How Primary Care Providers Respond to Children's Mental Health Needs: Strategies and Barriers

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Introduction

This report briefly reviews some of the major concerns related to mental health services for children, especially as they relate to the intersection of behavioral health and primary care. It summarizes the findings from a recent survey of pediatric providers in Connecticut – which show many of them to be unable to recognize, assess, or manage pediatric behavioral disorders – and concludes with recommendations for action.

Up to 20% of American children may experience mental health problems, but as many as 80% of those children may not receive the services they need.[1] One potential path to accessing care is through the pediatrician's office, since most children are seen by a primary care provider and, in some cases, parents may be willing to discuss their children's behavioral, learning, or emotional difficulties with health care providers.[2-4]

Over time, there has been an increase in the recognition of the importance of children's mental health needs, both generally and in the context of primary care.

In 1975, the term "new morbidity" was used to describe the increasing frequency of psychosocial, behavioral, and learning difficulties that pediatric patients were experiencing.[5] Since then, numerous papers have been published on the role of primary care providers in the identification, assessment, and treatment of behavioral and mental health problems.[6-10]

As many as 15% to 27% of pediatric patients may have emotional, behavioral, or learning problems[11-14] and up to 50% of office visits may involve such concerns.[15] Research has suggested, however, that many pediatric care providers do not have significant specialized training in the field of mental health or behavioral pediatrics[16, 17] and problems may go undetected or under-detected by providers.[18-20] In addition, some researchers have expressed concerns about ethical issues related to accurate problem identification if no follow-up services are available.[21]

The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country. Growing numbers of children are suffering needlessly because their emotional, behavioral, and development needs are not being met by those very institutions which were explicitly created to take care of them.

(United States Public Health Service, 2000)

Relevant Studies

Jane Williams and her colleagues[13, 22] surveyed 47 pediatricians in largely urban areas of North Carolina using a standard semi-structured interview to address such issues as frequency of patients seen with behavioral health disorders, diagnoses, comfort level with making diagnoses, and use of medication and non-medication treatments. On average, the providers reported that 15% of their patients had a behavioral health disorder, with attention deficit hyperactivity disorder (ADHD) as the most frequent problem, as well as the one that providers were most comfortable diagnosing and managing. Depression, anxiety, and oppositional defiant disorder (ODD) were the second most frequently cited. Eighty-seven percent of pediatricians reported using some type of screening or assessment tool, and 96% utilized non-medication interventions for children including "supportive counseling, education for coping with ADHD, behavior modification and/or stress management." (p. 601)[13]

Ninety-seven percent of the physicians reported referring patients to psychiatrists and 95% referred to psychologists for reasons such as diagnostic uncertainty, lack of response to treatment, serious depression, anxiety or bipolar disorder, need for more ongoing treatment, and complex psychosocial issues. In addition, more than 50% wanted additional information about patients from the specialists to whom they had referred. Finally, the respondents expressed interest in further education about psychopharmacology, diagnosis and treatment of depression and anxiety, and updates related to ADHD.

A survey of 505 general and family practitioners in British Columbia[23] assessed physician comfort level with behavior problems (e.g., disruptive, non-compliant, anti-social), social-emotional problems (low self esteem, fearfulness, social withdrawal), ADHD, and mood disorders. Physicians' reported comfort and skill levels with evaluation and management were highest for mood disorders and lowest for behavior disorders. Comfort and skill levels were related to factors such as recent participation in continuing medical education regarding psychosocial issues and numbers of children with the conditions who were seen each month.

Pediatric providers were most comfortable assessing for depression, anxiety-related problems, and ADHD. For all disorders except ADHD, the mean comfort levels for assessment were higher than for treatment.

