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2011

FUTURE OF PEDIATRICS CONFERENCE

Embracing Mental Health Care: Lessons Learned for Success



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



MEETING SUMMARY

Embracing Mental Health Care: Lessons Learned for Success

July 28, 2011

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™



GOAL

To empower pediatricians to address the health and well-being of children and youth with mental health concerns by

- Providing a broader understanding of the issues most important to families who have a child living with mental illness with particular emphasis on the role played by the primary care pediatrician
- Describing the unique advantage of primary care pediatricians in addressing mental health care and how this role differs from mental health specialty care
- Exploring practice management strategies used by primary care practices for identifying children at risk for mental health problems, coordinating appropriate care and referrals, and managing children with mental health problems
- Explaining the cultural aspects of mental health
- Highlighting the latest resources and tools for health care providers and other professionals

OVERVIEW

The American Academy of Pediatrics (AAP) is a national organization comprising more than 62,000 members, 66 state and local chapters, 29 national committees, 49 sections, 9 councils, and staff of

approximately 400. On July 28, 2011, the AAP Mental Health Initiatives hosted a preconference on “Embracing Mental Health Care: Lessons Learned for Success” in Chicago, IL.

This preconference was supported by the American Academy of Pediatrics Friends of Children Fund and the Child, Adolescent and Family Branch (CAFB), Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA). The content of this preconference does not necessarily reflect the views, opinions, or policies of CAFB, CMHS, SAMHSA or the Department of Health and Human Services.

Statements and opinions expressed are those of the authors and faculty, not necessarily those of the American Academy of Pediatrics.

Exremely engaged pediatricians, mental health specialists, government officials, researchers, and advocates met to embrace the challenge of caring for children and youth with mental health issues in the context of a rapidly changing health care system. The agenda was crafted to allow discussion of current efforts within government, primary care practices, and community-based agencies and from the perspective of patients and their families, with an eye toward breaking down walls and encouraging collaboration between sectors. There are small miracles happening all around the country that are changing the life-course trajectories of children, one family at a time. There are models that we can bring to scale, if we are able to muster the will. If one had to take a single message home from the day, it would be that, in order to meet the needs of patients and families, all who care for children with mental health concerns will need to continue to collaborate at home with the same vigor and enthusiasm that they brought to the conference to ensure that our constantly changing understanding of brain, development, and behavior is reflected in the systems of care that we create in our communities.

David Keller, MD, FAAP

WELCOME

V. Fan Tait, MD, FAAP

Associate Executive Director/Director, Department of Community & Specialty Pediatrics
American Academy of Pediatrics

Pediatric mental health issues are critically important. In keeping with the American Academy of Pediatrics (AAP) mission to attain optimal physical, mental, and social health and well-being for all infants, children,

adolescents, and young adults, the AAP Board of Directors recognized mental health as a strategic priority and established it as one of the organization's top agenda items.

Marian Earls, MD, FAAP

Medical Director, Guilford Child Health Inc.
Greensboro, NC

Mental health care is mainstream pediatrics. Pediatricians, if trained and supported, are ideally positioned to identify children with mental health problems, to triage for emergencies, to initiate care, and to collaborate with mental health and substance abuse specialists in facilitating a higher level of care when needed. The AAP Task Force on Mental Health (TFOMH) often referred to the "primary care advantage" in their work. Pediatric primary care clinicians have unique strengths and opportunities to prevent and address mental health and substance abuse problems in the medical home. They have a longitudinal, trusting relationship with the family; understand the importance of family in the care of children; know about child development in all of its domains; and have unique opportunities for prevention and early intervention not afforded to subspecialists who intervene at the time of crisis.

In 2004 the AAP Board of Directors appointed the TFOMH, charging it to assist pediatricians and other primary care clinicians in enhancing the mental health care that they provide to children and adolescents. The board's directive stemmed from the recognition that pediatric primary care clinicians will play an important part in promoting the mental health of children and providing treatment for children and adolescents who have mental health and substance abuse concerns. The TFOMH and the Vision of Pediatrics 2020 echoed the sentiment on the role of the pediatrician when stating the prevalence of chronic health issues such as mental health will continue to increase.

Since 2004 several tools and resources have been developed that have moved the field forward. For example, the AAP Committee on the Psychosocial Aspects of Child and Family Health and the TFOMH wrote a policy statement, "The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care," that defined practice competencies that move mental health services to the center of our practice and our advocacy as well as provide guidance to residency education and continuing education for primary care clinicians. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*, created by the TFOMH, provides resources to enable primary care pediatricians to provide evidence-based care for children with mental and behavioral health problems. The *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition integrates mental health care into the fabric of primary care practice. The themes include promoting family support, child development, and mental health. Other resources include

1. *Strategies for System Change in Children's Mental Health: A Chapter Action Kit*
2. "Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration" (*Pediatrics* 2009;123:1248)
3. "Enhancing Pediatric Mental Health Care: Algorithms for Primary Care" (*Pediatrics* 2010;125:S109)

This broad experience led to the goals of the preconference providing innovative best practice models for addressing mental health concerns and improving skills of clinicians by providing practical tools for clinical care.

WELCOME

Gary Blau, PhD

Chief, Child, Adolescent, and Family Branch Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

The Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes the importance of efforts to blend mental health care with primary care for children across the country.

Youth are an important part of the work. They have a culture of their own, and it is important to connect with them. SAMSHA sponsors a national youth organization called YouthMOVE (Motivating Others through Voices of Experience), which is now incorporated and in the last 2 years has grown to 30 chapters nationwide. They are motivated to help others make change and work with clinicians in helping them communicate better with young people.

