



Barriers to the Identification and Management of Psychosocial Problems: Changes From 2004 to 2013

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ABSTRACT

OBJECTIVE: Pediatricians report many barriers to caring for children with mental health (MH) problems. The American Academy of Pediatrics (AAP) has focused attention on MH problems, but the impact on perceived barriers is unknown. We examined whether perceived barriers and their correlates changed from 2004 to 2013.

METHODS: In 2004, 832 (52%) of 1600 and in 2013, 594 (36.7%) of 1617 of randomly selected AAP members surveyed responded to periodic surveys, answering questions about sociodemographics, practice characteristics, and 7 barriers to identifying, treating/managing, and referring child/adolescent MH problems. To reduce nonresponse bias, weighted descriptive and logistic regression analyses were conducted.

RESULTS: Lack of training in treatment of child MH problems (~66%) and lack of confidence treating children with counseling (~60%) did not differ across surveys. Five barriers (lack of training in identifying MH problems, lack of confidence diagnosing,

lack of confidence treating with medications, inadequate reimbursement, and lack of time) were less frequently endorsed in 2013 (all $P < .01$), although lack of time was still endorsed by 70% in 2013. In 2004, 34% of pediatricians endorsed 6 or 7 barriers compared to 26% in 2013 ($P < .005$). Practicing general pediatrics exclusively was associated with endorsing 6 or 7 barriers in both years ($P < .001$).

CONCLUSIONS: Although fewer barriers were endorsed in 2013, most pediatricians believe that they have inadequate training in treating child MH problems, a lack of confidence to counsel children, and limited time for these problems. These findings suggest significant barriers still exist, highlighting the need for improved developmental and behavioral pediatrics training.

KEYWORDS: access; child mental health; barriers; child psychosocial problems; primary care

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WHAT'S NEW

This study compares reported barriers from the 2004 and 2013 periodic surveys. Although pediatricians report fewer barriers in 2013, 66% continue to report lack of training in counseling or medication of children with mental health problems, suggesting deficits in developmental and behavioral pediatrics training.

MENTAL HEALTH (MH) problems in children and adolescents are prevalent (US range 9% to 13%) and produce immediate and long-lasting morbidity.^{1,2} However, despite increased recognition of these problems in pediatric primary care,^{1,3} the majority of youth with MH problems go undiagnosed and untreated.^{1,4,5}

Early studies suggested that provider characteristics, such as training and confidence,^{6–8} physician specialty, self-rated knowledge of the child and family,^{9,10} perceived lack of time and availability of MH services,^{6–8} and family characteristics and severity of the child's problem,^{10,11} affect recognition and management of youth MH problems. In 2004, the American Academy of Pediatrics (AAP) fielded a periodic survey (PS) to examine the perceived barriers to care for child MH problems and the physician, patient, practice, and organizational issues related to different types of barriers.⁴ Results from that survey suggested that barriers to identifying and managing children's problems fell into 3 areas—organizational issues, maternal issues, and child issues—with child barriers most often endorsed. Additional analysis of these data¹² identified

that although 80% of pediatricians agreed that they should be responsible for identifying youth MH problems and 70% agreed that they were responsible for treating/managing attention-deficit/hyperactivity disorder (ADHD), few pediatricians agreed that they were responsible for treating/managing other MH problems. The only predictor of endorsing treatment across the 7 MH problems in the survey was whether a pediatrician practiced general pediatrics exclusively.¹²

In 2007, the AAP, as a part of its Graduating Residents' Survey, assessed attitudes toward and training in MH issues.¹³ Although more than 90% of graduating residents completed a rotation (usually 4 weeks) in developmental and behavioral pediatrics (DBP), less than half rated their competencies as very good or excellent. As the length of DBP rotation increased, residents were more likely to rate their competence as high, and self-rated competency increased if residents reported being trained in a specific skill area. Similar to the 2004 PS, residents often agreed that they should be responsible for treating/managing ADHD (67%) but rarely agreed that they should be responsible for treating/managing the other MH problems.¹³

