



The Handbook of Child and Adolescent Systems of Care

The New Community Psychiatry

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Collaboration with Primary Care

Sharing Risks, Goals, and Outcomes in an Integrated System of Care

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We now have ample evidence of the great need for attention to mental health disorders among the children in the United States, along with the most specific directive in our history from the government to medical leaders to do something about it (Satcher, 2000). It is also clear that the need exceeds the reach of subspecialty providers and that all clinicians who take care of children need to work together for it to be addressed. New uses of federal dollars, such as the expansion of Medicaid via State Children's Health Insurance Program (SCHIP) and early and periodic screening, diagnosis, and treatment program funding of mental health interventions, are being considered to help pay for this care. Coordination of effort and resources is desirable for providers to have the greatest impact. In addition, the idea that physical and mental well-being are linked is supported by both ancient wisdom and the latest biomedical research (Cohen, 2000; Baum & Garofalo, 1999; Carney et al., 2001). Yet we are starting from a distinct disadvantage in this effort due to the lack of established systems to provide integrated care to children and adolescents.

CHALLENGES TO INTEGRATION

Although most clinical services are not intentionally integrated, the effects of pediatric or child psychiatric care are ultimately integrated within the person of the child. Various influences around the child, most importantly the family and sec-

ondarily the school, care delivery system, and community cultures, make that integration either easier or more difficult. The predominant health care model now delivers pediatric and child mental health services in settings that are greatly isolated from each other, with a sea of misunderstanding, mistrust, and frustration between them. In order for greater collaboration to occur, we need to understand the reasons for this, which include conflicting traditions, medical expense and managed care, confidentiality, and, most recently, carve-outs.

Conflicting Traditions

Pediatricians and family practitioners are typically trained to expect to interact with the family in an appointment or a crisis and only rarely to see a child alone. Parents are the immediate "customers" of pediatric recommendations, as well as the parties who implement the majority of the interventions (such as clear fluids, wound care, or nebulizer treatments), which mainly take place at home. Pediatricians or family practitioners are the child's first health care provider and are taught that they need to own the case. Consultation is obtained as needed from pediatric subspecialists who perform recognizable and familiar procedures and then report back recommendations to the pediatrician or family practice provider, who conveys them to the family. Finally, communication about the patient among primary care staff or providers is open, expected, and hindered only by time.

Child psychiatrists and mental health clinicians have been trained within a different tradition: they are expected to interact with the individual in an appointment or crisis and rarely meet with the whole family. Parents historically were peripheral to the interventions (such as play therapy, semistructured interviews, and psychotherapy), which mainly occurred in the office. Child psychiatrists traditionally pick up referrals, which they then keep; they rarely see themselves as pediatric subspecialists and do not expect to function under the direction of the primary care provider. The child mental health clinician is unlikely to be in contact with the primary care doctor at the beginning of treatment, psychiatric assessment and treatment processes are often unfamiliar and mysterious to primary care providers, and recommendations at termination are made to the patient and family but rarely passed on to the pediatrician. Communication about the mental health patient between staff members or providers is complicated, hampered by confidentiality issues and hindered by different vocabularies.

Medical Care Expense and Managed Care

Resource and reimbursement patterns shifted in response to the escalating costs of medical care in the 1980s. Private and public purchasers, primarily employer groups but also government programs such as Medicaid and Medicare, rebelled against the unchecked growth of the fee-for-service health care industry with its incentives aligned toward expenditures. In the new climate of health insurance premium reductions and cost control, managed care became a significant force

(Patterson, 1990; Wickizer & Lessler, 1996). The realignment of incentives toward avoiding expenditures altered care patterns almost overnight. Worries about excessively long, even "frivolous" hospitalizations of adolescents swung instead to worries about hospitals shutting down and being able to get children, first, into the hospital and, second, being able to keep them there when they needed care (Sabin & Daniels, 1999; Smoyak, 2000). To some extent, fragmentation of care is unavoidable in most health care delivery models, including traditional fee-for-service, but the onset of managed care and accountability within a financial cap brought new challenges to care coordination. Although some aspects of health maintenance organizations are actually conducive to integrated care, such as a single medical record, colocation of providers, and comprehensive pharmacy data, these benefits were soon eclipsed by the diminished role of local health maintenance organizations (HMOs) and the rise of national managed care companies. The two medical specialties that were historically the lowest paid, pediatricians and child psychiatrists, now had to compete for the same premium dollars within managed care (where adult "employee" and "members" were the major customers and children an afterthought in most service programming).

