PEDIATRIC PRIMARY CARE PROVIDERS AND MENTAL HEALTH THERAPISTS: CARE COORDINATION IN NON-INTEGRATED SETTINGS

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Human Development and Family Studies

2012

ABSTRACT

PEDIATRIC PRIMARY CARE PROVIDERS AND MENTAL HEALTH THERAPISTS: CARE COORDINATION IN NON-INTEGRATED SETTINGS

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The extent and quality of the relationships that mental health therapists have with pediatric care providers in non-integrated settings is unclear. It is necessary to discover how mental health therapists can collaborate effectively with medical providers given the needs and contexts of children with mental health needs. It is important to investigate some of the current barriers to involvement and what patterns of referral and collaboration are being used. The purpose of this study was to discover if mental health therapists are collaborating with medical providers, and if they are, how can they collaborate effectively given the needs and contexts of children with mental health needs. In-depth interviews were conducted with two groups of professionals who work with children: medical providers and mental health therapists in Kent County, Michigan. Professionals were interviewed and grounded theory methodology was used to analyze the data and develop collaboration and referral models between mental health therapists and medical providers.

Navigating the maze of the plethora of health insurance companies and plans seems to be a significant factor in the collaboration and referral processes for both mental health and medical providers. Each patient, with a different health insurance plan, requires professionals to approach referral and collaboration from separate directions. Some companies require referrals to specific professionals or agencies, and some provide lists of acceptable professionals, while some provide no directions at all. It is impossible for professionals to remember how each plan functions.

Thus, referral processes are often taken out of the control of the professionals and placed in the control of health insurance companies. This is frustrating and confusing for professionals.

Professionals agree that collaboration is an essential part of effective patient care. However, there appears to be confusion about how and what needs to be communicated between mental health and medical professionals. Both types of professionals report that it seems easier at times to rely on parents of children to communicate essential information. Professionals need to negotiate and implement more effective methods to sending pertinent information to each other. Finally, collaboration and referrals are related. It is obvious that professional relationships are built with communication over time and professionals with relationships tend to refer more to each other. Both medical and mental health professionals should work to get to know each other and develop positive relationships.

ACKNOWLEDGMENTS

I would like to thank Dr. Esther Onaga for providing support, guidance, mentorship, and patience over the course of my studies at Michigan State University. She was always available when I needed her and I will be eternally grateful for our relationship. I would also like to thank Dr. Rebecca Malouin for her guidance and education about the medical field. She helped me formulate the idea for this project, my research and interview questions, and connected me with her network of professionals in order to make this project possible. Dr. Marsha Carolan was always available when I had questions about qualitative data analysis. I would like to thank her for helping me to make sure that I was on the right track while I was in various stages of this project. Finally, I would like to thank Dr. Tina Timm and Dr. Brooke Ingersoll for serving on my doctoral guidance committee. Each member of my committee contributed their expertise to my project and has had a significant influence on my overall research as well as me as a person.

Thank you to all of my friends who have supported me through this journey. Thank you for all of the compassion, love, and listening ears. Rue, you are amazing person and I feel so lucky to be able to call you my friend. Even though many words may not have made it onto the paper when we “worked”, I will always cherish the time that we got to spend together sharing laughs and funny stories.

I would also like to thank the Michigan State University Graduate School and the Blue Cross and Blue Shield of Michigan Foundation for providing financial support for this dissertation project. This money helped to pay for all participant incentives, transcription costs, and other various expenses.

Thank you to Emily Schmittel for all of your help with coding data. Your help means the world to me because I knew I could depend on you to care for this research. I am so thankful that

we have become friends over the years and that we could work on a project together! I would also like to thank the individuals in the research group that helped me to transcribe the interviews. I know transcription is difficult and I cannot thank you more for your hard work. I am going to miss meeting on a weekly basis to talk about research. I have come to look forward to these meetings and I am sad to see them come to an end. I wish you all the best in the future with your education and your careers. You all work hard and I know it will pay off for you!

Finally, I would like to thank each participant who gave me time out of his or her busy schedule for an interview. The leaders and members of the Children's Healthcare Access Program were especially supportive through various stages of this project.

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CHAPTER 1

INTRODUCTION TO THE STUDY

Background of the Problem

Children with Special Healthcare Needs (CSHCN)

The Federal Maternal and Child Health Bureau's Division of Services for Children with Special Healthcare Needs established a work group to develop a definition for Children with Special Healthcare Needs (CSHCN). In 1998, they published the following definition for CSHCN: **"**Children with special healthcare needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (McPherson et al., 1998, p. 138). The work group defined "require health and related services" to mean specialized or enhanced medical and nursing services, therapeutic services, family support services, equipment and supplies, and related services. Reportedly, 12.8% of children in the United States under 18 years of age met the requirements for CSHCN in 2001 (van Dyck, Kogan, McPherson, Weissman, & Newacheck, 2004). In 2009, the percentage had increased to 13.9% (Strickland et al., 2009).

Children with Mental Health Needs

The focus of this dissertation is on a specific subset of CSHCN, children with emotional and behavioral disorders who have needs such as medication, therapeutic services and/or family support services (See Figure 1). Ganz and Tendulkar (2006) analyzed the National Survey of Children with Special Healthcare Needs and found that about 30% of those children had some form of emotional, developmental, or behavioral (EDB) condition.

Figure 1: CSHCN and Children with Mental Health Needs*

*For interpretation of the references to color in this and all other figures, the reader is referred to the electronic version of this dissertation.

Treating Mental Health Needs In Primary Care

Pediatric primary care providers (PPCPs) are professionals such as physicians, nurses, and medical assistants who work in medical settings serving children. While PPCPs may be the first professionals whom families go to when a mental health problem arises for children, PPCPs may not always be the most appropriate professionals to treat children with mental health needs. Some pediatricians and family physicians have reported hesitancy in making mental health diagnoses and thus will refer patients to other professionals for diagnoses (Steele, Lochrie, & Roberts, 2010; Williams, Klinepeter, Palmes, Pulley, & Foy, 2004). Other researchers have found that many pediatricians and family physicians were comfortable diagnosing certain disorders, but not prescribing medications to treat them (Davis et al., 2012; Fremont et al., 2008; Pidano, Kimmelblatt, & Neace, 2011a; Stein et al., 2008). Finally, it may not be cost-effective for PPCPs to treat mental health concerns in their office – Meadows, Valleley, Haack, Thorson,

and Evans (2011) reported that PPCPs are reimbursed less per minute for behavioral-only visits compared to reimbursement rates for medical-only visits or visits that combine behavioral and medical concerns.

Mental Health Therapists Meeting Mental Health Needs

Due to the increased amount of care that children with mental health needs require, it is imperative that children and families are able to seek out and receive the care that they need from professionals in the community. To address extra support that may be needed for children with mental health needs and their families such as psychotherapy or family support services, families of these children may seek out the services of a mental health therapist. Mental health therapists may have a variety of educational backgrounds, such as master's degrees or doctorate degrees in marriage and family therapy, social work, counseling psychology, or clinical psychology.

In addition to general mental health therapists, there is a subset of family therapists called "medical family therapists" who use systems theories to treat the entire family and collaborate with health professionals who work with clients with medical problems (Doherty, McDaniel, & Hepworth, 1994). One of the fundamental tenets of medical family therapy is that "all human problems are biopsychosocial systems problems. There are no psychosocial problems without biological features, and there are no biomedical problems without psychosocial features" (Doherty et al., 1994, p. 34). According to medical family therapists, it is impossible to separate out the biological and psychosocial aspects of individuals. Since medical family therapists treat psychosocial aspects, and medical providers treat the biological aspects, when using the biopsychosocial approach to treating individuals, it is necessary that these two professionals work together to help the patient.

In addition to medical family therapy, traditional family therapy has been shown to be an effective method to treat medical problems in families. One of the founding fathers of marriage and family therapy, Salvador Minuchin (1974) described how structural family therapy was applicable to families with children with chronic illnesses such as diabetes. Campbell (2003) explored research results and found that family therapy, when a child has a medical condition, has been shown to have "health benefits for asthma, diabetes, and cystic fibrosis, and show promise for reducing the psychosocial morbidity associated with cancer and cardiac surgery" (p. 272). Family therapists have also been developing standards of care for different childhood problems that are also commonly seen by pediatricians such as attention deficit hyperactivity disorder (ADHD; Orr, Miller, & Polson, 2005), self-injurious behaviors (Askew & Byrne, 2009) and anorexia nervosa (Eisler, 2005). Family therapy also has been shown to have financial benefits. Researchers have demonstrated that family therapy can be less expensive than individual treatments (Crane & Payne, 2009). Crane (2007) found that family therapy also could reduce the number of healthcare visits without increasing healthcare costs.

Care Coordination Between Primary Care Providers and Mental Health Therapists

Care coordination, interaction between providers in order to facilitate a patient's care, is an essential facet of patient care (American Academy of Pediatrics, Council on Children with Disabilities, 2005; Bodenheimer, 2008; Hunter & Goodie, 2010; McAllister, Presler, & Cooley, 2007). Regarding children with mental healthcare needs, when a PPCP is unable to provide mental health services in his or her office, it becomes necessary to coordinate care with mental health therapists to effectively diagnose and treat these children. PPCPs may not have all of the resources to provide therapy, intensive medication management, or support for the family, and may need to provide the family with additional resources. If PPCPs can assist families in

receiving adequate mental healthcare through referral to and collaboration with appropriate providers, children with mental health needs may be effectively treated.

The research about PPCPs and their relationships with mental health providers such as psychiatrists, psychologists, marriage and family therapists, and social workers regarding children states that there appears to be some significant barriers to successful relationships. PPCPs frequently mentioned barriers to positive relationships with mental health therapists such as a lack of availability of appointments with mental health therapists who see children (Davis et al., 2012; Kushner et al., 2001; Pfefferle, 2007; Pidano et al., 2011a; Trude & Stoddard, 2003), a lack of information being shared between the two professionals (Williams, Palmes, Klinepeter, Pully, & Foy, 2005; Yuen, Gerdes, & Waldfogel, 1999), and a lack of insurance coverage or reimbursement for collaboration (Pfefferle, 2007; Pidano et al., 2011a). Many insurance companies do not reimburse for services that are provided when the client is not present. This is a large deterrent for professionals to agree to spend time collaborating.

Various researchers have discussed the importance of care coordination and the different models of coordinating care between mental health and primary care providers for patients of all ages (Aitken & Curtis, 2004; Blount, 2003; Bronstein, 2003; Campo et al., 2005; Collins & Collins, 1994; Doherty, 1995; Dym & Berman, 1986; Enochs, Young, & Choate, 2006; Fickel, Parker, Yano, & Kirchner, 2007; Hepworth & Jackson, 1995; Hogan, Sederer, Smith, & Nossel, 2010; Hunter & Goodie, 2010; Katon, 1995; McDaniel, 1995; Richardson, McCauley, & Katon, 2009; Strozier & Walsh, 1998). Models about collaboration and consultation in these studies range from passing back and forth brief suggestions between professionals to conducting co-therapy, where the medical provider and the mental health therapist would both see the patient or the family together.

More recently, researchers have studied the effects of integrated primary care medical settings. Integration, or working side by side for the benefit of the patient, has been shown to have positive effects on patient care when a mental health provider is integrated into a primary care setting (Auxier, Farley, & Seifert, 2011; Brucker & Shields, 2003; Correll, Cantrell, & Dalton, 2011; Glenn, Atkins, & Singer, 1984; Guevara, Greenbaum, Shera, Bauer, & Schwarz, 2009; Pidano, Marcaly, Ihde, Kurowski, & Whitcomb, 2011b; Pomerantz et al., 2010; Valleley et al., 2007). Unfortunately, it seems that there are significant barriers that prevent integrated mental/behavioral healthcare from becoming a nationwide norm, "Many impediments to successful implementation persist, and these range from the reluctance of mental health practitioners to give up solo practice, the 50-minute hour, and their traditional mode of practice; archaic training models that don't prepare psychologists to provide integrated care; to the fact that our current third-party payor system is not constructed to meet the funding of this evolving system" (Cummings, O'Donohue, & Cummings, 2009, p. 38). Other researchers have echoed similar concerns about integrated primary care settings and have discussed what it might take for this type of model to become a nationwide norm (Kessler, Stafford, & Messier, 2009; Marloe, Hodgson, Lamson, White, & Irons, 2012; Pomerantz, Corson, & Detzer, 2009). It is not that an integrated primary care model is impossible, but rather it may not yet be a model that can be fully implemented without some significant changes to the healthcare system (Davis et al., 2012).

Statement of the Problem

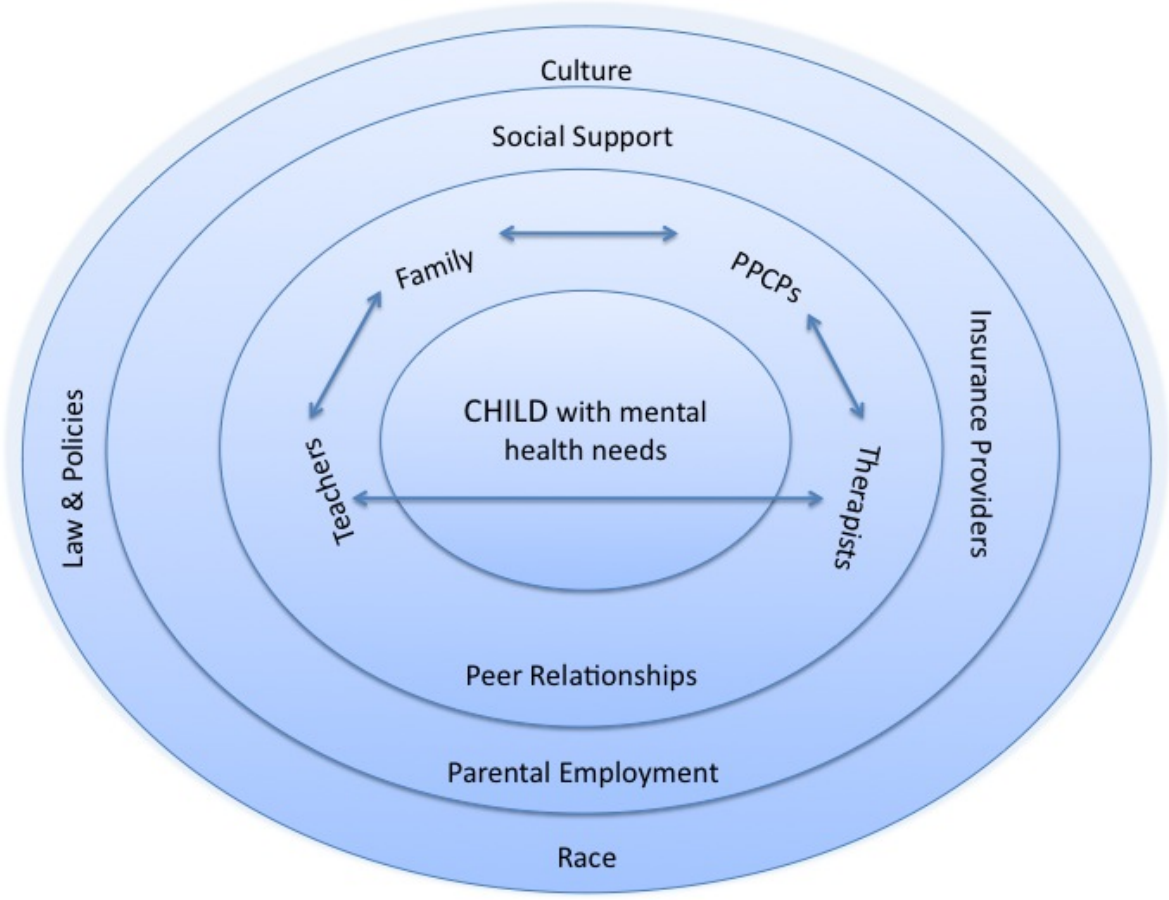
There is an obvious need for children with mental health concerns to receive care from professionals who are trained to diagnose and treat mental health concerns. It seems appropriate that mental health therapists who work with children would be included within the network of

providers for families with children with mental health needs. However, as the ideas of care coordination and integrated primary care are progressing, but not yet feasible for all providers, the “best practices” of mental health therapists being involved with and collaborating with pediatric primary care providers in non-integrated settings is unclear. The purpose of this study is to discover if mental health therapists are currently working to coordinate care with pediatric primary care providers through collaboration and referral procedures in non-integrated primary care systems.

Theoretical Framework: Human Ecological Theory

Urie Bronfenbrenner’s (1979) ecological model of human development is a fitting model that can help professionals and clinicians better understand children with mental health needs and their surrounding contexts (See Figure 2). In order for professionals to effectively treat children with mental health needs, they need to be aware of other individuals and systems that may be concurrently involved in the lives of children. Bronfenbrenner’s (1979) model can be used to accurately situate medical providers and mental health therapists within the larger context for a child and can be used to guide thinking about the overall network of providers who are involved with a child with mental health needs and his or family.

Figure 2: Ecological Model for Children with Mental Health Needs



Bronfenbrenner (1979) views the child's ecological environment as a "set of nested structures, each inside the next, like a set of Russian dolls" (Bronfenbrenner, 1979, p. 3). There are five different levels to Bronfenbrenner's model: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. Development of the child, according to Bronfenbrenner, is comprised of reciprocal interactions (both direct and indirect) between the person and each level of the environment. "Development is defined as the person's evolving conception of the ecological environment, and his relation to it, as well as the person's growing capacity to discover, sustain, or alter its properties" (Bronfenbrenner, 1979, p. 9).

Microsystem

The microsystem level involves the individual child and all "pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (Bronfenbrenner, 1979, p. 22). For a child with mental health needs this would include all relationships that the child has with surrounding individuals including family, peer relationships, teachers, and medical care providers.

Mesosystem

The mesosystem level includes the connections between the different individuals in the microsystem level. "A mesosystem comprises the interrelations among two or more settings in which the developing person actively participates (such as, for a child, the relations among home, school, and neighborhood peer group; for an adult, among family, work, and social life)" (Bronfenbrenner, 1979, p. 25). For children with mental health needs, the mesosystem can include a range of settings that might involve the couple relationship of the parents, the parent-teacher relationship, the parent-doctor relationship, and the relationships that professionals have with each other.

Exosystem

The third level of the contextual system is the exosystem, which includes social settings that "do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person" (Bronfenbrenner, 1979, p. 25). Exosystems pertaining to children with mental health needs might include social support, parental employment, and insurance providers.

Macrosystem

The macrosystem involves "consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies" (Bronfenbrenner, 1979, p. 26). At this level, children with mental health needs can be affected by culture and race.

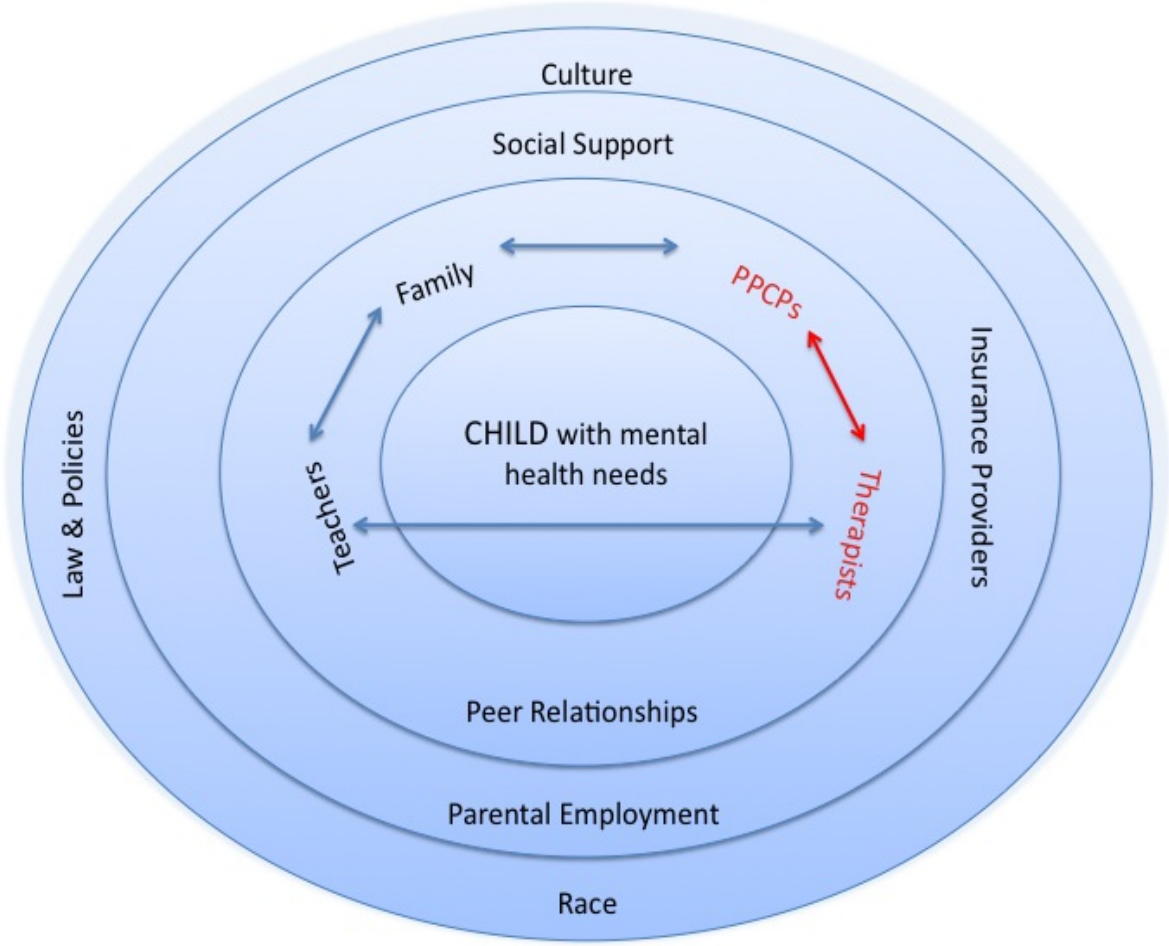
Chronosystem

The final level of Bronfenbrenner's model, the chronosystem, is a system that includes temporal factors (Bronfenbrenner, 1986). How a child changes and develops over time and what factors contribute to these changes are important to the chronosystem.