There are 3 things currently going on in the country that pediatricians should pay attention to

1. **Health reform:** Despite the continuing political turmoil, health reform under the Affordable Care Act is being implemented across the country. Much of the action right now is at the state level, and it is critically important that the AAP and its members pay careful attention to the benefit packages as they are formulated. “Health homes” and other practice innovations have tremendous potential for change in the states that embrace them.
2. **Mental health parity:** The mental health parity law passed in 2008, and the benefits are slowly rolling out in reimbursement schemes around the country. Reimbursement for new services such as behavioral health consultation services will change the way in which we approach mental health services for children in this country.
3. **Budget:** In the discussion on the budget, it is important that the voice of pediatricians and other child advocates are heard. As we move to establish access to care for children with mental health issues, issues of cost and quality will become paramount. In the

long run, establishment of systems of care for children will provide the greatest value to public and private payers. At any given time in this country, 1 out of every 5 children has a mental health issue. Those who work with children need to remind policy makers that half of all adults with mental illness report that symptoms began before age 14, so that investments in pediatric mental health care are likely to pay dividends in the long-term cost of caring for persons with mental illness.

SAMHSA emphasizes a system of care approach. A system of care is a comprehensive spectrum of services and supports that are organized into a coordinated network to meet the multiple and changing needs of individuals and their families—similar to the health home. Services and supports for families and youth are at the center of what we do, and we have created a value structure around this. The system of care concept really is a philosophical approach for a community. It facilitates coordination among each child’s service providers. Families partner with public and private organizations to develop individualized service plans for children. Systems of care help children, youth, and families thrive at home, in school, and in the community throughout their lives.

Like SAMHSA’s system of care framework, the health home should be family-driven and youth-guided, and grounded in the community in which they live. There should be a commitment of family and youth groups to the process as well as the engagement of pediatricians. Like the health home and the medical home, a system of care is a framework and guide, not a prescription. It is an opportunity to be flexible and creative and to work with families to be adaptive to the community’s needs. Working together to create integrated systems of care is the future of pediatrics.

The Family Experience With Primary Care

Dana Markey

Program Manager, National Alliance on Mental Illness
Arlington, VA

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for millions in America affected by mental illness. Founded in 1979, NAMI provides support, education, and empowerment for more than 500,000 members and supporters. NAMI raises public awareness, builds community, and steadfastly advocates for access to treatment, services, supports, and medical research. The NAMI Child and Adolescent Action Center focuses on children, adolescents, young adults, and their families.

The facts

- Thirteen percent of youth ages 8 to 15 live with mental illness. This figure jumps to 21% for youth ages 13 to 18.
- Half of all lifetime cases of mental illness begin by age 14.
- Despite the availability of effective intervention, there are delays of 8 to 10 years in the diagnosis of a mental health problem and beginning the intervention. These are critical developmental years in the life of a child.
- Fewer than one-half of children diagnosed with a mental illness seek mental health services in a given year (approximately 20%).

Primary care clinicians have a unique role and are often the first point of contact for families when it comes to their child's health and well-being, including their mental health. This puts primary care clinicians in a unique position to identify mental health concerns and communicate these concerns to the families.

NAMI surveyed more than 550 families in 40 states who had a child living with mental illness. The families responded to a broad range of questions related to their experiences discussing mental health concerns about their child with primary care clinicians and staff. The results from the survey reaffirmed the important role of primary care clinicians. The results of the survey showed

- Eighty-nine percent of families had discussed mental health concerns with their child's primary care clinician.
- Eighty-three percent felt it was important for primary care clinicians to discuss their child's mental health, even if there were no concerns.

Families were asked if there were any aspects of a primary care office that would make them feel more comfortable talking about their child's mental health. Responses included

- Provide resources: Include mental health resources in the waiting and examination rooms to help families feel more comfortable raising mental health concerns.
- Provide a private area: Families stressed the importance of a private area within the primary care office to discuss mental health concerns, with the option of not having the child present. It decreases concerns about others hearing and it helps families to feel less nervous.
- Educate office staff: A strong knowledge about mental health and community resources shows the practice is receptive to the topic of mental illness, is aware of mental health issues, and cares about children's mental health.
- Create a "safe zone": It is important to have a culture of nonjudgment, compassion, and understanding of mental health, which includes active listening, using positive language, having a positive attitude, and providing prompts to discuss mental health concerns.
- Provide mental health screening: Asking about developmental, emotional, and behavioral issues during well-child visits helps normalize mental health issues.

In the survey, the families suggested questions that would help to encourage open communication about mental health. These included

- Do you have any concerns about your child's mental health?
- How is your child behaving in school, in the community, and with peers?
- Have you noticed any changes in your child's moods?
- Is your child sleeping and eating well?
- Is there a family history of mental illness?

The most helpful comments anyone made about their child's mental health include

- There is hope: Families can often feel discouraged, so it helps when the primary care clinician is hopeful, encouraging, and positive.
- You are not alone: Families want to know that they are not alone having a child living with a mental illness.
- It's not your fault: Families emphasized the importance of primary care clinicians not blaming them for their child's mental illness.
- I understand: Acknowledging pain and showing empathy, compassion, and understanding is helpful.
- Your child has many strengths: Discussing strengths sets a positive tone for a conversation about mental health.

