Infusing Mental Health Services Into Primary Care for Very Young Children and Their Families

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At her son’s 6-month well-child visit, Mrs. Martin is fully engaged with the pediatric clinician, answering all his questions and listening carefully to what he says. And the baby, Glenn, appears interested in his surroundings, calm and well regulated. Yet as the visit ends, the mother says quietly, “we can’t get him to eat.” She explains that she and her husband have been trying to get Glenn to eat solid food for about 4 weeks and he just “purses his lips and refuses the food on the spoon.” After a lengthy discussion of the mechanisms of feeding: size of the spoon, consistency of the food, number of formula bottles he takes, and his current weight, which is appropriate for his age, the pediatric clinician seems to be running out of options for the conversation.

At no time during this lengthy conversation does Mrs. Martin ever glance at, acknowledge, or hold Glenn. Rather he is in his infant seat on the floor beside her chair. Near the end of this 10 minute conversation, he starts to fuss; Mrs. Martin silently picks him up and he immediately arches his back away from her body and looks off into space. As the pediatric clinician completes the visit with gentle reassurance the “he just needs to practice more and drink fewer bottles,” not once have mother and son looked at each other nor has the mother tried any techniques to soothe him or help him adjust to her body as she holds him.

Later, as the clinician recalls the visit, he feels uncomfortable but he can’t put his finger on what he might be missing or why he is so uneasy about this young family.

For many families with very young children, the pediatric well-child visit is the place to go to get information and support on raising their new baby. Pediatric primary care is accessible, offering evening and weekend hours; universally available given new health care regulations; and, perhaps most important, has no entrance criteria. All families are eligible for services and receive the same pediatric services whether it is a family with a teen mom, a neonatal intensive care unit baby, a first-time mom, or parents who are in recovery from addiction. Most families eagerly take their baby to their pediatric clinician (e.g., pediatrician, pediatric nurse practitioner, family medicine physician); in fact, taking the baby to the doctor is one way to feel and to be seen as a “good parent.” In this way pediatric well-child care is nonstigmatizing; instead of walking in the door of the mental health clinic or failure-to-thrive program, the pediatric clinician’s office is about wellness and the celebration of milestones achieved by the baby. This is the power and magic of pediatric primary care: to support parents in their child rearing, to validate parents’ ideas and concerns, and, in some cases, to facilitate changes in parental behavior (Lerner & Ciervo, 2010).

Pediatric care offers a window of opportunity for families with new babies. The birth of a baby brings many changes to the lives of the parents—new routines, new roles in the family, new equipment to manage, perhaps new housing or different employment status. Even before the baby is born many families make changes to accommodate the new life by quitting smoking, changing diet, or finding more stable employment to provide for the family. Change is the metaphor for the first year of life with a newborn, both for the baby

Abstract
Thinking beyond physical health to include mental health and emotional well-being offers the pediatric clinician different approaches to old challenges and a new lens through which to view infant and parent behavior. Because pediatric primary care is accessible, universally available, has no entrance criteria, and is nonstigmatizing, clinicians often serve as first responders for families in distress. Funding from the Irving Harris Foundation supports training of early childhood clinicians to work in primary care. These early childhood professionals create access to behavioral health services for populations that often face challenges and barriers when trying to access community resources.
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and for her parents. The pediatric clinician can be a powerful ally in identifying and supporting changes which the family makes for their new baby.

The timing and frequency of those early well-child visits create the foundation for building a trusting relationship between the pediatric clinician and the family. Pediatric clinicians have an initial built-in trust factor (“the doctor says...”) which can help parents identify changes they need to make to ensure the health and well-being of their new baby. And finally, pediatric clinicians are often the only professionals to interact with the family around this new baby, to have “eyes on” how the baby is growing and developing well into the preschool years, and to keep track of family dynamics and relationship development. Although families are often unable to locate, afford, or obtain a voucher for child care for their infants and young children, health care legislation has made it possible for the vast majority of families to access pediatric primary care services.

**Why Infuse Mental Health Issues Into Pediatric Practice?**

The hallmark of pediatric practice is anticipatory guidance, which includes conveying information that assists parents in understanding current and future developmentally salient issues with the hope of preventing future disturbance. Recommended topics include injury and violence prevention, sleep issues, nutritional counseling, and fostering optimal development. The American Academy of Pediatrics’ Bright Futures Task Force, a national health promotion and disease prevention initiative, highlights parental well-being; infant behavior, growth, and development; and parent–child relationship issues as salient factors for pediatric clinicians to address during well-child visits in the first year of life (Hagan, Shaw, & Duncan, 2008).

