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Is It Time to Talk? Understanding Specialty Child Mental Healthcare Providers' Decisions to Engage in Interdisciplinary Communication with Pediatricians

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Abstract

Communication between pediatric mental health and primary care providers is often inconsistent and frequently rated as unsatisfactory by providers of both disciplines. While numerous studies report pediatricians' desire for increased feedback from mental health providers, less is known about mental health providers' perspectives on collaborative communication with pediatricians. In the current qualitative study, 9 practitioners at 2 mental health practices participated in interviews about their experiences related to collaborating and communicating with pediatric providers. The interviews were analyzed inductively using thematic analysis procedures. Mental health providers consistently described the decision to communicate with pediatric primary care providers as occurring primarily when initiated by them, and on a "case by case" basis. Four determinants of the decision to initiate communication emerged from the interviews: severity of client concerns, mental health providers' own positive beliefs about collaborative/integrative mental health-pediatric care, perceptions of and past experiences with the primary care providers with whom they interact, and professional relationships with specific primary care providers. The findings of this study suggest that understanding and addressing the attitudes and beliefs that underlie both mental health and pediatric health care providers' decisions to engage in interprofessional communication is essential to establishing truly collaborative care.

Keywords

USA; mental health providers; collaborative care; communication; pediatric primary care; qualitative study; thematic analysis

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Approximately 10–20% of children in the United States meet criteria for a mental health disorder (American Academy of Pediatrics, 2012; Jellinek, 2013; Knapp & Foy, 2012), and the vast majority of these youth receive health care services from a primary care physician (PCP) (Bloom & Freeman, 2015). While pediatric PCPs tend to be comfortable assessing behavioral health conditions, for treatment they often seek mental health professionals to whom they can refer their patients (Pidano et al., 2011). The American Academy of Pediatrics (AAP) recommends, and the standards for the Patient-Centered Medical Home (PCMH) require, that pediatricians not only identify and attend to children's mental health issues, but also coordinate and oversee the provision of their patients' mental health care (American Academy of Pediatrics, 2009; National Committee for Quality Assurance, 2014).

The challenges of such interprofessional collaboration have been well documented throughout the healthcare arena (Hewett et al., 2009; Lewin & Reeves, 2011; McDougall et al., 2016; Watson et al., 2016), as well as specifically within children's services (Cooper et al., 2016; Easen et al., 2000; Salmon, 2004). Among many identified structural, individual, and service level barriers, lack of effective communication among providers is consistently cited as a key hindrance to interagency collaboration in children's mental health services (Cooper et al., 2016). Recognizing this fact, established competency recommendations and practice standards for mental health providers working in primary care settings include communication of urgent and routine clinical information to the primary care team to promote collaboration (e.g., American Psychological Association, 2013; National Association of Social Workers, 2005).

While similar guidelines for specialty mental health practices providing outpatient consultation or treatment do not yet exist, the Patient-Centered Medical Home Neighborhood (PCMH-N) extends the PCMH model to incorporate the specialists, hospitals, and other clinicians with whom PCPs collaborate when caring for their patients. Appreciating the importance and challenges of interprofessional relationships, core components of the PCMH-N principles include bi-directional communication and the development of formal agreements to guide communication, coordination, and co-management (American College of Physicians, 2010; Taylor et al., 2011). Collaborative communication among interprofessional providers treating childhood mental health is essential to making these partnerships effective, as without it there is a risk of fragmentation and service duplication. Coordinated communication between providers has been well received by parents of children (Greene et al., 2015) and is associated with positive family-provider relations and pediatric healthcare outcomes (American Academy of Pediatrics, 2014; Priddis & Wells, 2011).

However, communication between interprofessional providers – especially those located in separate practice settings – is cumbersome, time consuming, and typically occurs infrequently unless an emergency arises. Thus, collaborative communication practices remain inconsistent among practitioners and are frequently rated as unsatisfactory by both mental health and pediatric primary care providers. Numerous studies document pediatricians' desire for increased feedback from mental health specialists (Pidano et al., 2011; Ross et al., 2011; Williams et al., 2005), yet also report that pediatricians communicate with mental health providers about referred patients less than half of the time

(Ross et al., 2011; Yuen et al., 1999). Much less is known about mental health providers' perspectives on collaborative communication with pediatricians. A small body of research indicates that mental health providers also view collaborative relationships with PCPs as key to successful treatment (Kilbourne et al., 2012; Miller et al., 2004; Pereira et al., 2009).

The current study elicited child mental health providers' perspectives about collaborating and communicating with pediatric PCPs. The research question addressed was whether the views of mental health providers, especially with regard to their clients' concerns, and their preferences, successes, and barriers to effective communication with PCPs, are associated with their engagement with pediatricians in the collaborative care of children with mental health problems.

Method

Participants

Interviews were conducted with nine mental health providers from two northeast suburban specialty mental health outpatient practices. Participants were selected by convenience from independent group practices that had no formal coordinated or integrated care commitments with primary care physicians. All participants, regardless of their professional background or practice setting, provide psychotherapy to patients. In one practice, four licensed clinical social workers (LCSW; master's level), one psychologist (PsyD; doctoral level), and one licensed marriage and family therapist (LMFT; master's level) were interviewed, representing 38% of the total clinicians in the practice. In the other practice, two psychologists (PhD; doctoral level) and one licensed clinical social worker (LCSW; master's level) were interviewed, representing 43% of the total clinicians. All of the participants were female, which is consistent with the 90% representation of female clinicians in each practice, as well as women serving as the majority of mental health practitioners in the United States (American Psychological Association, 2015). As interviews were anonymous, additional demographic information was not collected.

