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PROVIDING DEPRESSION CARE IN THE MEDICAL HOME: WHAT CAN WE LEARN FROM ADHD?

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INTRODUCTION

Although many primary care providers (PCPs) are reluctant to manage adolescent depression,[1] they commonly provide care for children with attention deficit hyperactivity disorder (ADHD).[1, 2] We sought to describe differences in care for these common diseases in order to identify opportunities to improve depression care.

METHODS

PCPs from the St. Louis area completed a 29-item self-administered, mailed questionnaire (see eQuestionnaire). Questions assessed attitudes towards and behaviors regarding screening, diagnosis, and management of depressed adolescent patients. Four-point categorical scales were used to indicate agreement with attitudinal statements and confidence in delivery of depression care. Respondents also agreed or disagreed with statements about care for depression and ADHD. Washington University Human Research Protection Office approved the study.

RESULTS

Of the respondents (100 pediatricians, 4 PNPs, 45% response), 96% wanted to improve the care they provided and 47% agreed (strongly agree or agree) that adolescent depression should be cared for in the medical home. PCPs cared for few of their depressed patients (median 5%, IQR 0–25%), although many reported frequent problems accessing psychiatry (83%) and psychotherapy (46%). Patients were identified by parental (median 50%, IQR 10–88%) or patient complaint (median 30%, IQR 0–70%); only 4% of PCPs used a validated screening tool at annual visits. PCPs lacked confidence (not very or not confident) in interpreting screening tools (43%), assessing suicide risk (37%), providing supportive counseling (60%), and monitoring treatment response (39%), and 74% suggested additional training was needed.

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In contrast, PCPs cared for almost all their patients with ADHD (80%, IQR 70–90%) and felt adequately trained and confident to do so (Table 1). The difference in agreement that easy-to-use guidelines are available for these two disorders is notable.

The majority felt effective safe treatments were available for ADHD and depression. Although 67% prescribed selective serotonin reuptake inhibitors (SSRIs), 65% were reluctant due to concern about the Black Box warning (40%), unfamiliarity with use (29%), and fear of litigation (24%).

COMMENT

Although the PCPs in this survey overwhelmingly wanted to improve the care they provided for their depressed adolescents, the extent of care they provided currently was quite limited. They preferred to refer their depressed patients to mental heath specialists rather than provide care themselves (although access is clearly limited) and were reluctant to prescribe SSRIs (although they believe them to be safe and effective). Lack of confidence to recognize and manage depression and inadequate training were previously reported[1, 3] and likely reduce PCPs willingness to follow recent recommendations to screen all adolescents for depression.[4]

In contrast, most PCPs in this and other studies were confident in their ability to identify and manage children with ADHD without the help of mental health professionals.[3] Acceptance of the responsibility to provide ADHD care seems to have been accomplished by increasing awareness of the national guidelines published and promulgated by the AAP that encouraged PCPs they can and should provide this care, and availability of easy-to-use tools to aid diagnosis and treatment monitoring, and effective treatments.[3, 5] Thus it appears that a similar transition for depression care will require active promotion of national treatment guidelines by the AAP together with encouragement for PCPs to provide care for depression, education about how to use tools designed to aid diagnosis and treatment monitoring in the primary care setting (such as the PHQ-9)[6] and system changes to support timely access to mental health professionals when needed as well as improved reimbursement for time spent.

Although these data may not be generalizable as the study sample was small and from one geographical location, study findings and experience with ADHD suggest that such efforts would be welcomed by many PCPs and effective.

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Dr Garbutt had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Abbreviations

AAP	American Academy of Pediatrics
ADHD	Attention Deficit Hyperactivity Disorder
IQR	Interquartile range
NCRR	National Center for Research Resources

NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PHQ-9	Patient Health Questionnaire – 9
SSRI	Selective serotonin reuptake inhibitor

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TABLE 1

PCP Beliefs About Providing Mental Health Care for Depression and ADHD

	Percent Agreeing With Statement			
	Depression	ADHD	N	P value[a]
Referral to a mental health professional is seldom necessary	6%	77%	100	<0.001
I am adequately trained to provide effective care	29%	89%	102	<0.001
I feel confident in providing care	36%	92%	99	<0.001
Easy-to-use clinical practice guidelines are available	28%	72%	91	<0.001
A brief, easy-to-use tool to assess treatment response is available	34%	77%	93	<0.001
Most patients will adhere to treatment plan	41%	82%	96	<0.001
Most patients will return for follow-up visits	58%	94%	97	<0.001
A brief, easy-to-use diagnostic tool is available	52%	77%	93	0.001
Most parents desire treatment	72%	94%	98	<0.001
Reimbursement for providing care is adequate	21%	42%	91	0.003
Treatment is usually effective	77%	96%	91	<0.001
Effective, safe medications are available	80%	98%	97	<0.001

[a]Fisher's exact test was used