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'DOWN TO EARTH' ACADEMIC SKILLS COLUMN

Building Integrated Mental Health Services in Pediatric Primary Care: User Guide from the Academic Trenches

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Pediatric psychiatric disorders are common and rising, with 16.5% of US youth reportedly having at least one psychiatric disorder [1]. Since 2010, psychiatric problems among US teens have increased every year [2]. During the COVID-19 pandemic, studies have consistently found worsening behavior problems and increased anxiety, depression, and stress in children and adolescents [3–5]. According to the Agency for Healthcare Research and Quality, children who are Black, Indigenous, and People of Color (BIPOC) are at increased risk of experiencing COVID-19-related trauma and less likely to have access to psychiatric services, thus making them some of the most vulnerable children in the USA [6]. Health care disparities have also become markedly more apparent, with poor mental health outcomes disproportionately affecting the BIPOC population [7]. In October 2021, the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics, and the Children's Hospital Association jointly declared a national mental health emergency, which has particularly affected this group of vulnerable children [8].

For decades, the USA has been unable to meet the growing demand for child mental health services. In order to address this critical problem, both the American Academy of Pediatrics and AACAP have called for utilization of integrated care models to expand the youth mental health workforce [8, 9]. In collaboration with mental health specialists, primary care clinicians (PCCs) can increase their comfort level, develop their skills, and increase their capacity to meet the needs of children with mental health problems [10].

Integrated care models improve access and family engagement in evidence-based mental health services, reduce barriers to care, and improve patient outcomes [11]. There is significant variability in integrated care models, and the Substance Abuse and Mental Health Services Administration (SAMHSA) has outlined six levels of integration, progressing from minimal care coordination to colocation and to fully integrated [12]. Despite the differences in meaning, "co-located," "integrated," "collaborative," and "embedded" care are often used interchangeably in our day-to-day work, despite being very different concepts and models [13]. For this paper, "integrated" care refers to mental health care being available on site with PCCs, with variable degrees of collaboration throughout the evaluation and treatment process. In 2012, AACAP outlined strategies for successful integration, and since then, there have been numerous changes to the field, including expansion of telehealth and increased emphasis on health equity [14]. To date, there is no guide that captures the complexities of incorporating these elements into the current landscape of clinical practice. This article provides foundational and practical strategies for designing and implementing successful integrated care models in the rapidly evolving pediatric primary care setting, summarized in Table 1 [12, 15–22].

In addition, there are comprehensive resources to help clinicians build integrated care, including detailed definitions of roles and scopes of responsibilities of the integrated care team, financing strategies, and telehealth considerations, available from the University of Washington [16] and AACAP [23].

Additional Considerations in Building a Successful Program

While every clinic has unique characteristics and needs, certain guiding principles are transferable and provide a reliable scaffold for integrated care programs. First, understanding

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Table 1 Key steps in building an integrated care program

Key steps	Strategies	Resources
Step 1: Preparation		
Self-reflect to understand your motivation to do this work to help you develop shared goals with primary care clinicians (PCCs) Ask yourself: Why do *I* want to do integrated care? What are my goals?	Consider which of the following elements of integrated care pique your interest: - Population health and access to care - Interprofessional collaboration - Medical education - Scholarship, research, and quality improvement - Consultation model of clinical care	Collaboration with primary care resource collection from American Academy of Child and Adolescent Psychiatry (AACAP) [15] For an example, see Advancing Integrated Mental Health Solutions (AIMS) Center resource "Psychiatric Consultant Role and Job Description" [16]
Identify a practice that would be a good partner in building a pediatric integrated care program Ask yourself: Why does this clinic want to do integrated care? Are our goals aligned?	Understand the clinic's motivation to build an integrated care program, including: - The clinic's goals - Willingness to change the clinic's practice and expand the clinic's capacity to treat mental health concerns	Implementation guide and free office hours [16] AIMS Center resource "Broadly Defining Value for Your Model of Integrated Care" [16]
Get buy-in from leadership Ask yourself: Is this an institution that will support this model?	Reach out to key stakeholders and leaders from your institution/health care system to discuss shared goals and expectations. Ensure you have support before proceeding	Leadership buy-in [17]
Identify a mental health champion in the practice Ask yourself: Who will be my partner?	Finding a mental health champion can be easy or challenging depending on the practice Consider the following: - Who already treats youth with mental health concerns? - Who is most interested in mental health care and brings you cases or questions?	See AIMS Center [16] and search for "champions."
Step 2: Assessment		
Get to know the clinic by going into the clinic and observing Ask yourself: How do things operate now? What are the issues with the current workflows or practices that need to be addressed?	Visit the clinic, meet with the team, and shadow PCCs to - Evaluate current practice around caring for kids with mental health problems - Understand current screening processes - Assess the processes for handling mental health referrals - Determine the physical space for mental health team, patients, or shared work space	Levels of integration chart [12]
Conduct a PCC needs assessment for educational and clinical goals Ask yourself: How much experience do PCCs have with treating mental health concerns? Where do PCCs need support? What services are needed the most?	Survey PCCs to: - Assess baseline comfort and knowledge - Identify PCC priorities to develop services and improve buy-in - Establish a baseline to help assess program efficacy - Develop targeted educational content	Example needs assessment questionnaire available on request from corresponding author
Assess clinic readiness for integrated care Ask yourself: How ready is this practice for integrated care? What steps and resources are needed to get to where you want to be?	Discuss with program manager and stakeholders to understand desired referral workflow and staffing needs	Access Community Health Centers' model [18] Example readiness checklist for traditional collaborative care model [16]
Step 3: Design and implementation		
Use a population health approach to outline the model you are proposing, including the services your team will offer Ask yourself: Does this model meet the needs of the clinic, address shared goals, and align with my values? Who will prescribe medications?	To determine your integrated care program model, consider: - Consultation versus short-term care - Use of validated screening tools - Inclusion and exclusion criteria - Workflow for service linkage - Patient selection; triaging referrals for severity and complexity will help link patients with appropriate services (mild to moderate concerns: PCCs to manage with psychiatry support; moderate to severe concerns: link to outpatient psychiatry)	Determining level of integration/service [12] American Academy of Pediatrics, "Bright Futures List of Recommended Screening Tools" [19] Population Health Approach (with prevalence of each category in relative terms approximated in typical primary care setting): few = severe or multiple comorbid diagnoses; several = single straightforward diagnosis; most = at-risk or sub-syndromal

