

The Maryland Mental Health Initiative Advocacy Workshop

Child Psychiatrists and Pediatricians Working Together

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On June 7, 2008, over ninety mental health professionals and advocates met in Baltimore for the Maryland Mental Health Initiative's Advocacy Workshop. This working conference was convened to provide a forum for discussing how the state's pediatricians and child psychiatrists can work together to create a new system of collaboration for child and adolescent mental health care. Participants included a diverse group of child psychiatrists and pediatricians as well as representatives of mental health advocacy organizations, parent advocates, nurse practitioners, social workers, and others. Together the group worked to describe the current state of collaboration between pediatrics and child psychiatry in Maryland, barriers to such collaboration, and individual- and systems-level strategies for overcoming those barriers.

The Need for Collaborative Care

Conference participants cited several reasons to promote greater collaboration between pediatricians and child psychiatrists. First, for children under the care of a mental health specialist, collaboration with primary care providers is needed to ensure care coordination and medication management. Second, because child psychiatry is plagued by problems of stigma and limited access, many children with mental health problems are not under the care of a specialist. For these children, pediatricians can provide basic mental health care, but they often need ongoing consultation, resources, and supports from child psychiatry to do so. The need for pediatric-based mental health care is particularly acute for populations experiencing the greatest barriers to accessing specialist care, including low-income families, very young children, and those who need urgent care. For these reasons, establishing collaborative relationships among pediatricians and child

psychiatrists is a critical goal for health care quality and access.

Barriers to Collaboration

Participants identified many barriers which currently limit collaboration between pediatricians and child psychiatrists. First, the workforce shortage of child psychiatrists is severe, making it difficult for pediatricians to secure consultations and referrals. This shortage is exacerbated by the lack of networking opportunities that could better connect pediatricians and child psychiatrists. Second, even when providers know who to call, they often have trouble reaching each other because of heavy workloads and conflicting schedules. Third, participants noted that pediatricians and child psychiatrists differ in terms of their skill sets, documentation practices, and professional cultures, and few collaborative training opportunities are available to help providers establish common ground in regard to care coordination and documentation.

Finally, reimbursement issues further stymie cooperation because it is difficult for pediatricians to receive compensation for time spent delivering mental health services or collaborating with mental health specialists. Despite these barriers, participants believed that much could be done to address current problems.

Strategies for Change

Participants outlined several general strategies for fostering collaboration among pediatricians and child psychiatrists. They believed that:

1. Most broadly, collaborative care will require increased availability of mental health resources and supports for pediatricians. More specifically, pediatricians need greater access to mental health consultations, training in mental health-related skills, and reimbursement for the provision of mental health services.
2. Collaborative teaching and networking opportunities are needed, and the

development of “collaborative rounds” generated particular interest.

3. Channels of communication must be established, and these may include regional contact lists, greater reliance on email, and the use of one-sheet written forms to communicate information regarding diagnosis and treatment among providers.
4. Families and mental health advocacy organizations should be engaged as partners in cross-disciplinary information sharing and care coordination.
5. The feasibility of establishing systems-level models of collaboration should be investigated with options of interest including a state-funded consultation service for primary care providers, an internet-based decisional support system, and/or training for primary care providers in the delivery of mental health services. Of particular importance are issues of cost and the need to clarify the role of care coordinator.

Conference participants closed by expressing an interest in forming a small working group devoted to moving these issues forward at the state level, and a total of 45 people volunteered to be members of such a group.





I. Opening Remarks: Maxine Cunningham and Larry Wissow

Maxine Cunningham, Community Partner Liaison for the National Alliance on Mental Illness (NAMI) Metropolitan Baltimore, welcomed participants to the Maryland Mental Health Initiative's (MMHI) Advocacy Workshop. Cunningham emphasized the importance of provider collaboration from the standpoint of families affected by childhood mental illness. She also contextualized the goals of the conference as part of a larger three-pronged effort, undertaken by NAMI and others, for education, support, and advocacy. "While the focus of this conference is collaboration of pediatricians and child and adolescent psychiatrists, the ultimate goal we pursue is access availability and high quality mental health care for our children."

