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Childhood and adolescence are potentially stressful times due to academic expectations (e.g., increasing demands), social changes (e.g., peer pressure, bullying, social media), and developmental changes [1-3]. As such, it is not surprising that approximately 13% to 20% of children [4] and 20% of adolescents experience a diagnosable mental health disorder each year [5]. According to the Centers for Disease Control and Prevention [6], the most commonly diagnosed mental health disorders in US children include ADHD, behavioral disorders, and mood disorders (e.g., anxiety, depression). More specifically, approximately 6.1 million U.S. children between the ages of 2 to 17 have received a diagnosis of ADHD, whereas roughly 4.5 million of US children ages 3 to 17 have a diagnosed behavioral disorder. In terms of mood disorders, nearly 4.4 million U.S. children ages 3 to 17 have a diagnosis of anxiety, while roughly 1.9 million children in the same age group have a diagnosis of depression [7]. It is important to note that comorbidity is common; roughly one in three children with anxiety have a comorbid behavioral disorder or depression [7]. In addition, one in three children with a behavioral disorder also experience anxiety, while one in five experience comorbid depression [7]. Unfortunately, these symptoms are often exacerbated by toxic home environments, creating increased stress for the child or adolescent as well as for other family members.

Fortunately, early, accurate diagnosis, and subsequent

Review Article

Behavioral health in pediatric practice: The wheatfield pediatrics model

Abstract

Approximately 20% of children and adolescents experience a diagnosable mental health disorder each year. According to the Centers for Disease Control and Prevention, the most commonly diagnosed mental health disorders in US children include ADHD, behavioral disorders, and mood disorders (e.g., anxiety, depression). Given the personal, familial, social, and academic implications of these issues, many parents may seek to manage these challenges by medicating their child and thus seek guidance and consultation from the child's pediatrician about the possibility of beginning some form of psychotropic treatment. The need for adequate behavioral health resources for pediatric providers is further apparent by the early onset (e.g., prior to age 24) of most mental health disorders, along with the fact that nearly seventy-five percent of children diagnosed with mental health conditions are seen in primary care settings. This article describes an integrated behavioral health model being used in pediatric primary care at Wheatfield Pediatrics (i.e., the Wheatfield Pediatrics Model [WPM]) located in North Tonawanda, NY. Key features about the behavioral health provider role and responsibilities and workflow are discussed along with implementation obstacles.

treatment results in improved quality of life for children and their families [8]. Interestingly, much of this responsibility falls to primary care providers and yet, only 34% of families would classify their child's pediatrician as "knowledgeable" about mental illness [9]. This finding is particularly troubling since the pediatrician's office is typically the first line of defense for concerned parents who do not understand how to handle their child's emotional or behavioral concerns. Moreover, many parents seek to manage these challenges by medicating their child and thus seek guidance and consultation about the possibility of beginning some form of psychotropic treatment. These concerns are not merely academic exercises but are reflected in the number of children who go undiagnosed or improperly treated due to unavailable screening tools and poor education in the mental health area among pediatric providers. The need for adequate resources for these health providers is further apparent by the early onset of most mental health disorders (e.g., prior to age 24), along with the fact that nearly seventy-five percent of children diagnosed with mental health conditions are seen in primary care settings [9]. As such, the purpose of this paper is to describe an integrated behavioral health model being used in pediatric primary care at Wheatfield Pediatrics located in North Tonawanda, NY (i.e., the Wheatfield Pediatrics Model [WPM]). Key features about the behavioral health provider role and responsibilities and workflow will be discussed.

Behavioral health provider role

Given children's unique mental health needs, coupled



with the often complex and complicated nature of families, it is important that the individual selected for this position has training and experience in working with children and families; thus, it is our belief that this role should be filled by a licensed marriage and family therapist or doctoral level psychologist. Although others have asserted that the behavioral health care provider role could be filled by licensed mental health counselors or social workers and view these disciplines interchangeably, it is our contention that these disciplines do not receive the breadth of training in family systems and clinical focus in working with children and families which is essential for this position.

The integrated behavioral health program at Wheatfield Pediatrics is considered a triage service; clients are typically seen by the behavioral health provider for a limited number of sessions (4-6) and then referred into the community for more intensive therapy or additional services as needed. The role of the behavioral health provider fits within the overall mission of the practice which is to support the whole-person care for children and families by addressing medical, mental, and social health needs. He or she may also serve a consultation role in which families are linked with resources and services as needed; thus, the behavioral health provider works closely with the pediatric primary care provider to identify appropriate services and community resources.

Given the importance of assessment and screening along with the brief therapy approach utilized, the behavioral health provider engages in routine outcome monitoring with children and families through the use of Feedback Informed Treatment (FIT). FIT is a Continuous Quality Improvement (CQI) strategy in which therapists regularly monitor and use data on the therapeutic process (e.g., strength of alliance) and outcome (e.g., early change) to inform clinical practice and to ensure families feel connected to the therapist [10]. Given that one of the best predictors of successful outcome is the client's perception of the relationship by the end of the second session, alliance data allow the therapist to identify relationship ruptures early on and to modify treatment to better meet the family's needs. In addition, from this vantage point, children and families are perceived as partners in the change process, as they are asked to provide session-by-session feedback using brief, developmentally appropriate measures to ensure they are adequately progressing toward goals (i.e., effectiveness), which additionally fosters a sense of empowerment. Conversely, the focus on soliciting and responding to client feedback allows the therapist to identify the children and families who are not making treatment progress (i.e., outcome) in a timelier manner. Importantly, the data serve as a formal mechanism for discussing how to modify current services when the client is not making progress, based on the client's stated preferences (including whether a referral to another provider) which can provide a seamless transition point to other services if needed. The early identification of clients who are not progressing through client feedback may have implications for retention, especially since treatment dropout rates for children and adolescents range between 28% to 85% [11,12].

