Primary Care Provider Training in Screening, Assessment, and Treatment of Adolescent Depression

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Abstract

Objective: Adolescent depression is underrecognized and undertreated. Primary care providers (PCP) require training to successfully identify adolescents with depression. We examined the effects of a PCP training program in the screening, assessment, and treatment of adolescent depression (SAT-D) on adolescents' reports of PCP screening for adolescent depression at annual well visits and PCP SAT-D confidence and knowledge.

Methods: PCP (n = 31) attended one SAT-D training program consisting of a 60-minute SAT-D seminar and a 60-minute standardized patient session where PCP practiced SAT-D skills. A pre–post design evaluated effects of training on PCP depression screening practices as reported by 3 groups of adolescent patients at well visits (n = 582 before, n = 525 at 2 to 8 months after training, n = 208 at 18 to 24 months after training). A generalized linear mixed effects logistic regression controlled for provider and patient demographics that may have influenced depression screening. PCP SAT-D self-reported confidence and objectively tested knowledge were assessed at baseline, immediately after training, and at 4 to 6 months after training.

Results: On the basis of the regression analysis, PCP screening for adolescent depression increased significantly from pretraining (49%) to 2 to 8 months after training (68%, odds ratio 2.78, 95% confidence interval 2.10–3.68) and 18 to 24 months after training (74%, odds ratio 3.17, 95% confidence interval 2.16–4.67; both $P < .0001$). PCP SAT-D confidence and knowledge also significantly improved.

Conclusions: PCP SAT-D training resulted in significant increases in primary care screening for adolescent depression that were maintained up to 24 months after training. Future studies should determine if changes in PCP screening improve identification of adolescent depression and patient outcomes for adolescents with depression.

Keywords: adolescent depression; primary care; screening; standardized patient

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What's New

Adolescent patient reports of primary care provider (n = 31) practices before (n = 582) and then 2 to 8 months (n = 525) and 18 to 24 months (n = 208) after training showed significant improvements in depression screening. Future studies should determine if training improves depression identification and treatment outcomes.

Adolescent depression, a critical public health problem, is underrecognized and undertreated. Only 50% of cases are identified,[1] and of the 2 million US adolescents diagnosed annually with depression,[2] only a minority (38%) receive treatment.[2] Untreated adolescent depression leads to many adverse outcomes,[3,4] including suicide,[5] the third leading cause of death among US youth.[6] Early identification of depression represents an important opportunity to prevent the morbidity and mortality associated with depression and suicide.[7] Primary care providers (PCP) are uniquely positioned to identify early signs of depression. PCP evaluate 70% of adolescents annually,[8] including 45% of suicide victims within the month before completed suicide.[9] The American Academy of Pediatrics (AAP)[10] and the United States Preventive Task Force[11] both recommend primary care screening for adolescent depression, and the AAP has developed expert guidelines for the assessment and management of depression.[12,13] Despite these guidelines, PCP are screening few adolescents at annual well visits for depression.[14,15]

Although guidelines represent an important first step toward changing PCP practice patterns, additional interventions are needed to promote improvements in primary care assessment and management of depression.[16,17] PCP report that they lack sufficient training in depression assessment and management,[18–20] and they thus need additional practice to gain competence. Traditional

