In 2004, the American Academy of Pediatrics (AAP) Board of Directors formed the Task Force on Mental Health and charged it with developing strategies to improve the quality of child and adolescent mental health services in primary care. The task force acknowledged early in its deliberations that enhancing the mental health care that pediatricians and other primary care clinicians provide to children and adolescents will require systemic interventions at the national, state, and community levels to improve the financing of mental health care and access to mental health specialty resources. Systemic strategies toward achieving these improvements are the subject of other publications of the task force: “Strategies for System Change in Children’s Mental Health: A Chapter Action Kit”1 “Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration,”2 and “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community.”3

The task force also recognized that enhanced mental health practice will require competencies not currently achieved by many primary care clinicians; in the policy statement “The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care,”4 the task force collaborated with the AAP Committee on Psychosocial Aspects of Child and Family Health to outline these competencies and propose strategies for achieving them.

This report offers strategies for preparing the primary care practice itself for provision of enhanced mental health care services. The task force proposes incrementally applying chronic care principles to the care of children with mental health and substance abuse problems as primary care clinicians apply them to the care of children with chronic medical conditions such as asthma.

*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.

†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.
Most primary care clinicians will find that significant gaps exist between their current practice and the proposed ideal. The task force offers guidance in this report while recognizing that priorities for change and the sequence of change will be determined by the needs of the children and families whom the practice serves and by the capacity and resources of the practice.

APPLYING THE CHRONIC CARE MODEL TO CHILDREN WITH MENTAL HEALTH PROBLEMS

Children with mental health problems are children with special health care needs. Although many people can and do recover from their mental health problems, they may chronically experience symptoms and/or some level of impaired functioning. Although much of the literature on the chronic care model focuses on medical rather than mental health conditions and on adults rather than children with mental illness, the task force recognizes the applicability of chronic care methods to children with mental health problems and the potential importance of these methods in creating a “medical home” for children who experience mental health problems (Fig 1).

The payoff at the practice level can be substantial. For example, a majority of studies on depressed adults managed with chronic care methods in primary care settings have documented significant improvement in quality and outcomes. Moreover, most studies have shown decreases in the cost of care or reductions in the use of health services.

Most practices will not be able to implement quickly all or even most of the elements of the chronic care model. Practice change is a slow and incremental process that requires learning and modification at the practice level. Primary care clinicians and managers can consider which strategies seem most feasible and are most consistent with other aspects of their practice and gradually plan the enhancements they choose.

The Mental Health Practice Readiness Inventory (Appendix S3) can assist primary care clinicians and managers in assessing the strengths and needs of the practice and in setting its priorities. The inventory is organized in accordance with key elements in the chronic care model: (1) community resources; (2) health care financing; (3) support for children and families; (4) clinical information systems/delivery system redesign; and (5) decision support for clinicians. Individual clinicians and practices may have limited influence over some of these elements, but there are steps that any practice can take to improve mental health service delivery. Appendix S3 was designed to accompany reading of the following narrative and to structure practice-improvement initiatives.

The task force envisions that clinicians typically will make changes first on behalf of children and adolescents with recognized mental health disorders in their practice. Discussions with specialists about these patients will enhance the collaborative and clinical skills of primary care clinicians, and experience with scheduling, coding, and billing will build a business infrastructure for the practice’s mental health services. Clinicians can subsequently apply the chronic care principles to children whose mental health problems do not meet the criteria of a diagnosable disorder but require care and monitoring nevertheless. With chronic care management and business systems in place, clinicians will be prepared to enhance their efforts to identify children with occult mental health and substance abuse problems; these efforts may include routinely screening for mental health and substance problems at health supervision visits (see discussion in Appendix S4).

Efforts to implement screening before office systems, collaborative relationships, and referral supports are in place are unlikely to achieve sustainable benefits. Clinicians may choose to enhance their identification of children with mental health problems by focusing a screening effort on a particular age group or high-risk population within the practice or through mental health updates at acute

‡See definition, Appendix S9.
care visits (see “Decision Support” below).

COMMUNITY RESOURCES

Building resilience and promoting mental health in children and youth will require the participation of many organizations and individuals throughout the community. (See “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community” for a full discussion.) Treatment of children with mental illness will require strong collaborative relationships between primary care clinicians and the mental health specialty system. These collaborations will function in ways that will make practice better for both groups and care better for patients.

Create a Resource Guide of Community Mental Health and Substance Abuse Resources (and the Types of Payment Accepted)

This guide might include developmental-behavioral pediatricians, adolescent specialists, mental health and substance abuse specialists, family support groups, Early-Intervention (EI) services, human service agencies, child care consultants, parenting education programs, key school contacts, youth organizations, recreation programs, and others who are involved in supporting or serving children and families.

The task force has developed a table to summarize key mental health services necessary to care for children with common mental health problems (Appendix S1). A variety of specialists may be qualified and reimbursed to offer evidence-based services, depending on state licensing policies and insurers’ credentialing decisions. The selection of service providers depends on current information about the safety and efficacy of various treatments for the common childhood mental health disorders. Internet sources of this information include www.aap.org/mentalhealth, www.samhsa.gov, www.schoolpsychiatry.org, and www.aacap.org.

Methods to use in creating or adapting a resource guide for the practice are detailed in the chapter action kit and “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community.” Organizations in the community (eg, the public mental health agency; department of public health; local mental health association; local branches of consumer organizations such as the National Alliance on Mental Illness or Federation of Families for Children’s Mental Health; support groups for families of children with specific disabilities such as autism or attention-deficit/hyperactivity disorder [ADHD]) typically benefit from such an inventory and are willing to participate in developing it or in building on one that is already in place.

It is important to note the type(s) of third-party payment that each specialist or resource accepts and the types of assessment and/or therapies they provide. EI services are critical for young children who are experiencing socioemotional or developmental problems. As federally mandated services, they are universally available in the United States but variable in quality and accessibility. Details about EI referral criteria and intake procedures are important to include in the inventory.

The burgeoning body of knowledge about early brain development calls attention to the critical importance of parenting, attachment, and high-quality child care on the emotional, social, and cognitive development of young children. Many communities have begun offering such services as nurse visits to pregnant and parenting women who are at high-risk, parenting programs, child care consultation, and therapeutic child care settings. These resources should be included in the inventory, along with resources to help parents and teachers who are dealing with anxiety, depression, substance abuse, mental illness, or other personal challenges that affect the quality or continuity of their relationships with young children.

Schools are key partners in providing mental health services to children and in collecting data about children’s academic and social functioning. In rural areas of the country they may, in fact, be the major provider of mental health services to children. Guidance counselors are typically the initial contact for clinicians seeking to establish a connection with the child’s school; counselors, school nurses, or other school-based personnel may be helpful in making classroom observations, gathering behavior scales from teachers, assisting with implementation of classroom interventions, and pursuing testing for special educational services. They may also assist the primary care clinician in monitoring a child’s progress and providing support and education to the family. A school psychologist can provide psychological testing; a school social worker can often provide counseling and linkage to other school and community resources; and the school system’s special education officer can assist in determining a child’s eligibility for special educational services or respond to questions about those services. School-based health centers may house additional professionals, including mental health specialists; when collaborative relationships exist between school-based health centers and primary care clinicians, these centers augment, rather than fragment, care.

Involvement in extracurricular school activities enhances a child’s attachment to school and improves his or her resilience. Involvement in community service and involvement in a faith community are also protective for youth. Recreation programs, youth groups, and family
support groups may all play significant roles in providing children and adolescents with positive experiences and social skills; for this reason, all are relevant to child mental health and warrant inclusion in the practice’s resource directory.

