Promoting Early Brain and Child Development: Perceived Barriers and the Utilization of Resources to Address Them

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ABSTRACT

OBJECTIVE: Efforts to promote early brain and child development (EBCD) include initiatives to support healthy parent–child relationships, tools to identify family social-emotional risk factors, and referrals to community programs to address family risk factors. We sought to examine if pediatricians perceive barriers to implementing these activities, and if they utilize resources to address those barriers.

METHODS: Data were analyzed from 304 nontrainee pediatricians who practice general pediatrics and completed a 2013 American Academy of Pediatrics Periodic Survey. Sample weights were used to decrease nonresponse bias. Bivariate comparisons and multivariable regression analyses were conducted.

RESULTS: At least half of the pediatricians agreed that barriers to promoting EBCD include: a lack of tools to promote healthy parent–child relationships, a lack of tools to assess the family environment for social-emotional risk factors, and a lack of local resources to address family risks. Endorsing a lack of tools to assess the family environment as a barrier was associated with using fewer screening tools and community resources. Endorsing a lack of local resources as a barrier was associated with using fewer community resources and fewer initiatives to promote parent–child relationships. Interest in pediatric mental health was associated with using more initiatives to promote healthy parent–child relationships, screening tools, and community resources.

CONCLUSIONS: Although the majority of pediatricians perceive barriers to promoting EBCD, few are routinely using available resources to address these barriers. Addressing pediatricians' perceived barriers and encouraging interest in pediatric mental health may increase resource utilization and enhance efforts to promote EBCD.

KEYWORDS: community resources; mental health; primary care; screening; social-emotional

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WHAT'S NEW

The majority of pediatricians agree that barriers to promoting early brain and child development include a lack of resources that: promote healthy parent–child relationships, screen for familial social-emotional risks, and address the identified risks. Few are utilizing the known resources to address these barriers.

THE FAMILY-CENTERED PEDIATRIC medical home (FCPMH) greatly expands the scope of primary care and mandates that pediatricians address not only physical health but the social and emotional wellness of both children and their families.[1] The FCPMH recognizes the negative impact of early life adversities on early brain and child development (EBCD), as well as the critical role of pediatric providers in preventing, identifying, and ameliorating those adversities.[2] This focus on psychosocial aspects of pediatric care is not new[3] and continues to increase in importance due to the shortage of child and adolescent psychiatrists,[4] geographic differences in children's mental health (MH) services,[5] and continued disparities in access to and utilization of services.[6]

Given that the FCPMH is well positioned for identifying psychosocial, developmental, and MH needs of young children and their families, several major

initiatives have been mounted to improve pediatricians' competencies in these areas. By 1997, the Residency Review Committee for Pediatrics of the Accreditation Council for Graduate Medical Education required that pediatric residents have a minimum 1-month block rotation in developmental and behavioral pediatrics.[7] More recently, the American Academy of Pediatrics (AAP) focused attention on increasing pediatricians' knowledge about the impact of adverse childhood experiences (ACEs) on EBCD,[8] and many have called on pediatricians to routinely screen for common adversities early in life.[9–11] The AAP has developed and disseminated several resources to assist pediatricians in promoting healthy parent–child relationships, identifying familial social-emotional risk factors, and then addressing the risk factors identified.[12] These efforts include Bright Futures,[13] Connected Kids,[14] a grid for promoting EBCD in primary care,[15] and a Trauma Tool Box for Primary Care.[16]

However, despite these considerable efforts, pediatricians continue to endorse numerous barriers to identifying and treating childhood psychosocial problems,[17] and the limited available data suggest that pediatricians rarely ask about ACEs.[18] Pediatricians' perceptions of barriers to promoting EBCD in a proactive manner (as opposed to identifying and treating the child's psychopathologies) are largely unknown, as is their utilization of known resources that address those barriers. Finally, it is unclear whether pediatricians' interest in pediatric MH or their sense of responsibility for identifying family social-emotional risk factors are related to resource utilization.

In 2013, an AAP Periodic Survey of Fellows included a series of questions about perceived barriers to promoting EBCD, as well as the utilization of known resources to address family social-emotional risk factors. This survey also asked pediatricians to rank their interest in pediatric MH, and whether they believed that screening for social-emotional risk factors within the family was beyond the scope of the pediatric medical home. Therefore, the objectives of these analyses were to: 1) identify the percentages of pediatricians that endorse 3 different types of barriers to promoting EBCD (lack of practice-friendly tools to promote healthy parent–child relationships; lack of practice-friendly tools to assess the family environment for social-emotional risk factors; and lack of local resources available to address identified familial social-emotional risk factors); 2) explore whether endorsing these barriers is related to the utilization of 3 different classes of resources to promote EBCD (initiatives to promote healthy parent–child relationships; tools that screen family level social-emotional risk factors; and community resources used to address identified concerns); and 3) evaluate if resource utilization is related to physician sociodemographics, practice characteristics, an interest in pediatric MH, or endorsing the notion that screening for family level social-emotional risk factors is beyond the scope of the pediatric medical home.

METHODS

STUDY POPULATION AND PERIODIC SURVEY (PS) ADMINISTRATION

The study population for the 85th PS consisted of the US nonretired fellows of the AAP in 2013 (n = 54,491) (https://www.aap.org/). Since 1987, the PS has been used by the AAP to inform policy, develop new initiatives, or evaluate current projects. The PS 85 questionnaire, which was pretested for clarity and approved by the AAP institutional review board, was mailed 7 times to a random sample of 1617 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. Overall, 594 physicians responded (36.7%).

PS 85 QUESTIONNAIRE

The survey included questions used in previous PSs about sociodemographic characteristics (eg, age, sex, race/ethnicity, years in practice), practice characteristics (eg, type of practice, percentage of time spent in general pediatrics, number of ambulatory visits per week, patient race/ethnicity and insurance), and amount of training in developmental and behavioral pediatrics. Pediatricians were asked if they had attended a lecture or a conference on child MH in the past 2 years (yes/no), and their interest in further education in identifying or managing/treating child or adolescent MH problems (very, somewhat, not at all).

Pediatricians were asked whether screening for social-emotional risk factors within the family (eg, parental depression or substance use, domestic violence) is beyond the scope of the medical home using a 5-point Likert scale. Those who disagreed or strongly disagreed were coded as disagree, while those responding neutral, agree, or strongly agree were coded as agree. Neutral is a tacit endorsement of this statement because only those truly in disagreement with this characterization would go against the socially appropriate response in order to disagree.[19] Using a 4-point ordinal scale (not at all a barrier; somewhat a barrier; a moderate barrier; a significant barrier), pediatricians rated how much the following statements were a barrier to addressing EBCD in their practice: 1) lack of practice-friendly tools (eg, handouts, activities, Web-based resources) to promote healthy parent–child relationships; 2) lack of practice-friendly tools to assess the family environment for social-emotional risk factors (eg, parental depression, substance use, domestic violence, food scarcity); and 3) lack of local resources available to help address the familial social-emotional risk factors identified. Responses of a moderate or significant barrier were coded as endorsement of the barrier. Somewhat a barrier was not considered an endorsement because we were most interested in the largest barriers, as they are the logical targets for future interventions.

Finally, pediatricians were asked about their use of 3 different classes of resources: 4 initiatives to promote parent–child relationships (Bright Futures, Connected