Beyond ADHD: How Well Are We Doing?

Ruth E. K. Stein, MD; Amy Storfer-Isser, PhD; Bonnie D. Kerker, PhD; Andrew Garner, MD, PhD; Moira Szilagyi, MD, PhD; Kimberly E. Hoagwood, PhD; Karen G. O'Connor, BS; Sarah McCue Horwitz, PhD

From the Albert Einstein College of Medicine/Children's Hospital at Montefiore, New York, NY (Dr Stein); Statistical Research Consultants LLC, Schaumburg, Ill (Dr Storfer-Isser); Department of Child and Adolescent Psychiatry, New York University School of Medicine, New York, NY (Drs Kerker, Hoagwood, and Horwitz); Nathan Kline Institute of Psychiatric Research, Orangeburg, NY (Dr Kerker); Case Western Reserve University School of Medicine, Cleveland, Ohio (Dr Garner); University of California at Los Angeles, Los Angeles, Calif (Dr Szilagyi); and American Academy of Pediatrics, Elk Grove Village, Ill (Ms O'Connor)
The authors declare that they have no conflict of interest.
Address correspondence to Ruth E. K. Stein, MD, Albert Einstein College of Medicine/Children's Hospital at Montefiore, 1300 Morris Park Ave, Room 6B27 Van Etten, Bronx, NY 104661 (e-mail: ruth.stein@einstein.yu.edu).
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ABSTRACT

BACKGROUND AND OBJECTIVE: There has been increasing emphasis on the role of the pediatrician with respect to behavioral, learning, and mental health (MH) issues, and developmental behavioral rotations are now required in pediatric residency programs. We sought to examine whether this newer emphasis on MH is reflected in pediatricians' reports of their current practices.

METHODS: Data from 2 periodic surveys conducted in 2004 and 2013 by the American Academy of Pediatrics were examined to see whether there were differences in self-reported behaviors of usually inquiring/screening, treating/managing/comanaging, or referring patients for attention-deficit/hyperactivity disorder (ADHD), anxiety, depression, behavioral problems, or learning problems. We examined patterns for all practicing members and for those who practiced general pediatrics exclusively.

RESULTS: There were few changes over the decade in the percentage who inquired or screened among all clinicians; among those exclusively practicing general pediatrics, the percentage who inquired or screened increased about 10% for ADHD and depression. ADHD remained the only condition for which the majority of respondents treated/managed/comanaged (57%). While there was some increase in the percentages who treated other conditions, the other conditions were usually treated by <30% of respondents. A similar pattern of results was observed in analyses adjusted for physician, practice, and patient characteristics.

CONCLUSIONS: Despite the changing nature of pediatric practice and increased efforts to emphasize the importance of behavior, learning, and MH, the pediatric community appears to be making little progress toward providing for the long-term behavioral, learning, and MH needs of children and adolescents in its care.

KEYWORDS: ADHD; anxiety; behavior problems; depression; developmental behavioral pediatrics; learning problems; mental health; screening

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WHAT'S NEW

In a 2004 survey, pediatricians indicated they should be responsible for identifying mental health (MH) issues, but they reported they did little to treat patients with these conditions except for attention-deficit/hyperactivity disorder (ADHD). Almost a decade later, there are few changes. Despite a 1½ to 2 times increase in the percentage who report treating, managing, or comanaging MH conditions, still less than 30% treat any MH problems except ADHD.

FOR SEVERAL DECADES, senior pediatric leaders have expressed concern that pediatricians were getting inadequate training in the care of common behavioral, learning, and mental health (MH) issues that are frequently seen in pediatric practice.[1–3] In the face of waning acute infectious diseases and increasing numbers of children with chronic physical health conditions, MH, behavioral, and learning issues have become central concerns for children and adolescents, both among those cared for by general pediatricians and among those with chronic conditions followed predominantly in subspecialty settings.

Recent epidemiologic studies suggest that behavioral, learning, and MH issues are now among the most common conditions that concern parents who present to primary care pediatricians' offices[4]; they also are the most frequent causes of disability, accounting for 3 of the 5 most frequent disabling conditions, ahead of even asthma.[5] It is also well documented that MH conditions are even more prevalent

among the growing numbers of children and adolescents with chronic conditions affecting other body systems.[6–8] In the face of these epidemiologic and practice changes, it is important to understand the attitudes and actions of pediatricians towards the care of behavioral, learning, and MH issues over time.

