BASSETT/HOPKINS PROGRAM IN MENTAL HEALTH COMMUNICATION SKILLS FOR CHILD AND ADOLESCENT PRIMARY CARE PRACTITIONERS

Introduction: This module is comprised of text and accompanying short video vignettes designed to assist the pediatric clinician in sharpening skills in working with patients and families who present with mental health concerns. The video vignettes are linked to You Tube.

Background

- 10-20% of children/youth have mental health problems- an additional 16% or more of children and adolescents have an impairment in mental health functioning but do not meet the criteria for a disorder
- The average pediatrician sees 127 patients per week (27 have a mental health condition with impaired function/ 19 will have impaired function without meeting criteria for a disorder/ 36% of patients seen weekly may have impairment of functioning related to a mental health concern- over 1/3 seen)
- Less than half of these patients get mental health services and of those that do, most receive their mental health services from primary care clinicians and from schools

Pediatric primary care is a great resource for mental health

- Pediatric practitioners have expertise in development and can differentiate between age appropriate and age inappropriate behaviors
- Pediatric practitioners are positioned for early identification of problems
- Pediatric providers have the ability to deliver episodic/pulsed care
- Longitudinal relationships have the capacity to build trust
- Mental health is contextualized via the whole child rather than isolated to mental health

The therapeutic alliance: what does the primary care clinician offer to patients and families?

Someone who:

- is warm, supportive and listens
- is non-judgmental and respectful
- collaborates and is a "catalyst" for change, not a "cattle-prod"
- offers a safe platform for the patient and family to struggle with change
- remains available

Training objectives:

- To help pediatric primary care providers:
  - Efficiently uncover and clarify mental health concerns in the course of short regular visits and also in comprehensive behavioral visits

- Use a model of Connect/ Concerns/Create/Conclude to efficiently and collaboratively elicit concerns and develop a plan of action
- Help clinicians to address special situations including:
  -- Patients who are stuck
  -- Patients who are resistant
  -- Patients who disagree with each other
  -- Patients who are angry at you
  -- Patients who feel coerced into seeking mental health assistance

CONNECT/CONCERNS/CREATE/ CONCLUDE:
What can you manage in a 15 minute mental health encounter?

- **CONNECT**: Let patients know that their concerns have been heard and understood and reduce the level of conflict and concern (at least temporarily) through your response to the patient
- **CONCERNS (CRISIS?)**: Elicit major concerns and identify emergencies and crises
- **CREATE A PLAN**: Develop a preliminary plan of action
- **CONCLUDE**: What happens next? (e.g emergency or crisis intervention, behavioral plan, simple contract, referral, follow up visit)

- General Thoughts
  -- The 15 minute visit is a familiar concept to pediatric primary care practitioners
  -- This approach utilizes familiar pediatric advice and counselling techniques

What can you manage in a longer 45-60 minute comprehensive visit?

-- The above schema can also be used if the patient returns for a more comprehensive behavioral visit

-- When conducting a comprehensive visit, the clinician needs to decide whether to take a *problem focused approach* (see Behavioral Interview module) or if there is significant family conflict, the clinician may wish to take a *family focused approach* as outlined in full detail in this module.

I). Problem Focused Visit

A) A *problem focused* visit may be the appropriate starting point for dealing with a sleep problem or elimination problem. The connect, concerns, create, conclude model can be utilized. The clinician connects with the patient or family by greeting everyone and actively listening. Concerns are elicited using a more classic symptom focused line of questioning (who, what, where, when, and how often?). A plan of action is created and the visit is concluded with a summary and a sheduled follow up.

B). A more *comprehensive problem focused* diagnostic evaluation may be appropriate if evaluating the child for ADHD or a school problem (see Behavioral Interview module).

Once again the 4 C's model can be used. When eliciting concerns, one may wish to begin with open ended questions followed by more specific questions. A more expansive line of questioning may be required to screen for comorbid conditions. Once again, a plan of action is created and the visit is concluded with a summary.