Action steps that primary care clinicians can take when mental health concerns are raised included

1. Ask questions: Once concerns are shared, ask follow-up questions to have an interactive discussion about the concerns.
2. Screen: Mental health screening can be useful in identifying mental health concerns.
3. Evaluate: Before a mental health diagnosis is made, rule out other physical conditions that can mimic mental illness.
4. Discuss options and services: Families want to know the wide range of options that exist, including psychosocial interventions, community supports, and other resources, so they can make an informed decision on the best course of treatment. Not all families want medications immediately and would like to explore other interventions first.
5. Suggest local resources: Local resources often provide support to families and offer a connection to other families dealing with similar concerns.
6. Refer: Once mental illness is suspected, refer to mental health providers for further evaluation and treatment and to community-based services and supports.
7. Follow up: Families emphasized the importance of following up with any referrals to ensure that they received help or work with the family to make any necessary appointments.

8. Encourage and empower families: Primary care clinicians are in a position to emphasize the importance of mental health and encourage families to seek treatment and have the child remain in treatment.
9. Provide treatment when mental health providers are not available.
10. Check-in: Make sure family is doing well with treatment. Ask about mental health at every visit.

There were many positive experiences with primary care clinicians, highlighted by the families who completed the survey showing the strength and impact they can have on youth. Primary care clinicians play a key role in the lives of children and families. The survey summarizes the experiences of families and provides recommendations on how to strengthen the interactions between families, primary care clinicians, and staff. The survey responses and other helpful resources can be found at the NAMI Web site at www.NAMI.org/primarycare.

Moving Mental Health Forward

Barb Frankowski, MD, MPH, FAAP
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University of Vermont College of Medicine
Burlington, VT

In 2004 the American Academy of Pediatrics (AAP) Board of Directors appointed the Task Force on Mental Health (TFOMH), charging it to assist pediatricians and other pediatric primary care clinicians in enhancing the mental health care they provide to children and adolescents.

The board's directive stemmed from its recognition that (1) pediatric primary care clinicians will play an increasingly important role in promoting the social-emotional health of children and providing treatment—or serving as an entry point to specialty treatment—for children and adolescents who have mental health and substance abuse problems and (2) the growth in this role will involve transformational changes in pediatric primary care practice, requiring new knowledge and skills, payment structures, collaborative relationships, office systems, and resources.

The TFOMH had 3 main goals

Goal 1: Facilitate System Changes

Goal 2: Build Clinician Competencies/Competence

Goal 3: Incrementally Change Practice

Although there are many challenges involved in providing mental health care, the task force recognized “the primary care advantage.”

- A longitudinal, trusting relationship with patients and their families
- Unique opportunities for prevention of mental health problems through anticipatory guidance at routine health supervision visits throughout childhood
- Opportunities to screen for psychosocial problems in both the child and family
- To intervene early, as symptoms are just emerging
- The opportunity to recognize the barriers that often keep families from seeking help for their children’s problems—conflict within the family, denial, stigma, for example—and to address those barriers, facilitating the child’s and family’s readiness to engage in mental health care
- To provide diagnostic assessment and treatment within the medical home
- To refer for care, as needed, in the mental health specialty system
- To monitor and coordinate that care as is done for children and youth with other special health care needs

There are challenges for primary care clinicians in providing mental health and substance abuse services. These include

- Lack of adequate training in recognizing and managing mental health and substance abuse problems
- Time constraints and reluctance to raise these issues
- Inadequate pay—in some cases, not at all—for the mental health services provided
- Access to the mental health specialty resources needed to help with the care of patients whose needs exceed the primary care clinician’s capacity
- Administrative barriers to accessing mental health services for patients within their insurance plans
- Functioning in the dark, without feedback from the mental health or substance abuse specialists involved in your patients’ care

- Reluctance by children and families to seek mental health specialty care because of stigma or because of previous negative experiences

There are several approaches to using the *Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit*. In approach number 1, first consult the paper Table of Contents in the toolkit package. In it, you will find

- An introduction that describes the toolkit and its organization.
- A list of all the tools in the kit: first, introductory tools to help orient the user to the toolkit’s approach; then the rest of the tools, organized by topic areas. These topic areas correspond with the chronic care model, which the toolkit will help users to apply to the care of children with mental health and substance abuse problems, as is done for the care of children with chronic medical conditions such as asthma and diabetes. Descriptors are alongside each tool.
- A paper copy of the Mental Health Practice Readiness Inventory
- A laminated copy of both algorithms. Algorithm A guides pediatricians in promoting social-emotional health, identifying mental health and substance use concerns, engaging the family, and providing early intervention in primary care while Algorithm B guides pediatricians in assessing and caring for children with identified social-emotional, mental health, or substance abuse concerns.
- And last, there are examples of tools that will be mentioned later: the cluster guidance on disruptive behavior and aggression, a pamphlet that provides ways to improve mood naturally, and a pamphlet explaining to youth and families the mental health referral sources and the mental health referral process.

For approach number 2, at the navigation bar on the top, there will be the Mental Health Practice Readiness Inventory. There is a choice of viewing the PDF version of the inventory, which can be printed out, or the interactive version. The purpose of this inventory is to help assess the extent to which office systems promote and support mental health practice. Users can bring together their entire practice team to complete this tool together.

By entering a 1, 2, or 3 beside each item, then clicking on “submit,” users can obtain a profile of the practice’s strengths and needs. Users can also click on any individual item in the inventory to access tools related to that area of practice improvement. In addition to the inventory tool, users can also explore the inventory’s areas by using the top navigation bar.

The inventory’s areas are grouped to correspond with features of the chronic care model.