The pediatric primary care environment is ideally suited to emphasize both physical and mental health. After the birth of a baby, in which medical personnel have asked about and observed an intimate family experience like childbirth, there is often less resistance to answer when the pediatric clinician asks if a parent has been feeling sad or blue during the past 2 weeks or if the mother feels safe in her home.

Upon reflection, Glenn Martin’s pediatric clinician states that he completed the visit feeling helpless; he had no more advice to give. When the baby's posturing and emotional behavior are recalled, he begins to think about what the baby might be trying to tell him—is his sensory system challenged by being held? Is he unaccustomed to physical interaction from his caregivers? Is he on the autism spectrum? Or is the mom feeling isolated, anxious about feeding him? After all, what “good” mother cannot feed her child? Is she depressed? Is she stressed? Is there verbal or physical abuse occurring in the home? Is she being pressured by extended family to feed him before he is ready or to feed him foods he isn’t ready to eat?

Although considering the mental health implications of the feeding worries described by Mrs. Martin does not give him the answer to why Glenn refuses solid food, it does give the pediatric clinician new avenues of inquiry and approaches to the concern raised by the mother.

Thinking beyond physical health to include mental health and emotional well-being offers the pediatric clinician both different approaches to old challenges and a new lens through which to view child and parent behavior. Funding from the Irving Harris Foundation (Foundation) supports training of early childhood professionals to work in pediatric primary care settings. These early childhood professionals create access to behavioral health services in a setting where access to such care is often limited and for populations that often face challenges and barriers when trying to access community resources. Beyond providing direct services, early childhood professionals who work as an integrated team with pediatric clinicians in primary care settings function as reminders of early childhood and family mental health, providing education and guidance to pediatric primary care clinicians and, consequently, enhancing the quality of care patients receive (Talmi, Stafford, & Buchholz, 2009). As part of the Foundation’s Professional Development Network (PDN), Boston University School of Medicine has supported pediatric faculty who provide training in infant mental health to more than 42 pediatric residents per year during their monthly developmental and behavioral rotation. Faculty also teach and supervise developmental and behavioral pediatric fellows in their work with very young children and their families. At the University of Colorado School of Medicine, PDN funding allows for training of more than 150 pediatric health professionals and between four and six early childhood mental health clinicians working in the context of pediatric primary care through the Colorado Harris Program. Faculty of this program teach and supervise pediatric residents, physician’s assistant trainees, medical students, and other health professionals rotating through the pediatric clinic.

**Mental Health Concerns in Young Children**

In the last decade, understanding about the complexity of factors that can impact healthy child and family development has surged. Some critical lessons have come from the work on adverse childhood experiences and the long-term outcomes which can result from such adverse experiences as emotional, physical, and sexual abuse; household substance abuse; parental mental illness; incarceration; and parental domestic violence, separation, or divorce. This significant body of research (Bair-Merritt, Blackstone, & Feudtner, 2006; Dube et al., 2001) has fostered renewed interest in the concept of “toxic stress” and ongoing research into an ecobiodevelopmental framework that illustrates how early experiences and environmental influences can leave a lasting signature on the genetic predispositions that affect emerging brain development.
architecture and long-term health (Shonkoff et al., 2012). In particular situations, for example after the birth of a preterm infant, research has shown that maternal grief resolution impacts the quality of attachment security and emphasizes the critical role of clinicians in supporting grief resolution and improving the quality of maternal interaction (Shah, Clements, & Poehlmann, 2011). This paradigm truly shifts the role of the pediatric clinician to not just anticipating child development but preventing distress or disorder and impacting lifelong health and development.

The PDN supports the training of pediatric clinicians to identify children with such mental health concerns as autism, extreme impulsivity, and depression. By working closely with or participating in case conferences with early childhood mental health clinicians, pediatric clinicians are introduced to a different way of thinking about child behavior and parent–child relationships. PDN funding provides opportunities for cross-disciplinary training of primary care pediatric clinicians to screen and refer even very young children with mental health concerns.

