Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community

Pediatricians and other primary care clinicians caring for children traditionally have focused their attention on meeting the health care needs of individual children they see in their offices and clinics. However, effective care of the growing number of children and families who are experiencing chronic medical and mental disorders will also require a “population” health perspective. Many policy statements from the American Academy of Pediatrics (AAP) have pointed to the importance of the population perspective in providing and improving pediatric health services.1–10 From this perspective, all members of a community are affected by the health of its individual members. For children, mental health resides not solely within the child but within the web of interactions that connect the child, the family and school, health and other child service systems, and the neighborhood and community in which the child lives.11 This is not to deny that biology is a determinant of mental health and mental illness; rather, biological factors interact with the psychosocial environment to result in mental health, mental illness, and recovery from mental illness.

Primary care clinicians who are interested in enhancing mental health services in their community will need to form partnerships. Key partners for a community mental health advocacy effort include other primary care clinicians, developmental-behavioral pediatricians, adolescent health specialists, the local public mental health agency, representatives of the mental health care provider community (eg, psychiatrists, psychologists, social workers, substance abuse counselors, psychiatric nurse practitioners), community mental health activists including parents and youth, school system representatives, early childhood educators, Early-Intervention (EI) system representatives, representatives of the child protective and juvenile justice systems, and the local department of public health.

*Throughout this document, the term “primary care clinicians” is intended to encompass pediatricians, family physicians, nurse practitioners, and physician assistants who provide primary care to infants, children, and adolescents.

†Throughout this statement, the term “mental” is intended to encompass “behavioral,” “neurodevelopmental,” “psychiatric,” “psychological,” “social-emotional,” and “substance abuse,” as well as adjustment to stressors such as child abuse and neglect, foster care, separation or divorce of parents, domestic violence, parental or family mental health issues, natural disasters, school crises, military deployment of children’s loved ones, and the grief and loss accompanying any of these issues or the illness or death of family members. It also encompasses somatic manifestations of mental health issues, such as fatigue, headaches, eating disorders, and functional gastrointestinal symptoms. This is not to suggest that the full range or severity of all mental health problems is primarily managed by pediatric primary care clinicians but, rather, that children and adolescents may suffer from the full range and severity of mental health conditions and psychosocial stressors. As such, children with mental health needs, just as children with special physical and developmental needs, are children for whom pediatricians, family physicians, nurse practitioners, and physician assistants provide a medical home.
Primary care clinicians cannot feasibly pursue the strategies that follow in the absence of such partnerships. In every region of the United States, there is a public agency formally charged with managing and/or providing mental health services; this same agency may be charged with managing and/or providing EI services, or another agency may be charged with this responsibility. Some state public mental health agencies (eg, California, North Carolina) selectively serve only individuals with severely impairing conditions (severe emotional disorders). Whatever their target population, these agencies typically organize advisory groups of family members who have been affected by these disabilities (“consumers” or “clients” in the vocabulary of the mental health specialty system) and providers of EI, mental health, and/or substance abuse services. These groups often omit primary care clinicians from their membership but usually welcome primary care clinician involvement if it is offered. Consumer and advocacy groups such as the National Alliance on Mental Illness (NAMI), the Federation of Families for Children’s Mental Health (FFCMH), and the local Mental Health Association also welcome primary care clinicians’ interest and involvement in their activities. Increasingly, the public health community has come to view mental health as a public health issue, mirroring the clinical movement toward “reconnecting” the mind and the body. The Association of Maternal and Child Health Programs, in fact, devoted its 2004 national conference to reframing mental health as a public health issue.

Effective communication among primary care clinicians, mental health specialists, educators, and agency representatives depends on developing an understanding of the different cultures in which they function. For example, primary care clinicians may come to a community meeting thinking that their mental health responsibilities are prevention, early identification of mental health problems, and care of children who are mildly impaired with mental health disorders—perhaps only those with specific disorders such as attention-deficit/hyperactivity disorder. Representatives of a chronically underfunded public mental health system may be focused primarily on children who are severely impaired with mental health conditions; they may have been able to give little attention to prevention or early identification and to provision of consultative services to primary care clinicians for their less severely impaired patients. School system representatives may be focused primarily on behavioral problems that interfere with their students’ school attendance, classroom behavior, and academic success; representatives of social service agencies may be focused on the needs of children in foster care; and representatives of the juvenile justice system may be focused on the unmet mental health needs of adjudicated youth. Each group wants to engage the other’s time and resources for its priority activities. Ideally, the process of coming together opens primary care clinicians, families, and their community partners to new opportunities for mutual support and new solutions to common problems.

