Common Practice for Behavioral/Mental Health Screening in Pediatric Primary Care Settings

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Introduction

Background
- Mental health disorders in the United States are highly prevalent
  - 14-20% of children are affected each year1
  - 75% of adult mental health disorders onset prior to age 24 2
- There is an average six-plus year delay between symptom onset and a child’s first exposure to treatment3
- 25-35% of affected youth actually access treatment4
- There are not enough child and adolescent psychiatrists to meet the treatment need 5

- Current recommendations for primary care physicians (PCP) suggest screening and managing pediatric mental health conditions (specifically depression) 6, 7
- Physicians are wary citing time constraints, lack of proper training and lack of external resources 8, 9, 10
- Inconsistent management of attention deficit hyperactivity disorder (ADHD), anxiety and depressive disorders

Study Proposal
- Self-report questionnaire surveying pediatric primary care providers across the US
- Providers recruited by networking

Aims and Hypotheses
- To understand common practice in regards to choices of screening tool and treatments
- To investigate provider practice for ADHD, anxiety disorders and depressive disorders including:
  - Knowledge and skill screening, treating and referring for each disorder
  - First choice in screening tool, treatment (pharmacologic or behavioral) and referral practice
  - Perceived barriers to providing interventions
  - What dedicated mental health staff are employed and what are their roles
  - To assess areas for improvement in screening
  - We expect:
    - A high level of diversity in standard practice
    - Higher rates of screening for depression and ADHD compared to other disorders
    - Providers to feel more skilled managing ADHD and depression than anxiety disorders

Methods

Study Design
- Recruitment began 10/2018 and is ongoing
- Inclusion Criteria: any healthcare provider with specific training (i.e. MD, NP or DO) and currently practicing as a pediatric or adolescent primary care provider
- Providers were recruited via email containing an invitation to participate and the survey link
  - Initial recruitment began at Thomas Jefferson University and Philadelphia FIGHT Community Health Center
  - Participating providers were encouraged to share the survey link with colleagues

Data Collection
- Multiple choice self-report questionnaire administered online via REDCap data capture tool
- Demographics
  - Years in practice
  - Degree (e.g. MD, NP or DO)
  - Practice location (e.g. Urban, Suburban or Rural)
  - Practice type (e.g. Academic vs Private Practice)
- Outcome measures
  - Knowledge/skill diagnosing, treating and referring ADHD, anxiety and depression rated on a 5-point Likert scale
  - Percentage of providers screening for each disorder

Statistical analysis:
- Comparison of knowledge/skill in managing different mental health conditions (i.e. skill diagnosing ADHD vs anxiety, skill treating ADHD vs depression, etc.)
- Calculated using repeated-measures ANOVA with SPSS statistical software
- Percentage of providers screening for each disorder assessed

Results

Demographics (N = 11)
- Average years in practice = 22 ± 10 (from 7 to 40)

Discussion
- 91% screened for depression likely reflecting new emphasis current recommendations place on depression and suicidality
- Providers felt more skilled diagnosing and treating ADHD compared to anxiety perhaps due how long PCPs have managed ADHD specifically
- Few providers screen for anxiety disorders indicating an area in which new recommendations could be made

Conclusions

Limitations/Future Directions
- Small sample size
- Branching logic may have limited certain responses
- Comparing first choice of screening tool and treatment

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References

2. Current recommendations for primary care physicians (PCP) suggest screening and managing pediatric mental health conditions (specifically depression).
3. Physicians are wary citing time constraints, lack of proper training and lack of external resources.
4. Inconsistent management of attention deficit hyperactivity disorder (ADHD), anxiety and depressive disorders.
5. There was a significant difference in rated skill diagnosing the conditions assessed F(2, 20) = 13.671, p < 0.001. Post-hoc Bonferroni tests revealed the significant difference was between ADHD (M=3.73, SD=0.65) and anxiety (M=2.64, SD=0.81, p = 0.01). No other comparisons were significant.
6. There was a significant difference in rated skill treating the conditions assessed F(2, 20) = 14.933, p < 0.001. Post-hoc Bonferroni tests revealed the significant difference was between ADHD (M=3.45, SD=0.688) and anxiety (M=2.36, SD=0.5, p < 0.001) and ADHD and depression (M=2.73, SD=0.9, p = 0.036). No other comparisons were significant.
7. No other differences were found to be significant.