PREVENTIVE PEDIATRIC MENTAL HEALTH CARE: A CO-LOCATION MODEL

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ABSTRACT: Current practice recommendations in both the fields of infant mental health and pediatrics support the co-location of mental health professionals into the pediatric setting. Multiple policy reports and statements of the past 5 years have repeatedly argued the need for coordination and integration between mental health care and pediatrics (Halfon, Regalado, McLearn, Kuo, & Wright, 2003; Osofsky, 2004). The pediatric office is recognized as a universally accessed, nonstigmatized setting, ideal for the assessment and treatment of early childhood mental health problems. However, barriers to this type of care are rampant, including time limitations on the part of pediatricians, inadequate reimbursement structures, inadequate training of pediatricians, and insufficient connections between medical and mental health providers. An innovative response to these barriers is the co-location of a mental health professional in the pediatric practice to provide pediatrician education and appropriate screening, assessment, referral, and treatment of young patients. This article describes a successful program of this type situated in the Bronx, NY, where a psychologist with expertise in infant mental health spends 25 hours per week in a large pediatric practice to address the developmental and mental health needs of children aged 0–3 years old. Preliminary descriptive data regarding the patient population, screening scores, and disposition are presented.

RESUMEN: Las recomendaciones de la práctica actual, tanto en el campo de la salud mental infantil como en la pediatría, apoyan la co-locación de los profesionales de la salud mental en un ambiente de pediatría. Múltiples reportes y documentos de políticas en estos asuntos, en los últimos cinco años, han expresado repetidamente la necesidad de coordinación e integración entre el cuidado de la salud mental y la pediatría (Halfon, Regalado, McLearn, Kuo, y Wright, 2003; Osofsky, 2004). Se reconoce a la oficina pediátrica como un ambiente de acceso universal, sin estigmas, ideal para la evaluación y tratamiento de los problemas de salud mental en la temprana niñez. Sin embargo, las barreras a este tipo de cuidado son más cada vez, incluyendo las limitaciones de tiempo de los pediatras, las inadecuadas estructuras de reembolso, el inadecuado entrenamiento de los pediatras y las insuficientes conexiones entre los que prestan cuidados médicos y aquellos que prestan el cuidado de salud mental. Una respuesta innovadora a estas barreras es la co-locación de un profesional de la salud mental en la práctica pediátrica, con el fin de proveer educación pediátrica y una apropiada selección, evaluación, referencia, y tratamiento de los pacientes jóvenes. Este artículo describe un exitoso programa de este
Infant Mental Health Journal DOI 10.1002/imhj. Published on behalf of the Michigan Association for Infant Mental Health.

tipo, situado en el Bronx, Nueva York, donde un sicólogo con experiencia en salud mental infantil pasa 25 horas por semana en una práctica pediátrica grande, con el fin de dedicarse a las necesidades de salud mental y de desarrollo de los niños de edad entre recién nacidos y tres años. Se presenta información descriptiva preliminar con respecto a los pacientes, los puntajes de selección, y la disposición.

RÉSUMÉ: Résumé: Les recommandations actuelles de pratique à la fois dans les domaines de la santé mentale du nourrisson et de la pédiatrie soutiennent l’intégration de professionnels en santé mentale dans le contexte pédiatrique. Ces cinq dernières années, de nombreux rapports et dépositions ont soutenu avec insistance le besoin de coordination et d’intégration entre le soin en matière de santé mentale et la pédiatrie (Halfon, Regalado, McLearn, Kuo, and Wright, 2003; Osofsky, 2004). Le cabinet de pédiatrie est perçu par tous comme un contexte à l’accès universel, non-stigmatisé et idéal pour l’évaluation et le traitement de problèmes de santé mentale de la petite enfance. Cependant, les obstacles à ce type de soin sont endémiques, comprenant une formation insuffisante des pédiatres et des liens insuffisants entre les modes de soin médical et ceux en santé mentale. Un palliatif innovateur à ces obstacles est l’intégration d’un professionnel de santé mentale dans le cabinet de pédiatrie, afin d’offrir une éducation pédiatrique et les tests de dépistage appropriés, des évaluations, des recommandations de consultation, et des traitements aux jeunes patients. Cet article décrit la réussite d’un programme de ce type dans le Bronx à New York, où un psychologue expert en santé mentale de la petite enfance passe 25 heures par semaine dans un grand cabinet de pédiatrie afin de s’occuper des besoins en matière de développement et de santé mentale d’enfants de la naissance à l’âge de trois ans. Des données descriptives préliminaires concernant les patients, les scores aux tests de dépistage et la disposition sont présentées.

