Bridging the Divide Between Child Psychiatry and Primary Care: The Use of Telephone Consultation Within a Population-Based Collaborative System

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Mental health is a fundamental aspect of the general health and well being of children. As articulated in a recent policy statement published by the American Academy of Pediatrics, “Pediatric primary care providers have unique opportunities and a growing sense of responsibility to prevent and address mental health and substance abuse problems in the medical home.”\textsuperscript{1} Because of shortages in the workforce of child and adolescent psychiatry, and barriers to access for child psychiatry specialty services, pediatric primary care providers (PCPs) (throughout this article pediatric PCPs include both pediatricians and family physicians) find themselves at the “front lines” of the children’s mental health system and spend a significant portion of their time responding to mental health problems.\textsuperscript{2,3} Despite this, pediatricians have identified a lack of adequate training\textsuperscript{4} as well as difficulty with referrals to specialists\textsuperscript{5,6} as barriers to fulfilling this responsibility.

Thomas and Holzer\textsuperscript{7} have reported on the dearth and undesirable distribution of child and adolescent psychiatrists (CAPs) across the United States. It is more difficult to estimate the optimal size of the child and adolescent psychiatrist workforce in light

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of changing patterns of use of child and adolescent psychiatry within systems of mental health care. For example, a workforce of child psychiatrists who routinely provide psychotherapy for their patients (along with as-needed psychopharmacological treatment) would need to be much larger than a workforce of child psychiatrists whose role is exclusively devoted to diagnostic evaluations and psychopharmacological treatment. Although a variety of types of medical specialists may be involved in the care of children with psychiatric illness, it has been persuasively argued that child psychiatrists need to be involved in the treatment of all children with relatively complex and severe forms of psychiatric illness. In light of this, the estimate of 1.6 CAPs in the United States (actually orders of magnitude lower in some geographic areas) for every 1000 children with severe psychiatric illness may be considered a call to action for CAPs to design systems for collaborating with other medical professionals to optimize the use of their expertise in the care of children with severe forms of illness.

Recently published mental health competencies for pediatric primary care and the publication by the American Academy of Pediatrics of a mental health toolkit illustrate a burgeoning recognition within organized pediatrics of the need for PCPs to become actively engaged in the assessment and treatment of mental health problems for children in the primary care setting. Pediatric PCPs are ideally positioned to perform screening and early detection, a vital element of any public health approach to reduce morbidity and mortality associated with children’s psychiatric illness. Furthermore, the lack of stigma associated with care by a PCP stands in stark contrast to the feelings of discomfort and shame associated with seeing a mental health specialist. PCPs are commonly considered a trusted advisor for parents concerned about the behavior of their children or worried about their child’s emotional development. Pediatricians have been on the forefront of the contemporary movement for primary care systems to provide a “medical home” for children with special health care needs including mental health conditions. Consequently, CAPs would ordinarily be considered natural partners to pediatric PCPs.

Unfortunately, significant barriers have hindered the development of effective collaboration between CAPs and PCPs. There is a professional cultural divide between the mental health system and the physical health care system engendered by persistent stigma regarding psychiatric illness and reinforced by institutional separation of mental health within governmental public health agencies, health insurance programs, and health care delivery systems. In addition and perhaps most importantly, there is insufficient funding within fee-for-service reimbursement systems for indirect patient care services such as telephone consultation and other forms of physician-to-physician communication, particularly those on behalf of patients not physically seen on the same day. CAPs often work within mental health clinics that do not allow direct referrals to a CAP by a PCP. In such systems, insulated from direct referrals, CAPs do not readily develop collegial relationships with PCPs.

The Massachusetts Child Psychiatry Access Project (MCPAP) is a public initiative designed to improve access to care for children with mental health problems by providing pediatric PCPs with access to a collaborative relationship with regional child psychiatry teams offering consultation, care coordination, and educational programming. Six of these teams are distributed across the state of Massachusetts, each serving the pediatric primary care practices in its region. After an initial orientation and enrollment session on site at the primary care practice, the teams make a telephone consultation hotline available to the enrolled PCPs. PCPs are encouraged to call the hotline with any nature of question related to pediatric patients with a mental health problem. Questions regarding assessment, treatment planning, psychiatric medications, and resource navigation are answered by an appropriate member of
the team, which includes CAPs, child psychotherapists, and care coordinators. When clinically indicated, the team offers to provide a direct clinical evaluation of the patient, and/or direct assistance to the parent in securing appropriate services in the community. Since its inception in 2005, the program has enrolled more than 95% of the practices that see children and adolescents covering approximately 95% of the children and adolescents throughout the state. Enrolled PCPs have reported high levels of satisfaction with the program and significant improvement in their ability to meet the needs of youth with mental health problems.

