Behavioral Health Screening and Referral in the Pediatric Office

Julia Swartz, MSW; Howard S. King, MD, MPH; and Elizabeth A. Rider, MSW, MD

EDUCATIONAL OBJECTIVES

1. Review the AAP recommendations for mental health screening in the primary care setting.
2. Discuss the staged approach to discussing a mental health issue detected by pre-visit screening tools.
3. Identify the types of therapy currently available for children with mental health issues.

“The human and financial costs of emotional problems in children are both broad and deep; they affect children and their families, schools, communities, employers, and the nation as a whole.”

One in five children in the US has a diagnosable mental, emotional, or behavioral disorder that interferes with functioning and requires intervention. One in 10 children may suffer from a serious emotional disturbance. Half of adults with mental health disorders have symptoms by the age of 14 years. However, 80% of children do not receive the mental health services they need.

Studies show that children with depression and conduct disorders use more health care services and have higher health care costs when they become adults. Early identification and treatment of children with mental/behavioral health problems can reduce the burden of mental illness and its long-term consequences, and improved access to outpatient mental health services is cost-effective.
The significant shortage of pediatric mental health professionals and child/adolescent psychiatrists compounds the situation.

Pediatricians, family physicians, and other primary care clinicians increasingly serve as an essential first-line resource for psychosocial and mental health problems. The American Academy of Pediatrics (AAP) has proposed physician competencies needed to address the mental health problems of patients and to guide residency and continuing education of primary care physicians regarding mental health care.

Primary care physicians can help patients and families obtain counseling and other psychosocial and emotional support. Studies show that 65% of primary care pediatric visits are psychosocially motivated, and 85% of mothers of young children would welcome or not mind being asked about psychosocial and emotional stressors. Effective physician–parent communication is associated with treatment adherence, parental satisfaction with care, and enhanced discussion of psychosocial concerns.

The AAP’s Task Force on Mental Health recommends that primary care practices institute routine, periodic screening using validated instruments to identify children and adolescents with mental health symptoms or impaired functioning.

In Massachusetts, the Children’s Behavioral Health Initiative is a blueprint for children’s mental health system reform, designed to provide integrated behavioral and mental health services for children and their families. The initiative requires primary care physicians caring for MassHealth-insured pediatric patients to provide standardized behavioral health screening, using an approved screening tool, during well-child visits. If a problem is discovered, the primary care physician must provide necessary follow-up services, or refer and help the patient and family locate the recommended services. While physicians must offer screening, completion of the screening is voluntary for the family.

Although physicians manage many psychosocial and emotional issues in children, some may feel uncertain about handling complex emotional and mental health problems, or discussing therapy or other psychosocial referrals. Fewer than half of pediatricians are confident in their ability to make a referral for maternal depression. With more children being seen for behavioral, emotional, and psychosocial issues, and with the advent of required behavioral screening in some states and likely in others in the future, pediatric practitioners are being asked to provide initial assessments and appropriate referrals.

How can pediatricians — with busy, hectic practice environments, growing financial and time pressures, and inadequate reimbursements — help parents to obtain appropriate help for their children and themselves, and to make such referrals in a compassionate, non-stigmatizing, yet efficient manner?

AFTER THE BEHAVIORAL HEALTH ASSESSMENT

With required behavioral screening, some families may be relieved to hear acknowledgment of, and an offer to help with, problems of which they were already aware. Other families may be surprised or concerned. Adolescents may be challenging to engage. The pediatrician can use the behavioral screening tool to guide them through a particular area that the patient or parent has identified as a problem. By building rapport and understanding the patient’s and parent’s perspectives, we minimize the chance that they may feel judged or stigmatized by a label or diagnosis they may not be ready to hear.

How can we help patients and parents realize that they may benefit from consultation with a mental health professional? It has been said that, “Half of therapy is preparation for therapy.” Patients may be more open...
to a therapy referral if we can help them acknowledge that areas of their lives have come to a standstill.

Change happens in stages. In the initial stage, a psychosocial or emotional stressor becomes overwhelming or unmanageable, and the patient’s or parent’s coping style may no longer work, or may even exacerbate the issue, perhaps as a result of repeated attempts to avoid the problem. As patients discover that their attempts to handle a problem are ineffective, the patient, parent, or other family members and the physician may consider referral; patients are most likely to reach out, or may be more open to help at this time.