The significance of infant mental health is increasingly well established within the scientific and mental health communities. The research community has successfully documented the importance of prevention and early intervention in the developmental and social emotional well being of very young children. However, as noted by the National Scientific Council on the Developing Child (2005), despite the accumulation of evidence, a startling gap continues to persist between science and policy, such that programs to address very young children’s emotional and behavioral needs have been the exception rather than the rule. For example, current practice recommendations in the fields of both infant mental health and pediatrics support the co-location of mental health professionals into the pediatric setting, as multiple policy reports and statements of the past 5 years have repeatedly argued the need for coordination and integration between mental health care and pediatrics (Halfon, Regalado, McLearn, Kuo, & Wright, 2003; Osofsky, 2004). The pediatric office is recognized as a universally accessed, non-stigmatized setting, ideal for the assessment and treatment of early childhood mental health problems. However, barriers to this type of care are considerable, including time limitations on the part of pediatricians, inadequate reimbursement structures,
inadequate training of pediatricians, and insufficient connections between physical and mental health providers. Therefore, successful programs integrating the two fields are rare, especially for those that serve the youngest patients.

THE LOCAL CHALLENGE

New York City also suffers from a lack of comprehensive programs to address the mental health needs of its youngest citizens, and has recently undertaken to acknowledge previous shortcomings and better address specific needs. A 2004 report by the New York City Early Childhood Mental Health Strategic Work Group ("Work Group") comprised of practitioners from multiple disciplines and systems that serve young children, an advisory group to the New York City Department of Health and Mental Hygiene, described a critical lack of capacity to address early childhood mental health needs. The report detailed the unique mental health needs of young children and the lack of a publicly supported system of services for children in this age group. The authors concluded by outlining gaps and opportunities for the provision of infant mental health services and supports across other child serving systems.

Individual clinicians, many of whom were members of the Work Group, provided testimony to the New York City Council during several hearings. In response, the New York City Council allocated $1.2 million in FY 2004–2005, which was distributed across four organizations, including two domestic violence agencies in Manhattan, a school for developmentally disabled young children in Brooklyn, and a provider of early childhood mental health and developmental services in the Bronx: The Early Childhood Center (ECC) of the Albert Einstein College of Medicine.1

ECC developed five programs to extend mental health services and supports to very young children. The five programs include (1) an adult psychiatry program to address the mental health needs of caregivers; (2) a preschool consultation project designed to develop more socially and emotionally responsive classroom environments and reduce preschool expulsion rates; (3) a therapeutic visiting program for young children in foster care; (4) a family court consultation project to assist court personnel in making appropriate decisions for young children in care; and (5) a preventive pediatric mental health care program.

RESPONSE

The remainder of this article will discuss in detail the preventive pediatric mental health care program, consisting of the co-location of a bilingual ECC psychologist with expertise in early childhood mental health at the Comprehensive Family Care Center (CFCC), a Federally Qualified Community Health Center affiliated with Montefiore Medical Center in the Bronx. The program consists of provider education, infant and toddler screening, and linkages for referral and treatment. Issues related to reimbursement will also be discussed, and preliminary descriptive data will be presented.

CFCC was founded in 1967 under the auspices of the Albert Einstein College of Medicine and is the training site for 30 pediatric residents from the Department of Pediatrics of the

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1Of note, since FY2004–2005, New York City Council funding has continued, and the New York City Department of Health and Mental Hygiene awarded a grant for a model demonstration program of screening and referral for young children.

Infant Mental Health Journal DOI 10.1002/imhj. Published on behalf of the Michigan Association for Infant Mental Health.
Albert Einstein College of Medicine/Children’s Hospital at Montefiore. Approximately one-half of patients seen at CFCC are Hispanic, 31% are African-American, 4% are Caucasian, and the rest are a combination of Asian, African, and Eastern European immigrants. More than two-thirds of the patients served by CFCC are receiving Medicaid or are enrolled in Medicaid managed care plans, and 12% of the patients are uninsured. In 2004 CFCC provided for more than 75,000 patient visits, of which approximately 21,000 were pediatric visits. There are approximately 5000 children ages 0–18 years who received some form of care at CFCC, and approximately 3000 of these were children between the ages of birth and three years.

