

Psychiatric Assistance Line

One Solution to the Child and Adolescent Mental Health Crisis

BY TODD ARCHBOLD, LSW, MBA

Having timely access to mental health care is critical for children with psychiatric disorders. Because there is an extreme shortage of child and adolescent psychiatrists in the United States, initial assessment and treatment of children with psychiatric disorders often occurs in the primary care setting. To increase the likelihood of positive health outcomes for these children, primary care physicians need to be better equipped to meet children's mental health needs. One way is to offer them easier access to child and adolescent psychiatrists. The Psychiatric Assistance Line (PAL) is a service that does that. It allows primary care physicians and other clinicians immediate access to child and adolescent psychiatrists so they can either treat the patient in the primary care setting or refer the child to an appropriate specialist. This article describes the service and the extent to which it has been used since its inception in June of 2014.

One in five children in the United States will suffer from a diagnosable mental illness, and approximately 70 percent of them will exhibit symptoms before age 14.¹ A vast majority of these illnesses are highly treatable with appropriate evaluation and intervention. However, because there is a shortage of child and adolescent psychiatrists in this country, young people with psychiatric problems often face lengthy waits for appointments in outpatient settings or must seek care in hospital emergency rooms.

The shortage is more acute in some states than others. For example, Massachusetts has the most practitioners per 100,000 children (21.3 per 100,000), while Alaska has the fewest (3.1 per 100,000). Minnesota, which has approximately 70 board-certified child and adolescent psychiatrists (not all of whom are practicing), has one of the lowest rates, with only 5.8 per 100,000 children.² It is estimated that we would need 350 of these specialists to

adequately meet the needs of the youth in our state.

Because of the shortage of child and adolescent psychiatrists, much of the burden of providing mental health care has shifted to primary care clinicians. These clinicians are prescribing the majority of medications used to treat depression, anxiety and other mood disorders; however, many say they feel ill-equipped to manage patients with complex psychiatric illnesses.³

Psychiatric Consultation

Because they are on the front lines, primary care physicians tend to enjoy positive and trusting relationships with children and their families; have extensive knowledge about child development, allowing them to detect problems early; and work in settings that are not associated with the stigma of behavioral health treatment.⁴ For all those reasons, primary care physicians are often in the best position to assess and treat children with behavioral health issues.

Since the early 2000s, nearly 32 states have experimented with ways to better equip primary care physicians and other clinicians to care for these children. Many have designed programs to extend the reach of child and adolescent psychiatrists. The most well-known of these is the service developed by the Massachusetts Department of Mental Health in 2004. In 2010, the Minnesota Legislature authorized the Department of Human Services (DHS) to establish a similar program, the Minnesota Collaborative Psychiatric Consultation Service. The service, which was composed of five health systems (Mayo Clinic, Essentia Health, Allina Health, Sanford Health and PrairieCare Medical Group), was tasked with providing 1) voluntary and mandatory consultations to primary care physicians by board-certified child and adolescent psychiatrists, 2) clinical mental health triage by a licensed clinical social worker and 3) training on the assessment and treatment of youths with

mental illnesses. Services could be accessed by calling a toll-free number.

The Minnesota Collaborative Psychiatric Consultation Service operated for two years (from August 2012 to May 2014). During that time, it received nearly 1,800 phone calls from clinicians seeking advice regarding young psychiatric patients. However, the majority of calls were from physicians required by a state-funded health plan to call before prescribing a certain medication. The service also provided training in pediatric psychopharmacology to nearly 80 primary care providers statewide.⁵ At the end of its initial two-year period, the members of the collaborative service did not apply for renewal of funding.

A New Model

In June 2014, PrairieCare Medical Group applied for and received a grant from the Minnesota Department of Human Services to run a new service, the Psychiatric Assistance Line (PAL). The biggest difference between PAL and the Minnesota Collaborative Psychiatric Consultation Service is that physicians will not be required to contact PAL.

Before launching PAL, administrators at PrairieCare informally surveyed pediatricians in the Twin Cities metro area to find out about the services they most needed when caring for patients with mental illnesses. The majority said they wanted help with psychotropic medications. Another two-thirds wanted assistance with diagnosing or assessing patients. More than 40 percent wanted help with triage and referrals to behavioral health services. About half said they had “never” or “rarely” had access to child and adolescent psychiatry services.

