

## **MENTAL HEALTH COMMUNICATION TRAINING FOR PEDIATRIC PRIMARY CARE PROVIDERS: IMPACT ON DISPARITIES**

**Presentation for A System of Care for Children's  
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## **Why Primary Care is Important in the System of Care**

- 10-20% prevalence of mental disorder in primary care
- PCPs are among first professionals to identify and provide treatment
- Most children have an annual primary care visit
- PCPs see children over time
- Parents have positive attitudes about their child receiving mental health care from PCP



## **Barriers to Identification and Treatment of Mental Health Problems in Primary Care**

- Inadequate training & lack of confidence
- Lack of time & burden
- Limited collaboration with mental health specialists
- Low reimbursement
- Patients have low expectations that mental health services can help



## **Limitations of Current Primary Care Mental Health Quality Improvement Efforts**

- Most target specific disorders based on a chronic care model
- Difficult to accurately diagnose child mental health disorders, especially in primary care
- Children have functional impairments but do not meet diagnostic categories
- One-third of children with one diagnosis also have another diagnosis – complicates adherence to clinical guidelines



## **What Mental Health Treatment Skills Do Primary Care Providers Need**

- Skills that can be applied to a broad spectrum of mental disorders or symptoms clusters
- Skills that can address both child and parent mental health problems
- Skills that are adaptable to treatment preferences and culture
- Skills that help identify when disorder specific treatment is warranted
- Skills that build on existing knowledge



## **The Training Program**

Combines skills from:

- Motivational enhancement
- Family therapy
- Solution-focused cognitive therapy



## Training Domain 1: Elicit Parent and Child Mental Health Concerns

Training Goal	Specific Skill
Improve provider feelings of competency	See parallels between medical and mental health diagnosis and treatment process; apply knowledge of pediatric development to behavioral advice
Reduce provider fears of losing control of time	Manage rambling and set priorities
Demonstrate to family an interest in mental health related topics	Elicit full range of concerns, listen, respond with empathy and interest related topics
Engage both child and parent in discussion	Use techniques from family therapy to promote turn-taking

## Training Domain 2: Partner with Families to Find Acceptable Forms of Treatment

Training Goal	Specific Skill
Develop acceptable plan for treatment or further diagnosis	Offer choices and ask for feedback; use techniques from motivational interviewing to anticipate & respond to ambivalence & resistance
Address barriers to treating mental health problems	Ask about readiness to hear provider's assessment and recommendations; use motivational interviewing techniques to ask about barriers

## Training Domain 3: Increase Expectations that Treatment will be Helpful

Training Goal	Specific Skill
Respond to hopelessness, anger, and frustration	Use techniques from solution-focused cognitive therapy to identify practical goals, first steps, and sources of self-esteem; manage negative affect between parent and child during visit

## Training Delivery

- 3 cycles spaced 3 weeks apart
- Structured and active learning
- Small group discussion led by psychiatrist
- Each cycle immediately followed with 10 minute standardized patient visit
- Videotapes of patient visit given to provider for self-assessment
- Total of 4 hours of training

## Evaluation Design

- Cluster randomized clinical trial
- Compared outcomes of families who visited trained provider versus those who visited control provider
- Providers randomized within clinic
- Examined changes in parent emotional distress and child mental health symptoms and impairment for 6 month duration

## Clinics

- 16 in rural New York, suburban and urban Baltimore, and Washington, DC
- All served patients with mix of insurance
- Served children age infant to 18 years
- None had formal collaborative relationships with mental health specialists

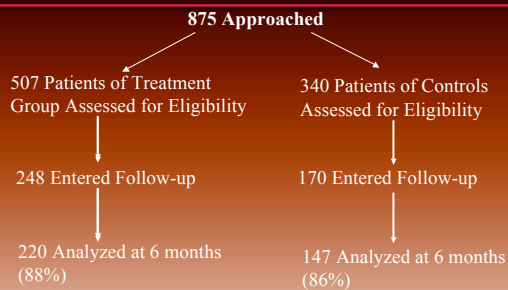
## Providers

Characteristic	Trained = 31	Control = 27
Female	65%	52%
Family practice	35%	41%
Pediatrics	65%	56%
Child behavior training	23%	19%
Child development	10%	4%
> 1 year in study site	84%	85%
Time since receiving degree	13.7 years	15.3 years
Physician Belief Scale		
Burden subscale	17.1	17.1
Belief and feelings subscale	13.6	15.0

