Rationale for Integrating Mental/Behavioral Health into Primary Pediatric Care
Raymond Hanbury, PhD, ABPP
Chief Psychologist, Dept. of Psychiatry
Jersey Shore University Medical Center

Program Director
Pediatric Psychiatry Collaborative Program

Associate Professor, Dept. of Psychiatry
& Dept. of Pediatrics
Seton Hall – Hackensack Meridian School of Medicine
Acknowledgement to Partners

- Kelley Analytics
- Team Staff Members
- NJ Chapter, American Academy of Pediatrics
Presenters’ Disclosure Statement

NOTHING TO DISCLOSE
Delivering Care Coordination

- Assessment
- Continuous Monitoring & Improvement
- Goal Setting
- Care Planning & Facilitation
Today’s Healthcare

Characteristics:
- Outcomes-oriented
- Enabled by technology
- Patient-centered
- Use of data and analytics
- Performance transparency
- Ability to partner across organizations
Turning the Ship:

Physician-managed health rather than health plan managed care

Creating need for new skill sets, policy, tools, and competencies

Drivers:
- Health care cost crisis
- Health reform
- Improved HIT
- Greater stakeholder alignment

- New models of care delivery and coordination
- Payment aligned with goals
- New tools for clinical alignment
- Better PHM capabilities
- Experience in performance management/data reporting
- Experience in population risk adjustment/risk mitigation
- Increased awareness of prevention and wellness value
- Educated, empowered patients
Creating Value and Serving People

- Adding community care coordination in primary care clinics and physician offices
- Using home monitoring technology linked through Home Care & Care Coordination
- Creating dedicated Palliative Care programs
- Accountable Care Organizations and Physician Hospital Organizations
- Forming a Clinically Integrative Network with our physicians and other partners
- Expanding the Pediatric Psychiatry Collaborative Program to include medication management & focus on high-risk patients
- Patient Centered Medical Homes
Mental health disorders have become the chronic disease of children and adolescents

- 30% of children seen in primary care settings exhibit signs of emotional disturbance
- 17% to 26% of children have active mental health problems; 22% of adolescents age 13-18 have severe impairment and/or distress
- 20% of children/adolescents have mental health problems (15% mild to moderate, 5% severe)
- Use of psychotropic medication with children and adolescents has risen dramatically
Epidemiology of Pediatric Mental Health Conditions

- 9.5-14.2% of children ages birth to 5 have Social-Emotional problems interfering with functioning
- 21% of children and adolescents in the U.S. meet diagnostic criteria for MH disorder with impaired functioning
- 16% of children and adolescents in the U.S. have impaired MH functioning and do not meet criteria for a disorder
- 13% of school-aged, 10% of preschool children with normal functioning have parents with “concerns”
- 50% of adults in U.S. with MH disorders had symptoms by the age of 14 years
Categories of Child/Adolescent Mental Health Disorders

Neurodevelopmental Disorders
- Autism Spectrum Disorder
- Attention Deficit Hyperactivity Disorder

Depressive and Bipolar Disorders
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)
- Bipolar Disorder
- Disruptive Mood Dysregulation Disorder

Anxiety Disorders
- Selective Mutism, Specific Phobia, Separation Anxiety, Social Anxiety, Panic Disorder, Agoraphobia, Generalized Anxiety
Categories of Child/Adolescent Mental Health Disorders (continued)

Disruptive, Impulse Control, and Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder

Trauma and Stressor-Related Disorders

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder

Feeding and Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Binge-Eating Disorder
Opportunity for Early Identification of Patients with Mental/Behavioral Concerns

Median age of onset of . . .

- Anxiety disorder = 6 years old
- Behavior disorder = 11 years old
- Mood disorder = 13 years old
- Substance abuse = 15 years old

- The average delay between onset of symptoms and intervention is 8 to 10 years
## Lifetime Prevalence Data, US

Face to face household survey, 2001-2003 using the WHO survey version

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>28.8%</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>20.8%</td>
</tr>
<tr>
<td>Impulse control disorders</td>
<td>24.8%</td>
</tr>
<tr>
<td>Substance use</td>
<td>14.6%</td>
</tr>
<tr>
<td>Any disorder</td>
<td>46.4%</td>
</tr>
</tbody>
</table>

*The National Co-Morbidity Survey Replication- Kessler, 2005*
Three Types of ACEs:

- **ABUSE**
  - Physical
  - Emotional
  - Sexual

- **NEGLECT**
  - Physical
  - Emotional

- **HOUSEHOLD DYSFUNCTION**
  - Mental Illness
  - Incarcerated Relative
  - Mother treated violently
  - Substance Abuse
  - Divorce

Source: Centers for Disease Control and Prevention; Credit: Robert Wood Johnson Foundation
Adverse Childhood Experiences (cont’d)

- Physical abuse
- Emotional abuse or neglect
- Sexual abuse
- Substance abuse in the household
- Incarcerated household member
- Household member with mental illness
- Mother treated violently
- Parental separation or divorce
Suicide

- Approximately 90% of children and adolescents who commit suicide have a mental disorder.
- States spend nearly $1 billion annually on medical costs associated with completed suicides and suicide attempts by youth up to 20 years of age.

Higher Health Care Utilization

- Youth that are experiencing emotional and behavioral problems, or with higher levels of psychosocial distress, are likely to be more frequent visitors to their primary care provider.
- When youth go untreated for mental illness, they use more health care services and incur higher health care costs in their adult years than others their age.
Consequences of Untreated Mental Illness in Children and Adolescents (continued)

School Failure
• Approximately 50% of students age 14 and older who suffer from mental illness drop out of high school; this is the highest dropout rate of any disability group.