The squeeze on mental health and primary care providers limited the previous consultation-liaison opportunities, such as team meetings, in both inpatient and outpatient settings. Even time for hallway consults or telephone contacts was slashed as productivity measures, misguidedly focused on face-to-face contact time, were put into place. Providers not only had less time to coordinate with each other; the shift to adult-driven relative value units (RVUs) for reimbursement meant that previous opportunities to participate in more community-based care planning appropriate for children, such as school meetings, became all but nonexistent. Colocation was now less likely; medical records were maintained separately (shared with benefit managers but not colleagues) as providers returned to the private office culture. And although pharmacy benefit data might be joined in one insurance record, individual prescribing clinicians in a network were less able to access the total pharmacy record readily to ensure protection against drug interactions or other risks.

The increased pressure on inpatient settings to limit both admissions and lengths of stay (Fendell, 1994; Lind, Rosenblatt, Attkisson, & Catalano, 1997), coupled with increased pressure on outpatient settings to limit time spent on the telephone or in meetings, resulted in less time for child psychiatrists to review information about a patient before seeing that person, talk with the patient or family when the patient was seen, think about the patient after the appointment, record the encounter, and generate a thoughtful plan.

All of this seriously undermined the intrinsic system capacity to coordinate care for children precisely at a time when external community resources, such as advocacy services developed in the late 1970s and early 1980s, were being phased out or closed due to reduced funding (Duchnowski & Friedman, 1990). Children

and families began to feel a stiff breeze blow between the gaps in the service delivery system; and health status reports, such as Kids Count, showed declining scores on protective factors, such as family health insurance coverage (Kids Count, 1999; Massachusetts Institute for Social and Economic Research, 2000).

Confidentiality

The confidentiality of the medical record is another issue that has complicated the delivery of integrated care and led to great controversy between providers and among members of the public. The decade between 1985 and 1995 saw steady advances in the sophistication of computerized medical records. For the first time, doctors working in integrated systems such as HMOs could access unified lab results, prescription records, and consultation notes for their patients regardless of the site where the care was provided. The benefits of such a system seemed obvious: it was much less likely that conflicting medications would be prescribed or that an after-hours provider would be unaware that a patient had recently been seen elsewhere and had an abnormal electrocardiogram. However, paralleling these advances was a deep unease growing among the general public regarding computerized access to personal information and concern about what safeguards were in place to protect privacy (Simmons, 1997).

It is noteworthy that this unease appeared to be primarily driven by adult patient needs and that there are distinct differences between internal medicine and pediatric practices regarding record keeping. Many adults are sensitive about both the possible stigma of mental health treatment itself and the possibility that details from their personal histories might be accessible from the record without their consent. They prefer not to disclose the content of their psychiatric symptomatology to their primary care providers, much less to their allergist or dermatologist, and certainly not at all to their insurer. These consumers pressed for a completely separate mental health record, which would be exempt from most record review and would require a separate release of information signature.

There is no question that the inappropriate intrusion into treatment planning by insurance reviewers and administrators was legitimate fuel for concerns about patient confidentiality. However, pediatricians, often the first to identify mental health conditions in their patients, were frustrated that after requesting a psychiatric consult, they were prevented by the newly modified medical records system from accessing their consultant's report. They were the primary recorders of family system or environmental risk (such as a non-English-speaking parent or problems with parental visitation), and they sought to maintain the traditional comprehensive medical record, warning of fragmented responses to family concerns if health care was not coordinated. Child psychiatrists, meanwhile, were burdened with duplicative and oddly divided record keeping so that medication refills and notes about side effects were no longer likely to be in the same place, making clinical coverage and care decisions both more burdensome and more risky.