**Become Knowledgeable About the Available Community Resources**

Most clinicians are understandably reluctant to refer to sources that are unknown to them. The authors of “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community” suggest some strategies for getting to know mental health specialists and other child advocates through participation in efforts to address community mental health issues and gaps in services. In a policy statement on mental health competencies, the AAP suggests ideas for joint educational efforts, which may serve the additional purpose of fostering interpersonal relationships. Referral families are also an invaluable source of information about community resources. Primary care practices can annotate their resource directory with the feedback received from children and families. This information will assist clinicians in creating matches between families and service providers or community programs.

**Develop Collaborative Relationships With Providers of Key Services**

Previous understanding about respective roles of primary care clinicians and key mental health service providers can create efficiencies and improve coordination of care. For example, school-based personnel and primary care clinicians can meet to determine how they will collaboratively assess and monitor the progress of children with learning and behavior problems that affect school performance. Together, they can decide what circumstances or symptoms will trigger an evaluation at the school; what tools will be used to measure children’s cognitive ability, academic achievement, and classroom behavior; who will gather the information and relay it to the primary care clinician; and what mechanisms will be used to convey the primary care clinician’s assessment and care plan back to the school and monitor the child’s progress in the classroom. Similarly, previous understanding with community agencies, such as child protective services or the juvenile justice system, about collecting a psychosocial and medical history from the biological parents before the child’s placement in foster care or a juvenile detention facility can greatly improve continuity of care and assessment of the child’s mental health needs. See the chapter action kit and “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community” for additional ideas about strengthening these relationships.

Ultimately, collaborative clinical relationships are built through jointly caring for children and families. Personal contact and conversation are the starting point; yet, there can be challenges for the busy primary care clinician and a mental health professional. Mental health professionals often lack “front-office” personnel and instead function with little support and use voice mail to capture messages while they are in therapy sessions. They are also extremely protective of their patients’ confidentiality, often exceeding standards of the Health Insurance Portability and Accountability Act (HIPAA). The primary care practice can develop office procedures to support collaboration (eg, routinely requesting families to sign a consent for exchange of information at the time of a referral; developing a previous understanding with mental health colleagues about a convenient time to chat; providing mental health colleagues with the primary care clinician’s direct line; or hosting “lunch and learn” sessions for primary care clinicians and mental health professionals to exchange information, review cases, and coordinate care). Section “Prepare for Participation in the Full Range of Collaborative Models” provides more detail about the types of collaborative relationships that clinicians can nurture, and section “Put Office Systems in Place to Support Screening, Assessment, and Collaboration” elaborates on office procedures to support collaboration.

**HEALTH CARE FINANCING**

To sustain innovations that improve care, primary care clinicians will require substantial enhancements in payment for their mental health services.

**Provide a Realistic Business Framework for Mental Health Services**

The task force recognizes that many primary care clinicians in the United States are not adequately paid for the mental health care they provide. In some cases, this inadequate payment is because primary care clinicians are not aware of coding mechanisms that lead to payment. In other cases, it is because insurers do not pay for the mental health services that primary care clinicians provide (screening, assessment, early intervention to address emerging problems that do not rise to the level of disorders, interaction with schools and agencies, consultation with mental health specialty providers, care coordination, patient and family education, and family conferences). Furthermore, many insurers do not allow primary care clini-
cians to serve as mental health providers; instead, their insurance plans have mental health “carve-outs”—separate mental health provider networks with separate “gate-keeping” or intake procedures—that exclude primary care clinicians from participation and disallow payment of primary care clinicians for the mental health treatment services they provide to children with mental health diagnoses. For clinicians who function in this type of environment, preparation for enhancements in mental health practice will require advocacy efforts aimed at insurers of their patients and major purchasers of their patients’ insurance plans. Strategies applicable to these efforts are detailed in the chapter action kit. A white paper developed jointly by the task force and the American Academy of Child and Adolescent Psychiatry addressing the administrative and financial barriers to providing collaborative mental health care was published in Pediatrics in April 2009.

Gain Access to Mental Health/Substance Abuse Provider Lists and Authorization Procedures of Major Public and Private Health Insurers

Because mental health benefits and formularies are quite variable and often poorly understood by patients and families, many offices struggle to find out what resources are appropriate for referral or prescribing and what the patient cost-sharing for such services is likely to be. Increasingly, large insurers are providing online resources for rapid access. In addition, some creative vendors (eg, Rachel Systems) provide such services for all insured patients in a region through a common Web portal so that office staff and clinicians can quickly identify appropriate resources and medications for any insured patients. Where such systems are not available, clinicians in a region (or perhaps AAP chapter or district) can collaborate or work through AAP chapter pediatric councils to acquire or develop such portals. Chapter pediatric councils are forums whereby pediatricians meet with health plan medical directors to discuss carrier policies and administrative practices that affect access to, quality of, coverage of, and payment for pediatric services.

Prepare the Practice to Code and Bill Effectively to Ensure Payment for Mental Health Services

The chapter action kit and “Enhancing Pediatric Health Care: Algorithms for Primary Care” (referred to throughout this article as “Algorithms for Primary Care”) provide tools to assist practices with coding and billing for mental health services. Informed by these tools and assisted by their practice manager and other staff members, primary care practices can create encounter forms to capture necessary documentation and ensure that the mental health services provided are billed for appropriately and efficiently. Supplemental Appendix S10 provides a listing of sample tools to assist primary care clinicians with these preparations.

SUPPORT FOR CHILDREN AND FAMILIES

Pediatric primary care practices are typically child- and family-friendly places and can readily take additional steps to normalize and destigmatize mental health concerns. Engagement of children and their families in their own care is one of the best correlates of successful outcomes. Such efforts may focus on child and family motivation, education, skill-building, or emotional support. When mental health specialty care is needed, children and families need support in the referral process.

Ensure That Children and Families With Mental Health Concerns Have a Positive First Contact With the Practice

Clinical staff, receptionists, and administrative staff may figure importantly in a child’s and family’s engagement or continuation in mental health care. McKay et al have developed a 1-day training that assists staff of outpatient mental health facilities in developing “first-contact skills” (including telephone engagement skills) and in identifying key barriers to seeking mental health care. Evaluation of sites that have implemented engagement strategies suggests that they have significantly higher appointment-keeping rates than sites that have not implemented these strategies. Although not developed specifically for primary care settings, the application of evidence-based engagement principles is likely to be beneficial to staff in primary care settings that provide mental health services.

Address Stigma

Creating an environment supportive of children and families facing mental health challenges requires that primary care practices address stigma. Clinicians can reflect with their staff members on the important role they can all play in making children and families comfortable to share and address mental health concerns. Staff members can examine their own knowledge and attitudes. They can affirm that mental illnesses are treatable; that children and adults living with these illnesses can achieve recovery and lead full and productive lives; and that mental illness is not a character flaw, a sign of moral weakness, or anyone’s fault. They can eliminate language that contributes to stigma through defining people by their condition (eg, referring to someone as “a
Promote the Concept of Mental Health as Integral to the Care of Children in the Medical Home

Separation of mental health services from medical care contributes to stigma, poor coordination of care, and increased costs. The office environment can speak to the importance of mental health and substance abuse issues (eg, posters that invite mental health and substance abuse questions, educational materials about common mental health problems, brochures for crisis lines and support groups, and meeting places for evening support and treatment groups). By implementing Bright Futures guidelines, primary care clinicians can normalize mental health care and incorporate conversation about psychosocial issues into every routine health supervision visit. When given the opportunity during a well-child visit, most parents will express some concern about a behavioral or developmental issue.

Many primary care practices have concerns about the time and expertise required to address mental health concerns and about poor payment for the mental health services they provide. The use of previsit questionnaires and electronic tools to gather information from youth and families in advance of an office visit can allow clinicians to redirect their time from gathering data to addressing concerns. The practice can host educational sessions to assist clinicians in acquiring new skills (eg, improving diagnostic skills, gaining knowledge of treatment strategies, applying “common-factors” techniques to address concerns in primary care encounters, developing a continuity or crisis plan for urgent mental health problems, closing a visit in a supportive and efficient manner, and facilitating coding and billing that are specific to mental health).