Juvenile and Criminal Justice Involvement
• Many youth with unidentified and untreated mental illness also end up in jails and prisons. 65% of boys and 75% of girls in juvenile detention suffer from mental illness.

Long Term Disability
• Mental illness is the 2nd leading cause of disability and premature mortality in the U.S.
Impact on Primary Care

“By 2020-2030, it is estimated that up to 40% of patient visits to pediatricians will involve long-term chronic disease management of physical and psychological/behavioral conditions.”

“In 2020 pediatricians have a wider array of skills including more in-depth knowledge of, and comfort treating, behavioral, developmental, and mental health concerns. Medical education includes mental health interventions, which are now an established aspect of pediatric care.”

-AAP Task Force on the Vision of Pediatrics 2020
Barriers to Enhancing MH Care in Primary Care Settings:

- Ambivalence / variability
- Discomfort
- Time constraints
- Poor payment
- Variable access to MH specialty resources
- Administrative barriers to MH services
- Limited information exchange with MH specialists
- Children and families’ reluctance to seek MH specialty care
Impact on Families

- Families are completely unprepared to have Mental Illness (MI) hit - the topic alone is loaded – stigma, blame and shame.

- The path from onset to acceptance of MI in a child can be long and difficult.

- The diagnosis impacts the whole family.

- There are predictable stages of emotional reaction for families.
Impact on Families (continued)

- Parents often miss or leave work – get called to come and pick up their child.

- Families face challenges in finding resources to help them cope.

- Families are often isolated and feel very alone when their child is diagnosed with a mental illness.
Service Gaps in Mental/Behavioral Health Care Services

Identification:
- Less than 50% of children & adolescents receive developmental & psychosocial surveillance
  - 20% - 40% identified in primary care (Kessler; Dulcan)

Referral and treatment:
- 70% of children/adolescents in need of treatment do not receive mental health services

Infrastructure:
- No system in place to track & follow chronic problems
- Lack of community-based coordination hinders access to care
Integrating Mental/Behavioral Health into Pediatric Primary Care for Young Children and Families
7 reasons supporting integration of mental health treatment into primary care:

- Burden of mental illness is great
- Mental & physical health problems interwoven
- Enormous treatment gap for mental health issues
- Primary care settings for mental health services enhance access
- Delivering mental health services in primary care settings reduces stigma & discrimination
- Treatment of mental health disorders in primary care settings is cost-effective
- The majority of people with mental health disorders treated in collaborative primary care have good outcomes
“The Primary Care Advantage”

Treat mental health disorders where the patient feels most comfortable receiving care

- Better coordination of care
- Mind and body connection
- Physical health is comorbid with mental health
- More likely to keep appointments where multiple issues are being addressed
- The majority of mental health treatment will occur in community health settings- with focus on preventive care and integration.
“The Primary Care Advantage” (continued)

- Longitudinal, trusting relationship
- Family centeredness
- Unique opportunities for prevention & anticipatory guidance
- Understanding of common social-emotional & learning issues in context of development
- Experience in coordinating w/specialists in care of children & youth w/ special health care needs (CYSHCN)
- Familiarity with chronic care principles & practice improvement methods
- Comfort with diagnostic uncertainty (e.g., fever)
Promotion Opportunities Within the Clinical Setting

- Encourage families to consider emotional development prior to visit (by using questionnaires, DVDs, newsletters, community events, parent groups, etc.)
- Develop or promote a mental health section on your website (include questions, facts, resources, etc.)
- Hang posters and other materials to help reduce stigma on mental/behavioral health disorders, and encourage families to ask about a child’s social-emotional health as well as physical health.
Pediatricians have many opportunities to identify mental/behavioral health and substance use issues throughout the relationship with their patients

- Via anticipatory guidance, standardized screening, promoting positive parenting, connecting families to treatment, interventions, community support and resource referrals, etc.
Currently 9 Hubs in NJ:

- To date, **412** providers in **8 Hubs across 20 counties** are participating in the PPC
- **Child/Adolescent Psychiatry** for consultative support
- **Psychologist/social worker** helps arrange appropriate services, evaluation for urgent cases
- **Assessment and evaluation** occur at no cost to family *(sliding scale for services – after initial consult)*

The Pediatric Psychiatry Collaborative “Hubs” in New Jersey
The PPC’s First 2 Years

Participation \textit{(to date)}:

- \textbf{412} primary care providers across \textbf{20 counties}
- \textbf{67,931} patients screened by primary care providers for mental/behavioral issues
- \textbf{3,588} mental health consultation services provided by the Hubs
  - \textit{Less than 13\% of consultations led to medication being prescribed.}
  - \textit{Most referrals were for some of the following needs: parent guidance, community referral, behavioral health consult, school guidance, diagnostic clarification.}
Parent/Family Perspective

“I was fortunate that when I spoke with my pediatrician again, he told me about the Cooper Hub and explained to me that he could put in a request to seek assistance from them regarding Stephen’s anxiety disorder. **Within two weeks of putting in the referral**, I had a call from a wonderful post-doctoral fellow telling me they were working on finding a local resources and a mental health provider in my network. **I soon received an email from the Hub with information for a psychologist who was in my network and could see Stephen for therapy.**

– Amy Kratchman
QUESTIONS?