The Hawai‘i Child and Adolescent Psychiatry Resources for Primary Care: An Evidence-Informed Tool to Improve Quality of Care

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Abstract

Mental health continues to be a significant concern both globally and locally in Hawai‘i, with nearly half of all mental illness beginning in childhood or adolescence. A shortage of mental health providers has led to less than a third of patients receiving appropriate and timely care. Primary care providers are often the first-line responders to untreated mental health conditions, but they are often underprepared to address these conditions. To help provide guidance to primary care providers and other first-line responders, a child and adolescent mental health resource manual was developed, that is tailored to Hawai‘i. This manual was presented at several pediatric didactic sessions and general conferences to describe its evolution, utility, to elicit feedback, as well as for an initial distribution. While feedback was overall positive, future manual development and strategic updates will be made to insure its suitability and timeliness, while continuing circulation efforts to primary care providers will ultimately benefit a greater proportion of children in need.

Keywords

Adolescent, child, mental health, primary care

Abbreviations

JABSOM = John A. Burns School of Medicine
PCP = Primary care provider

Introduction

Pediatric Mental Illness and Access to Psychiatric Care

In the United States, mental health conditions, defined as conditions affecting mood, thoughts, and behavior, affect about 20% of youth with about half occurring in childhood (<12 years of age) and the other half with an onset during adolescence.[1] Less than one-third of those in need, receive appropriate and timely care, in large part due to the shortage of mental health providers.[2] Compounded by stigma, these conditions, left untreated, worsen with time and affect both mortality and disability among children and adolescents.[3] Untreated and undertreated mental illness contributes to about one-third of excess cost and waste in our national health care system.[4]

In Hawai‘i, the staggering shortage of mental health providers is further magnified by the dearth of psychiatrists on the neighbor islands.[5] Although the prevalence of these conditions in Hawai‘i is consistent with those across the country,[6] ethnic and socioeconomic disparities unique to the islands further compound this problem, as demonstrated by Andrade and colleagues.[7] Common disorders in childhood include attention-deficit/hyperactivity disorder, anxiety, autism spectrum disorders, bipolar disorders, depression, eating disorders, disruptive behavior, and substance use disorders. Locally, Native Hawaiian youth had significantly higher rates of any psychiatric disorder (32.7%) when compared with non-Hawaiian youth (23.7%). This was due to significantly different anxiety disorder rates in Native Hawaiian.[7] Furthermore, Youth Risk Behavior Survey studies from 1999–2009 show that Native Hawaiian and Pacific Islander youth self-reported the highest rates of suicide-related behaviors, including but not limited to depression, and suicide attempts.[8] Native Hawaiians are more likely to live on the neighbor islands and rural parts of O‘ahu, isolated from mental health resources. Proportionally, more youth from these rural communities present to emergency rooms for treatment of mood and anxiety disorders, with discharge to outpatient services or transferred to inpatient care than youth residing in urban and suburban areas.[9]

Role of Primary Care Providers

Primary care providers (PCPs) are critical to the care of youth with mental illness, particularly on the neighbor islands, as they are often the first-line responders to untreated mental health conditions. Only about 20% of medical centers in Hawai‘i have access to onsite psychiatric consultation,[10] so providing opportunities for education and training of mental health conditions is crucial to improving patient care in emergency settings.[11] However, PCPs can feel pressured or unprepared to address complex psychiatric conditions and in prescribing psychotropic treatments. Indeed, professional isolation is a constant challenge and stressor in rural settings when providing care for complex patients, which can lead to physician burnout.[12]

PCPs who feel competent in suicide prevention are more willing to assess and treat suicidal patients in health care and community settings.[13-14] One goal of the National Strategy for Suicide Prevention is to increase the proportion of health care providers who receive training in the assessment and management of patients with risk of death by suicide. Indeed, this can be greatly reduced by 20%-70% via training of community-based mental health providers by recognizing and responding appropriately to suicidal individuals.[15-16]

The Department of Psychiatry within the University of Hawai'i's John A. Burns School of Medicine (JABSOM) has taken a leadership role in ensuring education and training needs are met in community and clinical settings with tangible benefits as physician education in suicide prevention has been shown to reduce suicide rates.[9,17] The DOP has also been involved in pilot programs involving behavioral health care integration in rural primary care settings in Hawai'i and elsewhere in the Pacific.[12,18] However, even for these pilot programs, structured to enhance accessibility of psychiatric expertise in rural primary care settings and provide real-time psychiatric consultation and supervision/training for PCPs, a need for accessible, relevant, up-to-date, and evidence-based resource manuals remains.