- **Community Resources:** Here’s where users will find, for example, guidance about the types of services patients will need and the mental health/substance abuse specialists who provide them, which mental health therapies have good evidence supporting them, how to create a community resource guide, and how to build relationships with colleagues in the mental health specialty community. This section is an important first step in readying a practice and building confidence to elicit mental health concerns.
- **Health Care Financing:** One of the key tools in this section is guidance on *Current Procedural Terminology (CPT)* coding for the mental health services you provide in primary care. Recognizing that you can’t enhance mental health services unless a sound business model supports them, this tool will be especially helpful to a practice manager.
- **Support for Children & Families:** Here is an array of materials to help users connect with children and families around mental health/substance abuse issues, as well as materials and sources for youth and family to enhance their own knowledge and capacity to self-manage. Examples of tools in this section are
 - A description of a generic approach to managing undifferentiated mental health problems. These are called “common factors” interventions, summarized by the mnemonic, HELP. This concept of a generic or common factors approach is central to the task force’s guidance. The HELP tool will most likely be one of the first tools used.
 - A guide to motivational counseling, also key to helping families who are not yet ready to see their child’s problem as a mental health issue, who cannot reach agreement on what action to take, or who are overwhelmed by negative perceptions.
 - The tool Understanding Family Reactions to Mental Illness.

– The brochure, “Your Child’s Mental Health: When to Seek Help and Where to Get Help.”

- **Clinical Information Systems/Delivery System Redesign:** Here users will find tools to help create systems within a practice: a registry for children in the practice with mental health problems and forms to document mental health activities and to exchange information with mental health specialists. Many of these forms are customizable.
- **Decision Support for Clinicians:** This section provides the clinical guidance needed in providing mental health/substance abuse services: Web sites, clinical guidelines, screening and assessment tools to help you in identifying children with mental health problems, and our task force’s guidance on managing the symptom clusters that present most commonly to primary care clinicians.

Approach number 3 includes clinical algorithms that can be used in a variety of ways. Go to the orange bar on the toolkit’s navigation bar, there is a block on the right that leads to the AAP TFOMH report. This report outlines strategies to enhance pediatric mental health at both the community level and in individual pediatric practices. It might be helpful to read the fourth article that introduces the clinical algorithms. These algorithms can help guide users through the process of implementing mental health care into a pediatric practice. Besides the report, the clinical algorithms can also be accessed through the toolkit’s navigation bar. Users can select the PDF version of these algorithms or the interactive version.

Algorithm A outlines a process for incorporating preventive mental health services—anticipatory guidance, surveillance, and screening—into well-child and acute care visits. This algorithm also provides guidance for addressing undifferentiated mental health concerns identified at these visits. This includes triage for mental health and social emergencies, engagement of the child and family in care, and initial interventions. The process described by Algorithm A may be accomplished at one visit or may require multiple visits, depending on the nature of the concern and the child’s response to your initial interventions.

When an identified concern requires further assessment, either by a primary care clinician or a mental health or substance abuse specialist, consult Algorithm B. This

algorithm provides guidance for decision-making about when and how to involve a mental health or substance abuse specialist and for the collaborative process of developing a plan to treat and monitor the child. Users will recognize, in this algorithm, the application of chronic care principles such as those you use in caring for children with chronic medical problems such as asthma and diabetes.

The algorithms in the toolkit are interactive and allow users to click on any step to find a series of resources on that particular step. By clicking individual boxes in the electronic versions of the algorithms, the user will find tabs leading to a general description of that step in the clinical process, guidance in preparing the practice for that step, competencies requisite to that step, clinical guidance for that step, tools and resources useful in carrying out that step, and *CPT* codes associated with that step.

Approach number 4 uses the “cluster guidance,” which is a series of tools that provide clinical framework and guidance for the assessment and care of children and adolescents with commonly presented symptoms and clusters. It is cross-linked to other resources, forms, and tools in this toolkit. This guidance can assist primary care practices in developing their protocols for the care of children with commonly presenting mental health problems.

There are 7 symptom clusters for which the toolkit provides primary care guidance.

- Background information about the clinical guidance
- Symptoms of social-emotional problems in children birth to 5
- Anxiety
- Depression
- Inattention and impulsivity
- Disruptive behavior and aggression
- Substance use and abuse
- Learning difficulties

Each cluster’s organization and content reflects the primary care thought process.

- General introduction, putting the whole topic into perspective
- Results from commonly used screeners
- Symptoms and clinical findings

- Differential diagnosis: conditions that mimic or may co-occur
- Tools for further assessment
- Evidence-based and evidence-informed interventions
- Plan of care—things that can be set in motion immediately in the primary care setting to educate the family about parenting an anxious child and to begin care of the child, even if planning a referral to a mental health specialist; includes resources for the family and indications for referral
- Resources for clinicians and references for the information

In addition to the top navigation bar, users may prefer to go directly to contents by hovering the cursor over the bright green rectangles on the home page. From these panels, users can access the algorithms, clusters, specific sections of the readiness inventory, and the inventory itself.

And if there is trouble finding a particular resource, just use the search feature on the home page.

There are several additional resources available from the AAP.

