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Integration of child mental health services to primary care: challenges and opportunities

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ABSTRACT

In the first decade of this new millennium, health professionals are faced with a rapidly increasing need for child mental health services and changing models of service provision. This gives us a unique opportunity to make provision for services where it has not been available before, or to improve upon the existing services. This paper

examines the challenges and opportunities while attempting to integrate child mental health services to primary care.

Keywords: child, mental health services, primary care

Introduction

Child mental health differs from other health fields in that almost all the 'patients' are brought for consultation somewhat against their will. We would be hard pressed to find a child who would wake up one morning and say, 'Mum, I think its time for me to go see a doctor for my anger and depression'. What duty and responsibility does this confer on us who work in the area of health, and child mental health? Mental health, which includes emotional and behavioural areas of health, is a critical component of child wellbeing and impacts on children's physical health, relationships, and learning. Appropriate treatment and intervention for children with emotional or behavioural difficulties has been shown to lessen the impact of mental health problems on school achievement, and relationships with family members and peers. Absence of intervention leads to school failure, poor employment opportunities,

and poverty in adulthood with significant risk for mental health problems including risk for substance abuse. For example, in the case of attention deficit hyperactivity disorder (ADHD), research has shown that when children with ADHD become adults, they tend to use more healthcare services and have higher healthcare costs as compared to adults who did not have ADHD in childhood.¹

Evidently, parents, teachers and general practitioners (GPs) are at the forefront of being able to identify mental health problems in the first instance and being able to either offer or serve as gateways to appropriate services. There is universal consensus that health professionals are currently faced with a rapidly increasing need for child mental health services, and as a consequence there has been a rethink about models of service provision for this age group.

Magnitude of the problem

In a recent joint position paper by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry, it was reported that although almost one in five children in the US suffers from a diagnosable mental disorder, only 20–25% of affected children receive treatment.² A quick check of other relevant studies in the area reveals that mental health problems are prevalent in children and adolescents attending primary care, with one-third of them being affected across their lifetimes.^{3–6} Despite possibilities for effective treatment, only about one-third to one-half of these young people receive professional help.⁶ The United States National Health Interview Survey (2005–2006) examined this issue in some detail.⁷ It found that 15% of children aged 4–17 years had parents who talked to a healthcare provider or school staff about their child's emotional or behavioural difficulties. This included 18% of boys and 11% of girls. About 5% were prescribed medication for difficulties with emotions or behaviour. Approximately 5% of children received 'treatment other than medication' for emotional or behavioural difficulties. The main difference in the finding from studies elsewhere in the world was that most of these children – 60% – received this treatment from a mental health private practice, clinic, or centre. In contrast, other government policies, for example the UK, have highlighted primary care for further development of child and adolescent mental health services.^{8,9} In this regard, the Audit Commission identified three roles for non-specialist staff: (i) early identification of mental health problems; (ii) offering treatment for less severe problems; and (iii) pursuing health promotion and problem prevention.^{10,11}

Focus on mental health care in primary care settings

Although the importance of mental health assessment and treatment in primary care is increasingly recognised, the research that underlies current practices largely stems from a considerable body of non-mental health primary care studies. A review of literature on health services research in paediatrics and primary care practice, focusing on primary care mental health services, revealed that the evolution of primary care mental health services for children has been slow, but the focus of research has changed with the development of clinical improvements. There has been a continuing expansion from a focus

initially on provider behaviour and quality to a growing attention to patient and systems' behaviour over time and within communities.¹² Current trends in electronic technology, practice consolidation and co-ordination, and personalised medicine are likely to increase the pace of change in mental health services for primary care. For example, several general practice networks in Australia have telephone or email access to a 'child psychiatrist on call' who provides advice to the GP in real time, thus contributing to an immediate positive outcome for the child and family. The US seems to have taken a slightly different approach with an increased reliance on nurse practitioners with advanced certification in child and adolescent psychiatry to make up for the shortage of frontline child and adolescent psychiatrists and improve access to mental health care for children.¹³

