Commentary: Missed Chances: Why so Many for so Long?

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The study by Mansbach-Kleinfeld et al. (2011) in Israel delivers a number of clear messages which mirror findings in other countries. Most adolescents attend primary care within the course of a year. This is contrary to the perception by many primary care practitioners (PCP) that they do not (1). The presence of a mental disorder increases the likelihood that they will attend and rates of depressive symptoms in attenders are increased when compared with non-attenders (2). Few of these are detected and only a minority receive any mental health intervention. The majority of mental health problems among attenders are internalizing disorders which are essentially treatable (3, 4), hence the chance is missed.

What are the implications of the missed opportunity? The undetected disorders are by definition associated with suffering and impairment. Anxiety and depressive disorders display persistence, recurrence and strong continuity with adult disorder, suggesting an opportunity for secondary prevention. Half of the adolescents attending their PCP in the UK with (mainly undetected) depression have been shown to remain depressed at 6-month follow-up (5). Adolescent depression has been associated with functional impairment (6, 7), health risk behaviors (8) and increased health service use (9, 10).

Why then are the chances missed? Repeatedly, health policy globally has highlighted and emphasized the crucial role of primary care in addressing unmet health need (11). This stated policy commitment has failed to translate into altered practice in the consulting room and the reasons are complex. Firstly, parents and adolescents rarely present with emotional and behavioral concerns to the PCP and both PCPs and adolescents fail to raise psychological concerns even when they are aware they are present (12). Secondly, earlier research suggested that adolescents viewed their PCPs as unsympathetic; subsequent research has indicated that many feel satisfied with the care they receive although they have concerns about confidentiality. Others do not believe that PCPs are adequately trained to deal with such problems (13) and they may have fears of stigmatization. The relevance of attitudes is further supported by the study by Ferrin et al. (2) showing that consultations of girls with depressive symptoms are influenced by whether they regard doctors as only interested in physical symptoms or not. Thirdly, Jacobson (14) demonstrated that adolescents receive shorter consultations than adults which reduces the chances of raising psychological issues though this study was carried out some years ago and now requires replicating to see whether this persists. Lastly many adolescents may require their parents to raise concern on their behalf although particularly with regard to internalizing disorders parents may not always be fully aware of their need.

In order to better understand the role of the PCP in the failure of detection, we explored the perceptions of family physicians (GPs) in the U.K. regarding adolescents, and particularly in relation to recognizing and responding to depression. Adolescents were perceived by them as qualitatively different in the way they consulted. GPs viewed adolescents as more complex and difficult, intermittently and impulsively using services. GPs also expressed difficulty in differentiating between disorder and "normal" developmental changes: they fear stigmatizing adolescents with diagnostic labels and the burden of time constraints for this work (1).

Many PCPs remain skeptical about the diagnostic validity of psychiatric disorders and believe that other psychiatric conditions such as hyperkinetic disorder are over-diagnosed (15). Many report lack of confidence in diagnosis and management (16), worry about over-medicalizing adolescents' lives (17, 18) and some advocate that responsibility lies with other agencies such as schools, community organizations and specialist services. However, it is important to note that even within developed countries specialist mental health services remain a scarce resource and in practice this translates into PCPs wishing to make referrals to specialist services expressing concern about the delays in getting help (19). It seems highly unlikely that specialist services will be in a position to attend to the range of adolescent depressive dis-

orders and for many of those a primary care intervention might the most appropriate option.

Seizing the chance! We welcome the call from Mansbach-Kleinfeld et al. (20) to Israel's policy makers, primary and secondary services for an integrated model of care which should follow improved identification within primary care. It is a message to be echoed across countries. Nevertheless, as outlined above, real change within the primary care setting will require attention to a range of areas. Not least parents and adolescents need information about the evidence for intervention for mental disorders and the role of the PCP so that they start to request help more actively and consistently (21).

PCPs require education and training which addresses attitudes, knowledge and skills. Although PCPs are able to detect the more severe disorders (19) detection of the less severely impaired needs improvement and may require an approach which employs systematic screening and clinical enquiry. Brief interventions which can be delivered within primary care need further development. An intervention of this nature for depression, the TIDY program, has been developed by our group and piloted and field tested in a number of practices in London. TIDY trained GPs to systematically screen and identify depressive disorder, and provided initial management within a ten-minute appointment. Management of mild to moderate depressive disorder included psycho-education, promotion of self-help, and advice about coping strategies; information was given both verbally and in leaflets. It was shown to be feasible, acceptable to adolescents and it increased detection of depression among attenders (22, 23).