Table 1 (continued)

Key steps	Strategies	Resources
Think about sustainability Ask yourself: Is this design likely to be self-sustaining or require additional funding?	Work with stakeholders to estimate the financial impact of the program and identify support. Consider: - Who the insurers are and services that are revenue-generating - Use of collaborative care codes - Grant support (very common way to start integrated care programs) - Institutional support and funding	Basic Billing Codes: See AIMS Center/resources/billing [16] Reimbursement Strategies [20]
Build in teaching Ask yourself: What are the knowledge gaps and what topics should I prioritize teaching? Who are the learners in the clinic?	Supporting PCCs in advancing mental health knowledge and skillset is critical and may include: - Case-based teaching: every interaction is an opportunity for a teachable moment - Case conferences: can be informal, a place to bring questions and comments - Lectures: high-yield topics	American Academy of Pediatrics educational resources to share with pediatricians [21] Review your state's child psychiatry access program website for local resources
Invest in relationships Ask yourself: How strong are my relationships with the PCCs? What are concrete ways to build and strengthen these relationships?	Engage PCCs early and often to partner effectively around shared goals: - Maximize in-person time with PCCs and clinic staff as able - Designate regularly scheduled meetings - Establish shared values and ethics (e.g., regularly discuss differences in approaches in treatment planning)	Engaging PCCs in integrated care [22]

the motivation and priorities of PCCs and stakeholders through thoughtful preparation and assessment will help build effective partnerships and design a program that meets everyone's needs. Then, in collaboration, determine the patient criteria for program qualification, decide what services to offer, and define program expectations and metrics for success. Make sure to consider whether the services are in alignment with what the clinic population needs and the level of engagement and readiness for practice change of the PCCs. Consider using a needs assessment as a tool to assess the skill level of PCCs and understand their needs (sample tool available on request from the corresponding author). Helpful questions may include, "How important is it for you to address the mental health needs of your patients?" and "How comfortable are you assessing/managing the mental health concerns of your patients?" Part of the assessment can help to establish buy-in from PCCs as they reflect on the questions posed.

Establishing expectations for provided services is also important. Integrated care services are generally intended to treat milder to moderate mental health issues in primary care, rather than take the place of outpatient psychiatric services. It is important to identify more severe and complex presentations and refer those to more appropriate services, like outpatient mental health care. Using criteria like age ranges, symptoms, or diagnoses can help clarify which patients are most appropriate for an integrated care model.

Another pivotal decision point to consider is whether the services offered will strictly be consultative or involve ongoing patient care. It is not uncommon for PCCs to initially express a desire for the psychiatrist to take over care or for PCCS even to be unsure about what help they need. The psychiatrist's role may require ongoing assessment and encouragement to help move all partners toward established goals of the integrated care program and needs of the patients. However, if the psychiatrist decides to provide ongoing patient care from the primary care setting, the psychiatrist will have less capacity to see other patients, and it is often more challenging to help PCCs build their skillset. Nuances of service selection and design are beyond the scope of this article, but it is important to consider this early and reassess it often.