The pediatric setting is an important location within which to address early childhood mental health. It is a universally accessed (especially with the advent of the State Child Health Insurance Program to expand insurance coverage for young children) and relatively non-stigmatizing venue. National reports suggest that more than 95% of very young children have a regular source of health care (Newacheck, Hung, Hochstein, & Halfon, 2002). Pediatric providers are often the only professionals to routinely see very young children. They are present from the first days of life, and ideally create a trusting and long-term relationship with children and their families. However, likely due to this unique opportunity, pediatricians are called upon to address an overwhelming variety of issues within increasingly time-limited well child visits. At CFCC, routine well child visits are 15 minutes in length, wherein pediatricians are expected to conduct the physical exam, deliver anticipatory guidance, conduct developmental surveillance, teach age appropriate injury and safety prevention techniques, determine correct immunization schedules, advocate and coordinate with school systems, complete needed forms, manage behavioral issues, and recognize and address issues of parental substance abuse, domestic violence, and mental health disorders (American Academy of Pediatrics [AAP], 2003; Belamarich, Gandica, Stein, & Racine, 2006). Pediatricians repeatedly report that 15 minutes is simply not enough time to adequately address these areas, and all too often the psychosocial areas fall by the wayside.

Two recent surveys further detail the extent of this problem. The Commonwealth Fund’s nationally representative Survey of Parents with Young Children (Taaffe Young, Davis, & Schoen, 1996) revealed that parents are eager for more information on issues of normal growth and development, such as discipline, toileting, sleeping, and crying. While parents were satisfied with pediatricians’ attention to medical concerns, they were less satisfied with attention to developmental and behavioral concerns. Only a little more than half of the 2000 parents interviewed felt satisfied with their pediatrician’s guidance on these matters. In an American Academy of Pediatrics survey, only 29% of pediatricians reported spending time discussing parental substance abuse and/or emotional support for parents (Halfon et al., 2001).

While some have suggested that pediatricians should themselves directly address these areas within their visit (cf. Gorski, 2001), others have sought more creative and perhaps more realistic ways to integrate already extant mental health services into the primary care setting. The Task Force on the Future of Pediatric Education II (2000) suggests that pediatric residents must receive instruction in developmental and behavioral pediatrics, with emphases on communication and counseling skills, knowledge of child development, and effective surveillance skills. Zero to Three, the national organization dedicated to the healthy development and well being of infants, toddlers, and their families, suggests that “physicians, time-pressured to provide both medical care and anticipatory guidance, would be best supported if they had ready access to screening tools, (including those that could be completed by parents), practical
information about referral information, and financing strategies” in their attempts to address the social emotional well being of young children (Ososfky, 2004). Thus, we may conceptualize the challenge of effective integration of infant mental health and pediatric care as consisting of four parts: the need for education of pediatric providers regarding early childhood development and mental health, comprehensive provision of adequate screening tools, linkages with community providers for referrals and treatment, and sufficient financial reimbursement.

Before describing the specific ways in which this challenge was addressed, it may be helpful to outline more specifically the job description of the psychologist implementing these services via the co-location model. The psychologist is a doctoral level, fully licensed, bilingual (Spanish and English) provider. She has extensive experience in early childhood mental health and was very familiar with the resources available in the community. Importantly, her title at this clinic is Infant Toddler Specialist (ITS), rather than Psychologist, to underscore the specific expertise and avoid the stigma attached to mental health labels.

The ITS spends 25 hours per week in the clinic, spread over 4 days. Because of the patient flow in this particular clinic, it is especially helpful to be present in the afternoon, when most of the patients are seen, and when the residents complete their continuity clinic. The psychologist’s office (a part-time nursing station, as well) is located immediately adjacent to the consult room, where residents present their cases to attending pediatricians. This is especially important, as providers constantly remark that the ease of walking out of one door and immediately into another increases the likelihood that they seek her services. If the ITS is unavailable, referral forms are located at the main nursing station and can be placed in her mailbox adjacent to the nursing station. Feedback to providers is delivered either in person, via confidential email, or as part of the medical chart. Each patient contact is documented in the medical chart, on specially colored progress notes to enhance quick identification of families known to the ITS.