Some HMOs, such as Harvard Pilgrim Health Care (HPHC) in Boston, made several sequential modifications in their medical record system within a matter of months in an effort to balance concerns about confidentiality and the need for communication about patient care (Leaning & McDonald, 1997). Each of these changes generated new complaints from dissenting groups that too much or too little information was available. The decision was ultimately made to dismantle the integrated computerized medical record and put notes by mental health staff in separate paper records. This was reassuring to those who felt private information from their therapy sessions was now better protected. However, others feared that unified, comprehensive medical record keeping, one of the elements that support excellence in the delivery of integrated patient care, had been dealt a significant blow. Notes about sexually transmitted diseases or substance abuse could still be included in the medical record if they were made by a primary care clinician. But a child psychiatrist's documentation of symptoms and medication side effects for a patient with attention deficit disorder, for example, could not be read by the child's pediatrician. In the new HPHC system, even mental health providers, working with the same patient but at different sites, were required to use separate, unlinked paper medical record systems.

The optimal way to document and track detailed patient information to support care coordination while protecting privacy remains a challenge. However, the disintegration of the patient record is impractical and undermines one of the great potential clinical quality advantages of an integrated care setting.

Carve-Outs

Notwithstanding all these challenges, the carve-out movement of the mid-1990s offered the most direct assault on the process of delivering high-quality integrated care (Jellinek & Little, 1998; Sharfstein, 2001). The separation of responsibility for mental illness (renamed *behavioral health*) from other forms of illness appeared to promise financial savings for insurers and employers alike. Mental health dollars were theoretically already managed by various means, such as gatekeeping by primary care, limitations on coverage, and newer, and escalating, copays. But managed care companies and physician groups were still struggling to find ways to reduce the cost of mental health service delivery further. They hoped to keep the percentage of the health care dollars spent on mental health to a minimum in order to sustain the overall favorable financial trend of ten years earlier. This was made more difficult in a buyers' market for members. Expensive tests, specialized treatments, and new drugs had been driving costs and expectations up, but employers and other purchasers of care were unwilling to support premium increases. The so-called behavioral health carve-outs, often for-profit companies, promised to manage mental health costs within a separate benefit outside the rest of the patient's care for which the carve-out

company would take the financial risk. This was to be accomplished by requiring all authorizations and treatment decisions to be routed through designated behavioral health benefit managers.

The carve-out model quickly became popular with purchasers of health care benefit packages since it appeared to offer a single solution for rising mental health costs, complaints about access to specialists, and the confidentiality problem. As a result of this widespread move to carve-outs, most people now negotiate psychiatric referral and treatment decisions through intermediaries whom they have never met and are unfamiliar with their overall health status.

In addition, the gulf between primary care and child mental health clinicians has only widened as the system offers little or no contact between them. Some child psychiatrists see pediatricians as seeking to compete for their business by prescribing Ritalin and billing for office-based "counseling." Some pediatricians see child psychiatrists as motivated by reimbursement rates alone and unwilling to share responsibility for a child's overall health and well-being. Providers in both groups complain that the other group does not initiate calls regarding care coordination or return them.

Child psychiatrists typically report feeling alienated or cut out of the mainstream health care delivery system, with an associated suggestion of second-class citizenship in the medical world. They resent being pushed into a dangerous, hectic, insurance-driven role of seeing six patients an hour as a "prescriber" rather than that of a highly trained clinician who diagnoses carefully over several hour-long visits and treats using an array of methods, including psychotherapy. They are angered by the added expectation that they work part time in several locations in order to have full-time hours. They are frustrated and distressed at traveling from site to site (unpaid), while maintaining the ethically and clinically required follow-up responsibility and emergency access for each site on their own time, all within the fifteen-minute visit reimbursement rate.

