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Enhancing Pediatric Mental Health Care: Algorithms for Primary Care

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ABBREVIATIONS

AAP—American Academy of Pediatrics
EI—early intervention
IDEA—Individuals With Disabilities Education Act
ADHD—attention-deficit/hyperactivity disorder

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In 2004, the American Academy of Pediatrics (AAP) Board of Directors appointed the Task Force on Mental Health and charged it to assist pediatricians and other primary care clinicians* in enhancing the mental† health care they provide. The task force determined that 3 goals were important to accomplishing its purpose:

Goal 1: Facilitate system changes

Goal 2: Build skills

Goal 3: Incrementally change practice

The task force recommended addressing the goals sequentially; that is, before implementing the clinical process proposed in this report, clinicians need to (1) accomplish system changes such as payment for mental health services provided by primary care clinicians[1,2] and development of clinical relationships with mental health specialists,[3] (2) achieve mental health competencies,[4] and (3) enhance their office systems by applying chronic care methods to the care of children with mental health problems.[5] Strategies the task force used to address these goals are summarized in the introduction to this supplement.[6]

In this report, the task force proposes a clinical process for delivering mental health services in pediatric primary care settings. The report summarizes key features of this clinical process, then provides algorithms developed in collaboration with informaticians from the AAP Council on Clinical Information Technology; these algorithms are intended to ensure clarity of the proposed process and facilitate its translation to electronic systems. Appendix S5 lists procedural codes that can be used in billing for each step of the process. An accompanying toolkit to assist with implementation is scheduled for distribution in spring 2010.

The concepts and process proposed in this report were developed by consensus of 4 groups, the members of which are listed in

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*Throughout this document, the term "primary care clinicians" is intended to encompass pediatricians, family physicians, nurse practitioners, and physician assistants who provide primary care to infants, children, and adolescents.

†Throughout this statement, the term "mental" is intended to encompass "behavioral," "neurodevelopmental," "psychiatric," "psychological," "social-emotional," and "substance abuse," as well as adjustment to stressors such as child abuse and neglect, foster care, separation or divorce of parents, domestic violence, parental or family mental health issues, natural disasters, school crises, military deployment of children's loved ones, and the grief and loss accompanying any of these issues or the illness or death of family members. It also encompasses somatic manifestations of mental health issues, such as fatigue, headaches, eating disorders, and functional gastrointestinal symptoms. This is not to suggest that the full range or severity of all mental health problems is primarily managed by pediatric primary care clinicians but, rather, that children and adolescents may suffer from the full range and severity of mental health conditions and psychosocial stressors. As such, children with mental health needs, just as children with special physical and developmental needs, are children for whom pediatricians, family physicians, nurse practitioners, and physician assistants provide a medical home.

Appendix S6. These members recognized that the "primary care advantage"[7] is the opportunity for longitudinal relationships with children and families—relationships that engender the trust to raise difficult issues and provide clinicians the insight necessary to note changes or concerns of their own. The psychiatry literature validates that a trusting therapeutic alliance predicts a person's engagement in care for mental illness and a favorable outcome of that care over and above any specific treatment including medications.[8]

KEY FEATURES OF THE RECOMMENDED PROCESS FOR ADDRESSING CHILDREN'S MENTAL HEALTH NEEDS IN PRIMARY CARE SETTINGS

The task force members determined that the primary care process for mental health care should:

- Build on the unique skills of primary care clinicians and the unique opportunities of the primary care setting. These opportunities include promotion of social-emotional health and resilience in children and families; recognition of adverse childhood experiences and environmental stressors associated with emotional and behavioral problems in children and adolescents; intervention to prevent mental health problems and/or to address emerging mental health problems; and care of children with mental health disorders in a non-stigmatizing and supportive medical home, coordinated with mental health specialty services, school, child care, and social services. Among the most important of the primary care opportunities is the primary care clinician's capacity to have a positive impact on a child's mental health problems without knowing precisely the child's diagnosis: evidence-based "generic" or "common-factors" interventions (see Table 1).

- Fit the rapid pace of primary care practice and not place additional burdens on clinicians already stressed by a full agenda and productivity requirements.

- Normalize conversations about mental health and substance use to communicate the importance of children's mental health, signal the clinician's openness to mental health concerns, and destigmatize mental health/substance use topics.

- Reflect confidence in the child's and family's capacity to be or to become mentally healthy or to maximize function in the face of mental illness. Rather than the traditional medical model, which focuses solely on problems and risks, a process for effective mental health care builds on child and family strengths and protective factors. (For more information, see Table 2 and Fig 1 in the accompanying task force report, "Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community."[3])

TABLE 1 Generic or Common-Factors Interventions: HELP

Primary care clinicians are accustomed to a certain level of diagnostic uncertainty. Children who present with fever are typically triaged on the basis of the child's clinical appearance: the very toxic-appearing child may require further diagnostic assessment and admission to the hospital for observation and presumptive treatment; the child with clinical findings that suggest a specific diagnosis may be treated as an outpatient and return for further attention if recovery does not progress as expected; the child with mild symptoms may simply require parental reassurance, symptomatic care, and monitoring. Clearly, in many instances the clinician can relieve parental distress and decrease the child's discomfort without knowing exactly what is causing the child's symptoms.

Similarly, in the absence of an emergent need, clinicians presented with a child's mental health problem can often take steps to address parents' distress and children's symptoms without knowing the specific diagnosis. They may offer parenting strategies to cope with common behavioral problems. They may offer advice about lifestyle issues that affect mental health, such as sleep, exercise, sunlight, diet, and 1-on-1 time for the parent and child. They can use effective family-centered techniques known as common factors, so called because they are common factors in a number of evidence-based interventions.[9–12] These factors can be represented by the mnemonic HELP:

H		Hope: increase the family's hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the child and family.
E		Empathy: communicate empathy by listening attentively.
L[2]		Language: use the child or family's own language to reflect your understanding of the problem as they see it and to give the child and family an opportunity to correct any misperceptions.
		Loyalty: communicate loyalty to the family by expressing your support and your commitment to help.
P[3]		Permission: ask the family's permission for you to ask more in-depth questions or make suggestions for further evaluation or management.
		Partnership: partner with the child and family to identify any barriers or resistance to addressing the problem, find strategies for bypassing or overcoming barriers, and find agreement on achievable steps that are aligned with the family's motivation.
		Plan: establish a plan (or incremental first step) through which the child and family will take some action(s), work toward greater readiness to take action, or monitor the problem and then follow-up with you, based on the child and family's preferences and sense of urgency. (The plan might include, eg, gathering information from other sources such as the child's school, making lifestyle changes, applying parenting strategies or self-management techniques, reviewing educational resources about the problem or condition, initiating specific treatment, seeking referral for further assessment or treatment, and/or returning for further family discussion.)

Considerable evidence suggests that medical generalists can readily learn and retain these techniques.[12–14]

Note that the use of multiple, brief visits (in contrast with the 45- to 60-minute visits common in mental health specialty practice) will often be necessary to address a child's mental health concerns in a busy primary care practice. Experienced primary care clinicians can readily acquire skills in bringing a visit to an efficient close and increasing the likelihood that youth and families will continue in care.[3] Results of studies in adult primary care have suggested that applying common-factors skills such as those represented by the HELP mnemonic can improve patient outcomes without increasing the length of visits.[15]

TABLE 2 Protective (Resilience) Factors in Children and Youth

Demonstrates physical, cognitive, emotional, social, and moral competencies

Engages in behaviors that promote wellness and contribute to a healthy lifestyle

Forms caring, supportive relationships with family, other adults, and peers

Engages in a positive way with the life of the community

Displays a sense of self-confidence, hopefulness, and well-being

Demonstrates resiliency when confronted with life stressors

Demonstrates increasingly responsible and independent decision-making

Adapted from Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008:521.