An American Academy of Pediatrics' Periodic Survey of Fellows specifically asked respondents if they thought they should care for patients with the "new morbidity".[24] Over 80% of participants agreed they should be responsible for identifying morbidity in children (as well as mothers), especially ADHD, eating disorders, depression and substance abuse, behavior problems and hostile parenting. They were least likely to see themselves as responsible for identifying learning problems. Few reported specifically asking questions related to conditions other than ADHD; for example, fewer than 30% generally ask about domestic violence, maternal depression, care giving, or hostile parenting. Only 54% reported treating ADHD, while depression was next most frequently treated (16%).

In summary, these studies suggest that while there are, indeed, large numbers of children with behavioral and emotional disorders, it is often challenging for pediatric primary care providers to recognize, assess, and manage these difficulties. In fact, many pediatric providers may not have been trained to do so and, understandably, may be uncomfortable with that expectation.

The Situation in Connecticut

This report is based on a 2006 survey of pediatric and family medicine providers who were members of a large, multi-site primary care group practice. The goals of the survey were:

- To study a local population of providers
- To assess the types and frequencies of behavioral health problems experienced by children in the pediatric panels
- To evaluate provider comfort level diagnosing and treating a wide range of such difficulties
- To determine whether pediatric care providers believe they should be asked to diagnose and treat children with behavioral health disorders
- To obtain information about management and referral patterns
- To assess perceived barriers to identification and management
- To assess providers' experience making mental health referrals
- To inquire about providers' interest in training related to pediatric behavioral health issues

The survey was distributed to 127 providers; 13 declined to participate and/or did not see children. Of the remaining 114 potential respondents, 48 participated (42.1%).

As Box 1 indicates, the majority of respondents were male, specialized in pediatrics, and had been in practice for 15 years. Perhaps surprisingly, more than half did not report having had any advanced training in behavioral pediatrics.

What Do Pediatric Primary Care Providers Encounter in Practice?

ADHD, ODD, depression, anxiety disorders, and developmental and learning disabilities were among

Box 1: The Participants

Gender
- 37.5% Female
- 62.5% Male

Degree
- 83.3% MD
- 16.7% DO, APRN, PA

Specialty
- 54.1% Pediatrics
- 37.5% Family Medicine

Years in Practice
- Median = 16-20
- Mean = 16.75

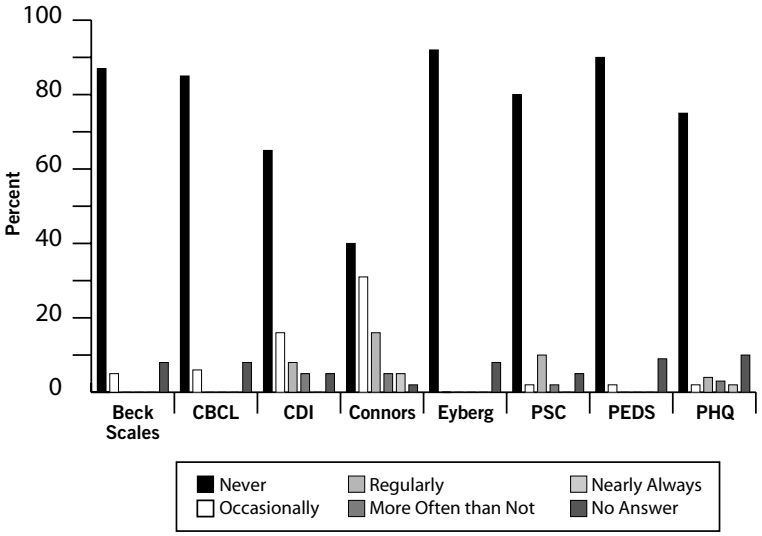
Advanced Training in Behavioral Pediatrics
- 2.1% Fellowship
- 10.4% Rotation
- 20.8% Continuing Education
- 6.3% Other
- 64.6% No Response

the disorders most frequently reported by providers as encountered in their pediatric patients. Participants were also asked to rate their comfort levels with both assessing and treating children with a variety of behavioral health problems. In addition, they were asked to indicate how likely they would be to refer such children to mental health specialty providers (See Box 2, Page 6). They were most comfortable assessing for depression, anxiety-related problems, and ADHD. For all disorders except ADHD, the mean comfort levels for assessment were higher than for treatment.

