

# Facilitating management of child and youth health problems in primary care

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# The problem

- 10-20% of children/youth have mental health problems
- Less than half get services
- Not enough services for all in need
- Need for services that include prevention, treatment, and surveillance at times of developmental change



# Why intervene in primary care?

- Known point of entry to larger MH system
- Accessible source of care for families
- Ability to integrate health and mental health
- Especially for children
  - Frequent visits facilitate prevention and follow-up
  - See parents and children together



# Current disappointments

- low rate of disclosure
  - Half of parents with concerns tell the doctor
- low levels of agreement between parents and providers on the nature of problems
  - Agree on problem less than half the time
- low follow-through on referrals to MH
  - About half of referrals accepted



# Barriers from patient perspective

- Primary care not thought of as mental health resource
  - Uncertain about doctor competencies
- Poor prior experiences
- Children/youth not given opportunity to speak



# Barriers from doctor perspective

- Discomfort with subject matter
- Perceived lack of time
- Perception of priorities
  - Physical versus mental health
- Lack of referral resources



# Rationale for training in communication skills

- Direct attack on part of the problem
- Address broad range of conditions
- Proven technology - skills can be taught inexpensively
- Improve outcomes of other interventions
  - Downstream effect of gateway provider
  - Improve doctors' willingness to learn more



# What skills to teach

- Promote disclosure of problems
- Keep doctor in control of visit
- Provide rapid relief for hopelessness and conflict
- Reduce likelihood of frustrating visit
- Make mental health comfortable for generalists



# Sources for skills to incorporate into routine visits

- “Evidence-based”
  - Patient-centered behaviors
  - “Solution-focused” cognitive therapy
  - Family therapy/dyadic visits
  - “Motivational Interviewing”



# Nine skill areas - 1

- Involving all parties
- Probing efficiently for the full list of concerns
- Setting an agenda for the visit
- Managing disagreements between parent and child (or between parents)



# Nine skill areas -2

- Responding to emotionally-extreme statements
- Proposing a diagnosis and giving advice
- Managing hopelessness and helplessness
- Managing “resistance”
- Patients who are angry at you/system



# Dilemmas about how to teach

- Structured versus unstructured
  - Quality control versus local relevance
- Didactic versus participatory
  - Efficiency and ineffectiveness versus time and impact
- Active versus passive learning
  - Effective versus ineffective; frightening versus comfortable



# Current model

- In-office, presented to small groups
- 3 cycles of:
  - 45-minute lecture/discussion led by child psychiatrist
  - 10 minute “standardized patient” visit
  - Self-review guided by software and paper tool
- Total group instruction time 3.5 hours spread over 2 months



# Structure of “lecture”

- Present rationale for each step
- Speak only briefly before asking for input (slides prompt this)
- Offer menu for each session and invite group to prioritize
- Encourage trainees to direct comments to each other; use their examples and lessons



# 1. Managing hopelessness

- Rationale
  - “Hopelessness” can come from anger, depression, chronic disempowerment
  - Regardless of cause, result is distorted view of past and abbreviated search for solutions
  - Often contagious – provider ideas are serially rejected



Your ideas for managing  
hopelessness?



# Seeing the situation differently

- Steps to promote a different perspective
  1. Ask to briefly hear the story from the top
  2. Empathize (not necessary to agree with overall assessment)
  3. Make “half empty” into “half full” – point out what accomplished despite adversity
  4. Shift focus to something small but possible rather than distant, difficult goal



# Seeing it differently



Click box to start film clip



# Visit with “standardized patient”

QuickTime™ and a  
Cinepak decompressor  
are needed to see this picture.



# Trial description

- 60 mid-career doctors, 9 sites in 2 states and DC (rural and urban)
  - Randomized to “now” or “later” training
- 816 children 5-15 screened with “SDQ”. 60% were negative, 20% possible, 20% probable.
- 326 possible and probable followed for 6 months
- 76% completed six month follow-up to date.



# Strengths and Difficulties Questionnaire Outcomes

- Total difficulties score (0-50, range 1-33, SD=6.55)
- Impairment (0-10, SD=2.74)
- Burden on family (0-2, SD=1.07)



# Change in total difficulties

	<b>Coefficient</b>	<b>P value</b>
Treatment	1.05	0.442
Minority parent	3.44	0.037
Treatment and minority parent (interaction)	-2.89	0.149
Private insurance	-1.29	0.141
Age	-.98	0.231
Sex (female)	1.51	.068
Constant	-4.84	0.000



# Change in impact rating

	<b>Coefficient</b>	<b>P value</b>
Treatment	.39	.41
Minority parent	1.76	.005
Treatment and minority parent (interaction)	-1.75	.024
Private insurance	-.55	.14
Age	-.33	.35
Sex	.21	.56
Constant	-1.44	0.001



# Change in burden rating

	<b>Coefficient</b>	<b>P value</b>
Treatment	.34	.12
Minority parent	.51	.06
Treatment and minority parent (interaction)	-.73	.027
Private insurance	-.08	.59
Age	-.10	.46
Sex	.12	.39
Constant	-.59	0.003



# Family function score at follow-up\*

	Coefficient	P value
Treatment	.09	.20
Minority parent	.24	.015
Treatment and minority parent (interaction)	-.46	.000
Private insurance	-.24	.000
Age	.13	.06
Sex	-.06	.35
Constant	1.74	0.000



\*McMaster GF, range 1-4, SD=.53, lower scores better

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# Conclusions

- Intervention impact may be limited to interactions with minority families
  - Report less collaboration and less psychosocial advice from doctors
- May not alter symptoms but improves perception of child and family function
  - Effect sizes range .64 - .87; moderate to large



# Conclusions

- Communication skills training seems acceptable to experienced doctors
  - Combine perspectives: what they feel they need, what “we” think they need
- Training has a clinical impact as a stand-alone intervention
  - Ultimately would want to pair it with other training and systems interventions



# Things to understand

- Mechanism of action
- Impact on overall population
- Impact on use of services
- Differences by primary care characteristics
  - Continuity
  - Schedules of well-child care



# Our team

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