In the design and implementation of MCPAP, telephone consultation serves as the primary interface between the child psychiatry teams and the PCPs. It is by far the most frequent service provided by the program. The reliable and immediate availability of consistent MCPAP team members over the telephone is designed to create a virtual presence of child psychiatry resources within the primary care practice. In this context the telephone consultations are oriented toward the following goals:

1. Provision of real-time case-based continuing education services regarding evidence and consensus-based practice guidelines, assessment strategies, and appropriate use of community mental health resources
2. Building a collaborative relationship supporting the growth of the PCP’s expertise and confidence in the ability to provide clinical management and/or coordinate care for youth with mental health problems
3. Provide a triage function to identify those patients who truly require the direct care of a CAP and to help PCPs define the limits of their own involvement in the mental health care of specific patients.

TELEPHONE CONSULTATIONS BETWEEN THE CHILD AND ADOLESCENT PSYCHIATRIST AND THE PEDIATRIC PCP

In this section, the activity of telephone consultation is explored in more depth through the use of case examples.

Case 1

**PCP:** I wanted to run this case by you. I have a 14-year-old girl I’ve known since infancy. Her mother filled out our mental health screener (PSC35) at the well child visit, positive score of 36. Symptoms rated often: Hopeless, irritable, angry, grades dropping, sadness, spends more time alone, having less fun, trouble sleeping, tired/low energy. Talked with the parent, sounds like it’s been going on for the last 3 months. Before that the kid was generally happy, content, good student, sociable. No prior mental health treatment. Began shortly after grandmother died, with whom the child was very close. I was thinking about prescribing an SSRI [selective serotonin reuptake inhibitor], but wanted to see what you thought.

**CAP:** Sure, no problem. A couple questions to consider before going forward: First, how certain do you feel about the diagnosis and how much do you want to be involved in the treatment?

**PCP:** I actually feel pretty certain. I used the SIGECAPS mnemonic [Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, Suicidal] and she pretty much has all of them. Regarding my involvement, as long as you’re available as a back-up, I feel OK about prescribing antidepressant medicine for this kid, and I think that they would prefer for me to do it, rather than go to a specialist.

**CAP:** Sounds good. Let’s talk for a minute about the diagnosis: in addition to the use of that mnemonic it’s important to make sure that you’re not dealing with other things
masquerading as depression. Any history of mood elevation? Substance abuse history? General medical issues? Trauma?

**PCP**: Nope, I’m pretty confident with this one. This is an intact, well-functioning family. No history of child abuse or trauma. Generally very healthy. No history of drug/alcohol usage. She actually looks sad, she’s more quiet than usual, and has a weary look.

**CAP**: OK. Have you talked with her individually?

**PCP**: Actually, not yet. I usually do, but this girl seemed pretty comfortable with her mother in the room.

**CAP**: Sounds like you’ve done a good workup...but I think that there are some key things which you’ll need an individual interview to ascertain. There might be some important history which her mom wouldn’t necessarily know about and which would be hard for her to talk about in front of her mother. How is your rapport with her?

**PCP**: Pretty good.

**CAP**: As long as you’re going to be getting involved in her treatment, I would recommend taking the time to talk with her by herself. You’ll need at least enough time to find out: (1) are there any things going on in her life which could be contributing to her depression? Some examples: breakup in a relationship, bullying, disciplinary event, conflict or disciplinary problem; (2) drug/alcohol history; (3) trauma history; (4) suicidal thoughts?; (5) willingness for treatment.

**PCP**: I can do that.

**CAP**: Regarding treatment, as long she’s not suicidal, and there are no unexpected complicating factors, I would recommend including a psychotherapy referral in your treatment plan. Psychotherapy, especially cognitive behavioral therapy, is considered to be an effective treatment for depression. Also, the psychotherapist can be a good partner to work with in treating her. You’ll need to reach out to the therapist to make sure that she keeps in touch with you. Using an SSRI would be perfectly reasonable either as an initial treatment in combination with psychotherapy, or added later if she’s not improving in therapy. Do you need any advice regarding selection of an SSRI, initial dosage, or titration guidelines?