Adverse childhood experiences may affect a person’s mental health for a lifetime. Examples include trauma such as abuse or neglect, placement in foster care, death of a loved one, a move, separation and divorce of parents, military deployment of parent(s) or a sibling, incarceration of a parent or sibling, breakup of a relationship, and exposure to violence or a natural disaster. The clinician will need to view all future physical and mental health issues in the family through the prism of the traumatic experience(s). Children vary widely in their reactions to these events depending on their developmental level, temperament, previous state of mental health, coping mechanisms, parental responses, and support system. Practices should establish office systems that routinely collect information about such stressful experiences in the child’s life and flag them in the health record of the child and siblings to signal clinicians’ interest and support, monitor the child(ren)’s adjustment over time, and make appropriate referrals if the child’s functioning is impaired. Conversely, overlooking such experiences and failing to follow-up on the child’s and family’s progress after a traumatic event are lost opportunities to connect with the child and family around important mental health issues.

The anniversary date of a traumatic event or loss can also be recorded on the anniversary of the loved one’s death can communicate support; it will also keep the door open to further conversations about the reactions of family members to trauma and loss and their effects on children.

Assure Children and Families About Confidentiality

People with mental health and substance abuse concerns are usually deeply concerned about confidentiality. Office procedures should ensure that all interactions between staff and children/families are private, including sign-in procedures, discussion of the reason for the visit or “chief complaint,” and each phase of the clinical process, including any referrals made to mental health or substance abuse specialists. In accordance with the HIPAA, the practice should post information about its privacy rules and offer families written information about them. Staff members can reinforce their commitment to maintaining confidentiality at the time they request consent for exchange of information with other health care providers and schools. All faxes should have cover sheets that label the information as confidential. When faxing information to schools or agencies that may have fax machines used by multiple staff members, previous arrangements may be necessary to ensure that the intended recipient is awaiting the fax and protects its confidentiality. Certain mental health information (eg, psychotherapy notes and any information related to substance abuse issues) is protected by federal statutes that supersede the HIPAA.

In states where minors are allowed to consent for their own mental health and substance abuse services, there should be a clear understanding with both youth and parents/guardians about “conditional confidentiality,”
which is the clinician’s right and responsibility to break confidentiality if he or she judges the youth or others to be in danger. Office procedures must ensure that youth treated for a mental health or substance abuse problem without their parent/guardian’s knowledge express their preferences in relation to messages left on telephones and mailing of communications such as billing statements, laboratory results, and explanations of benefits. Further guidance for the protection of confidentiality of mental health and substance abuse information can be found in the chapter action kit under “Strategies to Collaborate With Mental Health Professionals,”1 and the AAP Policy Web site (www.aappolicy.org).

Prepare to Address the Mental Health and Substance Abuse Needs of Adolescents

Children gradually assume responsibility for their own health care. The timing and pace will depend on the child’s maturity and cognitive abilities. By the time they reach adolescence, most of them will want an opportunity to air concerns directly with their health care providers and, at times, receive care without knowledge of their parents/guardians. The laws governing the confidentiality of minors’ health care in relation to their parents/guardians vary from state to state. Keeping these factors in mind, a primary care practice may choose to mark the occasion of a patient’s upcoming adolescent health supervision visit or 12th birthday by sending a letter to the adolescent and parents describing expectations for the adolescent’s increasing independence in seeking and receiving health care and their practices in relation to privacy. At every visit with an adolescent, clinicians should reinforce the conditional confidentiality of their relationship. Appointment scheduling for adolescents should take into account the need to speak with both the adolescent and the parent/guardian privately. Both conversations are important, because parents and guardians may not be fully aware of their adolescents’ activities or feelings, because the adolescents may be reluctant to share some concerns with their parents/guardians, and because youth and parents often differ in their ability to report on various mental health conditions (see “Algorithms for Primary Care”17). Further guidance on meeting the health care needs of adolescents is available in Bright Futures24 and from the Adolescent Health Working group.36

Focus Effort on Engagement of the Child and Family in Help-Seeking

At the time a primary care clinician identifies a child with a mental health problem, the child and family may be resistant to taking action to address the problem, perhaps because of the stigma of mental illness, conflict within the family, lack of resources, distraction by other family priorities, anger, denial, or a sense of hopelessness, possibly rooted in unsuccessful past efforts. Behavior-change science has demonstrated that people are in various stages of readiness to address a health problem: some are not even contemplating action, some are contemplating action but are ambivalent, some are ready to act, and some are already acting to create change.37 Rather than using a prescriptive approach, primary care clinicians are more effective if they assess a family’s readiness to address a problem and then help them to move to the next stage of readiness at their own pace.4,21,38 The practice can collaborate with a mental health professional to train clinicians in these techniques. Application of these techniques is quite manageable within the pace of a busy primary care practice, particularly if the primary care clinician is prepared with skills to bring a visit to an efficient and supportive close and to reschedule the family for additional brief sessions, if necessary.39 However, such primary care interventions are typically briefer than usual mental health outpatient services and different in content. Practice preparations to ensure appropriate scheduling, Current Procedural Terminology (CPT) coding, and billing for these sessions will help to make these activities sustainable. Guidance is available in the chapter action kit1 and in Supplemental Appendix S10.

Offer Self-help Interventions

Although not a substitute for specialty care, interactive support services that assist patients and their families in managing, tracking, and working on their symptoms seem to be effective in extending the reach and success of mental health care. Results of randomized trials support the efficacy of ADHD-support Web sites, online depression management, telephone case management, motivational interviewing services, text-messaging reminders for medication adherence, and related services.10–50 In addition, primary care practices can have available a range of written materials and Web resources aimed at promoting mental health, educating the child and family about particular behavioral challenges, and providing guidance in self-management and family management of problems. Whatever resources are offered, the primary care practice plays a critical role in monitoring to determine the child’s and family’s progress in managing problems.

Support Families in the Referral Process

Communication techniques, such as motivational interviewing, are helpful in preparing a family for referral to mental health specialty services, which is otherwise completed by a family less than 50% of the time.51,52 Primary care clinicians

PEDIATRICS Volume 125, Supplement 3, June 2010 S93

Downloaded from http://pediatrics.aappublications.org/ by guest on November 14, 2017
can also increase the likelihood that families complete referrals and successfully navigate the mental health system by providing referral support services, including telephone or personal contact by staff members, case workers, family advocates, or paid providers of peer support services. Written materials for families that describe the referral process and the types of mental health specialty resources available in the community will reinforce information shared verbally. It is critical to implement a tracking mechanism for children who are referred for mental health specialty care.

Identify Children Involved in the Mental Health System and Provide Them With a Medical Home

The practice will need to work systematically to identify children who have not shared information with their primary care clinician about their existing mental health condition(s). Some of them may be children with severe mental illness, known to the mental health specialty system but not to the primary care clinician. This situation may arise because the family self-referred into the mental health system or entered the mental health or juvenile justice system after a crisis such as a suicide attempt, group-home placement, arrest, or incarceration. Even families who have warm relationships with their child’s primary care clinician may feel embarrassed by their child’s problems and reluctant to share this information with the primary care clinician, not recognizing the primary care clinician’s potential role in coordinating services or the potential risk of keeping the primary care clinician unaware of psychiatric care, particularly pharmacologic treatment.