II). Family Focused Visit

A family focused approach is more appropriate if there is evidence of interpersonal conflict in the family that is contributing to the problem and if the goal is therapeutic intervention.
A family focused approach may:

- uncover significant concerns that may not be revealed in a more problem focused approach
- help to relieve interpersonal conflicts in the family by raising emotional issues and addressing communication difficulties
- increase the likelihood that families will follow through with a referral for mental health consultation by providing an initial platform to bring concerns into clearer focus
- be the appropriate approach if a problem focused approach has not been effective or if the problem is chronic

FAMILY FOCUSED INTERVENTIONS: (also see BI-PED modules on Family Communication Problems and Essential Communication Skills for Pediatric Practitioners)

The video vignettes in the remainder of this module highlight a family focused approach.

CONNECT: Beginning the encounter/ Setting the tone and the agenda for the visit (inclusive turn taking, dealing with interruptions)

A). General Thoughts: Greeting and involving everyone in the visit

- Children typically have little substantive participation
  --When children are involved they are more likely to be adherent to treatment and their parents are more likely to be satisfied with the visit
- Difficulties with family dialogue and feelings of exclusion often underlie or exacerbate many mental health problems- greeting everyone fosters inclusivity

B). Starting from the greeting* (see video #1 Connect- Greeting patients)

- Greet each person individually
- Use each person's name or ask for it
- Offer a handshake or some other appropriate body language
- Maintain a friendly but mid-range tone

* these skills from patient-centered care and family therapy

C). Show you expect to hear from both parties (see video #2

Connect-Taking turns- child and video #3 Connect-Taking turns- teen)

- Actively elicit concerns using open-ended questions ("Tell me about...") / Stay curious
- "I want to make sure I hear from you both
- "Who wants to go first?"
- Use body language that includes all parties

D). Skills when turn-taking is interrupted (see video #4 Connect-Interruption-child and video #5 Connect- Interruption-teen)

- Shift practitioner body language
- Acknowledge and re-direct ("I know you have something to say and everyone will have a chance- but your mother was talking first")
- Reminder of "rules" ("we are taking turns")
- Reinforce the need for mutual respect and consideration ("please let her finish what she was saying and then everyone will listen to you when it is your turn")
- Remind participants that the amount of time for the session is limited and that everyone needs to have time for their input without interruptions
- Consider the status of the person interrupting or being interrupted (it is reasonable to maintain some hierarchy by letting parents go first)

CONCERNS: Eliciting concerns/ dealing with rambling and digression

A) General Thoughts: Getting the full list of concerns

- The first issue broached is frequently not the most important
- Don't presume that the "chief complaint" is the sole reason for the visit (hidden agenda?)
- Try to focus on the emotional issues when eliciting concerns- patients feel "heard" when their emotional concerns have been addressed
- There may not be sufficient time to fully address the concerns and a follow up visit may be required
- Remember that the long term relationship makes the pediatric clinician the appropriate professional to inquire about concerns
- When soliciting concerns, remember that the problem may not have been fully formulated yet by the patient
- The consequences of not getting the agenda fully addressed include:
  --"Doorknob" questions: "By the way…"
  -- Patients may resist or not comply with an off-target plan that does not address the underlying concerns
  -- Family may keep returning with other concerns until the main concerns or hidden agenda have been addressed
- A collaborative approach with all parties participating enhances "buy in"
- While discussing concerns, check to make sure that the main concern is being addressed
- Common issues in agenda setting
  -- Parent and child/youth may have different priorities

-- Family priorities may not be the same as yours'
-- You may want to accomplish more than you have time for!

B). Skills for getting full agenda (see video #6 Eliciting concerns, video #7 Eliciting concerns- Anything else?, video #8 Eliciting concerns- Checking with both parties, video#9 Eliciting concerns- Pick one and video #10 Eliciting concerns- Prioritizing)

- Use open ended questions ("tell me more", "tell me what's going on", "what are your concerns?"), silence, and repeating back of phrases to elicit more details (also see BI-PED module on Essential Communication Skills for the Pediatric Practitioner)
- Try to avoid specific follow-up questions until after the major concerns are elicited
- Check with *all* parties for "anything else?"
- Review the list of concerns
- Ask for priorities ("You have mentioned several concerns—which one should we focus on today?" What is the worst thing going on?' "What is your most important concern?")