Methods

This quality improvement project was conducted by the Chief Fellows in child and adolescent psychiatry. The project goal was to develop and disseminate a handbook for PCPs to guide triage and psychiatric safety issues, manage basic psychiatric conditions, and recognize when to obtain specialized guidance for more complex psychiatric conditions. The goal was to mitigate some of the professional isolation experienced by PCPs in order to embolden them to approach mental health conditions with more confidence, as well as to offer their patients recommendations for additional community resources.

The manual was based on a similar publication from Seattle Children's Hospital, which focused on conditions that their primary care colleagues often sought guidance with.[19] The resources were tailored to those conditions considered relevant, as well as the appropriate resources available in the state and in the nation. Although the Chief Fellows did not engage the PCPs in the creation of this manual, the experience working with PCPs over time, especially those unfamiliar with managing basic psychiatric conditions and subsequently seeking appropriate resources, informed the writing group with the content and overall dimension of the manual. In order to compile a manual of resources, the authors looked to our training program for expertise as the training program included various sites that worked specifically with child populations, and the treatment teams consisted of members from various disciplines. The treatment teams included health care professionals in the community, such as social workers, researchers, and child and adolescent psychiatrists (both in practice and in training). Several questions were informally asked of them regarding the resource information they thought would be helpful to a PCP looking for guidance in managing mental health care needs. After integrating the catalogued resource information with the treatment guidelines, the Hawai'i Child and Adolescent Psychiatric Resources for Primary Care Manual was completed. The University of Hawai'i's Institutional Review Board acknowledged the project as quality improvement rather than research. Therefore, no formal review approval was necessary. The principles outlined in the Declaration of Helsinki and the Belmont Report were followed.

Results

The Hawai'i Child and Adolescent Psychiatry Resources for Primary Care Manual includes sections on how to access a provider, how to access community resources (eg, Hawai'i State Department of Health Child and Adolescent Mental Health Division and affiliated Family Guidance Centers), and a basic safety assessment tool called the "Crisis Intervention and Prevention" flowchart (Figure 1). For the most common pediatric mental health complaints presenting to the PCP, diagnosis and treatment flow charts as well as affiliated local and national resources are included. This is in alignment with the flow charts of the Seattle Children's Partnership Access Line, which created a similar guide specific for the Washington State area.[19] The manual included multiple mental health disorders: attention-deficit/hyperactivity disorder, anxiety, anxiety spectrum disorders, bipolar disorder, depression, disruptive behavior, and substance use disorder. The manual is available on the DOP JABSOM website under the resources tab. The manual also includes case presentations to inform the PCP. An example case involves a PCP with a 14-year-old patient seen in the office with suicidal ideation in the context of depression. The PCP, using the crisis flowsheet shown in Figure 1, and other resources included in the manual, determines the necessity for emergency intervention based on the presenting risk factors. If the risk is low, the PCP is guided with an additional flowsheet detailing medication treatment options, scales for further assessments, as well as community resources appropriate for individuals with depression. Conversely, if initial primary care driven interventions are insufficient, PCPs are also provided with information regarding how to refer a patient for more specialized psychiatric care services.

This manual was first presented at the annual Hawai'i Association of Osteopathic Physicians and Surgeons Conference in March 2017, and subsequently as an in-service at JABSOM, a Department of Pediatrics presentation lecture, and a Continuing Medical Education luncheon at the Queen's Medical Center. In addition to providing an overview of the manual, these presentations were held, in part, to elicit feedback for improvement. The audiences were chosen based on the desire to address a wide spectrum of PCPs, including general pediatricians affiliated with the 2 major community hospitals in Honolulu. To be sure, these providers are often first-line physicians involved in managing mental health conditions, who are also tasked with determining whether additional referrals to specific mental health providers are needed. After presenting the overview of the content and instruction on the use of the manual followed by a question and answer period, the manual was available for immediate distribution. The writing team did not systematically catalogue any formal feedback, nor did they seek or receive critiques of the manual after the distribution. Nevertheless, the response from PCP's in the community was perceived as very positive, and the authors will formally solicit feedback in the future to inform future editions. This manual has also been used as a resource for medical students' psychiatry clerkship, general