Conceptual Framework

For a system to effectively work together, all individuals need to communicate. Essentially, this flow of information from professionals working together can be represented in the mesosystem level of Bronfenbrenner's (1979) model (See Figure 3).

Figure 3: Conceptual Framework



Methodology and Research Questions

Grounded Theory

The primary purpose of this study is to investigate current patterns within a system and discover, from talking with stakeholders in that system, about new patterns of relationship that might be more effective. This search to understand a phenomenon in-depth and build a theory about how professionals can better work together seems to fit best with qualitative methodology and specifically within the postpositivist paradigm. Postpositivism seeks explanations of current patterns (Creswell, 2007). The grounded theory approach and postpositivism fit together;

grounded theory is different from other approaches in that it moves from description of a phenomenon to a search of an explanatory theory (Creswell, 2007).

As stated above, the extent and quality of the relationships that non-integrated mental health therapists have with medical providers, specifically a child's pediatric primary care provider, for children with mental health needs and their families is unclear. It is necessary to figure out how mental health therapists can effectively work with pediatric primary care providers when working in separate offices in order to increase services to children with mental health needs and their families. Grounded theory is necessary in order to develop an explanation for what is currently happening within these relationships, and to develop a model about how these relationships can be improved. The following research questions seek to discover information about the relationships between mental health therapists and pediatric primary care providers that will allow the development of a theory to better the lives of children with mental health needs. The term "collaboration" is defined as any action by a professional to coordinate care for their patient with another professional.

Major Research Questions

1. How can the collaborative relationship between mental health therapists and pediatric primary care providers (PPCPs) in non-integrated settings be created and/or be improved for children with mental health needs?

    a. What patterns of collaboration are currently present in the relationships between mental health therapists and PPCPs? Do they work? What can be changed to increase positive collaboration between the professionals?

b. What patterns of referral are currently present in the relationships between mental health therapists and PPCPs? Do they work? What can be changed to increase referrals between the professionals?

Trustworthiness

Trustworthiness of a qualitative study is akin to the concepts of validity and reliability in quantitative research. Trustworthiness can be established in numerous ways, but for the purposes of this research study it was established through reflexivity, multiple coders, peer review, and an audit trail. Daly's (2007) definition of reflexivity is: "the ways in which a researcher critically monitors and understands the role of the self in the research endeavor" (p. 188). As a researcher is integral to the completion of his or her research study, it is impossible to separate that researcher from the research. To be neutral, or unbiased, is impossible. Therefore, it is important for the researcher to be honest about his or her history and to reflect upon how that might influence the research. Using multiple coders means that more than one person will be looking at the data. This allows for dialogue about the results and increases reliability. Peer review is a process of gathering participants or colleagues of participants to view preliminary data. They can discuss with the researcher how statements were interpreted and identify and discuss any misunderstandings. The group members can also reflect upon their experiences and discuss their reactions to the experiences of other research participants. Finally, an audit trail was used in order to track the decision-making process and capture reactions, thoughts, and feelings of the researcher.

Reflexivity

It has been my personal goal in life to make this world a little better for the children who live in it. When my dreams of being a pediatrician ended with a chemistry class in college, I

moved into psychology and fell in love again with helping people. I worked in a group home for adults with developmental disabilities and quickly discovered that they were highly disconnected from their families. I decided to become a marriage and family therapist so I could help families of children with disabilities stay together.

As a master's level family therapist over the past seven years, I have worked with many families who have children with disabilities. I have witnessed the struggles that they go through to maintain jobs, find babysitters, and even locate medical providers who understand the needs of their families. I have learned how to advocate for these families through this process and it brings me satisfaction to know that I am able to help these families. More recently, my clinical practice has expanded to include quite a few children with mental health and behavioral problems. It is hard to see that they also struggle with finding competent professionals who can work effectively with the specific needs of their families.

I am a marriage and family therapist and I am biased. It frustrates me when I attempt to collaborate with medical providers who do not consistently return my calls. I dislike every moment of telling a mother to take her son to the emergency room because she cannot find a pediatrician who will take him because he has bipolar disorder. These children are diagnosed, left without care, and then sent to me when there is no one else left to help. In my experiences, it is difficult to establish relationships with other professionals. I know this is not true everywhere, but it has been true for me.

I hope that this study will begin to change things for these families. There are places in the United States, such as Kent County, Michigan, where collaboration between medical providers is being recognized and studied. In the future I want to be able to bring what works to other locations so more families can be helped.

Multiple Coders

A second graduate student trained in qualitative data analysis procedures was employed to assist with the data analysis process of this project. Once all of the interviews were transcribed, the two graduate students worked together as a team to code the data. This allowed for increased rigor of the data analysis process through the dialogue about codes and themes. The researchers sought consensus and agreement in order to enhance the data analysis process and provide a sense of trustworthiness to the data.

Peer Review

After all interviews were completed and the data was analyzed, a peer review meeting was held so the researcher could present the model to colleagues of the participants and receive feedback. Group members were allowed to talk about how the statements fit or did not fit with their own experiences. The group members were also able to talk with other group members about what this may mean for them in the future.

Members from the Grand Rapids Children's Healthcare Access Program (CHAP) behavioral health sub-committee were asked to attend the peer review meeting after the data was collected. CHAP is a program that has implemented the medical home concept to help increase access and reduce medical costs for children on public insurance (see description of CHAP below). The behavioral health sub-committee has worked diligently to improve the availability of behavioral health services for the children involved in CHAP. The advice of these participants was sought because they are interested in this topic professionally and they were seen as professionals who were knowledgeable about this topic.

Children's Healthcare Access Program (CHAP). CHAP started in 2008 and was developed as a demonstration project to provide children of Kent County, Michigan with high

quality healthcare services through the use of medical homes. Specifically targeted were children on public insurance (Medicaid). The goal of the program is to see if providing these children with medical homes will increase access, improve outcomes, and reduce overall healthcare costs and medical spending for these children. It was reported in the Year 1 Report (Klein, 2010) that CHAP was able to serve 2791 children and 2239 parents during the first year. Other key accomplishments include the creation of new partnerships and collaborations with professionals in the community, the development of a behavioral health workgroup to help improve the behavioral health referral process, improved healthcare access through the addition of 1,443 Medicaid slots, decreased inpatient hospitalization rates (3.3% compared to previous year), improved health outcomes in children, and efficient program costs (Klein, 2010).

Audit Trail

An audit trail is essentially documentation that the researcher keeps about how things are done during the research study. The trail detailed how and why decisions are made. It was also a place for the researcher to talk about reactions to events, thoughts, and feelings regarding the research study and data analysis.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Introduction

As presented in the first chapter, 13.9% of children under the age of 18 years old met qualifications to be classified as children with a special healthcare needs in 2009 (Strickland et al., 2009). A subset of CSHCN, about 30% of children according to Ganz and Tendulkar (2006), are affected by mental health needs. Due to their needs in addition to medical care, such as medication management, behavioral therapy, and family supports, is imperative that these children have access to appropriate providers to provide them with treatment. If pediatric primary care providers do not feel comfortable, have the time, or have the resources to diagnose and treat pediatric mental health needs, there should be a network of competent professionals to refer these children and their families to for assistance.

This chapter will provide an in-depth review of research regarding children with mental health needs and their surrounding systems using Bronfenbrenner's (1979) ecological model as an organizational tool. Bronfenbrenner's model can be used to provide a holistic view of a particular child and can give professionals awareness of who else may be participating and affecting the life of a child with mental health needs. Each level (microsystem, mesosystem, exosystem, macrosystem, and chronosystem) will be discussed as it pertains to children with mental health needs. It is important for mental health therapists to have a comprehensive picture of the bidirectional relationships that involve children with mental health needs.

The Individual Child

Internalizing and Externalizing Behavioral Disorders

Most clinicians and professionals use the Diagnostic and Statistical Manual (DSM-IV-TR; American Psychological Association [APA], 2000) to evaluate children for different internalizing and externalizing behavioral disorders. Internalizing behavioral disorders are those that are marked by symptoms that may not be observable. Disorders such as anxiety and depression are included in the internalizing category. Externalizing behavioral disorders are more visible and usually cause more disruption. Externalizing disorders include oppositional defiant disorder (ODD) and ADHD. When evaluating a child for behavioral disorders, it is important to consider the normal developmental trajectories of children. Often times the difference between a healthy negative reaction to a situation and a failure by the child to develop skills to control his or her behavioral can be difficult to discern. Additionally, it is necessary to evaluate other contextual factors such as parenting before attributing behavioral problems to a disorder.

Depending on the cognitive and language abilities of the child, it might be very difficult to diagnose him or her with anxiety or depression. Internalizing behaviors such as fear, worry, sadness, and withdrawal, might be hard to distinguish because a child may not be able to verbally express what they are feeling internally. It is also necessary to take into account normal fears or worries such as a fear of the dark or a fear of monsters. According to the DSM-IV-TR (APA, 2000), separation anxiety is when a child exhibits excessive and developmentally inappropriate anxiety when he or she is separated from a parent or caregiver. This disorder usually occurs in about four percent of children (APA, 2000). A child may be diagnosed with major depression when they show a depressed (or irritable) mood most of the day or a diminished interest in pleasure in all, or almost all, activities most of the day. Children must also experience a

significant weight loss, weight gain, or failure to meet expected weight gains. Finally, children must also exhibit insomnia, fatigue, and/or loss of concentration (APA, 2000).

Externalizing behaviors are characterized by outward, disruptive behaviors. When children exhibit behaviors that are negative, hostile, and defiant for a period of at least six months, children may be diagnosed with ODD (APA, 2000). According to Lavigne et al. (1998a; 1998b), ODD was the most common diagnosis in children attending regular pediatric practices. Twice as many boys were diagnosed with this disorder as compared to girls. ODD also often co-occurs with another common childhood externalizing behavior, ADHD (APA, 2000). Children with ADHD are hyperactive, impulsive, and/or inattentive. Again, this is a disorder that is found more frequently in boys. It also affects three to seven percent of school-age children (APA, 2000).

Prenatal and Genetic Factors

There is a plethora of research about the negative effects of exposure to teratogens on developing infants. Mental health and behavioral problems in children can often be linked to prenatal factors such as cigarette smoking, alcohol use, marijuana use, and cocaine use (Brook, Zhang, & Fagan, 2008; Davis et al., 2007; D'Onofrio et al., 2008; Morrow et al., 2009; Roza et al., 2009; Weinstock, 2005; Williams & Ross, 2007). A frequently researched teratogen linked to externalizing behaviors in young children is prenatal exposure to cigarette smoke (Brook et al., 2008; D'Onofio et al., 2008; Roza et al., 2009; Williams & Ross, 2007). Brook et al. (2008) also linked cigarette exposure to internalizing behaviors. Whether or not the relationship between cigarette exposure and internalizing behaviors is still significant after controlling for confounding variables such as low socioeconomic status, prenatal care, and race, is still being debated (Brook et al., 2008; D'Onofio et al., 2008; Williams & Ross, 2007).

It is apparent that there is an interaction between prenatal exposure to toxins and behavioral problems in children. Researchers have also investigated the relationship between maternal and paternal genetic factors that would predispose children to externalizing and internalizing behavioral problems. The relationship between parental mental health needs and child behavioral problems is prevalent in the literature (Alpern & Lyons-Ruth, 1993; Cunningham & Boyle, 2002; Dave, Sherr, Senior, & Nazareth, 2008; Forbes et al., 2006; Goldstein et al., 2007a; Kopp & Beauchaine, 2007; Ohannessian et al., 2004; Thompson et al., 2007). Kopp and Beauchaine (2007) found that depressive symptoms in the mother and antisocial characteristics in the father independently predicted child depression and conduct problems in children. Cunningham and Boyle (2002) found that mothers of children at risk for ADHD reported higher levels of depression than mothers in a non-ADHD subgroup.

Studies have found that many parents who engage in unhealthy behaviors during pregnancy also have a comorbid psychiatric disorder themselves (Ohannessian et al., 2004; Lucas, Goldschmidt, & Day, 2003; Roza et al., 2009). Perhaps parental mental health needs of the parent, using harmful substances during pregnancy, and child behavioral problems are all related. Maybe the relationship between parent mental health needs have and child behavioral problems is mediated by prenatal exposure to harmful substances. This area is obviously in need of more research.

Microsystem

The microsystem level involves the individuals who have a direct relationship with the child and who interact with him or her on a regular basis. For most children with mental health needs, individuals in the microsystem would include parents, siblings, peers, teachers, and medical care professionals. Because a child is often within a family system, sometimes it can be

difficult to separate a child's mental health disorder from effects stemming from his or her family and environment. It may also be difficult to correctly diagnose mental health needs for children who have trouble expressing their thoughts verbally. Often, professionals only have a list of reported behavioral problems from the parents or caregivers. Getting an accurate picture of a child with mental health needs and his or her surrounding contexts can be difficult for professionals.

Parents and Parenting Factors

There appears to be a significant relationship between child behavioral problems and parental stress (Briggs-Gowan, Carter, Skuban, & Horwitz, 2001; Duchovic, Gerkensmeyer, & Wu, 2009; Goldstein, Harvey, & Friedman-Weieneth, 2007b). Duchovic et al. (2009) reported that internalizing behavioral problems are more highly correlated with objective stress such as time demands, disruption of a social life, problems with employment, and financial concerns. Externalizing behaviors in children were more highly correlated with subjective stress such as worry, resentment, guilty feelings, sadness, fatigue, and anger. Correlation does not necessarily demonstrate causation; therefore it is difficult to discern how much stress was present before the child was born and exacerbated by the child's behavioral problems, and how much stress was caused by the child's behavioral problems.

Another relationship between parents and children with mental health needs appears to be the relationship between child behavioral problems and negative parenting strategies (Cunningham & Boyle, 2002; McKee et al., 2007). Cunningham and Boyle (2002) found that mothers of children at risk for ADHD and ODD reported twice as many negative parenting styles as positive parenting styles. McKee et al. (2007) found that internalizing problems in children were associated with mothers' harsh verbal discipline and fathers' harsh verbal and physical

discipline. Externalizing problems in children were associated with mothers' physical discipline and fathers' harsh verbal and physical discipline. Again the question can be asked about how parenting styles is related to child behavioral problems. Are the negative parenting style causing the increased behavioral problems, or are they in response to the behavioral problems? Goldstein et al. (2007b) suggested that researchers should conduct further longitudinal studies with parents with young children in order to begin to untangle some of these factors and decipher the role of parenting in behavioral problems of children.

Mental health therapists, and specifically mental health therapists who treat children with mental health needs, should acknowledge are that there are many factors that complicate the lives of these children and their families. The interplay of all of these factors results in stressed families who likely develop unhealthy coping skills and use ineffective parenting skills. It is evident that some parents of children with mental health concerns need assistance in the day-to-day functioning of their families. For example, parents of children with extreme behavioral or emotional problems interviewed by Briggs-Gowan et al. (2001) reported that they had trouble visiting family and friends, going to new places, and completing basic errands, which worried them on a regular basis.

Siblings

While there is an abundance of literature on the effects of having a child with behavioral problems on parents, there is much less available about siblings. Siblings are an integral part of the family and can often provide information to professionals that parents cannot. As parents and possibly even siblings may also be struggling with mental health needs of their own, it is important that they have access to mental healthcare as well. Researchers have reported that if children with emotional and behavioral problems had unmet mental health needs, siblings are

likely to have unmet needs as well (Dia & Harrington, 2006; Ganz & Tendulkar, 2006). Professionals should also take note that some siblings have reported that they have poor relationships with the child with behavioral problems. Kendall (1999) interviewed siblings from 11 families and found that siblings felt victimized by their sibling with ADHD. Often, siblings felt that caregivers overlooked their needs.

Peers

During childhood, learning how to make and subsequently keep friends is a major developmental milestone. This milestone is one that is perfected over many of the first years of life. In fact, as explained by Hay, Payne, and Chadwick (2004), interaction with other children usually begins for infants at a very young age as they come into contact with other infants in the hospital. Around six months, infants begin to acknowledge and try to interact with other children and adults. Next, prosocial behaviors such as sharing and helping usually come around the first birthday. At this age, time spent interacting with others also becomes longer and more complex (Shonkoff & Phillips, 2000). As toddlers are learning how to share around age two to three, conflict usually peaks, but is often resolved by mothers rather than the children themselves. Finally, playing in groups occurs around age four to five when children are better able to manage multiple inputs to play (Hay et al., 2004). Children at this age start to put together everything that they have learned about how to be a good friend such as managing conflict, sharing, and negotiating in order to play successfully with their peers. Overall, the development of peer relationships becomes more complex as children age and their cognitive and language abilities mature. Experience also matters in that children often do better when they have previous interactions with other children (Shonkoff & Phillips, 2000).

How children behave directly influences their success in making and keeping peer relationships. Researchers have clearly demonstrated that children with behavioral problems tend to have trouble making and keeping friends and even have troubles with victimization and bullying (Bagwell, Molina, Pelham, & Hoza, 2001; Twyman et al., 2010; Van Cleave & Davis, 2006). Shonkoff and Phillips (2000) mentioned, “Rejection by peers is likely to be both a cause and an effect of conduct problems” (p. 177). The authors further explained that children with behavioral problems often have more trouble with relationships, which subsequently contributes to an increase in their behavioral problems. To successfully navigate peer relationships in early childhood, children must learn how to get along with other peers and be able to control their emotions and behaviors so that other children want to engage in play with them.

It is important for professionals to be cognizant of different behavioral problems that children may experience in order to help children develop positive peer relationships. Behavioral problems have been shown to have a bidirectional relationship with peer relationship development in that children with externalizing and internalizing disorders often have trouble with making and keeping peer relationships, which then also tends to exacerbate their behavioral problems (Shonkoff & Phillips, 2000). Children with internalizing disorders such as depression or anxiety may have trouble initiating interactions or resolving conflict through healthy communication. A lack of friends from not being able to initiate interaction or communicate may cause a child to feel more depressed or anxious. Children with externalizing behaviors such as ADHD or ODD may throw tantrums or be overly aggressive, which may get in the way of learning how to share or negotiate with other children. Not learning appropriate ways of interacting with peers may lead children with ADHD or ODD to become frustrated and possibly more aggressive.

On the other hand, Newman, Lohman, and Newman (2007) found that if children who desire to belong to a peer group can be successful at developing and maintaining those relationships, they often can lead to fewer behavioral problems as compared to children who want to be in a peer group but are not successful at developing or maintaining those relationships Overall, it is imperative that children learn how to navigate the childhood task of developing and maintaining peer relationships. This task may become extremely difficult, if not impossible, if the child is also suffering from a behavioral disorder. It is important for professionals to be able to recognize and assess these children, and provide them the appropriate help.

Teachers

Teachers see children with mental health needs on a daily basis in their classrooms. Often, teachers spend more time with the children than other caregivers. Thus, teachers can be a valuable resource for children with mental health needs who need to be diagnosed and treated effectively. Teachers can model appropriate behavior for children and teach them appropriate coping skills. Beyond that, however, teachers are in a difficult position. With overcrowded classrooms, they cannot afford to spend extra time tending to just one or two students who need extra care. Mihalas, Morse, Allsopp, and McHatton (2009) discussed how many students with emotional and behavioral disorders are not getting what they need from school. Often they drop out, are expelled, or suspended. While school counselors may be of assistance, often they are not available and spread thinly between numerous schools (Adelman & Taylor, 2006). There is an obvious need for more attention to children with mental health and behavioral problems in schools.

Pediatric Primary Care Providers

When parents and/or teachers recognize that a child is having some difficulties with behaviors or mental health, the professional that usually sees the child is the pediatrician or the family physician. Whereas parents might think that these pediatric primary care providers (PPCPs) will be able to diagnose and treat their children, the results might depend on the type of provider. Rushton, Clark, and Freed (2000) found that in cases of childhood depression, family physicians used medications more often than pediatricians, and pediatricians more often referred patients out for services. Stein et al. (2008) found similar results about pediatricians. They surveyed over 600 pediatricians about their feelings towards their responsibility of diagnosing and treating children with mental health and behavioral problems. Most, 80%, of the pediatricians felt that pediatricians should be responsible for diagnosing disorders, but less than 30% thought it was their responsibility to treat these disorders.