- *Strategies for System Change in Children’s Mental Health: A Chapter Action Kit*. Outlines numerous strategies that AAP chapters can use to improve children’s mental health programs and services in their state. Included in the toolkit is a summary of collaborative programs around the country involving mental health services interfacing with pediatric clinical care settings.
- “Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Action and Collaboration.” A special article on administrative and financial barriers to collaborative mental health care. It was jointly developed with the American Academy of Child and Adolescent Psychiatry.
- “The Future of Pediatrics: Mental Health Competencies for Primary Care.” A policy statement on mental health competencies for primary care clinicians. This statement will be helpful in developing and guiding continuing medical education opportunities for practicing clinicians and assisting training programs in formulating curricula.

- “Enhancing Pediatric Mental Health Care: Algorithms for Primary Care.” A supplement to *Pediatrics*, which was presented and discussed.
- Collaborative Mental Health PediaLink Course. Many primary care clinicians cite a lack of referral sources as a major barrier to expanding their role in mental health care. The purpose of this course is to address this barrier.

Additional resources, including those listed above, can be found on the AAP Mental Health Initiatives Web site at www.aap.org/mentalhealth.

Primary Care Strategies

Larry Wissow, MD, MPH, FAAP

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Examples of cases that you may encounter in your practice involve the foster parent who brings in the bag of pills for “anger management” and says they aren’t working, or the parent who seems depressed or has revealed problems on a screening form, or in the middle of a short office visit the parent brings up concerns about the teen’s mood. What do these case examples have in common? They are likely to require more time than was allotted for the visit. From the start, there may be a concern that the problem is outside the range of the practice or the practitioner. And it is uncertain how long you will have to manage the situation pending a consultation or a referral.

Pediatric practices see the same range of severity of mental health problems as mental health professionals, but the distribution varies. There are many different ways to cope with the situation, including developing skills, collaborating with mental health providers, or finding a consultation model. The focus of this section is on developing skills to handle mental health concerns.

There are 2 parallel approaches to mental health care. One approach is making a specific psychiatric diagnosis and applying evidence-based treatment. The other is to identify people who have a problem, help them to

formulate the problem in terms that make sense to them and to you, and develop a plan.

To adopt the alternative approach, start with a focus on alliance with the family. Advice alone is not enough, and evidence from psychotherapy points out that the outcome is better over and above any specific treatment, including medication. The element of alliance and psychotherapy included an agreement on the nature of the problem, an agreement on what to do, and an effective bond with the provider.

Evidence shows that alliance starts with the initial interaction at the office. Practice climate predicts patient trust, and patient trust predicts whether patients will listen to the health professional. Alliance building incorporates feeling heard and understood, seeking agreement on a working formulation of the problem, and offering advice after obtaining permission to do so. Helping someone to feel heard and understood can be done by using open-ended questions, repeating the story, and asking for clarifications and priorities.

It can be difficult setting the agenda for the visit.

Parents and children often have different priorities.

Family priorities may not be the same as yours. Skills for setting the agenda include

- Making sure the process is clear to the patient/parent
- Playing back the list of concerns
- Asking for priorities
- Getting agreement from all parties
- Openly and collaboratively problem-solving about limitations of follow-up visits

In the end, the hope is to center the visit on the concerns of the patient and their family.

Once the concerns are understood, how do you get an agreement on a working formulation? One way to do that is to ask permission. Asking permission helps create buy-in to process, makes people feel in control, and levels the playing field. What is it that you really want to know?

- Sensitive but important details
- Data related to possible urgent treatment needs (including overall functioning)
- What they think might be the underlying issue

After understanding the concerns and getting buy-in to the process, the next step is asking permission to offer

advice: “We’ve thought about this problem, are you ready to hear some suggestions?” Summing up your thinking and checking for agreement is helpful. It is possible at this point that you may need to circle back to get more information.

When giving advice,

- Ask for permission: This helps patients maintain a sense of control.
- Ask for their ideas.
- Frame as a set of choices: Preferably include their ideas among the choices.
- Frame as short- and long-term plans: What might help now? What are diagnostic steps to take?

What advice can actually be given, especially if you feel that you are not an expert in mental health at this point? When in doubt, try to make the patient do as much work as possible. Families are extremely resourceful. They are often not looking for answers, but for validation of what they are already trying to do.

- Revisit what the family has thought about.
 - Have they thought about a specialist?
 - What would be their threshold for referral?
- Clarify environmental risks.
 - Current stresses for parent and the child
 - What can simply be acknowledged?
 - What can be taken off their plate temporarily?
 - What concrete assistance would generally make things better?

When responding to resistance in the primary care setting, emphasize choice and time to discuss the problem, apologize for getting ahead, and discuss what it would take to move the process forward. In general, revisit with the family frequently and look at the current stresses for the child and the family.

It’s important to build an alliance with families, and often that is treatment in and of itself. Clarifying concrete concerns and making clear that you are working toward addressing each concern is therapeutic. Developing rapport and appreciative advice may help many families while waiting for a more definitive diagnosis and treatment.

Adding Community Services to Your Pediatric Practice

Francis E. Rushton, Jr, MD, FAAP

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According to the National Survey on Early Childhood Health, parents really want to talk at a health maintenance visit about community violence, drug and alcohol use, parents’ emotional support, and having a supportive partner in their care. From the National Alliance on Mental Illness survey, families emphasized that having a primary care clinician ask about developmental, emotional, and behavioral issues during well-care visits was important and would help normalize mental health issues. It also helps make families feel more comfortable discussing these issues. They also stressed the importance of having primary care clinicians use mental health screening tools, questionnaires, and checklists as part of routine clinical practice.