Larry Wissow, MD, MPH, a pediatrician, child psychiatrist, and professor at the Johns Hopkins

Bloomberg School of Public Health, underscored Cunningham's message with current data related to mental health care access for children. Although between 10 to 20 percent of children are affected by some sort of mental health problem, less than half of this population receive care, and timely referrals are rare. In short, the health care system is plagued by "terrible problems with access, not enough services to go around, and the need for services that don't just address treatment, but that actually look at prevention and surveillance." Acknowledging the need to tailor interventions to local needs, Wissow encouraged the audience "to be creative, share your ideas and experiences, try to find solutions to the problems we all know are there, and perhaps most importantly, help us ask the questions that we haven't yet thought to answer."



II. Albert Zachik: *Maryland Mental Health Resources*

Al Zachik, MD MHA, a child psychiatrist and director of the Office of Child and Adolescent Services at the Maryland State Department of Health and Mental Hygiene (MD-DHMH), gave an overview of mental health initiatives currently under development at the state level. Areas of particular importance included:

- *Policy-making.* The 1915 (c) Medicaid Waiver will expand access to wraparound home and community-based services for youth who meet the medical necessity criteria for Residential Treatment Center level of care.
- *Early childhood and school-based mental health services.* Early childhood mental health consultation services will be made available to child centers and day care providers with the goal of successfully maintaining children with behavioral needs. For older children, Medicaid programs will allow for mental health

consultations for students and their teachers.

- *Foster care.* A new program will broaden crisis response to children in foster care placements.

More information about these and other programs can be found at the websites for MD-DHMH (www.maps-md.com) and for the Center for the Social and Emotional Foundations of Early Learning (vanderbilt.edu/csefel).

Zachik concluded by offering to take the group's ideas to interested parties throughout the state, including department secretaries in the children's cabinet and the Maryland Department of Education. "The collaboration between pediatrics and child psychiatry is something we've got to do more of. I'd love for us to come up with a few concrete suggestions that we can work on with you from the state level to make them happen."



III. Barry Sarvet: *Massachusetts Child Psychiatry Access Project*

Model overview. Barry Sarvet, a psychiatrist and chief of Child and Adolescent Psychiatry at Baystate Medical Center, presented an overview of the Massachusetts Child Psychiatry Access Project (MCPAP), a collaborative model he helped develop and currently co-directs. MCPAP is a state-wide psychiatric consultation service that aims to increase mental health access by supporting pediatricians in diagnosing and managing mental health problems, facilitating referrals, and communicating with families and other care providers. MCPAP is made up of six regional teams which are hosted by children's healthcare institutions across the state. Each team includes a care coordinator (1 FTE), a child psychiatrist (1 FTE), and a child therapist (1.5 FTE). Pediatricians who need consultation call the team in their region via a hotline, and the care coordinator triages their concern with the goal of providing support while the patient is still in the office.

Once calls are received, MCPAP teams may provide a number of services:

1. In many cases, the pediatrician consults with MCPAP providers directly over the phone to discuss diagnosis, treatment planning, medication management, therapeutic questions, or other topics. Whenever possible, the team works to support, rather than replace, pediatricians as the care provider. "We want to keep care in the community and the natural context."
2. When referrals are needed, the care coordinator contacts the family to help them find services appropriate to their location and insurance status. Sarvet noted that quality care coordination is one of the most important aspects of the model.
3. In acute situations, the teams' child therapists and psychiatrists can provide psychiatric consultations and brief, interim psychotherapy. Teams do not prescribe

medication, and a consultation letter is dictated immediately.

specialists at distinguishing pathology from normal development.