Work Flow

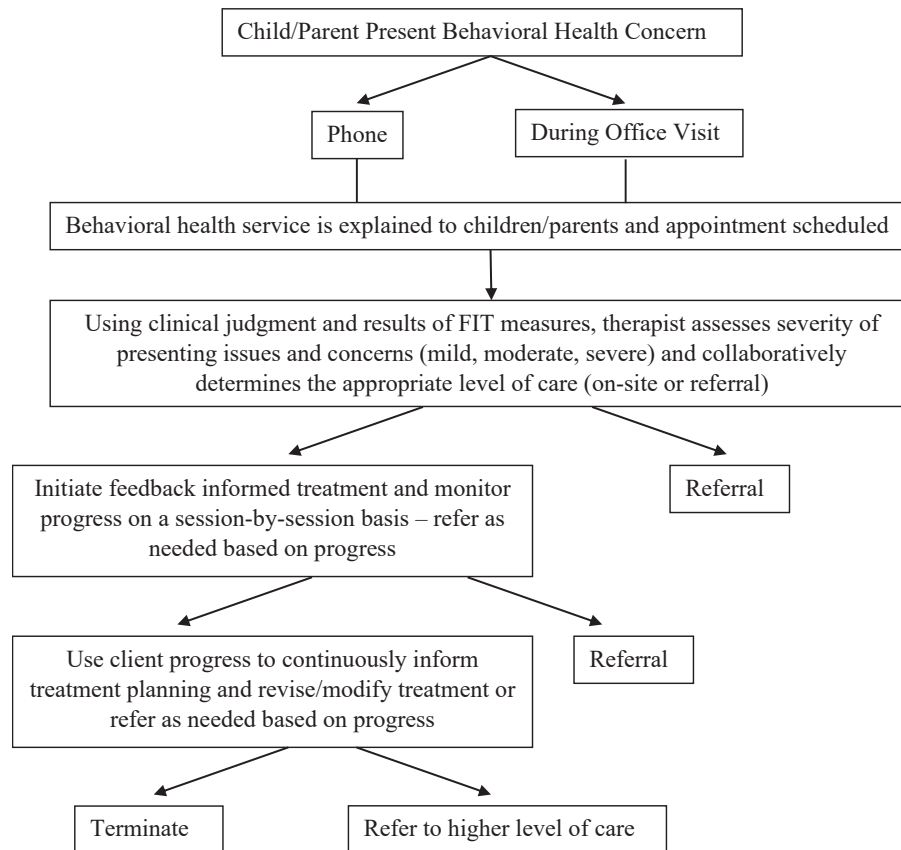
The behavioral health provider in the WPM is an important part of the pediatric care team and works closely with the nurse manager, providers, and front desk staff. Successful implementation efforts require a culture change in which the new treatment is embedded within the organization; thus, all staff must be clear on the rationale behind the new approach [13]. This type of shift is cultivated over time through an iterative process of collecting constructive criticism and incorporating it back into the system to refine and improve practice.

Pediatric Primary Care Providers (PPCP) and the behavioral health provider collaboratively develop individualized plans for meeting the child's and family's needs. The PPCP may initiate the process during office visits by describing the service and inviting the behavioral health provider in for a 'warm hand-off' in which he or she introduces him/herself and describes the behavioral health services offered on site. This process provides an opportunity for the therapist and client to begin forming a relationship, clarify concerns, and answer questions, each of which are all important components of engaging individuals in treatment. The hand-off may also serve as a bridge to counseling services, either within the office or community. Conversely, families who are already aware of the service can call the office to schedule an appointment with the behavioral health provider. Thus, there are two access points for engaging children and families in behavioral health services at the office: 1) provider initiated and 2) family initiated. In an effort to maintain continuity of care, PPCPs are copied on session notes so that they are able to monitor the status of treatment in an ongoing basis and are available for consultation as needed.

In addition to having an embedded behavioral health provider within the practice, Wheatfield Pediatrics also has a co-located community behavioral health provider who is available to see children and families in need of more intensive, frequent, and longer-term services. Thus, families have the opportunity to continue being seen in the office or can also receive a referral for a community provider as needed. Anecdotally, many children and families like the option of continuing to be seen at the office instead of having to go elsewhere, and report that the only reason they continued therapy was because they could still be seen at the practice. The following diagram describes the behavioral health workflow:

Obstacles

It is important to note that there are common obstacles to introducing a new service. One such obstacle is a lack of communication and information sharing among staff about the intervention and implementation progress [14]. Therefore, staff must be aware of the rationale and justification for the introduction of a new service, as well as any associated reverberations for the office and its patients. Another common obstacle is the lack of commitment and involvement from management and administration. Although many administrators/supervisors initially agree to adopting the new treatment, their support and commitment is not always overt. This results in staff not viewing the new service, as well as



The following diagram describes the behavioral health workflow:

any changes in policy and procedures, as important or an office priority; perception matters.

Conclusion

There is a worldwide need for early intervention of clinically diagnosable mental health concerns in children [15]. Previous studies reveal that unaddressed mental health problems among children and adolescents can result in lower educational achievement and poor physical and social outcomes [16,17]. As such, embedding behavioral health providers within pediatric primary care may have important implications for children's social-emotional adjustment and overall family functioning. Moreover, a systematic plan for installation of the new service is critical with careful consideration of the necessary procedural and structural changes necessary to support the new intervention [18]. We've described a comprehensive system for coordinated care and service linkages (WPM), a central tenant of patient-centered medical homes, which communicates and operates efficiently and effectively with minimal resources.

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