In another study, Williams et al. (2004) interviewed pediatricians about their diagnosing and treatment patterns of children with behavioral health needs. Pediatricians estimated about 15% of children in their practices had mental health disorders. The most common diagnosis was ADHD. Although pediatricians felt comfortable diagnosing and treating ADHD, for other behavioral health disorders, pediatricians varied on levels of comfort of diagnoses, and actual practice of making and treating diagnoses. Williams et al. (2004) reported that the pediatricians in their study hesitated to make diagnoses because they were unsure if a child met full diagnostic criteria, they were concerned about the effects of giving a child a label, and they personally were not comfortable giving diagnoses. Pediatricians have also reported needing to refer children for mental health services due the child's failure to respond to the medications that the pediatrician

prescribed, presence of severe affective symptoms, or the need for the child and/or the family to attend psychotherapy (Williams et al., 2005).

Mesosystem

The mesosystem is the connectivity and the relationships between the individuals in the microsystem. While it is important to recognize the relationship that individuals in the microsystem have with the child with mental health needs, it is also necessary to recognize the relationships that these individuals have with each other. These relationships influence these individuals who then influence the child. The main relationships between microsystem individuals that are particular to children with mental health needs are the couple relationship of the parents, the parent-professional relationship, and the pediatric primary care provider-mental health therapist relationship.

Couple Relationship

There appears to be a significant correlation between child behavioral problems and couple conflict (Goldstein et al., 2007a; Stadelmann, Perren, Groeben, & von Klitzing, 2010). Amato and Cheadle (2008) conducted a study investigated the links between parents' marital conflict, divorce, and children's behavioral problems. The researchers were primarily interested in testing the hypothesis that there is a genetic component to behavioral problems. If there is a genetic component, it is possible that there is not such a strong association between parental conflict and a child's behavioral problems: "According to this perspective, the link between parents' marital distress and child problems is spurious, with the central causal mechanism being the genetic transmission of personality traits and behavioral predispositions from parents to children" (p. 1153). Amato and Cheadle (2008) studied both biological and adopted children and

found that divorce was significantly associated with behavioral problems in both biological and adopted children.

Parent – Professional Relationship

The parent of a child with mental health needs will probably come into contact with a variety of professionals over the years. These professionals can range from pediatricians to teachers to social workers to mental health therapists. Blue-Banning, Summers, Frankland, Nelson, and Beegle (2004) also found six themes of a collaborative family-professional partnership. Parents in their study valued communication in their relationships with professionals. More specifically, professional communication is clear, honest, tactful, frequent, and positive. A second theme was commitment and shared goals for the family. The third theme was equality in decision-making. Next, parents reported that they valued skills, or competency in their child's disability. The fifth theme was trust in each other. Finally, parents reported that they needed respect for both themselves and their children.

Even though parents and teachers may not agree on a specific diagnosis for a child with behavioral and emotional problems (Ferdinand, van der Ende, & Verhulst, 2007), it is very important for parents and teachers to establish good relationships with each other. However, both school professionals and parents report that it is a challenge for them to communicate with each other (Ouellette, Briscoe, & Tyson, 2004). Parents interviewed by Ouellette et al. (2004) reported that they felt that school professionals did not listen to them or consider their views. Interactions were also primarily negative, and parents reported that they would like to hear more about their children's successes. Parents in this study requested that in addition to hearing more about their children's successes, they would also like for schools to have more flexibility in scheduling meetings.

Some researchers are looking into how a better relationship between parents and schools can be developed. Darch, Miao, and Shippen (2004) published an article for teachers on how to work most effectively with parents who have children with behavioral problems. They suggested four different features of a positive relationship: 1) being proactive about talking with parents before behavioral problems become an issue; 2) involve parents in school activities during the year; 3) talk with parents about the goals for the school year; and 4) be accommodating for diverse families. It appears that parents and teachers understand the benefits of communicating with each other for the sake of the child with mental health concerns. However, there are some barriers that are preventing this successful communication. It seems as though learning to communicate with each other would lead to better outcomes for the child. Obviously more research is needed in this area to develop some techniques for communication working around the mentioned barriers.

Parents are reporting that they value open, honest, and frequent communication when it comes to their children. Parents also want to be involved in treatment (Blue-Banning et al., 2004). As parents are a direct link between professionals and their children, it makes sense that they would want to be involved in their care. It is difficult to separate the child from the family and just treat the child. If medications have to be taken or behavioral therapy has to be done at home, parents must be involved. It seems as though professionals who can successfully communicate with parents would be more likely to help the child meet his or her treatment goals.

Pediatric Primary Care Provider - Mental Health Therapist Relationship

Please see the section in Chapter 1 titled, “Care Coordination Between Primary Care Providers and Mental Health Therapists” for a review on relationships between pediatric primary care providers and mental health therapists.

Exosystem

The exosystem includes social settings that do not necessarily involve the child, but affect the child nonetheless. Eventually, effects from the exosystem can filter down through the microsystem and the mesosystem to have either positive or negative effects on the child. While at this level, researchers usually reflect upon the effects on the families, it is important to still view the child as the center of the system. For a child with mental health needs, the exosystem involves factors such as social support, parental employment, and insurance providers.

Social Support

Social support can come in a variety of ways ranging from emotional support of a friend to the tangible, childcare support from a neighbor. While research has been conducted about social support as it pertains to the parents of children with mental health needs, very little research has been conducted about social support to individual children. Social support for parents is important to child well-being, so it is important to not overlook the importance of parent-level research. For example, Thompson et al. (2007) reported that poor family functioning, low social support, and parent psychological distress predicted mental health needs of children. Lindsey et al. (2008) also found that parents without supportive networks and with their own mental health needs are more likely to have children with mental health needs.

When a child has behavioral health problems, it can be difficult for parents to leave the house to attend support group meetings or meet with friends. Scharer (2005a; 2005b) suggested the use of an internet support group as a means for parents of children with behavioral health problems to connect to each other. The internet is an attractive option for parents who may have trouble leaving the house, finding babysitters, or who may be worried about the protection of

their identity. The use of using the internet for support is still under investigation (Scharer et al., 2009).

For children in particular, there is not a lot of research about social support. Appleyard, Egeland, and Sroufe (2007) studied families of at-risk children and found that: “Children who experienced more time with supportive individuals outside the mother, higher quality interactions with them, and more consistent social support had significantly fewer teacher-reported internalizing and externalizing problems at first grade” (p. 453). Other than parents, grandparents were reported as a major source of support for children. From this study it appears that outside social support focused directly on the child can have a positive affect similar to if the social support went through the parent first.

Parental Employment

The employment status of parents seems to have a relationship with all levels of the child’s ecological system. Starting from the individual child, it appears as though children with more severe symptoms have less frequent school attendance. Not having adequate childcare to take care of children when they miss school can lead to strain from missing work for the parents. Parental strain from missing work can lead to caregivers who decide to not participate in the workforce at all (Brennan & Brannan, 2005). Not being able to work can directly influence the financial situation of the family, often leading the family to experience financial distress. Financial distress can also contribute negative mental health. For example, Lee, Anderson, Horowitz, and August (2009) found that low family income leads to higher rates of depression, which leads to deficits in parenting skills, which can thus exacerbate child mental health needs as explained in the microsystem.

It seems as though a supportive work environment can make a big difference for parents of children with mental health needs. Parents reported that taking a leave from work improved their child's emotional and physical health, as well as their own emotional health. Unfortunately, most parents reported that taking a leave had a negative impact on their job performance. If they took an unpaid leave, it negatively impacted their finances (Schuster et al., 2009). What seems to be a never-ending cycle appears to be centered on the workplace of the parent. A supportive environment, where the parent can have flexible hours to care for his or her child if necessary, may help to reduce parent emotional distress, which may also have a positive effect on parenting skills.

Insurance Providers

Whether or not a child has health insurance can affect the level of care that he or she receives. DeRigne, Porterfield, and Metz (2009) also used the National Survey of Children with Special Healthcare Needs to investigate the prevalence of children who have unmet mental health needs, such as care or counseling, as reported by their parents. DeRigne et al. (2009) found that 20% of the almost 67% of children who needed care in the previous year, did not receive adequate mental health services. Uninsured children were almost three times more likely to have unmet needs as compared to insured children. Kataoka, Zhang, and Wells (2002) also found that uninsured children have more unmet need for mental healthcare compared to insured children (including publicly insured children).

Macrosystem

The macrosystem involves cultural variables that permeate all other levels. While there is not a lot of research on macrosystemic variables for children with mental health needs, there are a few articles that touch upon cultural and racial factors that can affect outcomes for these

children. In terms of the culture of the United States, according to a research study in 2007 (Pescosolido, Perry, Martin, McLeod, & Jensen, 2007), there is still quite a bit of stigma related to mental health treatment for children. About half of the participants, 1,393 noninstitutionalized adults from a representative sample of the U.S. population, agreed that a child who received mental health treatment would become an outsider at school and have negative consequences as an adult. Just over one third of participants reported that parents of children getting mental healthcare would feel like a failure. Quite possibly, this stigma relating to mental health treatment may contribute to why the needs of these children are not getting met.

Researchers have also studied how race factors into many of the levels of a child's ecosystem and have found racial factors to contribute to unmet mental health needs of children. A couple of studies have found that African-American caregivers are less likely than White caregivers to report mental health and behavioral problems for their children (Jaffe et al., 2005; Rose et al., 2010). If a child had Medicaid coverage, there was greater likelihood that African-American parents reported service needs (Rose et al., 2010). However, if need was reported, parents of African-American children reported higher unmet needs as compared to parents of White or Hispanic children (Inkelas, Raghavan, Larson, Kuo, & Ortega, 2007). Perhaps unmet need is due to biases from mental health therapists. Pottick, Kirk, Hsieh, and Tian (2007) surveyed 1,401 mental health therapists and asked them to judge whether or not a fictitious character in a vignette had a mental disorder or not. Using contextual information, the professionals reported White youths to have a disorder more frequently than African-American or Hispanic youths.

Chronosystem

The chronosystem involves how a child changes over time. While most of the studies about children with mental health needs concern young children, these children will eventually grow up and it is important for families to be able to prepare for adulthood. In a qualitative study, family members of young adults ages 16 to 24 with a mental health problem discussed some of the difficulties that family members have had transitioning into adulthood. Barriers to successful adulthood integration were identified as: lack of preparedness for adulthood, difficulties forming relationships, stigmatizing attitudes of family and community members, and lack of available community resources. Family members voiced concerns for more and earlier transition planning, and for mental health therapists to collaborate with family members to help support young adults making the transition (Jivanjee, Kruzich, & Gordon, 2009). It is important that researchers and professionals take the time to conduct longitudinal research to discover how children with mental health needs adapt to life as they get older and how professionals can best support them.

Summary

It is complex system of factors that seem to contribute to the development of a child with mental health needs. Because each child is different, with diverse contexts, it is difficult for researchers or professionals to develop one simple equation to explain a child's mental health. Throughout this chapter, Bronfenbrenner's (1979) ecological model has been useful in order to organize some of the research published about children with mental health needs.

From the research pertaining to the microsystem, it is evident that child behavioral problems can be attributed to many different factors. Parent mental health needs, parent stress, and parenting skills can all directly influence the mental health of the child. However, it also seems as though the mental health of the child can also affect factors such as parent stress and

parenting skills. The parent affects the child who in turn affects the parent; it is a cycle that appears to either exacerbate or help problems. Contributing to the mental health of children are also factors related to peers and siblings, who are same-age counterparts. Research clearly shows that these relationships are important, but often strained due to the mental health needs of the child. Unfortunately, these mental health concerns may worsen due to isolation, which can lead to further separation from peers and siblings. Finally, teachers and other direct care professionals are involved in the microsystem. A theme through much of the research is communication. All adults surrounding children with mental health needs desire and yet struggle to communicate with each other.

Communication among the adults is primarily discussed within the mesosystem level. Much of the research in this area is negative, suggesting that it is difficult for parents, teachers, and professionals to communicate with each other regarding children with mental health needs. A lack of time to meet and communicate seems to be the major concern regarding communication. The issue of time is a reoccurring theme among the different levels. Children with mental health needs take extra time in terms of parenting and families seem to be running in a variety of directions, from school to work to appointments. Professionals are also busy, trying to see as many patients as possible. Effective and efficient means of communication need to be developed in order to assist the individuals in the mesosystem to establish better relationships.

The exosystem level included social support (primarily for the parents), parental work, and insurance providers. While these levels do not necessarily affect children directly, they do eventually have affects that reach the child. For example, a parent with low social support seems to have higher stress, which can lead to poor parenting skills. Additionally, if a parent is fired from work, that stress and loss of income will also affect the child through the parent. Finally,

although children do not directly deal with insurance providers, whether or not the children have unmet mental health needs may be due to having insurance coverage or not. It is important for professionals to take into account all of these distal factors that eventually affect the child.

Finally, macrosystemic variables such as cultural stigma and race permeate through the different levels. If a family lives in a supportive culture, it appears as if it would be more acceptable to receive mental healthcare, and thus have less unmet mental health needs.

CHAPTER 3

PILOT STUDY

Introduction

To test the feasibility of the project, a small pilot study was conducted with professionals in the Lansing and East Lansing, Michigan areas. The main research questions for this pilot project were: 1) How feasible is the recruitment procedure for both mental health therapists and pediatric primary care providers? 2) Is an incentive needed? If so, how much is an appropriate incentive? and 3) Are the proposed interview questions clear and are they going to elicit answers that will help to answer the larger research questions?

After submitting a revision through the Michigan State University Institutional Review Board (IRB) permission was granted to begin this pilot study on Monday, February 28, 2011. There were two different informed consent documents; one offering a $20 gift card (See Appendix A) and one offering a $25 gift card (See Appendix B). Otherwise, all of the other aspects between the two informed consent documents were the same.

Mental Health Therapists

Recruitment

The researcher originally intended to locate mental health therapists through the American Association of Marriage and Family Therapy (AAMFT) Family Therapist Locator website as well as similar websites for psychologists and social workers. The researcher was then going to call each individual to: 1) ask if he or she would like to participate and determine eligibility for participation; 2) obtain his or her email to get them a copy of the informed consent; and 3) schedule an interview. The estimated time for each interview was 30 minutes to one hour. After receiving IRB approval, the names and telephone numbers of eight mental health therapists

in the Lansing and East Lansing area were gathered through the AAMFT website. On Thursday, March 3, 2011, eight mental health therapists were called. Six messages were left, none of which were ever returned. Luckily, two individuals picked up their telephones. Shortly into the conversation with the first individual, she informed the researcher that her experience was treating children and families with cancer. Unfortunately, she did not meet the criteria of the study because she did not see children with mental health needs and their families. The second individual met eligibility to participate and was interested in helping. The researcher asked for her email and emailed her a copy of the informed consent for her to review prior to the interview. She was rushed for time so she arranged to speak with the researcher the next day to set up an interview time. The next day, Friday, the researcher called the telephone number for the mental health therapist and it rang through to her voicemail. She never returned the message.

The researcher decided to take a different approach to recruitment. Three colleagues in the mental health field were emailed and asked to help with this pilot project. The researcher strategically picked a licensed psychologist, a licensed social worker, and a licensed marriage and family therapist. The informed consent was attached to each email. Two individuals were offered $20 and one individual was offered $25 in exchange for their participation. All three individuals replied and were willing to help with the pilot project.

Interview Process

The initial interview guide consisted of a screening questionnaire, a demographic section, and three main interview questions that asked about experiences working with children with mental health needs and medical providers. Primarily the researcher was interested in the collaboration and referral processes between these two types of professionals, so for each of these areas in the interview guide there was one main question and a few follow-up probe

questions that could be used as-needed. Following the interview questions there were five questions about the recruitment process, interview questions, and the incentives, that were meant to solicit feedback regarding the process.

The first participant was interviewed on March 14, 2011. She is a licensed psychologist with a Ph.D. in clinical psychology who worked down the hall from the researcher at their private practice in the community. She had been practicing therapy for about 7 years and saw 18 to 21 clients per week. She estimated that about half of her clients are children with mental and behavioral health needs. During our interview she answered all of the questions very concisely. There were a few questions that she asked for clarification before answering. Primarily, interviewing this participant demonstrated that there might be a difference between what a professional wants and what he/she actually expects to get from a pediatrician. For example, one of the questions asked, "What do you expect from a collaboration relationship?" This participant replied, "What do I *want* or what do I *expect*?" The researcher felt at that point that it was important for participants to answer both of those questions, as the answers might be different depending on their experiences. The other question we discussed for clarification was the question about the "scope of treatment" of the participant: "What do you consider your "scope of treatment" regarding children with behavioral and mental health needs?" With this question the researcher was attempting to elicit answers about therapeutic orientations or frameworks used when treating children with mental health needs. However, this participant pointed out that phrase "scope of treatment" was confusing to her. After discussing the question, she suggested that participants were asked about "their roles" regarding treatment of children with mental health needs. Other than those two questions, the participant reported that all of the other questions were clear. She also reported that she felt that the $20 incentive was fair. Overall, this

interview took about 20 minutes, including the follow-up questions that were asked at the end of the conversation.

Based on the feedback from the first interview, there were some significant changes to the interview questions. The "scope of treatment" question was reworded to read: "What do you consider your role in treating children with behavioral and mental health needs?" The probe question, "What do you expect from a collaboration relationship?" was eliminated and two more questions were added, "What do you want from a collaboration relationship?" and "What do you expect will happen?" The question, "What do you expect after you make a referral?" was also replaced with, "What do you want to happen after you make a referral" and "What do you expect will actually happen?"

After revising and adding to my interview questions based on the feedback from the first participant, the second participant was interviewed on March 18, 2011. This participant is a licensed Ph.D. social worker. He had been in the mental health field for 8 years, and in a private practice setting for 5 years. He saw about 14 total clients per week, 10 to 11 of those clients were children with mental health needs. This participant had a lot of experience working with pediatricians regarding his clients and was very helpful in providing feedback about the interview process. The interview questions started with demographic questions and then proceeded into questions about experiences working with clients. This participant reported that he felt that the way that the demographic questions were worded was awkward and sterile. He suggested that more was added to the introduction section about the importance of learning about the participants. He also commented on the reworded "scope of treatment" question. He was still confused by my question and suggested that the researcher ask, "What does your treatment look like with kids with behavioral and mental health needs?" This participant was also helpful with

the follow-up questions at the end of the interview. He thought that it would be very helpful to participants if the results were shared. However, he replied that he would not be interested in coming to a member checking meeting. He suggested that instead, participants should receive a two-page summary of the themes that were discovered through data analysis. Finally, he was asked about his thoughts regarding the $20 incentive. He replied that he would have done the interview anyways because of the friendship with the researcher and that $20 seemed like a lot of money. However, he was very grateful to receive the gift card. This interview took about 50 minutes to complete including the follow-up questions.

Between the second and the third mental health therapist interview, the researcher attempted to incorporate the suggestions from the second participant into the interview questions. The demographic and practice questions were restructured by adding an introduction sentence that would let the participants know why the researcher wanted to collect the information. The "scope of practice" question was reworded to read, "Can you describe your approach to working with children with behavioral and mental health needs?"

The third mental health therapist interview took place on March 21, 2011 and was with a licensed marriage and family mental health therapist with Ph.D. in marriage and family therapy. At the time of the interview she had been practicing therapy for 15 years and reported that she saw about 30 clients per week. She estimated that about 20 of her clients each week were children with mental health concerns. This participant answered all of the questions and did not seem to have any trouble with the wording of my questions. She received a $25 gift card and thought that the amount of money was appropriate for the time that we spent on the telephone. This interview took about a total of 20 minutes.

Conclusion

Based upon interview experiences with these three mental health therapists, significant changes were made to the research protocol and interview questions. The researcher realized that the recruitment procedure was not adequate. None of the six messages were left were returned. However, it did not appear as though email would be adequate to recruit professionals, as email addresses are not commonly posted online on directories such as the AAMFT Family Therapist Locator. For the dissertation project, the researcher decided to mail out letters to potential participants asking them to participate. A copy of the informed consent would be included with the letter.

Regarding the interview questions, the three pilot participants helped the researcher to rethink and reword many of the questions. Because these interviews were and will be over the telephone, it was tricky to help the interview to flow at a conversational pace without nonverbal cues from the other person. From the feedback from the pilot participants, the researcher decided to eliminate two of the demographic questions as they were not seen as relevant to the overall research questions or they were found them to be redundant. Changes were also made regarding the introductory statements and other transitions. Finally, the researcher expanded or clarified some of the probing questions.

As for the incentive, it appeared as though an incentive of some amount was necessary and a $20 gift card was sufficient for the participants. Finally, it was an effective use of time to complete this pilot study because the participants helped to change and clarify multiple questions in the interview guide.