With regard to assessment, providers were asked to indicate which, if any, behavioral health screening instruments they use in their practices. The results indicated that these instruments are infrequently used and, when they are, they are most likely used to assess for ADHD (Connors Scale, Vanderbilt Scale).

Psychosis, suicidal ideation/attempt, eating disorders, bipolar disorder and post traumatic stress disorder (PTSD) were among the diagnoses most likely to lead to referring a child to a mental health specialist. Although there was variability in the likelihood of referral to a specialist, on average (except for ADHD) health care providers were more likely than not to refer to a specialist. This suggests that even when providers are fairly comfortable treating children with mental health and behavioral problems, they still frequently refer such children to providers with more extensive and specific training.

Use of Screening Instruments



Beck Scales: Beck Youth Inventories | **CBCL:** Child Behavior Checklist (Achenbach) | **CDI:** Child Depression Inventory | **Connors:** Connors Scales | **Eyeberg:** Eyeberg Child Behavior Inventory | **PSC:** Pediatric Symptom Checklist | **PEDS:** Parents' Evaluation of Developmental Status | **PHQ:** Personal Health Questionnaire

When asked whether they agreed or disagreed that it is reasonable to expect pediatric primary health care providers to diagnose/assess or manage/treat behavioral health disorders, the responses were congruent with the finding that

Box 2: Provider Comfort Level and Referral Activity

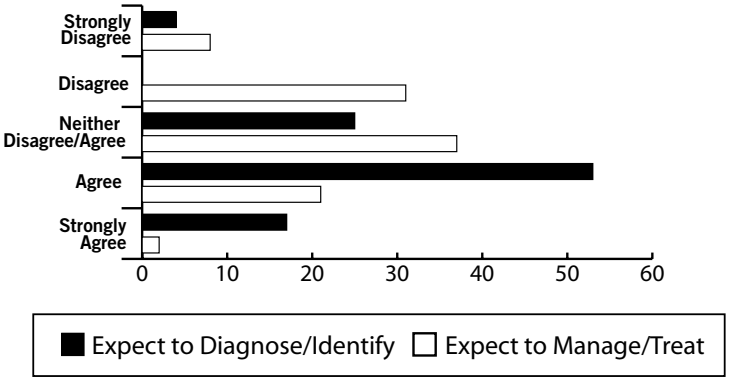
Diagnosis/ Problem	Mean Comfort Level with Assessment*	Mean Comfort Level with Treatment*	Mean Likelihood of Referring to MH**
ADHD	3.96	4.04	2.80
Anorexia	3.48	2.27	4.90
Bipolar Disorder	2.15	1.69	4.85
Bulimia	3.25	2.15	4.75
Depression	4.00	3.06	4.43
Developmental Disabilities	3.60	3.15	3.52
Generalized Anxiety	3.77	3.29	3.92
Learning Disorder	2.96	2.83	3.42
Neglect	3.50	2.94	3.98
ODD	2.92	2.17	4.38
Phobia	3.60	3.10	3.52
Physical Abuse	3.58	2.90	4.48
PTSD	2.69	2.04	4.77
Psychosis	2.28	1.27	4.98
School Refusal	3.69	3.25	3.65
Separation Anxiety	3.83	3.33	3.48
Sexual Abuse	2.98	2.04	4.73
Substance Abuse	3.42	2.35	4.50
Suicidal Ideation/Attempt	3.44	2.13	4.98

*Comfort levels: 5-point scale from Not very comfortable (1) to Entirely comfortable (5)
**Likelihood of referring to a MH specialist: 5-point scale from Not very likely (1) to Entirely likely (5)

providers are more comfortable assessing than treating children with these problems.

Provider Expectations

I believe it is reasonable to expect pediatric primary health care providers to diagnose/identify and manage/treat behavioral health disorders.