Pediatricians, meanwhile, indicate feeling abandoned and overwhelmed as they are asked to handle children with mental health crises by themselves in the emergency room or board the children on pediatric inpatient units when there is no child psychiatric resource to receive them. They feel pressured to take on the mental health prescription and medication management for these seriously at-risk children, since there is no one else to do it. And they resent the absence of backup from child psychiatrists who have left the larger system to go into cash-only private practices or taken on administrative positions.

Families dealing with carve-outs report confusion and desperation regarding how to get child psychiatric help when they need it. They recognize the difference between getting child mental health advice from a specialist versus from their primary care clinician (Briggs-Gowan, 2000). They have little or no choice regarding mental health providers, due to restricted panels, and the scarcity of

doctors or other clinicians who will accept carve-out company reimbursement levels. They note a loss of experience level and expertise in providers who are willing to see their children; training programs have also been hit hard, and intensive clinical supervision is not easily obtained. Many managed care companies have provider lists heavy in adult-trained providers, some willing to see children. Behavioral health utilization managers assign children to be treated by these providers, either when they are unaware of the lack of appropriate training or because they do not have specialty care available in their network. Parents feel solely responsible for any coordination that occurs among providers on behalf of their child, within mental health and across specialties.

NEED FOR INTEGRATION

For patients who themselves have, or whose family members have, adequate physical, emotional and financial resources, these barriers can be overcome or circumvented, although with difficulty. The tenacious, well-connected father will undertake as many telephone calls as necessary to make sure that the specialist his child has been referred to is truly qualified. The wealthy can seek the services they desire directly, without need for authorization. An educated and energetic mother may put in several hours directing the linkage among her daughter's various caregivers and treatments, even double-checking to make sure that her child's medical records were sent and read.

The need for coordination between primary and mental health care is directly proportional to the vulnerability of the patient. That is, the youngest, the oldest, and the sickest patients stand to benefit the most from close communication among the providers of their care. The ensuing risks when this does not happen in such cases are great, not only for the individual patients but for the population in general. These broader population risks can be summarized into three types: health care access, health care disparities, and health care quality, all of which represent reasons for integration of care.

Health Care Access

Among the more recent issues that have contributed to constraints on the delivery of integrated care is appropriate access to mental health and substance abuse providers. Consumer groups and health policy analysts began voicing concerns in the early 1990s about barriers in the path of patients requesting mental health referrals (Fendell, 1994). Many HMOs had attempted to contain mental health costs by requiring referrals from primary care providers (PCPs) or gatekeepers before mental health treatment could be obtained (Costello & Burns, 1988; Grembowski, Novak, & Roussel, 1997). Most children's health problems are self-limited; that is,

they resolve with time, regardless of what remedies are undertaken. But problems of a more serious nature or with complications require timely and accurate interventions for optimal results. Access to services is often less dependent on severity of health risk than on social and geographic circumstances. However, even those with comparatively generous health care benefits may suffer with regard to appropriate access to care. All patients and their families in a practice are affected when a small percentage of cases absorb the bulk of their doctor or nurse's time. Sometimes this occurs because these are truly the most severely ill cases. Other times, illnesses have been incorrectly or only partially treated at the outset, and new treatment plans are needed. Sometimes there may have been inadequate levels of patient or family follow-through on the doctor's directions. Regardless of the reason, the rest of the patients have to wait. This engenders a circular problem where some of those people waiting for care experience relapses, deterioration, or prolongation of symptoms that could have been avoided if they had been dealt with more promptly. This is particularly a problem when resources are already very limited, such as is the case nationally and internationally with child psychiatry (American Academy of Child and Adolescent Psychiatry, 1999). In a coherent system of care, where access can be appropriately supported by cross-training of other professionals, and even family members, to recognize clinical symptoms requiring greater expertise, access to subspecialty care is improved. Large medical systems may employ only one pediatric cardiologist, but clinical guidelines, mutual arrangements with other specialties (such as pediatrics or adult cardiology), and informed nursing staff can maintain an appropriate level of responsiveness and access as needed by the population. This is equally possible in child psychiatry, where integration within a larger, competent system would greatly improve appropriate access to care.