It is critical to the program model that the ITS is also employed by the Early Childhood Center, part of a much larger developmental evaluation and treatment clinic. When referrals outside of the program are necessary, this linkage is very important to the success of these referrals. More information about this particular aspect of the program is detailed in the “Linkages” section of this paper.

Education

The current program at CFCC seeks to educate pediatric providers about infant mental health and development, with a particular focus on topics relevant to pediatric visits. At the beginning of the program (March 2005), the ITS delivered education via daily clinic conferences to attending physicians and pediatric residents. The foci of this education included attachment theory, infant brain development within a relationship context, and postpartum depression and other “red flags” warranting referral. The education of physicians and pediatric residents since that time is ongoing and delivered in a consultative manner. For example, it was determined that the practice could benefit from increased education regarding the recognition of early onset language delays, and a week-long clinic conference was designed to equip providers with the latest referral recommendations regarding early onset language delays and logistical information about how to make these types of referrals in our community. Additionally, pediatric providers receive ongoing case consultation via collaboration with the ITS.

Infant Mental Health Journal DOI 10.1002/imhj. Published on behalf of the Michigan Association for Infant Mental Health.
During the summer of 2005, the director of 4th-year medical student education, who is also an attending pediatrician at CFCC, contacted the ITS regarding integrating infant mental health into the 4th-year ambulatory pediatrics rotation. As a result, 4th-year medical students rotating through CFCC spend four sessions with the ITS and complete a curriculum consisting of foundations of the infant mental health field (including policy, program design, and science), infant and toddler development, and clinical application within at-risk populations. These students read and review a selection of seminal articles in the above areas, accompany the ITS on pediatric clinic consultations, and present a case seen during the rotation to their peers during the final session. The end result is a cadre of trained professionals who can recognize a host of early warning signs related to infants’ and toddlers’ development and social emotional well being.

Informal surveys of both medical students and providers revealed important trends. Medical students were each evaluated after spending two group sessions (consisting of didactic lectures and student case presentations) and two individual sessions (seeing patients) with the ITS. The ITS evaluated the medical students in terms of their ability to effectively present cases with emphasis on the issues related to early childhood mental health, their ability to bridge potential barriers of race, social class, etc., and their ability to integrate readings into clinical judgment assessments. The vast majority of the students were judged “satisfactory” to “outstanding” in these areas, and these written evaluations were then included in each medical student’s grade for that rotation. One hundred percent of the students reported being satisfied (24%) or highly satisfied (76%) with the ITS experience.

Residents and attending pediatricians completed a questionnaire designed by the ITS (with assistance from a graduate intern in Public Health) to assess 4 areas related to early childhood mental health. Attitudes and beliefs were assessed by 4 questions, e.g., “How comfortable do you feel addressing parenting skills with parents of toddlers?” Knowledge was assessed by 8 questions, such as “Which of the following can be seen in infants of mothers suffering from postpartum depression?” Behavior and barriers were addressed by 2 questions, such as “What concerns do you have addressing these types of issues with your patients?” Finally, providers responded to 3 situational examples, noting their chosen disposition, and their comfort level dealing with issues of this sort, e.g., “A new foster mother reports that a 36-month-old who has been in her home for 2 days calls her ‘Mommy’ and frequently talks to strangers.”

Results of this survey were promising. More than 50% (21 of 40) of pediatricians completed the survey (10 of 20 residents, 4 of 10 interns, and 7 of 10 attending pediatricians). Attending pediatricians averaged 15.7 years of experience, residents 2.2, and interns 1. Ten of the respondents had children of their own. All respondents received educational services from the ITS in the manner detailed above. While only 29% of national pediatricians reported spending time discussing parental substance abuse and/or emotional support with parents of their pediatric patients, 55% of these respondents reported doing so (behavior). Even more impressive, 76% of CFCC providers reported addressing early childhood mental health issues with their families (behavior). Providers were assessed regarding their knowledge of specific speech and language milestones between the ages of 2 months and 36 months, and they answered 91% of these questions correctly (knowledge). In terms of barriers to addressing early childhood mental health issues during the pediatric visits, the most cited barrier was that to do so would “encroach upon visit time.” Following close behind was the concern that “other aspects of the visit are a higher priority.” While we attempted to administer the same
survey to a comparison group of pediatricians, an insufficient response rate made the analysis difficult, and validation of a tool such as this remains an area to be addressed more comprehensively in the future.