**PCP**: No, I usually start with fluoxetine at the dose of 10 mg and generally leave kids on it for 4 to 6 weeks before considering increasing the dose. Do you think that’s reasonable?

**CAP**: Yes, that’s a good approach. Do you need help with a psychotherapy referral?

**PCP**: Yeah, I’m not sure who takes her insurance.

**CAP**: OK, we can ask our care coordinator to call the parent to help them find someone who will be covered. We’ll call you back to let you know who we get and when the first appointment will be. Do you have any questions regarding follow-up?

**PCP**: No. I’m going to talk with them about treatment options. If I start the medication, I’ll see her in a week to check for side effects. Otherwise, I’ll have her back in a couple of weeks to see how she’s doing and to find out what’s happening with the psychotherapy referral. Of course, you’ll hear from me again if things don’t go well.

**CAP**: I know we will.

**Case 1 Discussion Points**

This is a moderately sophisticated PCP. Note the familiarity and collegiality with the consultant bred over a long-term collaborative relationship. The PCP has a relatively high level of confidence and the consultant needs to slow him down to be more thorough. Other PCPs are more insecure and inhibited regarding assessment and management, and the consultant may need to encourage them and help them to build confidence as their skills develop. He needs to be reminded to do an individual
interview, to consider differential diagnosis, and to assess for complicating factors. The individual interview is often unfamiliar terrain for a PCP. PCPs will often find it helpful for the consultant to recommend specific areas of attention for the individual interview, and may need more specific guidance regarding the rating of elements of mental status.

It is not uncommon for PCPs to overemphasize medication interventions. Medical management is more familiar than psychotherapy for many physicians. A reminder and advice regarding psychotherapy referral and coordination of care with other mental health providers seemed necessary in this conversation. Often PCPs do not automatically receive feedback from psychotherapists and need to be encouraged to take the first step. To be successful in primary care level mental health work, PCPs need to develop a network of relationships with community mental health providers and receive mentorship regarding this development from the telephone consultant. As is clear from this conversation, there will be a post-service activity provided by another member of the MCPAP team, the care coordinator, to help make the psychotherapy referral recommendation a reality as well as a promise to make sure that the PCP is informed about the resulting appointment. Finally, there is a joking acknowledgment of the subsequent “presence” of the consultant if there are untoward developments in this patient’s course of illness.

**Case 2**

**PCP**: Hi. Thanks for taking the call. I don’t really know this patient. He’s a 16-year-old boy who just moved to the area. His mother showed me a bag of empty bottles: risperidone 2 mg twice a day, lithium carbonate 600 mg once a day before noon (QAM), 900 mg once a day before bedtime, and Concerta [methylphenidate] 18 mg QAM. All with no refills, prescribed by someone out of state. We’ve called that doctor, but haven’t gotten any calls back. What do you think I should do? Should I refill this?

**CAP**: What did you find out about his history and what do you think of his current psychiatric condition?

**PCP**: Mother brought a discharge information sheet from 2 months ago from a psychiatric hospital. Apparently his discharge diagnosis was bipolar disorder and ADHD [attention deficit/hyperactivity disorder]. Mother told me that he’s had 4 psychiatric hospitalizations over the past 3 years and that he’s made several suicide attempts. Right now, she feels that he’s stable and has just started a new school in the area. But he has no mental health services. I talked with him. He’s calm, and seems to be in a positive mood. He was alert and his behavior was appropriate. I actually asked him about suicidal feelings as you’ve recommended to me before with kids who have bipolar disorder, and he said that he hasn’t been thinking about suicide in recent months since his hospitalization. I am concerned though about his weight. He’s about 40 pounds overweight, and his mother said he was very skinny before he started taking the risperidone. I’ve ordered a lipid profile and a fasting blood glucose level for starters.

**CAP**: Well he sounds stable, and his medication list is appropriate to his diagnosis. Given his history, it would be best for him to avoid any sudden changes or disruption in his medication treatment, so for now, I think that it would be OK to refill his meds on a short-term basis until his psychiatric medication treatment can be picked up by a child psychiatrist. Needless to say, he’s going to need some referrals. What role would you like to play in his care?

