Published in final edited form as:

J Adolesc Health. 2009 June ; 44(6): 516–517. doi:10.1016/j.jadohealth.2009.03.018.

Thinking Systematically About Early Identification

Kelly J Kelleher, M.D., M.P.H.

Department of Pediatrics, The Ohio State University, Columbus, Ohio

In 1978, Regier and colleagues pointed out the central role of primary care clinicians in caring for persons with mental disorders in the United States [1]. Noting that the vast majority of persons with mental disorders, including adolescents, are only seen in primary care settings, they called for increased identification by primary care physicians. Primary care settings are especially important to adolescents since it may be the only health care contact youths have during a critical time period. Since the Regier article, we have had three decades of research on clinician identification and screening, consensus groups, guidelines, screening tool development, and improved residency training in behavioral pediatrics. How are we doing?

In this issue of the *Journal of Adolescent Health*, Ozer and colleagues report their findings from two different data sources on teen reported emotional assessments by primary care clinicians [2]. First, they analyzed the California Health Insurance Survey for a random digit dial telephone sample asked to report on whether or not emotional symptoms were discussed with them by their primary care providers. Just less than one-third of the teens remembered any such discussion with their providers. This is the first study of screening for depression in adolescents in primary care to use a population sample. Next, they analyzed data from a similar set of questions administered to youth actually using primary care services in a large health system in the same state. Again, slightly less than a third of teens remembered any discussion of emotional symptoms.

There are some limitations to the Ozer findings. First, teens may fail to recall primary care clinicians' discussion of depression during primary care visits. Secondly, teens were asked only about provider discussion about symptoms, and not about screening instruments that might have been used in the waiting room or other locations. Similarly, we have no information about what providers might have discussed with parents. These limitations may have resulted in the underestimation of primary care clinicians' screening for depression. Still, the remarkable similarity of the results in two diverse samples and the similarity with other reports on under-recognition of emotional symptoms by primary care clinicians means that Ozer and colleagues are probably correct that, as was found repeatedly in prior research, primary care clinicians are missing many cases and appear to be little better than chance at identifying emotional distress [3,4].

The literature is full of suggestions about why most primary care clinicians do not screen for adolescent depression. For the most part, the literature to date has assumed that low rates of preventive services delivery to primary care patients is the fault of individual physicians who either need to work, learn, train, or remember more. There is some evidence that many primary care clinicians are not confident in their ability to identify depression and some do not feel it is their responsibility [5]. However, evidence from a wide variety of studies shows that the

large number of preventive services required, the limited contact adolescents have with primary care clinicians during office visits, the complex and confidential nature of some of these services, and the importance of ongoing monitoring make it almost impossible for individual clinicians to maintain high levels of quality, especially for mental health services [6,7]. In addition, there is limited evidence for the effectiveness of current primary care interventions for adolescent depression [8,9]. Clinicians are often reluctant to refer patients to mental health treatment, because community treatment services are often not evidence-based, are in short supply, and carry enormous stigma for many families. The opportunity costs for practices are also high when they are striving to meet many other prevention guidelines. Valenstein pointed out that primary care depression screening for adults cost an average of \$7/visit for staff time alone and yielded many false positives that burdened both the primary care staff and specialty care systems [10]. In short, the costs of depression screening for teens are still too high and the benefits are still too low for most primary care clinicians to engage in universal screening for adolescents.

If our explanation of why primary clinicians do not screen is correct, then the solution requires an overhaul of the system for identifying and treating adolescent depression. This system overhaul should target the effectiveness and efficiency of all preventive services for adolescents, not just mental healthcare. Ozer and colleagues conclude that, “Primary care clinicians/**systems** need to better utilize opportunities” to assess adolescents for emotional distress. There are promising models and components that do appear to improve care and lower costs. They include practices that organize regional mental health and other community services to enhance access, technologies that lower the cost of assessment and communication with adolescents, financing innovations that support more primary care assessment and case management activities, and partnerships among diverse organizations to engage youths in pro-social activities [11]. All of these are part of or consistent with the “medical home” model increasingly advocated by the American Academy of Pediatrics and other national organizations to develop system responses to the complex needs of our patients and their communities. Thirty years of blaming doctors for inadequate screening has not done the job. Real progress in improving preventive services will only be made when clinicians, patients and investigators all appreciate that the patient/doctor dyad has been, and should be, the patient/doctor/system triad.

References

1. Regier DA, Goldberg ID, Taube CA. The de facto US mental health services system: a public health perspective. *Archives of general Psychiatry* 1978;35(6):685–693. [PubMed: 306803]
2. Ozer EM, Zahnd EG, Adams SH, et al. Are Adolescents Being Screened for Emotional Distress in Primary Care? *Journal of Adolescent Health* Jun 2008;10:1–8.
3. Lecrubier Y. Widespread underrecognition and undertreatment of anxiety and mood disorders: results from 3 European studies. *The Journal of Clinical Psychiatry* 2007;68(Suppl 2):36–41. [PubMed: 17288506]
4. Brown JD, Riley AW, Wissow LS. Identification of youth psychosocial problems during pediatric primary care visits. *Administration and Policy in Mental Health* 2007;34 (3):269–281. [PubMed: 17226090]
5. Olson AL, Kelleher KJ, Kemper KJ, et al. Primary care pediatricians’ roles and perceived responsibilities in the identification and management of depression in children and adolescents. *Ambulatory Pediatrics* 2001;1(2):91–98. [PubMed: 11888379]
6. Chung PJ, Lee TC, Morrison JL, et al. Preventive care for children in the United States: quality and barriers. *Annual Review of Public Health* 2006;27:491–515.
7. Yarnall KS, Ostbye T, Krause KM, et al. Family physicians as team leaders: “time” to share and care. *Preventing Chronic Disease* 2009;6(2):A59. [PubMed: 19289002]

8. Cheung AH, Dewa CS, Levitt AJ, et al. Pediatric depressive disorders: management priorities in primary care. *Current Opinion in Pediatrics* 2008;20(5):551–559. [PubMed: 18781118]
9. Cheung AH, Zuckerbrot RA, Jensen PS, et al. Expert survey for the management of adolescent depression in primary care. *Pediatrics* 2008;121(1):e101–107. [PubMed: 18166529]
10. Valenstein M, Vijan S, Zeber JE, et al. The cost-utility of screening for depression in primary care. *Annals of Internal Medicine* 2001;134(5):345–360. [PubMed: 11242495]
11. Rosenthal T. The Medical Home: Growing Evidence to Support a New Approach to Primary Care. *Journal of American Board of Family Medicine* 2008;21(5):427–40.