- Incorporate tools for assessing the functioning of the child and family—routinely during health supervision visits, when faced with social-emotional challenges or symptoms, and periodically to monitor progress in mental health care.

- Take into consideration the many factors that may impede families from seeking or using mental health services for their children (eg, stigma, family conflict or dysfunction, cultural differences in conceptualizing mental health problems, a sense of hopelessness about recovery, inadequate financial resources or insurance coverage, or inaccessibility of specialty mental health services).

- Provide for effective partnership of primary care clinicians, families, mental health professionals, developmental-behavioral and adolescent specialists, educators, and agency personnel in both the assessment and care processes (see the accompanying task force reports "Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community"[3] and "Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice"[5]). It is critically important that relationships and procedures, worked out in advance, include protocols for sharing information among health professionals, schools, and agencies and for managing psychiatric and social emergencies identified by the primary care clinician.

- Reflect the many factors that contribute to decision-making about mental health care, including urgency of the needs, comfort of the primary care clinician, family preferences, and access to resources.

- Be consistent with evidence-based best practices, to the extent the evidence exists.

- Reflect the prevalence of substance use among children and adolescence, not just of illegal substances but prescription drugs that are readily accessible in many households (see Table 3). Not only do substances have a direct effect on the developing brains of young people and on their behavior, but their use also has an indirect effect through association with violence, car crashes, sexual activity, interpersonal conflict, and academic failure.

- Recognize the chronicity of many mental health problems in childhood and adolescence and incorporate evidence-based principles of chronic care management, such as those applied to asthma and diabetes,[17] without losing sight of each child's potential for recovery (see "Strategies for Preparing a Primary Care Practice"[5]).

- Ensure appropriate payment of primary care clinicians.

For definitions, see the introduction to this supplement.[6]

ALGORITHMS THAT DESCRIBE THE PROCESS

The following algorithms represent an idealized process for the mental health care of children in primary care settings. The figures in the algorithm do not represent a particular time frame: several steps in the process may take place at 1 contact, and 1 step in the process may require several contacts. For points at which data from outside sources are needed or referrals are

TABLE 3 Trends in Monthly and Annual Prevalence of Use of Various Drugs in Grades 8, 10, and 12[16]

8th-Graders, %		10th-Graders, %		12th-Graders, %	
Previous Year	Previous 30 d	Previous Year	Previous 30 d	Previous Year	Previous 30 d
Alcohol: 30.3	Alcohol: 14.9	Alcohol: 52.8	Alcohol: 30.4	Alcohol: 66.2	Alcohol: 43.5
Drunk: 12.2	Drunk: 5.4	Drunk: 31.2	Drunk: 15.5	Drunk: 47.0	Drunk: 27.4
Marijuana: 11.8	Marijuana: 6.5	Marijuana: 26.7	Marijuana: 15.9	Marijuana: 32.8	Marijuana: 20.6
Inhalants: 8.1	Inhalants: 3.8	Vicodin: 8.1[a]	Amphetamines: 3.3[a]	Vicodin: 9.7[a]	Narcotics other than heroin: 4.1[a]
Amphetamines: 4.1[a]	Amphetamines: 1.9[a]	Amphetamines: 7.1[a]	Inhalants: 2.2	Amphetamines: 6.6[a]	Amphetamines: 3.0[a]
OTC cough/cold medications: 3.8		Inhalants: 6.1	Tranquilizers: 2.0[a]	Tranquilizers: 6.3[a]; barbiturates: 5.2[a]	Barbiturates: 2.5[a]
Tranquilizers: 2.6[a]				OTC cough/cold medications: 5.9	Tranquilizers: 2.7[a]
		OTC cough/cold meds: 6.0			
	Cigarettes: 6.5; smokeless tobacco: 3.7		Cigarettes: 13.1; smokeless tobacco: 6.5		Cigarettes: 20.1; smokeless tobacco: 8.4

OTC indicates over-the-counter.
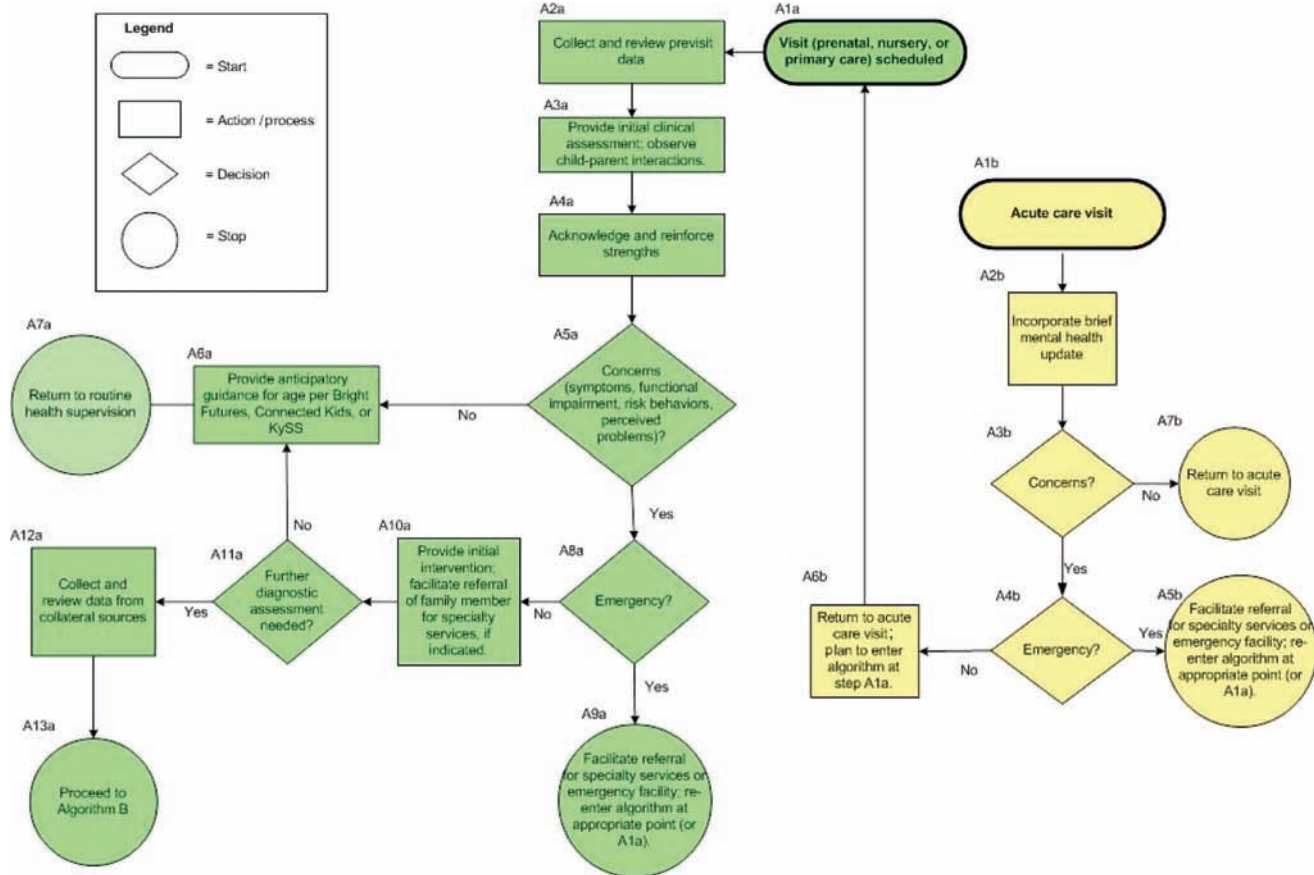[a] Prescription medication.