**PCP**: Well, I’m going to be his primary care provider, but I’m not a psychiatrist. I would like to follow him and make sure that he’s getting the services he needs.
CAP: Yes, that makes a lot of sense. Bipolar disorder, if that’s his correct diagnosis, is a chronic mental illness, so he’s going to need a lot of different services in the mental health system that will need to be coordinated. Hopefully, we can find some resources in the community for his mental health care coordination needs. It will be important for you to be in the loop regarding his services, and for you to correspond with his psychiatric medication provider to address the concerns about his probable medication-induced weight gain. By the way, we just posted an article to the MCPAP Web site on the metabolic side effects of atypical antipsychotics. You might take a peek at it since it’s pretty relevant to this patient.

PCP: Yeah, I got your email with the link to that article. I hadn’t had a chance to read it yet, but I’ll take a look at it today.

CAP: Great. Our care coordinator can contact this patient’s mother to get the ball rolling on the referrals. What kind of health insurance does he have?

PCP: Actually he’s on Medicaid.

CAP: That’s actually good news. Are you familiar with the new services which have been made available in our state for Medicaid kids? There’s a new service called Intensive Care Coordination for which this child would be eligible. It’s referred to as a “wrap-around” program which provides a care coordinator and a parent advocate who work with families over a long-term basis, helping them to address their mental health needs and maintain stability in the community. If we can get this guy into the program, they will include you as part of the team, and keep you informed of how things are going. I’ll give you the number which you should keep handy for other kids you come across. You can have your nurse call in the referral to this program and they’ll contact the family. In the meantime, we’ll ask our care coordinator to call the parent to help them find a therapist and psychiatric medication provider.

PCP: Sounds good. Appreciate the help.

Case 2 Discussion Points

This is unfortunately a relatively common scenario for PCPs. Psychiatric care for complex patients is often disrupted by moves, changes in provider organizations, inadequate planning at the time of discharge from inpatient care, or changes in insurance plans. A simple question in this case regarding whether or not it is all right to refill a prescription leads into an educational encounter regarding monitoring for metabolic syndrome associated with antipsychotic medication as well as the new availability of intensive home-based resources for children with severe mental illness in the community. Reassurance that the PCP is neither expected nor encouraged to provide ongoing direct treatment for a teenager with such a complex psychiatric history and medication regimen is provided. Beginning with inquiring about the PCP’s level of interest in remaining involved in this teenager’s mental health care, the consultant also helps the PCP establish a coherent role for this patient, including helping to monitor the medical risks associated with the psychiatric medication, identifying and helping the family to access additional mental health resources, and becoming a member of this teenager’s treatment team.

Case 3

PCP: Hi. How’ve you been? I have what I think is an “easy one” but I’m not entirely sure what I’m looking at.

CAP: I’ve been good…busy…and glad to hear from you. What’s up?

PCP: This is an extended family I’ve known for 35 years. Mom has schizophrenia but has done pretty well, works part-time and her father helps out. She was my patient...
from birth until she aged out of my practice...had her first psychotic break in high school...never married. Her dad has gone through some pretty bad winter depressions. She has one boy, 17 years old. Tommy was hospitalized on the mainland last year after a scary episode: paranoid, hearing voices, seeing things. He tried to walk off the island right into the ocean late one night. One of our fishermen saved him. Tommy was put on olanzapine and lithium carbonate. He’s back in school and on track to graduate next year...helps out my car mechanic...pretty skilled at it...but he’s gained a ton of weight and has a little tremor of his hands.

**CAP:** Thanks. That’s a great description. Are you prescribing his meds? Who’s doing each part of the treatment?

**PCP:** There’s an adult psychiatrist, Dr A.....good guy...comes down here once a week...does his med follow-up...has kept it all the same since Tommy got out of the hospital 8 months ago. Tommy wasn’t keen on the therapist at the local mental health center down here but he likes the social worker at the high school and stops by to talk to her almost every day. Medically, Tommy’s healthy as a horse. Mom brought him in because he’s so upset about the big belly he’s got now.

**CAP:** Ok. Let’s walk through some of the possible med side effects, lifestyle factors, and all the treaters’ roles.

**PCP:** Yup. I can tell you a few things: we gave Tommy that CRAFFT screening test you showed us...turns out he drinks some beer but never when he drives or enough to get drunk. I also know he likes his fast food...especially those French fries and milk shakes. And he smokes about half a pack a day.

