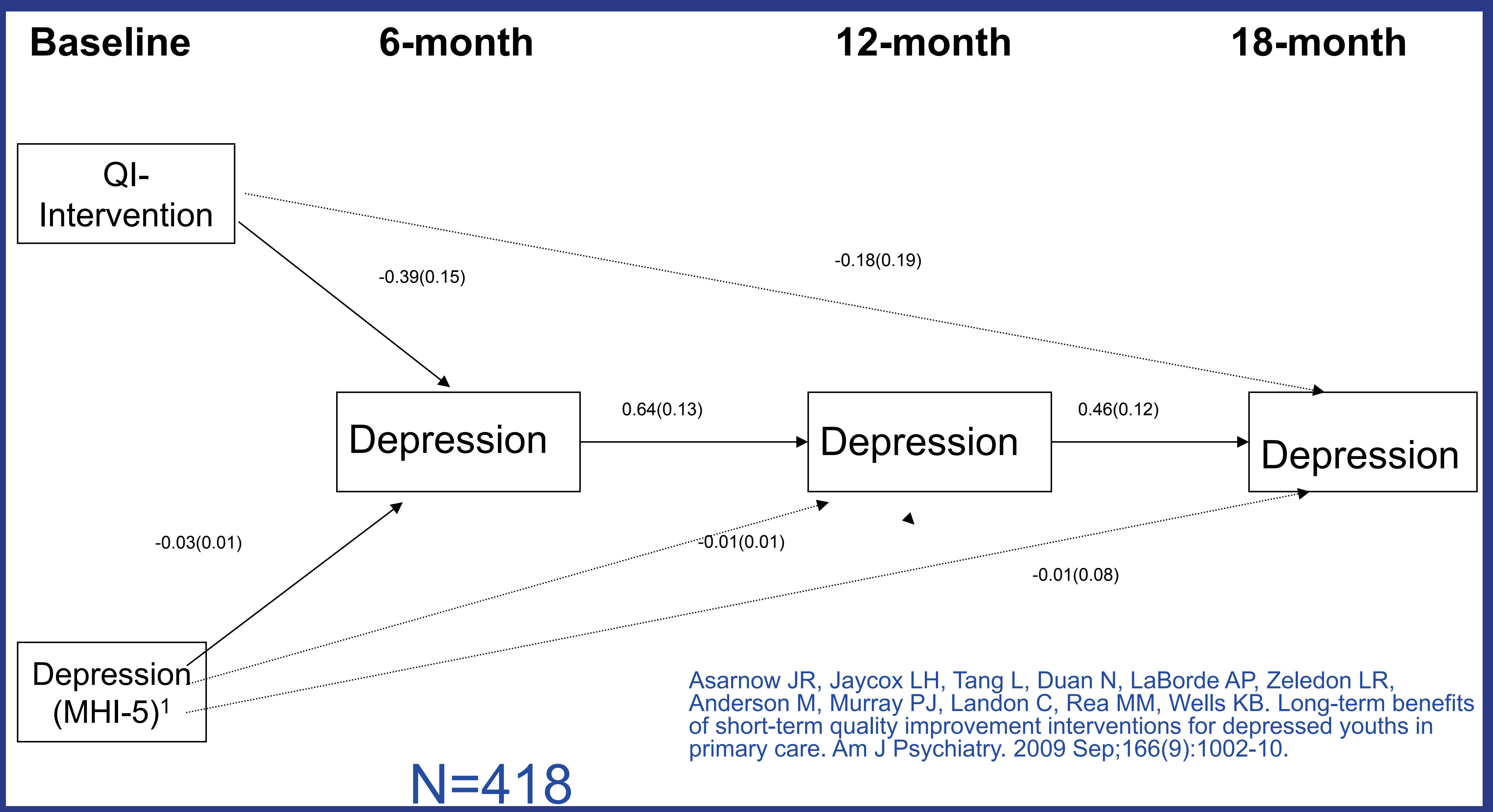


Long-term benefits of short-term quality improvement interventions for depressed youths in primary care

Asarnow JR, Jaycox LH, Tang L, Duan N, LaBorde AP, Zeledon LR, Anderson M, Murray PJ, Landon C, Rea MM, Wells KB.

American Journal of Psychiatry. 2009 Sep;166(9):1002-10.

Early Intervention Effects Shifted Youths Towards Healthier Pathways Through 18-Month Follow-Up



Conclusions:

- YPIC model of integrated mental health and primary care:
  - Improved access to evidence-based depression treatment through primary care
  - Improved quality of care
  - Improved youth outcomes
- Consistent with health care redesign & improvement

Thank You!

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