**Screening**

High quality screening and related prevention of early childhood mental health problems are foremost goals in the integration of infant mental health and pediatric care, outlined in such diverse publications as *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Shonkoff & Phillips, 2000), President Bush’s New Freedom Commission on Mental Health (2003) and the *Handbook of Infant, Toddler, and Preschool Mental Health Assessment* (DelCarmen-Wiggins & Carter, 2004). Recent recommendations from the Commonwealth Fund (Halfon, Regalado, McLearn, Kuo, & Wright, 2003) call for the inclusion of validated assessments, rather than informal clinical assessments by pediatricians, into a routine surveillance strategy. An important distinction is made between screening (one time) and monitoring (ongoing), and best practice suggests that a monitoring system is most effective to address longitudinal changes and age appropriate/specific social emotional development. The American Academy of Pediatrics, Council on Children with Disabilities (2006) presented an algorithm for developmental surveillance and screening (Policy Statement) recommending that standardized developmental screening tests be administered to all children, regardless of risk factors, at the 9-, 18-, and 30-month visits.

The Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) (Squires, Bricker, & Twombly, 2002) is a widely used and proven effective standardized screening/monitoring tool (Halfon et al., 2003). It is a parent-completed system, with questionnaires designed to coincide with well child visits beginning at the 6-month visit. Questionnaires are available in English and Spanish (the two dominant languages spoken by patients at CFCC) and each age range has its own empirically derived clinical cutoff score, at or above which children should be assessed further (based on answers provided by the parents, each questionnaire is scored to derive a total score). In addition, there are more open-ended questions where parents are asked to share any concerns not already addressed.

At CFCC, the nursing staff has been instrumental in the provision of questionnaires. Upon learning that a child is at the clinic for a 6-, 12-, 18-, 24-, 30-, or 36-month well child visit (to avoid duplication, questionnaires are only furnished during well child visits and not at sick visits or follow-up appointments), parents are provided with the age appropriate questionnaire. Each questionnaire is introduced by a cover letter stating the purpose of the screening, and signed by the ITS with relevant contact information. Pediatricians have been taught how to interpret and score the ASQ:SE, and they are asked to do so during the visit. If this is not possible, the completed questionnaire is delivered directly to the ITS’s mailbox. It remains a challenge to ensure that the questionnaire is consistently provided by the nursing staff, completed by the parents, returned to the provider, and reviewed by the provider before passing it along to the ITS. Putting systems in place to enhance this chain of events remains a priority.

After 6 months in operation, 584 infants and toddlers were screened during well child visits. Seventeen percent of these children received a score at or above the clinical cutoff. Table 1 presents the percentage of clinical scores by age.

Population is 46% Latino, 32% African-American, 8% Asian, 4% Multiracial, 2% Cau-
casian, and 8% Other. Seventy-four percent of children screened in this first cohort received some form of government-sponsored insurance or were uninsured, and the population was almost equally divided between males and females (51% female, 49% male). In this sense, these children were an accurate representation of the pediatric clinic at large. The trend of clinical screening scores provides further evidence for the cumulative and additive effects of risk, and the need for early identification and intervention. The authors of the ASQ:SE do not present national data for percentage of clinical scores in the general population (J. Squires, personal communication, January 24, 2007), but do report that the percentage of clinical scores ranged from 5% to 30%, primarily based on socioeconomic status.

When CFCC children receive a clinical score, follow-up may take a number of forms. Consultation with the provider is a necessary and primary aspect of follow-up, after which a continuum of options is presented to best meet the needs of the family. The ITS can meet with the family in the pediatric clinic, as part of the well child visit, and then again as needed as a separate visit. These visits include more comprehensive assessment, including the use of standardized assessment tools if necessary, parent education and guidance, and short-term infant parent psychotherapy. The ITS also answers a child development telephone information line and messages are retrieved and answered daily. Additionally, the ITS is the practice point person for many of the referrals to other educational services, such as Early Intervention. Finally, the ITS also completes home visits when necessary.

