Pediatric Mental Health Assessment in the Primary Care Setting

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Susan, a 14-year-old girl who you have been following since infancy, comes in for a follow-up visit to check the status of a borderline low hematocrit. She continues to complain of fatigue and lethargy. Her stepmother reports that she appears down and has been more sensitive and that it has become a major hassle to get Susan to do her chores. Upon further questioning, it becomes apparent that in addition to doing poorly in school, Susan has not been taking her recommended vitamins and that her stepmother did not take her for her repeat complete blood count (CBC) because it "was just too difficult." Susan's stepmother states that she does not know what to do and that it is impossible to get Susan to do anything including taking her vitamins due to lack of motivation.

Assessment

Being able to effectively evaluate, provide some treatment, and triage children, adolescents, and families who suffer from psychiatric conditions is essential for practicing pediatricians, especially in primary care settings. This type of assessment is best done as a multidimensional process, which involves obtaining and synthesizing information from multiple individuals, identifying types and severity of symptoms, and evaluating several aspects of individual and family level of functioning. The usual goals are to acquire enough information to develop a sense of the youth, the circumstances, and the psychiatric symptoms so that an appropriate diagnosis and

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intervention can be identified. PCPs also must determine whether the recognized difficulties are of a type and severity that can be managed in the primary care milieu or whether psychiatric consultation or referral is needed. Usually this procedure is complicated by the need to balance the goal of achieving a reasonable picture of a child and the environment and constraints of time, priorities, and resources. It is essential to have a framework that can structure the evaluation so the information necessary to make the short- and long-term decisions is obtained efficiently and effectively. Given the necessity to obtain a significant amount of information, generally from multiple individuals in different locations, utilizing an approach with data collected by various team members as well as utilizing forms that can be completed between office visits is optimal. This chapter discusses the process of assessing children, adolescents, and families, creating a case formulation and treatment plan, and incorporating mental health services into the primary care setting.

Given the degree of morbidity, associated cost, loss of productive years, and potential mortality associated with untreated mental illness in youth, there has been increasing attention placed on prevention and early intervention, especially in primary care settings [1]. These efforts have built upon the accumulating evidence supporting the importance of gene by environment interaction in the origin of medical and psychiatric disorders. This approach to understanding disease suggests that individuals have a baseline genetic risk and that the expression of disorders depends on exposure to certain environmental factors, including both protective factors and stressors. Universal prevention efforts are aimed at promoting mental wellness in children and families and minimizing environmental insults that may trigger the onset of illness. Prevention efforts aim to reduce modifiable risk factors and promote protective factors.

Universal prevention and early intervention initiatives are targeted at the environments in which children are often involved, such as the school system and the pediatric home. As children are typically assessed annually for a well-child check, this is an opportunity to include open dialogue about social and emotional health. Having a process in which all children and adolescents in the practice are screened for mental health and family difficulties helps identify issues early so that preventative and early interventions can be implemented. Collecting information about the youth's development and behavior as well as the family and school environment as a routine component of data collection, both initial and ongoing, allows practitioners to determine the baseline functioning of individual children, adolescents, and families as well as follow their progression over time.

Questionnaires and self-reports that can be completed by parents/caretakers, teachers, and older youth are an effective approach to collecting a range of information which can then be verified by a pediatric team member before the pediatrician sees the patient. This approach allows the time with the pediatrician to be targeted on confirming and enhancing the obtained information, determining the most likely diagnoses, and identifying how to proceed. Chapter 8 of this text explores measurement-based care and highlights select practical, public domain measures. Additionally, the websites of the American Academy of Pediatrics (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages) and the American

Academy of Child and Adolescent Psychiatry (http://www.aacap.org/AACAP/Resources_for_Primary_Care) have information on pediatric mental health assessment processes, data collection instruments, and rating scales. It is most effective to use general forms that collect a range of information and types of symptoms initially with more focused questionnaires during follow-up. While youth and their families may present with specific complaints, it is essential to remember that symptoms can have different etiologies i.e. just because inattention is a child's main difficulty does not necessarily mean that the child has an attentional disorder. And it is important to consider possible medical etiologies for the youth's symptoms [2–5].

Important considerations related to a psychiatric assessment, especially the initial one, include identifying the reason for the evaluation, who is seeking the assessment, who needs to be involved, what outcomes are being sought, what will the information be used for, potential confidentiality issues, and how much time is available/any potential deadlines. For example, evaluating a young child for developmental concerns involves significant differences compared to assessing an adolescent who is suspected of using substances. The evaluation is complicated by unique characteristics of children and adolescents as well as the need to include multiple individuals as informants. Consideration of the youth's developmental status is essential since it is constantly changing and impacts the presentation of psychiatric symptoms as well as the level of functioning. Important variables include age, cognitive functioning, emotional maturity, and social relationships.

