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COMMENTARY

Policy Recommendations to Promote Integrated Mental Health Care for Children and Youth

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PUBLIC HEALTH AND health care systems face many challenges as indicators of acuity and demand for child mental health services increase.[1–3] These systems have not been designed to detect problems early and intervene with potentially preventive interventions.[4,5] In addition, the child mental health workforce lacks sufficient capacity as it is presently configured.[6]

Integration of mental health services into primary care has been promoted as one answer to these challenges[7] and is endorsed by national and international organizations.[8,9] Nearly all children have primary care visits,[10] and the philosophy of pediatric primary care in the United States is oriented toward universal prevention, surveillance, and early intervention.[11] Primary care providers are seen as credible sources of psychosocial information and guidance,[12] and many families express a preference for getting psychosocial care in a primary care rather than a mental health setting.[13] Some of this preference comes from primary care being a more familiar and potentially less stigmatizing place to receive mental health care,[14] a factor that may be especially salient to patients who already experience racial or ethnic stigma.[15] Incorporating mental health as part of "routine" medical care also sends a message that emotional well-being is an essential part of one's overall wellness.[16]

Prior to the beginning of this century, very few pediatricians worked in close coordination with mental health professionals. Despite evidence that child/youth integrated care can be effective and practical,[17,18] still only about half of US pediatricians consider that they work in practices co-located with a behavioral health professional.[19] Integration continues to face significant barriers, including lack of consensus on how primary care and co-located mental health professionals should share roles, the need for substantial transformation in how practices operate if they are to provide mental health care,[20] financing schemes that do not incentivize treatment in primary care or collaboration with mental health providers,[21] and a lack of mental health practitioners trained to work in primary care settings (especially in linguistically and culturally diverse communities).[22,23]

To these structural barriers, however, additional dilemmas have emerged as the field of integrated care has evolved. First, there is the realization that conceptualizing integrated care as a binary partnership between mental health and primary care does not address the high level of co-occurrence of mental health, developmental, and psychosocial problems that limit the effectiveness of mental health treatments when they are applied in isolation.[24] As the United States and much of the world enter into an era of unprecedented social and economic challenge related to the novel coronavirus, which has disproportionately impacted populations already experiencing limited access to mental health services, the need to expand the scope of integration will only become greater.[25]

Second, there is the difficulty of translating the most widely known models of integrated care, developed in adult medicine, into pediatrics.[26] Compared to adult integrated care, child mental health integration must contend with presentations that vary significantly with age, which complicates screening and other forms of case-finding.[27] Child mental health treatment relies more on brief, practical psychosocial interventions compared to easier-to-deliver medication titration.[28,29] In addition, while nearly

everyone's mental health is related to that of the people they live with, children's mental health outcomes are particularly dependent on their parents' own mental health,[30] and thus treatment often must include plans to address parents' treatment needs and parent-child interactions.[31] The American Academy of Pediatrics has issued a policy statement outlining what it sees as pediatric providers' responsibilities to address parental mental health,[32] but there remains little precedent for directly addressing parent mental health in pediatric primary care, despite its profound effects on children.[33]

POLICY RECOMMENDATIONS

To date, integrated care has benefited from attempts at federal, state, and professional society levels to promote its implementation. With some exceptions, however, such as the Centers for Medicare and Medicaid Services' InCK initiative, and efforts by the American Board of Pediatrics and the American Academy of Pediatrics,[8,34,35] there has been a greater emphasis on doing so with care for adults.[36] Other policy analyses have addressed how health systems as a whole, including those with integrated care components, can promote child and family well-being in general.[37] The following recommendations focus more narrowly on integrating mental health into pediatric primary care. The recommendations are intended as a guide to policymakers, health system leaders and educators, and research funders; they address 4 goals that, based on the analysis above, we believe are central to the growth and effectiveness of pediatric integrated care.

1. Transform pediatric practice to address family psychosocial needs

First and foremost, policies must promote changes in the scope of pediatric primary care so that it can comprehensively address families' psychosocial needs.[38] Multigenerational social and emotional wellness needs to be accepted as an integral part of pediatric care and these aspects of health need to be effectively assessed and treated by pediatricians and/or in collaboration with community-based services that address social determinants of health.[31,39] State and federal programs have the ability to influence these transformations through regulatory changes, financial incentives, and corresponding technical assistance. Individual providers and health care organizations need the clear guidance, motivation, and knowledge of how to go about modifying their practices and building the community alliances they will need to provide truly integrated care. Requiring health care systems to report mental health-related metrics will allow state and federal authorities to optimally leverage incentives. Specific initiatives could include:

a. Federal and/or state incentives for implementing "Advanced Medical Home" or "High Performing Medical Home"[40,41] models that are foundations for integrated care. States can support these models by giving practices additional payments if they meet criteria for certification (see financing recommendations below). Incentives could be tailored to reward the use of integrated care to address disparities in mental health services and outcomes, as well as to reward coordination of child/youth and adult mental health services.
b. The federal government could expand past policy statements regarding the detection and treatment of parental mental health problems as part of pediatric primary care.[42] Expansions could include that attention to parental mental health extends beyond concern for maternal depression in the perinatal period, as well as stating the appropriateness of including relevant parent mental health information in the child's medical record. These statements, coupled with increased training for pediatricians in the detection and initial assessment of parental health issues, could help to clearly include attention to parental mental health as within the scope of pediatric practice.
c. The federal government (through Medicaid, Substance Abuse and Mental Health Services Administration, the Indian Health Service, and Health Resources and Services Administration) or individual states could fund programs that provide practices or health systems with the technical assistance needed to adopt pediatric integrated care, such as New York State's Collaborative Care Medicaid Program.[43,44] Additionally, the federal government could fund a national clearinghouse on pediatric integrated care efforts such inckmarks.org (which helps disseminate information related to the Center for Medicare and Medicaid Innovation InCK demonstration program),[34] or expansion of the current Substance Abuse and Mental Health Services Administration-sponsored integrated care site[45] to showcase exemplar efforts of individual practices/systems that have implemented integrated care (ideally representing all states since they have relatively unique population and policy environments, as well as models that work in communities with varying levels of mental health resources).
d. Health Resources and Services Administration could expand and institutionalize its support so that all states could have so-called "child psychiatry access programs" that promote interprofessional collaboration and education supporting mental health service delivery in the pediatric primary care.[46,47] These programs provide informal mental health consultation to primary care providers around specific patient's problems, and many currently have primary care provider training and practice transformation components which could be expanded to include helping integrated behavioral health providers (including those in schools) adopt and use evidence-based brief interventions or telepsychiatry when necessary. Coordinated with these "access programs," states, health care organizations,

and philanthropy could fund additional mental health skills training for primary care providers, taking advantage of the "access programs" ability to provide long-term, ongoing consultation and support for practice transformation.[48]

e. The federal government, as with earlier programs that supported adoption of electronic medical records, could have similar programs promoting collection of patient-reported outcome measures and the ability to communicate in a "closed referral loop" with key community social program partners.[49,50] These efforts would include 1) additional federal funding for public-domain systems such as PROMIS that could facilitate collection of family-level outcomes,[51,52] and 2) funding local development of programs that facilitate communication between primary care teams and external service providers such as schools, food and housing programs, and programs that economic security.[53]
f. The federal and state governments could create programs that increase their ability to hold payers accountable for the delivery of child/youth mental health care. For example, states could require that insurers and managed care organizations collect and publish statistics on out-of-network child behavioral health referrals, stratified by age, gender, ethnicity, and professional type (ie, psychiatric providers, therapists, neuropsychological testing). These statistics can be a proxy for the (in)adequacy of a network's mental health resources and the extent to which they are accessible by different populations. If states are authorizing the use of "collaborative care codes" (see below in financing), compiling statistics on the use of these codes could serve as a marker for the implementation of integrated care and potentially increased access and early intervention. Requiring additional codes that indicate the results of mental health screening in primary care can help document whether primary care is serving as an effective gateway for child/youth mental health services.[54]

2. Make pediatric integrated care financially feasible

Second, policies must make pediatric integrated care financially feasible for individual practices and health systems, especially at a time when limitations on overall social and health care resources may reduce the cross-subsidization of mental health care by services that have a positive "margin."[55] Pediatric integrated care does not produce the short-term cost-offsets potentially obtainable from adult integrated care, and psychological interventions for families with children are more time-consuming to deliver than prescribing medications for adults. Business models must take into account the investment in time it takes providers to build relationships with families (especially those who have experienced trauma or discrimination), directly support parents, collaborate with schools and other community organizations, and track a practice's population of children and youth with psychosocial needs. Financial feasibility varies from state to state and among practices with different payer mixes. Steps that could create more uniform opportunities across the country include:

a. The federal government, professional organizations, academics, and advocates can help disseminate to state health financing authorities examples of which components of integrated care can currently be paid for using Medicaid and Children's Health Insurance Program funds directly or as part of negotiating managed care contracts.[56,57] For example, states could preferentially award managed care contracts to organizations that have strong integrated care programs, provide or pay for preventive parenting services, have demonstrated, at-scale working linkages to services addressing the social determinants of health, coordinate parental and child mental health care, or reimburse for telepsychiatry as a method for implementing integrated care.
b. States can take several actions to reduce barriers to fee-for-service payment for integrated mental health services including:[21,55–57]

- Making it easier to empanel mental health providers who work in primary care settings,
- Making it easier to license primary care sites as also providing mental health services,
- Allowing primary care providers to refer to co-located or collaborating mental health providers without the need for authorization,
- Allowing first-line mental health treatment by co-located or collaborating mental health providers of all disciplines as part of medical benefits (without additional co-pays),
- Not requiring a formal mental health diagnosis for an initial series of mental health visits, and
- Allowing billing for mental health care on the same day as a primary care service.