Follow-up is often immediate, unless the ITS is with another patient or otherwise unavailable, and this is a very important aspect of the program’s success. Others have noted that the mental health professional co-located in the pediatric practice “borrows” from the trust already established in the parents’ secure attachment to the pediatric provider (Risholm Mothander, 1998). As previously noted, the ability to introduce the ITS as simply another member of the pediatric practice, with a specialty in early childhood development, greatly reduces the stigma associated with seeing a mental health professional. It also provides for a very important seamless transition, often tantamount to the successful provision of early childhood mental health services. One study reported that only 41% of children referred from a pediatric provider to an outside mental health specialist actually presented for the initial intake (U.S. Public Health Service, 2000). This model attempts to ensure that children are seen by the mental health professional as part of the well child visit, sending a strong message to families and pediatricians alike that mental health is an important component of overall well being.

### TABLE 1. Percentage of Clinical ASQ:SE Scores by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>6 months</th>
<th>12 months</th>
<th>18 months</th>
<th>24 months</th>
<th>30 months</th>
<th>36 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>97</td>
<td>106</td>
<td>84</td>
<td>116</td>
<td>61</td>
<td>120</td>
</tr>
<tr>
<td>% of children w/ clinical score</td>
<td>5%</td>
<td>9%</td>
<td>11%</td>
<td>23%</td>
<td>31%</td>
<td>26%</td>
</tr>
</tbody>
</table>

*Note: N=total number of children screened in that age range.*
Linkages

Many practices that use a screening/monitoring program face a major hurdle when attempting to provide appropriate follow-up care based on screener results. A recent publication by the Commonwealth Fund (Fine & Mayer, 2006) outlines these barriers as follows: practice-based barriers (time constraints, organizational constraints); service provider partnership barriers (communication and feedback issues, difficulty communicating across disciplines); and community systems barriers (primarily funding). This program, however, is especially effective due to the fact that the ITS divides her professional time between the pediatric practice and the Early Childhood Center, a unit of a larger developmental disabilities clinic that also provides mental health services. In this way, there is a seamless linkage with providers for treatment. Indeed, when possible, the ITS is the treating therapist, either within a short-term capacity at the pediatric practice, or when needed, a longer-term capacity at ECC. As ECC is part of a larger university affiliated center for the treatment of developmental and learning disabilities (Children’s Evaluation and Rehabilitation Center, or “CERC”), appropriate referrals can also be made to address these areas. As an illustration of the success of this model, rates of “successful referral” were compared between children referred for a developmental evaluation at CERC by the ITS, and children referred by any other outside source. “Successful referral” was defined as a child presenting at CERC for the initial evaluation. One hundred percent of patients \(N=29\) referred by the ITS from CFCC were a successful referral, compared to only 68% of a randomly selected equivalent control group referred by outside sources.

Of the 584 infants and toddlers screened from April 2005 to November 2005, ranges of clinically significant scores on the ASQ:SE rise from a low of 5% of the population at 6 months to 31% of the population at 30 months. In addition, many children’s caregivers or pediatric providers noted qualitative concerns on the questionnaire or in person, and these children were also considered to be at risk. As a result, over 200 children received some form of follow-up care or contact related to their social emotional development. Of these, 35% received intervention from the psychologist (this intervention ranged from one time consultations in the pediatric clinic to more intensive therapy delivered in a clinic or home setting); 26% were assessed via consultation with a provider or discussion with a caregiver, determined to be functioning within expected guidelines, but in need of continued monitoring; 23% were referred to another service (e.g., Early Intervention, the Committee on Preschool Special Education, lactation consultants, Early Head Start, the Early Childhood Center, etc.); and the remaining 16% declined any follow-up or did not respond to the offer of such follow-up. All data presented here are preliminary data meant to describe the population in question. Future analyses will examine child outcomes, measured via longitudinal screener scores, based on type of follow-up, presenting child (and, if applicable, parent) problem, socioeconomic status, race, and gender.

Reimbursement

The current program is funded by the City Council of New York City, through their initiative to better respond to the mental health needs of the youngest New Yorkers. While this was the first publicly funded program for infant and early childhood mental health in New York City, the year-to-year efforts necessary to be refunded are a challenge to program stability. Found-
dation support is currently being considered, as is the attempt to make the program self-sufficient through fee for service reimbursement. For example, the AAP policy statement (2006) presents a helpful table of Current Procedural Terminology codes for developmental screening, yet state by state policies regarding Medicaid and managed care often inhibit the ability to “unbundle” screening from other well child activities, and therefore make it difficult to receive additional reimbursement. The New Freedom Commission on Mental Health (2003), noting that expanded screening and collaborative care models could save lives, has called on the federal government to provide reimbursement for core components of such care, including screening, consultation, and home visits, and to abandon the need for a psychiatric diagnosis for reimbursement. At present, the area of reimbursement remains the most formidable obstacle to the widespread dissemination of programs such as this.

