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Individual-level factors influencing depression screening in the San Francisco Bay Area

Background

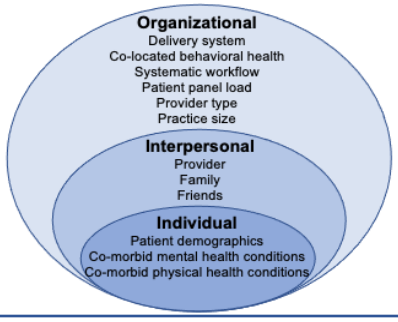
- Major depressive disorder affects an estimated 11% of the US population by age 18[1]
- Adolescent depression is underrecognized and undertreated, particularly among racial/ethnic minorities[2-4]
- Delivery of depression care in primary care settings has the potential to reduce racial/ethnic disparities

Goal: Adapt the Collaborative Care Model for depression to be delivered through Child Psychiatry Access Program

Question 1: How often are adolescents screened for depression (defined as administering a PHQ-2 and/or PHQ-9)?
Question 2: What are individual-level factors (see Figure 1) associated with the receipt of depression screening?

Hypotheses: (a) Overall rate of depression screening is low <10%. (b) Non-white adolescents have significantly lower rates in pediatric primary care settings.

Figure 1. Socio-ecological Framework



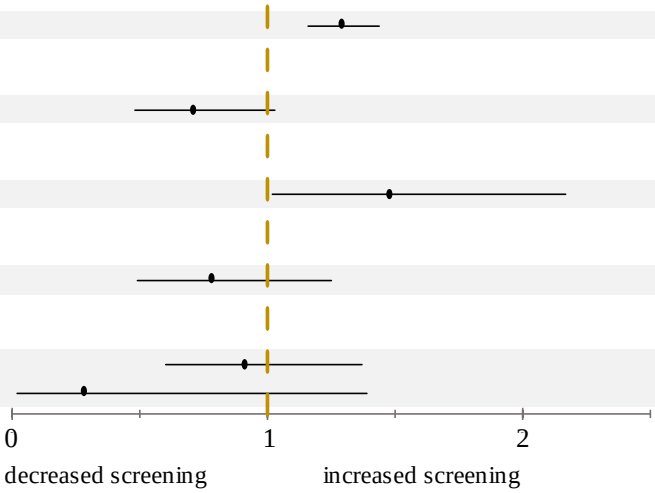
Method

- *Data source:* UCSF electronic health record
- *Sample (N~2,000):* (1) aged 12-17, (2) received primary care (defined as having at least one well-child visit during the study period of 2016-19 through UCSF)
- *Analysis:* Conduct logistic regression analyses to examine associations between individual-level correlates and depression screening.

Preliminary results

Table 1. Prevalence and Multi-Variate Model

Variable	Total (n = 955) n	Total (n = 955) %	Screened (n = 147) n	Screened (n = 147) %	OR Screened	P-value	
Age in years, mean (SD)	11.0 (17.9)		15.2 (1.8)			<0.001	*
Sex							
Female	493	51.6	87	59.2		-	
Male	462	48.4	60	40.8		0.069	
Race (%)							
Non-White	601	62.9	80	54.4		-	
White	354	37.1	67	45.6		0.041	*
Ethnicity							
Hispanic or Latino	172	18.0	29	19.7		-	
Not Hispanic or Latino	748	78.3	109	74.1		0.281	
Insurance							
Commercial	644	67.4	106	72.1		-	
Medicaid/CHIP	291	30.5	40	27.2		0.659	
Other or unknown	20	2.1	1	0.7		0.218	



Discussion/Next Steps

- Universal screening for depression coupled with initiatives, such as remote access to psychiatrists, may identify more people in need of psychiatric care, reducing disparities and initiating treatment early
- This project is part of a bigger study where we will conduct focus groups and pilot an adapted Collaborative Care Model intervention

1. Avenevoli S, Swendsen J, He J-P, Burstein M, Merikangas KR. Major Depression in the National Comorbidity Survey–Adolescent Supplement: Prevalence, Correlates, and Treatment. Journal of the American Academy of Child & Adolescent Psychiatry. 2015;54(1):37-44.e32.
2. Yucel A, Essien EJ, Sanyal S, et al. Racial/ethnic differences in the treatment of adolescent major depressive disorders (MDD) across healthcare providers participating in the medicaid program. *J Affect Disord.* 2018;235:155-161.
3. Lu W. Adolescent Depression: National Trends, Risk Factors, and Healthcare Disparities. *Am J Health Behav.* 2019;43(1):181-194.
4. Cummings JR, Ji X, Lally C, Druss BG. Racial and Ethnic Differences in Minimally Adequate Depression Care Among Medicaid-Enrolled Youth. *Journal of the American Academy of Child & Adolescent Psychiatry.* 2019;58(1):128-138.