Also, social and life experiences significantly can affect developmental and cognitive skills. Key environmental considerations include level of support, type and number of stresses, as well as the influence of cultural, ethnic, racial, and socioeconomic characteristics. Exposure to risk factors and extent of personal and family resilience are essential aspects of development. Assessment challenges include children and adolescents having less developed cognitive and language skills, being brought in by others rather than their own initiative, and having their behavior identified as the issue even when others' actions may be problematic as well as the youths. Additionally families may be ill prepared for the evaluation and treatment process and may have misconceptions and negative attributions about mental health. Many psychiatric disorders involve difficulties with communication, motivation, and initiative and tend to be more common in families who are struggling with health, mental health, and environmental adversities. The information collected during a psychiatric assessment should cover biological, psychological, and social aspects of the individual and problem and should identify potential barriers to treatment interventions.

The content of a psychiatric assessment is listed in Table 5.1; depending on the identified problem and the circumstances, various sections may be emphasized more than others, based on difficulties and developmental status. For example, a detailed school history is necessary in a youth with academic difficulties and may be less crucial in a child with a good school record but significant behavior problems at home. Information necessary for adolescents may not be relevant for younger children. Of note, much of the information overlaps with a standard

Table 5.1 Psychiatric assessment content

Patient identification
• Name, age, gender, school/employment status, living situation
Chief complaint
• Reason for visit, patient own words
History of presenting illness
• Story of illness, often helpful to obtain chronologically
• Includes relevant history, pertinent positives and negatives, related circumstances
• Symptoms: location/radiation, quality, quantity/severity, timing (onset/duration/frequency/progression), setting/context, factors relieve/aggravate, associated symptoms
Review of systems
• Systematic review of presence or absence of symptoms in all organ systems, head to toe
Allergies
• Any allergies to drugs and other substances
Past history (medical, surgical, obstetric/gynecologic, psychiatric)
• All previous disorders and treatment, including medications; adherence to treatment recommendations
• All preventative and well-person care
• All integrative and complementary medical care
• Puberty, menarche
• Pregnancies (for both boys and girls)
Medications
• Current medications and indications, dose, frequency, length of treatment; any adverse/side effects
• Includes over-the-counter (OTC), herbal, and homeopathic medications
School/employment history
• Level of educational attainment, any issues
• Current employment, relevant past employment
• Factors possibly related to health status (e.g., exposure to toxins, stress)
Developmental history
• Acquisition of milestones
• Current developmental abilities
• Temperament/personality/coping style
• Gender identification
Family history (medical/psychiatric)
• Immediate biological relatives, parents, siblings, children, grandparents, aunts/uncles, cousins, etc.
• Age of onset of any problems, individual affected, severity, type/response to treatment, alive or deceased
• Focus on inheritable disorders, problems with shared environmental factors
Personal social (peers, friends, family background, current circumstances, recreational activities, romantic relationships)
• Living situation/family constellation and functioning/parenting
• Recreational activities
• Relationships
• Sexual behavior and activity (e.g., birth control, type of sexual activity, who having sex with, etc.)
• Tobacco, alcohol, drug use, past and present

pediatric assessment. Additionally, other team members can assist in gathering much of the background information, which the primary care provider (PCP) can simply verify or clarify as needed, saving valuable time. An essential component of the evaluation is the mental status exam described in Table 5.2. Much of the data

Table 5.2 Mental status examination

Orientation
• Knows identity, location, time, purpose of session
Appearance/dress
• If age and activity appropriate
Level of consciousness
• Alertness, awareness, responsiveness
Attitude
• Level of cooperation, interest in process
Behavior
• If age and activity appropriate
Relatedness
• Ability to engage with interviewer and others
Motor activity/level of activity
• If age and activity appropriate; level of impulsivity
Speech and language
• Fluency, tone, pattern, descriptive detail; ability to communicate effectively
Mood
• Patients' description of how they feel
Affect
• Examiner observation of how the patient appears to feel
Thought content
• What patient discusses during the interview; includes content related to suicide, homicide, aggression
Thought process
• Level of logical thinking, organization, coherence
Cognitive abilities
• Attention: ability to attend to stimuli during interview/impacts memory performance
• Memory:
– Immediate: recall of events/items during interview
– Recent: recall of events during last week or so
– Remote: recall of events over years
• Problem-solving: calculations, reading, writing
Fund of knowledge
• Vocabulary/facts: general and/or related to patient's life
• Cognitive functioning: acquisition of concrete or abstract thinking
Insight
• Patient understanding of difficulties/situations
Judgment
• Patient ability to make reasonable decisions about factors and situations that impact functioning/life

related to this examination is obtained by observation and descriptions by the practitioner with the aim of identifying if there are areas in which the youth is not at the expected age-appropriate developmental level [6–9].