Moreover, the vocabulary of the mental health specialty system differs significantly from that of primary care clinicians. For example, the acronym “PCP” in primary care terminology means a primary care physician, but “PCP” in mental health terminology may mean a person-centered plan. Likewise, the term “screening” may have different meanings in the 2 systems. A glossary of mental health terms and select mental health resources, Supplemental Appendix S9 may be helpful to primary care clinicians in crossing this divide.*

STRATEGY 1: APPLY A “POPULATION” PERSPECTIVE TO GAIN UNDERSTANDING OF THE MENTAL HEALTH NEEDS OF CHILDREN AND YOUTH IN THE COMMUNITY

Many studies have identified factors that place children at risk for mental health problems later in life.12–14 There are also well-documented protective factors that reduce risks (Fig 1).11 Other protective factors include good nutrition, physical activity, and sleep.

As indicated by the horizontal arrows in Fig 1, the community, family, and child all contribute to creating the school environment, which can be a potent factor in fostering resilience in its students.

To identify needs and track progress toward community goals, primary care clinicians and their partners can examine measures of child well-being in their community (eg, child abuse and neglect reports, EI referrals, kindergarten screening results, adolescent suicide and homicide rates, high school dropout and graduation rates, suspension and expulsion rates, and substance abuse and teen pregnancy rates). An additional source for statistics is the Youth Risk Behavior Surveillance System.16 Analysis of data according to school or neighborhood may yield additional insights and lead to specific interventions tailored to a particular school or area in the community.

Primary care clinicians and their partners can look at the needs of special populations known to be at higher risk for mental health problems (eg, children affected by a disaster,16 children with parents deployed in military service,17 children with developmental disabilities,18,19 children who experience academic difficulties,20 and/or children in foster care).21 They can also

*See definition, Appendix S9.
review utilization of local or regional emergency facilities, mental health outpatient and inpatient services, nonprofit and private-sector programs, and the school system’s exceptional children’s or special educational services. Findings can assist in developing priorities for school-based initiatives and for either targeted or community-wide efforts to enhance protective factors (see Fig 1) or improve access to needed services.

There are pervasive racial and ethnic disparities in children’s health and educational outcomes and in their access to effective mental health services. These disparities call for attention to accessibility and cultural appropriateness of all the mental health systems that touch children and families. Attention should also be directed to issues such as racism, xenophobia, sexism, and homophobia, which may disproportionately affect the mental health of certain groups within the community by contributing to their stress, isolation, and socioeconomic disadvantage.

Just as the public health perspective enlightens a discussion of mental health, the mental health perspective can enlighten discussions of issues traditionally in the domain of public health (eg, physical inactivity, poor diet, environmental toxins [eg, lead, mercury], neighborhood violence, unintended pregnancy, and injuries). Each of these issues has mental health causes and/or effects; and each has implications for the mental, as well as physical, health of children in the community. Partnership across disciplines can result in fresh approaches.

**STRATEGY 2: INVENTORY THE COMMUNITY’S MENTAL HEALTH RESOURCES**

Primary care clinicians cite lack of referral sources as a major barrier to their identifying and meeting the mental health needs of children and their families. In some cases, primary care clinicians are unaware of existing EI and mental health specialty resources in their community. Ideally, the community would have a directory of mental health and substance abuse services available. The local community mental health agency, emergency department, EI provider, community resource line (accessed in some communities by dialing 211 or 311), family and consumer advocacy groups (such as the NAMI, Mental Health America, the FFCMH, Children and Adults With Attention Deficit/Hyperactivity Disorder [CHADD]), or health department may have directories that can provide a starting point. A community can seek funding for this process from nonprofit or governmental sources; frequently, the public mental health agency will fund and staff its continuation. Distribution of a paper version of

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**FIGURE 1**

the directory as a first step may serve to publicize it and guide primary care clinicians toward a Web site. For guidance in developing a directory, see Strategies for System Change in Children’s Mental Health: A Chapter Action Kit.