**CAP:** Do you know if he exercises at all?

**PCP:** Nothing aerobic. OK...got it. I’ll see if the school or his grandfather can get him to exercise a little. I remember, he used to ride his bike to town. I’ll also talk to him about food choices...and work my way up to the smoking cessation talk.

**CAP:** OK. And let’s go through the metabolic risks of his current meds.

**PCP:** Oh yeah. That was my hunch...and that olanzapine was right up there at the top of your antipsychotics chart for weight gain. Remind me: what else should I be on the look out for?

**CAP:** Increased cholesterol and lipids; decreased glucose metabolism—even to the point of eventual diabetes mellitus; central obesity with growing waist circumference; and high blood pressure. All of the metabolic syndrome components are also reviewed in detail on our MCPAP Web site.

**PCP:** OK. Great. I checked his blood pressure—it was a little high and I’ll run a fast-ing lipid and glucose, and an [hemoglobin] A1c.

**CAP:** There’s a few other labs to get while you’re at it. Lithium can also contribute to the weight gain and can have its own set of side effects. We’ll want to make sure the weight gain is not from lithium-induced hypothyroidism. And, over time, you’ll also want to keep an eye on renal function and the lithium level. Do you know if the psychiatrist monitors these or metabolic syndrome? Does he share lab results with you?

**PCP:** I think he checked the lithium level a few months ago...not the rest. I’ll add on a Thyroid panel with TSH [thyroid-stimulating hormone], and a BUN [blood urea nitrogen], creatinine and [electro]lytes, and another lithium level.

**CAP:** Great. While the olanzapine is more likely the primary driver of the weight gain, it’s going to be important to monitor all of these for the lithium over time. Also that mild tremor is probably the lithium. Is it a fine resting tremor? And not a problem for Tommy when he’s repairing the cars?

**PCP:** Right, it’s a resting tremor not intentional...doesn’t bother him at all. So, it’s probably just a benign side effect, huh? I’ll just make sure the lithium level’s not too
high. And I don’t see any abnormal involuntary movements at all. Still, should we be getting him off that olanzapine?

CAP: Excellent idea. That brings us back to defining everybody’s roles and coordinating the care. It sounds like Tommy has done very well psychiatrically on these meds. Do you know if Tommy was “manic”?

PCP: I’m not sure. They called him “schizoaffective” and the doc here hasn’t wanted to risk destabilizing him by changing the meds. Tommy’s been doing great and the initial crisis was pretty scary. Now, I guess the weight gain is going to force our hand.

CAP: Has Tommy ever looked depressed to you?

PCP: No, not really. Quiet kid. Doesn’t like to be in town when it gets crowded in the summer but not a true “loner.” Likes to be with one or two folks at a time. So, if you’re asking about “bipolar,” no not based on depressions anyway. I really do wonder the long-term outlook for this guy. How can you predict this?

CAP: Well, some of it will depend upon his diagnosis which may take some time to become clear. There’s the apparent family history and genetic predisposition to schizophrenia, with Mom’s diagnosis. Grandfather’s history of depression raises the odds of a familial affective disorder and his seasonal pattern raises the question of a bipolar variant. So, there may be genetic vulnerability to more than one type of disorder. The truth is, for Tommy, only time will tell. After the first psychotic break, you’ll watch the longitudinal course over the next decade and the diagnosis (and prognosis) will declare itself. Dr A. may already have some valuable clues: for example, whether Tommy has had any residual delusions or hallucinations suggestive of schizophrenia versus any enduring or recurrent mood disorder symptoms, during this almost full year of apparent recovery. There may also be hints in the hospital discharge summary: for example, were Tommy’s ideas about walking into the ocean thought to be grandiose? What was the nature of his speech, sleep pattern, energy level? That data will help guide us about his meds. Dr A. will also have to be the one to decide about changing the meds. Would you like us to coordinate communication? Our MCPAP social worker could speak with the high school social worker, gather some info, and put her in touch with Dr A. And I would be glad to chat with Dr A. and offer some ideas, especially about switching antipsychotic meds. If it turns out that he would like a child psychiatrist on the mainland to see Tommy, even for periodic consults, we can provide that at our site or our care coordinator can help arrange it closer to the ferry landing.

PCP: That would be great. And I’ll call you back once I have all the lab results, and talked with Tommy and his mom. If they and Dr A. decide to go for any consults, I bet Tommy’s grandparents would help bring him up there.

CAP: Terrific. I’ll speak to you next week. Thanks again for calling.