A comprehensive approach across the spectrum of disorders will require multifaceted programs that integrate improvements in detection, treatment and follow up, and include combinations of clinician and patient education, nurse case management, enhanced support from specialist services and monitoring of medication. Asarnow et al.'s randomized trial of a quality improvement program, along these lines, demonstrated improved quality of care, increased access to evidence based treatments and favorable outcomes for depressive disorder (24). For the most severely affected, in addition to this, new models of collaboration between primary care and specialist care are required in order to facilitate and improve access to specialist services. Innovative models that have been described share a number of features: rapid access by primary care workers to mental health specialist for discussion of cases, access to consultation where appropriate, short delay to specialist assessment, good communication of treatment needs, collaboration in delivery of intervention and treatment monitoring. These models serve to decrease the barriers often encountered between primary and secondary services and facilitate improved contact between professionals allowing for continuing education of PCPs in recognition and management of psychological problems and disorders (19, 25, 26).

Finally, the evidence base for interventions addressing adolescent mental health in primary care remains limited (27, 28). Further research is needed and this should address educational interventions for PCPs, the detection and management of disorders by the primary care team, and health service programs which improve collaboration with specialist services and other sectors. This will ensure we are able to effectively stop missing so many chances.

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References

1. Iliffe S, Williams G, Fernandez V, Vila M, Kramer T, Gledhill J, et al. General practitioners' understanding of depression in young people: Qualitative study. Prim Health Care Res Dev 2008;9:269-279.
2. Ferrin M, Gledhill J, Kramer T, Garralda E. Factors influencing primary care attendance in adolescents with high levels of depressive symptoms. Soc Psychiatry Psychiatr Epidemiol 2009;44:825-833.
3. Harrington R. Systematic review of efficacy of cognitive behaviour therapies in childhood and adolescent depressive disorders. BMJ 1998;316:1559-1563.
4. Cartwright-Hatton S, Roberts C, Chitsabesan P, Fothergill C, Harrington R. Systematic review of the efficacy of cognitive behavioural therapies for childhood and adolescent anxiety disorders. Br J Clin Psychol 2004;43:421-436.
5. Gledhill J, Garralda E. The short-term outcome of depressive disorder in adolescents attending primary care: A cohort study. Soc Psychiatry Psychiatr Epidemiol 2010 Sept. 4 [Epub ahead of print].
6. Asarnow JR, Jaycox LH, Duan N, Laborde AP, Rea MM, Tang L, et al. Depression and role impairment among adolescents in primary care clinics. J Adolesc Health 2005;37:477-483.
7. Rao U, Hammen C, Daley S. Continuity of depression during the transition to adulthood: A 5-year longitudinal study of young women. J Am Acad Child Adolesc Psychiatry 1999;38:908-915.
8. Fernandez V, Kramer T, Doig A, Fong G, Garralda E. Depressive symptoms and behavioural health risks in young people attending an urban sexual health clinic. Child Care Health Dev 2009;35:799-806.
9. Melzer H, Gatwood R, Goodman R, Ford T. The mental health of children and adolescents in Great Britain. London: HMSO, 2000.
10. Yates P, Kramer T, Garralda E. Depressive symptoms amongst adolescent primary care attenders: Levels and associations. Soc Psychiatry Psychiatr Epidemiol 2004;39:588-594.
11. World Health Organisation. Mental health: Facing the challenges, building solutions. Denmark: WHO, 2005.
12. Martinez R, Reynolds S, Howe A. Factors that influence the detection of psychological problems in adolescents attending general practice. Br J Gen Pract 2006;56:529.