Health Care Disparities

In some cases, sufficient educational and financial resources can partially offset the drawbacks of fragmented care, but for others, it is not possible to fill in the gaps personally. Examples of families or children in this group include a young immigrant family struggling to care for a premature infant across a language barrier, a depressed teenage girl who misses appointments set up to improve medication management of her serious asthma, and anyone with complex mental health or medical conditions. Unfortunately, in most modern health care systems, such at-risk populations are the least likely to enjoy integrated delivery of clinical services, thereby perpetuating the disparity in health outcomes for poor children and children of color (Samaan, 2000; Navarro & Shi, 2001; Politzer et al., 2001). The social costs of the increased morbidity within disadvantaged populations readily translate into financial costs for insurers, such as Medicaid and Medicare, and for the taxpayer. Countries and states with significant health care

disparities have no winners, only losers (Kennedy, Kawachi, Lochner, Jones, & Prothrow-Stith, 1997).

Health Care Quality

As the U.S. economy has taken a downturn, inpatient and outpatient facilities are closing, and staffing levels are being reduced in settings across the nation. The possibility of addressing availability and quality of appropriate child mental health services issue by increased numbers of specialty clinicians seems unlikely. Continuing with existing approaches appears to lead us into declining quality as resources, human and financial, cannot support those. Instead, we can consider looking at a broader, secondary prevention model, similar to that used in other countries (Belfer & Saraceno, 2002), with a three-pronged approach, which depends heavily on partnership with families. As we increase the population-wide, community-based recognition of child mental health issues, we obtain the opportunity to intervene earlier and manage illness more cost-effectively, with resultant improvement in outcomes for more children and families.

This model for improved child mental health outcomes at the population level depends on three co-occurring processes:

- Patients and families are informed (in their primary language) at all possible venues, such as churches, markets, and public transportation areas, regarding observable health risks and consequent needs in order to sensitize public awareness of child mental health.
- Local screening and early intervention efforts jointly sponsored by primary care and school system teams of nurses, teachers, volunteers, and others can, through their collective availability, shift the cost and morbidity curve to the left so that there are fewer high-end children needing scarce specialty resources.
- Community-based systems of care are created where families, agencies, schools, and informal supports can be linked to child psychiatrists, pediatric neurologists, and others as needed through the use of multidisciplinary protocols and clinical guidelines, along with clearly defined resources, action steps, and care processes for both urgent and routine situations.

In order for such ideal systems to function, there needs to be significant restructuring of roles and reimbursement in the mental health system. A first step in that process is to enhance the relationship between primary care and specialty mental health care for children and adolescents and to identify what supports that relationship requires to function well.

PRINCIPLES AND PRACTICES FOR COLLABORATION

The term *integrated care*, as it is being used here, refers to the delivery of primary and specialty health care, including mental health, within a system that supports a team approach (Call, Wisner, Blum, Kelly, & Nelson, 1997; U.S. Department of Health and Human Services, 2001). There is controversy regarding whether integrated care can best be delivered through outreach specifications placed on primary care (the public health medical home concept) or mental health and substance abuse providers (a variant born from responsibilities assigned to carve-outs when health care was divided into "mental" versus "health"). From either starting point, the underlying premise of an integrated model of care is that clinical interventions, including, but not limited to, medication, have the potential to interact with each other, for both good and for ill. Thus, it behooves the providers of these interventions to understand the implications of such interactions and seek the safest, most efficient combination of treatments for each patient.

Sharing Risks

There have been obvious gains in medical techniques and knowledge in the United States since the era when a community had one doctor providing care house by house, but there have also been losses. One of these is the clear ownership of care. When there is only one provider, things may be overlooked, or there may be too much to do, but there is no "turfig" or turning away from risk or responsibility out of the conviction that it is someone else's job to respond. In most health care settings in the United States today, care delivery is fragmented, and there are no clear owners of outcomes or process. The child mental health specialist does not consider himself or herself responsible for knowing whether a therapy patient gets a hepatitis B shot, and the primary care clinicians do not tend to inquire about suicidal ideation during their review of systems. Examples of successful integration of care, where the risks to the child are regularly shared, include when a pediatrician involves social services due to suspected child abuse or a therapist asks whether the sexually active adolescent patient is using birth control.