Primary care practices interested in folding these children into the medical home will need to scrutinize their intake forms and processes to ensure that they include queries about mental health specialty care. They will also need to take general steps to communicate their interest in mental health and substance abuse issues through integration of these topics into health supervision and acute care visits and through posters and brochures in the waiting room. The primary care clinician or practice manager may also advocate with local agencies and with contracted insurance plans to request notification of the primary care practice when a child seeks services from mental health professionals or prepares for discharge from a hospital or group home.

As these children are identified, they may be added to a registry and incorporated into chronic care protocols, as described below. The primary care practice will need to make a special effort to reassure the families of its support and willingness to partner with them and their child’s mental health specialty provider(s). Families of children with mental health disorders have a range of experiences in mental health specialty and primary care and will likely become important sources of education for the primary care clinician about community resources and supportive primary care practices. They are also potential fellow advocates in the quest for improved insurance benefits and payment rates.

Children with severely impairing mental illness often qualify for and/or receive services of a mental health case manager. This person is responsible for coordinating the agencies involved in the child’s care and for overseeing development and implementation of a “person-centered plan” (abbreviated PCP, which often confuses primary care providers, who are also known as PCPs) or “family-centered plan;” intended to create a system of care (SOC) around the child and family. The SOC philosophy, developed in the 1990s, reflects the influence of “consumers” (preferred term in the mental health advocacy community for people with mental illness) on mental health specialty care and has as its core principles:

- focus on strengths rather than problems;
- “nothing about us without us”;
- commitment to recovery as a goal;
- consumer choice among treatment options;
- services provided in the least restrictive environment; and
- a plan of care, developed with the family, built around the family’s needs and preferences, and articulating the therapeutic goals and roles of all service providers.

Primary care clinicians are often not engaged with specialty mental health systems of care for these children, and the primary care needs of these children may be overlooked. There may be a number of possible explanations: primary care clinicians may not feel that they have the expertise to participate in a mental health SOC; primary care clinicians may be unaware of community efforts toward building a SOC; mental health professionals and agencies may not recognize primary care clinicians’ potential to contribute to the child’s and family’s care; families may resist involvement of primary care clinicians because of stigma, and families and mental health professionals may be overwhelmed with the child’s mental illness to the neglect of any primary care concerns. Whatever the reasons, an expression of interest on the part of a primary care clinician is very likely to be appreciated and valued by families and mental health professionals. A natural entry point for the primary care clinician into a community’s mental health SOC efforts is the
mutual care of a child. However, to be effective, primary care clinicians and professional organizations that represent them must participate in systemic planning at the regional and state levels.

Increasingly, the essential role of primary care in SOC-planning efforts is being recognized. People with severe mental illness experience dramatically higher rates of morbidity and mortality from medical illnesses than do others. Incorporating primary care into the plan of care for all children with mental illness may establish a pattern that has lifelong benefits.

As adolescents with mental illness approach adulthood, they face transition to new primary care and specialty providers, as well as developmental tasks for which they may be inadequately prepared: completing high school or an equivalent course of study, attaining higher education, living independently, building social supports, finding employment and housing, and adhering to their treatment regimen. Although transition services for youth with mental illnesses are absent or insufficient in many communities, primary care clinicians can apply medical home principles, as they do for other youth with special health care needs: they can ensure that their practice provides education to young people and their families about transition issues and anticipates the health, educational, social, and vocational needs they may encounter. In communities without adequate transition resources for young people with mental illness, clinicians can partner with others to address deficiencies.

Prepare to Address the Mental Health and Substance Abuse Needs of Special Populations Within the Practice

Every day, children witness, hear about, or directly experience traumatic events (e.g., plane crash, tornado, war, crime, flood). Feelings Need Check Ups Too is a set of resources to help primary care clinicians address the needs of traumatized children. The US Task Force on Community Preventive Services recently conducted a systematic review of interventions for reducing psychological harm to youth after exposure to a traumatic event. Just 2 interventions met this task force’s criteria for evidence of effectiveness in helping traumatized children: trauma-focused individual cognitive behavioral therapy and trauma-focused group cognitive behavioral therapy. Ideally, these services would be available in every community and accessible to children in the practice.

Virtually all children in foster care have mental health needs. The authors of “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community” suggest strategies for collaborating with the community’s child protective services agency to address the needs of these children and their families. The AAP has created a task force to address the needs of children in foster care and provided Web resources at www.aap.org/fostercare. Children whose parents are serving in the military or are active members of the National Guard and Reserve are subject to stress, separation, and loss; resources for addressing the needs of these families can be found at:

- AAP Section on Uniformed Services (www.aap.org/sections/uniserv/deployment/index.htm)
- National Military Family Association—Operation Purple camps (www.nmfa.org)
- Military One Source (www.militaryonesource.com)
- Military Family Research Institute (www.mfri.purdue.edu)
- MilitaryHOMEFRONT (www.militaryhomefront.dod.mil)
- Tragedy Assistance Program for Survivors (www.taps.org)
- Military Child Education Coalition (www.militarychild.org)

Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are at higher risk than their heterosexual peers for substance use, depression, suicide, and harassment or violence in the community or school. The AAP has published a policy statement that underscores and draws providers’ attention to the health needs of LGBTQ youth. In addition, surveys of LGBTQ youth and parental and professional organizations that have particular needs for mental health and substance abuse services and social support. Through partnership with other health care and human service providers, primary care clinicians can determine how the medical home can best
serve the mental health needs of these children and coordinate services with the other providers. Primary care practices would benefit from a previous shared understanding about respective responsibilities for collecting a psychosocial history, administering and scoring mental health and substance abuse screening tools, enlisting support from nonprofit or volunteer agencies, and identifying culturally appropriate and accessible assessment and treatment services.

Ensure the Family Friendliness of the Practice
The practice can take general steps to ensure that it is partnering successfully with children and families. The AAP participated with Family Voices, the Maternal and Child Health Bureau, and other partners in developing tools to assess the family-centeredness of the care a practice provides. These tools, along with a guide that enables users to apply findings to practice improvements, are available at www.familyvoices.org.

Periodically Assess the Quality of Care the Practice Provides to Children With Mental Health Problems and Take Action to Improve Care
A number of resources are available to help primary care clinicians with their quality-improvement efforts, including AAP Practice Management Online (http://practice.aap.org), eQIPP (Education in Quality Improvement for Pediatric Practice [www.eqipp.org]), and the Improving Chronic Illness Care Web site (www.improvingchroniccare.org). Specific AAP projects also provide resources on particular topics (eg, “Bright Futures Training Intervention and Practicing Safety: Child Abuse and Neglect Prevention”). Clinicians may monitor their psychosocial care in maintenance of certification by using such quality-improvement programs as eQIPP and developing relevant pay-for-performance and quality indicators for health plans.

CLINICAL INFORMATION SYSTEMS AND DELIVERY SYSTEM REDESIGN
Clinical information systems ensure continuity of patient information across settings and time and facilitate collaboration between primary care clinicians and mental health professionals. Collaboration is particularly important in the care of children with comorbidities. Local resources and clinical circumstance will dictate the specific model(s) of collaboration and the design of delivery systems that are necessary to support them.

Create Registries of Children With Mental Health Problems
Preparing the practice to care for children with identified mental health conditions is similar to preparing the practice to care for children with chronic medical conditions such as diabetes or asthma. It depends on registries of children with mental health problems (including those who are not yet ready to address their problems). Although this step is greatly facilitated by an electronic health record (EHR), registries can be developed in the absence of an EHR through the use of claims data and other approaches. As examples, the AAP toolkit for ADHD\(^\text{80}\) contains tracking procedures for patients with ADHD; the Institute for Healthcare Improvement and the National Initiative for Children’s Healthcare Quality have frequently used condition-specific registries (which do not depend on EHRs) in their quality-improvement initiatives; a program called the Chronic Disease Electronic Management System (CDEMS), which incorporates an Access (Microsoft, Redmond, WA) database and is available free of charge, can be customized to meet the tracking and registry needs of a given practice.