Once the clinic has established what services the psychiatrist will provide and eligibility criteria for the program, the integrated psychiatrist will need to work toward being viewed by the PCCs as accessible and helpful. Consider protecting some time to be available for PCCs to ask questions and have spontaneous interactions by being situated physically in the clinic with the PCCs. Investing in face-to-face time with PCCs keeps the psychiatrist at the forefront in the PCCs' minds. These strategies are often an efficient use of the psychiatrist's time and help with engagement and advancing PCC mental health competency. If for any reason in-person interactions are not available (e.g., the psychiatrist

is working remotely), engaging with PCC colleagues may require more creativity. Some innovative ways include virtual case conferences or office hours.

In addition to availability, it is critical to develop a shared vision and goals between the psychiatrist and PCC partners. A mental health champion can be invaluable in this endeavor. Psychiatrists and PCCs come from different training backgrounds, have different ways of discussing clinical care, and often operate within different "cultures." An effective mental health champion can help bridge this gap, align team efforts, increase buy-in for the model, and guide program development. When conflicts arise in the care team, the mental health champion may be the psychiatrist's first partner in navigating these differences. Furthermore, the mental health champion is the psychiatrist's ally by extending the psychiatrist's reach in keeping mental health care on the forefront of the PCCs' minds even when the psychiatrist is not present. Identifying a champion may be obvious, such as a PCC who has completed additional mental health training, sees more than the PCC's share of patients with mental health diagnoses referred from other PCCs in the clinic, or has previously sought out consultation around cases. In some instances, it may take more time and work together to find out who are the PCCs in the clinic that will not shy away from implementing screening or prescribing a suggested medication, with whom the psychiatrist can ally and also become champions.

If the site includes trainees, it will be even more important to get the PCC team on board with the integrated care model. PCCs supervising residents will model attitudes toward mental health care and shape the next generation of PCCs. The psychiatrist's involvement in training can greatly influence trainees' attitudes toward mental health treatment in primary care, expand the mental health workforce, and enhance the program's impact.

Special Considerations for Underserved Populations

Social determinants of health, such as housing, racism, and education, can affect the overall wellbeing of patients and contribute to long-term health disparities [24]. Stress related to discrimination based on race, gender, and sexuality can adversely impact health [25]. In 2021, the US Surgeon General wrote a call to action to address the ongoing disparities in mental health care among marginalized youth [7]. However, attempting to provide mental health services to marginalized patients in an overstretched system often requires flexibility and creativity.

The integrated care model may be especially beneficial to children in marginalized communities because research has found that integrated care can improve access to youth mental health treatment [26]. In addition to access, by integrating mental health care into a trusted primary care setting, there may be less stigma for underserved and vulnerable families, increasing adherence to appointments, and, presumably, resulting in better outcomes. Because of these potential benefits, these children may be overly represented in referrals to the integrated psychiatrist when this model is viewed as the sole source of care provision. As PCCs are able to increasingly identify youth and families with unmet mental health needs, it is important to keep in mind the limitations of the integrated care model. While consolidating treatment in one place may appear attractive at first glance, children with more complex social identities and backgrounds may better benefit from close community partnerships outside the clinical space, such as school systems, child welfare agencies, and/or the juvenile justice system, where they spend more time [27]. When the clinic can establish working relationships with other community entities, it can greatly benefit the families they serve.

Coordinating with the clinic's mental health champion to examine how these youth might be best cared for in the clinic and how to effectively link to external services, when necessary, may also help address this disparity. Recognizing the vulnerability of underserved children and high rates of trauma in these populations is key; it is of utmost importance to work with one's practice to take a trauma-informed and culturally sensitive approach to providing care. Psychiatrists may also find themselves advocating with stakeholders more frequently to obtain continued support of these services for this group of patients, especially when barriers related to insurance or missed appointments arise. Regardless of the makeup of the clinic, knowing the population(s) served and staying true to a patient-centered approach will help develop an effective integrated care model.

Conflicts and Troubleshooting

Culture change at any institution can be challenging. Developing an initial program design often highlights different priorities among stakeholders. As a result, the initial design may need to differ from the ideal model, but choosing a starting point that meets PCCs and stakeholders where they are is critical. It is prudent to reinforce what the practice is already doing well and build off this foundation, including validating and praising PCCs for efforts to address their patients' mental health concerns. The following case example illustrates how to address communicating with a PCC whose goals are different from that of the child and adolescent psychiatrist (CAP):

PCC: I have a 6-year-old with potential attention-deficit/hyperactivity disorder that I would like to refer to you for diagnosis and treatment.
CAP: Great catch [praise]. What tipped you off for this kid [better understand the referral]?
PCC: The child is not listening to mom, school has been calling mom for hyperactive and disruptive behaviors for several months now.
CAP: What I would do for these kids would be to first have the parent and teacher fill out a screening tool [teaching moment]. Would you send these forms over to get this evaluation started?
PCC: Can't you do it? I'm not familiar with those forms.
CAP: I'm happy to go over the form with you when you have a minute [offer to help]. I find that parents are often more receptive when their physician initiates the process [teaching moment].