However, there is no greater disincentive to such outreach and expanded risk screening than to feel that there is no backup when problems are discovered. Child abuse most often goes unreported when there are underdeveloped response systems. Similarly, a therapist who has no link to medical providers is less equipped to take the next steps to steer her teenage patient toward birth control. It is critical in the encouragement and training of an interdisciplinary team approach to be able to describe clearly what the steps will be when a risk is uncovered and how resources can be accessed. Even the existence of cross-training

on a paper protocol can be a resource under these situations, although having a defined person to consult, directly or electronically, is infinitely preferable. Regardless of modality, it is more likely that population and individual health issues will be identified when areas of potential risk are understood by all who encounter the child or adolescent and when there are clear-cut processes for sharing the risk response among providers or a broader team (ideally including family, informal supports, and nonprofessionals).

Additional risk-sharing opportunities occur during the initiation of medications, or regarding the recognition of diagnoses, that span primary and specialty care categories (such as insulin or substance abuse). In these instances, failure to communicate and create shared strategies for patients will waste resources and adversely affect patients, as in the following two case examples:

Unaware of the boy's clinical status, a school social worker recommended anger management classes for a diabetic who was repeatedly hypoglycemic and irritable rather than suggesting his mother talk to the pediatrician about his insulin dose.

Unaware of the teenager's heavy alcohol use, her pediatrician prescribed inappropriate pain medication for her complaints of chronic headache rather than recognize the need for a pain management and addiction treatment approach.

The literal sharing of financial risk can help to underscore the interconnect- edness of the care delivery system. Ultimately, all risk sharing works to the ben- efit of the providers and other members of the caregiving community, as well as to the child or family. The burdens are too large and the need for creativity too great to bear alone. In addition, the involvement of mental health providers has been demonstrated to improve overall health and cost outcomes (referred to as medical cost offset) in several different studies (Shemo, 1985-1986; Thompson & Hylan, 1998). In an ideal collaboration among adults, the child reaps the re- ward of multiple perspectives; in addition, the joining together to manage the shared risk allows a perfect base on which to build common goals.

Sharing Goals

The most successful method for choosing treatment goals is to ask the family to identify them. We have gone from "doctor knows best," to "remember to talk to the family," to "family-focused" care, which stresses *"remember to listen to the family"* (Briggs, 1995; VanDenBerg & Grealish, 1996). Although primary care clinicians are still expected to maintain the protocol for immunizations and choose appropriate antibiotics when needed, other issues in the pediatrician's office are driven by parental concern, such as sleep patterns or school func- tioning. Eliciting the family's sense of the child, including his strengths and needs, is even more urgent for child mental health and substance abuse clini- cians, who do not have the "regular check-up" culture to rely on and must con-

nect with the family quickly or lose a treatment opportunity. Understanding how to hear what the family strengths and needs are is the first step toward choosing treatment goals.

Integrated care takes the list of goals that a family identifies for their child, and that an older child or adolescent identifies for himself or herself, and looks at the distribution of responsibilities for each goal. The family is like the chief executive officer in these settings, with the care community, including the pediatrician or child psychiatrist, as members of the board of directors, working together to implement the family's goals and objectives. In this way, communication among relevant parties is enhanced at the beginning and is not dependent on an emergency. Goals are focused and prioritized with built-in measures for success that allow for correction if they are not being met. Systems partners, such as teachers or social service workers, may be asked to be part of the treatment team; at a minimum, their views need to be understood for the optimal success of the plan.

Unless and until the needs of the members of the care planning team for high school freshman Michael are woven together into a shared mission, the efforts of the players will be at cross purposes with no clear end point or agreed-on measure of success.