**STRATEGY 3: DEVELOP OR STRENGTHEN RELATIONSHIPS WITH MENTAL HEALTH ADVOCATES, SCHOOLS, HUMAN SERVICE AGENCIES, MENTAL HEALTH AND SUBSTANCE ABUSE PROVIDERS, AND DEVELOPMENTAL SPECIALISTS BY COLLABORATING ON SYSTEM-FOCUSED INITIATIVES SUCH AS WORKING TO FILL GAPS IN NEEDED SERVICES AND CARE-COORDINATION MECHANISMS**

After identifying community mental health and substance abuse professionals and other mental health–related resources, primary care clinicians can form or join a multidisciplinary community group to address systemic issues such as gaps in needed services (including preventive programs), management of psychiatric emergencies (see Strategy 4), exchange of information between primary care clinicians and mental health professionals, and access to mental health/substance abuse services for the uninsured. Professionals who provide mental health services may function in separate “silos” from those who provide developmental-disabilities services; efforts to combine and coordinate their efforts may be fruitful.

Enhancing communication among disciplines is an important priority. Although relationships between primary care clinicians and medical subspecialists typically are built through the care of mutual patients, privacy concerns and perceived confidentiality barriers keep many mental health/substance abuse professionals from communicating with primary care clinicians. In fact, the Health Insurance Portability and Accountability Act (HIPAA) allows health care providers who are involved in the treatment of mutual patients to exchange information, excepting psychotherapy notes and information about substance use/abuse, even without the consent of patients. Dialogue with local mental health agencies, emergency departments, and others who provide mental health and substance abuse services can raise awareness about the importance of communication with primary care clinicians. Ideally, routine intake procedures of emergency departments and mental health specialty providers would prompt mental health professionals to seek families’ consent for exchange of information with primary care clinicians, and routine procedures in primary care clinicians’ offices would prompt staff to seek information about other sources of health care and request consent for exchange of information. Such routine procedures can become a goal of community-level problem-solving.

Service gaps will often dominate discussions among child mental health advocates. For children and adolescents, mental health specialty resources of all types are insufficient virtually everywhere. Infants and young children often are not even within the “target” population for public mental health program funding. There is a need for Medicaid and other insurers to incorporate the DC 0-3R (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood), which recognizes that some diagnoses may be transient in this age group and that children with significant problems may not fit Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR) criteria. There is also a need for public and private insurers to recognize that children and adolescents suffer impairment from mental health symptoms that may not rise to the level of a disorder. The classification system outlined in the Diagnostic and Statistical Manual for Primary Care (DSM-PC) reflects the full spectrum of behavioral issues that require the timely attention of primary care clinicians. Professional associations of primary care clinicians can partner with mental health specialty organizations and family and consumer advocacy groups to advocate for mental health and substance abuse services needed by children of all ages and public funding of mental health programs generally.

A list of key mental health and substance abuse services for children is included as Appendix S1. Efforts to fill gaps or expand capacity should build on available evidence about effective programs and services. The Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices is an excellent resource for primary care clinicians to use in partnership with local human service agencies, school systems, and nonprofit organizations to develop strategies that address community needs; this registry provides a database of current interventions for the prevention and treatment of mental and substance use disorders. Attached as Appendix S2 is a table which summarizes evidence-based child and adolescent psychosocial interventions; this resource for primary care clinicians is updated biennially. Essential services include those interventions that meet criteria for best support (levels 1 and 2 in the table of psychosocial interventions).

Care-coordination mechanisms are critically important to child and family well-being. Perrin et al defined a system of services for children and youth with special health care needs, including those with mental health prob-
lems, as "a family-centered network of community-based services designed to promote the healthy development and well-being of these children and their families"33 (see Fig 2).