There are several models for providing care. One model discussed was the formal social capital model of providing care adapted from Jack Shonkoff and Sam Meisels book on early childhood interventions. We want to have better health outcomes for children. Outcomes identified included

- Optimal intellectual growth
- Safety and health
- Motivated for learning
- Capable of reciprocal relationships
- Capable of emotional self-regulation
- Sense of conscience and responsibility

These outcomes are achieved by looking at family characteristics that include family mental health, child characteristics, socioeconomic status, and family connectedness. Families are embedded in systems of informal social capital, which include extended family, friends, neighbors, housing, education, language, and cultural beliefs. These in turn are embedded in formal social capital, which includes the medical home as well as child care, home visitation programs, schools, early intervention, social services, transportation, and other health care.

Having talked about the environment in which children are raised, how do you determine those that are in a child's environment that are not going to be successful in helping the child reach their optimal developmental status? In this model, screening is the first step, and there are many psychosocial screens that are available. Screening tools often help start discussions around mental health concerns.

Beaufort Pediatrics in South Carolina has an in-house mental health counselor, a care coordinator, a parent coordinator, a strong link to the local health department, physical therapy/occupational therapy services, and joint staffing for home visitor services. They use a tool called the Beaufort Stress Index, which is a derivative of Orr's Prenatal Social Environment Inventory. The Beaufort Stress Index looks at family characteristics, informal social supports, maternal mental health concerns, and child characteristics. When the group started screening Medicaid newborns in Beaufort, it was found that 25% were at high risk based on the environment in which they were being raised. Since then, the group has expanded the screening protocol.

Recently a survey was conducted of 18 practices in South Carolina; half had a mental health provider in their practice. Having a mental health provider in the practice is useful because you can do consults, link counseling to prescription management, provide a less threatening environment, allow for common charts, and support the medical home concept. Care coordinators are especially helpful with children with complex needs. The benefit is they are knowledgeable of referral services and able to communicate with other providers. Beaufort Pediatrics has the benefit of joint staffing in the practice, which includes monthly meetings to interface with the school system, health department, and home visiting programs for families at risk to ensure that appropriate services are offered.

The Well Baby Plus program looked at all Medicaid well-child visits from the downtown inner-city area of Beaufort and offered to do them in group well-child format. They were staffed by 8 clinicians, and group visits were scheduled using the American Academy of Pediatrics periodicity schedule. The group visits were held at the elementary school, where other auxiliary services were present, and linked to the "Parents as Teachers" home visiting program. The home visitors

provided assistance with coordination, appointment reminders, transportation, and post-visit reinforcement. When the program was evaluated, it was determined that families were more likely to attend the well-child visit, immunization delivery was improved, there was lower emergency department use, and family outcomes were improved in the intervention group.

In conclusion, coordinated care in the medical home involves recognition of need and screening, knowing community resources and linking to appropriate services, using a team-based approach to care, and focusing on both physical and mental health outcomes.

Obtaining Payment for Mental Health Services in the Pediatric Office

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Coding poses a tremendous challenge for pediatric practices. The "bible" of coding in the United States is the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)*, a collection of diagnoses that most acknowledge does not correspond to the developmental reality of mental illness in children. Europe is already using *ICD-10* and there are plans already in place to create *ICD-11*, adding layers of confusion to the process. In addition, the *Current Procedural Terminology* codes have been assigned a relative value that determines level of payment organized through the Resource-Based Relative Value Scale Update Committee, leading to a strange blend of codes that leaves most pediatricians dazed and confused. That system favors time-limited procedures; the committee has routinely rejected many proposals to allow accurate coding of pediatric practice. With the current coding system, we can't code things the way that they are, so we have to do the best that one can do. In addition, payers don't always pay for what we code. Many, for example, deny payment for any procedure associated with the diagnosis codes associated with anxiety, depression, or attention-deficit/hyperactivity disorder (ADHD) (290-319). Pediatricians could counter by using a

variety of other non-specific codes, such as **799.9** (unknown cause), **799.1** (attention of concentration), and **799.59** (other signs and symptoms involving cognition).

Pediatricians tend to undercode our procedures, which means, in general, pediatricians are reimbursed less than our adult care colleagues. While some in the coding world feel that “If you can’t die, it’s not a five,” the actual definition of a level 5 evaluation and management visit is often met by the extensive medical, educational, and social history that is part of a good behavioral health evaluation.

There are other codes that can help to capture the complexity of the work that we are doing for children with complex behavioral health problems. Code **96110** is now “developmental screening,” not developmental testing, limited and, with the modifier **25**, one can use that code to capture the interpretation of Vanderbilt ADHD Scales from 3 different observers as 3 separate screens. Also, you have to document in your note that you interpreted the rating scale to bill for the service. Pediatricians need to use the “prolonged visit” code more frequently to capture the “end of the day” or the “running the appointment through lunch” appointments. In terms of billing for ancillaries, use **99339** (home care plan oversight), and remember one needs to keep a log of those activities and link them to the patient’s diagnosis for monthly billing.

There are 10 tips for practitioners who want to integrate mental health work into their pediatric practice.

1. Find a medical home champion in the practice. Having a go-to person enhances a practice’s ability to solve problems when they arise. It can be a physician, a parent, or someone who is passionate about this work.
2. Treat this like other chronic illnesses. One of the biggest problems in the treatment of mental illness is the stigma that families perceive in the diagnosis. Primary care clinicians can help reduce the stigma by normalizing the condition.
3. Create a resource directory. This work can’t be done alone. Someone needs to identify potential allies and keep the list updated. Many social service agencies have done this already; ask for a copy. Don’t feel that it is necessary to reinvent the wheel.