c. States can expand the use of billing codes that support collaborative work so that both primary care and psychiatric providers can be paid for indirect consultation, case review, and coordination of referrals for both children and parents.[58] As part of paying for collaborative care, states can also allow billing for the services of community health workers or navigators who can link families to needed follow-up services and reinforce/deliver mental health treatments (see below in workforce).
d. The federal government and private insurers could allow wider latitude for billing for parent-directed services that also have potential for impact on the child.[42]

3. Develop a larger and more diverse integrated care workforce

Third, policies need to encourage development of the workforce so that integrated care can be delivered at scale.[6] Not only is there a general lack of child mental health workforce in most areas of the country, there is an even greater lack of providers trained to work at the interface of medicine, mental health, and community supports.[6,23,59] In our increasingly diverse society, this workforce has to speak multiple languages and be capable of delivering care to families from multiple cultures.

a. The federal government, states, and philanthropy could subsidize mental health training for peer/community health workers/navigators who would ideally be recruited from diverse communities and whose services could be paid through Medicaid prevention or case management mechanisms.[56,60] Subsidies to payers or health care providers could be tied to increasing the linguistic and cultural diversity of the workforce and providing long-term career pathways for those who start out in these important but entry-level positions.[61,62]
b. States could finance additional residency/fellowship slots in pediatrics, family practice, and child psychiatry that focus on integrated care.
c. States could require exposure to integrated care skills and meaningful training in mental health for any existing slots that the state currently funds, especially those aimed at producing physicians who will go into primary care.[23] States would have more leverage if medical education accreditation and licensing bodies required robust mental health curricular components in training programs for all primary care disciplines including physicians, physicians assistants, and nurse practitioners.[35]
d. States could additionally finance slots or tracks in nursing (including advanced practice), social work, and psychology, programs that target work in co-located or community settings.[63,64]

4. A robust research program developing the tools needed for pediatric integrated care

Finally, research dollars are needed to develop the case-finding methods and interventions that will bring pediatric integrated care to its full potential. This includes further development of screening processes that promote actionable discussions with families about their psychosocial strengths and weaknesses, trans-diagnostic and trans-system (medical and social) approaches to treatment,[29,65] more potent and deployable psychotherapeutic interventions suitable for primary care (including those that specifically address parent-child interaction),[33,66] and improved methods for helping practices adopt and sustain these tools. In the realm of global mental health, the US National Institute of Mental Health, Grand Challenges Canada, the Wellcome Trust, and the UK Department for International Development have invested heavily in research on integrated mental health care for adults and children.[7,67] A concerted cross-funder effort could support a similar domestic agenda which could include:

a. Development and testing of brief, broadband (trans-diagnostic) therapies that can be readily learned by individuals with and without formal mental health training and that can be delivered to families in a variable number of short sessions.[29,68]
b. Adaptation of parent support and parent-child interaction interventions for primary care, both in early childhood and across the pediatric age range.[4,69]
c. Investigation of alternative models of well-child care (such as group visits) that recognize the priority within well-child care for supporting the mental health and psychosocial needs of families.[38,70]
d. Exploration of novel uses of eHealth for providing integrated care services, including expanded use of telemedicine, the use of follow-up text messages and other modalities to prolong the impact of brief in-person mental health interventions, and the integration of on-line treatments for parents and other caregivers into services based in pediatrics.[71,72]
e. Development of efficient training and ongoing support programs for community health workers, peer navigators, and others who can both extend the mental health workforce and increase its capacity for providing care in diverse languages and from diverse cultural perspectives.[73,74]
f. Studying processes related to practice transformation and interaction across systems,[75] with particular focus on 1) methods for including diverse families in the design and adaptation process of interventions,[76] and 2) efficient methods for providing initial and long-term assistance to practices and systems as they implement and refine integrated care.[77]

CONCLUSION

Integrated care is considered to be one of the most promising directions for addressing inadequacies in the delivery of child and youth mental health services. It offers the opportunity to build problem detection and early intervention into an existing system of child health monitoring and promotion, as well as to create a greatly expanded number of sites where child and youth mental health care can be delivered. However, growth of pediatric integrated care continues to face barriers built into the way that pediatric primary care is delivered and financed. Policies need to support transformations in the scope of pediatric primary care, as well as financing mechanisms that make these transformations sustainable. A larger and more diverse mental health workforce will be needed to support an expansion of pediatric integrated care. Training programs for both primary care providers and a variety of current and potential mental health providers must provide clinicians with the skills they need to engage and

help families in the primary care setting. Finally, there remains much to be learned about interventions that could make pediatric integrated care more potent and easier to implement. Fortunately, there are strong foundations on which to address all of these needs; it should be possible to coordinate efforts in these directions and move pediatric integrated care forward at a time when it is particularly needed.

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