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Is it time to talk? Understanding specialty child mental healthcare providers' decisions to engage in interdisciplinary communication with pediatricians

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ABSTRACT

Communication between pediatric mental health and primary care providers is often inconsistent and frequently rated as unsatisfactory by providers of both disciplines. While numerous studies report pediatricians' desire for increased feedback from mental health providers, less is known about mental health providers' perspectives on collaborative communication with pediatricians. In the current qualitative study, 9 practitioners at 2 mental health practices participated in interviews about their experiences related to collaborating and communicating with pediatric providers. The interviews were analyzed inductively using thematic analysis procedures. Mental health providers consistently described the decision to communicate with pediatric primary care providers as occurring primarily when initiated by them, and on a "case by case" basis. Four determinants of the decision to initiate communication emerged from the interviews: severity of client concerns, mental health providers' own positive beliefs about collaborative/integrative mental health-pediatric care, perceptions of and past experiences with the primary care providers with whom they interact, and professional relationships with specific primary care providers. The findings of this study suggest that understanding and addressing the attitudes and beliefs that underlie both mental health and pediatric health care providers' decisions to engage in interprofessional communication is essential to establishing truly collaborative care.

Approximately 10–20% of children in the United States meet criteria for a mental health disorder (American Academy of Pediatrics, 2012; Jellinek, 2013; Knapp and Foy, 2012), and the vast majority of these youth receive health care services from a primary care physician (PCP) (Bloom and Freeman, 2015). While pediatric PCPs tend to be comfortable assessing behavioral health conditions, for treatment they often seek mental health professionals to whom they can refer their patients (Pidano et al., 2011). The American Academy of Pediatrics (AAP) recommends, and the standards for the Patient-Centered Medical Home (PCMH) require, that pediatricians not only identify and attend to children's mental health issues, but also coordinate and oversee the provision of their patients' mental health care (American Academy of Pediatrics, 2009; National Committee for Quality Assurance, 2014).

The challenges of such interprofessional collaboration have been well documented throughout the healthcare arena (Hewett et al., 2009; Lewin and Reeves, 2011; McDougall et al., 2016; Watson et al., 2016), as well as specifically within children's services (Cooper et al., 2016; Easen et al., 2000; Salmon, 2004). Among many identified structural, individual, and service level barriers, lack of effective communication among providers is consistently cited as a key hindrance to interagency collaboration in children's mental health services (Cooper et al., 2016). Recognizing this fact, established competency recommendations and practice standards for mental health providers working in primary care settings include communication of urgent and routine clinical information to the primary care team to promote collaboration (e.g., American Psychological Association, 2013; National Association of Social Workers, 2005).

While similar guidelines for specialty mental health practices providing outpatient consultation or treatment do not yet exist, the Patient-Centered Medical Home Neighborhood (PCMH-N) extends the PCMH model to incorporate the specialists, hospitals, and other

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clinicians with whom PCPs collaborate when caring for their patients. Appreciating the importance and challenges of interprofessional relationships, core components of the PCMH-N principles include bi-directional communication and the development of formal agreements to guide communication, coordination, and co-management (American College of Physicians, 2010; Taylor et al., 2011). Collaborative communication among interprofessional providers treating childhood mental health is essential to making these partnerships effective, as without it there is a risk of fragmentation and service duplication. Coordinated communication between providers has been well received by parents of children (Greene et al., 2015) and is associated with positive family-provider relations and pediatric healthcare outcomes (American Academy of Pediatrics, 2014; Priddis and Wells, 2011).

However, communication between interprofessional providers – especially those located in separate practice settings – is cumbersome, time consuming, and typically occurs infrequently unless an emergency arises. Thus, collaborative communication practices remain inconsistent among practitioners and are frequently rated as unsatisfactory by both mental health and pediatric primary care providers. Numerous studies document pediatricians' desire for increased feedback from mental health specialists (Pidano et al., 2011; Ross et al., 2011; Williams et al., 2005), yet also report that pediatricians communicate with mental health providers about referred patients less than half of the time (Ross et al., 2011; Yuen et al., 1999). Much less is known about mental health providers' perspectives on collaborative communication with pediatricians. A small body of research indicates that mental health providers also view collaborative relationships with PCPs as key to successful treatment (Kilbourne et al., 2012; Miller et al., 2004; Pereira et al., 2009).