PAL is designed to provide clinicians with information they need to diagnose and treat young patients with mental health conditions. It is staffed Monday through Friday from 8 a.m. to 5 p.m. by a clinical social worker who has immediate access to a child and adolescent psychiatrist. The psychiatrist’s role is to support the primary care physician and offer suggestions as needed. The social worker pro-

How PAL Works

CASE 1

A 13-year-old female experiences anxiety and panic attacks. She is described as always having been a “worrier” and now avoids school. She is academically advanced, having skipped a grade, and is in an accelerated program. Initial trials of Prozac and Zoloft were unsuccessful. Two weeks ago, she was prescribed citalopram (20 mg) with Atarax. The patient saw a counselor for about 18 months but stopped going last summer. Now, her anxiety is worsening and she showing symptoms of OCD. The caller’s main question: Should we try increasing her Zoloft to 150 mg or try another medication?

Consulting Psychiatrist: Suggests restarting cognitive behavioral therapy and trying Celexa up to 40 mg, if needed. Also discusses temporarily using benzodiazepine while titrating up on the Celexa and/or using Atarax as needed and augmentation with other medications including Intuniv, Neurontin, Abilify/Seroquel or risperidone.

Triage Social Worker: Encourages the family to talk with the school about evaluation for a 504 Plan or Individualized Education Program to address the patient’s problems at school. Provides information about the University of Minnesota’s Anxiety Clinic.

CASE 2

An 8-year-old male with ADHD, dyslexia and anxiety has been through a number of medication trials. The patient has tried Dexedrine, Strattera and Intuniv and has been taking citalopram for a month. The parent reports that the child “lost control” on the last three medications—yelling, screaming, etc. He even displayed those behaviors in the pediatrician’s office. He has experienced similar problems at school and is currently in a setting III special education program. The caller’s main questions: What should we try next? Are other services needed, if medications are unsuccessful? Should the patient see a psychiatrist?

Consulting Psychiatrist: Notes reactivity to and some benefit from previous stimulant trials. Reviews multiple medication options and suggested Abilify, then revisited stimulant options. Reviews risks, side effects and benefits of low-dose Abilify or Seroquel at bedtime, then revisits using Dexedrine or an alternative stimulant.

Triage Social Worker: Suggests skills program through local counseling center and/or through special education. If medication changes are unsuccessful, will help set up psychiatry appointment.

CASE 3

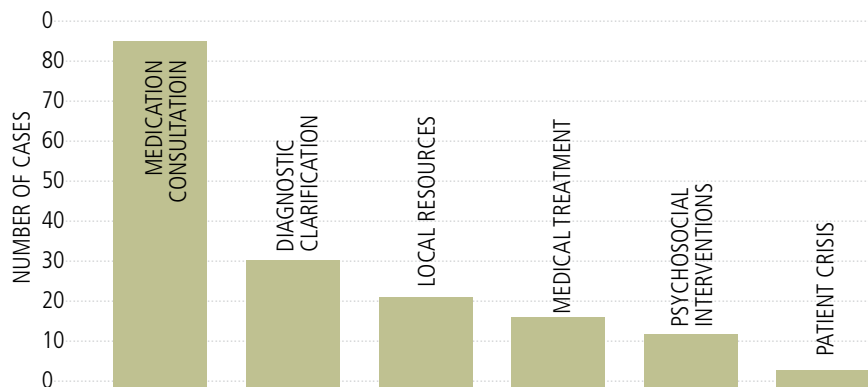
A 4-year-old male has been diagnosed with PTSD after multiple hospitalizations for urethral surgery. The patient just finished a month-long hospital stay and panics as soon as it gets dark. He will not sleep at night. In addition, he goes into flight mode when buckled into a car seat or high chair. Neither clonidine nor melatonin has helped. The child weighs 36 pounds and naps one to two hours a day.

Consulting Psychiatrist: Discusses changing clonidine doses and possibly using the drug during day. Suggests Vistaril as needed at bedtime (can repeat dose if child wakes during the night). Notes that trials of antihistamine and/or alpha agonist may be helpful as well.