Pediatric Primary Care Providers

Recruitment

The researcher located medical providers for the pilot study by looking up local pediatric practices online. Three practices (referred to as Practice A, B, and C) were found in the Lansing area and eight physicians were randomly selected out of the 12 possible physicians from these practices to participate. On Monday, March 14, 2011, the researcher mailed out recruitment letters and informed consents asking for pediatricians to participate in the research study. The four pediatricians from Practice A received informed consent forms for $25 incentives, and two pediatricians from Practice B and two pediatricians from Practice C received informed consent forms for $20 incentives. The researcher planned to call the practices about one week after mailing the letters to follow-up. On Monday, March 21, the practice manager at Practice A called the researcher. She said that one of the pediatricians was willing to have an interview at his office. This interview was arranged for the following Tuesday, March 29. The practice manager also said that she would assist by directly introducing the researcher to the other pediatricians in the office during the visit. On Tuesday, March 22, the researcher called the other two practices. The triage nurse from Practice B said that she would send a message to the pediatricians. At Practice C a receptionist said she would follow-up with the pediatricians directly. She called back the next day to say that the two physicians declined to participate in the study.

On March 24, a pediatrician from Practice B called the researcher during the middle of the day and said she was willing to participate. When she was asked about scheduling a time to participate, she said that at that time was the best time. Thankfully the researcher had voice recorders and interview questions ready to be used. The triage nurse from Practice B called back on Monday, March 28, to schedule an interview for that coming Friday to talk with the second

pediatrician. However, she called back on Tuesday to cancel the appointment. She never called back to reschedule.

When the researcher went to Practice A on March 29, she sat down with the practice manager and thanked her for her help with setting up the appointment to talk with the pediatrician. She recommended that it would be best to reach out to practice managers to recruit participants for the dissertation study. She then introduced the researcher to the other pediatricians. Unfortunately, none of the other three physicians scheduled an appointment for an interview.

Interview Process

The initial interview question guide for pediatricians was similar to the last version of the interview guide that was used for mental health therapists, but modified for the population. The interview guide consisted of a demographic section, and three main interview questions that asked about experiences working with children with mental health needs. Again, the researcher was interested in the collaboration and referral processes between mental health therapists and pediatric primary care professions, so for each of these areas there was one main question and a few follow-up probe questions that could be used as-needed. There was also a question about marriage and family therapists. The researcher was curious if medical providers were aware of this field and what (if any) general perceptions they had regarding working with marriage and family therapists.

The first pediatrician (from Practice B) was interviewed on March 24, 2011. She had been a practicing pediatrician for the past 30 years and at the time of the interview was working part-time in a practice in Lansing, Michigan. She estimated that she saw about 40 patients per week and about six to eight children with behavioral concerns per week. The participant was able

to answer all of the questions and did not seem to be confused about the wording of the questions. She graciously accepted the gift card. Overall, the interview took about 30 minutes.

The second medical provider from Practice A was interviewed on March 29, 2011. He had practiced medicine for the past 25 years and reported that he saw about 125 patients per week. He also estimated that about 40% of his patients were children with mental health concerns. Like the participant from Practice B, he answered all of the questions and provided the researcher with a wealth of information. He did not seem to have any trouble with any of the questions. This interview took about 30 minutes.

Conclusion

Interviewing medical providers is difficult because, in general, they are busy professionals with many patients on their schedules each day. The two pediatricians that were interviewed provided a lot of in-depth information that included content that would be useful in developing collaboration and referral models. They seemed to understand the interview questions and the interview flowed at a conversational pace. What the researcher learned from these two interviews is that in order to recruit medical providers, it is necessary to speak with the office manager, practice manager, or referral nurse first. Even though letters were mailed to the pediatricians, they were never spoken to directly to set up appointments. Finally, based on these two interviews the researcher concluded that the interview protocol was sufficient for the dissertation project. The questions appear to elicit the types of answers that would be needed to answer the research questions.

Final Conclusions

This pilot project was completed using three research questions to guide the project. The first question was, “How feasible is the recruitment procedure for both mental health therapists

and pediatric primary care providers?" At first it appeared that the recruitment procedure was insufficient. Recruiting mental health therapists through leaving messages was unsuccessful and only two of eight pediatricians were recruited. However, when the researcher was able to connect with these professionals, they provided information that would guide the recruitment procedure for my dissertation project. For mental health therapists the researcher will mail out introduction letters and informed consents and then follow-up with a telephone call about a week later. For medical providers the researcher will first call the practice/office managers or the referral nurse to introduce the study and talk about the best next steps depending on the particular project.

The second research question was, "Is an incentive needed? If so, how much is an appropriate incentive?" Following the pilot project it is evident that an incentive is necessary. Two professionals reported that they would not have participated if there were not an incentive. While a $20 incentive seemed sufficient for the three professionals who received that amount, the researcher decided to offer participants $25 for an interview. The reason for this is that most gift cards without activation or usage fees are in denominations of $25. The researcher decided to offer participants gift cards of $25 in order to not have fees and so there could be a wider selection of cards to for participants choose from.

The final research question was, "Are the proposed interview questions clear and are they going to elicit answers that will help to answer my larger research questions?" While the first drafts of the interview questions were not very clear, questions were redefined and reworded to become clear.

CHAPTER 4

MANUSCRIPTS

This dissertation has been completed using the 2-manuscript model. Data analysis and results have been included into the two manuscripts mentioned below. Articles will be submitted for publication one at a time. In order to avoid self-plagiarism, any information similar to one published paper will be replaced with a citation in the subsequent published papers.

Manuscript 1

Manuscript 1 is titled: "Pediatric Primary Care Providers and Mental Health Therapists: Care Coordination in Non-Integrated Settings." This manuscript will be submitted for publication in a peer-reviewed journal such as *Families, Systems, & Health, Social Science & Medicine* (Impact Factor 2.742), *Journal of Clinical Psychology in Medical Settings* (Impact Factor 1.506), or *Health & Social Work.*

Manuscript 2

Manuscript 2 is titled: "The Hidden Profession: Lack of Visibility of Marriage and Family Therapists in a Pediatric Medical Community." This manuscript will be submitted for publication in a peer-reviewed journal for marriage and family therapists such as *Journal of Marital and Family Therapy* (Impact Factor 1.116), *Family Process* (Impact Factor 1.275), or *Family Relations* (Impact Factor 1.32).

Manuscript 1

Pediatric Primary Care Providers and Mental Health Therapists: Care Coordination in Non-Integrated Settings

This research was supported by a Student Award Program grant from the Blue Cross and Blue Shield of Michigan Foundation

Abstract

Current processes about how mental health therapists and pediatric primary care providers (PPCPs) refer to and collaborate with each other about children with mental health concerns in non-integrated primary care settings are unknown. This qualitative study sought to describe current patterns between PPCPs and mental health therapists for the purpose of developing collaboration and referral models. Eighteen PPCPs and 16 mental health therapists were interviewed about their experiences working with each other regarding children with mental health concerns and data was analyzed using grounded theory methodology. The results highlight the frustrations that providers have working with and around health insurance companies. Satisfactory collaboration appears to be a balance of finding methods that work for both providers and overcoming significant barriers such as a lack of reimbursement for collaboration. Developing personal relationships between providers seems to lead to an increase in trust and thus an increase in levels of satisfaction with collaboration processes. Furthermore, the results suggest that mental health professionals should increase their visibility to medical providers and negotiate communications about patients to enhance collaboration.

Pediatric Primary Care Providers and Mental Health Therapists: Care Coordination in Non-Integrated Settings

Introduction

Treating Mental Health Needs In Primary Care

Pediatric primary care providers (PPCPs) are professionals such as physicians, nurses, and medical assistants who work in medical settings serving children. While PPCPs may be the first professionals whom families go to when a mental health problem arises for children, PPCPs may not always be the most appropriate professionals to treat children with mental health needs. Some pediatricians and family physicians have reported hesitancy in making mental health diagnoses and thus will refer patients to other professionals for diagnoses (Steele, Lochrie, & Roberts, 2010; Williams, Klinepeter, Palmes, Pulley, & Foy, 2004). Other researchers have found that many pediatricians and family physicians were comfortable diagnosing certain disorders, but not prescribing medications to treat them (Davis et al., 2012; Fremont et al., 2008; Pidano, Kimmelblatt, & Neace, 2011a; Stein et al., 2008). Finally, it may not be cost-effective for PPCPs to treat mental health concerns in their office – Meadows, Valleley, Haack, Thorson, and Evans (2011) reported that PPCPs are reimbursed less per minute for behavioral-only visits compared to reimbursement rates for medical-only visits or visits that combine behavioral and medical concerns.

Mental Health Therapists Meeting Mental Health Needs

It is imperative that children and families are able to seek out and receive the mental health care that they need from professionals in the community. To address extra support that may be needed for children with mental health needs and their families such as psychotherapy or family support services, families of these children may seek out the services of a mental health

therapist. Mental health therapists may have a variety of educational backgrounds, such as master's degrees or doctorate degrees in marriage and family therapy, social work, counseling psychology, or clinical psychology.

Care Coordination Between Primary Care Providers and Mental Health Therapists

Care coordination, interaction between providers in order to facilitate a patient's care, is an essential facet of patient care (American Academy of Pediatrics, Council on Children with Disabilities, 2005; Bodenheimer, 2008; Hunter & Goodie, 2010; McAllister, Presler, & Cooley, 2007). Regarding children with mental healthcare needs, when a PPCP is unable to provide mental health services in his or her office, it becomes necessary to coordinate care with mental health therapists to effectively diagnose and treat these children. PPCPs may not have all of the resources to provide therapy, intensive medication management, or support for the family, and may need to provide the family with additional resources. If PPCPs can assist families in receiving adequate mental healthcare through referral to and collaboration with appropriate providers, children with mental health needs may be effectively treated.

The research about PPCPs and their relationships with mental health providers such as psychiatrists, psychologists, marriage and family therapists, and social workers regarding children states that there appears to be some significant barriers to successful relationships. PPCPs frequently mentioned barriers to positive relationships with mental health therapists such as a lack of availability of appointments with mental health therapists who see children (Davis et al., 2012; Kushner et al., 2001; Pfefferle, 2007; Pidano et al., 2011a; Trude & Stoddard, 2003), a lack of information being shared between the two professionals (Williams, Palmes, Klinepeter, Pully, & Foy, 2005; Yuen, Gerdes, & Waldfogel, 1999), and a lack of insurance coverage or reimbursement for collaboration (Pfefferle, 2007; Pidano et al., 2011). Many insurance

companies do not reimburse for services that are provided when the client is not present. This is a large deterrent for professionals to agree to spend time collaborating.

Various researchers have discussed the importance of care coordination and the different models of coordinating care between mental health and primary care providers for patients of all ages (Aitken & Curtis, 2004; Blount, 2003; Bronstein, 2003; Campo et al., 2005; Collins & Collins, 1994; Doherty, 1995; Dym & Berman, 1986; Enochs, Young, & Choate, 2006; Fickel, Parker, Yano, & Kirchner, 2007; Hepworth & Jackson, 1995; Hogan, Sederer, Smith, & Nossel, 2010; Hunter & Goodie, 2010; Katon, 1995; McDaniel, 1995; Richardson, McCauley, & Katon, 2009; Strozier & Walsh, 1998). Models about collaboration and consultation in these studies range from passing back and forth brief suggestions between professionals to conducting co-therapy, where the medical provider and the mental health therapist would both see the patient or the family together.

More recently, researchers have studied the effects of integrated primary care medical settings. Integration, or working side by side for the benefit of the patient, has been shown to have positive effects on patient care when a mental health provider is integrated into a primary care setting (Auxier, Farley, & Seifert, 2011; Brucker & Shields, 2003; Correll, Cantrell, & Dalton, 2011; Glenn, Atkins, & Singer, 1984; Guevara, Greenbaum, Shera, Bauer, & Schwarz, 2009; Pidano, Marcaly, Ihde, Kurowski, & Whitcomb, 2011; Pomerantz et al., 2010; Valleley et al., 2007). Unfortunately, it seems that there are significant barriers that prevent integrated mental/behavioral healthcare from becoming a nationwide norm, “Many impediments to successful implementation persist, and these range from the reluctance of mental health practitioners to give up solo practice, the 50-minute hour, and their traditional mode of practice; archaic training models that don’t prepare psychologists to provide integrated care; to the fact

that our current third-party payor system is not constructed to meet the funding of this evolving system" (Cummings, O'Donohue, & Cummings, 2009, p. 38). Other researchers have echoed similar concerns about integrated primary care settings and have discussed what it might take for this type of model to become a nationwide norm (Kessler, Stafford, & Messier, 2009; Marloe, Hodgson, Lamson, White, & Irons, 2012; Pomerantz, Corson, & Detzer, 2009). It is not that an integrated primary care model is impossible, but rather it may not yet be a model that can be fully implemented without some significant changes to the healthcare system (Davis et al., 2012).

There is an obvious need for children with mental health concerns to receive care from professionals who are trained to diagnose and treat mental health concerns. It seems appropriate that mental health therapists who work with children would be included within the network of providers for families with children with mental health needs. However, as the ideas of care coordination and integrated primary care are progressing, but not yet feasible for all providers, the "best practices" of mental health therapists being involved with and collaborating with pediatric primary care providers in non-integrated settings is unclear. The purpose of this study is to discover if mental health therapists are currently working to coordinate care with pediatric primary care providers through collaboration and referral procedures in non-integrated primary care systems.

Methods

Participants

Licensed and practicing pediatric primary care providers and licensed and practicing mental health therapists in Kent County, Michigan, who treat children with mental health needs were recruited for interviews about their experiences working with each other. "Children" in this

study were defined as individuals between zero and 18 years of age. A “pediatric primary care provider” was defined as a professional with a degree in the medical field, who worked in a medical setting, and who treated children ages zero to 18 at their primary medical setting. Not all medical providers needed to treat only children, but children needed to be included as part of their practice. A “mental health therapist” was defined as a professional with a degree and a license to practice therapy.

Kent County, Michigan. Kent County is located on the western side of Michigan and according to the U.S. Census Bureau (2012), the 2010 population of Kent County was 602,622, while the state of Michigan’s total population was estimated to be 9,883,640. About 26% of the population of Kent County was reported to be under 18 years old. Caucasian individuals make up the largest race in Kent County (79.9%), similar to the entire state of Michigan (78.9%). The median household income from 2006 to 2010 was reported to be $49,532 in Kent County and $48,432 in the state of Michigan. The U.S. Census Bureau reported that 14.3% of persons in Kent County lived below the poverty level from 2006 to 2010. This figure is similar to the reported 14.8% of persons living below the poverty level across Michigan during that same time period.

Kent County’s mental health system is comprised of many agencies as well as mental health providers in private practice. Network180 is the community mental health agency for Kent County. This agency works to connect “individuals and their families to services for mental illness, substance use disorders, or developmental disabilities” (Network180, 2012). Network180 is has multiple locations around Kent County serving members of the community.

Just as there are many mental health agencies in Kent County, there are also a variety of healthcare facilities ranging from hospitals to smaller clinics with independent practitioners.

There are 40 hospitals in Kent County (MI HomeTownLocator, 2012) that accept a variety of health insurance plans as well as help patients without insurance.

Grounded Theory

The purpose of the current study was to investigate the professional experiences of pediatric primary care providers and mental health therapists to build a theoretical model to describe their current experiences working with each other regarding children with mental health concerns. Grounded theory is different from other qualitative approaches in that it moves from description of a phenomenon to a search of an explanatory theory (Creswell, 2007). The following research questions seek to discover information about the relationships between mental health therapists and pediatric primary care providers that will allow the development of a theory to better the lives of children with mental health needs. For the purpose of this study, the term "collaboration" is defined as any action by a professional to coordinate care for their patient with another professional.

Major Research Questions

1. How can the collaborative relationship between mental health therapists and pediatric primary care providers (PPCPs) in non-integrated settings be created and/or be improved for children with mental health needs?

    a. What patterns of collaboration are currently present in the relationships between mental health therapists and PPCPs? Do they work? What can be changed to increase positive collaboration between the professionals?

    b. What patterns of referral are currently present in the relationships between mental health therapists and PPCPs? Do they work? What can be changed to increase referrals between the professionals?

Procedure

Pediatric primary care provider recruitment. Research participants were found through locating medical practices within Kent County, Michigan. Practice managers, staff who are in charge of the schedules for medical professionals within each medical office, at each location were contacted via telephone first. During this conversation, the researcher gave a brief introduction about the research study and asked to send more information to the office. After establishing contact with the practice manager, the researcher emailed or faxed a letter describing the study and the informed consent document. The letter describing the study asked the practice manager to connect the researcher with medical providers who treat children ages zero to 18 for a short telephone interview. The letter also asked that the practice manager give a copy of the informed consent to providers who were interested in an interview. In some cases the practice manager called or emailed the researcher to set up interview times while in other instances providers called or emailed the researcher directly to set up the telephone interview. The researcher drove to meet two providers to at their offices to conduct the interviews in person.

Mental health therapist recruitment. Research participants were located by searching the internet for mental health therapists practicing in Kent County, Michigan who treated children ages zero to 18. A letter introducing the research study and the informed consent were mailed to each professional. The letter describing the study asked the provider to contact the researcher for a short telephone interview. All interviews with mental health therapists were completed over the telephone.

Interviews. At the time of the interview, each participant was asked if he or she had any questions about the study and to verbally consent to participate in the project. The researcher also explained that the interview would be audio-recorded. The researcher then used a semi-

structured interview guide to conduct the interview with each participant (See Interview Guides in Appendices D and E). Following the interview, participants were either given directly or were mailed $25 gift cards for their participation in this research study. Research participants were also asked to send information about the research study to colleagues in the area who might be interested in participating.

Following data analysis, all participants were invited to a meeting where the researcher presented the results that emerged from the initial interviews. While none of the original participants chose to attend the meeting, 12 medical and mental health providers from Kent County who were interested in this topic attended. These participants were members of the CHAP behavioral health workgroup (see description of CHAP below). The CHAP behavioral health workgroup is made up of individuals highly invested in the concepts of care coordination between medical and mental health professionals. All participants were asked to sign an informed consent document. This meeting was also audio recorded and two undergraduate students attended to take notes during the meeting. During this meeting, group members were allowed to talk about how their experiences fit or did not fit with the presented findings and to talk with others about the model and what this may mean for them in their practices.

Children's Healthcare Access Program (CHAP). CHAP started in 2008 and was developed as a demonstration project to provide children of Kent County, Michigan with high quality healthcare services through the use of medical homes. Specifically targeted were children on public insurance (Medicaid). The goal of the program is to see if providing these children with medical homes will increase access, improve outcomes, and reduce overall healthcare costs and medical spending for these children. It was reported in the Year 1 Report (Klein, 2010) that CHAP was able to serve 2,791 children and 2,239 parents during the first year. Other key

accomplishments include the creation of new partnerships and collaborations with professionals in the community, the development of a behavioral health workgroup to help improve the behavioral health referral process, improved healthcare access through the addition of 1,443 Medicaid slots, decreased inpatient hospitalization rates (3.3% compared to previous year), improved health outcomes in children, and efficient program costs (Klein, 2010).

Data Analysis

Data was coded using qualitative software and the three phases as described in Creswell (2007): open coding, axial coding, and selective coding. Open coding is the first stage of data analysis where the researcher looked for reoccurring categories of information. Axial coding is next, where the researcher focused on one open coding category ("core phenomenon") and used the data to develop categories around this core phenomenon. The researcher looked for types of supporting categories, such as casual conditions that may have caused the core phenomenon, strategies that were employed as a response to the core phenomenon, intervening conditions that may have influenced the strategies, and consequences or outcomes resulting from use of the strategies. Finally, selective coding was used to develop propositions that describe the interrelationships of the categories previously described (Creswell, 2007).

A graduate student trained in qualitative data analysis procedures was employed to assist with coding the data with the researcher, allowing for increased rigor of the data analysis process through the dialogue about codes and themes. The researchers sought consensus and agreement in order to enhance the data analysis process and provide a sense of trustworthiness to the data.

Trustworthiness

Trustworthiness of a qualitative study is akin to the concepts of validity and reliability in quantitative research. Trustworthiness can be established in numerous ways, but for the purposes

of this research study it was established through a reflexive statement written at the beginning of this study, multiple coders, peer review, and an audit trail that was maintained during the entire study.

Results

Participants

As described in Daly (2007), qualitative research is more likely to use a purposive sampling strategy and small sample sizes. In order to generate a theory or a model about the perspectives of pediatric primary care providers and mental health therapists about their relationships with each other, 18 licensed and practicing pediatric primary care providers and 16 licensed and practicing mental health therapists in Kent County who treat children with mental health needs were interviewed about their experiences.

Sixty-two medical practices were contacted, and 18 pediatric primary care providers agreed to complete an interview. The providers came from 12 different practices. Overall, there was a 19% practice participation rate. Seventy-four letters were mailed to mental health therapists. Forty-three people responded; therefore, there was a 58% overall response rate calculated from the total number of therapists who agreed to participate and those who declined participation. Some therapists agreed to participate but they did not meet the inclusion criteria. Overall, 16 mental health therapists were interviewed, which is a 22% participation rate.

