

A Clinical Care Algorithmic Toolkit for Promoting Screening and Next-Level Assessment of Pediatric Depression and Anxiety in Primary Care

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ABSTRACT

With a documented shortage in youth mental health services, pediatric primary care (PPC) providers face increased pressure to enhance their capacity to identify and manage common mental health problems among youth, such as anxiety and depression. Because 90% of U.S. youth regularly see a PPC provider, the primary care setting is well positioned to serve as a key access point for early identification, service provision, and connection to mental health services. In the context of task shifting, we evaluated a quality improvement

project designed to assist PPC providers in overcoming barriers to practice-wide mental health screening through implementing paper and computer-assisted clinical care algorithms. PPC providers were fairly successful at changing practice to better address mental health concerns when equipped with screening tools that included family mental health histories, next-level actions, and referral options. Task shifting is a promising strategy to enhance mental health services, particularly when guided by computer-assisted algorithms. *J Pediatr Health Care.* (2017) ■, ■-■.

KEY WORDS

Anxiety, depression, mental health, pediatric primary care, screening, task shifting

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Unaddressed mental health problems among children and adolescents continue to pose a significant public health dilemma. One out of every five children ages 9 to 17 years meets diagnostic criteria for a mental health disorder at some point during childhood, with fewer than a third of these children receiving mental health services (Merikangas et al., 2011; U.S. Department of Health and Human Services, 1999). Two common and often comorbid childhood disorders are depression and anxiety, with approximately 11% and 25%, respectively, of the general population of youth meeting diagnostic criteria, and 30% and 17% of these children exhibiting particularly severe depression and anxiety, respectively (Merikangas et al., 2010). To address this public health challenge, federal agencies

(SAMHSA-HRSA Center for Integrated Health Solutions, n.d.), the Affordable Care Act (Patient Protection and Affordable Care Act, 2010), professional associations (American Academy of Pediatrics [AAP], 2009), and nationally recognized quality improvement organizations (National Committee for Quality Assurance, 2015) are turning to pediatric primary care (PPC) providers to expand their scope of practice to include identifying and managing mental health concerns among pediatric patients. Indeed, more than 90% of children and adolescents across all economic and ethnic groups in the United States regularly see a PPC provider (National Center for Health Statistics, 2015), which means that for the large majority of youths, PPC providers could serve as a key point of access to early identification of mental health concerns, mental health services, and connection to mental health providers.

Analysis of 3 years of the Medical Expenditure Panel survey (2008 through 2011) shows that PPC providers play a larger role in the care of children with attention and mood disorders than any other professional (Anderson, Chen, Perrin, & Van Cleave, 2015), further highlighting that at least a third of children with these disorders see only a PPC provider for their mental health conditions. Given the documented shortage of pediatric mental health providers, and particularly child and adolescent psychiatrists (Hagan et al., 2001; Thomas & Holzer, 2006), PPC providers have the potential to fill many gaps in care for children with mental health needs.

PPC providers can use the traditional well-child visit in many ways to improve detection of and intervention for youth with mental health concerns. The AAP (2009) and federal Substance Abuse and Mental Health Services Administration (National Committee for Quality Assurance, 2015) encourage PPC providers to screen all children for mental health concerns at well-child visits. For children insured by Medicaid, the Commonwealth of Massachusetts mandates screening at all well-child visits (Center for Public Representation, 2007). Often, screening can be compensated on the same day as a well-child visit. However, practice-wide mental health screening is highly variable and thwarted by several systemic and practice-level barriers, which include insufficient access to psychometrically sound screening and next-level assessment tools; knowledge of proper administration, scoring, and interpretation of results of the tools; and staff support to facilitate practice-wide screening and next-level assessment and to connect children with mental health services when needed (U.S. Department of Health and Human Services, 1999).

Given the long-term relationship that PPC providers tend to establish with families, they are well positioned to serve as a hub for monitoring change in children's mental health symptoms across development, when mental health can fluctuate and problems

can emerge at various times and in response to various circumstances (Hagan et al., 2001), as well as in response to treatment interventions. Whether an intervention is provided by the PPC provider or an outside mental health provider, such a mental health surveillance system could help PPC providers determine the effectiveness of the intervention for a specific patient and whether an additional or alternative treatment is indicated. Currently, communication between PPC providers and mental health providers is less than optimal, and other than knowing that a child is receiving outside treatment, PPC providers often lack information about how well that child is responding to the treatment (Knowles, 2009). If PPC providers could routinely track symptoms across well-child visits or in follow-up visits, they may be better equipped to make meaningful recommendations about the direction of treatment (e.g., continue/discontinue treatment, consider additional/alternative treatment) and better inform referrals to mental health specialists.

A challenge for PPC providers is how to address mental health problems once they are identified. PPC providers largely lack the training and resources to provide mental health treatment when indicated, mental health services providers in the community are scarce or have long waiting lists, and communication between PPC providers and mental health professionals for consultation or co-management of patients' symptoms seldom happens (Pidano, Honigfeld, Bar-Halpern, & Vivian, 2014; Pidano, Kimmelblatt, & Neace, 2011).

Several models exist for extending PPC providers to incorporate more mental health work. Some models advocate for co-location of mental health providers in pediatric settings (Ward-Zimmerman & Cannata, 2012), and others improve referral mechanisms so that children identified in primary care as having mental health concerns can seamlessly receive evaluations and mental health interventions (Hilt et al., 2013; Sarvet et al., 2010; Van Cleave, Le, & Perrin, 2015). A third model increases the role of PPC providers to address mental health concerns by task shifting, as described by Wissow, van Ginneken, Chjandna, and Rahman (2016). Task shifting increases the skills of staff in PPC and the functions of the primary care setting to absorb more mental health tasks. Even in communities that have an adequate supply of mental health providers, which are very few, task shifting allows children to receive services in a familiar setting, from a familiar provider,

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