Maine Pediatric & Behavioral Health Partnership

Approaching Psychiatric Issues in Primary Care

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Maine Pediatric and Behavioral Health Partnership (MPBHP) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,851,222.00 with zero percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

MPBHP is a partnership between Maine CDC, Northern Light Acadia Hospital and MaineHealth

Northern Light Acadia Hospital

Department of Health and Human Services

MaineHealth

Learning Objectives

1. The healthcare team will identify at least one concept or strategy that may improve pediatric patient outcomes in their practice setting.
2. The healthcare team will understand how to approach psychiatric issues in primary care
3. The healthcare team will apply clinical domains when evaluating a psychiatric problem
4. The healthcare team will develop successful approaches to psychiatric assessments

Integrity & Independence in Continuing Interprofessional Development

All planners, faculty, and others in control of the content of this educational activity have no relevant financial relationships with ineligible entities (i.e., commercial organizations), except as noted below:

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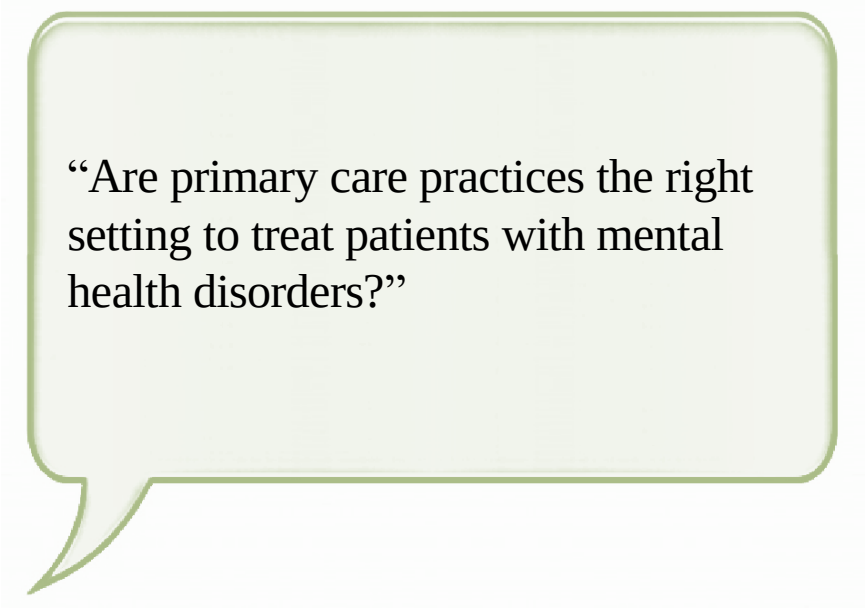

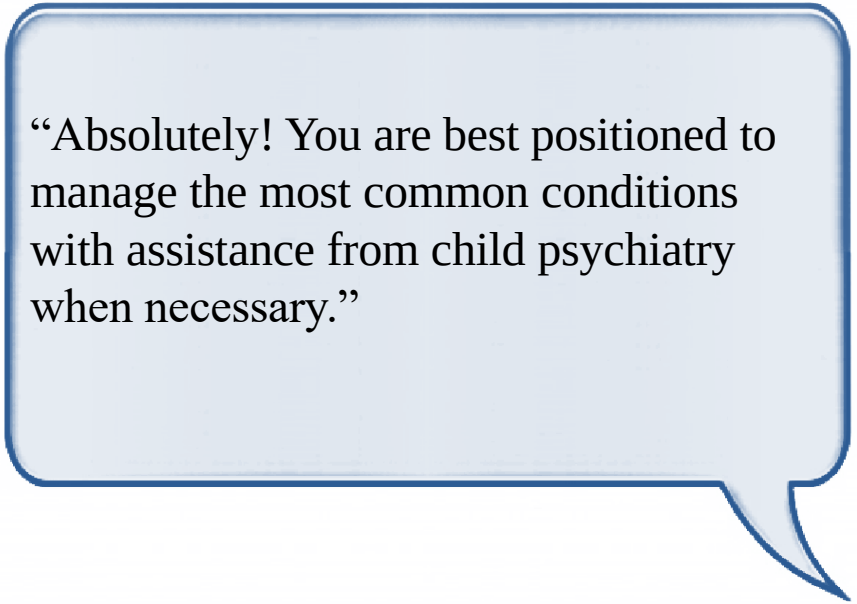

Primary care has:

- Long, trusting, therapeutic relationships with children and families
- Family-centered medical home
- Ability for timely intervention for common behavioral, social, emotional issues
- Understanding of common issues within a developmental context
- Experience working with specialists in a medical home model
- Location is often more convenient and connected to local resources

"We are so busy treating other health conditions, why do we have to dedicate any more time to child mental health?"