FIGURE 1
Algorithm A: promoting social-emotional health, identifying mental health and substance use concerns, engaging the family, and providing EI in primary care.

made, the process will necessarily extend to a return visit. A number of activities may occur before or after an encounter, such as preencounter parent/youth reports with validated tools. The task force invites clinicians to develop their own pace, informed by available resources, practice capacity, patient preferences, and circumstances.

Algorithm A (Fig 1) provides a framework for promoting social-emotional health and identifying and responding to new mental health concerns, whether raised by parents in scheduling the visit or suggested by the data-collection and assessment activities described. The ongoing care of children with identified mental health concerns is addressed in Algorithm B.

The task force suggests that primary care clinicians consider a sequence of

implementation that begins with Algorithm B, ensuring sound procedures for managing children with identified conditions before attempting to identify additional children with occult mental health needs. (See "Strategies for Preparing a Primary Care Practice"[5] for rationale and further discussion.)

Algorithm A: Promoting Social-Emotional Health, Identifying Mental Health and Substance Use Concerns, Engaging the Family, and Providing Early Intervention in Primary Care

A1a: Visit (Prenatal, Nursery, or Primary Care) Scheduled

Scheduling of any visit at any age can trigger data-gathering in advance of the visit, as described in step A2a.

A2a: Collect and Review Previsit Data

To create efficiency during scheduled visits, clinicians can adopt the use of a previsit questionnaire, either paper or electronic, filled out at the patient's home or in the waiting room. This questionnaire can incorporate validated instruments to screen for mental health problems and assess psychosocial functioning; these tools can be scored or interpreted before the visit. Such an approach enables the clinician to focus on building rapport and exploring findings rather than on rote data-gathering, while still being systematic in obtaining information. Such an approach is particularly important if a visit is scheduled for 1 of the following reasons:

● the parent or child has a mental health concern;

- the clinician has previously identified a mental health concern (eg, at an acute care or emergency department visit) and asked the child to return for further assessment;

- the child is in foster care or the juvenile justice system or, for any reason, is at increased risk for psychosocial problems (eg, homelessness, school dropout, death of a loved one, exposure to violence or other adverse childhood experience, parental mental illness);

- the child's child care provider or teacher has expressed concern about the child's development or behavior (or the child has been suspended or expelled); or

- the child has a chronic medical condition or disability that places him or her at greater risk than other children for mental health problems.‡

A structured process, developed by the practice in advance (see "Strategies for Preparing a Primary Care Practice"[5]), should ensure that the following content is covered:

- the family's priorities for the visit;

- family/social history (including stresses, support system, environmental risk assessment, trauma, separation, and loss);

- identification of the child's and family's strengths;

- functional assessment of the child and family by using validated instruments (see discussion in Supplemental Appendix S12);

- temperament[19] and risk behaviors;

- school or child care reports, particularly if school or child care personnel have expressed concerns; and

‡Unidentified mental health problems in children and youth with special health care needs may contribute to poor control of medical conditions, somatization, and overutilization of medical services by both the child and parents.[18]

- appropriate validated screening tool(s) for age (see discussion in Supplemental Appendix S12).

Electronic questionnaires provide an opportunity for the use of "item responses." For example, the computer asks the respondent 2 or 3 basic questions. If the answer is no to those questions, the respondent moves on; if the answer is yes, the computer asks more questions. If previsit data collection is not feasible, the clinician will need to incorporate data collection into the clinical encounter. In this case, exploration of positive findings may require a follow-up encounter.

A3a: Provide Initial Clinical Assessment; Observe Child-Parent Interactions

During the face-to-face encounter, the primary care clinician can complete the following steps:

- Identify, elicit, or review the child's and family's priorities for the visit.

- Review previsit questionnaire, other data collected, progress on any previous concerns, and adjustment and progress in child care, preschool, or school.

- Broaden the agenda by indicating openness to mental health issues. For example, elicit further information about any current concerns, the child's or family's past or current sources of care for the concerns, and progress on previous concerns; if screening tools have been completed, use any positive responses as a springboard to further discussion and clarification. Ask broad, open-ended questions such as, "What has been the hardest part about taking care of Jonah?" followed by, "What has been the best part?" Such questions convey the clinician's interest in family functioning and invite vexing questions that may have been posed to rela-

tives and friends but may have not been felt appropriate for this medical setting. Whatever methods are used to gather information, include inquiry about parental well-being (looking particularly for problems with parental mood, affect, or attachment to the child), the child's developmentally specific symptoms of emotional disturbance (see Table 1 in Supplemental Appendix S13), and the child's and family's strengths (see step A4a).

- Observe parent-child interaction.[20,21]

- Interact with the child.

- Complete interview and physical examination (including vision and hearing screening, because a sensory deficit may cause academic or behavioral difficulties).

- Identify the child's and family's strengths.

Primary care clinicians can gain additional insights from examining their own reaction to the parent and child and considering the family's cultural context.[22,23]

Additional physical assessment may be indicated in response to mental health concerns. Developmental disorders, epilepsy, sleep disorders, and endocrine disturbances are among conditions that may first manifest with behavioral or emotional symptoms. The extent of the physical examination and related testing depends on the type and severity of concerns raised. Repeated somatic complaints or exacerbation of a chronic medical condition may be the initial presentation of an emotional difficulty, so these symptoms may prompt further mental health assessment. Interpretation of findings may vary according to age. For example, physical symptoms, such as growth failure, might signal mental or emotional concerns in infants and young children. During middle childhood, academic difficulties can signal

mental health concerns or learning disabilities. In adolescents, school dropout or risky behaviors such as sexual activity or substance use may be associated with mental health problems. See Table 2 in Supplemental Appendix S13 for additional information.

At this point in the algorithm, the clinician need not feel pressed to make a diagnosis but simply to determine if there may be a mental health concern in the child or family.

The increasing independence of adolescents, and the likelihood that parents and guardians may not be fully aware of their adolescents' activities or feelings, reinforce the need for private, confidential discussions between clinicians and their adolescent patients. These discussions should augment, not replace, discussions with parents. Youth and parents differ in their ability to report on various mental health conditions: a parent may have a more accurate picture of the effects of externalizing symptoms (eg, hyperactivity, inattention, oppositionality), whereas youth may be better able to articulate the toll of internalizing symptoms or conditions (eg, anxiety or depression); or the youth and parents may disagree about the nature or importance of symptoms. As part of these discussions, clinicians are obliged to address confidentiality and its limits with both adolescents and their parents.[24,25]

A4a: Acknowledge and Reinforce Strengths

Effective mental health care requires that clinicians move from a medical model focused on problems to a more comprehensive view of the child's and family's capacities. There are 8 empirically determined independent "intelligences": linguistic, logical-mathematical, spatial, bodily kinesthetic, musical, interpersonal, intrapersonal, and naturalistic.[26] Acknowledging strengths ($\geq$1 of these intelligences; talents; qualities such as resilience, generosity, courage, tenacity, goal-orientation, focus; social supports such as strong family bonds, extended family support, or good peer relations; healthy behaviors such as regular exercise/sleep routines, participation in extracurricular or spiritual/religious activities; or attitudes such as hope, optimism, and motivation to seek help) can build rapport, provide groundwork for an intervention plan, and facilitate accomplishment of subsequent steps.[27] Diagnosing strengths may also stimulate the family to provide further opportunities for the child's development of competence, serving as a buffer for the challenges and peer pressures of adolescence and offering alternatives to risky activities.[27]

A5a: Concerns (Symptoms, Functional Impairment, Risk Behaviors, Perceived Problems)?