Responses on a 5-point Likert scale from Strongly Disagree (1) to Strongly Agree (5).
Mean Diagnose=3.79 Mean Manage=2.77 P<.0001

To obtain data about what pediatric providers are likely to do when they identify a child with a behavioral health problem, the survey asked about actions that providers take for various behavioral health issues. Possible actions included:

- ❖ Assess further
- ❖ Consult with a medical colleague
- ❖ Prescribe medication
- ❖ Manage without medications
- ❖ Consult with a mental health specialist
- ❖ Refer to a mental health specialist

For each of the problems in Box 2, providers were asked to indicate any or all of the actions they might take in assessing or treating a patient. Although a detailed analysis of their responses is beyond the scope of this report, the sample items in Box 3 give

Even when providers are fairly comfortable treating children with mental health and behavioral problems, they still frequently refer such children to providers with more extensive and specific training.

some indication of the strategies they were most and least likely to employ when faced with several behavioral problems. The results suggested that providers use a wide range of strategies and interventions, though this clearly varies from problem to problem. This further suggests that these primary health care providers, despite what may be limited training in behavioral pediatrics, are not assessing and managing different difficulties with a "one size fits all" approach.

Barriers

The literature identifies multiple barriers to mental health care including time, lack of knowledge and lack of mental health specialists.[17, 25, 26] This survey included several questions about impediments to identifying, assessing, and managing behavioral health and emotional difficulties for pediatric patients. **Six activities were of interest: problem identification, problem screening/assessment, medication management, counseling/guidance, and referral to a mental health specialist.** For each of these the participants indicated the extent (on a scale from [1] "Not a Barrier" to [5] "An Extreme Barrier") to which the following impede their ability to address behavioral health issues:

- ❖ Too little time
- ❖ Insufficient knowledge
- ❖ No or minimal reimbursement
- ❖ Lack of available specialists

Box 3:

Management of Selected Problems

Diagnosis/ Problem	Percent Yes (N=48)
ADHD	
Prescribe meds	83.3
Further assess	79.2
Refer MH	50.0
Consult Med	47.9
Manage/No meds	41.7
Consult MH	39.6
Bipolar Disorder	
Refer MH	85.4
Consult MH	45.8
Consult Med	16.3
Further assess	14.6
Prescribe meds	8.3
Manage/No meds	2.1
Depression	
Refer MH	68.8
Consult MH	60.4
Further assess	56.3
Prescribe meds	45.8
Manage/No meds	27.1
Consult Med	25.0
Oppositional Defiant Disorder	
Refer MH	81.2
Consult MH	43.8
Further assess	33.3
Manage/No meds	25.0
Consult Med	18.8
Prescribe meds	8.3
Generalized Anxiety Disorder	
Refer MH	64.6
Further assess	63.8
Consult MH	52.1
Prescribe meds	52.1
Consult Med	31.3
Manage/No meds	29.2