A significant amount of information can be obtained from questionnaires, rating scales, and other types of reports. However, interviewing the youth and caretakers is essential to the assessment process. Unless young or severely impaired, children and adolescents should be seen alone for at least part of the assessment to help with engagement and to discuss potentially sensitive information. It also can be very helpful to meet with parents without the youth in some situations. Of note, in situations where there is collaborative or integrated care and the team includes a mental health clinician who is eligible to bill for diagnostic psychiatric evaluation codes (90791 or 90792), these codes can be completed more than once for the same patient when separate diagnostic evaluations are conducted with the patient and other informants, such as guardians; however the interviews would have to be conducted on two separate days (CPT Coding Manual). Addressing confidentiality early in the process to clarify what information can and will be shared is recommended to promote transparency and avoid future complications.

Interviewer behaviors that can facilitate the interview process include: balancing attention between the youth and family, being flexible and allowing the youth and family to help determine the agenda and structure, adjusting the agenda and plan as necessary, positively responding to feedback, taking the necessary time to engage the participants and make them comfortable, being aware of and carefully managing sensitive topics, and emphasizing open-ended questioning. It is essential that interviewers be aware of and effectively manage their own beliefs, biases, and reactions. Prioritizing such details as having a physically comfortable and private interview space; preparing adequately; having clear, but adaptable assessment structure and goals; and effectively managing potential interfering factors such as other demands on the physician or unrealistic expectations of the evaluation can greatly improve the evaluation process. It is crucial to schedule enough time to conduct an adequate assessment which includes thoroughly evaluating all of the information obtained, conveying the physician's impressions and recommendations, and discussing possible concerns and questions. Possible challenges that can complicate an assessment include patient/caretaker refusal or inability to participate, difficulties obtaining information from patient or relevant others, contradictory information/perspectives from youth and caretakers, total focus on youth as the problem, or unwillingness to consider proposed diagnoses/treatments.

Once adequate information has been collected and analyzed, making a diagnosis is one of the initial steps. In the United States, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, https://www.psychiatry.org/psychiatrists/practice/dsm) developed by the American Psychiatric Association (APA) is the system used to diagnose psychiatric conditions. It is harmonized with the International Classification of Diseases (ICD) used by most of the rest of the world. It is a categorical approach with an emphasis on considering the dimensional, developmental, and lifespan aspects of illness; disorders are grouped based on similarities across a set of indicators which include biological, environmental, symptom, and other

factors. Conditions are in the general categories of neurodevelopment (e.g., autism spectrum disorder), internalizing (e.g., depression or anxiety disorders), externalizing (e.g., oppositional defiant disorder), neurocognitive (e.g., delirium), and others. Individuals of any age can be diagnosed with any illness as long as they meet the symptom and duration criteria.

Psychiatric disorder severity can be identified in addition to subtypes, specifiers, and remission status. All disorders require distress and/or impairment. Most illnesses have versions caused by medical conditions or substances. The DSM is a non-axial system with the relevant disorders, both psychiatric and medical, listed in order of importance; psychosocial and contextual factors as well as level of disability can be indicated with separate notations. No specific assessment tool is required to determine disability. Recent DSM revisions have improved the applicability of diagnostic criteria across the lifespan; however, it can be challenging to fit the symptoms of specific youth neatly into a diagnostic category, especially those disorders that were initially described in adults.

Developing a formulation to integrate and summarize the data to guide and inform treatment planning is crucial. While making a psychiatric diagnosis based on DSM criteria is necessary, a DSM diagnosis generally is not sufficient. A case formulation is a synthesis of the information obtained and clinician's observations, with goals of understanding the patient and situation (internal and external factors) and explaining patient's symptoms. The DSM diagnosis system is insufficient because it does not take the context of patient, family, or environment into account. In other words, it is not a "story" of the child or adolescent. The diagnosis alone does not describe the intricacies and uniqueness of each patient's situation. A more nuanced approach considering such factors is necessary to develop an understanding about where the youth's symptoms began and what can help the youth get better.

