Resources Support Pediatric Mental Health

BY DOUG BRUNK

FROM PEDIATRICS

A report from the American Academy of Pediatrics Task Force on Mental Health offers clinicians a comprehensive blueprint for improving delivery of mental health care services in pediatric settings.

The 135-page document, entitled "Enhancing Pediatric Mental Health Care," describes "what pediatricians and other primary care physicians can do at the community level, what they can do at the practice level, and how they can integrate the process of providing mental health services into the primary care flow," Dr. Jane Meschan Foy, chair of the task force, said in an interview.

Four years in the making, the report (Pediatrics 2010;125[suppl. 3]:S1-135) builds on three key documents previously published by the task force: "Strategies for System Change in Children's Mental Health: A Chapter Action Kit" (available at www.aap.org/mentalhealth/mh2ch.html), "The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care" (Pediatrics 2009;124:410-21), and "Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration" (Pediatrics 2009;123:1248-51).

The new report contains three main chapters followed by eight appendices and six supplemental appendices. Together with the previous reports, it addresses three main goals set by the task force: Facilitate system changes, build skills, and incrementally change practice.

"This is really a tour de force," said Dr. Martin T. Stein, who was not involved in developing the report. "It's an exceptionally comprehensive, well-written, and practical guideline for including psychological/psychosocial/mental health issues in the practice of primary care pediatrics. There are many practical tools such as thinking about your referral patterns, being aware of what's available in the community, and knowing the insurance sources.

"There is also a chapter on how to code for billing for mental health services, which is a critical issue in primary care. In addition, there is a practice readiness inventory, algorithms for early recognition of conditions, and good references to support the recommendations for diagnosis and screening in primary care," Dr. Stein, professor of pediatrics at the University of California, San Diego, said in an interview.

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Dr. Jane Meschan Foy (far right) and family nurse practitioner Beth Spangle (far left) talk with patient Garrett Locklear.

Dr. Foy, professor of pediatrics at Wake Forest University, Winston-Salem, N.C., called the pediatric primary care setting "a really good place to provide mental health services. It's a place where families are comfortable, a place where they have a trusting long-term relationship with a clinician."

In the report's first chapter, "Strategies for Preparing a Community," the task force outlines ways to gauge the mental health needs of children and youth in the community, and emphasizes the importance of developing or strengthening relationships with mental health advocates, schools, human service agencies, mental health and substance abuse providers, and developmental specialists.

For example, clinicians "might consider initiating previsit data collection from children in foster care," the report states. "Sharing the responsibility for previsit data collection with the foster care agency increases the likelihood that adults with knowledge of the child's mental health strengths and needs provide critical information."

In the second chapter, "Strategies for Preparing a Primary Care Practice," the task force recommends applying principles of the chronic care model to the care of children and youth with mental health problems. One critical element is a wide variety of partnerships to support and coordinate with primary care services.

"There are many new models of collaborative practice," Dr. Foy said. "We are excited about those that integrate a mental health professional into the primary care setting."

Dr. Foy acknowledged that while chronic care model principles have worked well in primary care for medical conditions such as asthma and diabetes, less is known about how these principles will affect the delivery of mental health care to children and youth.

The third chapter, "Algorithms for Primary Care," grew out of the work of four separate teams convened by the task force, including youth and families who have had mental health problems.

The chapter proposes a clinical process for promoting mental health, identifying mental health symptoms and concerns, engaging the family as early and effectively as possible to address emerging problems, collaborating with mental health specialists when needed, and monitoring the child's progress toward recovery or further care.

For her part, Dr. Foy said she hopes the report sends a message that primary care physicians are well positioned to provide a broad range of mental health care services to patients and their families.

Dr. Foy noted that primary care clinicians who care for children are "in a widely varied state of readiness to follow" the recommendations contained in the report. "Some are just beginning to think about expanding their mental health practice," she said. "Others have very sophisticated multidisciplinary approaches to mental health practice, and the majority is in between. I do think that most primary care clinicians will be able to find some action steps in the wide variety of recommendations that we have made."

The report was supported by the AAP, the AAP Friends of Children Fund, and the Substance Abuse and Mental Health Services Administration. Dr. Foy and Dr. Stein said that they had no financial conflicts of interest. ■

A Web-Based Screening Tool Helps Gauge Suicide Risk

BY DAMIAN McNAMARA

FROM THE ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY

ORLANDO — Primary care is a "ripe and rich environment" for youth suicide screening, and a new computer-based tool shows promise for identification of patients at risk, said Guy Diamond, Ph.D.

Dr. Diamond and his colleagues developed a Web-based behavioral health screen that adolescents and young adults can complete in about 10 minutes before seeing their doctor. The 55-item core questions also assess depression, anxiety, and trauma, as well as relevant behaviors, such as drug use and risky sexual behavior. "We put suicide into a bigger context," he said.

The tool, which Dr. Diamond and his colleagues hope to launch in the fall, addresses everything the American Medical Association and the American Academy of Pediatrics recommend is covered during screening. Although all patients get the same questions asked in the same way, the time to take the screen varies from 9 to 14 minutes, depending on how many symptoms a patient endorses. Responses to the core items can trigger up to 41 additional questions.

The standardized format reduces provider bias, helps focus the clinical visit, and increases case identification, said Dr. Diamond, who is on the psychiatry and behavioral science faculty at Children's Hospital of Pittsburgh.

Sensitivity and specificity are 83% and 87%, respectively, for suicidal risk; 85% and 76% for depression; and 88% and 67% for anxiety, Dr. Diamond said.

When the patient has completed the screen, an automatically generated report prints out with scaled scoring and flagged critical items. On the plus side, the report also identifies individual patient strengths—such as "has a job" or "gets along well with parents."

The screen's validity was demonstrated in a study of 1,547 primary care patients (Pediatrics 2010;125:945-52). A total of 209 (14%) of the 11- to 20-year-old respondents reported suicidal thoughts in the previous month. Girls, younger youths, substance users, depressed youths, youths who carried weapons, and those who had been in fights were at higher risk. Social workers were able to triage 205 (98%) of those identified, the majority on the same day. Most (152 patients or 74%) were recommended for a mental health evaluation.

Most other primary care screening tools inquire about symptoms that are current or from the previous 2 weeks, even though many physician visits are annual. "Kids who said no to 'current' but yes to 'past' are [still] very high risk," Dr. Diamond said. "They have just as many risk factors as kids who say they are currently at risk."

Dr. Diamond said primary care physicians are more likely, in general, to screen for suicide risk if it is part of a comprehensive screen. "When I ask a room of docs how many have seen suicide in their practice, four or five raise their hands. When I ask about depression, everyone raises their hands."

Although most screening instruments are still paper-and-pencil format, a computerized instrument offers several advantages, Dr. Diamond said. Automated scoring is one example, and greater flexibility to tailor the screen with practice-specific items is another. "If a practice doesn't want to ask about child abuse, we can take it out. If another practice wants to add an STD [sexually transmitted disease] question, we can do that."

The screen does not fully integrate with electronic medical record systems, Dr. Diamond said in response to a meeting attendee question. For now, the paper report is scanned as a pdf file and entered in the patient's EMR. He added that many doctors were initially nervous about using the tool, but that "many have now integrated it." ■

***Disclosures:** Dr. Diamond will have a financial interest in the screening instrument when it is launched in the fall. At that time, physicians will be able to license the tool, he said.*