From Theory to Action

Children's Community Pediatrics Behavioral Health System

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KEYWORDS

- Integrated care • Primary care • Pediatric behavioral health
- Behavioral health workforce

KEY POINTS

- Successful models of integration must first consider the needs of the providers and the capacity of the system to meet these needs.
- Providers and administrative early adopters and collaborators must endorse the model of integrated care.
- Successful integrated care therapists must have both general health and mental health expertise and a willingness to be flexible when responding to the needs of the practice and patients.
- Psychiatrists in integrated health care settings need unique skills related to interprofessional communication, patient stabilization, and system-level consultation.

INTRODUCTION

In 1977, Dr George Engel advocated for the biopsychosocial approach and questioned the silos of physical and psychosomatic medicine. Unfortunately, decreased communication between primary care and mental health care providers was reinforced by the exclusion of mental health care from health plans and privacy laws.[1]

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Outsourcing mental health care has resulted in a problematic disparity in health care. Integrated health care models attempt to cross the artificial boundary of behavioral and medical worlds in order to improve access to quality care that meets the need of the whole person.[2] Integrating behavioral health care with primary care and/or medical subspecialties requires certain considerations above and beyond building a traditional mental health or primary care setting. This article describes lessons learned from integrating behavioral health in a large pediatric primary care group.

It has been estimated that 13% to 20% of children living in the United States experience a mental disorder in a given year, with suicide as the second leading cause of death in the 12- to 17-year age range.[3] Fifty percent of pediatric office visits involve significant psychosocial concerns requiring intervention, and 75% of children with psychiatric disorders are being brought to a pediatric primary care provider.[4] These percentages continue to grow, with estimates of cost for youth mental health services in excess of $200 billion annually,[3] not taking into consideration the cost of disability for those without access to behavioral health resources.[5] These numbers become increasingly alarming when considering time-based growth, increasing costs per untreated individual over the lifespan, and the estimate that only 20% of children with recognized mental illness receive treatment.[6] There are significant missed opportunities given that half of all lifetime mental illnesses begin at 14 years of age and three-quarters by 24 years of age.[4] This is a time when many individuals are seen regularly through primary care: 84% of US children aged 0 to 17 years are reported as having a well-child visit in a review of 2014 data with substantial growth in accessibility of pediatric primary care since implementation of the Children's Health Insurance Program.[7] Access to child and adolescent psychiatry within this setting additionally addresses often-cited barriers of fragmented and difficult-to-access care due to location and insurance carve-outs and the stigma and distrust associated with the mental health care system.[5] By initiating services within the primary care setting and involving a trusted provider in psychoeducation and warm handoffs, treatment can be implemented earlier, which is both more effective and can avoid greater costs to the individual and family's quality of life and avoid the multiple costs of hospitalizations.[6] The role of a child psychiatrist as consultant is increasingly necessary considering the relative shortage of child and adolescent psychiatrists practicing in the United States and lack of infrastructure or trainees to meet this need in the foreseeable future.[8,9]

Several models exist to address integration of behavioral health and primary care: coordinated care, colocated care, and integrated care. *Coordinated care* relies on routine screening in the primary care setting and a referral relationship between the primary care provider and behavioral health clinician. There is a mechanism in place for routine exchange of information between treatment settings, and ultimately the primary care provider delivers interventions discussed with the specialist using brief algorithms. Additionally, the behavioral health consultant can assist with community referrals for additional supportive resources. *Colocated care* models contain medical and behavioral services in the same setting. There is a referral process in place for medical cases to be seen by behavioral specialists. A unique advantage of this model is the enhanced communication between primary care provider and mental health specialist, which allows for a greater quality of care to the individual particularly in cases whereby there are longitudinal and complex behavioral health care needs. Additionally, ongoing ease of consultation between behavioral health and primary care providers enhances the knowledge and skill sets of both groups. This model is also associated with an improved show rate for behavioral health treatment. *Integrated care* implies one collaborative treatment plan with both behavioral and medical