Case 3 Discussion Points

In some parts of Massachusetts, including rural areas and offshore islands, the lack of available child psychiatrists leads other physicians to provide this care. These situations can require creative adaptation of the MCPAP telephone consult model. Primary care pediatricians in these regions often know multiple generations of extended families and can offer rich context to the understanding of a case.

In all geographic regions, metabolic syndrome is a growing public health challenge, compounded by sedentary lifestyle, high-calorie diet, cigarette smoking, second-generation antipsychotic and other psychiatric medications. It is crucial that PCPs be aware of and become more aggressive in addressing these cardiovascular risks.

Case 3 also illustrates the multiple synergistic MCPAP educational approaches. The PCP had learned to administer screening tools for developmental, substance abuse,
and psychiatric disorders, and also had learned about metabolic syndrome at these same MCPAP continuing education conferences. The PCP has developed a trusting relationship over time with the MCPAP child psychiatrists on the team in her region. This collaboration makes it more comfortable for her and probable that she will access MCPAP for advice, allow herself to “think out loud” during the call, build on prior didactic sessions, and change her plan of action. The presence of detailed information on the MCPAP Web site, for example about metabolic syndrome, facilitates multimedia learning that can be accessed at the convenience of the PCP to reinforce data acquired at didactics and during telephone consults.

This session also illustrates the multiple opportunities that MCPAP telephone consults provide to informally address more aspects of a case than the PCP had originally anticipated. The narrow question of weight gain allowed fuller discussion of metabolic syndrome, and the more generic need for monitoring of multiple potential side effects not just of antipsychotics but also of lithium carbonate.

Finally, case 3 demonstrates how a narrow (“easy”) medication side effect question can lead to a broader immediate upgrade in coordination of care.

Case 4

3:05 PM

PCP: Thanks for taking my call immediately. I’ve got a new patient here in the office...a 4-year-old boy...looks pretty low functioning autistic to me...not much language...no eye contact...the family’s in crisis...the mom says the dad has one foot out the door...the boy has severe outbursts, biting them, biting his own arms, punching himself in the ear...the head...wakes them up screaming in the middle of the night. Mom says she won’t go anywhere near an ER [emergency room]...she brought him there last weekend when all this got worse...none of the hospitals that could manage him had a bed...they stayed all night, he got restrained...then he ended up back at home. She’s got no help, no services...he’s pretty calm here right now...do you have any ideas how we can help? I’m willing to prescribe something for him in the short run.

CAP: I can see him first thing tomorrow morning...just need you to take a good look at him medically right now. There’s nothing about autism that makes a kid immune to an ear infection, strep throat, or bad constipation. If his behavior really got so much worse in the past week, then something’s changed that’s causing him distress or pain. Let’s rule out a medical cause first...then see if something big happened in the house.

PCP: Makes sense...He was a little agitated when he first got here but I think he might let me examine him now...he’s a little tachycardic...I’ll call you back in 5 minutes.

CAP: OK. Thanks.

3:20 PM

PCP: Hi. OK. This is starting to make more sense. He’s got a temp of 101°, a left otitis media, some bruising on that same ear, bite marks with broken skin on both forearms. Belly’s soft. Throat’s red. Rapid strep negative. A little dry...judging by his mucous membranes. He’d had all he would take of being examined before I could get orthostatics but I don’t think he’s too badly dehydrated. Mom says he will swallow liquid meds. She also said that judging by what’s in his pull-ups he’s peeing, got moderately concentrated urine, and is moving his bowels. So, I’m going to start him on antibiotics, ibuprofen and the blue-ice flavor of Gatorade—mom says he likes that color for everything. She also said things are worse this week, but that they’ve been pretty bad on and off for months, so his ear may just be the icing on the cake. Mom would still
like to meet with you and your social worker as soon as he feels a little better...maybe by the end of this week.

**CAP:** Sure, we’d be glad to meet them. You can let mom know that we’ll be interested in any evals he’s ever had and that we’d like her husband to be here with her.

**PCP:** OK...gee, you know...these forearms were a little heartbreaking to look at...do you think we’re headed to risperidone pretty soon? It might help him sleep, too.