Case Vignettes

Tamika and Elijah. Tamika,2 aged 22, gave birth to a healthy boy named Elijah and presented for the first pediatric visit one week after his birth. During this first visit Tamika told Dr. Williams (Elijah’s pediatrician) that she had been hospitalized in a psychiatric setting ten times before becoming pregnant. The majority of these hospitalizations were in response to suicide attempts and many resulted in heavy doses of psychotropic medication. Tamika had received some therapy as a result, but was very distraught that her therapist was set to transfer to another town and would not be able to continue seeing her. Tamika reported very little social support, and acknowledged that her own mother suggested she was incapable of caring for an infant and would likely “kill the baby before he can have his first birthday.” While Elijah was a well appearing young baby with no complications, Dr. Williams remembered two of the red flags presented by the infant toddler psychologist—maternal depression and paucity of social support—and she referred the dyad for further assessment when Elijah was 6 days old.

Assessment was conducted by the ITS via home visits, as Tamika was obese and found it difficult to travel with the baby. Additionally, home visits were a natural environment in which to observe the interaction between the dyad and help to ensure a safe and appropriate caregiving environment. During the first home visit, which occurred when Elijah was 2 weeks old, Tamika was generally appropriate and attentive to his needs. However, she made multiple negative attributions regarding his behavior. For example, she said he was very “mean” at times, often “demanding,” and would become “truly angry” with her if she didn’t know what he wanted. She also reported thankfulness that Elijah was born a male, so that she didn’t need to protect him from sexual abuse (at this time she also disclosed her own history of being sexually abused from age 3 until age 7 by a male relative). Finally, she reported that Elijah “hates men,” even his own father, who visited occasionally. Others have noted the immense staying power of negative maternal attributions in the first year of life (Lieberman, 2000), and Elijah was already at risk for internalizing his own mother’s perspective of him as mean, demanding, and hateful toward men, at 2 weeks of age.

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2Names have been changed to protect identities.
Additional goals of the first visit were to assess Tamika’s social support network, evaluate her current mental state, ensure appropriate physical care of Elijah, and help her learn to operate the breast pump.

Home visits continued on a biweekly basis. Tamika generally presented well, although she would often offer glimpses into a frightening inner world. For example, she dreamt almost nightly that Elijah would die of SIDS, she often reported feeling aroused by breastfeeding, and she “wondered” whether or not she was arousing Elijah while cleaning his genital area. She was also insightful about the immense responsibility associated with being a primary caretaker for an infant, but worried constantly that she was going to “mess it up” and called the ITS almost daily. Lifelong messages of failure were threatening to take over from Tamika’s own desire to “do this right.”

At this point it was determined, through extensive reflective supervision with the senior clinician at ECC, that biweekly home visits were not sufficient to address the needs of this dyad. With Tamika’s input, the decision was made to refer them to ECC, and place them in a twice-weekly center based infant parent psychotherapy group. Additionally, she would receive an individual therapist as part of this group, and therefore would be seen 3 times per week. Around the time of this referral, the infant toddler psychologist also noted that Elijah was hypertonic in his upper right extremities, and he was referred to an occupational therapist for evaluation. Currently, Elijah and Tamika receive twice-weekly infant parent psychotherapy, and Elijah receives once-weekly physical and occupational therapy to address his right side hypertonicity.

Even in the most at-risk families, with previous histories of neglect or abuse, each new baby appears to present a brief opportunity to “do it right this time around.” There is often a sense of hopefulness, rather than the hopelessness which sets in all too soon in our most stressed and underprepared families. If we, as mental health professionals, can collaborate with pediatric providers to identify families still in those early days of hope, and can then effectively join with families to provide the supports necessary to keep that hope alive, we may have some hope ourselves at finally breaking cycles of maltreatment.

