



Variables Effecting Primary Care Physicians' Treatment of Children's Psychosocial Problems

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Although much of the research on children's mental health issues is related to specialized treatments or services, most children with psychosocial problems are diagnosed and treated by primary care physicians rather than mental health specialists. The research presented in this article examines relationships between primary care physician treatment choices (medication, referral for mental health treatment, and/or counseling by the physician during the office visit) and four domains of variables: patient attributes, clinician attributes, the clinician-patient relationship, and context and method factors (e.g. seasonal and geographic differences). Importantly, results revealed that physicians' perception of families' agreement with their children's diagnoses and treatments was significantly associated with physicians' final treatment choice decisions.

The sample for this study included 401 primary care family physicians in 44 U.S. states. Physicians, who each enrolled a sample of approximately 55 children between the ages of 4 and 15, were part of two primary care research networks: Pediatric Research in Office Settings (PROS) and the Ambulatory Sentinel Practice Network (ASPN). The final sample consisted of 21,150, primarily male (64%) children with a mean age of 8.8, who made non-emergency office visits. Clinicians identified a total of 4,012 (19%) of these youth as having a psychosocial problem. Among youth with psychosocial difficulties, the authors further distinguished between those who had previously received mental health services (1,394; 35%) and those who had not (2,618; 65%), because they believed that physicians might make different treatment decisions for children who were already receiving specialty services. The primary analysis examined the sample of 2,618 youth with psychosocial difficulties who had not previously received mental health services to identify factors associated with whether clinicians chose to counsel, medicate, and/or refer youth to a mental health specialist. Factors included child and family demographics, type of insurance, child and family problems, clinician demographics and training, type of clinician practice, clinician-patient relationship, type of office visit, season in which the visit was made, and geographical location. Data was gathered through questionnaires administered to clinicians and parents. Results revealed significant associations between several factors and the three types of treatment clinicians provided, as described below.

Factors related to counseling:

Clinicians were more likely to provide counseling to families whose child exhibited physical symptoms of a psychosocial problem (e.g. enuresis, sleeplessness) and/or whose child was younger. Clinicians were also more likely to counsel children who had been rated by parents as having more symptoms and who were from families with higher stress levels. Clinicians were sensitive to family perspectives; they were significantly less likely to provide counseling if they believed that the family did not agree with their assessment of the problem or treatment choice. Counseling occurred more often when the problem was noticed during the office visit, "suggesting that counseling was a first-line treatment" (p. 5).

Factors related to clinician referrals:

Referrals were associated with more severe parent ratings of child symptoms or higher parent-rated family stress. Children with emotional and behavioral difficulties were more likely to be referred than those without emotional and behavioral difficulties. Youth whose problems were first noticed during the office visit were more frequently referred than those with previously noted problems. Clinicians were more likely to refer when they felt that the family agreed about the problem or with the clinician's decision regarding treatment.



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Factors related to medication:

Analyses related to medication were limited to those youth with attention problems, because only 3% of children without attention problems were prescribed medication. Among youth with attention problems, children who were older were prescribed medication more frequently. Prescriptions were also more frequent for youth who had a previously recognized difficulty, who had slightly more severe parent-rated problems, and/or who made visits during the winter (probably because of more frequent recognition of attention problems by schools this time of year). Similar to counseling and referrals, clinicians were more likely to prescribe if families were in agreement with the diagnosis or treatment recommendation.

Many of the results of this study are encouraging. For instance, among this sample of primary care physicians, clinicians did not seem to make treatment choices based on other variables that were tested, such as children's ethnicity or insurance coverage, education level, or marital status of parents. One of the most salient findings was the importance for physicians of their relationship with parents. Across all three treatment choices (counseling, referral, & medication), clinicians seemed reluctant to choose a treatment without the agreement of families. Counseling emerged as an important treatment choice among physicians in this study, with clinicians more frequently choosing counseling than other treatments when children's problems were first recognized during the current office visit. Taken together, it would appear that process and relationship variables were more important elements of treatment decisions for doctors than system factors, such as physician training, family insurance coverage, and type of physician practice.

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