No, There Are No Concerns

If the child and family show no signs of functional impairment or distress and no risk behaviors are identified and no mental health concerns are raised by the family, derived from screening or perceived by the clinician, the clinician can move to step A6a.

Yes, There Are Concerns

Any positive findings (functional impairment; symptoms concerning to the child, family, or clinician; family distress; family member with mental illness; exposure to trauma; environmental risks such as a weapon in the home of a child with suicidal or homicidal thoughts; risky behaviors; or perceived problems) necessitate further attention by the clinician, beginning with step A8a below.

A6a: Provide Anticipatory Guidance for Age per Bright Futures, Connected Kids, or KySS

Strategies to promote mental health and provide anticipatory guidance appropriate to the child's age are provided in Bright Futures,[28] Connected Kids,[29] and KySS (Keep Your Children/Yourself Safe and Secure).[30] See also "Strategies for Preparing a Primary Care Practice"[5] and Appendix S2 and Appendix S7 for parenting resources and evidence-based programs for promoting mental health and enhancing school success.

A7a: Return to Routine Health Supervision

Clinicians can broaden the agenda to other issues and return to step A1a at the next scheduled contact.

A1b: Acute Care Visit

Because families sometimes miss routine health supervision visits, clinicians who are interested in eliciting mental health concerns will increase their effectiveness if they use the opportunity of acute care visits to elicit mental health concerns.

A2b: Incorporate Brief Mental Health Update

The task force has drawn from the expertise of its professional members, opinions of its youth and family members, and informal trials in primary care practices to develop the recommendation that clinicians use acute care visits as an opportunity to perform a brief mental health update (see "Strategies for Preparing a Primary Care Practice"[5]). There is a compelling need for further research to document costs and benefits of this approach and to establish best practice. The task force recognizes that incorporating a mental health update during acute care visits may be daunting in some practice environments. Clinicians might consider implementing acute

care mental health activities incrementally, beginning perhaps with children who have missed routine health supervision visits or those in certain high-risk groups, such as children in foster care. Alternatively, clinicians can use the context of the acute care visit (eg, an injury) to lead naturally into mental health topics (eg, "Had you or your friends been drinking when this happened?" or "Has this person [the perpetrator of the injury] ever threatened you or injured you before?").

Because of the association between sleep difficulties and mental health conditions, questions regarding sleep are helpful throughout childhood. The wording of such questions is important to adolescents, who may have conflict with their parents around sleep issues. The task force recommends that clinicians avoid questions that require only yes or no answers and phrasing such as, "Are you getting enough sleep?" Instead, clinicians might ask, for example, "How hard is it for you to fall asleep when you want to?"

Responses to these questions provide information that can alert clinicians to the need for more extensive assessment. In the absence of any concern, 3 to 5 general questions can be completed in as many minutes. Appendix S8 provides examples. If a concern is identified, the clinician can express interest, triage for emergencies as in step 8a, and plan with the family to address the concern at a scheduled follow-up visit (step 1a). (The HELP mnemonic, shown in Table 1, provides guidance for engaging the family and closing the visit supportively.)

During adolescence, it is important that the clinician address questions to the patient in a private setting and explain the conditional confidentiality of the conversation. The clinician can question younger children privately, depending on practice protocols and the comfort of the patient and parent. In all instances, the clinician should also direct questions to the parents. Discrepancies in responses between the parent and child may signal different levels of awareness, varying perceptions of the importance of an issue, or family conflict that should be explored further.

Adolescents caution that questions on substance abuse and other sensitive topics may seem intrusive and be unlikely to yield a candid response during a brief mental health update. A framing statement such as, "Many young people I'm seeing feel lots of stress this time of year" or "…lots of pressure to use drugs," or a circular question such as "Do any of your friends smoke, drink, or use other drugs?" may be better received than direct questions about the adolescent's behaviors. If the clinician has cause for concern, such as deteriorating school performance or injuries, or if this is an issue that he or she is already following, more specificity is warranted. The Adolescent Health Working Group's *Behavioral Health: An Adolescent Provider Toolkit*[31] provides tools to aid in conversing with adolescents. The number 1 reason that teenagers do not disclose sensitive information is that clinicians do not assure them of confidentiality.[32]

A3b: Concerns?

These might be the child's, the family's, or the clinician's concerns.

No, There Are No Concerns
    Proceed to step A7b.

Yes, There Are Concerns
    If mental health or substance abuse concerns are raised by parents, children, youth, or the clinician as a result of the brief mental health update, the process moves on to triaging for emergencies: step A4b/A8a.

A7b: Return to Acute Care Visit

If no concerns are raised, clinicians can acknowledge the child's and family's strengths and return to the acute care visit.

A4b/A8a: Emergency?

The presence of a mental health, substance use, or social-emotional concern triggers the triage process. Psychiatric and social emergencies include sexual or physical abuse, suicidality, threat of violence to or by the child, psychosis, addiction to or withdrawal from substances, acute intoxication, and family dysfunction or social circumstances that threaten the safety of the child (eg, domestic violence). Inadequate family resources (eg, homelessness or hunger) may also pose urgent health and safety risks. Supplemental Appendix S14 provides a tool for assisting in identifying suicide risk.

Primary care clinicians must have a system in place to ensure immediate evaluation of children with suicidal thoughts (see "Strategies for Preparing a Primary Care Practice"[5]) or themselves ask key questions regarding suicidal thoughts, presence of a plan, access to lethal weapons such as firearms, and support systems. On the basis of responses, the clinician can assess the level of risk and determine if immediate intervention is indicated.

No, Findings Do Not Suggest an Emergency
    Go to box A6b.

Yes, Findings Suggest an Emergency
    Go to A5b/A9a.

A6b: Return to Acute Care Visit; Plan to Enter Algorithm at Step A1a

If there are no findings that suggest a psychiatric or social emergency, apply the generic skills represented by the HELP mnemonic (Table 1). The plan may involve an incremental first step

toward addressing a barrier or returning to the algorithm at step A1a.

A5b/A9a: Facilitate Referral for Specialty Services or Emergency Facility; Reenter Algorithm at Appropriate Point (or A1a)

The presence of certain psychiatric or social emergencies (eg, suspicion of abuse or neglect, risk of homicide) may require immediate action mandated by state law (eg, reporting to social services or legal authorities) and steps to protect the safety of anyone threatened by the emergency, as well as referral for psychiatric care. Ideally, procedures would have been established in advance with mental health specialty and social service providers in the community or region (see "Strategies for Preparing a Community"[3] and "Strategies for Preparing a Primary Care Practice"[5]). The clinician should provide medical care as indicated, follow procedures for notification of authorities, provide reassurance to the child and family about the clinician's ongoing interest in the child and family, and put in place a plan to follow-up and provide other medical home services.

The clinician can facilitate sharing of information with mental health specialty or social service providers by obtaining written permission from the family for exchange of information. After receiving mental health specialty care and/or social services for the emergent issue(s), children who are up-to-date on routine health supervision ideally reenter the primary care process at step B1b of Algorithm B; those who are not up-to-date would ideally reenter at step A1a of Algorithm A. In either case, information about the child's and/or family's progress in mental health specialty treatment and/or social services is critical to primary care follow-up.