4. Post signage. Put up some signage or posters highlighting interest in mental health work, so that no one is surprised by the interest in the topic.
5. Modify the visit template. These visits take time. Be sure to allow enough time to get the work done.
6. If space permits, have a counseling room. Conversations about mental health issues are stressful. Having a room that is set apart so families are not embarrassed by shouting and screaming can be helpful.
7. Confidential medical records. Especially with the electronic health record, spend some time thinking about how to integrate mental health notes with the rest of the record, especially for adolescent patients. Also remember that, within the office, access to the records is on a need-to-know basis.
8. Develop a mental health history form. It can save time, especially if the parent fills it out in advance.
9. Use behavioral health screenings. The evidence says that mental health screening will help identify problems more frequently and earlier than active surveillance. Doing screenings routinely also normalizes behavioral health within the context of practice and helps build trust with families, who need to know that their concerns will be heard in a nonjudgmental way.
10. Use rating scales. Rating scales are subjective but, especially if they are completed by the same observers over time, they offer an excellent means of tracking the course over time.

With these practical tips, pediatricians can engage in the care of children with mental illness in the current payment and practice environment.

Models for Enhancing Mental Health in Primary Care

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The future of pediatrics will bring changes to the way in which we practice, and some of those changes were highlighted. The World Health Organization states that “there is no health care without mental health care.” The

statistics cited earlier have real meaning to pediatric practice. Only 25% of the 14 million children in the United States with mental illness ever receive any treatment, and those that are treated are often undertreated. The “future of nontreatment” is bleak. Mental illness is the leading cause of disability in adults and is often associated with the downward spiral into poverty. In the United States, the cost of untreated mental illness is more than \$100 billion each year.

The key to managing this overwhelming burden of care is appropriate training and collaborative relationships, which allow primary care pediatricians to deliver mental health services to children and families. Sometimes the best screening that you can do is to simply listen to the family. The problem for many pediatricians is one of accessing resources and expertise. Many larger practices in Alabama now have colocated mental health services. In some rural areas, practices use a telepsychiatry link with a leading psychiatrist 200 miles away. The psychiatrist “sees” patients in rural practices and within 48 hours securely transmits an evaluation to both the pediatrician and the local mental health center that is involved in comanaging the patient.

Mental health carve-outs work to the detriment of patients, since most childhood mental health problems present in the pediatric office. Attention-deficit/hyperactivity disorder, depression, anxiety disorders, and substance abuse all present in the primary care setting; so do behavior problems that do not meet the criteria for a properly coded *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* diagnosis, such as the crying baby, temper tantrums, oppositional behavior, or the “teenager with an attitude.” Often what is perceived by parents as abnormal are not unusual behaviors and what is normal, and primary care clinicians generally are the ones who sort that out. It is really important to get policy makers to understand that mental health care done by primary care clinicians as part of the team saves money by preventing hospitalization over time. Payment reform would encourage collocation and collaborative care for mental illness.

In January 2004 the Alabama Chapter of the American Academy of Pediatrics met with a group of stakeholders in a statewide Child Psychiatry Institute to begin the process of collaboration on telemedicine services. The meeting has continued annually, and more than 100 pediatricians participate each year. The system is fairly straightforward. A child in need of evaluation or treatment is identified by a primary care physician who completes a 15-page background form with the caregiver. The child and family register with a local mental health service provider so that they have access to a Master’s level therapist for ongoing treatment locally. The staff at the pediatric office sends all paperwork to the psychiatrist for pre-review and makes an appointment for the telemedicine visit. The initial visit is at least 1 hour and results in the report mentioned earlier. Follow-up is undertaken on a monthly or bi-monthly basis in collaboration with the local mental health agency. The primary care physician writes prescriptions, follows up with the patient, arranges for prior approval for medications when needed, and communicates with the family and psychiatrist.

The mental health services provide counseling and case management, seeing the child at school whenever feasible. They have seen more than 300 children over the last 5 years. It hasn’t been easy; there have been obstacles. Turf issues, telecommunications issues, lack of specific skills such as cognitive-behavioral therapy, and a general lack of understanding of mental illness makes this challenging. In the end, it is important to recognize that mental illness is a chronic disease that probably isn’t going to go away. It is important to appreciate and enjoy success and to congratulate families on how well they are doing. With the wisdom of Stephen Covey, “The main thing is to keep the main thing the main thing,” and the main thing is the child. In the end, the children like “talking to the guy on the TV” and they don’t end up in psychiatric hospitals, which makes it all worthwhile.

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Collaborative mental health care for children can be defined as “the sustainable provision of direct and indirect clinical consultation, education, and care coordination assistance to a primary care practice by a consistent group of children's mental health professionals on a real-time basis.” The Massachusetts Child Psychiatry Access Project (MCPAP) is based on the observation that there will never be enough child psychiatrists to handle the clinical needs in the community. Currently there are about 8.6 child psychiatrists per 100,000 children and youth in the United States, with a horribly skewed distribution and a work style that is based on the therapeutic hour. In addition, there is an inverse relationship between the number of psychiatrists and the degree of poverty in the community. There really is no other way to provide services except within primary care practice because, at the end of the day, pediatricians have a long-term relationship with the family.

Child psychiatrists often don't see themselves as pediatric subspecialists. The frequent failure to interface with pediatricians is often due to a multitude of factors, including pattern of workflow, hours, tradition, and family expectations. In the end, however, building relationships between pediatricians and the child psychiatrists is the key to coping with the shortage of child psychiatrists throughout the country. That insight is at the core of the MCPAP.