Roberts et al34 delineated 6 central characteristics of such a system: (1) responsive to family challenges, priorities, and strengths; (2) developed in partnership with constituents; (3) reflective and respectful of the cultural norms and practices of the participating families; (4) accessible to everyone; (5) affordable to those who need assistance; and (6) organized and coordinated through collaboration so that resources are equitably distributed in an efficient and effective manner. To these characteristics Perrin et al added that such a system recognizes and addresses the specific developmental needs of infants, children, and adolescents and their important developmental transitions and is organized to promote the cost-effective provision of services.35 In the mental health specialty world, such a system is called a system of care (SOC). Studies have revealed that involvement in a SOC improves coordination of care and educational outcomes for children and youth with mental illness and other psychosocial challenges.35 In communities where such a system is under development, primary care clinicians can be valuable partners in its design. A primary care clinician's involvement in an individual child's SOC planning is an invaluable opportunity for building professional relationships while enhancing the child's care.

The Early Childhood Comprehensive Services (ECCS) initiative, funded by the Maternal and Child Health Bureau (MCHB) to implement the MCHB strategic plan for early childhood health, has allowed 49 states to develop plans for building a comprehensive system of health care for young children. The ECCS Web site36 provides resource information on governance, community-level systems building, finance, indicators, and outcomes; and plans for improving developmental services.

School-Based Services

It is important to include schools in a community mental health SOC. Schools are the largest de facto provider of mental health services,37 and school-based mental health personnel (guidance counselors, social workers, psychologists) typically function in parallel with the mental health system. Although their focus is often on attendance, testing, and, in high schools, course selection and college preparation, these school-based mental health professionals may play an important role in children's comprehensive mental health care, especially when they have an effective connection with community mental health systems. School social workers are more likely than other school personnel to provide direct mental health services and community referrals for children and families; however, many school social workers have unreasonably high case loads and sometimes travel to multiple schools. School-based health centers in many areas of the country provide students with enhanced access to an array of health services including mental health and substance abuse care; such programs are especially effective when linked to a student's primary care medical home and to the SOC in the community. Advocacy for enhanced school-based mental health services requires partnership with the local school board and/or school health advisory council, as well as mental health specialty partners, other community health and services agencies, youth, parents, and teachers.

Schools may also play an important role in prevention of mental health...
problems. As an example, with the Good Behavior Game, a 1-year intervention for elementary school classrooms, participants have manifested reduced aggressive and disruptive behaviors during the first grade and, over the long-term, reduced risk of alcohol and drug abuse and suicide attempts.\(^5\) Information regarding evidence-based interventions is in ref. 39.

**Preventive Services**

A growing body of evidence has shown that there is a window of opportunity for prevention of mental health disorders that will otherwise emerge later in adolescence or adulthood. A number of interventions have been shown effective in at-risk groups (eg, the Clarke Cognitive-Behavioral Prevention Intervention for adolescents at risk of depression).\(^3\) Community partners can collaborate to identify children at risk and implement programs that match needs with resources.

Recent scientific developments toward understanding the brain development of infants and young children have highlighted the critical influence of parenting, attachment, and early childhood education on the emotional, social, and cognitive development of young children\(^4\) and the role of attachment disturbances in many child and adult disorders.\(^5\)–\(^8\) Many communities have responded to this new science by offering such services as nurse visits to pregnant and parenting women at high risk, parenting programs, child care consultation, and therapeutic child care settings. Appendix S7 provides resources to assist in determining which programs that target young children are most promising. Ideally, communities would also have resources to help parents and teachers dealing with depression, substance abuse, mental illness, or other challenges that affect the quality or continuity of their relationships with young children.\(^9\)

**EI Services**

In the United States, EI services target children, from birth to 36 months of age, with delayed development or a condition associated with developmental delay. The EI program, Part C of the Individuals With Disabilities Education Act (IDEA), is federally mandated to include such services as special instruction and, usually, interventions such as speech/language, occupational and physical therapy; nutrition; and audiologic and psychological services.\(^6\) In some states, it also provides intervention services to children at risk for poor developmental outcomes.\(^6\) Its funding, resources, and procedures vary from state to state and, at times, from community to community\(^6\); however, it serves as a doorway to early identification of developmental disabilities and to a variety of services for infants and toddlers and their families.

A key variation from state to state is the agency responsible for EI programs; it may be the public health system, the public school system, the mental health system, or some combination of these systems. When EI is a public school responsibility, it often includes limited or no medical involvement. Eligibility also varies; some states offer services to children at risk for developmental problems, as well as those with identified problems, but others are more restrictive. States and communities also vary in the expertise and availability of EI providers. If the EI program does not offer medical services, such as consultation by developmental-behavioral pediatricians or child psychiatrists with expertise in infant mental health, primary care clinicians will need other referral sources with special expertise in this age group. For families in which maternal depression and attachment are concerns, it is important to identify sources of treatment for the mother-infant dyad as well as for the mother herself.