"Half of lifetime mental illness starts by the age of 14, and 75% by the age of 24. Many conditions can improve if treated early, so it is important to screen often in pediatric populations and learn to manage more common conditions."

- 17.4% of U.S. children 2-8 years old have a mental, behavioral or developmental disorder [3]
- 20% of U.S. children 9-17 years old have a diagnosable psychiatric condition [4]
- Not a single state has enough child psychiatrists; there are only about 6300 child psychiatrists and a need for about 30,000 [5]
- In 2012, only 15-20% of children with psychiatric conditions seen by specialty care; 75% of these kids were seen in primary care [6,7,8]

"How can consulting with a psychiatric provider help me care for my patients in pediatrics?"

"Research shows that regular access to child psychiatry can increase primary care comfort in treating the most common psychiatric conditions from 8% to 63%."

MCPAP (Massachusetts Child Psychiatry Access Program) research:

- 28% of initial consultations led to a face-to-face consultation with child psychiatry
- Primary care agrees to manage follow up care for 50% of patients in MCPAP
- Pediatric ability to have a consult in a timely manner went from 8% to 80%
- This model has now been adopted in over 28 states [8]

"Okay, I'm ready! What should I be managing in primary care and how can you help?"

"If you screen regularly for mental health issues and provide routine care, we will provide help on diagnostic questions and treatment recommendations."

Level 0: Preventative services and screening

- 13-year-old presenting for a well-child check with no presenting concerns

Level 1: Early intervention and early care provision

- 13-year-old presenting for a well-child check with parent-identified problems of impulsivity and poor peer relationships that could be signs of ADHD

Financing Collaborative Care (aacap.org)

"What about the cases where I need help co-managing or need psychiatry to manage them?"

"We hope to help you stabilize some patients in primary care with further consultation as needed and ultimately see the more complex patients in psychiatry."

Level 2: Specialty Consultation, Treatment and Coordination

- 13-year-old receiving psychotherapy and a medication for depression, being seen by the PCP for follow up.

Level 3: Intensive mental health services for complex problems

- 13-year-old with bipolar disorder with a history of out-of-home mental health placements, recently hospitalized for mania and now needing to be seen post-discharge.

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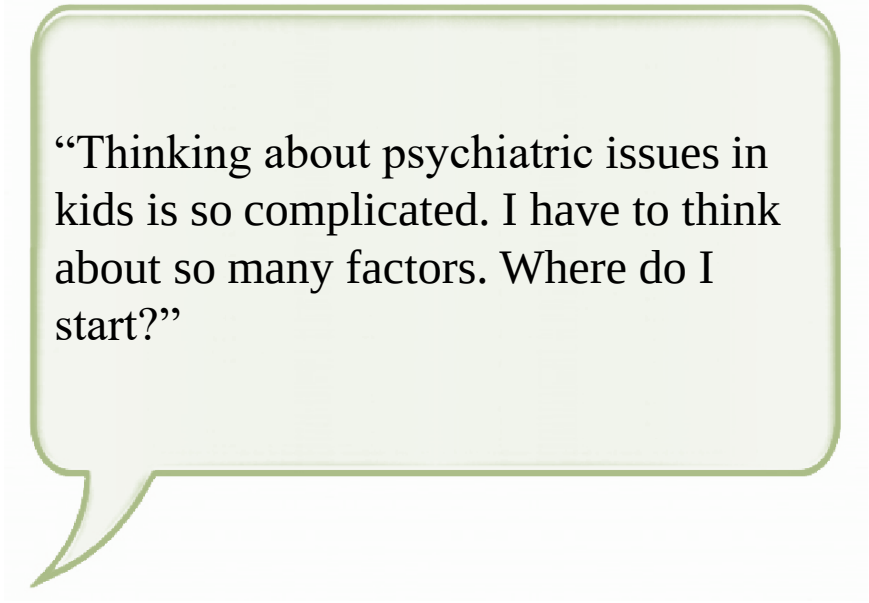