Eleven female and seven male pediatric medical providers participated in an interview. Six participants were Doctors of Medicine (MD), four were Doctors of Osteopathic Medicine (DO), four were Nurse Practitioners (NP), one was a Registered Nurse (RN), and three professionals were certified medical assistants (CMA). Medical providers practiced in a variety of settings. Twelve professionals practiced in a family practice setting, four professionals

practiced in a pediatric office, and two professionals worked in a hospital setting. Professionals were also asked how long they have been practicing in the medical field. The number of years worked in the field ranged from 1.5 months to 42 years. The average time worked was 16 years, while the mode was 13 years. Professionals reported that they see anywhere from 10 to 400 patients per week. Two professionals could not recall how many patients they saw each week. Professionals were also asked to estimate the percentage of children that they see and that ranged from 10% to 100%. Three professionals could not recall the percentage of children. Finally, professionals were asked to estimate the percentage of children with mental health concerns and the participants reported percentages that ranged from 5% to 50%. One professional was unsure about this percentage. Please see Table 1 for complete information about PPCPs.

Eleven female and five male mental health therapists participated in an interview. Six participants had their Ph.D.'s, and 10 professionals had Master's degrees. The types of degrees were: Clinical Psychology, Counseling Psychology, School Psychology, Social Work, and Marriage and Family Therapy. Nine participants practiced in a group practice or agency setting and seven practiced in a private practice setting. Mental health therapists were also asked how long they had been practicing. The number of years ranged from five to 44 years. The average time practicing in the field was 17.38 years, while the mode was 13.5 years. Mental health therapists reported that they saw seven to 45 patients per week. Professionals were also asked to estimate how many children they saw with mental and behavioral health concerns. Participants estimated that they saw anywhere from 6% to 100% children with mental and behavioral health concerns. One professional was unsure about this percentage. See Table 2 for complete information about mental health therapists.

Table 1: *Information for Medical Providers*

Initials of Provider	Gender	License Type	Setting	Yrs in Field	Patients per week	Children per week	Children with MH concerns
JS	F	RN	Family Practice	32	40-50	100%	unknown
LS	F	NP	Pediatric Office	22	80	100%	20-25%
FD	M	MD	Family Practice	1.5 months	80-100	35-40%	20%
TH	M	MD	Family Practice	25	100	unknown	5%
SR	M	MD	Family Practice	14	70	20-25%	15%
AZ	M	MD	Family Practice	23	80-85	30-40%	10-15%
NW	M	MD	Pediatric Office	16	100-125	100%	25%
KH	F	CMA	Family Practice	4.5	120-200	40%	10%
CA	F	CMA	Family Practice	1	75	30%	30-45%
SS	F	DO	Family Practice	34	80	10%	5%
KJ	F	NP	Pediatric Office	42	80-90	100%	20%

Table 1 (cont'd)

Initials of Provider	Gender	License Type	Setting	Yrs in Field	Patients per week	Children per week	Children with MH concerns
DC	F	DO	Resident at hospital	1	80	12%	20%
MS	M	MD	Family Practice	12	unknown	unknown	20%
KA	M	DO	Family Practice	9	unknown	unknown	15-20%
HP	F	DO	Resident at hospital	5 months	10	100%	50%
CP	F	NP	Pediatric Office	34	30-45	100%	25-30%
LA	F	NP	Family Practice	8	20	30%	30-50%
MB	F	CMA	Family Practice	10	400	25%	8%

Table 2: Information for Mental Health Therapists

Initials of Provider	Gender	Degree	License Type	Setting	Yrs in Field	Patients per week	Children per week
BD	F	M.S. in Marriage & Family Therapy	LMFT	Private Practice	28	27	25%
JD	M	Ph.D. in Counseling Psychology	LMFT, LP	Private Practice	25	30	unknown
LP	F	M.A. in Clinical Psychology	LLP	Private Practice	10	20	23%
KS	F	M.S. in Social Work	LMSW	Group Practice	23	28-32	23%
LM	F	M.S. in Social Work	LMSW	Private Practice	25	20-25	6%
AH	M	Ph.D. in Clinical Psychology	LP	Group Practice	27	35	80%
KD	F	Ph.D. in School Psychology	LP	Group Practice	5	20-25	80%
JB	F	M.S. in Social Work	LCSW	Private Practice	10	25	60%
SC	F	Ph.D. in Counseling Psychology	LP	Group Practice	15	20-25	50%
DF	F	Ph.D. in Clinical Psych	LP	Group Practice	7	45	18%
SN	F	M.S. in Social Work	LMSW	Private Practice	28	25-30	60%
GM	M	Ph.D. in Clinical Psychology	LP	Private Practice	44	15-16	40%

Table 2 (cont'd)

Initials of Provider	Gender	Degree	License Type	Setting	Yrs in Field	Patients per week	Children per week
ML	F	M.A. in Clinical Psychology	LLP, LPC	Group Practice	6	9	33%
PT	M	M.S. in Social Work	LMSW	Group Practice	7	7-8	100%
SZ	M	M.S. in Social Work	LMSW	Group Practice	6	20-25	90%
JK	F	M.S. in Marriage & Family Therapy	LMFT, LLP	Group Practice	12	15	43%

Data Analysis

The interviews were transcribed verbatim by paid undergraduate research assistants using transcription software. Each transcript was double checked for accuracy by a second research assistant, and then by the lead researcher. Following transcription, data was coded using TAMS (Weinstein, 2012) qualitative data analysis software. The analytic process involved the researcher and a paid graduate student using the grounded theory approach. First, the researcher and the graduate student coded each interview transcript separately by highlighting significant statements. They then worked together to assemble similar and reoccurring statements into different codes, or group. There were 29 different codes for PPCPs and 31 different codes for mental health therapists. The language of the participants guided code names. The researcher then sorted the codes through comparing and contrasting them to help identify relationships among the codes.

Axial codes were grouped into selective codes and are depicted in referral and collaboration models for each type of professional. For PPCPs, each code fit into one of five selective codes. The first four selective codes are depicted the referral model (See Figure 4) and the last two selective code is represented in the collaboration model (See Figure 5). For mental health therapists, each code fit into one of five selective codes. The first two selective codes are depicted the referral model (See Figure 6) and the last three selective codes are represented in the collaboration model (See Figure 7).

Figure 4: Model Representing Referrals from PPCPs to Mental Health Therapists. Bolded statements indicate selective codes.

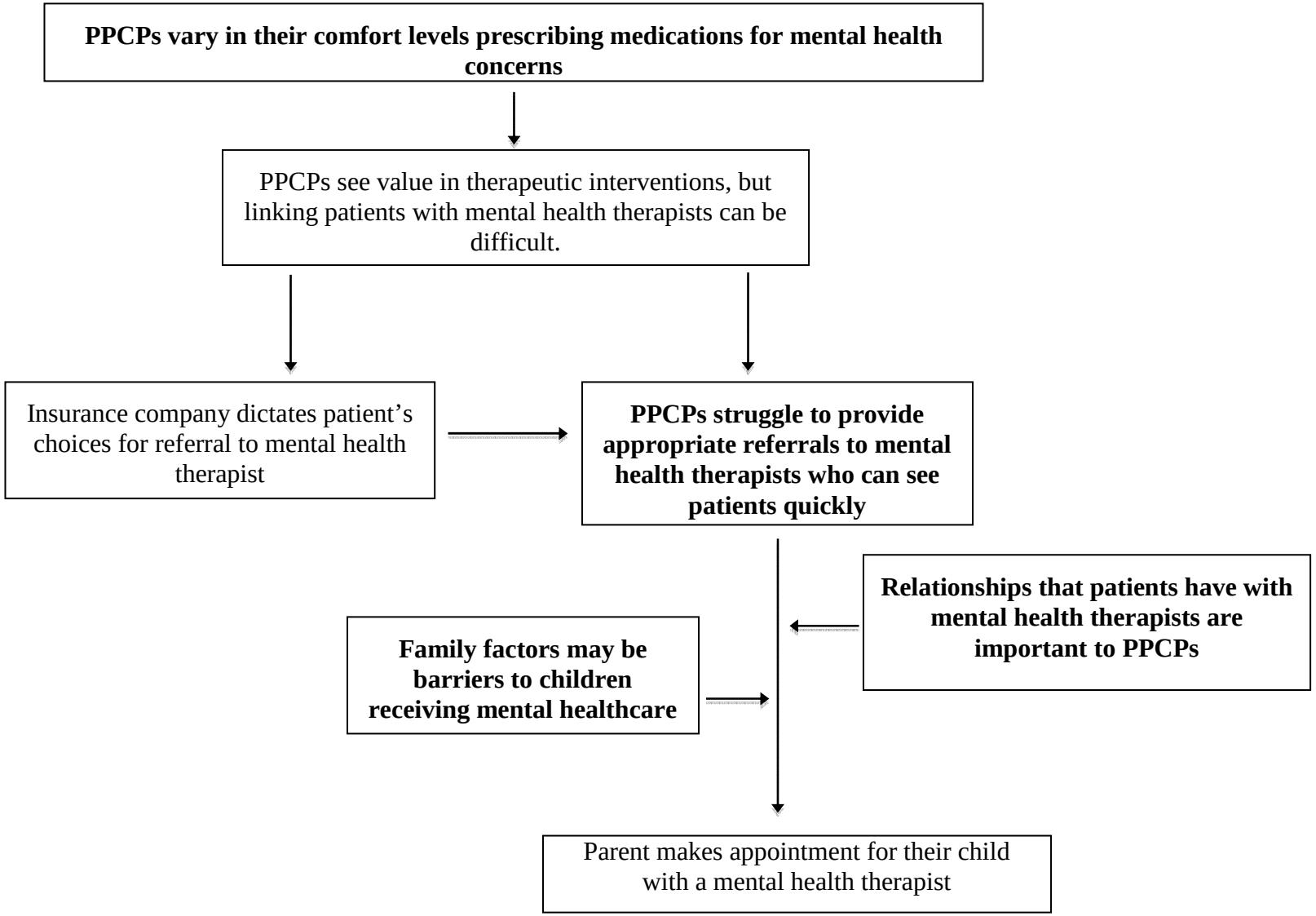


Figure 5: Model Representing Collaboration Processes Between PPCPs and Mental Health Therapists. Bolded statements indicate selective codes.

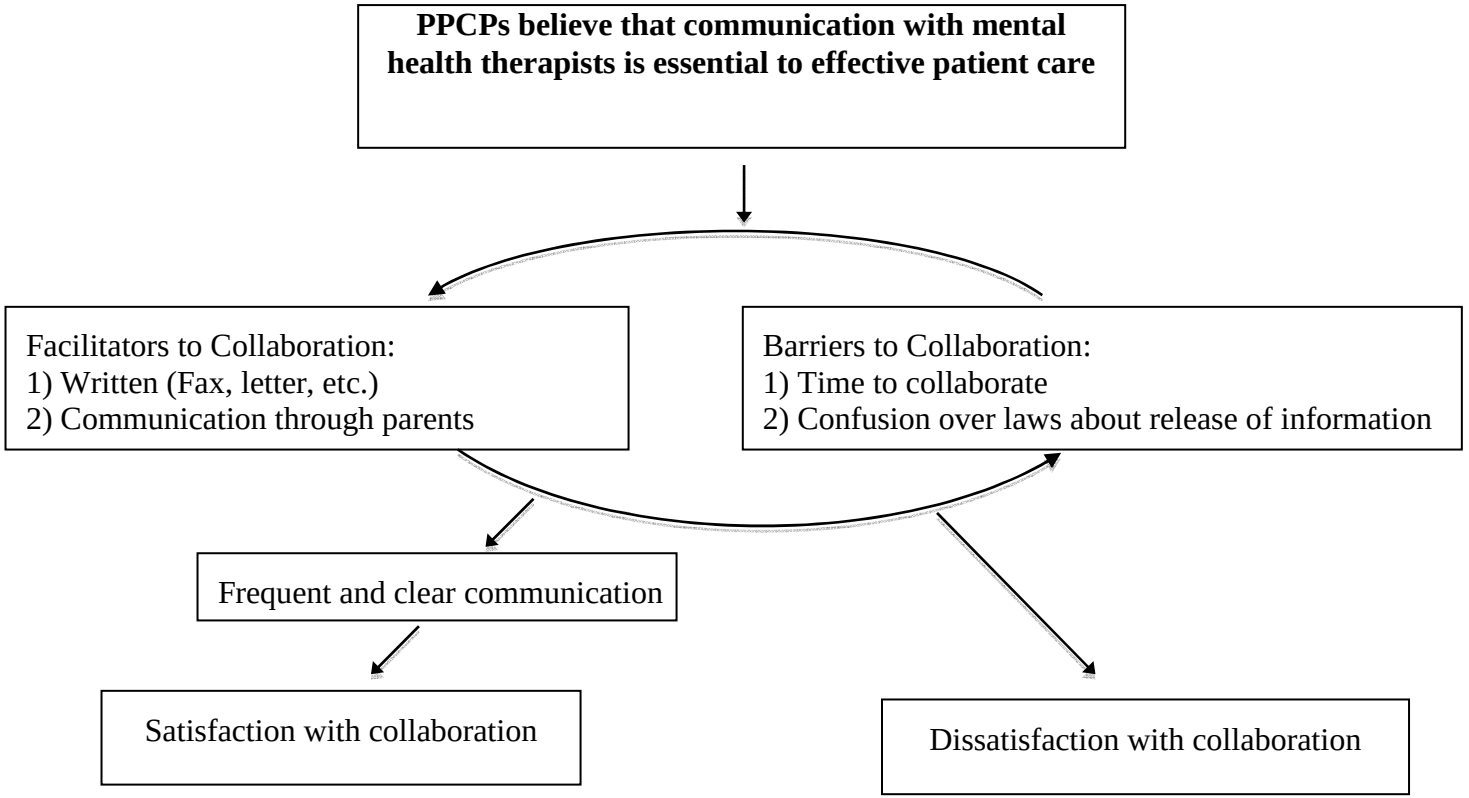


Figure 6: Model Representing Referrals from Mental Health Therapists to PPCPs. Bolded statements indicate selective codes.

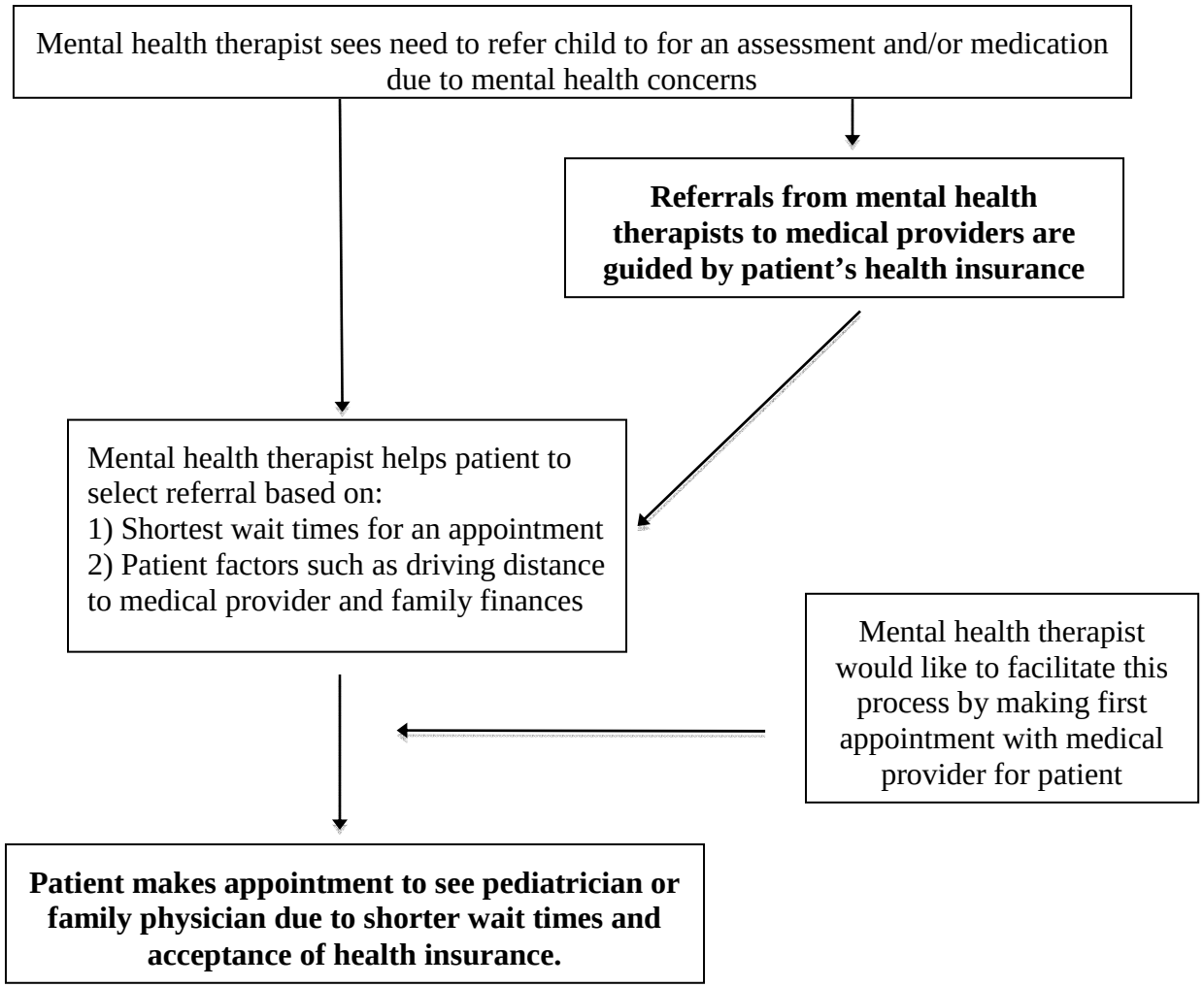
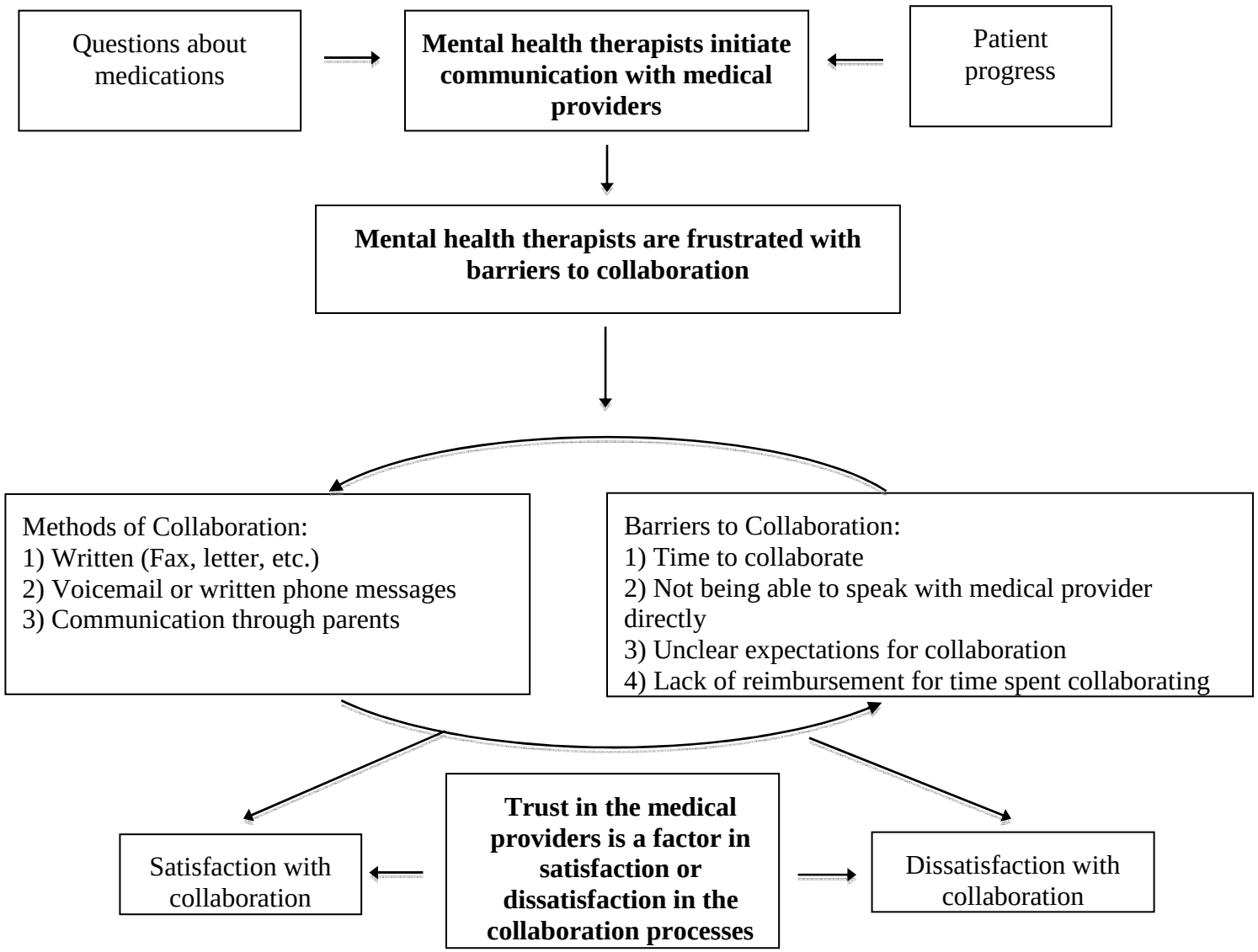


Figure 7: Model Representing Collaboration Processes Between Mental Health Therapists and PPCPs. Bolded statements indicate selective codes.



