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EARLY RECOGNITION OF ADOLESCENT MENTAL HEALTH PROBLEMS AND REFERRAL PATHWAYS IN ROUTINE CARE

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Abstract. This article outlines an evidence-based approach for routine pediatric and primary care settings: (1) normalize confidential conversations and use validated screeners, (2) confirm positives with focused clinical assessment and functional impairment review, (3) stratify risk—especially suicide/self-harm risk—and implement same-day safety steps when needed, and (4) establish stepped referral pathways for counseling, specialty mental health, and urgent services.
Keywords: adolescent mental health; early recognition; primary care; screening; depression; anxiety; suicide risk.

INTRODUCTION

Early recognition of adolescent mental health problems is not a "nice-to-have"—it is a core safety function of routine care. Adolescence is a period when depression, anxiety, trauma-related symptoms, eating disorders, and substance use commonly emerge or intensify, yet many young people present with indirect signals rather than clear mental-health complaints. A clinician may see sleep problems, appetite changes, abdominal pain, headaches, school avoidance, or repeated visits for vague fatigue. If the visit stays purely biomedical, opportunities are missed; if the visit includes a brief private check-in and a structured screener, the same appointment can become an early intervention. The U.S. Preventive Services Task Force supports screening for major depressive disorder in adolescents aged 12–18 years—specifically when "adequate systems" exist for diagnosis, treatment, and monitoring—highlighting that screening is only as good as the follow-up system behind it [1].

Routine care has two advantages that specialist services do not: repeated contact and trust built over time. But those advantages only work if clinicians apply consistent methods. The GLAD-PC guidelines emphasize practice preparation, systematic identification, assessment, and initial management of adolescent depression in primary care, including the need for organized workflows rather than ad-hoc decision-making [2]. In real life, this means normalizing mental health questions ("we ask everyone"), ensuring private time with the teen, and using validated tools instead of "vibes." It also means having an agreed pathway for positives: what to do today, what to schedule next, and when to escalate urgently. Without that pathway, screening simply discovers a problem and leaves it standing in the hallway like an uninvited guest.

MATERIALS AND METHODS

A practical model starts with **how you set the room**. Adolescents are far more likely to disclose mood symptoms, self-harm thoughts, bullying, sexual violence, or substance use when clinicians (1) explain confidentiality clearly, (2) ensure a brief period without parents present, and (3) ask directly and calmly. WHO mhGAP guidance for non-specialist settings reinforces that common mental health conditions can be identified and managed in routine care with structured assessment and clear next steps, and it explicitly addresses self-harm/suicide management within general health services [3]. Clinically, the opening script matters: "I talk with every teen alone for a few minutes. What you share

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is private unless I'm worried you could be harmed or hurt someone." That one sentence reduces fear and increases honesty. It also prevents the most common failure mode: the teen who says "I'm fine" in front of a parent, then disappears from care until a crisis.

Next comes **screening and case-finding**. Evidence supports routine depression screening in adolescents when systems exist for diagnostic confirmation and follow-up [1]. In practice, many clinics use PHQ-9 Modified for Teens or PHQ-A for depression, and may add a brief anxiety screener depending on local workflow. Screening should not be limited to "well visits only," because many teens who avoid preventive visits still show up for sports physicals, minor illnesses, or chronic disease follow-ups—perfect moments for opportunistic screening. GLAD-PC recommends annual screening for depression in adolescents 12 and older and stresses using validated instruments [2]. The key operational point is consistency: if screening depends on the clinician remembering, it will fail; if it is built into intake forms or nurse workflow, it becomes routine. And yes—teens sometimes roll their eyes at the questions. That's fine. A rolling eye is not a contraindication; it's just adolescence doing adolescence.

A positive screener triggers **a short, structured clinical assessment**, not a long interrogation. Confirm symptoms (duration, severity, functional impairment), review safety (suicidal thoughts, self-harm, access to lethal means), and screen for common comorbidities that change management (substance use, trauma, eating problems). GLAD-PC emphasizes assessing severity, evaluating for comorbid conditions, and determining functional impairment and safety risk as part of the primary care role [2]. It is also crucial to differentiate "distress" from "disorder" without dismissing either: distress still deserves support, while disorder needs structured treatment. A clinician can often do this with three anchors: (1) time course (weeks vs months), (2) impairment (school, sleep, relationships), and (3) safety. If impairment is significant or symptoms are persistent, do not "wait and see" without a follow-up date—waiting is only a plan if it has a calendar.

RESULTS AND DISCUSSION

Suicide and self-harm risk require special handling because risk prediction is imperfect, but safety steps are actionable. The USPSTF concludes evidence is insufficient to recommend universal suicide risk screening in asymptomatic youth, but that does not mean clinicians should avoid asking when there are warning signs or when depression screening is positive [1]. The American Academy of Pediatrics Blueprint for Youth Suicide Prevention provides clinical strategies for suicide risk screening and outlines what to do when risk is identified, including safety planning and referral linkage [5]. NICE guidance on self-harm covers assessment and management to prevent recurrence, emphasizing the need for psychosocial assessment and appropriate aftercare planning [4]. In routine care, the minimum safe sequence is: ask directly about suicidal thoughts and self-harm, assess immediacy (plan, intent, means), involve caregivers when safety is a concern, reduce access to lethal means, and arrange same-day urgent evaluation if risk is high. This is not dramatics—it is standard prevention.

With recognition and risk stratification in place, clinicians need **a stepped referral pathway** that matches severity and local resources. For mild symptoms without safety risk, GLAD-PC supports "active monitoring" with frequent follow-up, psychoeducation, sleep and activity support, and problem-solving—while still keeping escalation triggers clear [2]. For moderate depression or significant impairment, referral to evidence-based psychotherapy (such as CBT or interpersonal therapy) is appropriate, often with comanagement between primary care and mental health. For severe

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depression, psychosis, mania, active substance dependence, eating disorders with medical instability, or high suicide risk, urgent specialty evaluation is indicated; if same-day specialty care is not available, emergency services may be necessary. WHO mhGAP similarly frames management by severity and emphasizes referral for conditions beyond the scope of non-specialist care, while still supporting initial stabilization steps in general settings [3]. The pathway should be written down in the clinic—who to call, where to send, what documentation is required—because in a crisis, nobody performs well with a "we'll figure it out" protocol.

CONCLUSION

Early recognition of adolescent mental health problems in routine care is achievable when clinics treat it as a standard workflow: confidential teen time, validated screening, focused diagnostic confirmation, safety assessment, and a written referral pathway matched to severity. Evidence supports screening adolescents 12–18 for depression when systems for treatment and follow-up exist, and GLAD-PC provides practical primary-care guidance for identification, assessment, active monitoring, and comanagement strategies. Suicide and self-harm prevention requires direct, calm assessment and rapid escalation when risk is high, informed by structured guidance such as NICE self-harm recommendations and the AAP Blueprint for Youth Suicide Prevention. WHO mhGAP reinforces that non-specialist health services can play a decisive role in identifying and responding to priority mental health conditions, while also clarifying when referral is essential.

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