During this initial stage of change, a primary care consultation may require more time than the usual health maintenance or illness-associated encounter, and is scheduled accordingly or during “off hours” in the office. The physician can make a therapeutic intervention by listening empathically, and validating and supporting the patient’s and family’s experience. For some physicians, the intervention will remain brief; others may prefer to explore more about the psychological life of their patient. Either way, most patients are relieved to have the opportunity to share their concerns.

Physicians can learn therapy referral techniques as part of their therapeutic armamentarium. The referral’s success is often associated with the skill and compassion the physician brings to their relationship with the patient and the patient’s family. Perhaps most important is how we listen; patients will trust us in sharing their personal narrative if we provide them our full attention and sufficient time to share their story. A recent Pediatric Annals article examines communication skills for relationship-centered care and provides strategies for developing and enhancing doctor-patient interactions.

Some patients will accept a mental health referral; others will need more time and follow-up, in much the same way as clinicians follow up on other ongoing medical issues.

SUGGESTED APPROACHES

The following approaches, from three intervention comfort levels, provide suggestions for how physicians can engage patients and family members after disclosure of an emotional stressor or concerning behavioral screening result. An important caveat: There is no “correct” way to talk with patients about these issues, other than with sensitivity and understanding. What is important, and what patients will hear and remember, is a physician’s caring tone and motivation to help.

Minimal Intervention

In this approach, a physician might say to his/her patient: “I’m pleased you felt comfortable sharing your concerns today. I agree that this is important and needs addressing. Although it isn’t my area of expertise and training, there is someone I know and trust who I believe could be helpful to you.”

Another suggestion: “I appreciate your trusting me enough to bring this concern to my attention. I’d like to help you find someone I believe could be especially helpful for you.”

For patients with problems identified by behavioral screening: “Thank you for taking the time to complete the behavioral screening. As you may know, your insurer now requires us to

SIDEBAR 1.

Behavioral/Mental Health Services: Types of Therapy

Client-Centered Therapy (CCT): Developed by psychologist Carl Rogers, CCT emphasizes the therapist’s empathy with the client, ability to see the world as the client does, and the use of unconditional positive regard. Client-centered therapy’s humanistic approach aims to help clients increase self-acceptance and personal growth by providing a supportive emotional environment.

Cognitive-Behavioral Therapy (CBT): Grounded in the belief that changing thoughts and behaviors has a positive effect on our emotions. This method often uses reframing of assumptions or habits, changing behavior patterns, journaling, and relaxation techniques. CBT is effective for a wide range of problems; studies show it is beneficial in anxiety and panic disorders, and mild to moderate depression.

Family Systems Therapy (FST): The family is the patient. Communication patterns between family members are emphasized. Problems are viewed as the product of these interactions rather than attributed to one individual. This method has been used with families of individuals suffering from serious psychological disorders and families in transitional crises. Family therapy may also supplement other psychotherapies.

Play Therapy: Uses developmentally appropriate play-based treatments to understand, communicate with and treat children. The child’s natural means of expression — ie, play — is used therapeutically to help children handle emotional stress, trauma, family, and other problems. Non-directed play therapy and skills-based play therapy are two forms of this modality.

Psychodynamic Therapy: Core principle is that uncovering the unconscious is paramount to healing and growth. Patients work to bring their unconscious feelings and desires to the surface so they can understand them and become aware of how these affect their lives. This approach depends heavily upon the therapeutic relationship and uses a variety of interventions. Psychodynamic therapy is effective in treating depression and other issues.

Psychotherapy: Generally refers to treating emotional or mental problems by talking with a mental health professional. Interpersonal psychotherapy focuses on the patient’s relationships with others (eg, spouses, children, other family members, co-workers) with the goal of improving those relationships.

Source: Rider E.
administer it once a year. (or: As you may know, our practice has decided to administer it once a year.) I appreciate your willingness to share. This form tells us that your child may be having some difficulties with X. Is this an area of concern for you?” It is important to validate with the patient and family the findings on the behavioral screening, acknowledge their reactions, and understand their perspective.

If the parent minimizes the concerns, explore a specific item on the assessment, a chief complaint from the parent, or a behavioral observation. Some parents may need to hear their concerns reflected back to them to raise their awareness. After further discussion, the physician might offer: “Your child may benefit from some additional help and support around X. Would you like some help finding someone who specializes in this area, or do you have someone you are already comfortable with?” If the patient/parent refuses the offer, be mindful of having “planted a seed” that this is a concern, and to follow up at the next visit.