Explanation of the PPCP Models

1. PPCPs vary in their comfort levels with prescribing medications for mental health concerns. Pediatric primary care providers (PPCPs) had a variety of comfort levels when treating children with mental health concerns. While some PPCPs reported feeling more comfortable due to their own personal experiences or education about mental health concerns and medications, often, the severity or lack of clarity about mental health concerns and complexity of medications determined physician comfort with medication management. Providers seemed most comfortable with trying one or two medications for less severe diagnoses (ADHD, depression, anxiety, etc.). However, due to long wait times to see psychiatrists, PPCPs reported that they felt the need to prescribe medications even when not comfortable. One provider explained,

> Well, I have to start treating myself, which often times is at the point of multiple medications or treating a diagnosis that I'm not comfortable following myself and have requested psychiatric consultation. Instead of letting the child be on no treatment, I begin the treatment that I feel would be their best bet and then ask the psychiatrist to take over management and adjust medication or add medications as needed.

Not having enough access to psychiatrists was mentioned as a significant barrier to children receiving proper medication management. Medical professionals would like to refer patients to psychiatrists for medication management or an evaluation, but they reported that it is nearly impossible to find a psychiatrist who would see a child relatively quickly. The range of wait times to get a child into a psychiatrist ranged from a few weeks to a few months. Thus, the burden of medication falls to the PPCP, who may not be comfortable taking on this responsibility.

2. PPCPs struggle to provide appropriate referrals to mental health therapists who can see patients quickly. Most providers reported that they support therapeutic interventions in

addition to medication. PPCPs would like to see children in therapy in addition to taking medications, and in some instances, providers mentioned that they would like children to try therapy prior to beginning medication. However, participants reported that they are frustrated when trying to connect patients with mental health therapists. Referrals to mental health therapists seem to be largely dictated by the insurance companies. Health insurance companies contract with particular mental health therapists to provide services for their members. Members of a particular insurance company will only get services reimbursed if they seek services from these contracted providers. Depending on the particular insurance company, providers and agencies can be overloaded with referrals, causing waitlist times for appointments to be long. If members choose to seek services from therapists not in-network with their health insurance company, members are either left to pay for all of the services out-of-pocket, or they are required to pay a large deductible and/or co-pays for out-of-network services.

PPCPs reported that it is impossible to keep up with mental health therapists who are contracted with particular health insurance companies. Lists of contracted mental health therapists change on a regular basis with the fluctuation of providers moving in and out of the geographic area. When patients seek referrals for mental health services through their insurance companies, PPCPs reported that often families are responsible for connecting with mental health therapists in terms of finding a mental health therapist contracted with their insurance company and making the first appointment.

When providers do have the option to provide patients with referrals, they reported that they try to take patient factors into account such as the age of the patient and the driving distance to the mental health therapist. They try to connect patients with providers who specialize in seeing children of that specific age. They also try to find therapists who are located close to the

patient's home to reduce transportation expenses. In these cases, the PPCP would most likely try to use a referral list that is kept in the office. Ultimately, PPCPs would like to have a directory of mental health therapists in area; put together by a third party, because it is hard to keep referral lists current. "We have a list that we have trouble keeping current of professionals - psychologists, therapists, hospitals, clinics - that we will use as a starting point to get them going… just keeping current with who is taking new patients, and what the coverage is, it is harder to do, people come and go in the community…" reflected one provider.

There is also uncertainty with giving patients referral lists because of unknown wait times to get an appointment with a mental health therapist and assurance that all professionals on the lists see children. When a PPCP does not have in mind a specific mental health therapist who will be a good fit for the patient, he or she might try to use personal resources such as calling mental health therapists familiar to the provider in the area for a consultation or the referral might get passed to someone else in the office (such as a referral nurse) who will help the patient find a mental health therapist. Most likely, due to a lack of availability and uncertainty about professional clinical interests, the patient will be referred to a local agency because of the variety of professionals in the agency. PPCPs reported that they assume that when they referred a patient to a mental health agency, the agency will be able to find a mental health therapist in the office appropriate for that patient or give the patient a referral to another mental health service provider or agency.

3. Relationships that patients have with mental health therapists are important to PPCPs. PPCPs see value in establishing relationships with mental health therapists. They want to know about the other professional because the relationship, or the fit, between the mental health therapist and the patient are important to the provider. The PPCP wants to know that the

patient will be comfortable with the mental health therapist, thus helping therapy to be more successful, “You know what I want to see is my patient doing better, so you know if they [therapist] can establish an effective therapeutic relationship with my patient, the next time I see them they’re saying, ‘yeah this therapy has been really helpful and this is the goal and this is what I’m working on,’ obviously that is best” remarked one medical provider. PPCPs reported that they would like to get to know more mental health therapists in the community face to face and are open to marketing by mental health therapists in the area to help become increase familiarity between professionals**.**

4. Family factors may be barriers to children receiving mental healthcare. Other barriers to referring patients to mental health therapists for services are the patients themselves or their parents. PPCPs reported that some parents seemed reluctant to have their child evaluated or seek counseling for a mental health concern. One provider commented, “You know having the parents agree that that’s what they want to do, that counseling is appropriate, sometimes we have to talk to both parents for them to understand why its important. Parents can also be skeptical about putting children on medication, which may result in fewer follow-throughs with making appointments and longer wait periods before children are seen. Finally, PPCPs reported that the cost of mental health services is a barrier to treatment, especially when the patient does not have adequate insurance or coinsurance payments are high.

5. PPCPs believe that communication with mental health therapists is essential to effective patient care. While PPCPs prefer to have written reports from mental health therapists following a referral, this does not always happen. Written communication helps providers to provide better care for their patients because they can be aware of how the patient is progressing through treatment. It is also easier for them to maintain the information and retain it with the

patient's file. One provider commented,

> I prefer a fax over a phone call, because then it can be saved into something I can go back to. I've had providers call me in the middle of a busy day, and you know you're listening, but six other people are trying to get your attention, and you don't always absorb everything and can't always remember all of the things that they pointed out. So I prefer written communications via fax or via the U.S. mail.

Some PPCPs reported that they preferred a written note following each therapy session, while others preferred progress notes periodically through treatment. The length of the desired report also depended on the provider. Some providers reported that they desired longer, comprehensive summaries:

> My preferred summary is a sometimes two, sometimes five, occasionally 10 page letter that goes through the details of the testing they have done and the results that they found, the follow up with the family, especially during the testing phase or even the counseling phase. They [therapists] don't have to send me weekly reports if they are seeing them [patients] weekly, but I'll get a three month summary or a six month summary or I'll get a summary of things that have dramatically changed and sometimes those are one page, but you know it's written directed to me, about our patient that we are mutually caring for, and it helps speed direct care

Other providers commented that they did not have time to read longer reports and preferred one-page summaries such as one provider, "I would say personally I appreciate having a concise report. Sometimes it is pages and pages long so while I appreciate that evaluation was thorough, if it can be summarized that helps me." There was no consensus in this area as to what exactly providers desired in terms of treatment notes or summaries. Many providers discussed that they at least would like to know the mental health therapist's thoughts on the child's diagnosis, therapeutic treatment goals, and adherence to treatment. However, despite differences in preferences for types of notes, it was clear that getting some information from mental health therapists is essential to all PPCPs. Providers reported that they have better feedback and communication with agencies rather than private practitioners. They reported that these agencies

often have a standard session feedback form that all providers in that office use.

Due to frustrations such as lack of communication, the amount of time that it takes to collaborate with mental health therapists**,** lack of reimbursement for time spent collaborating, and confusion over laws that allow release of information**,** pediatric primary care providers will often rely on the patients and the families to relay information between the two providers. Even though providers prefer written communication from mental health therapists, most providers stated that if a mental health therapist has questions about a particular patient they are welcome to call the office to speak over the telephone. Overall, it seems that frequent and clear communication between the two professionals helps the PPCP to be satisfied with the collaboration process.

Explanation of the Mental Health Therapist Models

1. Referrals from mental health therapists to medical providers are guided by patient's health insurance. When a mental health therapist feels that a child could benefit from a referral for medication due to a mental health concern, participants reported that initiation of the referral process was typically dictated by the patient's type of medical insurance. Participants reported that some insurance companies are restrictive and even though they would prefer to refer to a specific psychiatrist or medical provider; they have to first refer the patient and his or her parents to their insurance company to see if he or she has coverage for that type of appointment. "I always have to check on what the insurance coverage is that the patient has, because they have to work within what the provider has. So traditionally that's what you do first," reflected one mental health therapist.

2. Patient makes appointment to see pediatrician or family physician due to shorter wait times and acceptance of health insurance. Generally, after the patient's parents have contacted the health insurance company, the therapist is provided with a list of medical providers

that will take the patient's type of health insurance or the therapist is told that the patient is required to see a particular provider or agency, such as a community mental health agency, for medication purposes. If the mental health therapist is given a list of acceptable medical providers and the patient is not required to see a particular professional, participants reported that they often offer to review these lists with patients and their parents. One therapist commented that "I know a lot of times with insurance its hard to even refer to a particular psychiatrist, because of the limitations of if they are covered, so a lot of times I'll try to guide them to look at their behavioral health benefits on their insurance and even help them with that process because it seems overwhelming for a lot of people." Mental health therapists reported that they look for providers on these lists who they have worked with before, providers who have available appointments, and providers who are located close in proximity to where the patient lives.

Even though mental health therapists expressed interest in referring to a psychiatrist for mental health concerns for children, ultimately it seems patients are most often referred to their pediatricians or family physician for mental health needs because they are more accessible than psychiatrists. One participant mentioned that, "It depends on the situation but I do tend to work quite a bit with pediatricians and primary care physicians because quite frankly I have found them to be more accessible…" Another participant reflected that the wait time for a child psychiatrist, "Here it's probably closer to about a month or two, which is still a long way out for a lot of families…I mean if a client has to wait for a month or two to get in to an appointment and then wait another month for the meds to really start working were talking 3, 4, 5 months down the line and a lot of time wasted." There seems to be a shortage of psychiatrists who have available appointments and who can see the children quickly in this area. Therefore, in order to

have children seen quickly for mental health concerns, providers reported that they ask parents to make an appointment with the child's pediatrician or primary care physician.

It appears that the parents of the patients are responsible for choosing their own referrals in that they are responsible for navigating the maze of their healthcare insurance to secure an appointment with a professional that will accept their healthcare insurance. Mental health therapists reported being willing to recommend different providers, and even call to check on availability of appointments, but parents are responsible for making the first appointment with a medical provider - whether that is their own pediatrician or family physician or a psychiatrist. One therapist described, "If there was a need for medication then there are a couple people here in town that I would suggest to the parents that are psychiatrists if they don't already have somebody that they are aware of. So what I would do is just give them their names and then I would leave it up to the parents to contact them."

3. Mental health therapists initiate communication with medical providers. Many mental health therapists view that collaboration is necessary for effective care of the patient. In terms of the actual process of collaboration, mental health therapists reported that they are the professionals who generally initiate the communication with the medical provider, rather than the medical provider initiating communications. Communication from the mental health therapist seems to be dictated by how progress is going with the patient or if the mental health therapist has questions or uncertainty about medications. As one therapist summarized, "if the client still is continuing to regress then there is more attention placed on trying to make that one on one phone call, or one will be scheduled….So if the clients doing well, then you know, communication does not happen. But if they are continuing to regress then there would be a point something would be scheduled." Barriers to collaboration include not having enough time

in their daily schedules to contact medical providers and not receiving reimbursement from health insurance companies to provide this service, "You are putting in time for something that there isn't any reimbursement for, so you become limited in how much you can actually do that so it is tough to want to help people and know that there are opportunities to do it, but just not the hours in the day to do it then" reflected one therapist.

4. Mental health therapists are frustrated with barriers to collaboration.

Mental health therapists reported that they use primarily written communication with medical providers, but they would like to use a variety of methods to reach medical providers such as exchanging voicemails with medical providers or having face-to-face communication with them. Not being able to speak with the physician directly was mentioned frequently as a frustration. Instead, mental health therapists reported that they have to go through the nurse to speak with the provider whereas they would like to speak with the other provider directly on the telephone**.** One participant reflected upon her experiences with trying to reach a physician,

> There are so many gatekeepers to talking with a physician. There's a nurse, and then you leave her a message and then they try to get to the doctor, and the doctor might hear second hand from the nurse what you want, and then they'll require a reports so then you'll write something and fax it over about what you need. You know I wish that, ideally in a perfect world I would love to have a private voicemail for professionals to leave messages back and forth to one another. I can't imagine that I would ever catch a doc between clients, but if the doc has a private voicemail that I as a clinician can say 'Hey I need you to see Jane Doe here and the sixty seconds cliff note version is what I'm looking for. Feel free to call me on my blackberry at your convenience and let me know your thoughts.' …We can do that with message machines. But by the time we get to paperwork and three degrees of playing telephone tag that can be awfully tough, and it's not very personal…

Mental health therapists indicated that current collaboration and communication processes frequently involve the parents of the patients, which some mental health therapists viewed as empowerment. Some therapists mentioned that they compose treatment summaries with the patients and then give them the treatment summaries to take to the medical providers, "A lot of

them just kind of go with it [the letter] and then I'll find out from the parents that they [medical provider] read the letter and that they appreciated the letter" mentioned a therapist. Overall, the biggest barriers to mental health therapists collaborating with medical providers seemed to be not having enough time to thoroughly speak with medical providers**,** unclear expectations about what the other types of providers would like in terms of communications, and a lack of reimbursement for time spent collaborating.

5. Trust in the other medical providers is a factor in satisfaction or dissatisfaction in the collaboration processes. In terms of outcomes for current collaboration processes, mental health therapists seemed be split between being satisfied and dissatisfied. Being satisfied does not necessarily mean that there is frequent communication or collaboration. For some mental health therapists, a lack of collaboration is satisfactory because the mental health therapist trusts that other professionals are competently doing their job. One provider mentioned, "Frankly there are a lot of times that we [therapist and medical provider] don't talk about cases cause I just trust them that they are doing their part." Trust in the other professional seemed to be a large component of the relationships between mental health therapists and medical providers and seemed to be built through established relationships that happened over time through being located in an office near a medical provider, and meeting professionals that expressed value in therapeutic treatment. One therapist reflected, "I think all the other positions and professionals who worked with me respected my depth of knowledge and training and vice versa."

Mental health therapists had a variety of ideas on how some of the barriers could be overcome to lead to better relationships with medical providers. Mental health therapists thought that some level of integrated care, such as co-location, would help to increase collaboration between professionals. Some mental health therapists also thought that electronic medical

records would enhance communication with medical providers by making it easier to gain access to patient records for either the mental health therapist or the medical provider. Finally, mental health therapists acknowledged that it would benefit their patients as well as their relationships with medical providers if they made an effort to network and become more visible to the medical community.

Discussion

Even though researchers have discussed the importance of care coordination and the different models of coordinating care between mental health therapists and primary care providers for patients of all ages that would potentially enhance relationships (Aitken & Curtis, 2004; Blount, 2003; Bronstein, 2003; Campo et al., 2005; Collins & Collins, 1994; Doherty, 1995; Dym & Berman, 1986; Enochs, Young, & Choate, 2006; Fickel, Parker, Yano, & Kirchner, 2007; Hepworth & Jackson, 1995; Hogan, Sederer, Smith, & Nossel, 2010; Hunter & Goodie, 2010; Katon, 1995; McDaniel, 1995; Richardson, McCauley, & Katon, 2009; Strozier & Walsh, 1998), it does not appear that these models are being used consistently by the majority of professionals in practice in this community. Overall, participants interviewed in this study expressed desire to connect patients with competent providers but frustrations over referral and collaboration processes can turn maintaining interprofessional relationships into an arduous task. It is essential that providers can understand the perspectives of each other regarding interprofessional collaboration and referral in order to help manage these relationships (Sessa, 1996; Shih, Wang, Bucher, & Stotzer, 2009).

Referral Patterns

Referrals from PPCPs to mental health therapists. Overwhelmingly, PPCPs reported the need for their pediatric patients to have more access to mental health providers for both

medication management and for therapy. The PPCPs in this study echoed professionals in other research studies (Williams et al., 2004) in that they have differing levels of comfort when it comes to treating mental health concerns of children in their office. While some providers are more comfortable with prescribing medications for mental health concerns, others are not. However, due to a lack of access to the appropriate providers, such as psychiatrists, physicians and pediatricians are often forced to treat children with mental health concerns even when they are not comfortable doing so. Not having enough access to psychiatrists is a significant barrier to children receiving adequate care for their mental health concerns.

Keeping a list of mental health therapists in the physician's office to give to patients appears to no longer be the most effective method of referral for therapy, taking into account the prominent influence of health insurance companies and that it seems impossible for medical offices to keep these lists current. For patients who have to rely on their health insurance company to reimburse for mental health services, the health insurance companies provide lists of acceptable mental health therapists. Unfortunately, these lists do not always specify which therapists see children or which therapists are accepting new patients. Most often, PPCPs leave families to navigate the maze of their own health insurance company. Providers would like to be more involved in helping families select appropriate mental health therapists, but this primarily depends on the patient's type of health insurance.

If a mental health therapist is not listed as a provider with the patient's health insurance company, most likely that provider will never be considered unless that provider has developed a relationship with the PPCP. Pediatric primary care providers expressed that they would like to keep a referral list of trusted professionals in the office to use when referring children to mental health therapists. Patient-provider fit is important to PPCPs. However, it is also important that

patients are seen quickly and that costs, such as driving distance and out-of-pocket expenses, are kept to a minimum. This is a difficult balance for PPCPs to maintain. This explains why agencies with multiple providers, who accept a variety of health insurance, are most often used for referrals.

Referrals from mental health therapists to PPCPs. Mental health therapists often see children who would benefit from medication in addition to therapy in order to help them with their mental health concerns. While the mental health therapist might see benefit in referring the child to a psychiatrist, more often the child is sent back to his or her PPCP (pediatrician or family physician) to begin the process of medication management. This seems to be largely a factor of the patient's health insurance coverage and the long wait times for children to get in to see a psychiatrist. Despite evidence that PPCPs may not be completely comfortable treating mental health concerns of pediatric patients (Williams et al., 2004), it appears that pediatricians and family physicians are still the more accessible professionals as compared to psychiatrists who might be more qualified to treat mental health concerns.

Connections between referral patterns. Both types of professionals expressed that they would prefer to refer children with mental health concerns to a psychiatrist for a medical diagnosis or medication evaluation. However, due to a shortage of available child psychiatrists, it seems nearly impossible to get a child into a psychiatrist's office for an appointment in a timely manner. Instead, even though it is not the ideal situation, mental health therapists and PPCPs seem to lean on each other for these needs. Both types of professionals also expressed frustrations with health insurance companies. Based on an insurance company's list of acceptable providers, it is difficult to know who is accepting new patients and who sees children with mental health concerns. Thus, mental health therapists refer back to the child's PPCP for

treatment or a referral, and PPCPs leave the decision of where to take the child up to the child's parents. Neither situation is reported to be ideal. However, there does not seem to be a solution given the considerable influence that health insurance companies have over services.

Collaboration Patterns

Collaboration from PPCPs to mental health therapists. Pediatric primary care providers reported that they struggle to get information from mental health therapists, but yet it is important for them to have information about the patient's treatment with mental health therapists. They prefer to have written feedback about treatment, but will often rely on the parents of the patients to report on how mental health treatment is proceeding. With extremely busy schedules, it seems as though PPCPs do not have the time to contact mental health therapists directly to request information and thus ask parents to relay information. Not being able to seek reimbursement for these services is also a deterrent to spending extra time tracking down information. These results align with previous research (Pfefferle, 2007) discussing barriers to collaboration.

If the PPCP can establish a relationship with a mental health therapist that includes consistent and clear communication about a patient, this seems to lead to increased satisfaction with the collaboration and the overall relationship between the providers. If the PPCP struggles to get information from the mental health therapist, he or she becomes dissatisfied and most likely tends to avoid referring patient to that provider.

Collaboration from mental health therapists to PPCPs. Mental health therapists reported that most often they are the providers to initiate communications with the PPCPs when they have questions or concerns. While this seems to be acceptable to most mental health therapists, many providers expressed frustrations and confusion over best methods of

collaboration with PPCPs. While they understand the benefit of written communication so that it can be easily added to a patient's medical record, occasionally mental health therapists would like to speak with PPCPs over the telephone. This seems nearly impossible given time constraints in that both professionals are often booked back-to-back with patients. Time spent writing reports and speaking with medical providers is not reimbursed by health insurance companies; therefore, deterring collaboration.