Administration and evaluation. MCPAP is a public program funded as a line item through the Massachusetts Department of Mental Health and administered by the state's Medicaid managed care entity. Costing \$3 million annually, MCPAP services are available to all children and families regardless of insurance status. Each team serves a catchment area of about 250,000 children, and teams typically take 8 to 20 calls per day. Initial program evaluation is positive according to a pre/post-provider questionnaire, which indicates that 90% of providers rate MCPAP as useful and 84% feel better able to meet the needs of children with psychiatric problems.

Arguments for collaborative practice. In discussing the development of MCPAP, Sarvet acknowledged that the model is viewed as "controversial" by some. He outlined several arguments critical to developing a collaborative model:

- The workforce shortage of child mental health specialists is severe. With only 1.6 child and adolescent psychiatrists for every 1,000 children with a severe DSM IV diagnosis, "we have a major access problem, and we can't do business as usual."
- Market forces are not resulting in rational, equitable distribution of services. "If we rely on pure market factors, that means that most offices are filled with kids who aren't that sick and can be seen within 15 minutes. They're often the least complicated."
- To meet current demand, a compromise is needed between psychotherapy models, which are time- and resource-intensive, and managed care models which are time-constrained and overly reliant on pharmacological intervention.
- Pediatricians are natural partners in mental health care because they see so many children, their services are less stigmatized, they are prevention-oriented, and they are often more skilled than

Overcoming barriers to collaborative

practice. In addition to the reasons for a model like MCPAP, Sarvet emphasized the need to acknowledge barriers to collaborative practice:

- Elitism. Child psychiatrists may feel that pediatricians lack the skill and training needed to provide mental health services.
- Training and reimbursement. Pediatricians may resent being asked to provide mental health care when they are under-trained and under-reimbursed for those services.
- Lack of communication and mistrust. "We work in silos and there is a legacy of poor communication between pediatricians and child psychiatrists.... There's a lot of anger and resentment on the part of pediatricians who feel that they've been abandoned by child psychiatry.... So child psychiatrists have to have a thick skin to do this kind of work."

According to Sarvet, addressing these barriers requires a commitment to flexible scheduling, concise written and verbal communication, practical advice, and collegial interactions. He also noted that recent collaboration between ACAP and AAP is promising and indicative of a burgeoning interest in this area.

Program development. MCPAP began with the efforts of an interdisciplinary taskforce, which spent five years building a state-wide coalition before the model was implemented. Sarvet emphasized the need to be inclusive in the planning process: "The coalition is the rate limiting step. Making it broad enough and having enough public awareness [is one of the biggest challenges]. [Among our supporters] pediatricians were very vocal, the Boston Globe was friendly, parent advocate organizations were very important." He added that even representatives from the insurance industry were included. Although the initial process of coalition building was lengthy, funding and implementation followed relatively rapidly. Sarvet and his colleagues are now working to make the model available to schools.



IV. Ray Sturner and Barbara Howard: *Child Health and Development Interactive System*

Overview. Pediatricians Ray Sturner and Barbara Howard, of The Johns Hopkins University School of Medicine and the Center for Promotion of Child Development through Primary Care, presented the Child Health and Development Interactive System (CHADIS). CHADIS is an internet-based decision support system that provides assessment tools and resources for families and health professionals. The program is meant to improve provider-family and provider-provider communication, streamline and organize the medical encounter, and offer resources to support providers and families.

Family component. More specifically, parents and children use CHADIS to complete pre-visit, online questionnaires suited to the age and needs of the child. Surveys include tools for assessing young children (e.g., Ages & Stages Questionnaire®, MCHAT for autism, infant mental health measures), school-age children (e.g., Pediatric Symptom Checklist), and teens (e.g., Patient Health Questionnaire for Adolescents (PHQ-A)). In addition to child screens, CHADIS assists families in documenting family history, assessing the home environment, and evaluating caregivers' own concerns in areas such as partner violence and depression. Because surveys are completed prior to medical appointments, assessments can be self-paced.