**CAP:** Maybe. Let’s see if we can figure out what drives the behaviors when he’s medically at baseline, and whether we can quickly get some home-based ABA [applied behavior analysis] services in place and/or a therapeutic preschool program for him. For safety reasons we might have to use some meds at least for a while to reduce the frequency and intensity of his violent outbursts. In the long run, the ABA is a powerfully effective, evidence-based approach to reduce self-injurious and aggressive behaviors, and to foster the acquisition of skills and communication. For sleep, we can sometimes get lucky with an over-the-counter med like melatonin coupled with a better evening and bedtime routine.

**PCP:** I know we’re getting ahead of ourselves a bit here but I’m trying to prepare for him being only halfway better a week from now. How are you going to find him those ABA services anyway...isn’t he too old for free “EI” [early intervention]?

**CAP:** Yes, the EI ends at age 36 months, but the then Special Ed eligibility kicks in and they live in a town that belongs to a regional collaborative with some pretty good preschool and kindergarten programs for autism spectrum kids. There’s also some good news on the home-based ABA side: the state agency that used to be called DMR [Department of Mental Retardation] and had deemed autism to be an exclusionary criteria has been re-named DDS [Department of Developmental Services] and now specifically includes autism. While DDS is mostly geared for ages 22 and up, it does provide some home-based respite and ABA services for kids. There may be some other help on the way—there’s a bill working its way through the State House to have medical insurance cover ABA. So, one way or another, we’ll help get them connected to some support and training services.

**PCP:** If he needs meds and a child psychiatrist, will you give me some treatment recommendations and connect them to someone who knows this population?

**CAP:** Absolutely. By the way, great job making him feel safe enough for you to examine him today.

**PCP:** Thanks for that feedback and for being there at the key moment...It’s strange...I keep thinking that now that we’re using the M-CHAT screening tool I probably could have spotted his autism if he had been my patient 2 years ago and gotten him into EI a long time ago. We are catching a lot of autism spectrum kids way earlier now. OK, I’ll let you know how he does with the antibiotics. See you.

**Case 4 Discussion Points**

MCPAP is not designed to be an emergency service but, because it provides nearly immediate telephone access, MCPAP can be relevant in urgent situations. In other instances, timely face-to-face evaluations can clarify diagnosis and treatment needs and help determine whether the PCP can treat the patient. In this case, despite the urgency of the case, an emergency room visit was avoided as well as an urgent search for a CAP.

The MCPAP child psychiatrist most commonly provides consultation on developmental, substance abuse, and psychiatric disorders for the purpose of clarifying diagnosis and recommending treatments. With special populations such as youth with autism spectrum disorder, eating disorders, or chronic medical conditions, the role of MCPAP both by telephone and in person can be more helpful to the PCP than a traditional consult-liaison model at addressing the interplay of medical and
psychiatric factors. In all cases, the full MCPAP model facilitates screening, early detection, timely referral, and rational triage, all made possible through a trusting, continuous relationship and multiple, complementary educational vehicles.

The PCP in case 4 wonders if risperidone is going to be necessary. Without MCPAP, faced with a behavioral crisis, this PCP might have felt obliged to prescribe medication. However, with MCPAP, the consultant was able to suggest better options. More than half of all MCPAP consultations do not result in the use of psychotropic medications, thus avoiding dependence on medications and their side effects.

Case 4 also illustrates the increasing prevalence of autism spectrum disorder and the resultant need for PCPs to care for this population. Essential home, community, and school-based services, including high-quality ABA treatment, are often hard to access both because of the shortage of an expert workforce and because of each local jurisdiction’s bureaucratic rules. MCPAP can help PCPs and families to define the nature of the problem, the best matched treatments, and how to efficiently navigate the maze of state agencies; this sometimes requires a thorough face-to-face evaluation that also allows one to address family crises that might otherwise divert the family’s attention.

**DISCUSSION**

With the experience of more than 20,000 MCPAP encounters, responding to the mental health needs of more than 6000 youth per year, as the examples given here show, PCPs respond favorably to a consultation rather than a referral for many situations. The consultation process rationalizes the use of scarce child psychiatry and behavioral health services. The authors’ data show that more than 95% of all practices with more than 200 youths use the service during a year. The consultations cover a wide range of topics with varying complexity, resulting in the need for telephonic advice, care coordination, or face-to-face visits. A key factor in MCPAP’s success is the PCP’s trust that the MCPAP team is always a telephone call away if the treatment plan does not go as expected. This allows PCPs to take greater responsibility than in the usual system in which they would refer to a child psychiatrist and then be challenged to get help with follow-up. The vignettes given here stress the importance of educating the PCP to improve future care, again something that would not happen in the traditional practice.