Recognizing the prevalence of MH problems, their importance for children's optimal functioning and pediatricians' unique strengths for identifying and managing MH problems, the AAP has focused considerable attention on these issues over the past 15 years.¹⁴⁻¹⁷ However, the impact of these efforts on perceived barriers for caring for MH problems is unknown. Thus, the AAP again surveyed members on the diagnosis and management of children's MH problems in 2013. Using data from the 2004 and 2013 PSs, this study sought to answer 2 questions: first, have perceived physician-child barriers changed between the 2 PSs? And second, have the physician, patient, and practice/organization characteristics associated with endorsing physician-child barriers changed over time?

METHODS

PS ADMINISTRATION

The study populations consisted of the US nonretired members of the AAP in 2004 ($n = 50,818$) and 2013 ($n = 54,491$) (<http://www.aap.org/>). The PS has been conducted multiple times yearly since 1987 to inform policy, develop new initiatives, or evaluate current projects. Each questionnaire was pretested for clarity and approved by the AAP institutional review board.

The 2004 questionnaire was sent 7 times to 1600 randomly selected members beginning in March 2004, with the final mailing in August 2004. An e-mail reminder was sent to those with an e-mail address, and a postcard reminder was sent to those without one. The 2013 questionnaire was sent 7 times to 1617 randomly selected members beginning in July 2013 and ending in December 2013. An e-mail reminder was sent with a link to an electronic version of the survey. Neither the sample selection process nor the survey administration procedures changed between the 2 surveys. Samples are selected randomly on the basis of the last 3 digits of the AAP membership identification numbers,

which are randomly assigned. In 2004, a total of 832 (52.0%) responded, and in 2013, a total of 594 (36.7%) responded. These analyses included only pediatricians who had completed their residency training and who provided patient care (687 in 2004 and 510 in 2013).

SURVEY QUESTIONNAIRES

Both surveys asked questions used in previous PSs about sociodemographic characteristics (eg, age, sex, race/ethnicity, years in practice) and practice characteristics (eg, type of practice, percentage of time spent in general pediatrics, number of ambulatory visits per week, patient race/ethnicity, and insurance). Questions were asked about child, adolescent, and adult MH, including residency and fellowship training, interest in further education in identifying and treating common MH problems, and availability of MH services in their community. Also included were 7 questions with responses on a 5-point Likert scale ranging from strongly agree to strongly disagree to assess physician's perceptions of barriers to identifying, treating/managing, and referring common MH problems in children and adolescents, originally developed for the studies of Olson et al¹⁸ and Williams et al.¹⁹

MEASURES

For each of the 7 items measuring perceived barriers to identifying, referring, and treating/managing child/adolescent MH problems, pediatricians who responded with strongly agree or agree were coded as endorsing the barrier. Pediatricians who endorsed many barriers, defined a priori as 6 or 7 barriers, were compared to those who endorsed 0 to 5 barriers. Pediatricians who reported completing a fellowship in DBP, child psychiatry, adolescent medicine, and/or behavioral sciences were coded as completing a fellowship in a child MH-related area. Physicians were coded as providing MH services to children/adolescents in 2004 if they answered yes to a yes/no question about whether they provided medication, counseling, or psychotherapy to children/adolescents. In 2013, physicians were coded as providing child/adolescent MH services if they reported usually treating/managing/comanaging ADHD, child or adolescent depression, behavior management problems, learning disabilities, anxiety disorders, substance abuse, and/or eating disorders.

ANALYSIS

Although both samples reflect the AAP membership at the time of the surveys (data not shown; samples are extremely similar to the full membership on sex, age, and region), nonresponse was considerable. For each survey, sample weights were created to minimize potential bias due to differential nonresponse and to ensure that the respondents were representative of the membership. Logistic regression was used to estimate the probability of responding to each survey to create a propensity score; auxiliary information available for both responders and nonresponders were included as predictors (age, sex, region, and membership status). The methods used to create the sample weights for the 2004 survey are described elsewhere.⁴ For the 2013

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