The current study elicited child mental health providers' perspectives about collaborating and communicating with pediatric PCPs. The research question addressed was whether the views of mental health providers, especially with regard to their clients' concerns, and their preferences, successes, and barriers to effective communication with PCPs, are associated with their engagement with pediatricians in the collaborative care of children with mental health problems.

1. Method

1.1. Participants

Interviews were conducted with nine mental health providers from two northeast suburban specialty mental health outpatient practices. Participants were selected by convenience from independent group practices that had no formal coordinated or integrated care commitments with primary care physicians. All participants, regardless of their professional background or practice setting, provide psychotherapy to patients. In one practice, four licensed clinical social workers (LCSW; master's level), one psychologist (PsyD; doctoral level), and one licensed marriage and family therapist (LMFT; master's level) were interviewed, representing 38% of the total clinicians in the practice. In the other practice, two psychologists (PhD; doctoral level) and one licensed clinical social worker (LCSW; master's level) were interviewed, representing 43% of the total clinicians. All of the participants were female, which is consistent with the 90% representation of female clinicians in each practice, as well as women serving as the majority of mental health practitioners in the United States (American Psychological Association, 2015). As interviews were anonymous, additional demographic information was not collected.

1.2. Procedures

The interviews analyzed in this study were part of a larger study aimed at increasing interprofessional collaboration (see Greene et al., 2016), procedures for which were approved by the UConn Health Institutional Review Board. In the first phase of the study, researchers conducted key informant interviews with mental health and primary care providers at two pairs of geographically proximate pediatric mental health and medical practices with the aim of eliciting information from practitioners about their preferred strategies for achieving timely, responsive, collaborative communication and treatment. Providers also provided feedback on proposed relationship-building methods including joint trainings, continuing professional education sessions, case conferences, meetings and e-mail exchanges with the goal of establishing relationships and increasing knowledge about each other's areas of expertise and expectations. Potential participants in the interviews were informed that their responses would be anonymous (no identifying information was collected) and provided a description of the study's purpose, risks and potential benefits. Participants were given as long as they needed to review this information, to ask questions, and to consider their participation in the interview. All providers who indicated interest in the study chose to participate.

1.3. Interview administration

The second author conducted interviews with participants averaging 29 min in length, between October 2012 and January 2013. Each interview began with an open-ended question asking providers to report on times when interacting with a PCP did and did not work well, followed by more focused questions about current practices and preferences related to referrals, consultation, and communication with pediatricians. Additionally, providers provided feedback about potential barriers to collaborative treatment and proposed relationship-building methods with pediatrics colleagues. The interview closed with another open-ended question that asked providers to identify what would provide the most improvement to their interprofessional collaborations. All interviews were audio recorded.

1.4. Data analysis

The goal of the interviews was to gather information from mental health providers about their communication and collaborative care practices with pediatricians in order to inform the development of an interdisciplinary intervention aimed at improving interprofessional communication (Greene et al., 2016). Interviews were analyzed by the first and second authors using thematic analysis (Braun and Clarke, 2006) to identify themes regarding what mental health providers identify as concerns, preferences, successes, and barriers to communicating with PCPs. An inductive approach to identifying the themes was used; identified themes emerged from the interview data collected rather than following closely from the initial research questions asked.

In the first step of the thematic analysis, a research assistant and the second author transcribed the interviews verbatim. Second, the interviews were read and re-read to provide familiarity with the data, and initial thoughts were recorded. Third, sentences with significant meaning were assigned a code. Authors generated codes independently, and then discussed the codes until consensus was reached (Hill et al., 2005). Fourth, each author independently grouped the codes into sub-categories, categories and main themes (Burnard, 1991), then came to consensus. Fifth, coded data extracts within each theme were reviewed for appropriateness, and themes were refined. Finally,