Help-seeking patterns in the context of child mental health morbidity

It is all good when parents do consult professionals for emotional and behavioural problems in their children. In fact, help-seeking preferences vary widely in different cultures, with only a minority preferring to consult mental health professionals. For example, a study of the help-seeking preference for mental health problems in children in the United Arab Emirates (UAE) found that only 37% preferred to consult a mental health specialist.¹⁴ Common barriers to seeking professional help include social stigma and the difficulty on the part of the family of accepting the fact that their child has a mental health problem, coupled with the negative perceptions of family and friends about mental health treatment and lack of trust and faith in the usefulness of such treatment. Many in these cultural contexts consult traditional healers and alternative medicine avenues before consulting mental health professionals. Other barriers to seeking professional help include practical and logistic difficulties in accessing the services, as well as cost, availability and accessibility of mental health services. Primary care providers (PCPs) play a critical role in the identification and treatment of child and adolescent mental health problems but few studies have examined parents' attitudes on receiving advice about child mental health from a PCP, and whether attitudes are associated with race or ethnicity. A study in Brazil looked at the possibility of using community-based primary care to increase access to mental health services for children.¹⁵ Parents reported

that they found non-professional staff (extended relatives, friends, community elders) a more likely support than primary care clinicians who were perceived as rushed and uninterested and attributing all child mental health problems to life in poor, violent communities. The authors identified the need, in the first instance, to educate primary care clinicians in being able to identify mental health problems. Another similar study collected data from both parents and PCPs during 773 visits to 54 PCPs in 13 diverse clinics in the US. Families were 56.5% white, 33.3% African-American and 10.1% Hispanic. The study found that Hispanic were more likely than non-Hispanic individuals to agree that PCPs should treat child mental health, and were more willing to allow their child to receive medications or visit a therapist for a mental health problem if recommended by the PCP. African-American participants were significantly less willing than white and Hispanic individuals to allow their child to receive medication for mental health, but did not differ in their willingness to visit a therapist. The authors concluded that race and ethnicity were associated with parents' attitudes on receiving advice about child mental health from a PCP and that primary care may be a good point of intervention for Hispanic youth with mental health needs.¹⁶ The spirit of these findings could possibly be generalised worldwide.

Perceived challenges in integration of child mental health services to primary care

The key issue is to be able to address child mental health needs in a way that is both accessible and acceptable to the given community. One way of achieving this would be to increase the accessibility and effectiveness of child and adolescent mental health services through the involvement of primary care professionals and the delivery of interventions in the primary care setting. However, little is known about the actual clinical and cost-effectiveness of such service delivery. One study systematically reviewed the evidence concerning the effectiveness of interventions for child and adolescent mental health problems in primary care, and interventions designed to improve the skills of primary care staff.³ They found some preliminary evidence that treatments by specialist staff working in primary care were effective, although the quality of included studies was variable and no data were available on the cost-effectiveness of interventions. Equally, some educational interventions were found to have a good

potential for increasing the skills and confidence of primary care staff. However, controlled evaluations were rare and few studies reported actual changes in professional behaviour or patient health outcomes.

Opportunities for integration at primary care level

An efficient and cost-effective way of addressing the child mental health needs of a country, regardless of its economic status, would be to implement mental health screening programmes in schools and to integrating them with primary healthcare facilities.¹⁷ Such programmes could easily be implemented utilising the existing resources and taking into account the local health priorities. However, this will need to be complemented with provisions for treatment and care, which again could integrate available school and primary health personnel resources. In this regard, it is important to provide training for primary healthcare staff, teachers and other professionals who work with children, in an attempt to increase their ability and confidence in the detection of mental health problems. It is also important that the detection of mental health needs in children is matched up with appropriate referral systems, pathways of care, and mental health service provision.

Even when children with mental health problems are in contact with primary healthcare services, there is still the question as to whether they would be identified and receive appropriate help. A study of children attending a primary care facility in the UAE observed that, while around 40% had a mental health problem, only 1% was identified by the primary care physician.¹⁸ The reasons for this include lack of parental awareness and lack of recognition by the primary care staff as well as lack of resources and opportunities for referral to specialist mental health services. Thus, the type and severity of the disorder, parental education and awareness, age and sex of the child, and family and social background factors determine which affected children access services. With the existing deficiencies and gaps in services and patterns of service use, a greater emphasis on developing resources at population and primary care levels is urgently needed, with emphasis on public health education, improved training of primary care staff and increased accessibility of specialist mental health services.

Mental health care, when provided in the primary care or school health clinic setting, is often perceived favourably by families and offers the added advantage of integrated care with the child's other

healthcare needs. A model of a joint clinic, run by the GP or paediatrician together with the child and adolescent psychiatrist in the school or primary health clinic has found success in some settings.¹⁹ Following assessment and initial intervention in such a setting, those children who either do not respond or whose needs cannot be met at the primary care level could be referred for specialised services.

