GUIDANCE FOR PRIMARY CARE CLINICIANS: MANAGING COMMON MENTAL HEALTH SYMPTOMS IN CHILDREN AND ADOLESCENTS: BACKGROUND

Background

The clinical guidance that follows offers primary-care–friendly pathways to helping children who are experiencing common social-emotional or mental health symptoms. This guidance is intended to fit within the broader context of the American Academy of Pediatrics (AAP) Task Force on Mental Health (TFOMH) clinical algorithms report, which outlines a process for providing mental health* services in the primary care setting and provides algorithms to illustrate that process.

A critical, overarching principle of the process envisioned by the TFOMH is awareness of the fact that children and families faced with a social-emotional, mental health, or substance abuse problem may or may not be ready to see the problem as "mental health" related or to seek or accept the primary care clinician's help. The problem may have been first identified through the screening or surveillance process at the time of a routine health supervision visit; it may have presented as a somatic complaint at an acute care visit; or it may surface as poor school performance or attendance, or as conflict with peers or authority figures. The problem may have caused conflict and anger within the family and differing ideas about its cause or management. It may be viewed by the family as a manifestation of the child's willful personality, laziness, or character flaw; it may be viewed by an adolescent as the parents' unrealistic expectations or need for control. The child and family may feel stigmatized by having a mental health problem. They may have negative perceptions about the value of mental health therapy.

Primary care clinicians cannot expect successful outcomes if they approach mental health problems prescriptively, as they do infectious diseases or injuries. Fewer than half of referrals for mental health treatment are kept,[1] and fewer than half of children who start mental health treatment finish.[2] Successful treatment of mental health problems in primary care—or successful referral for mental health treatment—depends first on the clinician's engaging the child and family, reaching agreement on the nature of the problem (not necessarily a diagnosis), reaching agreement on what to do and when to do it, and creating an affective bond between the child and family and the clinician, a sense of trust, optimism, and relief. In the literature of mental health, this is known as a *therapeutic alliance. The quality of this alliance predicts outcome over and above any specific treatment, including medication.*[3,4]

Techniques to build this therapeutic alliance are core skills—*common factors* in effective mental health practice addressing a wide range of mental health conditions.[5] They are readily acquired by experienced primary care clinicians[6,7] who typically have longitudinal and trusting relationships with the children and families in their care. The TFOMH has described them using the mnemonic HELP, explained in this section of the toolkit. Application of these techniques will necessarily precede primary care assessment and be woven into any interventions the clinician seeks to implement or referrals made.

The AAP TFOMH offers the following general guidance to primary care clinicians in making decisions about their role in assessment and treatment of pediatric mental health problems:

Children Younger Than 5 Years

If a child younger than 5 years has emotional or behavioral problems that do not respond to initial interventions, the primary care clinician should consider referring the child for an assessment by a developmental-behavioral pediatrician, a mental health specialist with expertise in early childhood, a specific professional (eg, speech pathologist), or a developmental evaluation team. Every community has an agency assigned by the state to provide Early Intervention (EI) services to children from birth to age 2 years, 11 months with developmental problems; some states also extend EI services to children at risk for developmental

*The term *mental* throughout this statement is intended to encompass *behavioral, neurodevelopmental, psychiatric, psychological, emotional,* and *substance abuse,* as well as adjustment to stressors such as child abuse and neglect, foster care, separation or divorce of parents, domestic violence, parental or family mental health issues, natural disasters, school crises, military deployment of children's loved ones, and the grief and loss accompanying any of these issues or the illness or death of family members. It also encompasses somatic manifestations of mental health issues such as fatigue, headaches, eating disorders, and functional gastrointestinal symptoms. This is not to suggest that the full range or severity of all mental health problems is primarily managed by pediatric primary care clinicians, but rather that children and adolescents may suffer from the full range and severity of mental health conditions and psychosocial stressors. As such, children with mental health needs, like children with special physical and developmental needs, are children for whom pediatricians, family physicians, pediatric nurse practitioners, and physician assistants provide a medical home.

problems. In many states, another agency, such as the public school system, is responsible for assessment, care coordination, and education of children aged 3 to 5 years. Examples of problems requiring further evaluation by one of these resources include disordered parent-child relationship, parental mental illness, language or communication delay, very disruptive behavior with aggression, abuse or neglect of the child, and self-injury. Even if the decision is to refer, the primary care clinician can offer interventions to manage acute symptoms and decrease the family's distress while awaiting specialty care. The guidance that follows can be used for this purpose.

See "Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice" for a discussion of evidence-based interventions for infants and young children, their parents, and caregivers. When community resources are insufficient or ineffective, primary care clinicians can partner with developmental-behavioral pediatricians, early childhood educators, parent educators, and mental health providers to build or strengthen the critically important service system for this population.

Children and Adolescents 5 to 21 Years of Age

Primary care clinicians should consider referring to a mental health specialist for further evaluation children and adolescents aged 5 to 21 years with one or more of the following problems:

- Suicidal intent
- Severe functional impairment
- Rapid cycling mood
- Depressive symptoms in a preadolescent
- Extreme outbursts or problems with conduct
- Severe eating problems
- Psychotic thoughts or behavior
- Self-injury
- Comorbidity of substance abuse and mental health problems
- Attention-deficit/hyperactivity disorder with comorbidities
- Any other problem the clinician does not feel prepared to address

Again, even if the decision is to refer, the primary care clinician can offer interventions to manage acute symptoms and decrease the family's distress while awaiting specialty care. The guidance that follows can be used for this purpose.

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