C). Dealing with rambling and digression

1) General thoughts

- Digression can be a risk of over use of "open-ended" questions
- Some rambling can be the patient's attempt to formulate the problem
- Your interruptions can help if they promote focus in a gentle non-leading way
- Just when to break in is a matter of your style and the amount of time you have

2.) Skills for dealing with rambling (see video #9 Eliciting concerns- Pick one and video#10 Eliciting concerns- Prioritizing))

- "I want to make sure we don't run out of time…"
- Summarize your understanding and ask for additional concerns
- Specifically ask for the major concern ("Which one of your concerns is the most serious or the most important to address?" "what is your highest priority?")
- "Pick one of your concerns to start with."
- Ask for a specific example

CREATE A PLAN (see video #11 Create a plan- Detailed account and video #12 Creating a plan-Exceptions)

A). General Thoughts

- This the opportunity to brainstorm and generate ideas

- Collaboratively problem solve but let the family take the lead in generating ideas
- It is best to keep plans and goals *specific* and not too vague
- It is best to keep plans and goals *limited* and avoid taking on too much
- Plans generated in the 15 minute session may be more limited and may simply entail planning a referral to a mental health consultant or setting up a follow up visit with you

B). Generating ideas (see video #13 Create a plan- Frame positively, videos #14 and #14A Create a plan- Setting a goal and the Family Communication module in BI-PED)

1) Go over the problems/events in detail and encourage the family to bring up new ideas and to consider new perspectives
2) What was the thing that worked best in the past, even if it was only a little?
3) Ask about exceptions – Was there a time in the past when things were good for just a bit? What was happening then?

C). Operationalizing the plan

1) The desired behavior should be framed as a positive vs. "not doing X" (elicit clear observable behaviors as the goal)

   -- "If I could videotape your home or if I was a fly on the wall, what would I see everybody doing differently that would be a sign of improvement?"

   -- Miracle question: "If I could wave a magic wand, what would you like to see everybody doing differently that would let you know that things have improved?"

   -- "Instead question": "What would you like your son to be doing ***instead*** of yelling at you?"

D). Making goals reasonable (see videos 14 and 14A Create a plan- Setting a goal)

-- People frequently set unattainable goals or goals that are too vague or too ambitious

-- More concrete goals lend themselves to more concrete and easily formulated action

-- Focus on a small change that can be made that would be considered progress

-- There are many familiar metaphors

- Long journey starts with single step
- Little steps uphill, big steps downhill

E). Giving advice

- After the patients have had a chance to generate their own ideas, you may wish to offer additional suggestions
- Ask for permission to provide advice ("I have some thoughts about we have been discussing"… or "some people in similar situations have found certain things to be helpful"… "is it ok if I share some other ideas?")
- Ask the patient for feedback on your ideas

CONCLUDE:

A). Present your impression (see video #15 Conclude- Giving advice)

- Make a clear transition from information gathering to summing up
- Ask parent/child/youth what they think the symptoms might mean or their "diagnosis" of the
- problem
- Try to avoid overuse of medical jargon
- It is reasonable to be honest if your impression is not fully formulated ("I think there is an element of anxiety and attentional problems. It would be helpful to meet again to explore this some more

B). General thoughts (see video #16 Conclude- Readiness to act and video #17 Conclude- Barriers

- In a 15 minute session, seek agreement on a plan for immediate help or for further evaluation
- In a 15 minute session, the plan may be simply referral to a mental health consultant or follow up with you for a more comprehensive session
- In a comprehensive visit, take more time to conclude the session
- Seek agreement from all parties if possible and avoid taking sides (see video 9A Seeking agreement) ("e.g. You may not all agree on all aspects of the plan but are you willing to give it a try?")
- Summarize the plan or have the patient summarize
- Ask about readiness to act ("How ready are you to begin?" "What is your time frame?")
  -- People may be aware of a problem but not yet ready to act on it
- Ask about barriers ("What may get in the way of your enacting the plan?")
- Praise the patients for their hard work
- Be prepared to review successes and failures at a follow up visit or by telephone