**Child Psychiatry Services**

Although many communities do not have child psychiatrists, several regions of the country have used creative strategies to gain access to child psychiatry consultation for primary care clinicians. In Massachusetts, a statewide psychiatry telephone consultation service was established to assist primary care clinicians in assessing and managing the mental health problems of children and adolescents. Results of an initial evaluation of this program suggested high rates of use and satisfaction among participating primary care clinicians.\(^1\) Several states are using telepsychiatry clinics to provide access to consultation for children remote from child psychiatrists. The AAP’s mental health Web site\(^1\) provides examples of consultation models. In many rural areas, consultation is provided by general psychiatrists whose training in child psychiatry may be limited; in such areas, educational programs to enhance the psychiatrists’ pediatric skills and their access to child psychiatrists for consultation may be useful adjuncts.

**Recreational Resources and Volunteer Service**

Children also benefit from resources to enhance their social experiences and promote physical activity. Boys’ and girls’ clubs, summer camps and enrichment programs, and sports and recreational activities may provide children and adolescents with structure and opportunities to develop social skills and confidence. Volunteer service activities have been shown to be beneficial to young people’s social and emotional development.\(^1\)
ment in extracurricular school activities and/or youth religious organizations has a protective effect on adolescent mental health. Although the children at highest risk in a community may not currently be involved in these activities, an understanding of barriers to their participation (eg, transportation, preparticipation physicals) can inform efforts to engage them.

**Transition Services**

As adolescents with mental illness age out of pediatric care, insurance plans, and community resources that supported them during their childhood, they must find new providers of their primary and specialty health care and face the stresses experienced by other young adults with special needs. They may have limited educational, vocational, or social opportunities; financial hardships; difficulty finding housing; and inadequate services to assist them in overcoming or coping with these problems and in achieving their health, educational, vocational, and social goals. Primary care clinicians can partner with the mental health community to address deficiencies in transition services for young people who are living with mental illness. Programs in several areas of the country may serve as models.

**STRATEGY 4: DEVELOP A COMMUNITY PROTOCOL FOR MANAGING PSYCHIATRIC EMERGENCIES**

Deaths attributable to homicide, suicide, and child abuse are tragically common. Life-threatening mental health problems, including acute intoxication, delirium, psychosis, mania, severe family dysfunction or acute stress responses, domestic violence, severe mood disorders, and medical crises associated with eating disorders, also occur frequently. Primary care clinicians may be the only source from whom a child and family are comfortable seeking help. Primary care clinicians have a role in preventing crises by identifying children with mental health/substance abuse problems early in their course, developing a relationship when the child is not in crisis, and collaborating with the family to develop a crisis plan in advance. Primary care clinicians also have a role in applying a management strategy to a crisis situation, which involves assessing the level of urgency of the child’s need for care, identifying intervention options, and using appropriate resources.

A natural disaster, act of violence, war, or industrial accident may inflict trauma and loss on many children and families simultaneously—those directly exposed and those emotionally exposed through death or injury of loved ones—and may pose even greater threats to children with preexisting mental health issues. Primary care clinicians have a role in planning with their community partners to deal with both the short-term and long-term aftermath of these crises. Emergency departments in many communities are not well equipped to address psychiatric emergencies in children and adolescents. Through overcrowding, exposure to stressful sights and sounds, and long delays, they may inadvertently increase the distress and trauma experienced by children and their families. Boarding of child and adolescent psychiatric patients in nonspecialized settings should be avoided as much as possible. When such boarding is unavoidable, every attempt should be made to ensure that such patients are hospitalized in the least restrictive setting possible and transferred to a psychiatric facility as expeditiously as possible. When optimal services are unavailable, primary care clinicians can participate in community and regional efforts to fund and develop them.