## Recruitment of Families

- Eligible if child pain less than 4 on 1-10 scale
- Screened using Strengths and Difficulties Questionnaire (SDQ): those with “possible” or “probable” meeting of DSM criteria enrolled into follow-up

## Enrollment and Follow-up



## Participating Youth

Characteristic	Visited Trained Provider = 248	Visited Control Provider = 170
Female	51%	39%
Age	10.7	9.9
African American	37%	19%
Latino	10%	14%
White	49%	61%
Other	4%	6%
Private health insurance	47%	45%
Mental health services in 6 months before recruitment	47%	52%

## Participating Parents

Characteristic	Visited Trained Provider = 248	Visited Control Provider = 170
Female	92%	89%
High school graduate	75%	73%
Age	36.8	37.6

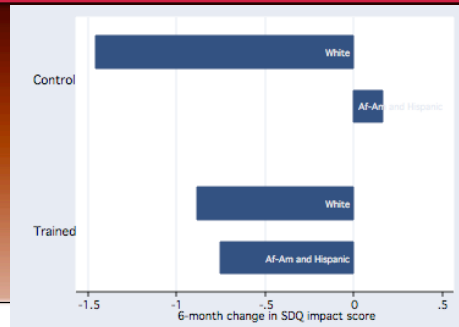
## 6 Month Outcome Measures

Youth Mental Health Symptoms and Impairment	Parent completed Strengths and Difficulties Questionnaire
Parent Emotional Distress	Parent completed General Health Questionnaire

## Statistical Analysis

- Multivariate linear regression that accounted clustering of patients within provider and controlled for geography, use of other mental health services, age, gender
- Interaction terms to test differential impact of training according to patient race and ethnicity

## Unadjusted 6 Month Change in Child Mental Health Impairment



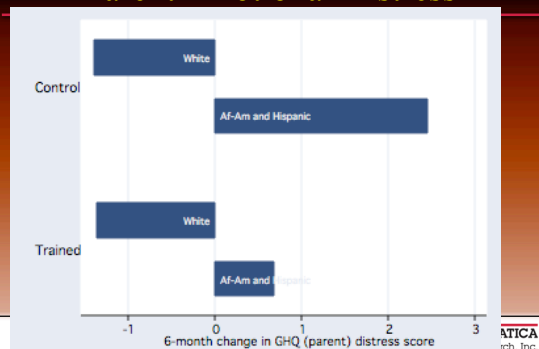
## Unadjusted Change in Child Impairment

Sample	SDQ At Baseline	6 Month Change
All visited trained	2.4	-.88
All visited control	2.2	-.83
African American (n = 125)		
Visited trained	2.0	-.76
Visited control	2.3	.16
Latino (n = 48)		
Visited trained	1.6	-.85
Visited control	.70	-.14
Caucasian (n = 233)		
Visited trained	2.8	-.89
Visited control	2.6	-1.5

## Summary of Child Results

- Minority children visiting trained provider had a mean improvement in impairment of .91 points more (CI: -1.8 to -0.05) than Caucasian children
- Training improved impairment among minority youth but not Caucasian youth

## Unadjusted 6 Month Change in Parent Emotional Distress



## Unadjusted Change in Parent Emotional Distress

Sample	GHQ at Enrollment	Change at 6 Months
All visited trained	3.3	-.41
All visited control	3.2	-.006
African American (n = 119)		
Visited trained	2.5	.77
Visited control	2.9	3.0
Latino (n = 48)		
Visited trained	2.2	.68
Visited control	1.0	2.4
Caucasian (n = 233)		
Visited trained	4.2	-1.2
Visited control	3.8	-1.3

## Summary of Parent Results

- Visiting trained provider was associated with 1.7 GHQ points (CI: -3.2 to -0.11) less worsening of symptoms compared with controls
- Training improved the worsening of emotional distress among minority parents

## Why Would Training Impact Minority Families

- Providers may have learned to agree on acceptable form of treatment
- May have improved minorities' expectations that treatment would help
- May have gained skills to increase trust among minorities

## Implications for the System of Care

- Training may provide PCPs with skills that can be used to improve identification and treatment
- May complement disorder specific interventions
- Collaboration with specialists needed
- Similar training may be useful to other treatment settings

## Collaborators and Further Reading

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- Ivor Horn, Children's National Medical Center
- Mary's Center for Maternal and Child Care, DC
- Johns Hopkins Community Physicians, Baltimore

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