The list of these needs might include:

- Michael's wish for his assistant principal to "give him a break."
- His mother's wish to be uninterrupted at work by calls from Michael's school.
- His therapist's concern that Michael may be using both alcohol and marijuana.
- His father's view that alcohol is all right but marijuana is not.
- His pediatrician's discomfort with requests for covert urine screening.

The team mission derived for Michael that all could agree with from such a list might be: "Michael making it safely to tenth grade." Thus, all interventions or modalities (whether therapy or detention) are reviewed in the context of the question, "How does this enhance or decrease the chance that Michael will make it safely to tenth grade?"

Strength-based goals to support this mission could include:

- Recruiting the assistant principal to the team and using his interest to provide information to the family
- Finding a way to involve the family that does not undermine the mother's job security
- Encouraging Michael's (and his team's) increased understanding of the triggers or motivation behind his substance use
- Creating a shared parental assessment of objective risk to Michael if he uses any substances
- Clarifying for other team members the role of the pediatrician (and urine tests)

Interventions tied to these goals might include:

- A school-based liaison to meet regularly with parents (before work) and take over monitoring of student from the assistant principal

- A crisis plan for implementation in school with Michael's father as backup
- An after-school psychoeducational group for Michael on decision making
- A meeting to include the therapist, Michael's parents, and the pediatrician to review actual and relative risks of suspected substances and clarify parental strategy and communication
- Clarification regarding the clinical site policy regarding urine screening and pediatric role in suspected substance abuse

All the while, there would need to be parameters in place, such as summer school if Michael has not mastered certain curriculum items by March, transfer to a more intensive clinical setting for academics if his behavior (including weekend or evening activities which result in emergency room visits) does not improve by January, participation in recreational activities contingent on successful attendance in a twelve-week psychoeducational group for teenagers, and commitment from Michael's family to take part in concurrent family work to pursue his concerns regarding his father's alcohol use and his mother's depression. Michael's pediatrician can justify involvement in these meetings as supporting the goal of the patient's "getting safely to tenth grade," especially because her participation should be outcomes driven. Time spent in meeting every three weeks is less expensive than emergency room visits (under a cap) for inebriation or a residential treatment program for substance abuse.

Sharing Outcomes

No intervention, whether strictly medical or in some other therapeutic realm, should be undertaken without a clear sense of anticipated, or at least hoped-for, specific outcomes. This hardly sounds controversial, but it is actually not typical of child therapies, many of which have been accurately charged by families and primary care providers with being diffuse, nonspecific, and unmeasurable. Linked to the need to tie interventions to goals and monitor outcomes is the need to change interventions based on so-called process measures—indicators along the path of the ultimate outcomes that will address whether the mission was achieved.

In the example, if Michael never attended the after-school group, it would not make sense to leave everything the same and keep noting that he was not attending the group. Either the appropriateness of the intervention would need to be reconsidered, or the rest of the action steps were insufficient to support this intervention's being successful. In other words, something needs to change. This accountability helps support the integrated team's energy and effectiveness rather than having it sink into an atrophied relic of a treatment team that repeats failed strategies.

Child mental health outcomes do not occur in a vacuum but are the reflection of the interplay between risk and opportunity. An integrated clinical approach within an overall community-based system of care allows a wider array of opportunities to modify innate and acquired sources of risk to healthy development for children and adolescents.

To the extent possible, given local variation in health care delivery systems, child mental health and primary care clinicians should seek to build a close collaboration regarding both child population health risks and those of the individual families and children in their care. Integrated clinical care delivery should be a key element for organized systems of care and demanded by family and mental health advocates. There is an increasing body of evidence that strategic, coordinated efforts within a strength-based approach can shift the outcome for otherwise severely at-risk children toward the mean (Duchnowski & Johnson, 1993; Evans, Huz, McNulty, & Banks, 1996; Burns & Farmer, 1996). Not only is this good for the children and families involved, it allows for resources to be reallocated toward earlier recognition and treatment for those who might otherwise not have received care (Cole, 1996). Ultimately, consistent application of this strategy contributes to improvement in the overall health status of the community.

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