MCPAP ultimately becomes more than just a consultation service to PCPs. MCPAP monitors the pulse of the child mental health system. For example, when increased calls were received about eating disorders or the side effects of atypical antipsychotic medications, these topics were added to a local conference agenda, an article was written for the Web site, and emails with this information were sent to all PCPs. One insurer has inadequate access in a particular region, so that insurer is contacted about expanding its network. Several children’s psychiatric medication providers leave a local area within a short time, creating an access crisis, and the local MCPAP team gives a “heads-up” to the PCPs and supports them until resources are recruited.

The increasing importance of the care coordinator cannot be underestimated; as the PCPs have become more knowledgeable, the calls get more complex and the need to help the PCPs find behavioral health providers becomes greater. Also, the PCPs learn that the care coordinator is an indispensable resource because the care coordinator stays up to date on specific resources on various insurance networks. Often when the PCP’s usual referral resource is busy, the care coordinator will know of another provider with availability. The care coordinators supported by discussions with the team know which providers have specific expertise such as
cognitive behavior therapy (CBT), ABA, or complex medication management. The PCPs also learn that a call from the MCPAP care coordinator may get a youth an appointment because of the relationships that build up between the MCPAP team and local providers.

Because of the variability in knowledge and enthusiasm for behavioral health among PCPs, a very individualistic approach to each practice and PCP has been necessary. Through regular contact, the team is able to tailor the consultation according to the level of sophistication of that PCP. The ideal consultation is not “cook-book” psychiatry for the PCP but an adult learning, educational interaction. Over time, the authors have found that many PCPs become more comfortable taking care of clinical issues that they had never anticipated handling themselves. The pace of skill acquisition and increased comfort is also highly variable among the PCPs. Assessment and treatment of patients with developmental, substance abuse, and psychiatric disorders may be new territory for many PCPs, including early career physicians who have received relatively little mental health teaching during their residency.

A minority of consultations require a face-to-face psychiatric visit (28%). The consultant is usually able, over the phone, to decide if the youth is too complex for the particular PCP or the management can be done by the PCP. Some face-to-face visits are done to support and reassure the PCP so that management can stay with the PCP. The consultant becomes the educator, using the specific case to demonstrate and teach what the PCP might be able to do on his or her own with the next similar situation.

As shown, the MCPAP model emphasizes the use of electronic voice communication for consultation and collaboration with PCPs. Interactive video technology could be used as a substitute for the direct in-person patient evaluations in larger geographic regions in which patients or physicians would otherwise need to traverse long distances for the service to be provided. Such an application of video telepsychiatry would not, however, serve as an appropriate substitute for the telephone consultation activities within MCPAP because having the CAP “see” every patient would not as effectively promote the skill development of the PCP. In addition, such evaluations provided to every patient would not significantly conserve the availability of the existing workforce of CAPs for treating the most complicated patients in their community.

Many practices are moving toward becoming a patient-centered medical home (PCMH). Will MCPAP still be needed? Yes, most likely even more so. The PCMH may include a social worker or psychologist who would be able to manage the nonmedication mental health needs of the practice, but this will place even more pressure on the PCPs to prescribe and be comfortable with a wide range of diagnoses. To ensure that PCPs can do this work, a MCPAP-like program would be required.

MCPAP has also been proven to serve as valuable infrastructure to support the launching of system of care initiatives. In Massachusetts, when the remedy for a class action lawsuit against the state required the implementation of standardized behavioral health screening of all Medicaid youth during well child visits, MCPAP became a ready source of consultation to assist PCPs in making this change. By adding 4 screening tool consultants to the MCPAP program for a year, PCPs had a ready path for help from a source which they were accustomed to using. Once implementation was completed, MCPAP has continued to be available for PCP questions that arise from screening and to be a source of information about the new child mental health services developed by the state. MCPAP has tested the practicality of guidelines such as the GLAD-PC (Guidelines for Adolescent Depression in Primary
Care\textsuperscript{14} and has assisted in the triage of scarce resources for autism spectrum disorders. MCPAP is available to help implement uniform change across the health care system. Ultimately, the success of a single telephone consultation hinges on the platform on which it is built: the ongoing relationship; the complementary educational and care coordination features of the model; and the capacity to supplement the call with a timely face-to-face evaluation.

REFERENCES