Cher, Kevin, and Dahlia. Cher had been bringing her son Kevin (age 2.5) and her daughter Dahlia (age 6) to CFCC since they were born. She was at the clinic for the children’s well child checkups, and filled out a 30-month ASQ:SE for Kevin. His score was under the clinical cutoff, with just a few positive endorsements of behaviors such as tantrums and defiance. However, Cher responded to the open-ended question of “Is there anything that worries you about your child” with the following: Since his father was killed 3 months ago, his tantrums have gotten worse. Is this normal? The pediatrician brought this to the ITS and reported that Cher had not mentioned her husband’s murder until the very end of the visit.

The ITS met with Cher and her children after the well child visits were completed. Cher reported that, although her husband was murdered 3 months prior, neither she nor her children had been offered any mental health services. Although there was a full legal investigation underway, the mental health needs of this traumatized family had been completely neglected. As concerning as this was, it was of even greater concern that both children had likely observed the murder. Shortly after loading the children in the car with their aunt one morning, their father walked down the sidewalk. As he rounded the corner, he was shot and killed. Immediate chaos ensued, and the children were gradually taken inside. As Cher admitted, “I have no idea how much they saw.”

Worrisome behaviors, indicative of Post Traumatic Stress Disorder symptomology, were
evident in all three. Kevin experienced nightmares, constantly cried out for his father, and engaged in aggressive behavior and tantrums. Dahlia avoided the corner where the murder occurred, and told her mother and other family members that they needed to stop crying. Cher was in a self-admitted state of denial and continued to attend graduate school and care for her two small children on her own. She reported avoiding thinking about her husband and trying to “move on” as if the trauma had not occurred.

It was determined that this family would benefit from therapeutic services, and the infant toddler psychologist began to see them on a weekly basis. Additionally, Cher was referred to a counselor at her college who could provide individual therapy (the fact that this counselor was onsite was very important to Cher, and she repeatedly mentioned how thankful she was that she could receive counseling at her school and the children could receive counseling at their doctor’s office). This therapy continues, with a focus on successful grieving related to both children and improved behavior management skills provided to Cher (as her husband was previously the disciplinarian for Kevin).

CLINICAL IMPLICATIONS

The co-location of an infant toddler psychologist into a pediatric practice greatly enhances the ability to provide needed mental health services to a large population of very young children. All providers in the practice receive relevant continuing education, and all children from birth to 3 years of age are screened, thereby succeeding in a true primary prevention design.

Additionally, the ITS is available on an ongoing basis to families, serving as a secure base to which families may return as their children grow. Indeed, many families, made aware of the infant toddler psychologist’s presence by the screening forms (with an introductory letter including contact information) use the psychologist as an ongoing resource as new issues emerge. While one mother called after watching a program on autism and worrying that her young boy was displaying worrisome signs, another called after losing an unborn child to a miscarriage and wondering how to speak with her young son about this loss.

Providers also greatly benefit from the ability to consult with the ITS on a daily basis. Their own ability to notice and appropriately refer those in need of services has increased dramatically since the beginning of the program. Parents notice this change and remark that they are finally receiving helpful answers instead of being told, “Well, two-year-olds tantrum. This is normal behavior at this age.” Providers are seen as increasingly responsive to their patients’ needs, and the medical home is truly becoming a home in which multiple presenting problems are addressed.

Increased research is needed in multiple areas. Further preliminary analysis of this program will include focus on outcome measures, such as reduction in ASQ:SE scores across time, and comparison of physician referrals to referrals generated from the screening tool. If our pilot data suggests efficacy, we will undertake a more systematic analysis of our program, enrolling subjects through an Internal Review Board (IRB) approved protocol. Assuming that this program is shown to be effective, a randomized control comparison could be undertaken to demonstrate the applicability of this model to other populations and communities. Finally, standardization analysis is needed to generate a useful and reliable survey of physician knowledge of infant mental health.

The single threat to the program’s viability is reimbursement. There are multiple challenges associated with providing mental health services, including screening, within a medical
clinic. This is also the most significant impediment to the ability to recreate this program in other pediatric settings, along with a paucity of sufficiently trained infant mental health psychologists. More attention to both these matters is needed if we seek to improve systems of care for our youngest patients.

REFERENCES


Infant Mental Health Journal DOI 10.1002/imhj. Published on behalf of the Michigan Association for Infant Mental Health.