Pediatrician-Psychiatrist Partnerships Expand Access to Mental Health Care

Bridget M. Kuehn

Pediatricians are often the first clinicians to see young patients with mental health conditions, but they may feel ill equipped to provide care for such patients. They may also struggle to find specialists to whom they can refer more complicated cases because many geographical areas face significant shortages of child and adolescent psychiatrists. To address these problems and expand access to mental health care, many states are creating programs that provide pediatricians with training along with real-time access to support from mental health professionals.

One leader in this approach is Massachusetts, which created the Massachusetts Child Psychiatry Access Project (MCPAP) in 2005. The program provides pediatricians throughout the state with access to training and expertise from mental health specialists at academic centers nearby. Now other states, including New York, Ohio, Washington, and Nebraska, are following suit with similar programs (Gabel S and Sarvet B et al. Psychiatric Serv. 2011;62[8]:827-829).

Filling a Gap

About 20% of US children and adolescents have a mental or emotional disorder that interferes with their ability to function, according to a 1999 report from the US Surgeon General, but only about 1 in 5 of these are identified and treated in a given year (http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec1.html). Untreated mental health problems can have lasting consequences for these young people. For example, such individuals are more likely to drop out of school, commit crimes and end up in the criminal justice system, or commit suicide, according to the American Academy of Child and Adolescent Psychiatry.

But with fewer than 7000 child psychiatrists in the United States, there simply aren’t enough specialists to care for these young people, explained John March, MD, MPH, chief of child and adolescent psychiatry at Duke University Medical Center in Durham, NC. The problem can be particularly acute in rural areas, where there may be no child psychiatrists at all.

Faced with this disconnect between the demand for services and the supply of specialists, many groups are looking for a model of care that can close this gap, he explained. One approach that is likely to become more common is multispecialty practices, March said. For example, a multiphysician pediatric practice might include a child psychiatrist.

Another model being probed is one in which pediatricians provide most mental health care with consultation from child psychiatrists and other mental health professionals, who can provide support or take over in the most complex cases.

Greater emphasis on prevention of mental illness and the likely future development of more targeted therapies for mental health conditions also favor a greater role for pediatricians in psychiatric care, March noted. “It won’t be long until we have treatments that are preventive,” he said. “They are really going to transform the way we take care of patients with mental health conditions, and that will occur in the pediatrician’s office.”

Still, these developments require a primary care workforce prepared to take on this new role. “All of this will depend on upgrading the skills of primary care physicians,” March said.

Preceptorship Model

Several states have adopted a model in which primary care physicians can receive training, consultation, and other...
support services from a team of child mental health specialists.

With an initial outlay of $2.5 million and stable funding since the program was started, Massachusetts’ MCPAP is the oldest such program. The MCPAP consists of 6 teams of 4 to 9 individuals, including child psychiatrists, care coordinators, and licensed family and child therapists, based at academic centers throughout the state. Officials from the program visit primary care practices to enroll them and provide them with access to a hotline. Physicians calling the hotline can consult a child psychiatrist about a diagnosis or treatment plan or receive advice about family issues from a social worker or advanced practice nurse.

In most cases, the primary care physicians provide the mental health care the patient needs, as well as attending to their overall health care. “We allow physicians in our catchment areas to provide a medical home to patients with mental illness,” explained Barry Sarvet, MD, chief of the division of child psychiatry at Baystate Medical Center in Springfield, Mass, and statewide co-medical director of the MCPAP.

But if a child needs additional care, the program can also help physicians connect the patient with a counseling service in their community. When necessary, more complicated cases can be directly evaluated by a child psychiatrist. “We do some triage to maximize the use of limited child psychiatrists for those children whose conditions are most severe and complex,” Sarvet said.

Sarvet said these consultations provide physicians with on-the-job training similar to that received during residency, in which an attending physician guides a trainee who is primarily responsible for patient care. “Our model of providing consultation quickly when the patient is in the office is similar to preceptor training,” he said.

Additionally, physicians enrolled in the program may attend educational programs hosted by the MCPAP in their area and receive information about training opportunities elsewhere. The program also maintains a Web site (http://www.mcpp.org) that provides various resources for clinicians and families. For example, the Web site has a guideline for pediatrics on the use of medications to treat depression and another on monitoring patients being treated with atypical antipsychotic medications.

Data collected on the program between 2005 and 2008 indicate it has been well received and well used by pediatrics (Sarvet B et al. Pediatrics. 2010;126[6]:1191-1200). Sarvet noted that in the past, mental health programs have had a difficult time getting physicians to participate. But so far, the MCPAP has enrolled pediatricians serving 95% of the children in the state, and more than three-quarters of the enrolled physicians call the hotline each quarter, Sarvet said.

“It hasn’t been easy,” Sarvet said. “We’ve had to do a lot of creative work to engage physicians beyond the initial orientation meeting to prove it’s worth their time. We’ve made ourselves useful enough they keep coming back.”