Provider component. Once families complete CHADIS-based questionnaires, providers can then review the results with the help of an electronic textbook. CHADIS assists the clinician in interpreting results and in finding relevant

handouts, resources, and printouts for families. Additionally, CHADIS facilitates documentation by making findings part of electronic or printed medical records.

Cross-disciplinary component. In addition to supporting family-provider interactions, CHADIS is designed to promote cross-disciplinary communication as well. For example, a school-input mechanism allows children's teachers to submit validated assessments online, which can be particularly valuable in the treatment of problems that are commonly manifested in school settings such as Attention Deficit Hyperactivity Disorder (ADHD). All data can be shared securely online with parent consent. In this way, CHADIS can be used as a HIPAA-compliant platform for cross-disciplinary collaboration.

In summary, the CHADIS model aims to facilitate the care process by:

- Providing preliminary data to facilitate intake.
- Providing access to school data and feedback.
- Connecting patients and providers with other mental health tools and resources.
- Supporting communication among primary care, mental health, and school-based professionals.
- Assisting with reimbursement documentation.

More information on CHADIS can be found at www.chadis.com. Additionally, providers can participate in CHADIS-based "collaborative rounds" via twice monthly interactive web casts.



V. Larry Wissow: *Primary Care Communication Skills*

Overview. Larry Wissow, a pediatrician, child psychiatrist, and professor at the Johns Hopkins Bloomberg School of Public Health, discussed his research regarding a “common factors” approach to mental health in pediatric primary care. Recognizing parallels between the heretofore distinct research areas of patient-provider communication and psychotherapy, a common factors approach seeks to identify aspects of patient-provider interactions that have therapeutic value across clusters of similar mental health problems. In contrast to the traditional evidence-based progression of disease-specific diagnosis followed by diagnosis-specific treatment, a common factors approach takes a different tack. Patients first describe their problem in their own terms, and providers then consider whether the patient’s complaints align with one of a small number of disease clusters (e.g., low mood, anxiety, conduct problems or attention). If a patient’s problem does fall within one of these clusters, the provider uses a “basket of skills” which are broadly applicable to that cluster. For example, many treatments for anxiety/avoidance

involve elements of exposure and modeling. Instead of devoting the majority of the visit to narrowing in on a more specific definition, a common factors approach suggests that the provider should pursue a general intervention employing exposure and modeling, along with other strategies known to generically promote behavior change (e.g., being optimistic about the process, setting achievable and concrete goals, engaging the patient, etc.).

Advantages of a common factors approach. A common factors approach to treatment stands to address some of the major challenges associated with traditional, diagnosis-specific mental health care. Specifically, Wissow noted that:

- Current models for integrating mental health into primary care tend to focus narrowly on identifying and treating children with specific disorders, even though the majority of children with mental health problems seen in primary care have significant dysfunction in the absence of a single diagnosable disorder.
- Even when diagnostic criteria are met, the

process of diagnosis is often lengthy and poorly-suited to 20-minute timeframe of many pediatric visits.

- Families (and, in turn, providers) are often frustrated by the delay between receiving a mental health referral from a pediatrician and actually accessing specialist services. “Moments of opportunity can be lost if we can’t do things quickly.”
- Stigma associated with mental health care may prevent families from seeking or accepting referrals, even in cases in which specialist services are available.

For all of these reasons, a new model of mental health care is needed for pediatric primary care providers. In suggesting generic “toolkits” for intervention, a common factors model of communication allows pediatricians to provide an immediate response to families experiencing mental health problems, even in the absence of a specific diagnosis. This broad-based approach has the advantage of feeling familiar to pediatricians and being well-matched to the generalist nature of pediatric primary care.

Training in common factors. Wissow and his colleagues have developed a three-hour multi-

media training for teaching common factors skills to pediatricians, and research has shown this training to be associated with significant improvement in patient symptoms and function. The training consists of guided discussion of a number of video-based case presentations. Skill building areas include:

- Time management (e.g., managing rambling and interruptions).
- Agenda setting (e.g., eliciting information from parents and youth, enforcing conversational turn taking).
- Managing anger and demoralization.
- Problem solving.

