Program Increases Mental Health Access in Mass.

BY DENISE NAPOLI

FROM PEDIATRICS

A state-funded initiative to offer free mental health consultations to pediatric primary care physicians increased the proportion of pediatricians who said they were able to meet the needs of their psychiatric patients from 8% to 63% in 3.5 years.

Indeed, the program's success means it could offer a model for how to at least temporarily increase access to psychiatric care among children and adolescents. The initiative, known as the Massachusetts Child Psychiatry Access Project (MCPAP), began in July 2005 with the goal of increasing access to mental health services among pediatric patients (Pediatrics 2010 Nov. 8 [doi:10.1542/peds.2009-1340]).

According to Dr. Barry Sarvet, medical director of the Baystate Medical Center MCPAP site in Springfield as well as the lead author of the study, the program divided the state of Massachusetts into six regions. Each region was serviced by one team of at least one child psychiatrist, one child and family psychotherapist, and one care coordinator. Each team was tasked with providing "immediate informal telephonic consultation" to the primary care clinicians (PCCs) in its region; timely, as-needed formal outpatient consultations; assistance in coordinating community mental health services; and also "continuing professional education regarding children's mental health designed specifically for PCCs."

At enrollment, PCCs were asked to complete a survey asking about their satisfaction with current mental health resources and access to mental health care for their patients; 514 providers filled this out. Of these, 385 completed a similar follow-up survey in 2008 or 2009.

"By the end of 2008, 353 practices including 1,341 PCCs were oriented and voluntarily enrolled to participate in the program," wrote Dr. Sarvet, who is also chief of child and adolescent psychiatry at Baystate Medical Center and associate clinical professor of psychiatry at Tufts University, Boston, and his associates. The participating practices serviced an estimated 1.36 million children and adolescents, which represented 95% of the child/adolescent population of Massachusetts.

Regarding the first duty of the teams – to provide telephone consultation to PCCs in their region – by Dec. 31, 2008, the six teams had logged 14,174 phone calls, mostly for diagnostic assistance (34%), information about resources in the community (27%), and medication questions (27%), they said.

Many of these initial phone calls led to an outpatient consultation for the patient with the MCPAP team's psychiatrist or an advanced practice registered nurse (combined, 28%) or psychotherapist (15%). However, based on these calls, many patients (24%) also simply continued receiving care through their PCC. The remaining cases resulted in a variety of outcomes, including referral to a community psychiatric crisis center or referral to a psychiatrist in the community.

The MCPAP teams also logged 702 "educational encounters" during the study period, including discussions on child psychiatry with PCCs either at their practices or over the phone, and conducted several day-long and half-day conferences on pediatric mental health topics.

According to the 2008 and 2009 surveys, more than 90% of PCCs either agreed or strongly agreed that their consultations with the MCPAP teams had been useful, Dr. Sarvet and his associates said. Moreover, the percentage of PCCs who agreed or strongly agreed that their patients had adequate access to a child psychiatrist increased from 5% to 33%, while the percentage of PCCs who said that they themselves could meet the psychiatric needs of their patients increased from 8% to 63%.

Finally, the percentage of PCCs who stated that they were able to obtain a child psychiatry consultation in a timely manner increased from 8% to 80%.

"The MCPAP model provides the opportunity to dramatically expand the capacity of the clinical workforce for these children and to make mental health services more accessible for those families who experience barriers to assessment and treatment within the traditional mental health system," they wrote.

And while "the approximate cost of $0.16 per member per month for the operation of the program is by no means insignificant. … reduction in the utilization of acute psychiatric treatment for previously untreated mental health problems may justify this cost," they added.

One of the investigators serves as a consultant to AstraZeneca, is a member of the speakers bureau for Ortho-McNeil Pharmaceutical, and has received a speaker's honorarium from Shire. Another investigator serves as a consultant to Forest Laboratories and GlaxoSmithKline. The other authors indicated they have no financial relationships relevant to this article. ■

VIEW ON THE NEWS

MCPAP Program 'Encouraging'

The MCPAP has been a wonderful tool to increase primary care providers' confidence in recognizing, referring, and treating mental illness in their practice.