Physicians who were enrolled in the program during that period also reported high levels of satisfaction, with more than 90% of respondents saying they found the consultations useful. But only 38% (n=514) of the 1341 primary care clinicians surveyed in 2005 returned their questionnaires, so Sarvet and his colleagues acknowledged that the result could be skewed if physicians who valued the program responded more often than those who didn’t. Physicians also reported greater confidence in their ability to care for children with mental health problems. In an initial survey, 8% of respondents reported they were able to meet the needs of such children compared with 63% reporting such competency in a 2008 follow-up survey.

STATES EMBRACE MODEL
Massachusetts’ success with the MCPAP has inspired other states to follow suit.

Last year, New York State launched Project Teach, a program modeled after the MCPAP, with $1.1 million in funding, said Stewart Gabel, MD, medical director of Children and Family Services at the New York State Office of Mental Health in Albany. The program is a collaboration of the state’s Office of Mental Health with other local and state agencies, the Conference of Local Mental Hygiene Directors, the American Academy of Pediatrics, and the New York State Academy of Family Physicians. The program operates out of 2 centers and provides consultation to participating physicians by telephone, through teleconferencing, or in person. It also helps link patients to additional services if needed.

Gabel said these types of programs offer a model by which a few child psychiatrists can provide care for many children and may offer cost savings by preventing hospitalizations. “These programs are a good value,” he said.

To support these efforts and expand their reach, several programs have banded together to form the National Network of Child Psychiatry Access Programs. The network is based at the Center for Mental Health Services in Pediatric Primary Care at Johns Hopkins University in Baltimore. The program’s Web site (http://web.jhu.edu/pedmentalhealth/mcppap.html) lists state programs already established as well as programs in development.

In Nebraska, where great distances may separate patients from child psychiatrists, and pediatricians and family practitioners may be the only option for care, some clinicians are taking advantage of training offered by the Reach Institute through the Pediatric Pharmacotherapy Program (http://www.glad-pc.org/). Christopher J. Kratochwill, MD, of the University of Nebraska Medical Center in Omaha, explained that the program brings together small groups of physicians for an intensive 3-day training program. This is followed up by 6 months of regular teleconferences during which the participants can discuss cases and their management among themselves and with specialists. The program was created by Peter Jensen, MD, program director of the Reach Institute, and has been used to train physicians across the country. The training has also been used in conjunction with New York State’s program.

March said changes are also needed in medical education to boost pediatrics’ competence in mental health care. He
noted that many family practice training programs provide instruction in mental health care, and that this can be incorporated into pediatric training. He said such programs need to place greater emphasis on simple rules for diagnosing mental health conditions and what types of care can be offered in a pediatric setting. “That would go a long way to improve the care of children with mental illness and reduce the variation in practice,” he said.

While specialists will continue to serve as a safety net in the care of patients with more complicated mental illness, March noted that pediatricians must play a role even in the care of these patients—for example, by avoiding the use of antibiotics that have central nervous system effects in patients who are being treated for mental health conditions.

“There’s no expectation that pediatricians should be able to manage complex psychiatric disease, but they need to be able to identify patients with these conditions and know how to arrange a referral and co-manage their care,” March said. □

State Diabetes Programs Need Adapted Guidelines

Rebecca Voelker

A survey of federally funded state diabetes prevention and control programs shows that while most circulate diabetes practice guidelines, few consider how to adapt those recommendations for population health rather than individual disease management.

Researchers at the University of California, San Francisco, surveyed diabetes programs operating within public health departments in all 50 states and 7 US territories. Of 52 that responded, 77% said they circulate diabetes guidelines. Of those, 60% said they use guidelines from specialty groups such as the American Diabetes Association or the American Society of Clinical Endocrinologists. About one-third of the programs that circulate guidelines said they develop their own based on published recommendations (Sarkar U et al. Am J Public Health. 2011;101[10]:1871-1873).

Even though most of the state diabetes programs surveyed disseminate practice guidelines, many said they don’t have the resources to provide services that constitute complete adherence to the guidelines. They also don’t determine which of the individual recommendations will make the best use of their scarce resources to improve the public’s health.

For example, the programs surveyed ranked glycemic control as more important to public health than blood pressure or lipid control with regard to diabetes management. While all 3 are important, the researchers said current evidence shows that blood pressure control is the most cost-effective way to reduce diabetes-related morbidity and mortality.

“Glycemic control is important for preventing microvascular complications, [but] it is far more costly per quality-adjusted life-year than are blood pressure and lipid control and retinal screening,” the researchers wrote. They also said that only 6 of the programs surveyed circulated information on recent findings from clinical studies showing that tight glycemic control was associated with increased mortality.

While cost-effectiveness is just 1 consideration, the researchers noted that it is the mission of public health programs to improve population health at low costs and to provide safety net health services for vulnerable populations.

The researchers said that state diabetes programs need better data to determine how they can adapt and prioritize recommendations within diabetes practice guidelines to improve the health of the populations they serve. □

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