Wissow noted that such training is not meant to replace specialist services. Rather, common factor training aims to equip primary care providers with “communication skills that are psychotherapeutic as well as a relatively limited tool kit of practice elements. This training is not the ‘be all and end all,’ but can be an effective way to help kids who don’t meet criteria, who won’t use referrals, or who need to be stabilized while waiting for referrals.”





VI. Small Group Discussions

Integral to the workshop were opportunities for participants to discuss their own perspectives on pediatric-child psychiatric collaboration. Discussions were structured using break out session devoted to discussing seven different case studies. These cases, which are available upon request, imagined the arrival of seven different patients in a pediatrician's office: 1) an adolescent patient whose mother is concerned about her irritable behavior; 2) a sixteen-year-old patient who has made a suicidal gesture; 3) an eight-year-old with ADHD who is exhibiting aggression; 4) a twelve-year-old patient with ADHD whose mother wants the child's pediatrician to assume the management of his complex medication regimen; 5) an aggressive ten-year-old who may have ADHD; 6) a three-year-old who has been dismissed from pre-school due to aggressive behavior; and 7) a nine-year-old with autism and escalating behavioral problems. Each workgroup, which included both pediatricians and child psychiatrists, addressed one case by discussing the challenges and possible solutions related to caring for the patient in question. Afterwards, group facilitators shared

important points from their discussions, and common themes are summarized below.

A. The Need for Care Coordination

Problem: Participants in four groups discussed the fragmentation of care that occurs in the absence of a clearly defined care coordination role. "Who's responsible for care? Who's coordinating? Who's in charge of medication?" This issue was deemed particularly pertinent in the urgent care scenario given the importance of finding patients alternative sources of care should they fail to be admitted to the emergency room.

Solutions: Participants were clearly intrigued by models, such as MCPAP and CHADIS, which aim to facilitate care coordination. However, participants differed in their assumptions about *who* should serve in this role. One group was attracted to the MCPAP model, which employs professional care coordinators, but at the same time, the high cost of such a model raised concern. Other groups assumed that pediatricians and/or patients' parents should be trained to better assume the coordinator role,

and CHADIS was mentioned as a way to support such a model.

B. Improving Communication between Pediatricians and Child Psychiatrists

Problem: Five different groups discussed difficulties that pediatricians and child psychiatrists have in communicating with each other. First, providers, especially pediatricians, may not know who to contact. Second, both groups have difficulty reaching each other on the phone. Third, participants, especially but not exclusively pediatricians, noted that upon issuing a referral they do not receive the same notification of treatment from child psychiatrists that other specialists typically provide.

Psychiatrists responded that the sensitivity of mental health information and a tradition in the field of strict confidentiality was often to blame. They added that they, too, would benefit from the sharing of information such as patients' developmental histories.

Solutions: Participants offered several solutions aimed at improving communication. First, they recommended compiling regional directories that providers could use to get in touch with each other. Second, they recommended that providers use email more often and consider taking calls from other providers directly, even if they are in an appointment. Third, they recommended that child psychiatrists adopt the practice of sending pediatricians a one page summary of their evaluation and treatment plans, either directly or via parents. Finally, participants observed that networking and relationship-building between pediatrics and child psychiatry would facilitate this process.

C. Increasing Access to Mental Health Resources and Supports for Pediatricians

Problem: Six groups discussed the scarcity of mental health resources and the resultant impact on pediatricians. Discussants agreed that pediatricians needed support in managing complex mental health issues, particularly when medications are involved.

They noted an inadequate number of child psychiatrists in general, but added that urgent evaluations and services for young children were particularly scarce.

Solutions: Given the broad nature of this problem, participants provided few specific solutions in this area beyond increasing psychiatric services, especially those for urgent situations and young children. They noted, however, that this problem is intimately related to reimbursement and training (see below).

