

# Screening for Depression in Adolescents

Ned Calonge, MD, MPH  
Chair, US Preventive Services  
Task Force

# Major Depressive Disorder in Adolescents

- Prevalence (13-18) = 5.6% (females 5.9%, males 4.6%)
- Point prevalence in primary care settings reported from 9-21%
- Associated morbidity and mortality: decrease school performance, poor social functioning, early pregnancy, increased physical illness, substance abuse, increased psych and medical hospitalizations, increased health care costs (medical and mental health), and suicide

# USPSTF 2009 Update

- 2002 recommendation: I statement (insufficient evidence to recommend for or against)
- Scope of update:
  - » Studies of screening efficacy (none)
  - » Studies of screening instrument accuracy (4 new, 9 total)
  - » Studies of harms of screening (no direct evidence)
  - » Studies of treatment: 8 new SSRI studies, 9 new psychotherapy studies, 1 combination SSRI & psychotherapy
  - » Studies of harms of treatment (9 studies of harms of SSRIs)

# Screening instruments

- 9 studies involving 6 instruments
  - » 6 in school settings
  - » 2 in primary care settings
  - » 1 in a community setting
- In primary care settings:
  - » PHQ-A: sensitivity 73%, specificity 94%
  - » BDI-PC: sensitivity 91%, specificity 91%

# Harms of screening

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- No harms identified
- Evidence that discussing suicide does not increase suicide risk

# Benefits of treatment: Psychotherapy

- The majority of RCTs revealed treated patients had higher response rates, remission rates, or greater reductions in MDD symptoms after treatment compared with controls
- Different types were efficacious including group cognitive-behavioral therapy and interpersonal therapy

# Benefits of treatment: SSRIs

- SSRI users had higher response rates than controls taking placebos, absolute risk difference = 12%
- Fluoxetine and citalopram statistically better than others
- Absolute risk difference for fluoxetine = 20%, NNT = 5

# Benefits of treatment: Combined

- Single study
- Nearly 3 of 4 (71%) responded to combined therapy vs. 1/3 (35%) of controls
- NNT = 2-3

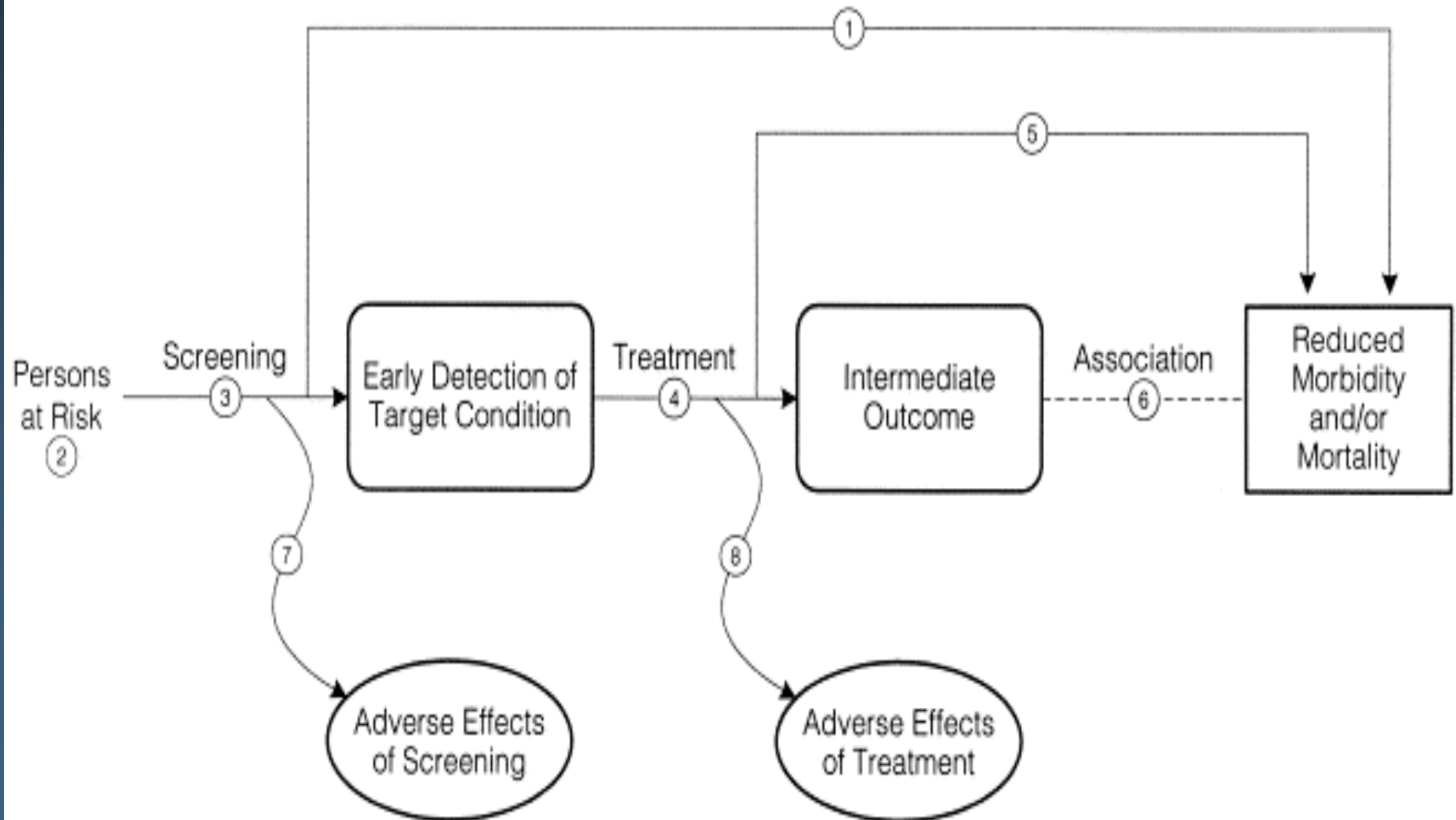
# Harms of treatment: Psychotherapy

- No evidence of harms

# Harms of treatment: SSRIs

- Conservative estimates: treatment with antidepressants increase absolute risk of suicidality by 1-2%
- For fluoxetine, 6% of those treated vs. 4% of those on placebo experienced suicidal ideation or behavior
- NNH = 50-112
- Increase rate of conversion from unipolar to bipolar depressive disorder, 7.7% vs. 2.5%

# Analytic framework for screening for a disease



# Recommendation

- The UPSTF 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. (B recommendation)

# Clinical considerations

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- Treating depressed youth with SSRIs is associated with an increased risk of suicidality and, therefore, should only be considered if judicious clinical monitoring is possible.

# Other considerations

- Studies are needed to evaluate:
  - » Comparative effectiveness of pharmacologic and non-pharmacologic treatments
  - » Collaborative care management approaches compared with usual clinical care
  - » The prevalence of MDD in adolescents in primary health care settings according to age, gender, and race/ethnicity