The goals and skills here include reflective listening; being “present;” demonstrating empathy; building upon the doctor-patient relationship; engaging the parent in identifying an area of concern; validating the patient’s and parent’s concerns; and offering resources.19

**Moderate Intervention**

“I can see that this issue is causing you real concern. I greatly appreciate your bringing it to my attention. I’d like to help you get connected to the right kind of resources. For me to help you do so, would you be comfortable telling me a little more about this?”

For those identified by behavioral screening: “Thank you for taking the time to complete the behavioral screening form. As you may know, your insurer now requires us to administer it once a year. (or: As you may know, our practice has decided to administer it once a year.) I appreciate your sharing. This tool tells us your child may be having some difficulties/problems with X. Is this something you have noticed or thought about before?”

In this approach, we work to understand the patient’s perspective and to encourage the patient to express what they are struggling with and what their goals may be.

Whenever possible, use the language and description the patient uses. For example, if the patient or parent says, “I’m so afraid ...” you might respond, “What about this scares you?” If the patient uses a term or description, ask for clarification of what this means for them. For example, if they say, “I just feel uneasy,” you might respond, “Can you tell me more? Can you describe what feeling uneasy means for you?” Further exploration might include: “When do you feel uneasy? How long have you felt this way?” Some patients prefer to answer open-ended questions; others seem more comfortable with a list of options.20

When ending the discussion, it is helpful to provide feedback and to summarize your understanding of the patient’s perspective and experience: “It sounds like you have been struggling to communicate with your child. What I hear from you is that attempts to resolve these issues seem to end up in loud arguments. Do I have it right?” Then, “That can be frustrating. You seem aware that these arguments are affecting your children. Do you think counseling might help?”

“Therapists can be very helpful in facilitating communication and conflict resolution between family members. I can give you the name of someone I know and trust who I believe would be helpful in this area. Is this something you would be interested in pursuing?” If the patient agrees, the physician can offer to help facilitate the connection with the therapist: “Would you like

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**SIDEBAR 2.**

**General Resources for Pediatric Practitioners**

- American Academy of Pediatrics. Children’s Mental Health in Primary Care: www.aap.org/mentalhealth
  (Accompanying background: www.aap.org/commnpeds/docs/mentalhealth/docs/psychosocialinterventionsbackground.pdf)
- Families for Depression Awareness: www.familyaware.org/
- Massachusetts General Hospital. School Psychiatry Program and Madhi Resource Center: www2.massgeneral.org/schoolpsychiatry/
- SAMHSA’s National Mental Health Information Center. United States Department of Health and Human Services: www.healthfinder.gov/organizations/HR2480.htm
- TeenScreen National Center for Mental Health Checkups at Columbia University: www.teenscreen.org/programs/primary-care/

me to call to set up an appointment, or would you prefer to do that yourself?”

This scenario includes the goals and skills of the minimal intervention approach, and adds respectful curiosity, further understanding of the patient’s perspective, reaching agreement on ways to address the issue, and closure.19

Extended Intervention

“You have brought up (we have talked about) some very important issues today. I’m pleased you are comfortable sharing these concerns with me. I would like to give you the time and attention these issues deserve. Unfortunately, the office schedule today doesn’t permit me sufficient time to do justice to your concerns. Would you be willing to come back another time so we could discuss this further? I could arrange my schedule to give us more time.”

In this approach, we are setting the stage for a diagnostic interview. The expectations are clear regarding how the time will be spent. If the patient or parent declines, the physician can still provide a mental health referral if needed. What is most important is that caring and availability have been offered.

Ideally, when the physician sees the patient again, the physician can ask how things are going with the previously shared issues. Checking in demonstrates to patients that when they are ready, you are available. By providing the patient time to consider further discussion, you encourage them to take a more active stance on their own behalf.

Family history and the background of the current psychosocial and emotional stressors can be explored during the diagnostic interview. The same skills and goals are paramount: being “present” with the patient; building a relationship; reflecting and seeking to understand the patient’s perspective and feelings; and showing respect and empathy for their concerns.19,21 The physician can follow up on previously identified concerns and work collaboratively with the patient and family to understand the problems and agree on how to proceed: “The last time we met, we spoke about the issue of (or your concerns about) X. I’m pleased that today we have time to discuss this issue and some possible resources.”