D. Reaching Out to Families and Mental Health Advocacy Organizations

Problem: Six groups discussed the need to reach out to parents and mental health advocacy organizations. In



the case of families, participants saw the need to help families navigate fragmented systems of care as well as to enlist families' help in communication and information sharing among different members of the health care team. At the same time, participants believed that providers were not fully taking advantage of the resources, assistance, and guidance they could receive from patient advocacy organizations such as NAMI and the Maryland Coalition for Children.

Solutions: Participants recommended that providers work to educate and empower families so that they are better able to navigate the healthcare system. Families should be encouraged to share copies of medical records across various healthcare providers. Participants also recommended partnering more closely with patient advocacy organizations. More specifically, such organizations should be invited to participate in ground rounds in pediatric community hospitals to help pediatricians become more aware of available resources.

E. Increasing Opportunities for Training and Networking

Problem: Four groups highlighted a need for workforce development in mental health issues. Participants felt that pediatricians often lacked the knowledge they needed to deal effectively with mental health issues and that both groups needed more knowledge of and experience with collaborative practice. Discussants noted that few opportunities currently exist for the training and networking needed.

Solutions: For pediatricians, participants recommended CMEs to address the management of more complex mental health scenarios, including medication monitoring. As previously mentioned, participants also voiced a need to raise awareness about available resources such as the state's 24-hour referral hotline. For both pediatricians and child psychiatrists, discussants endorsed the idea of collaborative rounds among providers who share patients. More generally, they also supported professional networking efforts that "develop relationships and put a face to a name because some people are unlikely to call someone off a list."

F. Addressing Issues of Reimbursement and Insurance

Problem: Four groups discussed the importance of financing collaboration both at the level of individual providers and more systematically. Participants noted that pediatricians often have trouble receiving reimbursement for the provision of mental health services, and neither pediatricians nor child psychiatrists are compensated for time spent collaborating. At the systems level, discussants noted that a lack of funding for mental health resources is problematic and could impede efforts to establish state-wide models of care.

Solutions: Discussants suggested working for universal systems of coding and reimbursement as well as more generally pressuring insurance providers and other payers to provide better coverage for mental health services.





VII. Participant Questionnaires

Conference participants responded to two written questionnaires during the course of the workshop. The first, administered before the opening remarks, asked them to identify barriers to collaborative care. The second, administered as the conference came to a close, asked them to express their interest in the collaborative models presented in the workshop and to propose “next steps” for advancing collaboration.

A. Pre-conference questionnaire: Barriers to collaboration

The pre-conference questionnaire consisted of an open-ended question requesting participants to name three of the top barriers to collaboration among pediatricians and child-psychiatrists. Overall, pediatricians, child psychiatrists, and other respondents indicated similar concerns, although tallies suggest different priorities by group. Pediatricians, for example, most often noted the lack of access to mental health services while child psychiatrists most often

reported time to be an important barrier.

Pediatrician Responses (n=28)

1. Lack of access to mental health services (n=17)
 - “Lack of psychiatrists in area”
 - “Access to mental health care”
2. Economic and insurance issues (n=14)
 - “Mental health services are poorly covered by insurance”
3. Lack of communication between pediatricians and child psychiatrists (n=12)
 - “Communication about cases/patients being seen by both”
 - “Hard to reach/get through to one another”
4. Lack of shared knowledge/training/ understanding related to mental health care and interdisciplinary collaboration (n=10)
 - “Lack of understanding of various fields”
 - “Pediatrician awareness and training”
5. Time (n=6)
6. Lack of networking opportunities (n=4)

- “Little opportunity to get to know psych folks”

Child Psychiatrist Responses (n=27)