My community has embarked upon a similar initiative, modeled on MCPAP, which additionally invites referrals and consultations from schools and uses data about school absenteeism, academic performance, and behavior to determine the functional impact of patients' presenting problems and to monitor their treatment response. Indeed, programs aiming to increase access to specialists and also boost primary care providers' expertise have since cropped up across America. Examples include the Pediatric Psychiatry Network in Ohio and the CentraCare Integrative Behavioral HealthCare Initiative in Minnesota.

Nevertheless, the sobering statistic remains: In most parts of the country, only about 20% of children who need mental health services receive them.

Although these programs represent positive steps toward improving access, more work is needed. Pediatric residents need more training in identifying and managing children with mental health problems – those that rise to the level of disorders, as well as those that are emerging and those that cause problems in functioning without a diagnosable disorder. Educators and other school-based personnel also need to be empowered to collaborate with mental health professionals, and, quite simply, we need more child psychiatrists, especially in rural areas. There are steps that primary care physicians can take immediately to improve mental health outcomes in their practices. The first and most critical of these is to develop an inventory of mental health resources in the community, and to then use it. The second is to access the American Academy of Pediatrics' resources on mental health, located at http://aap.org/mentalhealth. The site also has links to MCPAP-like programs, listed by state, under the heading "collaborative projects," as well as links to other organizations that focus on pediatric mental health.

DR. JANE M. FOY *is professor of pediatrics at Wake Forest University, Winston-Salem, N.C. She is also a former chair of the American Academy of Pediatrics Task Force on Mental Health. She said she had no conflicts of interest relevant to this topic.*

Many Children With RLS Have Psychiatric Comorbidities

BY BRUCE JANCIN

FROM THE ANNUAL MEETING OF THE ASSOCIATED PROFESSIONAL SLEEP SOCIETIES

SAN ANTONIO – Psychiatric comorbidities are present in two-thirds of children with restless legs syndrome, according to a study.

Moreover, multiple psychiatric diagnoses were extremely common in this retrospective study of 376 children aged 2-18 years who met National Institutes of Health consensus criteria for definite or probable restless legs syndrome (RLS). Indeed, boys with RLS were actually more likely to have two or more psychiatric diagnoses than a single one. Multiple psychiatric comorbidities also were quite common in girls with RLS, reported Dr. Samuel J. Pullen of the Mayo Clinic, Rochester, Minn.

Attention-deficit/hyperactivity disorder (ADHD) has been shown in other studies to be common in children with RLS. That was the case in this large series as well, with 1 in 4 of the youths carrying a diagnosis of ADHD.

However, other psychiatric comorbidities were common in these patients, too. This observation constitutes a novel contribution to the field, as previously there has been uncertainty surrounding the rates of psychiatric disorders other than ADHD in children with RLS, according to Dr. Pullen.

Mood disorders were present in 21% of the youths with RLS, anxiety disorders in 12.8%, and disruptive behavior disorder in 10.6%.

ADHD and disruptive behavior disorder were more than twice as frequent in boys as in girls with RLS. Mood disorders were more common in girls.

Two psychiatric diagnoses were present in 27.8% of boys and 19.9% of girls. Three or more psychiatric diagnoses were carried by 15.6% of boys and 7.1% of girls.

Many of the children received multiple trials of psychotropic medications during the course of their treatment. This is concerning, as other studies have linked these drugs to worsening RLS symptoms, Dr. Pullen noted.

The mean serum ferritin level in the study population was 27.8 ng/mL.

Twelve of 15 study participants who underwent psychogenomic profiling displayed genetic derangement at one of three cytochrome P-450 alleles known to be associated with ultrarapid metabolism of psychotropic drugs. This may be associated with increased susceptibility to drug side effects—such as worsening of RLS symptoms. Dr. Pullen indicated that he and his coinvestigators plan further studies of this phenomenon.

The chief take-away point from this 376-patient study, he added, is that sleep specialists should inquire about psychiatric comorbidities in their patients with childhood RLS, while child psychiatrists should ask their patients about symptoms of RLS, a treatable comorbidity.

Dr. Pullen reported having no relevant financial disclosures. ■