Use Monitoring, Prescribing, and Tracking Systems for Psychosocial Therapy and Psychotropic Drugs
Some children have mental health problems that resolve quickly; some children have mental health disorders that require treatment to be administered over extended periods of time and monitored for initial remission and symptoms of recurrence; and some children recover from mental health disorders or return to normal functioning. Primary care systems cannot act as a medical home for children with mental health problems without the capacity to monitor receipt and outcomes of treatment. Monitoring systems can be set up in a variety of ways that ensure that information will be shared among the family, EI specialist, school (or preschool), and health care providers and between primary care clinicians and specialists. At the core of such a system are a registry of children with a certain condition (see above) and an established protocol that assigns responsibility for communication to a certain team member who will assist in the monitoring process (see below). Although “tickler” systems—the use of manual reminders entered onto a staff member’s calendar or a “record review” entered onto a provider’s clinic schedule—can be used for this purpose, electronic systems that are capable of extracting information from records and producing notices, reports, and/or appointments are especially useful.

Put Into Place a Plan for Managing Psychiatric and Social Emergencies
Primary care clinicians need access to emergency services for children and adolescents with suicidal thoughts...
and other psychiatric emergencies. Virtually all communities in the United States have some resource and process identified for handling psychiatric emergencies, although capacity varies widely and, in many areas, depends on law enforcement agencies and emergency departments. Some communities have 24-hour, 7-days/week emergency psychiatric facilities and/or mobile response units staffed by experienced personnel. Primary care practices need to be aware of these services, participate in community dialogue about management of psychiatric and social emergencies, and establish office protocols that link youth and families immediately to appropriate services. (See the chapter action kit1 and “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community”2 for further discussion of this strategy.)

Put Office Systems in Place to Support Screening, Assessment, and Collaboration

Office procedures to ensure exchange of information between the primary care practice and mental health specialists are critical for effective care and coordination. Although the HIPAA actually allows mental health professionals and primary care clinicians involved in the care of the same patient to exchange information (other than psychotherapy notes and substance abuse records) without the patient’s and family’s consent, the mental health culture is very protective of privacy, even from referring physicians. Primary care clinicians may need to educate mental health professionals about the concept of the medical home for children with special health care needs, the primary care clinician’s role and interest in the care of children with mental illness, and the primary care clinician’s need for information about their patients’ mental health treatment, especially as it may affect other elements of a child’s care (including medication interactions).

Many children and families will readily agree to the exchange of information between their mental health professional and primary care clinician, if asked. Routine use of forms that document consent for exchange of information will facilitate communication. Use of fax-back forms (see Supplemental Appendix S11 for an example) or other methods to facilitate exchange has been helpful in some communities.82,83 Telephone calls may be less convenient for mental health professionals, who are typically scheduled with back-to-back 45- to 60-minute appointments and have little administrative support; however, previous understanding about convenient times to talk may be beneficial. E-mail is often convenient, but as with other uses of e-mail in health care settings, secure communication must be in place and confidentiality must be carefully considered.

Whatever methods are used, primary care practices can demonstrate their commitment to bidirectional communication with mental health specialists. Office procedures can ensure that specialists receive, for example, a summary of the presenting concern, the family’s level of engagement in the process, results from tools used to measure symptoms and/or functioning, and the primary care clinician’s capacity and preferences in relation to comanagement. The primary care practice can create the expectation that, in return, it will receive from the mental health specialist a summary of diagnostic findings, treatment recommendations, and clarification of respective roles in ongoing comanagement of the identified problem.

Collaboratively Develop Care Plans

Chronic care principles suggest that optimal outcomes are achieved when the family, primary care clinician, and specialists involved in assessment and treatment collaboratively develop a comprehensive plan of care. Key elements of collaborative care plans include identification of family concerns, education of the family about the condition and self-management strategies, listing of all professionals involved in the care of the child, listing of the strengths and resources available to the family and child, a comprehensive account of diagnoses and therapies, therapeutic goals, and a specific plan for monitoring progress toward these goals, including periodic functional assessment. Care-plan development is discussed in more depth in “Algorithms for Primary Care.”21 Sample paper-based care plans for chronic conditions in pediatric settings are available at the AAP Web site under the medical home toolkit section.84

Prepare for Participation in the Full Range of Collaborative Models

Previous strategies have addressed the need for a resource directory and for relationships with providers of key mental health services. The model of collaboration between a primary care practice and mental health specialist(s) in a particular clinical situation depends on the needs of the child, child and family preferences, availability of the needed resources, and the primary care clinician’s comfort with the child’s condition(s) and its severity. A child may move between models as the mental health condition changes in severity or the child achieves recovery. In regions where mental health specialty services are inaccessible or insufficient, including most rural areas of the country, primary care practices may need to plan for collaboration by telephone, Inter-
A psychologist or other nonphysician specialists. Innovative systems in several regions of the country have been developed to provide decision support for primary care clinicians.1,85-88 Social workers or referral coordinators can help patients navigate public and private mental health specialty systems. In all collaborative models, a system of communication among providers is critically important to prevent clinicians from relying on family members as conduits of clinical information.

**Primary Care Only**

In this model, the child can be assessed and managed appropriately and successfully in the primary care practice. The child’s mental health needs are clear and, typically, uncomplicated by comorbidities, and the child responds positively to primary care interventions. For example, the child with ADHD who requires medication and behavioral management but does not have coexisting conditions may be managed in primary care. The practice is prepared to work directly with the child and family in developing, implementing, and monitoring the child’s plan of care.

**Primary Care With Consultation**

This model is applicable to children with chronic medical conditions accompanied by impairing mental health comorbidities, such as anxiety or depression, and to children with mental health disorders that are beyond the comfort or capacity of primary care clinicians. The primary care practice serves as the source of primary care and coordination of school and specialty services, fostering relationships that enable the primary care clinician to consult with:

1. A psychologist or other nonphysician mental health therapist (eg, licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor). The primary care clinician typically provides the initial assessment and asks the mental health professional to help clarify the diagnosis; to provide information about types of psychosocial treatment approaches that may be beneficial; to guide the primary care clinician’s management; and/or to review or address complicating developments such as new behavior problems, family conflicts, and high-risk behaviors. The primary care clinician manages the prescription and monitoring of medication, if it is a part of the treatment plan. This type of mental health consultation may involve the child’s face-to-face visit(s) with the mental health specialist and/or intermittent conversations between the specialist and the primary care clinician. It may occur with or without consultation with a physician specialist, as described below.

2. A physician specialist, such as a child and adolescent psychiatrist, developmental-behavioral pediatrician, neurodevelopmental pediatrician, pediatric neurologist, or adolescent specialist. The primary care clinician (or collaborating mental health specialist, as described above) may pose specific questions about diagnosis or management strategies, including medication issues (eg, choice of agent, potential interactions, adverse effects, dosage adjustments), coexisting conditions, and suicide risk or other safety concerns. The consulting physician may provide an initial evaluation with the intention that the child will return to the primary care clinician (and mental health specialist) for ongoing care. The consultant may also offer advice intermittently when new behavior problems, medication questions, family conflicts, or high-risk behaviors occur.

**Shared Care**

In this model, the primary care practice fosters relationships that enable its clinicians to “share” the mental health care of the child with 1 or more mental health specialists; that is, both (or all) are jointly responsible for monitoring mental health symptoms, response to therapy, and effects of medication, if prescribed. In this model, ongoing communication about the child among the providers is particularly critical.