In some communities, specific psychiatric emergency services are available (eg, mobile crisis units that can be deployed to a physician’s office or school; mental health screening, triage, and referral centers; mental health/ substance abuse intake facilities; intensive outpatient treatment programs); however, primary care clinicians (as well as school and agency personnel with whom primary care clinicians collaborate) may be unaware of them. As part of their inventory of mental health resources, pediatric primary care clinicians can identify and prepare to use the emergency mental health services that are most appropriate for children and adolescents, often in the mental health system rather than an emergency department. The primary care clinicians can negotiate with providers of emergency mental health services to secure ready access for their patients in crisis and/or “urgent” assessment slots. In addition, primary care clinicians can work with these mental health providers to ensure that primary care clinicians are informed about children served in their system and that arrangements are made for their continued monitoring and care after discharge from hospital or residential facilities.

**STRATEGY 5: ALIGN WITH COMMUNITY PARTNERS IN ADDRESSING THE MENTAL HEALTH NEEDS OF CHILDREN WITHIN THE PRIMARY CARE PRACTICE**

Depending on community priorities, the clinician may choose initially to target the practice’s mental health services to those of a particular age group, such as adolescents; a high-need group within the population, such as children in foster care; children affected by a disaster; children with parents deployed in military service; or children in a certain neighborhood or...
school associated with poor health or educational outcomes. In some settings, the clinician can seek the cooperation of school nurses, school-based health centers, or community agencies (eg, public health, social services, juvenile justice) to administer and collect mental health history and screening tools needed by the primary care clinician and provide them in advance of the primary care visit.64

As an example, clinicians might consider initiating previsit data collection from children in foster care. Sharing the responsibility for previsit data collection with the foster care agency increases the likelihood that adults with knowledge of the child’s mental health strengths and needs provide critical information. Many states mandate that children placed in foster care receive a mental health assessment within 1 month of placement. Primary care clinicians may participate in providing this assessment. There may also be some mechanism to assess for acute mental health needs (suicidality, homicidality, severe aggression, ongoing psychotropic medication needs, or the risk of withdrawal symptoms in a substance-addicted adolescent cut off from his or her supply) within 1 or 2 days of foster placement. Again, the primary care clinician may incorporate this assessment into a primary care visit.

As a second example, clinicians can work with their local school system(s) to develop a community protocol for assessing and managing school-aged children who experience problems with attention, behavior, or learning. With parental permission, school personnel are usually willing to collect and share information with the primary care clinician. This information could include behavior scales, such as the Vanderbilt ADHD Scales and the Strengths and Difficulties Questionnaire, Teacher Version; grades and end-of-grade test results; and psychoeducational evaluations, including formal cognitive testing, individually administered educational achievement testing, or other standardized assessments, such as neuropsychological testing. A clear description of the child’s academic program, including any special services provided informally or through an individualized education plan or 504 plan also should be provided before the medical evaluation. In turn, the primary care clinician can provide the school with clinical findings, a description of treatment provided, and follow-up plans (including a mechanism to monitor medication effects) as needed and with proper permission from parents. In a North Carolina community, such a protocol, which streamlines primary care clinicians’ assessment of children who are experiencing school difficulties and facilitates communication about their ongoing care, has been in place for >15 years.64

**STRATEGY 6: PARTICIPATE IN AAP CHAPTER EFFORTS TO ADDRESS PAYMENT AND BROADER SYSTEM ISSUES**

Primary care clinicians require adequate payment for the mental health services they provide and a policy environment that supports primary care clinicians’ involvement in mental health care. These issues require understanding of the additional time and effort needed to address mental health issues in primary care practice. There are a growing number of successful AAP chapter advocacy efforts that have achieved significant policy changes in private (employer-based) health insurance, state Medicaid programs, and the State Children’s Health Insurance Program.65 Examples of system features that support and foster mental health practice in primary care settings are:

- payment of primary care clinicians for their mental health services;
- payment for multiple mental health visits to the primary care clinician before the establishment of a diagnosis (ie, for problem-level conditions and/or conditions for which the clinician is not ready to assign a diagnostic code);
- authorization of mental health referrals by primary care clinicians;
- notification of the primary care clinician when a child enters the mental health specialty system;
- payment structure that supports mental health professionals collocated or integrated within the primary care setting;
- independent enrollment of Medicaid mental health providers, which makes it possible for primary care clinicians to refer directly to a mental health professional (rather than through an agency’s cumbersome intake process) and develop a collaborative relationship with that professional in the mutual care of the child;
- payment to primary care clinicians for the services of their employed mental health professionals; and
- an electronic system to access families’ mental health benefits and provider panels.