Special Situations

I). When patients are stuck*

A). General Thoughts

- Patients may feel stuck and experience a sense of "hopelessness" that may come from anger, depression, and chronic disempowerment
- Hopelessness can result in a distorted view of the problem and a limited search for solutions by the patient
- Provider ideas may be rejected

* These skills come from solution-focused cognitive therapy

B). Managing patients who are stuck: seeing the situation differently/ reframing (see video #18 Patient who is stuck-Seeing it differently)

- Steps to promote a different perspective
  - Listen carefully and empathize (but not necessarily agreeing) with the patient
  - Help the patient to brainstorm and generate new ideas
  - Make "half empty" into "half full" – point out what has been accomplished despite adversity
  - Search for past success and exceptions ("When in the past have things gone well or been better?... what was going on then?")
  - Shift the focus to *something small but possible* rather than a more distant, difficult goal
  - *Reframe* the situation (e.g reframe the hyperactive child as someone who has not learned to sit still ***yet*)**

II. When patients are resistant*

A). General Thoughts

- Patients may become resistant if they:
  -- feel coerced or pushed to do something that they are not ready to do, even if they are interested
  -- feel like they have lost control
  -- are feeling guilt or shame and not prepared to openly share their concerns or feel that they will be judged

- Resistance is evident when the clinician presents solutions and the patient responds with "we have tried everything" or simply rejects the offered solution
- Even the term "resistance" implies that we push the patients and they react – not a collaborative model
- The best treatment is prevention through collaboration: asking permission, getting opinions, offering choices, etc.
- When resistance happens, the goal is to "roll," treat it as normal, present an alternative suggestion and don't push

- "Rolling" does not mean that you give up your leadership role
  -- It does mean acknowledging that the patient and/ or family have control and emphasizing that their agreement and collaboration are necessary

*these skills come from motivational interviewing

B). Managing resistance (see video #19 Resistance-Reflect resistance and wait)

1) General Tips

- Listen carefully: it is possible that the resistance stems from additional underlying concerns that have not yet been raised
- Reflect the resistance and wait for an explanation ("It sounds like you feel strongly about not starting ADHD medication, what are your concerns?")
- Apologize for "getting ahead" of the patient and move the conversation back to an area of comfort (if the subject area is too sensitive, it may be prudent to move on to a different topic)

2). Help patients to feel in control

a). Emphasize choice (video #20 Resistance-Reassure about power to choose)

1). Assure the family that the final decision making and choices are in their hands
-- People fear losing control of the situation
-- Patients may feel that they are prematurely being pushed to make a commitment or that they are being coerced (e.g. by the school, court or social services)

3.) Help patients to address their ambivalence (also see BI-PED module on Motivational Interviewing)

a). Exploring pros and cons (videos #21 and #22 Resistance-Reviewing pros and cons)

- Ask the parent/child to list out the pros and cons (or benefits and costs) of acting or not acting – this approach promotes an internal dialog in the patient rather than the more "clinician talks- patient listens" prescriptive approach
- The goal is *not* to force an immediate decision but to lay out the dilemma and let the patient struggle with their ambivalence
  - Be supportive "I can see why this is so hard for you."
  - Ask "What might it take to turn some of those cons into pros?"
  - Draw a *char*t of the pros and cons with the patient
  - It is often better to refrain from commandeering the encounter and let the patient/ family struggle with their options

b). Puzzle over discrepancy (see video #23 Resistance-Dealing with choice and discrepancy)

- Resistance to intervention (or persistence of maladaptive behavior) often doesn't make sense in light of a parent's or child's stated goals
- Curiously point out and empathize with this ***discrepancy***

("I know that you are feeling conflicted about wanting to treat your child's ADHD but also feeling uncertain about medication" or " I know you want to go to a good college... how does smoking marijuana every day interfere with this plan?")