A10a: Provide Initial Intervention; Facilitate Referral of Family Member for Specialty Services if Indicated

If there are no signs of an emergent situation, the clinician can provide initial common-factors interventions (see Table 1, HELP mnemonic). The plan of action might require multiple visits and include any of the following elements, in accordance with the family's wishes:

- Offer to provide advice, if wanted, on parenting techniques to address acute problems (eg, toileting, homework, sibling conflicts, anger outbursts) and general steps the family can take to enhance the child's and family's mental health, such as improving sleep hygiene or nutrition, reducing time spent watching television or using electronic media, increasing outdoor time, increasing physical activity, learning stress management techniques, or scheduling a special time each day for the parent to give 1-on-1 attention to each child. Resources include *Bright Futures in Practice—Mental Health*,[33,34] the American Academy of Child and Adolescent Psychiatry Web site,[35] the AAP Healthy Children Web site,[36] and AAP publications and brochures.

- Inquire about any traumatic events or losses in the life of the child and family that may have triggered the child's symptoms or may be contributing to the child's or family's problems in coping. Examples of such events or losses include the death of a loved one or pet; a move; homelessness; conflict, separation, or divorce of parents; military deployment of the parent(s) or other loved ones; incarceration of the child or a loved one; breakup of a relationship; abuse or bullying by the child or targeting the child; exposure to violence (either directly or emotionally, through death or injury of a loved one); or a natural disaster. It is necessary to inquire separately of youth and parents, because some events that affect children and adolescents may go unrecognized by the parent or be confidential from the parent, and some parents may be reluctant to discuss some events or losses in front of their children. In the case of trauma exposure, the clinician should allow the child to share his or her own narrative of the experience but not lead the child and family into reliving the incident, which may result in further trauma to those who experienced it. Children vary widely in their reactions to trauma and loss, depending on their developmental level, temperament, previous state of mental health, coping mechanisms, parental responses, and support system. It is important for the primary care clinician to express empathy, to assess the functional impact of the loss or trauma on the child and family, to offer support, to put in place a mechanism for monitoring the child's and family's short-term and long-term progress, and to continue offering empathy and support with each contact. Guides are available to help clinicians in this process.[37] If the impact is severe and/or persistent, it may be appropriate to offer counseling through a community referral.

- Offer community resources and educational materials that may aid the child or parents in understanding the mental health problem(s) being addressed. These resources can also include important Web sites (eg, www.healthychildren.org,[36] www.nami.org,[38] www.chadd.org,[39] www.napnap.org,[40] www.ffcmh.org,[41] www.samhsa.gov,[42] www.aacap.org,[35]

and www.compassionatefriends. org[43]).

- If a family member has medical, mental health, or social needs that contribute to the child's problem or to family stress, explore this person's readiness to seek and accept help and initiate referrals as appropriate, taking care to avoid "blaming" language.

If screening-tool results and/or other findings suggest that the child's problem falls into certain common symptom "clusters," there may be strategies that motivated parents can learn during brief primary care encounters and/or from well-vetted resources. The task force developed guidance related to children from birth to 5 years of age with symptoms of social-emotional problems and for older children with the symptom clusters of inattention and impulsivity, anxiety, depression, disruptive behavior and/or aggression, substance abuse, and learning difficulties.

At the close of every visit, ensure that all steps in the HELP mnemonic (see Table 1) have been completed. Application of this approach has been shown to be effective in decreasing the parents' distress and improving children's functioning across a number of mental health problems.[12] Using this approach in multiple visits may yield additional benefits. The clinician can monitor the child's progress by enlisting the parents to observe for persistence or worsening of symptoms, by making telephone contact with the family at appropriate intervals, and/or by inquiring at the time of return visits.

A11a: Further Diagnostic Assessment Needed?

No

In the absence of functional impairment or indications of a specific,

treatable condition, further assessment may not be necessary. Examples include a 10-year-old who is attending a new school and experiencing decreased sociability; an adolescent mother with mild anxiety; sleeplessness after a minor motor vehicle crash; increased parent-child conflict at a time of family stress; and flare-ups of chronic but relatively mild problems related to temperament or delayed social skills.

Yes

Indications for further diagnostic assessment include impaired functioning; screening results that suggest the probability of a disorder; symptoms that worsen or persist despite initial intervention; a parent or child who manifests distress out of proportion to findings; and clinician concern or discomfort.

A12a: Collect and Review Data From Collateral Sources

If findings point to academic or behavioral problems in school or difficulty with peers, primary care clinicians need information from the child's school and/or child care provider. Office procedures should ensure that parents of school-aged children complete a form that authorizes the school and primary care clinician to exchange information. Specifically, the primary care clinician is looking for details about the child's functioning in the school setting and any discrepancy between cognitive ability and academic achievement that would suggest a learning disability. Developing a community understanding about the role of school personnel in collecting data for primary care clinicians and the role of primary care clinicians in informing school personnel about students' medical and mental health needs greatly facilitates interaction

between the primary care clinician and school personnel[44] (see "Strategies for Preparing a Community"[3] and "Strategies for Preparing a Primary Care Practice"[5]). The primary care clinician can also request information about preschool-aged children from their child care provider(s).[45]

If parents are separated, divorced, or in conflict, it is important to gather information from the parent who is not represented at the visit, if that parent is involved in the child's life. If a grandparent, foster parent, or other guardian is involved in the care of the child, information from this individual is also important. Several validated tools have parent versions that can be used for this purpose (see Supplemental Appendix S12). Use of a tool does not substitute for including this caregiver in future discussions involving the child.

If there has been previous involvement of other agencies or health professionals with the child or family, clinicians need to obtain the youth's and family's (or guardian's) consent to request records from these sources. For children in foster care, it is critically important to work through case workers to collect information from biological and foster parents if adults who are unfamiliar with the child's history accompanied the child to the visit.

A13a: Proceed to Algorithm B

Algorithm B (Fig 2) describes the process of further assessment and care for children who present with or manifest mental health concerns that negatively affect their functioning and/or do not respond to initial intervention.