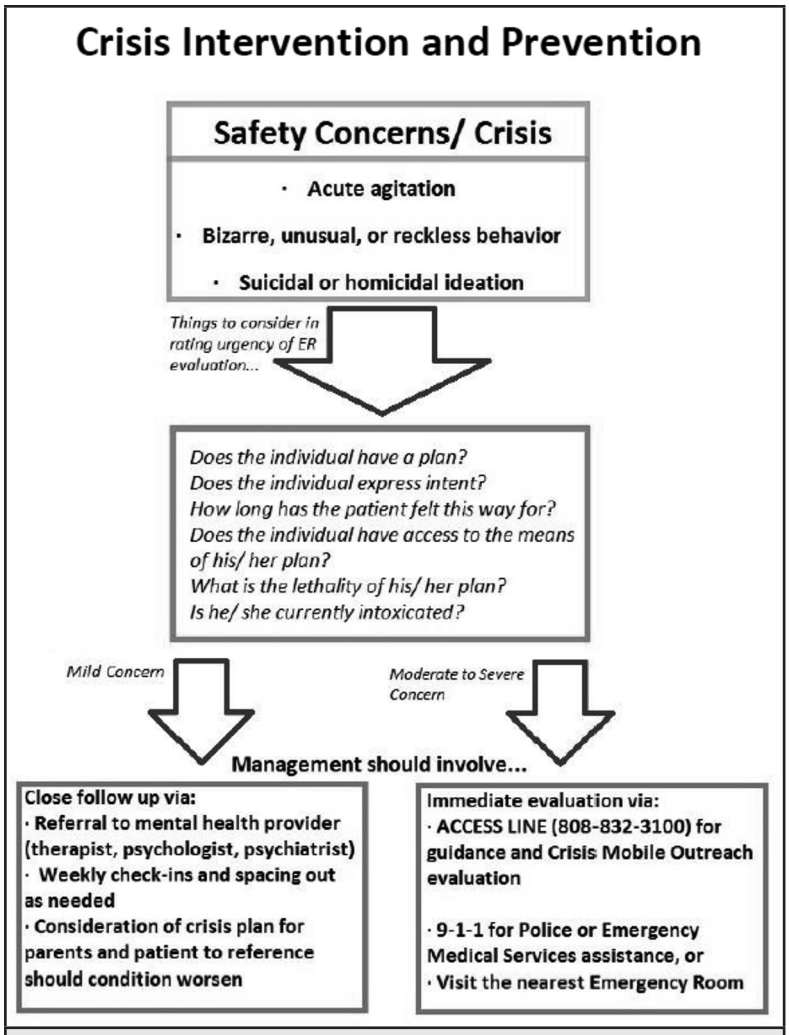

Figure 1. Flowchart of Crisis Intervention and Prevention in Assessment of Need for Emergency Room (ER) Evaluation

psychiatry residents, and child and adolescent psychiatry fellows while rotating through the inpatient child and adolescent psychiatry unit. The document is will be updated annually or as best practices evolve. The process will be managed by the original author who is a practicing psychiatrist (RSL) engaged in both inpatient and outpatient psychiatric care.

Discussion

Feedback from the local practitioners was positive over the utility of the manual, while acknowledging its primary focus on Hawai‘i. Indeed, the intended use in our local community guided the selection of content, tailored to medical practitioners in the state of Hawai‘i as well as concentrating on identifying appropriate health care resources. A manual applicable to a nationwide audience would also be of value. To be sure, the broader distribution would result in assisting PCPs globally in providing greater access to those seeking mental health services. Finally, the utility of formal user feedback may be exploited to inform future updates in an ongoing adaptation of the handbook's content, as well as an assessment tool of its usefulness. In this context, the utility of the manual may also be linked to numerous longitudinal assessment measures, including increased health care quality, increased accessibility, improved timeliness of diagnosis and treatment, established cost effectiveness (as assesed through rates of psychiatric hospitalizations and emergency visits), and decreased suicide and violence rates in the community.

Conflict of Interest

None of the authors identify any conflict of interest.

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