The DSM criteria tend to have an overemphasis on individual psychopathology, minimizing the influential role of psychological or social factors. The purpose of case formulation is to provide an integrated picture and a focus for treatment planning. Rather than simply state a diagnosis of mental illness, it includes information that is distinctive and descriptive, permitting the development of hypotheses about underlying causes, precipitants, and maintaining factors as well as potential strengths and ameliorating factors. Additionally, case formulation describes an integrated understanding of a particular issue at a specific point in time. A formulation is not a "complete explanation" of a person and may change depending on the acquisition of new information or changes in events or circumstances.

There are a variety of approaches to formulating clinical cases. One commonly used in medicine is the biopsychosocial model, which describes the patient's difficulties, level of functioning, abilities, and circumstances in biological, psychological, and social terms. Biological factors are those related to the characteristics of living organisms. Psychological factors refer to processes that are internal to the individual's mind, while social attributes are those related to the environment. Take the example of a young child who has been abused. The abuse is the social component. The biological component is the changes to the child's brain and

Table 5.3 Biopsychosocial model

Biological
• Family/genetic history
• Temperament
• Development (height, weight, physical abilities, age, stage of maturity)
• Intelligence
• Medical conditions
Psychological (child and family)
• Emotional development
• Personality styles
• Coping strategies
• Child's sense of self-esteem
Social
• Peers
• Family relationships
• School
• Extracurricular activities
• Community
• Race, ethnicity, culture
• Economic status
• Spirituality

neuroendocrine system, and the psychological component is the child's thoughts and feelings about why the abuse occurred. It is important to include areas of resilience in addition to information on risk factors. The main components of the biopsychosocial model for case formulation are listed in Table 5.3.

Formulations include protective or ameliorating factors (strengths) that contribute to resilience, qualities that are different and distinctive about this child and family, underlying causes or precipitants of the problem, and factors responsible for condition maintenance. It is a synthesis of information with an indication of its relative importance and connections, a coherent, comprehensive, and succinct summary, which includes an explanation of the presenting problem or symptom. A common structure consists of introductory and concluding statements with the body consisting of the three general categories of biological, psychological, and social factors. Employing a brief model in which the formulation is a short paragraph promotes usability. An example of a biopsychosocial formulation for the case described at the beginning of the chapter is given in Table 5.4.

The case formulation then can be used to inform and guide treatment planning. It helps prioritize the problems and issues and provides information on individual, family and environmental strengths, protective factors, and any other characteristics that would promote resilience. Determining and implementing the desired interventions is based upon a number of factors. These include the problems needing to be addressed and the desired changes. An additional very practical factor is what therapies are available and most appropriate for the targeted difficulties, youth and family. Treatment plans are based on a comprehensive understanding of the child's and family's problems and strengths. Collaborating with youth and families in the

Table 5.4 Biopsychosocial formulation example

Susan is a 14-year-old female with significant symptoms for several months of sadness, fatigue, poor concentration, low self-esteem, declining academic performance, increased appetite, and decreased social interaction consistent with major depressive disorder.
Biological
Relevant biological factors include a family history with several immediate family members having identified depressive and anxiety disorders. Susan recently started her menses and possibly has iron deficiency.
Psychological
Contributing psychological issues include the recent appearance of her stepmother and subsequent disappearance of her biological mother. Feelings of abandonment and loss were significant for Susan, and she appears to be struggling with perceived rejection despite having a good relationship with her father and stepmother. Susan has several strengths including a positive sense of self and feelings of self-worth. She has adopted some positive coping strategies including using dance and writing to help cope with her symptoms.
Social
Her father and stepmother have a history of loud verbal arguments with one another, primarily around financial and childrearing issues, but they have recently been in less conflict due to their concern for Susan. Susan has two close friends who have maintained frequent contact despite Susan's current refusal to see them.

process of plan development is a necessary step in patient-centered care. Additionally, all possible relevant resources and coordination and communication among providers should be used.

Treatment targets should include short- and long-term goals or interventions for the child, caretakers, and environment. Treatment should have a staged series of interventions that target specific difficulties with specific goals and objectives in a manner that allows periodic reassessments and adjustments. Treatment aims should focus on outcomes that are realistic and attainable by translating disorders or problems into specific thoughts, feelings, or actions, which can be targeted by particular interventions. Overall, interventions generally are designed to support an individual and family achieve a typical developmental trajectory ("normal functioning") or to help youth obtain the highest level of functioning possible given the youth's condition. Treatment plans should be designed so that they can be periodically reviewed and modified, allowing the monitoring of progress and possible adaptions as the child develops [10].

