Integrated Behavioral Health Care in Pediatric Subspecialty Clinics

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KEYWORDS

• Integrated care • Health care • Psychosomatic medicine • Pediatric
• Child psychiatry • Comorbidity • Specialty care

KEY POINTS

- Pediatric subspecialty clinic integrated care lags behind primary care.
- Subspecialty care has significant mental health-associated costs and burdens that necessitate integrated behavioral health.
- Child psychiatrists have unique value and skills to colead teams and facilitate treatment in subspecialty care clinics.

INTRODUCTION

With one-fifth of all children and adolescents estimated to have a diagnosable psychiatric disorder,[1] there is an emerging national consensus regarding the importance of providing integrated behavioral health (BH) care in pediatric primary care. These disorders are associated with a disproportionately higher burden of chronic physical disease with accompanying elevated symptom burden, functional impairment, and treatment complexity.[2] It is common for these youths with comorbid BH and physical health conditions to be seen in the subspecialty care setting, which in turn has led to the implementation of models of integrated BH care in pediatric subspecialty clinics.

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Abbreviations	
BH	Behavioral health
CAP	Child and adolescent psychiatrist
CF	Cystic fibrosis
NMDA-R	*N*-methyl-D-aspartate receptor

To date, although the subspecialty literature describes a number of "interdisciplinary" BH programs in a variety of different medical specialty settings, it has not framed (or described) these programs as integrated, despite having the core components of integrated BH care partnerships, namely, consultation, direct service, care coordination, and specialty care provider education.[3] Yet these programs are by no means universal. Although there are similarities between primary and subspecialty care, there are important differences. Compared with primary care providers, subspecialty providers are more likely to consider themselves solely focused on their subspecialty or organ group and are less attuned to responding to mild to moderate psychiatric illnesses.[4] Many patients with chronic physical illnesses tend to identify their subspecialist as their primary care provider with their pediatrician being seen less often, sometimes not for months or even years. These differences may inadvertently place youth at greater risk of having their psychosocial needs inadequately identified.

Integrated BH care in the pediatric subspecialty clinic offers youth with chronic physical illnesses a care setting whereby they are approached from a biopsychosocial perspective as opposed to only an organ system or medical model approach. This article reviews the current status of integrated BH care in six pediatric subspecialty care settings, namely, oncology, palliative care, pain, neuropsychiatry, cystic fibrosis (CF), and transplantation. Although there are many examples of integrated BH, these were selected for their variance, to showcase differences in historical origin (ie, older to newer), service models (eg, embedded to consultative), and robustness of integration (eg, shared decision making to symptom focused).

PEDIATRIC ONCOLOGY

Although survival has vastly improved over the past 20 to 30 years for pediatric oncology patients,[5] the highly distressing treatments and rates of morbidity and mortality have led to the integration of psychiatrists and other BH clinicians embedded in oncology clinics more consistently than other subspecialty settings. It is seen in an evolving integrated field with its own moniker—psychosocial oncology or psychooncology.[6] Pediatric psychosocial oncology is a part of national mission statements, included in decision making bodies such as the Children's Oncology Group, and the benefits of collaborative interdisciplinary work and hospital and medical system support for this integrated care can been seen in national psychosocial standards endorsing integrated psychosocial care.

The Pediatric Psychosocial Standards of Care is an attestation by oncologists, hematologists, and psychosocial oncologists on the importance of providing an integrated BH care model.[7] These standards describe embedded BH care along with the benefits of BH clinicians as coleaders and comanagers of pediatric oncology patients, including specific recommendations for the involvement of child and adolescent psychiatrists (CAPs).[8] Through national credentialing of centers of excellence, which include BH clinicians, these standards will likely reinforce the need for hospitals to include BH integrated care as part of standard care for oncology patients.