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continuing medical education using didactic lectures alone has minimal impact on clinical practice,[17] so a more comprehensive, multifaceted educational intervention is needed to facilitate screening. One British group developed such a training program for general practitioners that incorporated a practical tool kit to facilitate office-based screening for adolescent depression.[21] Although limited by a low general practitioner participation rate (5.7%), the program showed modest posttraining improvements in general practitioner screening for and identification of adolescent depression.[21] However, that program did not include explicit training on conducting suicide risk assessment, which is a key component of depression assessment. The training also did not include structured opportunities to practice critical skills in communicating with adolescents about depression and suicide. There has only been one report of a training program that allowed PCP to practice clinical skills in both adolescent depression and suicide risk assessment using standardized patients (SP).[15] Compared with untrained PCP, trained PCP were significantly more likely to report use of a standardized depression screening tool (50% vs 19%, $P = .001$) and diagnosis of adolescent depression (96% vs 78%, $P = .013$) in the past 3 months.[15] One limitation of the study was that PCP practices were measured by asking pediatricians to recall whether or not that they had screened for or diagnosed adolescent depression in the past 3 months. Because depression screening was reported retrospectively and by physicians, who tend to both overestimate and underestimate preventive service delivery,[22] the validity and reliability of these reports of depression screening is questionable. A better way to measure PCP screening practices may have been to survey adolescent patients immediately after each well visit; adolescent patients have been shown to reliably recall discussions with their provider about preventive care even 2 weeks after a visit.[22,23] Another limitation of the previous study was that training focused on assessment but not on management of depression with antidepressant medication. Given the shortage of mental health providers, it is critical that PCP gain skills and knowledge in both assessment and management of depression.

The present study evaluated a brief program of PCP training in the screening, assessment, and treatment of adolescent depression (SAT-D), including the use of antidepressant medication. The primary outcome was the frequency of PCP screening for adolescent depression at well visits as reported by adolescent patients. Secondary outcomes were PCP SAT-D self-reported confidence and objectively tested knowledge. Exploratory outcomes included the frequency of PCP: 1) identification of adolescent depression, 2) discussion of evidence-based treatment for depression, and 3) administration of a standardized depression screening tool (long-term follow-up only). We hypothesized that this enhanced training program would increase the frequency of PCP depression screening as reported by adolescent patients at well visits and also improve PCP SAT-D confidence and knowledge.

METHODS

STUDY DESIGN

A pre–post design assessed changes in adolescent patient reports of PCP screening for depression (primary outcome) at baseline versus 2 to 8 months and versus 18 to 24 months after training. Because both follow-up periods occurred during the school year, when fewer adolescent well visits occur, 6 months were required to collect a comparable number of adolescent well visit surveys. Secondary outcomes included PCP SAT-D self-reported confidence and objectively tested knowledge. Follow-up measurement of PCP SAT-D confidence and knowledge occurred immediately after training and again at 4 to 6 months after training. Exploratory outcomes included the frequency of PCP: 1) identification of adolescent depression, 2) discussion of evidence-based treatment for depression, and 3) administration of a standardized depression screening tool (at 18 to 24 months after training only) (Figure). As a preliminary study, this pre–post design offered the advantage of a prospective direct benefit to all participating PCP. In addition, it allowed our team to determine the effects of the SAT-D intervention in order to justify a more rigorous future randomized controlled trial. The study took place at 4 outpatient primary care clinics in Jacksonville, Florida, from August 2012 to August 2014.

Both the Nemours Foundation and the University of Florida institutional review boards approved the protocol. PCP provided written informed consent to participate. PCP were not aware of which patients were participating in the study. Adolescents and their parents were informed before data collection about the purpose and procedures of the research study and that participation was voluntary. Adolescents had no knowledge about whether or not their PCP had completed training. Adolescent patients reported anonymously on whether their PCP asked them about depression but reported no clinical information about symptoms of depression. Because adolescents were reporting anonymously on physician screening practices but not on any individual health information, the institutional review board waived the requirement for documentation of parental permission and adolescent assent.

PARTICIPANTS/RECRUITMENT

Primary Care Providers

The primary investigator invited 4 group practices of PCP in Jacksonville, Florida, that each provided care to 200 or more adolescents annually and represented a diverse mix of patients with private and Medicaid insurance. PCP were not compensated for their time but were offered 2 hours of continuing medical education credit as a participation incentive.

Adolescent Patients at Well Visits

All adolescent patients (aged 12 to 18 years) of participating PCP and the adolescents' caregivers who arrived for well visits during the study period were given a letter at

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