Finally, one of the most prominent themes mentioned by mental health therapists in regards to collaboration was the theme of trust. A mental health therapist's satisfaction or dissatisfaction with collaboration processes does not necessarily have to do with frequency of collaboration. Rather, there is an added element of trust that the mental health therapist has in the PPCP that contributes to satisfaction with the process. If the mental health therapist trusts that the PPCP is competently providing for the child, satisfaction is higher. Trust seems to be built through relationships developed over time and knowing that the provider values the work of the mental health therapist. Building trust with mental health therapists is essential to developing positive collaboration experiences. Unconditional trust stems from shared values and leads to people feeling "that they are not mere coworkers or business acquaintances, but colleagues, friends, or team members." (Jones & George, 1998, p. 539). This unconditional trust facilitates good feelings and desires to cooperate, even where there is a cost to doing so (Jones & George, 1998).

Connections between collaboration patterns. While PPCPs stated that receiving information about therapy treatment is important to their medical treatment of a child and that they rarely receive this feedback, most mental health therapists reported initiating contact and sending feedback to medical providers. There appears to be a discrepancy among what is being

sent and how often. However, mental health therapists expressed confusion over what was desired in terms of feedback; therefore, negotiation of this feedback would be an important step to implement to collaboration processes between mental health therapists and medical providers who treat children with mental health concerns.

Limitations

Both PPCPs and mental health therapists are very busy professionals, scheduling appointments generally back-to-back. Both types of professionals struggled to find time in their schedules to spend long periods of time on the telephone completing an interview. Obviously, more time on the telephone would have allowed for elaboration of answers and more in-depth questioning. Another limitation is that both types of professionals mentioned relationships with psychiatrists, yet no psychiatrists were interviewed as part of this study. It would be important for future research to include the perspectives of psychiatrists on their involvement with PPCPs and mental health therapists. Finally, this study was completed with professionals in a larger metropolitan area. While participants were located around the county in various practice types with diverse populations, results of this study may not be generalizable to professionals in other areas that differ in size or population.

Implications

The relationships between pediatric primary care providers (PPCPs) and mental health therapists overall would appear to benefit from increased empathy from both sides. Empathy has been eloquently described as the "force that makes a community whole through recognizing the interconnectedness and interdependencies among us rather than it merely being a collection of individuals" (Pavlovich & Krahnke, 2012). According to Lamm, Batson, and Decety (2007), empathy includes three primary components: "(1) an affective response to another person, which

some believe entails sharing that person's emotional state; (2) a cognitive capacity to take the perspective of the other person; and (3) some monitoring mechanisms that keep track of the origins (self vs. other) of the experienced feelings" (p. 42). Empathy connects human beings allowing shared experiences. It "creates connectedness conditions of goodwill, suspension of judgment towards the other and the finding of common ground for solution building" (Pavlovich & Krahnke, 2012, p. 135). To take the perspective of the other provider and to develop empathy for the barriers they work with would appear to help both medical professionals and mental health therapists to develop deeper and more effective connections and relationships.

Implications For Pediatric Primary Care Providers

Pediatric primary care providers (PPCPs) who wish to receive feedback from mental health therapists about children with mental health concerns should consider contacting mental health therapists about receiving feedback if they do not receive what they need in a timely manner. Due to confusion over what PPCPs need or desire, the mental health therapist may be hesitant in sending feedback. Overall, PPCPs should consider developing their own session feedback forms to guide mental health therapists when providing information about a patient's sessions. Medical providers might also consider indicating the best methods to get into contact with him or her if a mental health therapist has any questions or concerns that cannot be addressed with written communication.

While most mental health therapists interviewed for this study practiced in a group or solo practice, many were open to some form of practice integration, or attending medical appointments in the office. Understandably, there are significant barriers that might prevent practice integration, but it is important for PPCPs to understand that face-to-face interactions with mental health therapists help to build relationships and trust. Some mental health therapists

also thought that having access to electronic medical records would also enhance collaboration, but given guidelines about access to protected health information, this idea might be complicated to implement. Given that trust is an important factor when considering satisfaction of provider relationships, PPCPs might benefit from working to develop trust with mental health therapists in their geographic area. It seems imperative to positive collaboration that PPCPs communicate value in mental health interventions and the work of mental health therapists. This can be done through both written and verbal communications.

Implications For Mental Health Therapists

It would be helpful for mental health therapists to try to take the perspective of medical providers who treat children with mental health needs. Understanding the barriers that they face and the difficulties that they have in treating these children is important to developing a teamwork approach to helping these children and their families. According to Shih et al. (2009), perspective taking stimulates empathy towards other people. It appears that being able to take the perspective of medical providers and develop some empathy about the frustrations that some medical providers face when treating children with mental health needs would benefit the collaborative relationships between these two types of professionals.

Mental health therapists should understand that it is difficult for PPCPs to keep track of which mental health therapists see children and who has available appointments. Referrals from PPCPs also largely depend on the types of health insurance that the mental health therapist can accept. Being able to accept reimbursement from numerous health insurance plans and sending timely feedback about a patient's appointment to PPCPs not only helps the provider to provide effective care to the patient, it also helps the PPCP to become aware of available therapists.

Mental health therapists also should consider increasing networking efforts so PPCPs can learn more about their specialties and clinical interests. Patient-provider fit is important to PPCPs and getting to know providers on a face-to-face basis can help PPCPs to match patients with appropriate mental health therapists. PPCPs reported that they are open to networking efforts such as face-to-face meetings and receiving flyers and informational brochures.

Another way to "network" with PPCPs is through effective collaboration methods. PPCPs expressed that they would like to receive written reports about a patient's treatment progress. Providing faxed or mailed reports about a patient's treatment increases satisfaction with the PPCP about collaboration. Having PPCPs satisfied with services provided by the mental health therapist might lead to positive associations and thus increased referrals. Mental health therapists should consider contacting the PPCP to negotiate and discuss what to include in these written reports. PPCPs reported that they are open to receiving telephone calls from mental health therapists. As discussed by San Martin-Rodriguez, Beaulieu, D'Amour, and Ferrada-Videla, (2005), interprofessional collaboration involves professionals who are willing to collaborate, trust each other, have respect for each other, and have the ability to communicate.

Conclusions

As the medical field continues to evolve, it is important that the relationships between pediatric primary care providers and mental health therapists continue to change as well. Current referral patterns between the providers seem to be largely dictated by health insurance companies rather than preferences of the provider. While PPCPs and mental health therapists both prefer to make referrals to psychiatrists or other specific providers, it is hard for them to manage large lists of acceptable professionals provided by the insurance companies. With the significant number of mental health therapists vying for referrals, it is important to increase visibility to PPCPs to

receive referrals. It is also important to PPCPs that these mental health therapists are able to see their patients quickly. Effective collaboration also appears to increase visibility, referrals, and satisfaction of medical providers with services. However, the extent of the collaboration needs to be negotiated with each provider as not all medical providers wish to receive the same information. Effective collaboration is a balance of finding methods that work for both providers and overcoming significant barriers. Developing personal relationships seems to lead to an increase in trust and thus an increase in levels of satisfaction with the collaboration processes.

Manuscript #2

The Hidden Profession: Lack of Visibility of Marriage and Family Therapists in a Pediatric Medical Community

This research was supported by a Student Award Program grant from the Blue Cross and Blue Shield of Michigan Foundation.

Abstract

The current perceptions of pediatric primary care providers (PPCPs) regarding marriage and family therapists are largely unknown. Eighteen PPCPs who see children with mental health concerns were interviewed about their experiences referring to and working with marriage and family therapists. It is evident that providers are confused about the field of marriage and family therapy. Current perceptions reflect that providers perceive marriage and family therapists to only see adults or couples. Providers are unaware of marriage and family therapists in their geographic area and they are unaware of who they treat. Recommendations for marriage and family therapists to increase visibility and clarity of their role to pediatric primary care providers are provided.

The Hidden Profession: Lack of Visibility of Marriage and Family Therapists in a Pediatric Medical Community

Introduction

Marriage and family therapy has been shown to be an effective method to treat families with both mental health and medical problems. One of the founding fathers of marriage and family therapy, Salvador Minuchin (1974) described how structural family therapy was applicable to families with children with chronic illnesses such as diabetes. Campbell (2003) explored research results and found that family therapy, when a child has a medical condition, has been shown to have "health benefits for asthma, diabetes, and cystic fibrosis, and show promise for reducing the psychosocial morbidity associated with cancer and cardiac surgery" (p. 272). Family therapists have also been developing standards of care for different childhood problems that are also commonly seen by pediatricians such as Attention Deficit Hyperactivity Disorder (ADHD; Orr, Miller, & Polson, 2005), self-injurious behaviors (Askew & Byrne, 2009) and anorexia nervosa (Eisler, 2005). Family therapy also has been shown to have financial benefits. Researchers have demonstrated that family therapy can be less expensive than individual treatments (Crane & Payne, 2009). Crane (2007) found that family therapy also could reduce the number of healthcare visits without increasing healthcare costs.

In addition to general marriage and family therapists, there is a subset of family therapists called "medical family therapists" who use systems theories to treat the entire family and collaborate with health professionals who work with clients with medical problems (Doherty, McDaniel, & Hepworth, 1994). One of the fundamental tenets of medical family therapy is that "all human problems are biopsychosocial systems problems. There are no psychosocial problems without biological features, and there are no biomedical problems without psychosocial features"

(Doherty et al., 1994, p. 34). According to medical family therapists, it is impossible to separate out the biological and psychosocial aspects of individuals. Since medical family therapists treat the psychosocial aspects, and medical providers treat the biological aspects, when using the biopsychosocial approach to treating individuals, it is necessary that these two professionals work together to help the patient.

Clark, Linville, and Rosen (2009) interviewed family physicians about their experiences working with marriage and family therapists. While this study was not particularly about providers who treat children with mental health concerns, the results are important to consider when viewing the relationships between medical professionals and marriage and family therapists. The authors reported that physicians seemed unaware of marriage and family therapists in their geographic area, were unaware of the clinical expertise and scope of practice of marriage and family therapists, and when patients were referred to marriage and family therapists, the therapists provided limited feedback to the physicians (Clark et al., 2009).

The purpose of this study is to investigate, from the perspective of the pediatric primary care provider (PPCP), the extent of the relationships that they have with marriage and family therapists. More specifically, this study is an examination of the current referral and collaboration processes between PPCPs and marriage and family therapists. Suggestions as to how these relationships can be strengthened are also sought.

Methods

This study was part of a larger research study where the authors investigated the experiences of pediatric primary care providers (PPCPs) working with mental health therapists regarding children with mental health concerns (Citation for Manuscript 1). In addition to providing information about experiences working with all types of mental health therapists,

PPCPs were also specifically asked about their experiences working with marriage and family therapists. Grounded theory methodology was used for the research study as help build a theory to explain current experiences of medical providers and their relationships with marriage and family therapists. The research questions used for this portion of the research study were: A) What patterns of referral are currently present in the relationships between marriage and family therapists and PPCPs? B) Do they work? C) What can be changed to increase referrals between marriage and family therapists and PPCPs?

Eighteen pediatric primary care providers were interviewed as part of a larger study. Detailed information about the providers, how they were recruited, and a description of data analysis procedures can be found in the article titled "Pediatric Primary Care Providers and Mental Health Therapists: Care Coordination in Non-Integrated Settings" (Citation for Manuscript 1).

Results

Reflections of Pediatric Primary Care Providers on Working with Marriage and Family Therapists

1. Providers are confused about the scope of treatment for marriage and family therapists. Pediatric primary care providers (PPCPs) were asked if they ever worked with or referred children to marriage and family therapists and most providers were confused about the marriage and family therapy profession in general. Some providers were unaware of the profession and reported that they thought that marriage and family therapists were a subspecialty of another profession such as social workers or psychologists. It was difficult for providers to describe marriage and family therapists as distinct professionals. Some providers perceived that marriage and family therapists only worked with individual adults or couples. Reflected one

provider, “I guess when you say marriage and family therapists it’s kind of like I lock into the marriage part and forget about the family part.” Finally, some providers even thought that marriage and family therapists were not qualified to treat children, “I tend to recommend to families that the kids have a separate counselor who specializes in children versus using the marital specialist who is dealing with mom and dad.”

2. Providers do not actively refer children with mental health concerns to marriage and family therapists. When providers were asked about their experiences referring to marriage and family therapists, many providers reported that they were unaware of marriage and family therapists in their geographic area. One provider reflected, I would have no idea how to tell me patient to get in touch with them. I would probably end up telling them to call Pine Rest and see if they’ve got any…” Additionally, a lack of referral to marriage and family therapists seems to be related to the fact that not many marriage and family therapists are contracted to work with various health insurance companies and thus are not listed on referral sources. Providers stated that they cannot refer to professionals who do not accept health insurance because patients would not be able to pay for the services. Another reason that providers did not seem to refer to marriage and family therapists was because providers were not aware of who in their area was a marriage and family therapist, “I don’t think family therapists sell themselves enough, I will have to say that. I think it’s been a real benefit for us for people to come in and introduce themselves and say what it is that they do and what they handle. And I don’t see that happening very much.” Finally, it seems providers were frustrated with a lack of session feedback from marriage and family therapists regarding the children that see. One provider reflected upon his experience with a young patient who was involved in family treatment, “I can’t say I’ve ever received a report back from that group of counselors regarding the family unit. It just seems like they don’t feel

the need to communicate that with me, because I'm the provider of the children even though clearly it affects them."

3. Providers are open to working with marriage and family therapists. Of the providers who were aware and despite a lack of collaborative experiences with marriage and family therapists, providers seemed willing to work with marriage and family therapists. One provider talked about how she thought that family treatment would be helpful for some of her patients, "I think it would definitely be helpful in the right situation cause I think some of our problems here are family-oriented and having the family involved in treatment and discussion actually will help a lot of these cases. I definitely would be for working with marriage and family therapists for sure."

4. Awareness of marriage and family therapists is correlated with efforts by marriage and family therapists to network with medical providers. The providers who were aware of marriage and family therapists in their geographic area were aware of them due to networking efforts by the marriage and family therapists. Making efforts to make face-to-face introductions or sending information to the professional's office seemed to make an impression with the providers. "I know that some of our families do go to those and yes, I know a few because in some of those pamphlets they discuss that they specifically do family counseling and marriage counseling." Medical providers like to know who they are referring their patients to and they want to refer to mental health therapists who have interest in treating the specific problems of their patients. It is obvious that a networking done by marriage and family therapists can help increase referrals from providers.

Discussion

Through these interviews it is evident that pediatric primary care providers are confused about the field of marriage and family therapy. Referrals to mental health therapists seem to be primarily guided by health insurance companies and if marriage and family therapists are not contracted to work with health insurance companies and accept reimbursement from them, there is a high probability that PPCPs will not even know that the therapist is available to see their patients. According to the American Association for Marriage and Family Therapy (AAMFT), marriage and family therapists are not recognized by all health insurance plans. The state of Michigan seems to have fewer insurance companies recognizing marriage and family therapists than other states (AAMFT, 2012).

Medical professionals also have many misconceptions about the marriage and family therapy field, ranging from thinking that marriage and family therapy is a subspecialty of another professional or that marriage and family therapists only see adults or couples. Marriage and family therapists appear to be hidden behind other types of mental health therapists, or by referral processes that do not include them. It is not that PPCPs do not value the marriage and family therapy field; it is that they are unaware of what they do and who they treat.

PPCPs did report that they are open to working with marriage and family therapists in the future provided that barriers such as accepting health insurance reimbursement were eliminated. While each state is different in terms of recognition of marriage and family therapists, it is important for national and state organizations attempt to remedy this barrier through assisting marriage and family therapists to become contracted with health insurance companies. Otherwise, it is possible that marriage and family therapists might always be hidden behind other

professionals who are more visible to medical professionals using referral lists developed by health insurance companies.

Limitations

While the participants in this study varied on type of provider, length of time in practice, and type of practice setting, they all practice in a relatively large city. The results of this study may not be generalizable to other practice locations such as smaller cities or rural areas. Additionally, medical professionals are extremely busy and it was difficult to interview them for long periods of time. While all of the participants answered all of the research questions, elaboration on some answers were not possible due to time constraints.

Implications for Clinical Practice

The primary concern for a marriage and family therapist seeking referrals from pediatricians and family physicians for children with mental health concerns is visibility. It is imperative that marriage and family therapists network themselves and their profession to medical providers in their communities. Medical professionals interviewed for this study reported that they were open to receiving pamphlets (about a clinical topic or about a provider) or even for face-to-face introductions.

Marriage and family therapists who treat children and who want to network with pediatric medical professionals should think about the different clinical topics that they might have interest in that might also be pertinent to the medical profession. Flyers or brochures can easily be produced and sent to professionals to give out to patients. These topics might include diagnostic criteria for particular mental health concerns, parenting tips for parents of children with mental health concerns, or resources in the community for parents. Information about the

marriage and family therapist can also be placed on the brochure as a way to network to medical providers as well as potential clients.

Pediatric medical providers also expressed that they would be open to face-to-face networking attempts by mental health therapists in their geographic area (Citation for Manuscript 1). It might be useful for marriage and family therapists to contact provider offices and set up appointments to conduct introductions. Perhaps making introductions at a lunch hour while providing food to the providers might make the best impression, as this is how physicians are used to being approached by other professionals looking to network with them (such as pharmaceutical representatives). It would be also be important to bring brochures and business cards for the providers themselves as well as for providers to give to their patients. During this meeting, marriage and family therapists should be prepared to discuss clinical experiences and interests, availability of appointments, and accepted methods of reimbursement such as a list of insurance companies the therapist works with. Finally, the therapist could use this opportunity to discuss methods of collaboration and what information the medical providers would like to receive back if they do refer a patient to the marriage and family therapist.

CHAPTER 5

FINAL CONCLUSION

Overview of the Study

When a child has medical needs as well as mental health needs, care coordination, the interaction between their pediatric primary care providers (PPCPs) and other providers, becomes a necessary component of care for children (American Academy of Pediatrics, Council on Children with Disabilities, 2005; Bodenheimer, 2008; Hunter & Goodie, 2010; McAllister et al., 2007). Not all PPCPs are able to provide mental health services in their offices; therefore, these medical providers need to coordinate care with mental health therapists to treat these children. The research on PPCPs working with mental health therapists demonstrates that there are significant barriers to the two professionals working together (Davis et al., 2012; Kushner et al., 2001; Pfefferle, 2007; Pidano et al., 2011; Trude & Stoddard, 2003; Williams et al., 2005; Yuen et al., 1999).

Over the years, different models of care coordination between mental health and primary care providers have emerged (Aitken & Curtis, 2004; Blount, 2003; Bronstein, 2003; Campo et al., 2005; Collins & Collins, 1994; Doherty, 1995; Dym & Berman, 1986; Enochs et al., 2006; Fickel et al., 2007; Hepworth & Jackson, 1995; Hogan et al., 2010; Hunter & Goodie, 2010; Katon, 1995; McDaniel, 1995; Richardson et al., 2009; Strozier & Walsh, 1998). Integrated care, working side by side for the benefit of the patient, has become the latest trend in care coordination and patient care. Integrating mental or behavioral healthcare services with primary care has been shown to have positive outcomes (Auxier et al., 2011; Brucker & Shields, 2003; Correll et al, 2011; Glenn et al., 1984; Guevara, et al., 2009; Pidano et al., 2011; Pomerantz et al., 2010; Valleley et al., 2007).

While there are positive outcomes to integrated care, not all professionals are following the trend. For professionals who choose to remain in private or group practices in non-integrated settings, it is important that effective care coordination for non-integrated practice models is investigated. The purpose of this study was to discover if mental health therapists are currently working to coordinate care with pediatric primary care providers through collaboration and referral procedures in non-integrated primary care systems.

Major Findings

Care Coordination Between Medical Providers and Mental Health Therapists

Both pediatric primary care providers and mental health therapists were interviewed about their reciprocal referral and collaborative experiences. Using grounded theory methodology, five selective codes emerged from the interviews with pediatric primary care providers about their experiences working with mental health therapists: 1. PPCPs vary in their comfort levels with prescribing medications for mental health concerns; 2. PPCPs struggle to provide appropriate referrals to mental health therapists who can see patients quickly; 3. Relationships that patients have with mental health therapists are important to PPCPs; 4. Family factors may be barriers to children receiving mental healthcare; and 5. PPCPs believe that communication with mental health therapists is essential to effective patient care. Five selective codes emerged from the interviews with mental health therapists about their experiences working with medical providers: 1. Referrals from mental health therapists to medical providers are guided by patient's health insurance; 2. Patient makes appointment to see pediatrician or family physician due to shorter wait times and acceptance of health insurance; 3. Mental health therapists initiate communication with medical providers; 4. Mental health therapists are

frustrated with barriers to collaboration; and 5. Trust in the other medical providers is a factor in satisfaction or dissatisfaction in the collaboration processes.

Medical Providers Working with Marriage and Family Therapists

Pediatric primary care providers were also asked to provide reflections about working with marriage and family therapists. A finding major finding was that medical providers are confused about the scope of treatment regarding marriage and family therapists. Medical providers seem to view marriage and family therapists as only treating adult populations or as a subspecialty of another type of mental health therapist such as a social worker or psychologist. Medical providers reported that they do not specifically seek out services of marriage and family therapists. Primarily this is a result of heavy reliance on health insurance companies to dictate referrals as well as a general unawareness of the profession.

