Integration of Pediatric Mental Health Care: An Evidence-Based Workshop for Primary Care Providers

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ABSTRACT

Introduction: Pediatric primary care providers (PCPs) are being asked to care for children with mental health (MH) disorders but cite inadequate training as a barrier. An intensive workshop may improve the PCPs' level of knowledge and lead to an increase in quality care for children with MH disorders. We compared pediatric PCPs' knowledge, comfort, and practice in the evaluation and management of pediatric patients with attention deficit–hyperactivity disorder, depression, anxiety, and autism spectrum disorders before and after a 2-day educational workshop.

Method: Study participants (n = 30) were recruited from rural areas of Pennsylvania. A pre- and posttest design was used. A 15-question multiple choice knowledge test and a 19-question survey of comfort and practice were administered before and after the workshop.

Results: The mean knowledge test number correct increased from 9.19 before the workshop to 12.23 after the workshop ($p < .0001$). Survey scores increased from 34.6 before the workshop to 44.14 after the workshop ($p < .0001$).

Discussion: Intensive workshops may be an effective method of training PCPs on provision of MH care in pediatric primary care practice. J Pediatr Health Care. (2014) *28*, 23-34.

KEY WORDS

Mental health integration, primary care, pediatric mental health, workshop

In the United States, as many as one out of every four to five youth will experience a mental health (MH) problem over the course of their lifetime (Merikangas et al., 2010). Access to specialty MH care is problematic because of a shortage of child and adolescent psychiatrists, geographic unavailability of mental health services (United States Department of Health and Human Services [USDHHS] Health Resources and Services Administration, 2012), and lengthy delays between referral and intake (Heneghan et al., 2008). The most common disorders evaluated in primary care settings include attention deficit–hyperactivity disorder (ADHD), depression, and anxiety (American Academy of Child and Adolescent Psychiatry [AACAP] Work Group on Quality Issues, 2007a, 2007b, 2007c). Increasing numbers of children with autism are also being evaluated and followed up in primary care (Golnik & Maccabee-Ryaboy, 2010).

Pediatric primary care providers (PCPs), including nurse practitioners (NPs), physician assistants (PAs), and physicians, are being asked to care for children

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with behavioral and MH disorders in their practices but are inadequately prepared to care for these patients (Kolko, Campo, Kelleher, & Cheng 2010). PCPs self-report unease and inadequate training as barriers to initiating care (Carbone, Behl, Azor, & Murphy, 2010; Kolko et al., 2010). Additional identified barriers include lack of time to thoroughly evaluate the pediatric patient with mental health concerns (AACAP Committee on Health Care Access and Economics Task Force on Mental Health, 2009; Kolko et al., 2010; Schlesinger, 2008) and lack of reimbursement to PCPs for mental health treatment (Barclay, 2009; Heneghan et al., 2008; National Institute for Health Care Management, 2009).

Further training in the diagnosis and management of common MH disorders and a plan for integration of care may improve the PCPs' level of comfort, lead to an increase in high-quality care provided in the primary care setting, and help fill the void that exists in access to and provision of pediatric mental health care in the United States today.

NEED FOR INTEGRATION OF MENTAL HEALTH INTO PRIMARY CARE

The need for integration of pediatric mental health services into pediatric primary care is great. Children and adolescents are being seen in greater numbers in primary care offices for the assessment, evaluation, and treatment of disorders including ADHD, anxiety, and depression (AACAP Work Group on Quality Issues, 2007a, 2007b, 2007c). According to the most recent Centers for Disease Control and Prevention (CDC) report, the diagnosis of autism spectrum disorder is on the rise, with an average of 1 out of every 88 children in the United States having this diagnosis (CDC, 2012). With increasing numbers of children and adolescents needing ongoing mental and behavioral health care, it is vital that PCPs meet the need and that practices develop plans to provide integrated mental health care for patients. In an integrated model, PCPs may be able to manage the majority of mild to moderate disorders in their practices, while referring the more complex and serious disorders to psychiatrists, psychiatric nurse practitioners, or mental health specialists.

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Fifteen million children and adolescents have been identified as needing a psychiatrist (National Association of Pediatric Nurse Practitioners [NAPNAP], 2007), and yet approximately 65% of these children and adolescents receive minimal or no services for their MH need (Merikangas et al., 2011). According to AACAP (2010), approximately 7000 child and adolescent psychiatrists are available in the United States, with about 300 per year completing training (Barclay, 2009). Geographic distribution varies, and some rural areas have virtually no access to care (Thomas, Ellis, Konrad, Holzer, & Morissey, 2009). For every 100,000 youth in the United States, there is an average of 8.7 child and adolescent psychiatrists available, with wide variations between states (Thomas & Holzer, 2006). This lack of services has major implications for children and families. Many children go untreated, and for these children, the consequences are serious and far reaching.

Children and adolescents with untreated MH disorders are at increased risk for a myriad of psychosocial problems that affect the child or adolescent and family in the present and future. Children and adolescents with a MH disorder may experience impairment in relationships with family, peers, and within the school system (Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management, 2011). The child or adolescent with a MH disorder may have problems interacting with parents, siblings, or both, thus creating a strained and potentially dysfunctional family dynamic (Foley, 2011). They may have difficulties with forming peer relationships and/or functioning effectively in the school environment, leading to academic failure, poor employment opportunities, and poverty (AACAP Work Group on Quality Issues, 2007b; Barclay, 2009). Financially, this burden is substantial. Loss of income alone in persons with ADHD is estimated to be at a minimum $67 billion (Biederman & Farone, 2006). In addition, adolescents may demonstrate an increase in risk-taking behaviors, resulting in teen pregnancy and legal problems (AACAP Work Group on Quality Issues, 2007b; Barclay, 2009). Children and adolescents with an untreated MH disorder are also at risk for additional comorbidities, substance abuse (AACAP Work Group on Quality Issues, 2007b; Barclay, 2009), injuries/accidents (AACAP ADHD Resource Center, 2010), and mortality and suicide. According to AACAP (2008), suicide is the third leading cause of death in 15- to 24-year-olds and ranks sixth in those in the 5- to 14-year age group, thus demonstrating the need for appropriate and timely treatment.

CURRENT INITIATIVES

In response to the abject need to address this care deficit in a vulnerable population, the American Academy of Pediatrics (AAP) has described the "medical

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