Given the fact that around 50% of adult psychiatric disorders have their origin in childhood and early adolescence, prevention research should focus on this early period of life, with surveillance and monitoring of 'at-risk' children, coupled with appropriate early-intervention strategies. Early intervention targets children in the early stages of disorders. This, however, becomes more complicated when some child and adolescent mental health teams, perhaps in an attempt to prevent being inundated with referrals, exclude ADHD, conduct disorder (CD) and pervasive developmental disorder (PDD). Let us examine how primary care would grapple with two common childhood psychiatric disorders, CD and depression.

One study found that children with CD and their families are in contact with multiple agencies, but there is limited evidence on their patterns of service utilisation.²⁰ Use of social services was significantly higher by children with CD than those with emotional disorders (ED) in the absence of co-morbidity, while use of specialist child mental health and paediatric services was significantly higher by children with hyperkinetic disorders (HD) than those with CD. Also, children who had co-morbid physical disorders used more primary healthcare services compared to those without physical disorders. Specialist services use was associated with co-morbidity with learning disabilities, physical and psychiatric disorders. Several correlates of services use in CD appeared non-specific, i.e. associated with use of different services, indicating the possibility of indiscriminate use of different types of services. These results highlight the need for effective organisation and co-ordination of services, as well as the establishment of clear referral and care pathways. Involvement of specialist child mental health services should be requested in the presence of mental health co-morbidity.

Primary care clinics have become the *de facto* mental health clinics for teens with mental health problems such as depression, as evidenced by a survey of multidisciplinary experts; however, there was little guidance found for primary care professionals who are faced with treating this population.²¹ One recommendation was for routine surveillance for youth at high risk for depression, as well as the use of standardised measures as diagnostic aids. For treatment, 'active monitoring' was deemed appropriate in

mild depression with recent onset. Medication and psychotherapy were considered acceptable options for treatment of moderate depression. Those without complicating factors such as co-morbid illness, who are started on antidepressants, need to be followed within two weeks after initiation. The survey supported the identification and management of adolescent depression in the primary care setting and, in specific situations, referral and co-management with specialty mental health professionals. Even with the recent controversies around treatment, experts across primary care and specialty mental health alike agreed that active monitoring, pharmacotherapy with selective serotonin reuptake inhibitors, and psychotherapy can be appropriate when initiated within primary care settings. With the significant shortage of children's mental health professionals, co-ordinated and shared care with the primary care physician becomes the only viable and sustainable way of meeting child mental health needs in the community.

Future directions in child mental health service provision

Children's mental health needs are varied, complex and changing, based on the developmental stage, and this requires comprehensive and flexible approaches that address the young person's basic needs, education and family connection as well as advocating for security and protection, and recognising and addressing the needs of the more vulnerable children. The current problem of access to mental health care for children and adolescents could be improved with additional funding and change in perceptions of policy makers. Health service planning must take into account the developmental differences while providing access to the existing system with a better targeted and integrated care of mental health, substance use, child protection and vocational-rehabilitation services.

The identified top priorities for global mental health research include epidemiological studies on child and adolescent mental disorders, and this is particularly true for countries and regions that have limited knowledge of the nature and occurrence of child mental health morbidity. In sub-Saharan Africa, mental disorders are known to account for nearly 10% of the total burden of disease,²² and while there is agreement that mental health services should be integrated in primary care,²³ studies of mental illness in general practice in Africa have found low recognition by GPs and a reluctance of GPs to refer to

specialists.²⁴ Thus, studies examining the epidemiology of child mental disorders and cost-effective interventions that can be delivered within the constraints of inadequate resources and poor economies should take priority in Africa.

Providing assessment, early intervention and continued monitoring at the primary care level, with a co-ordinated management plan including primary care clinicians, mental health professionals, school personnel, and others involved in the care of the child, offers the unique opportunity to engage families and maintain young people in treatment without stigma. Early mental health screening and the availability and use of appropriate mental health services are among the goals of the President's New Freedom Commission on Mental Health.^{25,26} Currently, governments and health services all over the world vary widely in determining the best solution to this issue. What is, however, clear is that culturally sensitive assessments and intervention methods, and creation of age-appropriate services within the primary care and school health setting should take priority. The unique strengths of the primary care physician and opportunities available in the primary care setting should be utilised to address the unmet child mental health needs of the community. Administrative and financial barriers that hinder integration should be addressed and, where appropriate, mental health resources should be restructured to include primary care clinicians. In addition, a significant programme of research is required if the potential for child and adolescent mental health services in primary care is to be realised in an effective and efficient way.

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CONFLICTS OF INTEREST

None.

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Received ?????

Accepted ?????