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EDITORIAL NOTE

Collaborative practices and partnerships across school mental health and pediatric primary care settings

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ABSTRACT
Education and primary care sectors have been called upon to attend to shortages in access to mental health services among children and adolescents. In response, these settings have increasingly attempted to address this need, though research exploring such collaborative efforts remains limited. The current special issue features research examining collaborations between school and paediatric primary care settings, bringing original research and clinical examples to bear on partnerships which leverage opportunities to improve access to high-quality mental health care. Articles in this special issue underscore the positive youth outcomes associated with effective collaboration across these systems and augment the literature describing innovative and successful approaches to this work. Further, articles in this issue identify barriers to collaborative efforts and present opportunities for future research and practice.

Despite estimates that 14–20% of U.S. youth experience a mental, emotional or behavioural disorder that interferes with daily functioning (National Research Council & Institute of Medicine, 2009), approximately 70% of children and adolescents do not receive mental health services (Merikangas et al., 2011). In order to more adequately address the mental health needs of American youth, several national calls have supported the expansion of mental health services for students in non-traditional mental health settings, including primary care and school settings (e.g. American Academy of Pediatrics (AAP) Task Force on Mental Health, 2009; President’s New Freedom Commission on Mental Health’s, 2003). Requests to improve the integration of mental health care in schools have long been promoted (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007) and a body of literature supporting the positive impact of school mental health (SMH) services on youth outcomes exists (Kutcher, Wei, & Weist, 2015; Weist, Lever, Bradshaw, & Owens, 2014). In addition to schools, primary care settings have been noted as critical locations for mental health care integration (World Health Organization, 2005), in part because of their potential to overcome numerous barriers to care, as well as the unique strengths presented by paediatric primary care providers (PCPs; Bray, Frank, McDaniel, & Heldring, 2004; Hagan, Shaw, & Duncan, 2008; Kolko, 2009). Indeed, efforts to support the integration of mental health in paediatric primary care.
are underway, ranging from coordinating with external specialty care providers to the integration of mental health providers within the paediatric primary care setting (Kolko & Perrin, 2014), with initial evaluations providing support for such integrative efforts (Asarnow et al., 2005; Brown, Wissow, & Riley, 2007; Sarvet et al., 2010; Weersing, Gonzalez, Campo, & Lucas, 2008).

The need for an interprofessional, inter-system approach has been underscored as a method to improve the quality of mental health care provided to youth (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). Cross-system collaboration among settings that interact to influence a child’s development (see Bronfenbrenner, 1979) is believed to have the potential to facilitate screening, prevention and intervention efforts thus improving health outcomes, reducing health care costs and involving and empowering key individuals in the youth’s life to support wellness (American Academy of Pediatrics, Council on Children with Disabilities, 2005; Stroul & Friedman, 1986). This has fuelled a focus on coordinated services provided by medical, mental health and educational professions, to better address the mental, emotional and behavioural health care needs of youth (Hoagwood, Kelleher, Feil, & Comer, 2000; Tolan & Dodge, 2005), with a particular focus on collaborative partnerships between schools and paediatric primary care settings (Power, Blum, Guevara, Jones, & Leslie, 2013; Power & Bradley-Klug, 2013; Shaw, 2003; Wodrich & Landau, 1999).

Several models exist to guide increased collaboration across systems, including schools and primary care settings (American Academy of Pediatrics, Medical Home Initiative for Children with Special Needs Advisory Committee, 2002; Stroul & Friedman, 1986). Training efforts are one primary mechanism identified to support these collaborative efforts (Bradley-Klug & Armstrong, 2014; Power, Shapiro, & DuPaul, 2003). For example, school psychology training programmes have been encouraged to include practical experiences that require interprofessional collaboration (IPC) with PCPs, as well as supplemental coursework on medical- and health-related issues and collaborative methods in medical settings (Bradley-Klug et al., 2013). In a similar vein, resources exist to train PCPs to better understand school systems and policies and improve cross-system collaboration (Bohnenkamp, Curtis, Brandt, Lever, & Stephan, 2014). Despite resource development, training and other aspects which reflect momentum in this area of collaborative partnership between schools and primary care, such partnerships have neither been consistently developed nor implemented (Schwab & Gelfman, 2005; Shapiro & Manz, 2004), and research studying implementation processes and outcomes is limited. Therefore, additional literature guiding the process of IPC across school and paediatric primary care settings is greatly needed by both sectors to advance this research and practice agenda to enhance access to mental health care for youth.

**Current special issue**

This special issue features research examining collaborations across school and paediatric primary care settings in the United States to meet the mental health needs of youth. The five articles in the special issue consider both the advantages of and barriers to IPC across these two settings and describe novel approaches to this work. Finally, articles in this special issue provide avenues for future research in this much needed but minimally addressed area.

Lyon et al. (2016) review models of care integration and describe the advantage of such models in advancing the health and mental health care of youth. They highlight the
Collaborative Care model, applied in paediatric primary care settings, as a particularly relevant model for application in schools. Outlining the synergy between multi-tiered systems of support (MTSS) in the school setting and elements of the Collaborative Care model, they highlight the adaptation of the Collaborative Care model for use in school settings. Specifically, they present an adapted service delivery and coordination model, the Accessible, Collaborative Care for Effective School-based Services in Schools model, that has the potential to better facilitate the delivery of high-quality, coordinated care between SMH providers and PCPs to support positive mental health and educational outcomes for youth. Finally, they put forth several avenues for future inquiry regarding this and other Collaborative Care models.