In this case, the psychiatrist uses praise and multiple teaching moments to create a common goal with the PCC and shape behavior change. Over time the program will evolve, guided by shared goals; do not be surprised if it takes several program iterations. Conducting regularly scheduled (e.g., annual) needs assessments helps track progress and guide programmatic changes as the PCCs become more skilled and comfortable. Table 2 identifies some common challenges that might occur when developing a well-functioning integrated mental health program and offers some problem-solving strategies.

Table 2 Troubleshooting common challenges with integrated care models

Challenge	Strategies
Primary care clinicians (PCCs) want the psychiatrist to accept and manage all/most patients with mental health problems Example: "Why can't you see every patient that I refer?"	Acknowledge and validate that PCCs are stretched Have ongoing, open, non-judgmental discussion about goals and expectations for the model and practice reflective listening. Practical responses might begin with "Let me understand your situation better so I can help you better with that" and "I think what you're asking is…" Check on your expectations: take baby steps toward more independent practice for PCCs with you doing "more" initially Become familiar with local resources for varying levels of mental health care in the area Facilitate referrals if/when possible when patients require more support from subspecialists
PCC resistance Example: "I can't/don't have time to do this."	Collaborative techniques: • Validate the PCC's discomfort • Provide positive reinforcement • In notes and conversations with PCCs, provide clear, step-by-step recommendations and include anticipatory guidance about how to respond to potential problems • Consider framing this model as a part of a quality improvement project, especially if trainees are involved • Acknowledge the challenges that come with changing practices • Refocus the discussion on how integrated care is an opportunity to better serve patients in the practice with health care professionals they already know and trust Identify the PCCs who are more receptive, more willing to share patients, and align closely with them Radically accept the fact that not every PCC will want change
Patients are not making appointments or referrals Examples: "I don't know what happened; they said they can make it!" "Can *you* call the patients to reschedule when they don't show?"	Have an easily reachable front desk team; having close communication with families about their needs and wants during scheduling can help Consider the use of telehealth to engage more patients Use missed appointment time to teach PCCs (e.g., the patient will *eventually* show up to see them) Expedite time from initial referral to first available appointment Consider "walk-in" slots and warm handoffs
You are limited to being in a virtual setting or managing a satellite site Examples: "We don't have space in clinic."	Consider having a virtual team huddle before clinic to anticipate needs and estimate time of brief consultation Consider having telehealth consultation at time of primary care visit available to help facilitate warm-hand off and introduction to mental health services Consider holding case conferences or virtual office hour(s) Consider having regularly scheduled team meetings to stay informed of the workflow

Sometimes, challenges may be insurmountable for some clinics to overcome, either at the design or implementation stage. It is important to note that not all practices are ready to develop a pediatric psychiatry integrated care model. Clues that the practice might not be ready include, but are not limited to, an unwillingness from clinicians to learn and develop new skills, lack of support from the administrative staff, and constraints imposed by external stakeholders [28]. It is also important to note that not everyone changes at the same pace, and the process requires consistent pruning to set realistic expectations for all parties involved. A successful partnership requires openness to change, willingness to learn and develop new practices, and the desire and drive to encourage one another within a practice to make the necessary changes. Even PCCs who at first seem reluctant to see any patients with mental health issues may be more willing to expand their skill set after an "easy win," such as success starting a stimulant medication or an antidepressant for the first time.

Conclusion

It is critical for child and adolescent mental health care professionals and PCCs to partner in addressing the youth mental health crisis and service gap. Integrated care programs can be an effective way to make use of limited mental health resources and expand the workforce. Integrated care programs may also help address, but not solve, the disparity in mental health care received by underserved communities.

By following the process described in this article and focusing on the key steps, you can develop a successful integrated care program that fits the specific needs of your clinical setting. Putting in the work up front to do a needs assessment, to get buy-in from the key stakeholders, and to develop relationships with clinic partners will be a worthwhile and essential investment.

Challenges will arise, but laying the groundwork in this way will allow stakeholders to troubleshoot and problem solve as long as they have a strong foundation. Ultimately, centering these efforts around a shared passion for youth health can lead to successful and innovative collaborations.

Declarations

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