For some children and families, the need for additional assessment will cause increased anxiety, and some may respond to this anxiety with re-
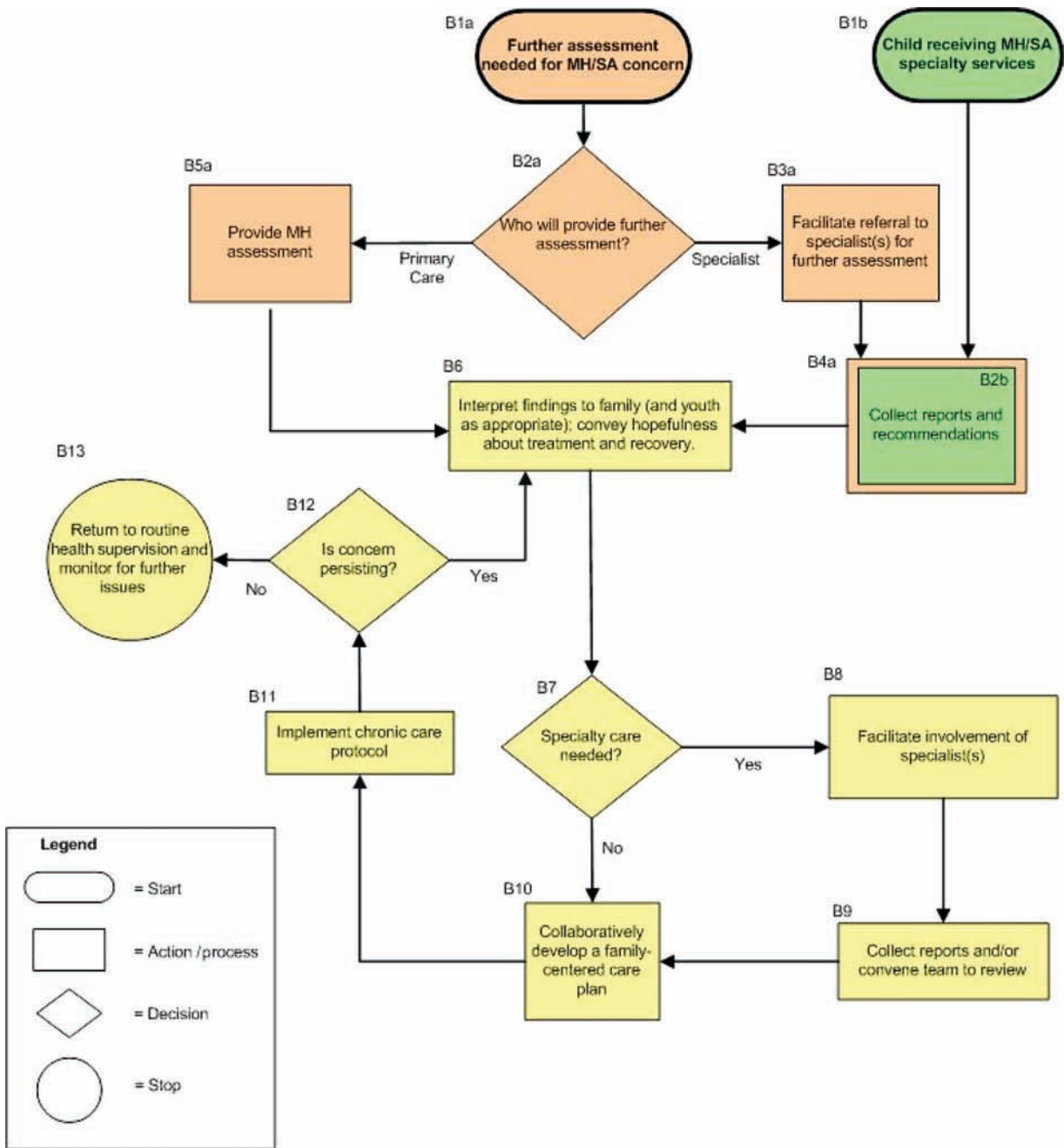
FIGURE 2
Algorithm B: assessment and care of children with identified social-emotional, mental health (MH), or substance abuse (SA) concerns, ages 0 to 21 years.

sistance. Clinicians can comfort and reassure the child and family by fully understanding the family's opinions, preferences, cultural perspective on seeking mental health care, resources (including health insurance coverage), and priorities; establishing agreement on the nature and implications of current concerns and the family's readiness to seek further consultation or treatment; emphasizing strengths and assets; and rolling with resistance to further assessment (eg, by offering a follow-up conference to discuss further if the family is not ready). If the assessment process is deferred to a subsequent visit because of time pressures, the need to collect further information, or the family's lack of readiness, then clinicians may choose to follow-up with a telephone call. It is important to use office tracking mechanisms to ensure follow-up of children and families who are not yet ready to take action (see "Strategies for Preparing a Primary Care Practice"[5]).

Algorithm B: Assessment and Care of Children With Identified Social-Emotional, Mental Health, or Substance Abuse Concerns, Ages 0 to 21 Years

B1a: Further Assessment Needed for Mental Health/Substance Abuse Concern

Enter the algorithm at this point if a social-emotional or mental health concern or functional impairment has been previously identified by the primary care clinician; if symptoms identified by screening instruments, questionnaire, interview, or observation suggest the probability of a disorder and/or do not respond to the initial intervention; or if the parent or child manifests distress out of proportion to findings. In making this decision, consider the persistence and severity of the problem and the family's and child's readiness to seek help. If the family or child is not ready to seek help, apply common-factors techniques (see the HELP mnemonic in Table 1) to reach agreement on an incremental step.

B1b: Child Receiving Mental Health/ Substance Abuse Specialty Services

Enter the algorithm at this point if the child is currently involved in mental health specialty care. The primary care clinician can express interest in collaborating with the mental health specialist(s) and move on to step B2b/B4a. If the primary care clinician meets resistance, he or she can explore its roots as in Algorithm A, step A10a.

B2a: Who Will Provide Further Assessment?

At this point the clinician will consider findings from earlier steps in the process, his or her own competence to provide further assessment in the area(s) suggested by earlier findings;

and family preferences and resources, including health insurance benefits and any health plan requirements for accessing mental health services. The task force offers the following as general guidance.

Children Younger Than 5 Years of Age

The task force has developed guidance for primary care clinicians in assessing and responding to social-emotional problems in children younger than 5 years of age and disturbances in parent-child relationships. This guidance includes indications for referral to a developmental-behavioral pediatrician, mental health specialist with expertise in early childhood, therapist for the parent or the parent-child dyad, specific professional (eg, speech pathologist), developmental evaluation team, or other community resource.

Every community in the United States has an agency assigned by the state to provide Early Intervention (EI) services. These include assessment and care coordination, as mandated by the Individuals With Disabilities Education Act (IDEA), for children from birth to 3 years of age with developmental problems; however, general and subspecialty pediatric assessment are often not included in the EI assessment process. Children 0 to 3 years of age who qualify for services (occupational, physical, or speech therapy; education) must receive them in the least restrictive environment (usually their home) on the basis of their documented delay in language, motor, personal social, and/or adaptive domains. Some states extend EI services to 0- to 36-month-old children who are at risk for developmental problems, as well as those with diagnosed problems. The IDEA specifies that states receiving certain categories of federal funding must provide assessment and an Individual Family Services Plan to all 0- to 3-year-olds who are substantiated as abused or

neglected or who are identified as affected by illegal substance abuse or withdrawal symptoms that result from prenatal drug exposure. Developmental and educational services for children aged 3 to 5 years are also mandated and regulated by the IDEA. In most states, the public school system is responsible for developmental assessment and education of children with significant delays, whereas in other states, the EI programs continue to provide assessment and services for this age group.

Examples of problems that require further evaluation by 1 of these resources include disordered parent-child relationship, parental mental illness, language or communication delay, disruptive behavior with aggression, abuse or neglect of the child, and self-injury. See "Strategies for Preparing a Primary Care Practice"[5] and Appendix S2 for evidence-based interventions for infants and young children, their parents, and/or caregivers. High-quality child care and preschool have a protective long-lasting benefit, especially for children at high developmental and behavioral risk; clinicians may also refer to these programs. When community resources are insufficient or ineffective, primary care clinicians can partner with developmental-behavioral pediatricians, early childhood educators, parent educators, and mental health providers to build or strengthen the critically important service system for this population.

Children Aged 5 to 21 Years

Primary care clinicians should consider referring to a mental health specialist for further evaluation children aged 5 to 21 years of age with 1 or more of the following problems:

- suicidal intent;
- severe functional impairment;
- rapid cycling mood;
- depressive symptoms in a preadolescent;

- extreme outbursts/problems with conduct;
- severe eating problems;
- psychotic thoughts or behavior;
- self-injury;
- comorbidity of substance abuse and mental health problems;
- a score of 2 or more on the CRAFFT (car, relax, alone, forget, friends, trouble) screening tool[46];
- attention-deficit/hyperactivity disorder (ADHD) with comorbidities; and
- any other problem that the clinician does not feel prepared to address.