1. The primary care clinician may share the care of the child with a:
   - child and adolescent psychiatrist, who provides not only an initial evaluation but also ongoing treatment; and/or
   - mental health specialist such as a psychologist or social worker, who provides individual, group, or family psychosocial therapy; and/or
   - multidisciplinary team, which may include the child’s mental health case manager; an agency representative from the Department of Social Services or Juvenile Justice system, a mental health therapist, and school representative(s) such as a social worker; school counselor; and/or special education individual education plan (IEP) case manager; in situations that involve children with higher levels of complexity, additional multidisciplinary team members may participate (eg, teams that care for children with mental health disorders who require partial hospitalization or day treatment may include representatives of the mental health specialty facility); children with chronic medical conditions, such as cancer or
chronic pulmonary disease, may include the child’s medical subspecialist or specialty clinic coordinator.

2. Key features of shared-care models include:
   - central role of the child and family in developing the plan of care;
   - mutual understanding of the roles of family members, school or child care personnel, and providers, including frequency of and responsibility for follow-up, with mental health specialists assuming relatively more responsibility for children with safety concerns and those whose mental health conditions are of high severity or acuity;
   - general health supervision by the primary care clinician, including care of medical illnesses, immunizations and other preventive services, and coordination of specialty and educational services; and
   - a communication protocol, including parental consent for exchange of information, clear understanding of respective responsibilities and mechanisms for monitoring progress toward therapeutic goals, mechanisms for sharing information among providers, and contact persons in each provider’s practice and child’s school or child care setting.

**Specialty Care**

In this model, the mental health specialty system assumes responsibility for the child’s care because of the level of severity and complexity of the child’s problems, higher levels of concern regarding safety, and/or the coexistence of other complicating mental health or social conditions. The primary care practice ideally receives regular communication about progress and any changes in the level of care such as hospitalization or group-home placement and makes recommendations concerning the child’s ongoing primary medical care and coordination of medical specialty services. Examples include a child with psychosis or major depressive disorder.

**Consider Co-locating a Mental Health Specialist**

A growing number of practices across the country have successfully integrated 1 or more mental health specialists into the primary care setting. Primary care clinicians who have a co-located mental health professional have reported a greater likelihood of consultation and referral than those who do not have a co-located mental health professional. Although studies have focused primarily on adults with depression, integrated care programs have also been tested for anxiety, alcohol use, and ADHD in primary care settings. Although it is not possible to distinguish the effects of increased attention to mental health problems from the effects of specific integration strategies, case reports have suggested the benefits of integrated models compared with usual care. Examples include improved Healthcare Effectiveness Data and Information Set (HEDIS) indicators for depression, lower utilization of mental health specialty services, lower overall costs per patient, lower emergency department utilization, and lower hospital admissions; cost-neutrality; lower psychiatric inpatient admissions and length of stay; and lower medical inpatient length of stay. The events of September 11, 2001, Hurricane Katrina, and other disasters have emphasized the particular need for primary care practices to integrate mental health services in times of disasters. Evidence points to families’ preference for these services within primary care settings, as compared with traditional mental health settings.

**Role of Mental Health Specialist in Primary Care**

The role of a co-located mental health professional is ideally developed in response to the needs of the practice and the population it serves. Collaboration with primary care clinicians may fall within any or all of the collaborative models described above. In areas that suffer from a shortage of child psychiatrists or developmental-behavioral pediatrics, a co-located mental health specialist, such as a licensed clinical social worker or psychologist, enhances the level of assessment that is shared in advance with consulting physicians, which increases the efficiency and appropriateness of the consultative process, and facilitates implementation of a treatment plan and follow-up afterward. This type of arrangement also enriches the involved primary care clinicians and specialists through informal consultation and shared problem-solving around children and families in their mutual care.

The co-located mental health specialist may function in a number of ways, depending on practice preferences and business realities. He or she may function similarly to his or her role in a mental health specialty site, offering traditional mental health assessment and treatment services in 30- to 60-minute blocks, or the mental health specialist may provide services more closely integrated with the primary care clinician’s services: he or she may “off-load” certain activities from the primary care clinician, such as collecting an interval history, scoring mental health screening tools, and/or providing supportive services such as parent education. The co-located mental health specialist can collaborate with the primary care clinician to assess
children with identified problems, communicate with school personnel or other mental health providers, provide mental health interventions, address barriers to care, monitor progress in care, provide periodic contact and support to the family, and/or link the child and family to referral sources. He or she may work from a specific chronic care protocol or generally in response to the needs that present to the practice. In one model, a mental health case manager supported by the practice provided many of the nonreimbursed mental health services such as data collection and care coordination; this case manager created efficiencies and increased primary care clinicians’ productivity, more than compensating for the cost of supporting this position. In all models, primary care clinicians and their patients benefit from the cross-fertilization of multidisciplinary practice. In fully integrated mental health models, the collaboration with a mental health specialist in primary care is a seamless part of all encounters.

**Business Arrangements for Co-location Models**

Choice of business arrangements depends importantly on the mental health benefit structure and reimbursement rates of regional public and private insurers, their requirements for authorizing services, and their requirements for credentialing mental health specialists to participate in their plans. Practices that are contemplating co-location should develop a business plan based on their unique needs, resources, payer mix, and rates of payment. The simplest financial arrangement is one in which the primary care practice rents office space to an independent mental health provider who performs his or her own billing and collecting of fees; however, this model may limit the extent to which real integration can occur. Other business models include a mental health specialist employed by the primary care practice and a mental health specialist employed by a mental health agency or hospital and “out-stationed” in the primary care practice. Some states support integrated models by allowing payment of mental health specialists in Article 28 facilities (eg, hospital, primary care settings, school-based health centers). Practices with a high concentration of Medicaid beneficiaries should pay particular attention to their state’s Medicaid “incident to” rules; these rules may allow mental health specialists employed by a physician or by the same entity that employs the physician to bill in a physician’s name, “incident to” that physician’s on-site supervision. This arrangement, if available, may allow a higher payment rate, more flexibility, and more genuine integration of the mental health professional into the practice than arrangements in which the mental health specialist bills directly for his or her services, adhering to traditional mental health codes and billing processes. Further discussion of this issue is included in the chapter action kit.

A number of successful co-location models have been sustained with grant dollars during the implementation phase, until reimbursements became sufficient to support the mental health specialist. In several regions of the country, co-location models are sustained through third-party reimbursement. The task force is collecting the experiences of primary care practices that have co-located or integrated a mental health specialist. The task force places high priority on research to identify best practices in implementing, sustaining, and evaluating these models.

Some practices have also incorporated a child psychiatrist (usually employed by a separate entity such as a mental health agency or academic institution) who provides periodic consultation on site or through telephone or telemedicine hook-up. The primary care clinician or the practice’s integrated mental health specialist can greatly improve the efficiency of psychiatric consultation services by gathering data and performing a psychosocial assessment in advance of the psychiatrist’s encounter with the child and family, by posing specific clinical questions to be answered by the psychiatrist, by spending time with the child and family after the psychiatric consultation to provide education about the psychiatrist’s findings and recommendations, by identifying and addressing any barriers to engaging in further care, and by following up with the family periodically to monitor progress.

Figure 2 provides an overview of the characteristics of an integrated care system.

**DECISION SUPPORT**

Tools that inform diagnosis and management at various stages and for diverse conditions will assist primary care practices in enhancing their mental health care.

**Select Validated Functional Assessment Tool(s) for Use in Identifying Mental Health Problems and in Monitoring a Child’s and Family’s Progress Toward Therapeutic Goals**

Although primary care clinicians are accustomed to using spirometry for assessing and monitoring children with asthma and A1C hemoglobin levels in children with type 1 diabetes, they may be unfamiliar with tools used for assessing and monitoring the clinical status of children with mental health conditions.
In mental health specialty practice, tools that measure child and family functioning are a routine part of the assessment and monitoring process. Such tools can provide clinicians with information about a child’s areas of strength, as well as their problem areas. The tools may also lead to identification of children who do not meet diagnostic criteria for a specific mental health disorder but have some impairment in functioning at home, at school, or with peers, and/or they may measure the effects that a child’s mental health disorder has on the child, the family, the child’s interpersonal relationships, and the child’s school performance.