The next article by Arora, Connors, Biscardi, and Hill (2016) drills down from this system-level framework to better understand service provider competencies needed to engage in IPC. Specifically, Arora and colleagues provide an in-depth investigation into SMH professionals’ training, comfort and attitudes towards IPC with paediatric PCPs. They note that, while most SMH providers view IPC as important and desire additional training to support this collaboration, they have a wide range of prior training in and current comfort with IPC practices with PCPs. Further, they found that attitudes towards IPC predict self-reported frequency of IPC with paediatric PCPs, which highlights the value of systematically measuring and addressing provider attitudes about IPC. This article puts forth future directions in both research and training related to supporting IPC among SMH providers to efficiently and effectively partner to deliver coordinated care with PCPs.

Building on this need for additional training, Adams, Hinojosa, Armstrong, Takagish, and Dabrow (2016) investigate the training and service outcomes of a co-located mental health collaboration model with doctoral-level school psychologist trainees and PCPs in paediatric primary care settings. The results of this initial pilot study are promising, with SMH providers and paediatric PCPs, indicating satisfaction with the collaboration model. In addition, caregivers of paediatric patients reported satisfaction with the collaborative services provided and positive impact on their child’s health and well-being. Lessons learned to guide future efforts are also provided, including potential solutions to funding challenges, the need for co-located school psychologist time allocation and a focus on workflow practices to improve efficiency and service capability.

Not all school-primary care collaborations have the physical proximity or data systems to effectively share information. Power et al. (2016) investigate the use of technology to promote the exchange of information between primary care and school providers to improve outcomes for students with ADHD. They describe the development and implementation of an electronic system, the ADHD Care Assistant and report on the feasibility of its use and differences in patterns of usage. A number of barriers to electronic communication across settings are identified, including challenges with additional consent on electronic form completion related to privacy and confidentiality regulations. The identification of barriers to electronic communication across settings provides important information for future studies to investigate how to mitigate these barriers and further streamline information sharing and care coordination by leveraging technology solutions.

Finally, Huber et al. (2016) present a comprehensive description of the implementation of a collaborative, multi-tiered public health model involving schools, community mental health, juvenile justice and primary care practice to promote access to youth mental health services. This article goes beyond just the collaboration of SMH and primary care and
describes the processes implemented by an entire community to connect their child serving systems to promote access to youth mental health services. Huber and colleagues describe specific collaborations between SMH and primary care, in addition to system-wide collaboration practices that have applicability for streamlining collaboration across sectors. Further, they examine the initiative’s impact by assessing number of mental health screenings administered, access to social-emotional curriculum and, when indicated, access to Tier II supports before and after implementation. Incrementally more children were screened across the four years of implementation and, by the end of the programme, universal screening occurred in the juvenile court and in the majority of primary practices and schools. Relatedly, three-quarters of those with positive screens received needed services in their school. Additionally, by the end of the initiative, a large majority of all students were in classrooms with teachers trained in and equipped with an evidence-based, social-emotional curriculum. Finally, the authors noted that, while screening increased over the course of the initiative, the number of positive screens decreased, as did youth entering the juvenile justice system. These findings suggest positive change in the access to and impact of youth mental health services after the implementation of the collaboration model.

The articles in this special issue provide systems-level and component-specific innovations and challenges to collaboration between SMH professionals and paediatric PCPs. Several important themes emerge across all including: (1) organizational and workflow restructuring; (2) privacy and confidentiality considerations; and (3) training needs. Strategies for both system-level, organizational change and clear protocols for cross-context, professional collaboration are described as paramount to the successes of collaborative efforts. For instance, Huber et al. (2016) describe the use of needs assessments and resource mapping to identify community needs, current system structure and resources to inform collaborative planning. They also identify the benefit of regular meetings with individuals from each sector to, for instance, inform continued adaptations to the programme, as well as ensure buy-in and proper implementation of their programme. An implementation manual with procedures and formal agreements across sectors was also instrumental to institutionalizing the model within their system. Lyon et al. (2016) suggest potential workflow restructuring within the MTSS and Collaborative Care frameworks, including the identification of an existing school employee to function as a care manager. These and additional innovations with regard to collaboration structures and protocols are highlighted across articles within the special issue.

An additional consideration stressed within collaboration protocols is the process for information exchange across providers. Accordingly, all articles highlight challenges and successes with regard to streamlining practices to be in compliance with the privacy and confidentiality laws that govern education, health and mental health care, including the Family Educational Rights and Privacy Act and the Health Insurance Privacy and Portability Act. Power et al. (2016) discuss their particular challenges with this in their implementation of the ADHD Care Assistant, while Huber et al. (2016) describe a particular success in information sharing with the creation of an omnibus exchange of information form and several other communication protocols approved by all involved organizations’ legal counsels.

In addition to organizational and information exchange process, training considerations for both SMH and paediatric PCPs are highlighted as critical levers for change. Specifically, the bi-directional utility of interprofessional training that allows school and paediatric PCPs to interact and learn each other’s work context, including profession-specific language, culture and expertise, is described as beneficial to current and future collaborations.
(Adams et al., 2016; Arora et al., 2016). Arora et al. (2016), for instance, note that SMH providers’ attitudes towards collaboration are related to subsequent engagement in IPC, suggesting the importance of interprofessional training experiences to supporting subsequent collaboration across school and paediatric PCPs.

**Conclusion**

Education and primary care sectors are increasingly addressing the need for improving access to mental health services for underserved youth. Interprofessional care across such child-serving systems has been identified as critical to supporting the delivery of high-quality, cost-effective care, and both school and paediatric primary care settings have demonstrated the potential for the delivery of inter-system, collaborative mental health services. However, examinations of collaborative efforts across these unique settings are limited and needed to guide future efforts. The articles in this special issue address this need, underscoring the positive youth outcomes resulting from both individual and systematic collaboration between SMH providers and PCPs, and add to the literature describing innovative and successful approaches to this work.

**Disclosure statement**

No potential conflict of interest was reported by the authors.

**References**