Primary care clinicians with requisite competencies[4] can effectively assess children 5 to 21 years of age with mild-to-moderate levels of functional impairment associated with the following symptom clusters:

- anxiety;
- inattention and impulsivity;
- disruptive behavior and aggression;
- depression;
- substance use; and
- learning difficulties.

Tools developed by the task force outline primary care assessment of children with symptoms in each of these clusters and suggest specific indications for specialty referral of children who experience symptoms in that cluster.

B3a: Facilitate Referral to Specialist(s) for Further Assessment

Clinicians in a wide range of disciplines can provide diagnostic assistance in these situations, including developmental-behavioral pediatricians, neurodevelopmental pediatricians, adolescent medicine specialists, pediatric neurologists, psychiatrists, EI specialists, clinical psychologists, school psychologists, clinical social workers, advanced practice nurses with specialized psychiatric training, and substance abuse specialists. These professionals may practice in public mental health or developmental clinics, in schools, in private practice, or in university settings.

If a mental health referral will require authorization by the family's health insurance plan; entry into a carved-out, or parallel, private behavioral health insurance plan; or entry into the public mental health system, the family will likely need guidance and time to research the options. If so, the clinician can bring the visit to a close (again following the HELP mnemonic [Table 1]) and schedule a return visit or an appointment with a staff member to facilitate this process.

The decision to involve a specialist in diagnostic assessment means that the primary care clinician's role will include communicating with the specialist. As with any other specialty referral, the process is enhanced by conveying to the specialist the nature of the concern and the primary care clinician's specific questions, results of previous assessment and intervention efforts, and openness to discussion with the professional. Although the Health Insurance Portability and Accountability Act (HIPAA) allows exchange of information among professionals who are involved in the care of a mutual patient, many mental health professionals are reluctant to share information without express consent of the child and family. By obtaining written consent and sending it to the mental health professional, the primary care clinician can convey interest and facilitate communication.

Established relationships with specialists greatly facilitate the primary care clinician's role in making an effective referral. The *Strategies for System Change in Children's Mental Health: A Chapter Action Kit*[1] and the AAP Task Force on Mental Health reports "Strategies for Preparing a Community"[3] and "Strategies for Preparing a Primary Care Practice"[5] have a number of suggestions for building these relationships at the practice, community, regional, and state levels. Integration of a mental health professional within the primary care practice is a model that has particular promise. Primary care clinicians will likely experience growth in their own comfort and competence as a result of interaction with mental health professionals.

It is critical that the practice track children referred for specialty care. If the family is unsuccessful in acquiring a timely assessment for the child, the primary care clinician can offer generic intervention efforts (as described in Algorithm A), further primary care assessment and management strategies, or periodic telephone contacts to monitor for worsening or emergent problems. It may be necessary in some instances to use emergency procedures to obtain needed services.

B2b/B4a: Collect Reports and Recommendations

After requesting the (youth's and) family's permission to gather information from other professionals and agencies involved with the child, the primary care clinician can send requests.

B5a: Provide Mental Health Assessment

The primary care clinician and family may decide to proceed with assessment by the primary care clinician if the child or adolescent does not show signs of severe impairment and if the clinician feels comfortable with further steps in the assessment process, given the presenting symptoms. Using existing guidelines (eg, ADHD guidelines from the AAP,[47,48] *Guidelines for Adolescent Depression in Primary Care [GLAD-PC]*,[49,50] and "Treatment Recommendations for the Use of Anti-

psychotics for Aggressive Youth [TRAAY]"[51,52]); practice parameters[53,54]; and expert opinion of task force members, the task force developed guidance to assist clinicians in further assessment of children with positive screening results or clinical findings that fall into the following clusters of symptoms:

- social-emotional problems in children from birth to 5 years of age
- anxiety;
- depression;
- inattention, impulsivity;
- disruptive behavior, aggression;
- substance use; and
- learning difficulties.

B6: Interpret Findings to Family (and Youth as Appropriate); Convey Hopefulness About Treatment and Recovery

This is a critical point in the process. As the provider of medical home services, the primary care clinician has a role in interpreting diagnostic findings to the family, educating the family about the child's condition, reinforcing child and family strengths, and creating a sense of hopefulness about treatment and recovery. This conversation is critical regardless of whether or not the family will seek specialty care and may, in fact, contribute to the family's readiness to seek that care. To facilitate this conversation and to offer some strategies for initiating care immediately, the task force has drawn from the common elements of effective psychosocial interventions to provide guidance in the primary care management of common symptom clusters (listed above).

The suggestions outlined in the cluster guidance do not replace specialty care but can offer the family some relief while awaiting specialty care or while achieving greater readiness to seek care. In some situations, particularly

those that involve emerging conditions or conditions associated with mild functional impairment, these interventions may themselves constitute effective treatment.

If a specialist has been involved in the diagnostic process, the clinician may choose to invite this individual to the conference, depending on family preferences and logistic considerations. Some children with severe emotional disturbance may have a mental health or EI care manager involved in their care; if so, his or her participation is critically important to the process. The care manager may organize periodic meetings of teachers, social workers, and agency representatives involved with the child and family. In the mental health specialty system, such processes are part of a system-of-care approach—an evidence-based care-coordination system built around the family's strengths and priorities (see "Strategies for Preparing a Community"[3] and "Strategies for Preparing a Primary Care Practice"[5]). If so, the primary care clinician (or his or her staff representative), although often inadvertently omitted, would likely be a welcome addition; joining that team may substitute for convening a primary care conference. Although participation in such activities is time-consuming, it may ultimately produce efficiencies in the care of children and adolescents with complex conditions.

If the inclusion of involved specialists is not feasible, the primary care clinician needs previous information from them to ensure understanding of the child's problems and to discuss the options for further care with the family (and youth, as appropriate). It is important that the family not be placed in the position of transmitting information between professionals who are involved in their child's care.

Families also may use this opportunity to inform and educate the clinician

about the various facets of the child's condition and specific preferences regarding treatment options.

B7: Specialty Care§ Needed?

The answer will depend on clinical circumstances, family preferences, and the clinician's comfort. If a child is in foster care, the decision may also depend on the preference or policy of the child welfare agency that is overseeing the child's care.

To facilitate this conversation, the primary care clinician needs current information about evidence-based interventions appropriate to the child's condition. Appendix S2, "Evidence-Based Child and Adolescent Psychosocial Interventions," includes succinct and reliable sources for this information. The primary care clinician also needs to convey his or her own level of comfort with the child's problem and its severity and the level of consultation and support available.

If the child's problems fall into multiple diagnostic domains but there is a predominant area of concern, the clinician, in concert with the youth and/or family, may decide to address the predominant concern first. The clinician and family may decide to initiate care within the primary care setting and reassess the need for consultation at a later date. Depending on the child's and family's level of readiness to seek help, the primary care clinician can apply common-factors methods (see Table 1) to reach consensus on the next steps, which may involve implementing general management strategies or specific treatment by the primary care clinician or the involvement of specialist(s). If the family wishes to seek specialty care, the primary care clinician has a role in providing care until the child connects with the specialist and then collaborating with specialist(s) to monitor the child's progress.

§See definition, Appendix S9.

If the clinician and family decide to involve 1 or more specialists, there are a variety of collaborative models that can be developed (see "Strategies for Preparing a Primary Care Practice"[5]). If the primary care clinician will be the sole provider of mental health care, the process continues at step B10.