1. Time (n=16)
 - “Folks too busy”
 - “Work of pediatricians requires different use of time”
2. Lack of shared knowledge/training/ understanding related to mental health care and interdisciplinary collaboration (n=12)
 - “Lack of training for collaboration”
 - “Developing common, shared approach”
 - “Lack of understanding of other discipline”
3. Economic and insurance issues (n=11)
 - “No payment for time spent collaborating”
 - “Insurance”
4. Lack of communication between pediatricians and child psychiatrists (n=11)
 - “Reaching pediatricians”
 - “Lack of established channels”
5. Lack of networking opportunities (n=7)
 - “Lack of opportunity for discourse”
 - “Not enough venues to share ideas”
6. Lack of access to mental health services (n=5)
 - “Few child psychiatrists”

*Other Responses (n=13)**

1. Lack of shared knowledge/training/ understanding related to mental health care and interdisciplinary collaboration (n=8)
 - “Knowledge of pediatricians regarding psych treatments/diagnoses”
 - “Pediatricians are not fully trained in all the ways mental illness can present”
2. Time (n=6)
 - “Pediatricians having time to hear all data from families and doing what is necessary with data to be helpful to parents”
3. Lack of communication between pediatricians and child psychiatrists (n=5)
 - “Anxiety about communicating with colleagues”
4. Economic and insurance issues (n=3)

***Other responses” include those of family members, advocates, social workers, nurses, and psychologists.*

B. Post-conference questionnaire: Strategies for moving forward

A total of 66 responses were collected for this questionnaire, and these included 26 pediatricians, 25 child psychiatrists, 12 “other” perspectives, and 2 non-respondents.

Part I: Solutions for Collaboration among Child Psychiatrists and Pediatricians

In the first part of the questionnaire, respondents were asked to provide three “feasible solutions” to the barrier to collaborative practice. Themes emerging from these open-ended responses included the following suggestions:

1. Facilitate communication between pediatricians and child psychiatrists generally or on a provider-to-provider basis (39 respondents, including 24 pediatricians and 15 child psychiatrists). Out of this total, specific recommendations included:
 - A. Develop contact/resource lists of child psychiatrists and pediatricians (n=12)
 - B. Increase access to psychiatric services (n=6)
 - C. Use one-sheet written forms to facilitate communication regarding treatment, background, etc. (n=5)
2. Adopt a more formalized model or system of collaboration (30 respondents, including 13 pediatricians and 8 child psychiatrists). Of this total, specific recommendations were:
 - A. MCPAP model (n=12)
 - B. CHADIS (n=4)
3. Increase opportunities for interdisciplinary training and conferences (33 respondents, including 12 pediatricians and 13 child psychiatrists). Suggestions included: more joint CMEs, collaborative rounds, peer supervision, and mental health communication and skills training.
4. Address financial/insurance/reimbursement issues (18 respondents, including 6 pediatricians and 7 child psychiatrists).

Part II: Participant Interest in Various Interventions

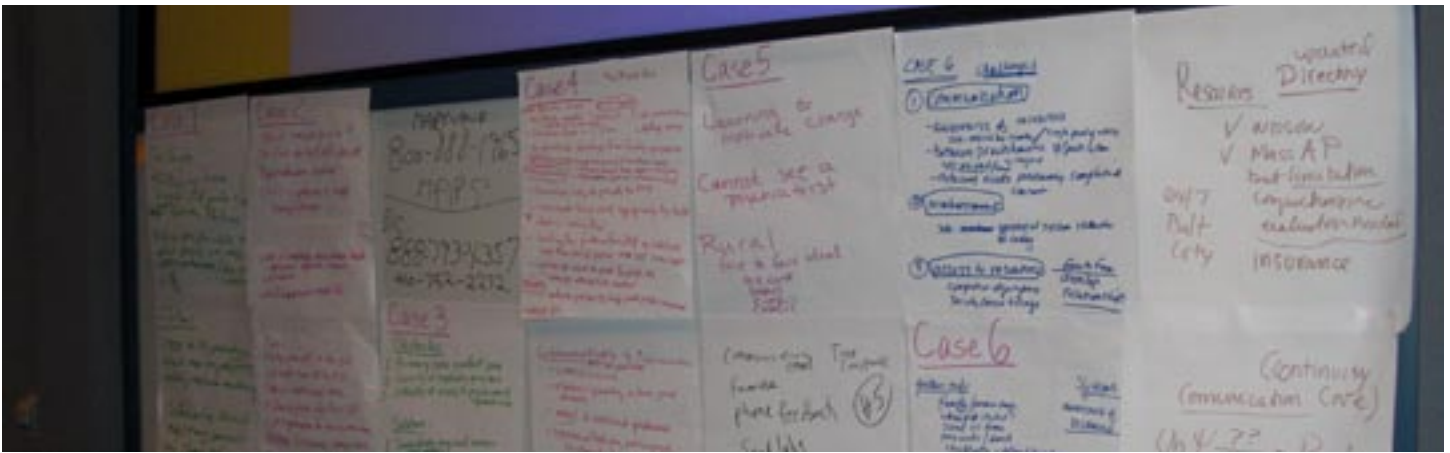
The second part of the questionnaire asked conference participants to indicate their interest in using the interventions or models of collaboration discussed during the workshop. The following tallies show respondent interest:

- A. Psychiatric consultation model for primary care providers (n=46, including 19 pediatricians, 16 child psychiatrists)
- B. Electronic decision support system (n=44, including 17 pediatricians, 15 child psychiatrists)
- C. Process training in mental health communication and treatment (n=40, including 19 pediatricians, 13 child psychiatrists)
- D. Case-based web casts (n=36, including 18 pediatricians, 14 child psychiatrists)
- E. Topic-based lectures (n= 27, including 15 pediatricians, 7 child psychiatrists).
Of those who indicated interest, topics suggested included: psychopharmacology (5 respondents), training in counseling skills (3), and anxiety and depression (2)

Part III: Participant Interest in Work Group Participation

A total of 45 respondents indicated an interest in being part of a workgroup (including 18 pediatricians and 19 child psychiatrists).

Topic areas of interest included: foster care (9 respondents), emergency/crisis response (2), mental health for young children/infants (2), mood disorders (2).



VIII. Future Directions

In his closing remarks, Al Zachik told the group, “We can’t lose what’s happened here today because it’s so valuable to the state [of Maryland]. The interest, the energy is here.” He added that he would be a willing partner in efforts to organize a small working group that could carry the work of conference participants forward. In concert with the Maryland Blueprint for Mental Health, such an effort could be an important contribution to ongoing efforts to develop a state-wide care management structure. As a jumping off point for such a working group, the recommendations of the participants of the MMHI Advocacy Workshop are summarized below.

Increase Mental Health Resources and Supports for Pediatricians

- Increase the availability of child psychiatric services and consultation, with special attention to the areas of urgent evaluation and early childhood care.
- Work to improve coverage and reimbursement for mental health services.

Create Teaching and Networking Opportunities

- Develop CMEs for pediatricians in issues related to mental health, including patient-provider communication and medication monitoring.
- Raise awareness about available mental health resources and organizations.
- Organize collaborative rounds for pediatricians and child psychiatrists who share patients.

Establish Channels of Communication

- Develop regional contact lists of child psychiatrists and pediatricians.
- Establish agreements among provider groups for taking/returning calls (e.g., access to direct numbers, etc.).
- Use email more often.
- Use one-sheet written forms to facilitate communication among providers regarding treatment, background, etc.

Reach Out to Families and Mental Health Advocacy Organizations

- Help families to navigate systems of care and encourage them to share copies of medical records across various healthcare providers.
- Create opportunities for patient advocacy organizations to participate in the training of pediatricians (e.g., during pediatric ground rounds).

Investigate the Feasibility of Systems-Level Models of Collaboration

- Clarify opinions about who should be responsible for the coordination of care (i.e., professional care coordinators, pediatricians, parents).
- Analyze models in terms of cost of implementation and available funds.
- Continue the broad-based coalition-building needed to support state-wide efforts.

For more information, please visit www.jhsph.edu/interpersonal_capacity/.