Measuring the global functioning of children and families offers the following potential benefits to primary care clinicians:

- Functional assessments demonstrate better interreporter reliability than symptom-based assessments for a number of mental health disorders;
- Impaired functioning may precede the recognition of specific mental health symptoms and may resolve more slowly than symptoms;
- Identifying areas of functional strength and challenge can guide the development and monitoring of treatment goals; and
- Improved functional outcome is a measure of the efficacy of mental health services and is important to children and families.

Although many tools used to assess mental health functioning are not applicable in primary care settings, a few have shown promise in assisting primary care clinicians in screening, assessment, and monitoring of children and adolescents for mental health problems, and several are available in the public domain. Appendix S4 summarizes the task force’s current recommendations in relation to these tools.

**Select Instruments for the Assessment of Children Whose Screening Results or Clinical Findings Suggest the Presence of a Mental Health or Substance Abuse Problem**

A number of tools are available to assist the clinician in further assessment of children with suspected mental health or substance abuse problems. The task force has compiled a table of those with sound psychometric properties and potential for use in primary care settings. See Supplemental Appendix S12 for a summary of their characteristics and resources for further information.

**Identify Reliable, Current Sources of Information Concerning Diagnostic Classification of Mental Health Problems and Evidence About the Safety and Efficacy of Treatments**

The task force has developed guidance to assist primary care clinicians in the assessment and management of children from birth to 5 years of age with symptoms of social-emotional problems and school-aged children with problems of inattention/impulsivity, anxiety, depression, disruptive behavior/aggression, substance use, and learning difficulties. This guidance outlines the type of assessment indicated by presenting symptoms or screening results, lists evidence-based psychosocial interventions, suggests primary care–appropriate approaches to initiating care and assisting families with self-management, and lists psychopharmacologic agents approved by the US Food and Drug Administration for use in children with disorders diagnosed within each cluster of symptoms. Several resources are available to assist clinicians in weighing the risks and benefits of mental health and substance abuse treatments.

Primary care clinicians are often faced with caring for children who have been prescribed a psychopharmacologic medication (or multiple medications) by a mental health specialist, sometimes without access to ongoing consultation with that specialist, which underscores the importance of the strategy that follows.

**Develop and Implement Evidence-Based Protocols**

Development of office protocols and flow sheets, in accordance with evidence-
based guidelines or locally developed standards of care, will “routinize” the essential elements of the care process. A logical starting point might be children with ADHD, a mental health disorder that most pediatricians feel comfortable assessing and managing and for which there exist established clinical guidelines and extensive experience in quality-improvement efforts.

Implementing mental health management protocols within the practice will involve a team-building process and significant participation by nonphysician staff. These staff members may be charged with, for instance, requesting information or records from schools, the child welfare system, and other care providers when a child on the registry is scheduled for a visit; collecting and scoring assessment tools in advance of the visit; clarifying insurance benefit and provider issues; scheduling medication checks (adverse effects, laboratory surveillance, refills); obtaining height and weight measurements and vital signs; periodically assessing the functioning of the child and family (see below); checking progress toward therapeutic goals; calling the child and/or family for a structured follow-up or appointment reminder or recall after a missed visit; and/or assisting with the referral process. These mechanisms can be enhanced through an EHR system that improves access to the chart for all treating clinicians and support staff (at appropriate levels), improves routing of information to appropriate clinicians, supports jointly developed care management plans, automates recall for missed appointments, and embeds the results of automatically scored behavioral and functional scales. Other models in development include Web-based portals that allow youth or parents to complete previsit questionnaires and send results to an EHR or other electronic tool, which then links the clinician to sources of information about the child’s presenting difficulties. Regardless of the specific tools, primary care clinicians must consider both the content of particular instruments or tools and how such tools will be administered, recorded, and monitored.

Examples of protocols and tools for ongoing management of chronic medical conditions can be found on the AAP medical home Web site (www.medicalhomeinfo.org). Specific protocols for tracking and monitoring mental health conditions are available for ADHD and adolescent depression.

The mass introduction of EHRs will eventually automate the use of evidence-based physician order sets, flow sheets, and tracking reports to assist in improving the quality of care for persons with chronic conditions. Electronic reminders, quality reports, and standardized order sets have already been shown to reduce medical errors, improve patient satisfaction, increase guideline-compliant care by physicians, and assist in identifying unmet health care needs. Although few of these studies to date have focused on pediatric mental health and electronic records, the improvements in care are likely to be substantial.

Establish a Relationship With a Psychiatrist Who Has Expertise With Children and Adolescents

This strategy is a significant challenge in many communities. In a number of areas of the country, primary care clinicians have collaborated with academic institutions to develop models of telepsychiatry, regional consultation, or co-location within the practice. Evaluation of several programs has demonstrated their value in enhancing the self-efficacy of primary care clinicians and decreasing their use of polypharmacy for pediatric mental health disorders. A more complete discussion of these strategies is included in the chapter action kit and “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community.”

Routinely Screen for Mental Health and Substance Abuse Problems in the Child and Family

Many children with mental health problems or difficulty in their parent-child relationships, families experiencing psychosocial stresses, and parents with mental illness are not identified as needing mental health or social services, although they may frequent primary care settings. This is particularly true for children with special health care needs. Furthermore, their unrecognized mental health problems may drive their utilization (and their parents’ utilization) of medical services. Although an exhaustive review of the literature on mental health screening was beyond the scope of the task force, the task force reviewed the literature for answers to several important questions related to screening in primary care settings. From this review and guidance of experts in the field of general pediatrics, developmental-behavioral pediatrics, adolescent medicine, and child psychiatry, the task force concluded that the many unmet mental health needs of children, adolescents, and their families warrant enhanced primary care efforts to identify children with occult mental health problems and families in need of mental health or social assistance.

Bright Futures affirmed the importance of using all routine health supervision visits for surveillance of a child’s and family’s psychosocial well-being. The task force members believe that there is a strong case for routine periodic mental health screening of
children and their families by using validated instruments. This case is summarized in Appendix S4. Primary care clinicians also need to weigh the limitations of screening tools, particularly their use in populations for which English is a second language and for which the cultural context of a child’s behavior and family’s parenting may differ from that of the populations in which the screening tools were validated. For practices in which screening is not routine, primary care clinicians need to make special efforts to enhance their skills in eliciting mental health concerns.38

Several authors have described steps necessary to support the integration of screening.118–121 These steps include “selling” clinicians and staff on the benefits of screening (eg, parent engagement, early identification of problems, responsiveness to family needs), addressing barriers to screening (eg, insufficient training of physicians, time pressures, inadequate payment, uncertain referral sources, parental resistance), and preparing the practice (eg, identifying a physician champion, mapping practice workflow, training office staff, identifying community referral sources, developing systems for bidirectional communication with referral sources, and developing tracking tools including a practice registry for children with positive screening results—those whose parents choose not to take action, as well as those who do).

While recognizing the need for more studies in the pediatric population, particularly to determine outcomes of children identified through a screening process, the task force proposes that primary care practices consider routine screening to enhance identification of children with mental health symptoms or impaired functioning (Table 1) and identification of risks in the family and environment (Table 2). When possible, it is advantageous to have youth or parents complete screening tools before a visit, either on paper or electronically, and to have scoring completed in advance, which enables the primary care clinicians to use the office visit for building rapport and expanding discussion of any concerns rather than for rote data collection.