Findings from the American Academy of Pediatrics (AAP) 59th Periodic Survey (PS) conducted in 2004 showed that less than 50% of pediatricians who practiced general pediatrics were providing MH and behavioral care to their child and adolescent patients with anxiety, depression, behavioral problems, and learning problems.[9] The only exception to this pattern was attention-deficit/hyperactivity disorder (ADHD), which the majority of pediatricians addressed in their practice and which had been heavily promoted by the AAP beginning with guidelines in 2001.[10] These findings were further supported by a subsequent AAP survey of graduating residents, which also found similarly low rates of reported care for MH issues among those most recently trained.[11]

Since 2004 there has been considerable emphasis on the need for pediatricians to address these issues. There is growing awareness of the familial nature and lifelong health implications of many MH and learning problems.[12] It is also increasingly clear that these conditions have long-term academic, employment, and functional implications for children, their families, and society.[13–15] A GuideLine for management of Adolescent Depression in Primary Care (GLAD-PC) that was widely endorsed by pediatric and MH organizations, including the AAP, was made available on the Internet.[16,17] Subsequently, the United States Preventive Services Task Force recommended universal screening of adolescents for depression in 2009 if adequate supports for diagnosis and treatment are available to care for identified problems.[18] Several states have also implemented payment incentives and/or requirements for some forms of MH screening, and the Mental Health Task force of the AAP,[19] as well as the widely disseminated *Bright Futures*,[20,21] have promoted far wider responsibilities for pediatricians. Additionally, since February 1997, the Residency Review Committee of the American Council for Graduate Medical Education has required all pediatrics residents to complete a developmental and behavioral pediatrics 1-month rotation. However, there are no data on what impact these changes in practice demands, policy recommendations, and training have had on actual pediatric practice.

The AAP's 85th PS, conducted in 2013, repeated many of the questions that originally appeared in the 2004 PS 59 and provided an opportunity to assess how pediatricians' practice behaviors have changed and whether there have been improvements in the percentage of pediatricians who reported identifying, treating, or comanaging behavioral MH. Previous data suggest that it may take as long as 1 to 2 decades for recommended changes to be adopted,[22–24] and enough time has now elapsed that we hoped to see some changes in pediatricians' self-reported behavior.

Our objective was to assess whether the increasing emphasis on the role of the pediatrician with respect to the care of patients with behavioral, learning, and MH issues is reflected in changes in the reported practices of pediatricians. We sought to examine their current practices with respect to usually identifying, treating/managing, and referring patients and to compare the responses across the 2 surveys.

METHODS

Data come from the 2004 and 2013 AAP 59th and 85th PSs, each sent to a random sample of approximately 1600 of the >50,000 pediatricians who are nonretired US members of the AAP. The details of the surveys have been previously described.[25,26] In brief, beginning in March 2004, the PS 59 questionnaire was sent to 1600 members, with the final mailing in August 2004; 832 members (52.0%) responded. Between July and December 2013, the PS 85 questionnaire was sent to 1617 members, of whom 594 (36.7%) responded. Sample weights were created for each survey to ensure that the respondents were representative of the AAP membership and to minimize potential bias due to differential nonresponse. As previously described,[25] logistic regression was used to estimate the probability of responding to the survey, and auxiliary information available for both responders and nonresponders was included as predictors (age, sex, region). The sample weights were rescaled such that the mean was unity and the sum was equal to the analytic sample size for each survey. The analyses in this report were restricted to pediatricians who provide patient care, completed their residency training, and answered questions about inquiring, treating, and referring for 5 prevalent child/adolescent conditions (665 in 2004 and 478 in 2013).

AAP PSs

The 2004 and 2013 PSs included sociodemographic questions, practice characteristics (eg, practice type, location), and experience with MH problems in their practices. Questions on self-reported behaviors were ascertained by asking clinicians how often (never, sometimes, or usually) they inquire, screen (ie, systematically use a formal instrument), treat/manage, and refer each of 5 conditions: ADHD, anxiety, depression, behavioral problems, and learning problems. In the 2013 sample we combined the responses on screening and inquiring because screening was not asked about in 2004. We assumed that most of those who were screening would have indicated that they were usually inquiring, if they had not had the option of indicating that they were screening. The data supported our assumption: in 2013 almost everyone who was screening was inquiring (78% to 88%), but not all who inquired reported they were screening (36% to 52%). We also combined the separate responses on child and adolescent depression in the 2013 sample, as they were not asked separately in the 2004 survey. Those 2013 respondents who reported "usually" for either the child or adolescent