- ❖ Lack of available office staff
- ❖ Concern about labeling children/stigma

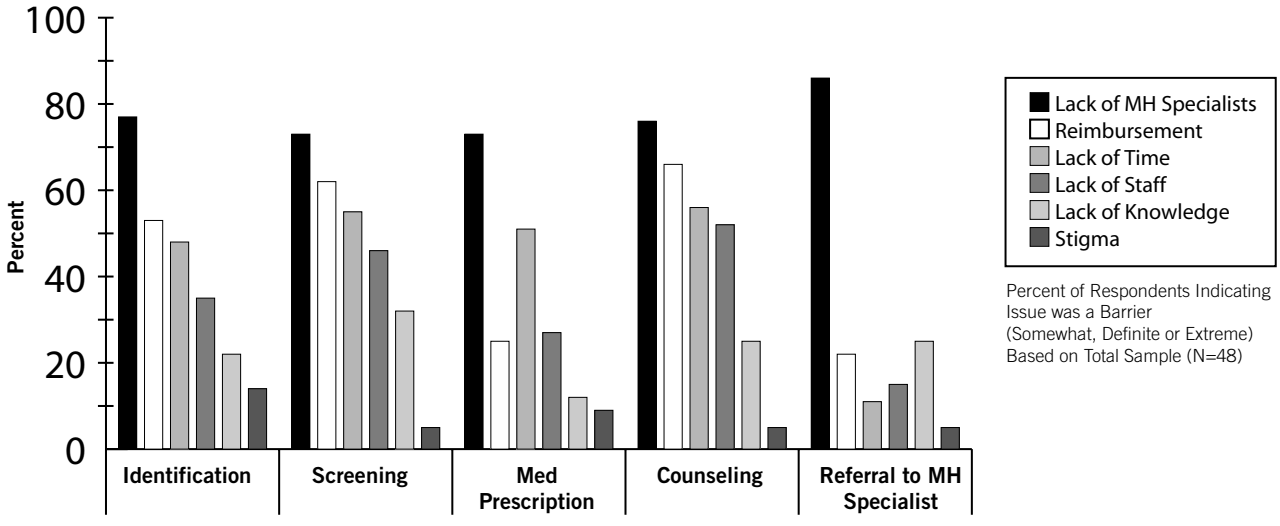
For each of the activities mentioned, providers indicated that the most serious barrier they experienced was "lack of available specialists." This is consistent with the finding that 40% of the survey respondents reported a three- to six-month wait when patients were referred for mental health services and another 38% indicated a one- to two-month wait. Although this survey did not specifically ask about the ethical issue of identifying children's issues when there are few resources to treat them, the results suggest that concerns such as those expressed by Perrin[21, 27] may be well founded.

Several other barriers were noted as well. Lack of time was frequently reported as a barrier to identification, screening and counseling, and insufficient knowledge was noted as a barrier to identification, screening, drug prescription, and counseling. Lack of staff was less frequently cited and the issue of potential stigma for patients was the least common concern.

Awareness, Access, and Collaboration

Because pediatric primary health care providers are confronted so frequently with assessing and either treating or arranging for the treatment of children and adolescents with emotional and behavioral problems, this survey asked several specific questions about their experiences with community resources and providers.

Barriers to Problem Identification, Screening, Medication Prescription, Counseling, and Referral to Mental Health Specialists



Percent of Respondents Indicating Issue was a Barrier (Somewhat, Definite or Extreme) Based on Total Sample (N=48)

Respondents believed that approximately 90% of their patients have difficulty obtaining services and nearly 70% reported that they, themselves, have difficulty accessing such services for their patients.

The providers rated each of the following questions on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree):

- ❖ I am aware of mental health resources in the community.
- ❖ There are mental health agencies or providers with whom I am able to consult as needed.
- ❖ I have difficulty accessing mental health consultation or services for my patients when needed.
- ❖ My patients have difficulty accessing mental health services when needed.
- ❖ I would like to have a formal, consultative relationship with a mental health provider.
- ❖ It would be beneficial to have a mental health provider on-site in my practice, at least for a day or two a week.

Seventy-three percent of the respondents indicated that they either agreed or strongly agreed with the statement about resource awareness; only 40%, however, indicated that they had agencies or specialists with whom they can consult when needed. This confirms the dilemma that a pediatric provider may face when suspecting a patient has a behavioral health disorder: more than half, as noted previously, have no specialized training in behavioral pediatrics and about as many have no specialist available with whom to consult.

Providers indicated that both they and their patients have difficulty accessing mental health services when patients need them. Respondents believed that approximately 90% of their patients have difficulty obtaining services and nearly 70% reported that they, themselves, have difficulty accessing such services for their patients. These difficulties, combined with long waiting times for service and under-utilization of screening and identification protocols, may be contributing factors to the disturbing statistics showing that so many children who need mental health care don't receive it.