The program has an ambitious set of goals.

- Improve access to treatment for children with psychiatric illness.
- Promote the inclusion of child psychiatry within the scope of practice of primary care.
- Restore a functional primary care/specialist relationship between primary care providers (PCPs) and child and adolescent psychiatrists.
- Promote the rational use of scarce specialty resources for the most complex and high-risk children.

The program involves dedicated teams throughout Massachusetts, funded by the Commonwealth, who work with pediatricians to provide care. Funding is from the state government, and the program is open to any child residing in Massachusetts. The program begins with a phone call from the pediatric office with a question. The call goes to a team, housed in 1 of 6 academic medical centers throughout the state, and is answered by a clinician within 30 minutes. The pediatrician and the clinician assess the need and deal with it. This can include advice on medication management, advice on therapy, referral to a mental health facility, or a consultation in office with the child psychiatrist. Whatever the treatment, the team includes a care coordinator who tracks referrals and appointments to ensure that the system is being appropriately used. The in-person consultations happen within 2 weeks and result in a report to the primary care pediatrician, allowing care to move back to the primary care practice for ongoing treatment.

The key to the program is the primary care pediatrician, and the relationship that develops between the PCP and the psychiatrist over time. The psychiatrist and the team help to nurture and develop PCP knowledge and skills in child psychiatry. Much of the resource information is available online as well (www.MCPAP.com).

So far there are 407 practices enrolled in the program, with 1,440 full-time employees of PCPs that have managed 84,439 encounters as of June 30, 2011. Eighty-one percent of the child-caring practices in the state use MCPAP, encompassing almost all of the patients in Massachusetts at a cost of about \$0.18 per child per month. Use continues to be brisk, and the assessment of the program by pediatricians has been extremely successful.

The program is becoming more widespread across the country. Recently, the National Network for Child Psychiatry Access Projects (www.nncpap.org) has been formed to better evaluate the effectiveness of the program and to provide technical support to new programs that are beginning to blossom around the country. This is a platform for the improvement of the quality of mental health care. MCPAP was invaluable when the state implemented universal screening for behavioral health conditions throughout the Commonwealth.

Cultural Aspects of Mental Health

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The world is changing rapidly. In the United States, 33% of the population is what used to be called “people of color.” That forms the background for Surgeon General David Thatcher’s statement in 2001, “A fundamental weakness of mental health systems is the failure to recognize the importance of CULTURE in the epidemiology, conceptualization, treatment, recovery, and prevention of mental health problems.” Culture represents the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices “peculiar” to a particular group of people, and it provides them with a general design for living, and patterns for interpreting reality. Everyone has a culture, but we are generally not aware of it until we meet someone from another culture. There is as much diversity within culture as there is outside of that culture, and patients often need support in understanding that diversity. The relative importance of the various “brands” of culture is important for clinicians to understand and is idiosyncratic to the patient and their history.

How do we know that we have culture? You may use an exercise to help people understand. For example, ask people to think about how they treat a common cold. We know that the science of the common cold revolves around hydrating and fever control, but all people have beliefs about the treatment of the common cold, rooted in something that their grandmother told them. Even something as basic as Maslow’s hierarchy of needs has a cultural bias. While in the West, “self-actualization” is at the top of the pyramid, in Eastern cultures “love and belonging” may take precedence. Even the analysis of culture is fraught with cultural bias. Still, those biases affect behavior and are at the root of the health disparities that exist throughout our health care system.

One of the goals espoused by the president’s New Freedom Commission was that “disparities in mental health are eliminated.” There are system-induced, community-induced, and culture-induced barriers to mental health treatment. For example, the location of

services relative to the bus lines is a barrier to care. If you have to take 4 buses to get there, you frequently will not make your appointment. Stigma associated within the community is another barrier. If you will be shamed in front of your friends, then you probably won’t show up for a therapy session. Culture is another problem. Many people around the world have no word for mental illness. Why would a family agree to take medication for a problem that they have no word to describe?

Families would much prefer to receive services in the pediatrician’s office. It reduces stigma and makes the care palatable. Calling a mental health facility a “family center” or “children’s place” does not disguise the reality for the family. Families in communities of color just do not want to go there. In the current reality, to serve communities of color, services need to be out in the world.

Cultural competence is a set of problem-solving skills that include

- Recognition of the dynamic interplay between the heritage and adaptation dimensions of culture in shaping human behavior
- The ability to use the knowledge acquired about an individual’s heritage and adaptation challenges to maximize the effectiveness of assessment, diagnosis, and treatment
- Internalization (ie, incorporation into one’s clinical problem-solving repertoire) of this process of recognition, acquisition, and use of cultural dynamics so that it can be routinely applied to diverse groups, professionals, and consumers to work effectively in cross-cultural situations.

These individual skills are important. They also need to inform organization structures that we create to reflect these processes. That involves working in teams, using interpreters as cultural brokers, and making awareness of cultural competence a central mission within the structure and governance of organizations.

Cultural competence is a journey. We are transforming the language of problems and disease into the language of hope, healing, recovery, and resilience. We are moving from specialized professionals and experts to social networks with many types of expertise. We are moving from a mind/brain dichotomy to an integration of mind, body, spirit, and social context.

Closing Remarks

Dr Earls closed with a reflection on the day. She said, “We have covered the waterfront” of mental health services in primary care, providing practical tools that will help practitioners move forward. She asked all to remain engaged with the work of the task force, as we take the next steps toward the future of pediatrics.

Acknowledgment

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