Currently, there is a spectrum of interventions, biological, psychological, and environmental, that can be employed to help children and adolescents with psychiatric illnesses. While medications are important and effective treatment agents, many children and adolescents who have psychiatric difficulties can be effectively treated with psychotherapeutic and psychosocial interventions. A key decision for pediatricians during the assessment process is the determination of whether the youth and family should be referred for therapy elsewhere or if the issues are treatable within the pediatric practice.

Factors to consider include risk of harm to self or others, the child's functional status, level of family functioning, the presence of psychiatric and/or medical

comorbidities, protective factors, and the capacity of the office to manage the presenting symptoms. Milder and earlier stages of illness tend to be more manageable in an outpatient primary care practice. While there are exceptions, in general, cases in which the families need significant interventions are probably best referred, as are cases in which the child is severely ill, treatment requires multiple interventions involving a variety of individuals and institutions and/or the psychotherapeutic treatments require significant time and expertise. Imminent risk of harm to self or others warrants immediate psychiatric evaluation. The chapters in Part II of this text provide additional diagnosis-specific guidance on when to refer.

In Susan's case, the level of depression is in the moderate range. She is having a decline in both academic and social functioning. There are significant family factors perpetuating her depressive symptoms. There is no presence of self-harm or suicidal ideation. Though there is family discord, she had a good relationship with her guardians, and they are involved in her treatment. It is reasonable to consider psychotherapy without medication. However, family therapy may play an important role in her treatment. For this reason, the provider may consider collaborative care with or direct referral to a mental health provider.

There are some basic psychotherapeutic interventions that can be implemented in the primary care setting. Elements of supportive therapy can readily be incorporated into the pediatric home. One of the principal elements is the relationship with the clinician. The clinician's approach should be encouraging and nonjudgmental, and the clinician can use reflective listening skills to build rapport and allow patients to hear their own thoughts and identify their feelings. Reflective listening involves identifying the basic message being conveyed and paying attention to verbal and nonverbal expression of the child's feelings. The listener may repeat or paraphrase key elements of the underlying emotion back to the speaker without introducing additional meaning to those emotions [11]. The clinician should identify strengths in the child and family and foster these strengths. It is helpful to be familiar with the basic concepts of behavioral management including the concepts of positive reinforcement of desired behaviors and establishing age-appropriate consequences for negative behaviors.

Considerations for Integrating Mental Health into the Pediatric Setting

Training to enhance the mental health skills of the clinician is helpful when considering integrating mental health treatment in the primary care setting. This may take several forms. Ongoing peer consultation has been used successfully in several programs across the country. This has led to increased use of rating scales, more systematic monitoring of response, and improved patient outcomes [12, 13]. The pediatric provider can attend presentations and workshops, review online material, and utilize the medical and psychological literature review both to sharpen current skills and to learn new ones.

Table 5.5 Types of mental health providers

Licensed clinical social worker (LSCW)	Completed a masters or higher degree in social work. Has completed a minimum number of supervised postgraduate clinical supervision (varies by state). Trained to diagnose mental health disorders and to provide individual, group, and family counseling. Trained in case management and helping people obtain tangible services
Licensed professional counselor (LPC)	Completed a master's or higher degree in psychology or related field. Completed a minimum number of supervised postgraduate clinical supervision (varies by state). Trained to diagnose mental health disorders and to provide individual, group, and family counseling
Licensed family and marital therapist (LMFT)	Completed a master's degree or higher degree in psychology or related field. Completed additional training in marital and family therapy
Advanced practice registered nurse (APRN) in mental health	Certified nurse specialist (CNS) or nurse practitioner (NP). Completed a degree in nursing and a master's or doctorate degree in psychiatric mental health nursing. Able to assess diagnosis and treat mental health disorders. In some states can prescribe medication either independently or under supervision of a physician
Child and adolescent psychologist	A doctorate-level psychologist who completed a PhD, PsyD, or ED in psychology. Trained to diagnose and treat a variety of mental health disorders. Trained to administer and interpret a variety of tests to aid in diagnosis and treatment planning. Trained in counseling and psychotherapy
Child and adolescent psychiatrist (CAP)	Completed a medical doctorate (MD). Completed a 5–6-year residency program in general, child, and adolescent psychiatry. Trained to diagnose and treat a variety of mental health disorders. Trained in psychotherapy and in the use of medication in the treatment of mental disorders