There are a number of possible collaborative activities and relationships between pediatric and mental health care providers ranging from informal agreements to triage, consultation, and integrated health care teams.[28, 29] Participants in this study rated statements about two possible formal relationships with behavioral health care providers. Eighty-five percent expressed the desire to have a formal relationship with a mental health professional (Agree/Strongly Agree) while 60% indicated an interest in having such a professional on-site. At first glance, this finding may seem counter-intuitive, as one might expect that

Box 4: Training Interest

	Percent Interested/ Very Interested	Percent Not very interested/ No interest
Abuse/Neglect	58.3	37.5
ADHD	72.9	23.0
Anxiety	85.5	10.4
Behavioral Management/ Parent Counseling	79.2	16.7
Bipolar Disorder	66.7	29.2
Bullying	70.9	25.0
Depression	87.5	6.3
Eating Disorders	85.5	12.5
Grief/Loss	75.0	20.9
Impact of parental mental health problems	73.0	23.0
Impact of Separation/Divorce	81.3	16.7
Learning Disabilities	75.0	20.9
Oppositional Defiant Disorder	70.8	25.0
Peer/Interpersonal Problems	77.1	20.9
Substance Abuse	77.1	18.8
Trauma/PTSD	66.7	31.3

most providers would want a specialist in their offices. They may be concerned, however, that having a mental health clinician on-site would create issues related to autonomy/reporting relationship, space availability, and reimbursement for services, and would require changes in office procedures.
It is clear, however, that the majority of respondents do want some type of closer tie with a behavioral health specialist.

Training

The providers in this study were asked to indicate their level of interest in further training related to pediatric behavioral health. Fifty percent agreed that they had an interest, and another 14.6% strongly agreed. They were then asked to rate their level of interest for 16 specific topics on a scale from 1 (no interest at all) to 4 (very interested). Box 4 summarizes the results.

As Box 4 indicates, the majority of respondents demonstrated some level of interest in every topic, with depression, anxiety, and eating disorders attracting the greatest number of interested providers. Abuse/neglect, trauma, and bipolar disorder were of interest to a smaller (but still significant) number of providers, perhaps because these are problems for which they would be likely to refer children and adolescents to mental health specialists (See Box 2, Page 6).

Summary & Recommendations

Although based on a small group of primary health care providers, this survey provided a preliminary view of behavioral health issues in the context of pediatric practice in Connecticut. Similar to previous studies,[10, 24] respondents reported a high level of agreement that pediatric providers should be responsible for identifying/diagnosing behavioral health disorders.

The respondents saw the management and treatment of children with such disorders, however, as a somewhat less reasonable expectation. They also reported higher comfort levels with such disorders as depression, ADHD and anxiety, and they frequently utilize non-medication interventions with their patients.

The majority of respondents want some type of closer tie with a behavioral health specialist.

The most striking findings from this study are 1) the lack of mental health specialists who are available to work with children, adolescents and families, and 2) the difficulties accessing those who are in practice. Respondents also expressed strong interest in more formal relationships with behavioral health professionals.

Recommendations that follow from these survey results are:

- Identify children and adolescents in need of mental health services as early as possible, by promoting more successful strategies for screening and identification of emotional and behavioral problems. Brief and readily accessible screening instruments are available. But screening, while critical, is not sufficient. Providers also need assistance in connecting children to the most appropriate mental health providers and services in the community.

- Build the capacity of health and mental health professionals in Connecticut to address children's behavioral health issues. This includes training behavioral health and primary care providers to deliver more prevention and early intervention services to mitigate problems. In addition, training and improved reimbursement are two promising strategies for increasing the number of mental health clinicians.

- Continue to promote and evaluate such strategies as the co-location of mental health in pediatric settings and develop new systems for consultation and referral, so that patients with mental health problems aren't left waiting for care. Interdisciplinary collaboration and communication should be pursued.

- Find more effective ways to support pediatric primary care providers, whose lack of time and insufficient knowledge can be barriers when they try to address their patients' behavioral health difficulties. Reimbursement, practice tools, and seamless referral systems will address these barriers.

Conclusion

The available research and literature point clearly to the need for better integration of physical and mental health care. As we approach that ideal more closely, there is little doubt that the children of Connecticut will benefit in terms of their health, well-being, and overall development.

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