Models That Successfully Infuse Mental Health Into Pediatric Primary Care

There are several models currently infusing maternal and infant mental health perspectives and services into primary care including Healthy Steps for Young Children, Project DULCE, and Fussy Baby.

Healthy Steps for Young Children

In the pediatric primary care setting, families are afforded a layer of protection and confidentiality in which they can explore their worries, concerns, and delights about their child, themselves, and their role as parents. After the birth of a new baby, the infant and family are in a dynamic state of flux. New parents are often receptive to professional information, guidance, and support to help them cope with the demands of new parenthood. Pediatric care for young children offers a powerful vehicle to infuse mental health services into an ongoing system of care (Zeanah & Gleason, 2009). Although pediatric practices may not recognize or feel the potential power they have to influence a child’s outcome, they create an unparalleled, nonstigmatizing environment from which to offer families information and support about their child’s social–emotional well-being and about their growth as a family (Zuckerman, Kaplan-Sanoff, Parker, & Young, 1997).

The Healthy Steps for Young Children program is a national initiative that emphasizes a close relationship between pediatric clinicians and parents in addressing the physical, emotional, and intellectual growth and development of children from birth to 3 years old (Kaplan-Sanoff, 2001; Zuckerman, Parker, Kaplan-Sanoff, Augustyn, & Barth, 2004). Developed more than 15 years ago as an approach to provide developmental information and parenting support through primary care pediatrics for all families with infants and young children, Healthy Steps is now a recognized evidence-based model of care, designated by the Substance Abuse and Mental Health Services Administration and the Affordable Care Act Maternal Infant Early Childhood Home Visiting (MIECHV) program as one of several approved for federal funding. In addition it has been shown to substantially increase clinician and trainee ratings of their preparedness to deliver behavioral and developmental care and increased the ratings of the quality of care provided (Randolph et al., 2011).

In a traditional pediatric practice, one pediatrician typically tries to address all of the child’s health and developmental needs. Healthy Steps expands the model of a solo pediatrician to include a new member to the health care team—the Healthy Steps specialist who enhances the information and services available to parents. The Healthy Steps specialist can be a new team member or a nurse, child development specialist, or social worker already working in the practice. Healthy Steps specialists are trained in child development, early intervention, child care, social work, counseling, or nursing to address major behavioral and developmental issues, focusing on the child within the context of the family (Kaplan-Sanoff, Lerner, & Bernard, 2000). In a recent study, families participating in the Healthy Steps Program in Colorado were more likely to have the following developmental topics addressed during primary care visits than those families not participating in the program: language development, social skills, importance of play, daily routines, sleep, healthy eating, temperament, parent feelings including postpartum depression, home safety, and breastfeeding (Buchholz & Talmi, 2012).

Healthy Steps helped parents better understand their child’s behavior and development, thereby producing more favorable disciplinary practices. In the JAMA 2003 report (Minkovitz et al.), Healthy Steps mothers enrolled in the national evaluation that had experienced sadness, reported depressive symptoms, or limited their activities because of feeling anxious or depressed, were 1.6 times more likely than mothers not enrolled in Healthy Steps to report that they had discussed feeling sad with someone in their Healthy Steps practice (Minkovitz et al., 2003; Minkovitz et al., 2007). Along with the 5 year follow-up study these findings supported the idea that the pediatric practice can be an effective vehicle for discussing and screening adult mental health concerns (Minkovitz et al. 2007). In Colorado, MIECHV funding is being used to expand the continuum of home visiting programs and create greater access to home visitation services in the first 3 years of life statewide. In addition, Project DULCE: Developmental Understanding and Legal Collaboration for Everyone is funded by The Center for Social Policy Quality.
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Improvement Center on Early Childhood (n.d.) using an abbreviated Healthy Steps approach to address the issue of child abuse prevention.