III.) When patients disagree (also see BI-PED module on Family Communication Problems)

A) General Thoughts

- Arguments:
  - -- take time
  - -- are polarizing
  - -- leave participants and clinician feeling helpless

B). Managing disagreements by normalizing* (see videos #24 and #25 Disagreements- Normalizing)

- Recognize the importance of the issue and, by saying that it is normal/common, suggest that it can be solved ("Oppositional behavior in teens is quite normal and I think we can talk about what is going on and come up with a plan that will work for everybody")
- Shift emphasis from emotions to behavior ("What do you think you might do instead of yelling at your parents?")

* These skills come from family therapy and solution-focused cognitive therapy

C). Managing disagreements by pointing out areas of agreement (see video #26 Disagreements- Finding areas of agreement)

- Suggest that the underlying apparent differences in details are agreement on principles
- Suggest that disagreement actually stems from mutual concern, caring, or respect ("I see that you are frequently arguing but I think at the bottom of all of this, you really care about each other")

D). Avoid taking sides

- This can be difficult if you believe one party is in fact, not being reasonable
- Risks anger from *both* parties
- If you feel that you need to take sides, it may be prudent to speak to each person alone
- Reinforce the need for mutual respect and consideration

E). Responding to emotionally extreme statements (video # 27 Disagreements- Say it another way)

General Thoughts:

- Addressing extreme statements helps to:
  - manage negative affect in the visit (and help people move on to problem solving)

- demonstrates that dialog is possible

- There are several "flavors" of extreme statements
  - "Black or white" statements leave no room for discussion ("He is *always* bad"," she *never* listens to me")
  - Critical comments about family members

1). Responding to "black and white" statements

-- Challenge these kinds of statements and ask the patient to rephrase their statement

2). Responding to critical remarks: "Can you say it another way?"

- The goal is to avoid polarization
- Ask patients to use "I messages" instead of "you messages" ("When you yell at me, it gets me really upset" instead of "when you yell at me it just shows me how nasty you are")

IV). When Patients are angry at you

General Thoughts

- People often have legitimate reasons for anger and frustration
- Systems of health care can be genuinely frustrating
- You are an easy target – so is your office staff
- Repairing "ruptures" with your patients can cement relationships with people who have problems with trust

A). Dealing with the patient who is angry at you (see videos #28 and #29 When patient is angry at the clinician)

- "You said you would call the school and you didn't."
  - Listen politely/ reflective listening "I can see that you are really upset"
  - Apologize briefly but sincerely
- If you feel you did nothing wrong, don't defend yourself but apologize for any distress the patient may have experienced
- Tell the patient that you will try not to let the problem happen again

V). When Patients feel coerced (see video #30 Coerced Patient)

General Thoughts

- Patients who feel they have come against their will
  - Children and teens are frequently brought under protest
  - Schools demand treatment for behavior problem
  - Social service agencies and courts refer families for evaluation and treatment
- Don't vilify coercive force
  - Can undermine legitimacy of the whole therapeutic system, including you!
  - Can re-enforce family self-image as victim: gratifying in short term but harmful in long term

1). Dealing with coerced patients

- Three-stage approach
  1. Acknowledge and empathize with the anger ("I know that you really did not want to come here today")
  2. Distinguish yourself from the coercive force
     "I respect the school's concern, but whether we decide to try a medication is up to us, not them."
  3. Offer choice and promote a sense of control
  ("We can approach this in several ways – what would you like to do?")

VI.) When to refer patients for mental health consultation

- Problem is refractory to primary care interventions
- Problem is out of the comfort zone of the primary care practitioner
- Family requests a mental health referral
- Significant psychopathology is present
- Significant marital and/or family discord is present

Finally: The role of the clinician in behavioural change is to remain a "catalyst" not a "cattle-prod". Accept that some patients and families are not ready for change—remain patient, accepting, respectful and available

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