13. Biddle L, Donovan JL, Gunnell D, Sharp D. Young adults' perceptions of GPs as a help source for mental distress: A qualitative study. Br J Gen Pract 2006;56:924-931.
14. Jacobson L, Wilkinson C, Owen P. Is the potential of teenage consultations being missed? A study of consultation times in primary care. Fam Pract 1994;11:296-299.
15. Klasen H, Goodman R. Parents and GPs at cross-purposes over hyperactivity: A qualitative study of possible barriers to treatment. Br J Gen Pract 2000;50:199-202.
16. Churchill RD. Child and adolescent mental health. In: Cohen A, ed. Delivering mental health for primary care: An evidence-based approach. London: Royal College of General Practitioners, 2008.
17. Iliffe S, Gledhill J, da Cunha F, Kramer T, Garralda E. The recognition of adolescent depression in general practice: Issues in the acquisition of new skills. Prim Care Psychiatry 2004;9:51-56.
18. MacFarlane A, McPherson A. Primary health care and adolescence. BMJ 1995;311:825-826.
19. Connor DF, McLaughlin TJ, Jeffers-Terry M, O'Brien WH, Stille CJ, Young LM, et al. Targeted child psychiatric services: A new model of pediatric primary clinician-child psychiatry collaborative care. Clin Pediatr 2006;45:423-434.
20. Mansbach-Kleinfeld I, Palt H, Ifrah A, Levinson D, Farbstein I. Missed chances: Primary care practitioners' opportunity to identify, treat and refer adolescents with mental disorders. Isr J Psychiatry Relat Sci 2011;48:150-156.
21. Haller D, Sanci L, Sawyer S, Patton G. The identification of young people's emotional distress: A study in primary care. Br J Gen Pract 2009;59:e61-70.
22. Gledhill J, Kramer T, Iliffe S, Garralda E. Training general practitioners in the identification and management of adolescent depression within the consultation: A feasibility study. J Adolesc 2003;26:245-250.
23. Kramer T, Iliffe S, Gledhill J, Garralda E. Recognising and responding to adolescent depression in general practice: Developing and implementing the Therapeutic Identification of Depression in Young People (TIDY) programme. Clin Child Psychol Psychiatry, in press.
24. Asarnow JR, Jaycox LH, Duan N, LaBorde AP, Rea MM, Murray P, et al. Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: A randomized controlled trial. JAMA 2005;293:311-319.
25. Campo JV, Shafer S, Strohm J, Lucas A, Cassesse CG, Schaeffer D, et al. Pediatric behavioural health in primary care: A collaborative approach. J Am Psychiatr Nurses Assoc 2005;11:276-282.
26. MacDonald W, Bradley S, Bower P, Kramer T, Sibbald B, Garralda E, et al. Primary Mental Health Workers in child and adolescent mental health services. J Adv Nurs 2004;46:78-87.
27. Bower P, Garralda E, Kramer T, Harrington R, Sibbald B. The treatment of child and adolescent mental health problems in primary care: A systematic review. Fam Pract 2001;18:373-382.
28. Kramer T, Garralda E. Primary healthcare psychiatry. In: Rutter M, editor. Rutter's Child and Adolescent Psychiatry. 5th ed. Oxford: Blackwell, 2008.

Commentary

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This is a very important article. It provides us with data about adolescents' use of PCP services and indicates that this group can be seen as high utilizers of primary care services. This is in keeping with our knowledge that people in distress tend to seek help from primary care physicians. This is in contrast to the use of PCP services by adults suffering from depression and/or anxiety (1, 2). This issue has been dealt with less in adolescents worldwide and in Israel particularly. As a high proportion of psychopathology begins in adolescence it is of paramount importance that we are able to plan the optimal approach to detection and treatment in this group. The information in this work could certainly be used to develop such a plan.

However, there are some limitations to this article. It is not clear who is included in the term PCP. Does it include the pediatrician or only the family physician? It is possible that the choice of the medical caregiver could affect the help seeking behavior. The authors use the diagnostic terms used for minors. It is not clear if this is the best approach. For instance, concepts like separation anxiety or oppositional disorder are included. But, major issues in adolescence like eating disorders, schizophrenia, bipolar disorders and somatoform disorders are omitted.

We are aware of the burden of these disorders on mental health care and the fact that they tend to appear in early adolescence and the importance of early intervention. These omissions could affect any public health plan.

Though this article does not state so overtly, it implies that diagnosed patients should be looked after by mental health professionals. But due to shortage of manpower this is practically impossible and it is even questionable if it is desirable. Moreover, it is not clear if the reason of a visit to the PCP by a patient with a mental health problem is psychiatric or due to a concomitant physical complaint (3). The increase in the rate of visits might be due to the tendency to seek help in other stressful situations other than the overt symptoms of their mental health program. Therefore it would be helpful in planning to have information about the reasons leading to the consultation.