There are several types of mental health providers with whom the PCP may interface. These providers have a variety of levels of education and formal training. The differences between various providers are outlined in Table 5.5. It is helpful for the pediatric provider to become familiar with local mental health providers who can serve as consultants and collaborators that may assist with referral sources. The pediatric clinician may consider having a care coordinator, particularly one with additional training in behavioral health, to assist the provider in performing mental health assessments, gathering supporting history, and helping the provider and family execute the treatment plan. The care coordinator can help to administer rating scales, obtain collateral history, and coordinate follow-up care. The coordinator may be a pediatric technician, a pediatric nurse, or a master's level pediatric mental health provider.

Primary Care Only

In this model, the primary care provider (PCP) directly provides mental health services. The PCP prescribes medications and administers brief psychological and/or behavioral interventions. The PCP assumes the role of monitoring progress of treatments using patient/parent interviews and validated rating scales. The PCP may

utilize the care coordinator to assist in obtaining history, completing rating scales, providing brief interventions, and helping the family to navigate the treatment plan. This model is applicable to children with uncomplicated mental health problems, minimal or no comorbid psychiatric illnesses, and mild to moderate impairment in functioning, such as a child with uncomplicated attention deficit hyperactivity disorder (ADHD) who may need medication and behavioral interventions.

Consultation with a Mental Health Provider

In the consultation model, the mental health specialist provides brief, focused clinical recommendations to the PCP. This can include information about diagnosis, treatment needs, treatment approach, and availability of resources. These consultations may vary in terms of their frequency (as needed, regularly scheduled) and format (phone, video conferencing, in person). The consultation is most fruitful when the primary care clinician has completed an initial assessment and has outlined a specific question for the consultant. Several regional and statewide consultation models have emerged across the country in recent years. These programs offer a variety of services including a "warm line," where the pediatric clinician can call a child mental health specialist for consultation on a specific case, webinar trainings, webinar case presentations, and assistance with locating mental health resources [12, 13]. In this model, the pediatrician may also use a staff member to serve as a care coordinator. This approach may be best suited for children and families with more complicated behavioral health needs, higher levels of functional impairment, and physical and mental health comorbidities.

Collaboration with a Mental Health Provider

In the collaborative model, the primary care provider works together with a mental health specialist or multidisciplinary team. This may be accomplished between sites (primary care and mental health) or with an on-site mental health specialist. This specialist may be a child and adolescent psychiatrist, a child psychologist, or a master's level mental health professional trained to work with children. Ownership of the treatment is shared to varying degrees between pediatrics and mental health. For example, the PCP may provide initial assessment and treatment planning and decide that medication and therapy would be appropriate interventions. The PCP may initiate medications and have the specialist provide psychotherapy. Or, for example, in the case of a child with diabetes mellitus with associated depression, the PCP may treat the medical illness while the mental health provider manages the comorbid depression. Both providers would work together to track progress in the management of depressive symptoms and would communicate regularly about the patient's care.

Having a behavioral health consultant in the primary care home allows for the patient to be treated in an environment where he/she already feels comfortable

receiving care. This helps to reduce the stigma associated with mental health treatment, allows for more rapid access to mental health services, and helps to facilitate future referrals outside of the clinic if needed. When the PCP and behavioral health specialist collaborate and track outcomes, there has been demonstrated improvement in both physical and mental health outcomes [14, 15].

Direct Referral

In this model, the PCP refers the child to specialty care, and the mental health provider assumes responsibility for behavioral health care. This model is appropriate for children with the most severe needs, whether due to severity of symptoms, degree of functional impairment, family issues, degree of comorbidity, or other factors.

Summary

Various combinations of these practices may be appropriate for different PCPs. It may be helpful for the pediatric office to develop an algorithm to determine which patients may be treated more effectively in the medical home and which may need consultation as opposed to referral directly to mental health services. Barriers to integrated care include time constraints and lack of adequate reimbursement systems. While ICD-10 has added new codes for reimbursement for mental health in the primary care setting, further advocacy in this area is warranted.

Though challenging, performing quality psychiatric assessments in outpatient pediatric settings is possible and, given the number of children and adolescents affected and the shortage of child mental health providers, necessary. The likelihood of having success increases with having a team approach, a range of information gathering techniques, a clear evaluation structure, and a sense of what problems are manageable in the office setting. There are several ways to integrate mental health treatment into the primary care setting. The strategies implemented will vary by practice setting.

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