B8: Facilitate Involvement of Specialist(s)

This step is similar to step B3a, in which the clinician and family choose to involve 1 or more specialists in assessment. If the child is younger than 5 years, the primary care clinician should consider referring him or her for an assessment by a developmental-behavioral pediatrician, mental health specialist with expertise in early childhood, a specific professional (eg, speech pathologist), and/or a developmental evaluation team. The local EI agency provides intervention and care-coordination services for children from birth to 3 years of age in addition to assessment as described in step B3a; this agency or another, such as the public school system, provides care coordination and education of children aged 3 to 5 years to comply with the IDEA. For children aged 5 to 21 years, the primary care clinician can involve a developmental-behavioral pediatrician, adolescent specialist, or mental health or substance abuse professional, depending on accessibility and family resources.

If mental health referral will require authorization by the family's health insurance plan; entry into a carved-out, or parallel, private behavioral health insurance plan; or entry into the public mental health system, the family will likely need guidance and time to research the options; if so, the clinician can bring the visit to a close (again following the HELP mnemonic [Table 1]) and schedule a return visit or an appointment with a staff member to facilitate this process.

The decision to involve a specialist or agency in treatment means that the primary care clinician's role will include communicating with other care providers. The process is enhanced by conveying to the referral source the results of previous assessment and intervention efforts and openness to discussion with the professional who will provide therapy. Although the HIPPA allows exchange of information among professionals involved in the care of a mutual patient, many mental health professionals are reluctant to share information without express consent of the child and family. By obtaining written consent (or, for children in foster care, enlisting the case worker's help in obtaining written consent of the legal guardian) and sending it to the mental health professional, the primary care clinician can convey interest and facilitate communication.

As with referrals for diagnostic assessment, it is critical that the practice track children who have been referred for specialty treatment. If the family is unsuccessful in acquiring treatment in a timely way, the primary care clinician can offer to continue generic intervention efforts (as described in Algorithm A), initiate treatment, or make periodic telephone contacts to monitor for worsening or emergent problems. It may be necessary in some instances to use emergency procedures to obtain needed services.

B9: Collect Reports and/or Convene Team to Review

Once the specialist has met with the child and family to develop treatment recommendations, the primary care clinician needs feedback. Forms for exchange of information may facilitate this process (see "Strategies for Preparing a Primary Care Practice"[5] and Appendix S11). Telephone and e-mail contacts may be helpful in some instances. Alternatively or additionally, the clinician may invite other providers of care (including case workers for children in foster care) to participate in a face-to-face meeting with the family. For children in the foster care system it is critically important not only to collect information from case workers but also to convey information back to the worker. If the child changes placement and the caregivers are unaware of what happened in the pediatrician's office, the child does not receive the benefit of continuity of care in the new placement.

B10: Collaboratively Develop a Family-Centered Care Plan

This process requires that the professionals involved reach consensus with the family and with each other about a comprehensive plan of care. The focus of the care plan is seeking improvement in the child's overall emotional health and functioning. The care plan articulates the child's and the family's goals; child and family strengths; service and educational needs; the roles of involved service providers, family members, and other caregivers; plans for follow-up and routine health supervision; plan for emergencies, if they should occur; and, ultimately, plans for self-care and/or family care, transition to adult primary care and specialty health services, and the other services and care coordination needed to support the young person's achievement of his or her educational, social, and vocational goals in adulthood. Ideally, the family, other caregivers, school personnel, case workers, and service providers participate in the plan's development, either by attending the conference or contributing recommendations before the conference. Together, they can set the timetable, determine need for involvement of

additional or alternative specialist(s), and select interventions. They can also establish a plan for monitoring treatment response and safety and create a common understanding of limits of confidentiality. For adolescents, direct input to the plan is critical for engagement and the success of treatment.

For children previously involved in mental health specialty care, a care plan may be in place and may omit primary care issues, such as healthy lifestyle (eg, nutrition, exercise, sleep, stress management, social support), routine health supervision, or care of chronic medical conditions. In this instance, the primary care clinician can point to the roles that he or she can play in coordinating and complementing the care of the mental health specialist(s).

It will be helpful for the primary care clinician to have available sample care plans for common mental health conditions and for common circumstances such as foster care placement and parental separation or divorce, which signal traumatic transitions and require frequent follow-up. For children and youth in foster care, some states are using Web-based medical "passports," which include information on the child's history, immunizations, medications, chronic conditions, etc. The AAP Task Force on Foster Care and the AAP Council in Clinical Information Technology are developing guidelines for medical passports (specifically, the health-information content needed and who should have access to the passport).

B11: Implement Chronic Care Protocol

Methods used to monitor children with chronic medical conditions such as asthma and diabetes can be useful in the care of children with mental health and substance abuse conditions. "Strategies for Preparing a Primary Care Practice"[5] describes steps in implementing chronic care methods for children with mental health problems, as for other children and youth with special health care needs. It is important to institute a monitoring mechanism for children and youth who are not yet ready to seek or accept care for mental health problems, as well as for those who are.

The interval between contacts will be determined by the acuity and severity of the child's condition; the child's and family's strengths, needs, and preferences; adverse effects and monitoring requirements of any treatments; and the level of the child's impairment. Just as spirometry measures pulmonary function and assists the clinician in monitoring children with asthma, global functional assessment scales assist the primary care clinician in monitoring children with mental illness (see "Strategies for Preparing a Primary Care Practice"[5]). There are existing pediatric guidelines for assessment and treatment of ADHD[47,48] and adolescent depression,[49] treatment algorithms for depression,[50,55] and practice parameters from the American Academy of Child and Adolescent Psychiatry[51–54] to assist clinicians who choose to proceed with assessment and treatment in the primary care office. When children are being followed by specialist(s), the primary care clinician and specialist(s) need to develop a coordinated follow-up plan in collaboration with the family (see "Strategies for Preparing a Primary Care Practice"[5]).

B12: Is Concern Persisting?

Neither designation as a child or youth with special health care needs nor the identification or diagnosis of a mental health concern or condition is necessarily permanent. Children and families can and do recover. To assess the child's current status, the primary

care clinician needs to gather and review progress reports from other professionals involved in the child's care; for school-aged children, review functional assessment scales completed by the parent, teacher, and youth; and perform his or her own clinical assessment. When pharmacologic agents are part of the treatment plan, clinicians may also need to obtain laboratory tests to monitor levels and/or adverse effects. At each contact, the clinician also needs to consider the routine health supervision requirements of the child and monitoring of comorbid medical conditions.

Yes

If a concern persists, the primary care clinician should periodically reconvene a conference with the family (and youth) to determine if further assessment and/or a change of plan is indicated.

No

If the child and family show no signs that the concern is persisting, the clinician can move to step B13.

B13: Return to Routine Health Supervision and Monitor for Further Issues

If and when a concern is resolved, children and youth can be returned to the process of care described in Algorithm A.

CONCLUSIONS

To enhance mental health practice, the task force recommends that primary care clinicians begin by addressing systemic issues such as payment and access to mental health specialty resources, achieving competence in core mental health skills, and preparing office systems that integrate mental health services and apply chronic care methods to children with mental health problems. The task force then

proposes a clinical process, described in this report, for promoting the social-emotional health of all children and for addressing mental health concerns in primary care settings. Two algorithms describe this process, with text linking the reader to additional resources and references. The process is aimed at communicating the importance of mental health care to children and families, assisting parents in promoting their children's social-emotional health, increasing the likelihood that concerns will be identified promptly and managed effectively, and enhancing children's opportunity to recover from mental health problems.

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