Depending on the physician’s relationship with the patient and what the patient needs, the physician may ask: “Can you tell me when you first became concerned about this issue? How has this been affecting you and your family? What have you tried to resolve this issue? How has that worked? Do you recognize this in any other area of your life or with family members? What are your greatest concerns or fears about this? Do you have some ideas about what might be helpful?” It is important to listen in a way that the patient and family members feel heard and understood.22

Close the discussion in a similar fashion to the moderate intervention approach, respectfully reflecting back to the patient what they have shared, validating their concerns, and offering a psychotherapeutic referral if needed.

The Children’s Emotional Health Link’s pediatrician-parent communica-
tion training program, Emotional and Psychosocial Issues in Children and Families: Pediatrics for the New Millennium, has trained approximately 45 pediatricians and nine nurse practitioners to invite parents back to explore further a concern they have raised. No parent has refused to come back for another appointment to discuss at length a mental health concern for a child. In some instances, the additional extended appointment has been the best intervention for the family. If the physician provides a safe environment and demonstrates active and effective listening, sometimes there is no need for further intervention.

MANAGEMENT OF DIFFICULT ISSUES

With their crowded curriculums, residency training programs often find it challenging to provide residents opportunities to develop their interpersonal and communication skills, to self-reflect, and to understand and practice relationship-centered care. For practicing physicians, opportunities exist to learn and enhance these skills in continuing professional development programs. Acquiring these skills can significantly enhance the physician’s ability to manage effectively the complex mental, behavioral, and psychosocial issues increasingly seen in practice.

BUILDING A NETWORK OF RESOURCES

Various resource networks provide mental health referrals (eg, the National Association of Social Workers [NASW] Referral Service), although the process often works best when primary care physicians and mental health clinicians develop ongoing relationships of their own. Building these relationships, which integrate medicine and mental health, allows both clinicians to provide a consistency of care and collaboration that serves the best interests of the patient.

Physicians can locate mental health clinicians by asking colleagues and patients, when appropriate, with whom they have had good results and a positive experience. A good mental health practitioner will be open to and interested in working with the primary care physician.

Some families have employee assistance programs (EAPs) available to them as part of their employee benefits. The EAP model typically provides short-term intervention, usually three to five visits, with the opportunity to be referred elsewhere for long-term treatment if needed.

With little time, one can develop ongoing relationships with mental health clinicians in a variety of settings. Although phone contact can be difficult to coordinate, it is possible. Physicians can discuss through email general concerns and collaboration goals, or they can invite a local mental health clinician to visit a practice site and discuss common goals. Mental health clinicians in some areas co-locate or join primary care practices. Some of these on-site professionals have access to patients’ medical records and can coordinate the care of their patients with primary care physicians.

Familiarity with various forms of mental health practice and treatment can help develop professional relationships and match your patients’ needs. The AAP report on evidence-based child and adolescent psychosocial interventions, updated twice yearly, provides research-based recommendations for treatment interventions based on randomized trials for children and adolescents with mental health needs. Sidebar 1 (see page 612) lists commonly practiced forms of mental health treatment.

Barriers to adequate reimbursement continue to exist for the range of mental health-related services provided by primary care physicians and mental health professionals. The AAP and the American Academy of Child and Adolescent Psychiatry developed a joint position paper that addresses administrative and financial issues faced when providing behavioral and mental health services to children and adolescents, and provides recommendations to insurance purchasers, payers, and managed behavioral health organizations. Physicians should be reimbursed for their time spent exploring psychosocial and emotional issues. Sidebars 2, 3, and 4 (see pages 613-614) provide general and behavioral screening resources and specific diagnostic coding and billing information.

CONCLUSION

Pediatricians, family physicians, and other primary care clinicians provide initial and front-line care for children and families with psychosocial, behavioral, and mental health problems, and frequently manage many of these issues. Primary care physicians are in a unique position to help patients and families with more severe problems.
obtain mental health treatment and/or other psychosocial support.

Discussing emotional and psychosocial problems with patients is satisfying for some physicians while possibly challenging for others. Gaining experience through the art of developing the therapy referral can increase comfort with the process and enhance relationships with patients and their families.

REFERENCES