Project DULCE

Many environmental and family stressors contribute to child abuse and neglect. Project DULCE combines two powerful models—Healthy Steps and the Medical Legal Partnership, a program which provides legal advocacy and services for families needing assistance with nutritional benefits, housing supports, electricity and heat shut-off protection, and educational placement for children with special needs to prevent the parental stress often associated with child abuse. It has never been more important for pediatricians, child development specialists, and legal advocates to engage in structured collaboration on behalf of vulnerable children who continue to experience barriers to care and barriers to services that in many instances could be eliminated through legal advocacy. There is greater acknowledgment of the role of social needs in determining a child’s health status, as reflected in one study which found that 85% of clinicians believe that unmet social needs are leading directly to worse health for all Americans (Robert Wood Johnson Foundation, 2011). Indeed, health reform efforts such as MIECHV are shining a spotlight on harmful, population-level health and service disparities that, through a legal lens, can be understood as a profound civil rights issue.

Project DULCE is a randomized control trial recruiting all families with newborns who are receiving their pediatric well-child care at Boston Medical Center with the exception of significantly premature babies and those with Narcotic Abstinence Syndrome. Project DULCE has two primary goals: (a) helping parents understand their newborn’s behavior through providing child development information specific to their child and (b) reducing maltreatment by addressing the risk factors which many families bring to parenting. The Project DULCE intervention aims to promote positive parenting while reducing family risk factors and, in so doing, increase resilience, resulting in more optimal child development, and reducing maltreatment. Project DULCE focuses on supporting six family protective factors:

1. Parental resilience: a parent’s ability to bounce back from difficulties
2. Social connections: a network of informal or formal supports, for example, friends, family, faith group
3. Concrete supports: knowing where to turn for help and how to help, for example, identifying and accessing programs to help with food, housing, utilities, or child care
4. Knowledge of parenting and child development: parents know how children grow, what behaviors are appropriate at a given age
5. Social and emotional competence of children: children learn to talk about and handle feelings
6. Attachment: understanding appropriate emotional and behavioral relationships between children and familiar adults

Conclusion

Child development and infant mental health specialists have a unique opportunity to engage in preventative, universal efforts in the context of pediatric primary care settings. Lessons learned from Healthy Steps and Project DULCE, sites can provide suggestions on how infant mental health professionals can augment the role of primary care pediatricians to support families as they raise their infants and young children. These suggestions include:

1. Ask about a child’s primary care clinician. Families are likely to seek advice and support from their primary care clinicians and often establish close relationships with their pediatricians. These relationships are long-standing and important in the lives of young children. Understanding the relationship between a family and a health care clinician offers information about the resources and supports available to families. For example, some pediatric clinicians conduct routine developmental and social–emotional screening. This information is often useful to both parents and early childhood professionals in understanding a child’s current functioning and needs.
2. Get to know primary care clinicians in the community. When primary care clinicians are familiar with early childhood professionals, they are more likely to refer and utilize their services appropriately. As described by one pediatrician: “Now I can put a face to a referral program and have more confidence in my referral working for the family.” Providing information and resources to pediatric practices improves communication between systems of care that are central in the lives of young children.
3. Obtain permission from families to share information with primary care clinicians. Communication among different providers is essential in creating medical homes.

Learn More

Bright Futures

For additional information on medical homes see www.cdph.state.ca.us/ps/hcp/medicalhome/index.html
www.medicalhomeinfo.org/
for young children. With consent from families, early childhood professionals can establish bi-directional communication with primary care clinicians in order to coordinate services, understand clinical presentations, and offer targeted support to young children and their families.

4. Help families find suitable primary care clinics. Having a medical home is important for healthy development. For families who have not established a relationship with a consistent primary care clinician, early childhood professionals can help identify clinicians who would meet the needs of young children. Ideally, primary care practices would use standardized developmental screenings, including screening for social–emotional and family issues, and would offer comprehensive services that are culturally responsive and in the family’s language of choice.

Connection to the health care system is critical in providing comprehensive services to young children and in fostering family-centered medical homes. Early childhood professionals (e.g., infant mental health specialists, Healthy Steps specialists, Fussy Baby specialists) working within pediatric primary care settings provide high-quality care to young children and their families and collaborate closely with pediatric clinicians to ensure that families’ needs are met. Support from the PDN has allowed an expansion of cross-disciplinary training opportunities for primary care pediatric clinicians. Such interprofessional education and cross-training ultimately functions to transform the way health services are delivered by establishing integrated, coordinated, and comprehensive practices. Finally, for vulnerable young children and their families, identifying pediatric clinicians who can offer comprehensive services, including standardized developmental screening, social–emotional screening, and family support, strengthens the resources and supports available to families as they navigate complex systems of care.

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References