In many areas of the country, managed care “carve-outs” (separate insurance plans that deliver mental health/substance abuse benefits) provide their insured customers with a limited panel of mental health professionals who may or may not have expertise in working with children and adolescents and may or may not provide evidence-based interventions; furthermore, the primary care clinician may have no access to the list of mental health professionals on an insurance plan’s mental health panel. Typically, families must access these services directly. In these
situations, it will be necessary for primary care clinicians to partner with regional or state groups of primary care clinicians and to focus advocacy efforts on regional directors of these ambulatory managed care plans and on insured families and their employers to make them more knowledgeable of pediatric needs. For AAP chapters that have established managed care “pediatric councils” (groups of pediatricians who meet periodically with medical directors of the region’s major managed care plans and other insurers), mental health/substance abuse advocacy issues can become agenda items (eg, notification of the primary care clinician when a family accesses mental health services, routine exchange of information between mental health providers and primary care clinicians, and expansion of mental health panels to include pediatric specialists). The recently adopted federal law that mandates parity of mental health and physical health insurance benefits should provide incentive for such efforts.

Strategies for System Change in Children’s Mental Health: A Chapter Action Kit45 and the AAP mental health Web site28 offer strategies for AAP chapters and other primary care professional associations to use in their attempts to achieve equity of mental health benefits in insurance plans, fair payment of primary care clinicians and mental health professionals for the services they provide, policies that support and promote collaboration, and support of public mental health systems. The Task Force on Mental Health worked with the Academy of Child and Adolescent Psychiatry to develop a white paper on administrative and financial barriers to children’s mental health care, which was published in Pediatrics in April 2009.46 Consumer groups such as the NAMI and the FFCMH are invaluable to primary care clinicians’ advocacy efforts, as they have been to the task force’s work.

**STRATEGY 7: ADDRESS STIGMA THROUGH PUBLIC EDUCATION**

Stigma prevents many children and families from seeking care for their mental health and substance abuse concerns. Primary care clinicians can partner effectively with mental health advocates and mental health professionals to combat stigma at the community level. Such partnerships with local NAMI, Children and Adults With Attention Deficit/Hyperactivity Disorder, and FFCMH organizations, for example, have focused on:

- battling stigma with facts (eg, mental illnesses are treatable; children and adults who live with these illnesses can achieve recovery and lead full and productive lives; children often have behavioral problems; mental illness is not a character flaw, a sign of moral weakness, or anyone’s fault);
- establishing support groups and education programs for families (combating the social isolation that so often accompanies mental illness, for both the child and family); and
- eliminating language that contributes to stigma through defining people by their condition and using “people-first” language (eg, referring to someone as “a person with schizophrenia” rather than “a schizophrenic”).

**CONCLUSIONS**

Enhancing the mental health of children requires a population perspective that recognizes collective opportunities to promote mental health, reduce the risk of mental illness, and improve mental health services. Each clinician will choose strategies in accordance with his or her community’s specific needs and his or her practice’s priorities. Forming a group of interested primary care clinicians, developmental and adolescent specialists, advocates, educators, agency representatives, and mental health/substance abuse professionals offers the benefit of enhancing relationships while ensuring coordination and synergy of effort. The resources available on the AAP mental health Web site28 can provide assistance. By facilitating system changes at the community level, the primary care clinician can set the stage for enhancements in mental health care at the practice level.

Community-level strategies for enhancing children’s mental health include:

- apply a “population” perspective to gain understanding of the mental health needs of children and youth in the community;
- inventory the community’s mental health resources;
- develop or strengthen relationships with mental health advocates, schools, human service agencies, mental health and substance abuse providers, and developmental specialists by collaborating on system-focused initiatives;
- develop a community protocol for managing psychiatric emergencies;
- align with community partners in addressing the mental health needs of children within the primary care practice;
- participate in AAP chapter efforts to address payment and broader system issues; and
- address stigma through public education.

**AAP TASK FORCE ON MENTAL HEALTH**

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Jane Meschan Foy, James Perrin and for the American Academy of Pediatrics Task Force
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