For many practices, routinely screening their patients as proposed will require incremental implementation. Depending on the population served by the practice and its health risks and strengths, the clinician may choose to begin with routine mental health/substance abuse screening of an age group, such as adolescents, or a high-needs groups within the population, such as children in foster care or children with parents who have been deployed in military service. In some settings, the practice may seek cooperation of school guidance counselors or nurses, school-based clinics, or community agencies (eg, public health, social services, juvenile justice) to collect previsit data at their intake points and relay the information to the practice.

Supplemental Appendix S12 contains examples of mental health screening tools that have sound psychometric properties and are accessible to primary care clinicians. In each category, the task force has noted several tools that can be most feasibly implemented in primary care settings. Use of these or other screening tools does not replace the clinical interview needed to confirm findings and expand on identified problems.

Characteristics of tools the task force selected for Supplemental Appendix S12 include the following:

- User-friendly: not requiring special training to administer.
- Designed to elicit information from multiple reporters (ie, versions are available for completion by youth, parents, and teachers): multiple data sources offer additional in-

### TABLE 1 Proposed Mental Health Screening of Children and Adolescents in Primary Care Settings

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use validated instruments to screen for socioemotional problems in children at 0–5 y of age with abnormal developmental screening test results (typically performed at 9, 18, and 24 or 30 mo) or abnormal autism screening test result (typically performed at 18 and 24 mo); at any time clinician observes poor growth and/or attachment and/or symptoms, such as excessive crying, clinginess, or fearfulness for developmental stage, or regression to earlier behavior; and at any time family identifies psychosocial concerns.</td>
</tr>
<tr>
<td>2</td>
<td>Use validated instruments to screen all school-aged children (ages 5 through adolescence) for symptoms of mental illness and impaired psychosocial functioning at health maintenance visits; at any time of family disruption, poor school performance, reported behavioral difficulties, recurrent somatic complaints, or involvement of a social service or juvenile justice agency; and/or when child or family identifies psychosocial concerns.</td>
</tr>
<tr>
<td>3</td>
<td>In addition to 2 above, screen all adolescents for substance use (including tobacco) at each health maintenance visit and whenever circumstances such as an injury, car crash, or decrease in school performance suggest the possibility of substance abuse. If adolescent reports using substance(s), assess for extent of use.</td>
</tr>
</tbody>
</table>

* For adolescents, screening with paper-and-pencil tools is more likely to elicit concerns than an interview; electronic tools are more likely to elicit concerns than paper-and-pencil tools122 and may be perceived as more confidential.123

### TABLE 2 Proposed Screening and Surveillance of Family and Social Environment for Risk Factors

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Obtain a history of trauma exposure and update child and family’s psychosocial history (eg, parent distress or discord, domestic violence, parental substance abuse or mental illness, youth and family social support, grief and loss issues) at each health maintenance visit and as dictated by clinical need.</td>
</tr>
<tr>
<td>2</td>
<td>Screen for maternal depression in the first year of life of the child and when psychosocial history indicates. The incidence of postpartum maternal depression peaks when infants are between 2 and 6 mo of age.124</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use validated instruments to screen for socioemotional problems in children at 0–5 y of age with abnormal developmental screening test results (typically performed at 9, 18, and 24 or 30 mo) or abnormal autism screening test result (typically performed at 18 and 24 mo); at any time clinician observes poor growth and/or attachment and/or symptoms, such as excessive crying, clinginess, or fearfulness for developmental stage, or regression to earlier behavior; and at any time family identifies psychosocial concerns.</td>
</tr>
<tr>
<td>2</td>
<td>Use validated instruments to screen all school-aged children (ages 5 through adolescence) for symptoms of mental illness and impaired psychosocial functioning at health maintenance visits; at any time of family disruption, poor school performance, reported behavioral difficulties, recurrent somatic complaints, or involvement of a social service or juvenile justice agency; and/or when child or family identifies psychosocial concerns.</td>
</tr>
<tr>
<td>3</td>
<td>In addition to 2 above, screen all adolescents for substance use (including tobacco) at each health maintenance visit and whenever circumstances such as an injury, car crash, or decrease in school performance suggest the possibility of substance abuse. If adolescent reports using substance(s), assess for extent of use.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Obtain a history of trauma exposure and update child and family’s psychosocial history (eg, parent distress or discord, domestic violence, parental substance abuse or mental illness, youth and family social support, grief and loss issues) at each health maintenance visit and as dictated by clinical need.</td>
</tr>
<tr>
<td>2</td>
<td>Screen for maternal depression in the first year of life of the child and when psychosocial history indicates. The incidence of postpartum maternal depression peaks when infants are between 2 and 6 mo of age.124</td>
</tr>
</tbody>
</table>
sights in the course of mental health assessment.

- Available in multiple platforms: providing options for youth and families to complete screens on-line outside the office or via computer in the waiting room may have advantages; however, some practices will prefer traditional pen-and-paper screenings.
- Relatively brief and easily scored: the task force suggests that screenings require no longer than 10 to 15 minutes to complete.
- Multilingual: screenings should be available in the preferred language of each reporter.
- Available in the public domain.

**Use Acute Care Visits to Elicit Mental Health Concerns**

Recognizing that many school-aged children and adolescents do not seek routine health supervision, members of the task force urge that primary care practices consider using acute care visits as opportunities for brief mental health updates, especially for those children and adolescents who do not receive routine health supervision services. The task force drew from the expertise of its professional members, opinions of its youth and family participants, and informal trials in primary care practices to develop sample questions that primary care clinicians can consider using during acute care visits. These sample questions are included as Appendix S8. Research is necessary to determine outcomes and best practices.

**CONCLUSIONS**

Depending on their pace and practice style, primary care clinicians may choose to try several of these questions and then gradually implement the routine use of those that are most comfortable and yield the most helpful responses. Alternatively, clinicians can use the context of the acute care visit (eg, an injury) to lead naturally into mental health topics (eg, “Had you or your friends been drinking when this happened?” or “Has this person [the perpetrator of the injury] ever threatened you or injured you before?”).

Because of the association between sleep difficulties and mental health conditions, use of questions regarding sleep is helpful throughout childhood. “Algorithms for Primary Care” provides more specificity about clinical approaches.

**REFERENCES**


4. American Academy of Pediatrics, Commit-


Downloaded from http://pediatrics.aappublications.org/ by guest on November 14, 2017
104. American Academy of Pediatrics, Subcommittee on Attention-Deficit/Hyperactivity Disorder, Committee on Quality Improvement. Clinical practice guideline: treat-


Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice

Jane Meschan Foy, Kelly J. Kelleher, Danielle Laraque and for the American Academy of Pediatrics Task Force on Mental Health

Pediatrics 2010;125:S87
DOI: 10.1542/peds.2010-0788E

Updated Information & Services
including high resolution figures, can be found at:
http://pediatrics.aappublications.org/content/125/Supplement_3/S87

References
This article cites 65 articles, 17 of which you can access for free at:
http://pediatrics.aappublications.org/content/125/Supplement_3/S87.full#ref-list-1

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
Administration/Practice Management
http://classic.pediatrics.aappublications.org/cgi/collection/administration_practice_management_sub
System-Based Practice
http://classic.pediatrics.aappublications.org/cgi/collection/system-based_practice_sub

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
https://shop.aap.org/licensing-permissions/

Reprints
Information about ordering reprints can be found online:
http://classic.pediatrics.aappublications.org/content/reprints

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since . Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2010 by the American Academy of Pediatrics. All rights reserved. Print ISSN: .

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice

Jane Meschan Foy, Kelly J. Kelleher, Danielle Laraque and for the American Academy of Pediatrics Task Force on Mental Health

*Pediatrics* 2010;125;S87
DOI: 10.1542/peds.2010-0788E

The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://pediatrics.aappublications.org/content/125/Supplement_3/S87