EDITORIALS

Primary Care Providers and Childhood Mental Health Conditions

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ABBREVIATIONS. ADHD, attention deficit hyperactivity disorder; PCP, primary care physician.

The survey by Rushton, Clark, and Freed1 in this issue of the Journal of the Ambulatory Pediatric Association addresses an important issue in the primary care management of mental conditions in children. For primary care clinicians, the situation for depression in adults has remarkable similarities to that of attention deficit hyperactivity disorder (ADHD) in children. It occurs in 5% to 9% of the population,2 making it too common for the disorder to be totally managed in the mental health care sector, and it has psychopharmacological treatments (selective serotonin reuptake inhibitors) that are relatively safe and effective. Like ADHD, psychosocial interventions (primarily psychotherapy for depression) are effective alternative or complementary treatments. These characteristics have resulted in the less severe forms of depression in adults being treated by their primary care clinicians usually with a selective serotonin reuptake inhibitor and sometimes in collaboration with a psychologist or social worker providing psychotherapy.

Although ADHD has been commonly treated by primary care physicians (PCPs),3–5 these physicians, as Rushton et al’s survey1 demonstrates, are more reluctant to treat children with depression directly. Given the limited resources and access that many families have to mental health services, it is likely that primary care clinicians will have to play a more active role in the future. To do so, they will require more training. Whereas it is possible to diagnose children with ADHD based on parent and teacher reports, depression, as an internalizing condition, requires more scrutiny and interviews of the children themselves. In the past PCPs have underdiagnosed depression in children.6 PCPs need better tools and training in diagnosing depressive disorders in children and better training in the use of the psychotropic medications available to treat depression.

If PCPs are to become major players in the treatment of uncomplicated and milder forms of depression in childhood, they will need to be able to collaborate with psychologists or social workers who can provide the psychotherapeutic component. They will also need adequate compensation for their time, because the management will likely require more time than most physical illnesses. Currently, the ability to collaborate and receive adequate compensation have been restricted in many places by the development of behavioral health carve-outs that place restrictions on the PCPs’ ability to collaborate and do not provide adequate compensation for PCP mental health activities. As Rushton et al1 identify, it will be important to determine what will be the most effective and efficient way to identify and treat children with depression in future research. As the distinctions between physical and mental illness continue to blur and our knowledge and abilities to treat such conditions as depression increase, it will be important to examine models of care delivery that incorporate the resources of primary care clinicians and allow them to work in collaboration with mental health clinicians. Not only does this arrangement allow for an expanded capacity to provide treatment, but it also affords the opportunity to identify children at an earlier time in the disease process when, hopefully, earlier intervention may reduce the severity and course of the disorder. In these times when the cost of care is an important part of the consideration of services, it will be important to determine if primary care models of care for mental disorders are feasible and effective in reducing both mental illness and the cost of care.

REFERENCES
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