Social Worker: Offers referrals for therapy, including play therapy, or hospital services that help kids who have had traumatic medical experiences.

FIGURE 1

Reason for Consultation



vides assistance with triage and referrals (see “How PAL Works”).

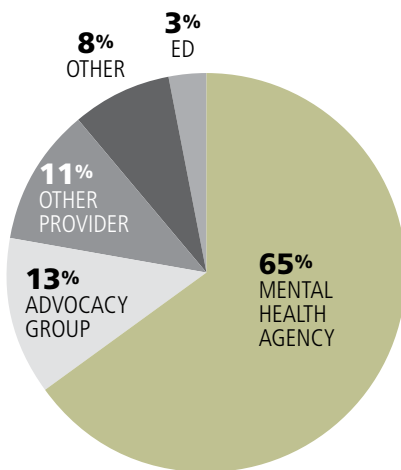
To assess whether this new effort is effective, the Department of Human Services is tracking data on the service. In its first six months, PAL received 100 calls. More than 60% of callers called the service; 40% accessed it on line. Seventy-three percent of those who used it were pediatricians; 6% were family physicians.

The patients they called about ranged in age from 3 years to 39 years. (Although PAL is intended for physicians treating youths, the psychiatrists who staff the line are also knowledgeable about treating adults.) Fifty-nine percent were male and 41% female. The most common working diagnosis has been anxiety, followed by depression and ADHD.

Almost all of the callers cited multiple reasons for their calls, with a majority wanting answers to questions about a medication protocol for a specific patient (Figure 1). The majority of the calls lasted 10 to 20 minutes and the most common suggestion was a medication change. In only one case did the consulting psychiatrist recommend discontinuing a particular medication. Also, nonmedication therapy was recommended in almost every case, if the patient wasn’t already seeing a therapist. Other calls involved recommendations for medication titrations, tapers and changes in dosing times or frequency. In two cases, the social worker recommended a referral to an emergency department. Of the referrals made through PAL,

FIGURE 2

Where Referrals Were Made



65% were to a mental health agency, 13% to an advocacy group and 11% to another type of provider (Figure 2).

In its first six months, PAL served 74 clinicians from 41 clinics. It is on target to provide more than 300 consultations in its first year. After each consultation, callers are asked to complete a brief survey. Thus far, 100% of respondents have stated they felt the consultation was helpful, and 98% said they felt more confident in their ability to manage psychiatric conditions after talking to an expert.

Conclusion

The Psychiatric Assistance Line already has empowered primary care providers to treat psychiatric conditions in children and

adolescents. We believe it is an efficient, cost-effective way to meet a tremendous need. When pediatricians, family physicians and their staffs can effectively manage their patients’ mental health problems in the primary care setting, children and their families are better served and child and adolescent psychiatrists can focus on treating those patients with the most complex problems. If children are to have adequate and timely mental health care, innovations such as PAL must be available and used. **MM**

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The Psychiatric Assistance Line can be accessed by calling 855-431-6468 or online at www.mnpsychconsult.com. Online inquiries are answered via secure email.



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The Minnesota Medical Association (MMA), the Steve Rummeler Hope Foundation (SRHF), and the University of Minnesota Medical School began a collaboration to bring medical education on the topic of opioids to medical students, residents, and practicing doctors. The lectures are recorded live at the University of Minnesota Medical School and made available for CME on the MMA website, with underwriting by the SRHF. The hope of the series is to create a medical curriculum on pain, opioids, and addiction, as it should be in a medical school setting: balanced, practical, evidence-based information free of commercial bias.

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VIDEO 2: "An Editorial on Pain"

Bret Haake, MD, MBA, HealthPartners Medical Group, Regions Hospital

VIDEO 3: "Pain Psychology, Mental Status Exam, and Non-Opioid Options for High Risk Patients"

Charles Reznikoff, MD, Division of Addiction Medicine, Hennepin County Medical Center, Assistant Professor of Medicine, University of Minnesota Medical School

Adeya Richmond, PhD, LP, Senior Clinical Psychologist, Psychology Department, Hennepin County Medical Center

Sebastian Ksionski, MD, Pain Program/CMC Director, Hennepin County Medical Center

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