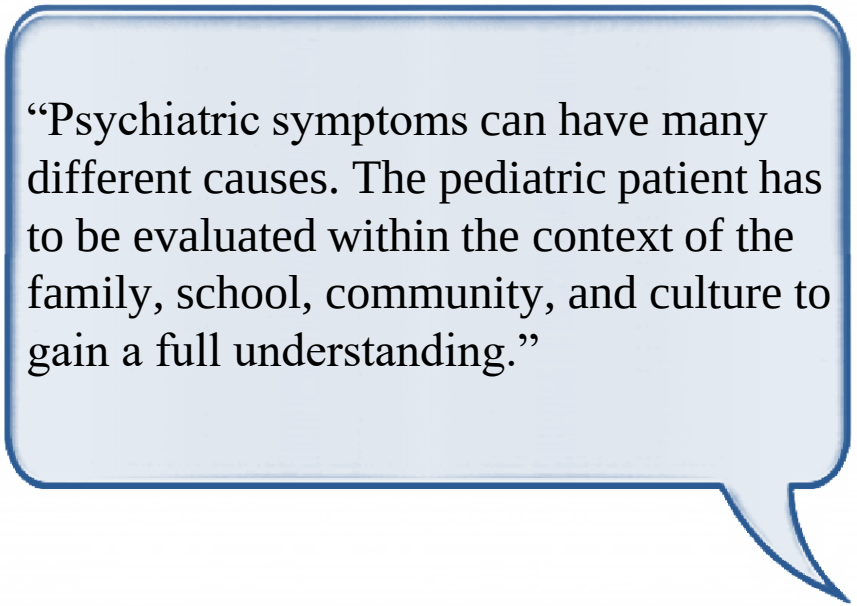

The clinician must both prioritize diagnoses and symptoms and continually reevaluate the formulation.

Purpose of the diagnostic assessment:

- Is there psychopathology present?
- What is the differential diagnosis?
- Is treatment indicated?
- What are the treatment recommendations?
- How does the clinician facilitate the family and child’s engagement in treatment?

"So, I have to consider the context of a particular concern, including a good understanding of a child in their environment. How do I approach a concern that comes to my attention?"

"The concern is often a more severe form of issues found in many children (fears, tantrums, aggression). You need a good understanding of normal and abnormal development and range of expected behaviors at different ages to put the concern in context."

Aim of the assessment:

- Identify reasons and factors leading to the referral (Why now? Clarify social context)
- Obtain general picture of developmental functioning
- Understand nature and extent of functional impairment, behavioral difficulties, distress
- Identify individual, familial, and environmental factors that may account for, influence, or ameliorate these difficulties

"So, I understand that concerns are often due to a decline in functioning or not doing as well as peers. How should I approach the psychiatric concern that is brought to me?"

"It's most important to be empathetic, understanding, and non-judgmental, and allow the person bringing the concern to tell the story in their own way. Often the most therapeutic intervention is feeling heard and validated by the listening clinician."

General principles:

- Must be able to gather information appropriate to developmental level
- Usually need multiple visits to obtain a more accurate picture
- Should have time to talk to both child and parents alone
- Need information from various sources: the child, family, school, other agencies
- Can use screening questions to focus the interview

"What is specific to the parent part of the interview that I need to keep in mind?"

"As the parent is essential to the care and well-being of the child, the parent needs to sees you as an ally. The parent is also an important source of information for the history of the concern in the context of the child and family history."

Parental/caregiver interview:

- Chief complaints often come from adults in the child's life
- Parents are more likely to present externalizing or disruptive behaviors
- Caregivers are more accurate with time-related info, family history
- Can learn about current difficulties, impact on the family
- Can give history of development in the context of family history and events
- Use interview to obtain a sense of family and parental functioning

"What is specific to the child part of the interview that I need to keep in mind?"

"In order to gain the child's trust, discuss the limits of confidentiality and present yourself as an ally. You also need to gather info in a manner appropriate to the maturity of the child, including nonverbal communication and social interactions."

Child interview:

- Child's understanding, motivation, and ability to cooperate is variable
- Start adolescent interview together to enhance adolescent agency
- Child more likely to report anxious or depressive symptoms, suicidal thoughts
- Child more accurate with feelings and attitudes
- Children under 10 often less reliable
- Child may be only source of info about abuse, substance use, DV

"When is it important to obtain information from other sources besides the patient and the caregiver?"

"Ideally, you would always hear from other sources, but especially if there are school-related issues, the caregivers have very different viewpoints or a difficult relationship, or there is something about the concern that is not making sense."

Reasons for varying viewpoints on a problem:

- Context of observation or amount of time spent with the child
- How the individual perceives or evaluates information
- The individuals' propensity or ability to report what they see
- Concern may only be apparent in certain circumstances

"So once I have all the details about the concern, how do I make a formulation about the situation and the particular child?"

"A given concern can have different functions and clinical implications for different children and in different environmental settings. History taking and diagnostic formulation are not separate processes, but guide questions and diagnostic possibilities."

What to consider:

- Preceding circumstances
- Immediate precipitants
- Associated behaviors
- Consequences of the problem
- Broader developmental and familial context

"So, once I have done all of those pieces, I then fully understand the concern and can move forward with the treatment, right?

"Yes and no. You have an initial hypothesis and create a treatment plan based on that hypothesis, but will need to keep reassessing based on treatment response."

- Not unusual to have problems present later (weeks, months, years) that were not apparent initially
- New circumstances or information may later come to light
- Development happens, both individually and in a family
- A degree of humility and constant reformulation is key!

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