Study Limitations

All of the professionals interviewed appear busy seeing patients every day. While it was difficult for some providers to find the time, the professionals who were interviewed gave up their time to speak about their experiences with care coordination. Longer interviews with additional questions could have been helpful and would have provided additional in-depth information. However, out of respect for the professionals' time, interviews were concise and the researcher tried to be respectful if the professional seemed rushed or indicated that he or she had to end the interview.

Another limitation is that psychiatrists were not interviewed as part of this study, even though both medical professionals and mental health therapists mentioned relationships with psychiatrists when treating children with mental health concerns. Where psychiatrists would "fit" in this study – amongst medical professionals or mental health therapists – is unknown. During

the peer review session, the participants discussed this notion of where psychiatrists would fit and were unable to come to a consensus. It appears that medical professionals view psychiatrists as mental health professionals and mental health professionals view them as medical professionals. Perhaps it is unclear because they are medically trained professionals who specialize in the mental health treatment of their patients. It would be important for future research to include an investigation of which "side" psychiatrists would place themselves.

Additionally, for this specific study, participants included medical professionals and family-systems therapists. Family-systems therapists treat families using family therapy models of treatment, and are actually a smaller population of professionals who work therapeutically with families. Not all therapists identify themselves as family-systems therapists even though they may use some of the same treatment models when working therapeutically with children and their families. Therefore, the population of therapists was expanded to mental health therapists who treat children in their practice in order to ensure that it would be possible to conduct enough interviews to achieve saturation of the data. The researcher, a licensed marriage and family therapist, does not see psychiatrists practicing therapy in the same way as psychologists, social workers, professional counselors, or marriage and family therapists. The researcher views psychiatrists more of a source for medications rather than therapeutic treatment, although the researcher acknowledges that some psychiatrists do spend longer sessions with patients conducting talk therapy. Therefore, they were not included as part of this study. While this is a bias of the researcher, it is clear from the peer review meeting that both medical professionals and mental health professionals do not agree as to where psychiatrists would fit within the parameters of this current study. As stated above, the next steps of this research should

include an investigation as to where psychiatrists think that they would fit – the medical professional group, the mental health therapist group, or perhaps neither group.

Finally, this study was completed with professionals in a county in Michigan. It would be considered a diverse county for Michigan as it included a large city as well as smaller suburbs. However, results of this study may not be generalizable to professionals in other areas that differ in size or population. Also, the medical or mental health systems represented in this study may be different from other areas that have alternative strengths or weaknesses.

Future Research

Expansion of this current study should include the perspectives of psychiatrists. It is unknown whether psychiatrists consider themselves to be medical providers or mental health therapists, but since both professionals in this study mentioned frustrations in working with psychiatrists, interviewing them might provide some valuable insight into how to improve relationships regarding all providers who treat children with mental health concerns. It would be important to seek out their perspectives on working with both mental health therapists and medical providers and how they see referral and collaboration processes currently occurring and how they can be improved. Additionally, children with mental health concerns might visit other types of providers for care. It might be beneficial to also interview developmental pediatricians, developmental neurologists, or other specialists who work with children with mental health concerns about their experiences working together.

It also seems like expanding this current study to other areas of Michigan as well as other states would be important to help develop models of collaboration and referral that would be more generalizable to various types of professionals. For example, how are the models similar or different in rural areas, or in areas of high or low socioeconomic status?

Implementing interventions for improvements made to the referral and collaboration processes would be an important next step in this line of research. Both medical providers and mental health therapists reported about aspects of their relationships with the other providers that could be improved. Perhaps implementing a feedback sheet following referral and measuring subsequent effectiveness would provide professionals with a tool that would be useful in their practices.

Final Conclusions

Navigating the maze of the plethora of health insurance companies and plans seems to be a significant factor in the collaboration and referral processes for both mental health and medical providers. Each patient, with a different health insurance plan, requires providers to approach referral and collaboration from separate directions. Some companies require referrals to specific providers or agencies, and some provide lists of acceptable providers, while some provide no directions at all. It is impossible for providers to remember how each plan functions. Thus, referral processes are taken out of the control of the providers and placed in the control of health insurance companies. This is frustrating and confusing for providers. Some providers have adapted by asking patients to contact their insurance companies to gather instructions about referrals, while other providers use outdated referral lists that increases irritation of both providers and patients. Overall, it is clear that the system is not working. Mental health therapists who are not on insurance panels are not being recommended because they are invisible to patients and providers who use health insurance referral lists. More efforts need to be made to increase visibility of mental health therapists. Additionally, mental health therapists and medical providers need to work together to become more aware of each other's specialties and interests so that patients can be seen expediently by competent professionals.

Professionals agree that collaboration is an essential part of coordinated patient care. However, there appears to be confusion about how and what needs to be communicated between mental health and medical professionals. Both professionals report that it seems easier at times to rely on parents of children to communicate essential information. While some professionals see involvement of parents as empowerment, not all professionals agreed that parents should be the sole source of information. Providers need to negotiate and implement more effective methods to sending pertinent information to each other. Thus future efforts to create structures and opportunities in which both medical and mental health professionals can work to get to know each other and develop positive relationships are worthwhile investments to yield optimum care for children with mental health needs.

APPENDICES

APPENDIX A

INFORMED CONSENT A FOR PILOT STUDY

Research Participant Information and Consent Form For Interviews

Study Title: Where Do Family Therapists Fit into the Medical Neighborhood for Children with Behavioral and Mental Health Needs?

Researcher and Title: Dr. Rebecca Malouin, Principal Investigator

Department and Institution: Family Medicine and Pediatrics & Human Development, Michigan State University

Address and Contact Information: Dr. Malouin can be reached by telephone: (517) 884-0453, e-mail: rebecca.malouin@ht.msu.edu or regular mail: B113 Clinical Center, East Lansing, MI 48824.

1. Purpose of Research:

Michigan State University researchers are interested in your opinions and experiences working with other professionals regarding children with behavioral and mental health needs. We seek to discover how family systems therapists can collaborate more effectively with medical professionals given the needs and contexts of children with mental and behavioral health problems. It is necessary to discover some of the current barriers to involvement, how other professionals perceive the family therapy profession, and what patterns of referral and collaboration are being used and if they work or not. You are invited to share your experiences by participating in a face-to-face or telephone interview with one of our researchers.

2. What You Will Do:

If you decide to participate in this study, the interview will take approximately thirty minutes to one hour and will be audiotaped. Interviews must be audiotaped for data analysis purposes. Following data analysis, you are invited to a meeting with all participants in your professional area. The meeting will involve participants gathering together at one location to learn about and discuss the results of the study. If you would like to participate, please give your contact information with the researcher who will contact you at a later date to schedule this meeting. You are not required to participate in this meeting.

3. Potential Benefits:

You will not directly benefit from your participation in this study. However, your participation in this study may contribute to the understanding about the relationship between professionals who serve children with behavioral and mental health needs and their families.

4. Potential Risks:

There are no physical, legal, or economic risks to participating in the study.

5. Privacy and Confidentiality

Your confidentiality will be protected to the maximum extent allowable by law. Your responses will remain confidential. Your name will be replaced with a number that corresponds with your name. Responses will remain confidential by replacing any identifying information with that number. This list as well as the audiotapes will be kept in a locked cabinet at MSU. All completed interviews will be transcribed and stored in computer files that require passwords for up to three (3) years. All other records will also be kept for at least three (3) years after the project closes. Only members of the MSU research team, the University Institutional Review Board, or the Human Research Protection Program will be able to access your records. This study may be published or presented at professional meetings, but the identities of all research participants will remain anonymous.

6. Your Rights to Participate, Say No, or Withdraw:

Participation is completely voluntary. You have the right to withdraw or refuse to answer any questions without penalty at any time during the interview process.

7. Costs and Compensation for Being in the Study:

The only costs associated with this study will be your time. You will be provided with a $25 gift card after completion of the interview.

8. Contact Information for Questions and Concerns:

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury (i.e. physical, psychological, social, financial, or otherwise), please contact the researcher, Dr. Rebecca Malouin who can be reached by telephone: (517) 884-0453,

e-mail: rebecca.malouin@ht.msu.edu or regular mail: B113 Clinical Center, East Lansing, MI 48824.

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu, or regular mail at 207 Olds Hall, MSU, East Lansing, MI 48824.

You indicate your voluntary agreement to participate by completing this interview.

APPENDIX B

INFORMED CONSENT B FOR PILOT STUDY

Research Participant Information and Consent Form For Interviews

Study Title: Where Do Family Therapists Fit into the Medical Neighborhood for Children with Behavioral and Mental Health Needs?

Researcher and Title: Dr. Rebecca Malouin, Principal Investigator

Department and Institution: Family Medicine and Pediatrics & Human Development, Michigan State University

Address and Contact Information: Dr. Malouin can be reached by telephone: (517) 884-0453, e-mail: rebecca.malouin@ht.msu.edu or regular mail: B113 Clinical Center, East Lansing, MI 48824.

1. Purpose of Research:

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2. What You Will Do:

If you decide to participate in this study, the interview will take approximately thirty minutes to one hour and will be audiotaped. Interviews must be audiotaped for data analysis purposes. Following data analysis, you are invited to a meeting with all participants in your professional area. The meeting will involve participants gathering together at one location to learn about and discuss the results of the study. If you would like to participate, please give your contact information with the researcher who will contact you at a later date to schedule this meeting. You are not required to participate in this meeting.

3. Potential Benefits:

You will not directly benefit from your participation in this study. However, your participation in this study may contribute to the understanding about the relationship between professionals who serve children with behavioral and mental health needs and their families.

4. Potential Risks:

There are no physical, legal, or economic risks to participating in the study.

5. Privacy and Confidentiality

Your confidentiality will be protected to the maximum extent allowable by law. Your responses will remain confidential. Your name will be replaced with a number that corresponds with your name. Responses will remain confidential by replacing any identifying information with that number. This list as well as the audiotapes will be kept in a locked cabinet at MSU. All completed interviews will be transcribed and stored in computer files that require passwords for up to three (3) years. All other records will also be kept for at least three (3) years after the project closes. Only members of the MSU research team, the University Institutional Review Board, or the Human Research Protection Program will be able to access your records. This study may be published or presented at professional meetings, but the identities of all research participants will remain anonymous.

6. Your Rights to Participate, Say No, or Withdraw:

Participation is completely voluntary. You have the right to withdraw or refuse to answer any questions without penalty at any time during the interview process.

7. Costs and Compensation for Being in the Study:

The only costs associated with this study will be your time. You will be provided with a $20 gift card after completion of the interview.

8. Contact Information for Questions and Concerns:

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury (i.e. physical, psychological, social, financial, or otherwise), please contact the researcher, Dr. Rebecca Malouin who can be reached by telephone: (517) 884-0453,

e-mail: rebecca.malouin@ht.msu.edu or regular mail: B113 Clinical Center, East Lansing, MI 48824.

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu, or regular mail at 207 Olds Hall, MSU, East Lansing, MI 48824.

You indicate your voluntary agreement to participate by completing this interview.

APPENDIX C

INFORMED CONSENT FOR INTERVIEWS

Research Participant Information and Consent Form For Interviews

Study Title: Where Do Family Therapists Fit into the Medical Neighborhood for Children with Behavioral and Mental Health Needs?

Researcher and Title: Dr. Rebecca Malouin, Principal Investigator

Department and Institution: Family Medicine and Pediatrics & Human Development, Michigan State University

Address and Contact Information: Dr. Malouin can be reached by telephone: (517) 884-0453, e-mail: rebecca.malouin@ht.msu.edu or regular mail: B113 Clinical Center, East Lansing, MI 48824.

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2. What You Will Do:

If you decide to participate in this study, the interview will take approximately thirty minutes to one hour and will be audiotaped. Interviews must be audiotaped for data analysis purposes. Following data analysis, you are invited to a meeting with all participants in your professional area. The meeting will involve participants gathering together at one location to learn about and discuss the results of the study. If you would like to participate, please give your contact information with the researcher who will contact you at a later date to schedule this meeting. You are not required to participate in this meeting.

3. Potential Benefits:

You will not directly benefit from your participation in this study. However, your participation in this study may contribute to the understanding about the relationship between professionals who serve children with behavioral and mental health needs and their families.

4. Potential Risks:

There are no physical, legal, or economic risks to participating in the study.

5. Privacy and Confidentiality

Your confidentiality will be protected to the maximum extent allowable by law. Your responses will remain confidential. Your name will be replaced with a number that corresponds with your name. Responses will remain confidential by replacing any identifying information with that number. This list as well as the audiotapes will be kept in a locked cabinet at MSU. All completed interviews will be transcribed and stored in computer files that require passwords for up to three (3) years. All other records will also be kept for at least three (3) years after the project closes. Only members of the MSU research team, the University Institutional Review Board, or the Human Research Protection Program will be able to access your records. This study may be published or presented at professional meetings, but the identities of all research participants will remain anonymous.

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Participation is completely voluntary. You have the right to withdraw or refuse to answer any questions without penalty at any time during the interview process.

7. Costs and Compensation for Being in the Study:

The only costs associated with this study will be your time. You will be provided with a $25 gift card after completion of the interview.

8. Contact Information for Questions and Concerns:

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury (i.e. physical, psychological, social, financial, or otherwise), please contact the researcher, Dr. Rebecca Malouin who can be reached by telephone: (517) 884-0453,

e-mail: rebecca.malouin@ht.msu.edu or regular mail: B113 Clinical Center, East Lansing, MI 48824.

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu, or regular mail at 207 Olds Hall, MSU, East Lansing, MI 48824.

You indicate your voluntary agreement to participate by completing this interview.

APPENDIX D

INTERVIEW GUIDE FOR MENTAL HEALTH THERAPISTS

Interview Guide for Mental Health Professionals

Thank you for helping me with my study about how mental health professionals can effectively work with medical professionals regarding children with behavioral and mental health needs. First, it is important for us to know a little about the people we are interviewing.

1. What type of licensure do you have? (LMSW, LMFT, LPC, etc.)

2. What type of degree do you have?

_____ M.A., M.S., or MSW

_____Ph.D. or PsyD.

3. What area did you get your degree in? (Clinical Psychology, Marriage and Family Therapy,

etc.)

Next, I would like to begin by asking you a few questions about your experiences working with children and families in Grand Rapids.

4. How long have you been practicing therapy? (Years)

5. How many total clients or families per week do you see on average?

6. How many children with mental health needs do you see per week on average?

Next, I would like to ask you a few questions about your experiences working with medical professionals regarding the children you see in therapy.

7. Can you describe your approach to working with children with behavioral and mental health needs?

8. Please talk about the referral process for children with mental health needs.
Probes:

a. Who do you refer to for mental health needs such as diagnosis, medication, etc.?
b. What factors guide your decisions for who to refer to?
c. What do you want to happen after you make a referral?
d. What do you expect will actually happen?

9. Please talk about the collaboration that you may have with medical professionals regarding children with mental health needs.
Probes:

a. Who do you primarily collaborate with (doctor, nurse, etc.)?
b. What do you want from a collaboration relationship?
c. What do you expect will happen?
d. What do you think are the major difficulties in working with other professionals?
e. How do you think these barriers can be overcome in order to establish more efficient and effective relationships with other professionals?

Thank you very much for giving me your time for this interview.

One the ways that we are recruiting participants for this research study is through word of mouth. Can you please give me the name and possibly the contact information for another mental health professional who works with children with behavioral and mental health needs?

Name:

Telephone Number:

Please tell me the address where I should send your gift card for participating in this study:

APPENDIX E

INTERVIEW GUIDE FOR MEDICAL PROVIDERS

Interview Guide for Pediatric Primary Care Medical Providers

Thank you for helping me with my study about how mental health professionals can effectively work with medical professionals regarding children with behavioral and mental health needs. First, it is important for us to know a little about the people we are interviewing.

1. What type of degree do you have? (LPN, PA, MD, D.O., etc.)

2. How long have you been practicing medicine or working in a medical office? (Years)

3. How many total patients per week do you see on average?

4. How many children with mental health needs do you see per week on average?

5. What do you see are the major issues in Grand Rapids for families with children with behavioral and mental health needs in receiving care?

Next, I would like to ask you a few questions about your experiences working with children with behavioral and mental health needs and your experiences working with mental health professionals.

6. When treating a child with behavioral and mental health needs, at what point would you want to get the help of another professional to help you with this child's needs?

7. Please talk about the referral and collaboration processes to mental health professionals for children with mental health needs.
Probes:

a. Who do you refer to for mental health needs?
b. What factors guide your decisions for who to refer to?
c. What do you expect after you make a referral?
d. What information do you want to see from the therapist/psychiatrist?
e. If you do not get a form from them, how do you get the information you need?
f. If another professional needed information from you or needed to speak with you, what is the best way they could contact you?
g. What do you think are the major difficulties in working with other professionals?
h. How do you think these barriers can be overcome in order to establish more efficient and effective relationships with other professionals?

8. What do you know about licensed marriage and family therapists?
Probes:

a. What do you know about the education of MFTs?
b. What do you know about the theoretical orientation most MFTs use?
c. Do you refer to MFTs?
d. What are some benefits that you see to working with MFTs?
e. What do you see as major barriers to working with MFTs?
f. How do you think these barriers can be overcome to establish more relationships with MFTs?

Thank you very much for giving me your time for this interview.

One the ways that we are recruiting participants for this research study is through word of mouth. Can you please give me the name and possibly the contact information for another medical professional who works with children with behavioral and mental health needs?

Name:
Telephone Number:
Please tell me the address where I should send your gift card for participating in this study:

APPENDIX F

INFORMED CONSENT FOR PEER REVIEW MEETING

Research Participant Information and Consent Form for Peer Review Meeting

Study Title: Where Do Family Therapists Fit into the Medical Neighborhood for Children with Behavioral and Mental Health Needs?

Researcher and Title: Dr. Rebecca Malouin, Principal Investigator

Department and Institution: Family Medicine and Pediatrics & Human Development, Michigan State University

Address and Contact Information: Dr. Malouin can be reached by telephone: (517) 884-0453, e-mail: rebecca.malouin@ht.msu.edu or regular mail: B113 Clinical Center, East Lansing, MI 48824.

1. Purpose of Research:

Michigan State University researchers are interested in your opinions and experiences working with other professionals regarding children with behavioral and mental health needs. We seek to discover how family systems therapists can collaborate more effectively with medical professionals given the needs and contexts of children with mental and behavioral health problems. It is necessary to discover some of the current barriers to involvement, how other professionals perceive the family therapy profession, and what patterns of referral and collaboration are being used and if they work or not.

The purpose of this meeting is for the researcher to present information and results from the interviews that were completed previously. You have been invited, as well as other participants from your professional area, to share your thoughts and reactions to the results that will be presented today.

2. What You Will Do:

Once everyone has been seated, general introductions will be conducted. Next, the graduate student who conducted the interviews will discuss the results of the interviews with you via a powerpoint presentation. You will then have time to discuss any thoughts and reactions that you may have about the results. This meeting will take approximately one hour and will be audiotaped. This meeting must be audiotaped for data analysis. Additional researchers will also be present to take notes on the discussion.

3. Potential Benefits:

You will not directly benefit from your participation in this study. However, your participation in this study may contribute to the understanding about the relationship between professionals who serve children with behavioral and mental health needs and their families. During this meeting you will also have the chance to meet other professionals similar to you.

4. Potential Risks:

There are no physical, legal, or economic risks to participating in the study.

5. Privacy and Confidentiality

Your confidentiality will be protected to the maximum extent allowable by law. Please note that these meetings are not confidential as you will be meeting and discussing the results of interviews with other participants. Meeting participants are asked not to share information discussed during this meeting with individuals who did not attend, but there is no guarantee that this will not happen. If you have concerns about this, please discuss your concerns with the researcher before the meeting begins.

The meeting with be transcribed, but your name will be replaced with a number that corresponds with your name. Responses will remain confidential by replacing any identifying information with that number. This list as well as the audiotapes will be kept in a locked cabinet at MSU. All completed interviews will be transcribed and stored in computer files that require passwords for up to three (3) years. All other records will also be kept for at least three (3) years after the project closes. Only members of the MSU research team, the University Institutional Review Board, or the Human Research Protection Program will be able to access your records.

6. Your Rights to Participate, Say No, or Withdraw:

Participation is completely voluntary. You have the right to withdraw or refuse to answer any questions without penalty at any time during the interview process.

7. Costs and Compensation for Being in the Study:

The only costs associated with this study will be your time. You will be provided with light refreshments during the meeting.

8. Contact Information for Questions and Concerns:

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury (i.e. physical, psychological, social, financial, or otherwise), please contact the researcher, Dr. Rebecca Malouin who can be reached by telephone: (517) 884-0453,

e-mail: rebecca.malouin@ht.msu.edu or regular mail: B113 Clinical Center, East Lansing, MI 48824.

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu, or regular mail at 207 Olds Hall, MSU, East Lansing, MI 48824.

9. Documentation of Informed Consent for Peer Review Meeting.

a. Your signature below means that you voluntarily agree to participate in this group meeting.

_____

Participant's Printed Name

_____ _____

Participant's Signature Date

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