Challenges and Opportunities to Facilitate Team Effectiveness in Pediatric Depression Screening

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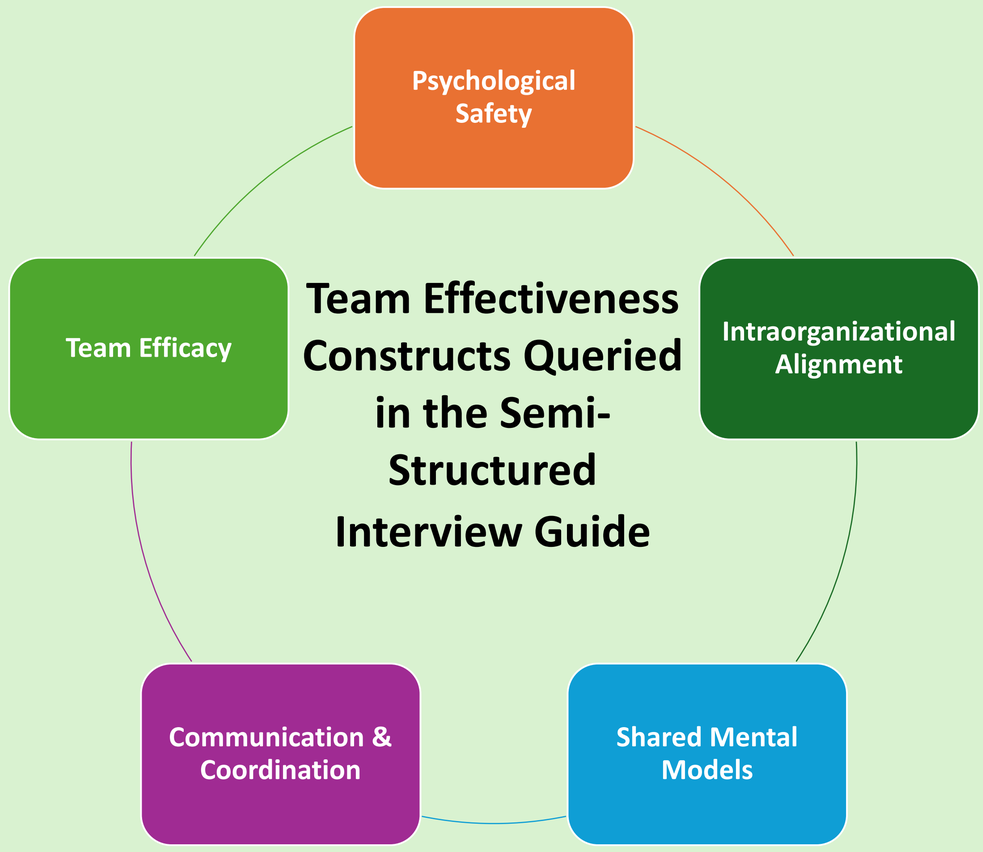
Background

- As of 2016, the US Preventative Services Task Force recommends screening for major depressive disorder in adolescents 12-18 years of age and specifies that screening should be implemented alongside procedures that can support appropriate diagnosis, treatment and follow-up.[1]
- Multiple hospital systems have implemented depression protocols in response to the growing prevalence of pediatric depression.[2] However, there is a lack of evidence of effective follow-up for patients that screen positive.[3]
- The purpose of the parent study is to refine and test a team-based strategy to improve the implementation of depression screening within pediatric healthcare settings.[4]
- This work reports qualitative findings from the perspectives of staff across multiple units regarding determinants of pediatric depression screening.



Methods

- Eight focus groups with 37 staff members from four medical units at Rady Children's Hospital San Diego (RCHSD) were conducted between 7/26/2024 to 3/31/2025.
- Semi-structured interviews were used to elucidate communication pathways and identify team-based challenges (*see Figure 1*) and potential solutions to implementing the existing depression screening protocol at RCHSD.[5]
- Focus groups were recorded and transcribed, then analyzed using rapid qualitative analysis.[6,7]

Results

- Seven common themes related to challenges in depression screening were identified across units.
  - These themes included challenges in Patient Health Questionnaire (PHQ) screener administration, unclear roles of social workers versus medical team members in triage and assessment and limited access to behavioral health services following referral.
- Communication pathways generated by the research team identified that challenges occurred within three stages of the depression care cascade: screening, assessment, and disposition planning.

Figure 1: Challenges in Depression Screening

Screening	Assessment	Disposition Planning
PHQ Appropriateness for Patients	Siloing of Medical & Behavioral Health Roles	Screening Delaying Discharge
Administering to Neurodivergent Patients	Challenges with Behavioral Health Services Referral & Coordination	Care Follow-Up
Privacy to Complete the PHQ		

Privacy for Completing the PHQ:
"I do hear the medical assistants, they'll make comments sometimes that the parent was hovering over them or the parent was answering the questions... so I really don't think they are given full privacy."
- Nurse Practitioner

Siloing of Roles:
"We just have some providers that are just really nervous about mental health and don't have the training or the comfortability... that can be challenging if we have more acute cases, to then have to go do an evaluation when that technically doesn't even meet criteria for us to see."
- Social Worker

Follow-Up After Discharge:
"How do we follow up on that? Maybe it's something that's preventable, but we don't know because I don't think we have anyone who closes the loop on that... If we assigned it to someone, I am sure it would get done."
- Nurse

Conclusions

- Findings highlight a need for team-based strategies at three specific stages of the depression screening process: screening, assessment and disposition planning.
- In particular, the siloing of behavioral health and medical team member roles across all stages presented challenges to effective depression screening.
- The siloing of roles and other challenges listed in Figure 1 indicate an opportunity to identify a team-based intervention that could clarify outcomes, team member roles and responsibilities, and expectations for communication and other processes within the depression care cascade.
- These findings will guide the design of a team-based implementation strategy, which will be evaluated in a forthcoming pilot trial.[3]

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References