This is the first study of PCP service utilization in Israel by adolescents with mental health problems. It teaches us of the high utilization rate by this group and points out that like in the adult population the PCP plays a major role in the help seeking behavior of adolescents. In spite of its limitation this study can serve us in the future planning of the management of mental health problems in this age group.

The role of the PCP is complex and can be divided into the following stages:

1. Recognition of a mental health problem
2. Diagnosis
3. Treatment
4. Referral to secondary mental health services

Future planning should refer to each stage.

The way to use the fact that adolescents in distress tend to turn to the PCP in their help seeking would be influenced by future research based on the methodology of this work.

In spite of its limitations this work should serve as the basis of any such work.

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References

1. Barrett JE, Barrett JA, Oxman TE, Gerber PD. The prevalence of psychiatric disorders in a primary care practice. Arch Gen Psychiatry 1988;45:1100-1106.
2. Mansbach-Kleinfeld I, Farbstein I, Levinson D, et al. Use of services for mental disorders and unmet needs: Results from the Israel Survey on Mental Health among Adolescents (ISMEHA). Psychiatr Serv 2010;61:241-249.
3. Lacovides A, Siamouli M. Comorbid mental and somatic disorders: An epidemiological perspective. Curr Opin Psychiatry 2008;21:417-421.

Authors' response

I. Mansbach-Kleinfeld, H. Palti, A. Ifrah, D. Levinson and I. Farbstein

We are grateful to Prof. Kramer and Prof. Garralda for their most enlightening commentary, which adds further depth and dimensions to the issues raised in our article. We also thank Prof. Munitz for his comments and the questions he raises, and we would like to clarify some of the issues brought up by him.

1. In the Methods section of our article (paragraph 5, "Assessment of Services Utilization"), the term "primary care practitioner" is clearly defined as including general practitioner, pediatrician and internist. This definition is one utilized in previous Israeli studies (1) and by the Israel Central Bureau of Statistics (2).
2. With reference to the diagnostic categories, we used the Development and Well-being Assessment inventory (DAWBA) (3), a well known instrument to detect mental disorders among adolescents and one widely used in epidemiological studies. We used the version created in 2000, which did not include eating disorders, Tourette's syndrome and other mental disorders. Versions of the DAWBA created subsequently, which are currently being translated into Hebrew, do include these disorders, and can certainly be used in future studies.
3. We do not claim, even implicitly, that all diagnosed adolescents should be cared for by mental health professionals. On the contrary, in the Introduction section of the article, our stated aim includes a discussion of "…issues related to the involvement of PCPs in the identification and care for adolescents with mental disorders and concerns"; and in the "Conclusions" we clearly state that "…The school setting has an important role, as it is widely agreed that mental health intervention with children and adolescents is best targeted at the child's environment. A comprehensive approach needs to be adopted, which includes mental health professionals, parents, teachers, PCP. …"
4. With regard to the fact that information about the specific reason for the PCP visit is lacking, we certainly agree that this is a limitation, and one that we clearly list as such in our article. However, we do wish to point out that data is presented from other studies indicating that although a very small percentage of adolescents present with psychiatric complaints when attending primary care, more than one third of them were found to have a psychiatric disorder in the previous year (4). Therefore, whether or not the reason for the visit is overtly presented as an emotional or behavioral concern does not affect our claim that the PCP has an opportunity to detect, during the course of routine clinical work, adolescents with mental problems who are not being cared for by any professional source of care.

Again, we thank our commentators for their thought-provoking insights and their encouraging remarks, which provide welcome support and recognition of the vital importance of addressing the mental health needs of adolescents in Israel in the framework of a comprehensive model.

References

1. Tabenkin H, Gross R. The role of the primary care physician in the Israeli health care system as a "gatekeeper" – the viewpoint of health care policy makers. Health Policy 2000;52:73-85.
2. Statistical Abstract of Israel 2002. Central Bureau of Statistics. Jerusalem, Israel. http://www.cbs.gov.il/shnaton53/shnatone53.htm (Retrieved on June 18, 2009).
3. Goodman R, Ford T, Richards H, et al. The Development and Well-Being Assessment: Description and initial validation of an integrated assessment of child and adolescent psychopathology. J Child Psychol Psychiatry 2000; 41: 645-656.
4. Kramer T, Garralda ME. Psychiatric disorders in adolescents in primary care. Br J Psychiatry 1998;173: 508-513.