Depression in Youths: Strategies for Improving Treatment & Patient Outcomes

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UCLA Youth Stress & Mood Program - YSAM

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

California Depression Treatment Quality Improvement Project

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

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

<table>
<thead>
<tr>
<th><strong>DURATION</strong></th>
<th>≥two weeks</th>
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<tbody>
<tr>
<td><strong># OF S/XS</strong></td>
<td>5/9 symptoms, including depressed/irritable mood in youths or loss of interest/pleasure</td>
</tr>
</tbody>
</table>
| **CORE SYMPTOMS** | Depressed/irritable mood  
Loss of interest/pleasure |
| **OTHER SYMPTOMS** | Weight/ Appetite  
Insomnia/Hypersomnia  
Agitation/Retardation  
Fatigue  
Worthlessness/Guilt  
Concentration/Indecisiveness  
Thoughts Death/Suicidality |
| **SEVERITY** | Distress or Functional Impairment |
| **EXCLUSION** | Not due to drugs, medical condition, schizophrenia spectrum or other psychotic disorder. No history of mania or hypomania. |
# Dysthymia - Persistent Depressive Disorder - DSM-V Youths

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th>≥ 1 year, Never without symptoms for &gt; 2 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong># of S/Xs</strong></td>
<td>2/5 symptoms, while depressed</td>
</tr>
</tbody>
</table>
| **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/Hypersomnia 
                      Fatigue/Low energy 
                      Low Self Esteem 
                      Concentration/Indecisiveness 
                      Hopelessness |
| **Severity**   | Distress or Functional Impairment              |
| **Exclusion**  | Not due to drugs, medical condition, schizophrenia 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 \(~60\%\text{-}69\%\) into young adulthood\(^c\)

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

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
TORDIA Supports Value of CBT-Clinical Response by Treatment Group

Developing Relapse Prevention CBT for Youth with Major Depressive Disorder

NIMH R34 MH72737; PI: Kennard

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

Screened in Primary Care
N=4002

Eligible Screened Youth
N=1034

Baseline Assessment, N=418

Randomized to Treatment
N=418

UC (n=207) QI (n=211)

6-Month Follow-Up, N=344
12-Month Follow-Up, N=327
18-Month Follow-Up, N=322


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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


Journal of the American Medical Association
Depression Outcomes: Lower Rates of Severe Depression in QI vs. UC Group

% CES-D ≥ 24

- QI: 31%
- UC: 42%

p < .02
Long-term benefits of short-term quality improvement interventions for depressed youths in primary care

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