Procedures

The interviews analyzed in this study were part of a larger study aimed at increasing interprofessional collaboration (see Greene et al., 2016), procedures for which were approved by the UConn Health Institutional Review Board. In the first phase of the study, researchers conducted key informant interviews with mental health and primary care providers at two pairs of geographically proximate pediatric mental health and medical practices with the aim of eliciting information from practitioners about their preferred strategies for achieving timely, responsive, collaborative communication and treatment. Providers also provided feedback on proposed relationship-building methods including joint trainings, continuing professional education sessions, case conferences, meetings and e-mail exchanges with the goal of establishing relationships and increasing knowledge about each other's areas of expertise and expectations. Potential participants in the interviews were informed that their responses would be anonymous (no identifying information was collected) and provided a description of the study's purpose, risks and potential benefits. Participants were given as long as they needed to review this information, to ask questions,

and to consider their participation in the interview. All providers who indicated interest in the study chose to participate.

Interview Administration

The second author conducted interviews with participants averaging 29 minutes in length, between October 2012 and January 2013. Each interview began with an open-ended question asking providers to report on times when interacting with a PCP did and did not work well, followed by more focused questions about current practices and preferences related to referrals, consultation, and communication with pediatricians. Additionally, providers provided feedback about potential barriers to collaborative treatment and proposed relationship-building methods with pediatrics colleagues. The interview closed with another open-ended question that asked providers to identify what would provide the most improvement to their interprofessional collaborations. All interviews were audio recorded.

Data Analysis

The goal of the interviews was to gather information from mental health providers about their communication and collaborative care practices with pediatricians in order to inform the development of an interdisciplinary intervention aimed at improving interprofessional communication (Greene et al., 2016). Interviews were analyzed by the first and second authors using thematic analysis (Braun & Clarke, 2006) to identify themes regarding what mental health providers identify as concerns, preferences, successes, and barriers to communicating with PCPs. An inductive approach to identifying the themes was used; identified themes emerged from the interview data collected rather than following closely from the initial research questions asked.

In the first step of the thematic analysis, a research assistant and the second author transcribed the interviews verbatim. Second, the interviews were read and re-read to provide familiarity with the data, and initial thoughts were recorded. Third, sentences with significant meaning were assigned a code. Authors generated codes independently, and then discussed the codes until consensus was reached (Hill et al., 2005). Fourth, each author independently grouped the codes into sub-categories, categories and main themes (Burnard, 1991), then came to consensus. Fifth, coded data extracts within each theme were reviewed for appropriateness, and themes were refined. Finally, themes were defined, ensuring they were consistent with interview content.

Results

Nine interviews with mental health clinicians were analyzed for this study. Within this sample of mental health clinicians with relatively similar characteristics associated with the research question, there was a significant amount of redundancy of themes across interviews, thus suggesting that saturation was achieved (Guest et al., 2006). Twenty-two categories were originally identified from the data, which were organized into five themes (see Table 1). The first and most comprehensive theme involved the factors influencing communication with pediatric PCPs, and is the focus of this paper.

Mental health providers consistently described the decision to communicate with pediatric PCPs as occurring primarily when initiated by them (rather than by the pediatrician), and as being done in a case-by-case nonsystematic manner. Despite the fact that this aspect of communication was never directly enquired, 8 of the 9 providers interviewed indicated that the decision to contact a child's pediatrician was the mental health provider's responsibility and was evaluated independently for each client, as exemplified by the following two statements:

"I think it is case specific. I think some cases you have to be in touch a lot. Other cases, it is probably not as important." (Provider #3)

"...the procedure we have is collaborative between yourself, your supervisor, and the child psychiatrist to determine that we need to be in touch with the pediatrician..." (Provider #4)

In addition to this general context for communication by mental health providers with their pediatric colleagues, specific factors that were identified by the mental health providers as influencing their decision whether or not to initiate communication with a pediatric provider fell into four categories: severity of client concerns, mental health providers' own positive beliefs about collaborative/integrative mental health-pediatric care, perceptions of and past experiences with the primary care providers with whom they interact, and professional relationships with specific primary care providers.

Severity of Client Concerns

Mental health providers frequently cited client characteristics as influencing their decision to communicate with pediatricians. More than half ($n = 5$) mentioned contacting PCPs in response to medical illness or other health concerns. In fact, one provider stated this was the only routine reason for initiating communication with a pediatrician: \

"Unless there's a reason, medically, to be in touch with the pediatrician's office, we do not routinely do that for people" (Provider #1)

A majority of providers ($n = 5$) also stated that they would contact a pediatrician if their client's symptom presentation was complicated or severe, or if they were concerned about the child's safety. Three providers noted they would contact a PCP to discuss psychopharmacological medications. Two providers noted they communicate with pediatricians in situations involving abuse or neglect.

Other providers noted that the need for collaboration with pediatricians often is not apparent for routine care, when physical health, safety, or medication issues are not present. If there are no medical indicators or somatic complaints, it may not be obvious for mental health practitioners to communicate with PCPs. One provider noted,

"...kids come in in ways that are sometimes more specifically not related to health issues. So it might be they are shy, is the example that comes to my mind. So the medical interface doesn't always seem as obvious" (Provider #8).

Positive Beliefs about Collaborative/Integrative Mental Health-Pediatric Care

Two characteristics of the individual mental health provider's beliefs about collaboration emerged as important factors influencing the initiation of communication: possessing a holistic perspective of mind-body integration, and believing that increased communication improves the care of the patient.

One-third of the mental health providers articulated a belief that the mind and body are connected. These providers stressed the importance of treating the whole child, and recognized the overlap of emotional and physical symptoms. For example, one provider stated,

"The way I look at it is I see so much overlap in emotional things coming out in somatic symptoms" (Provider #2).

The providers who articulated this belief viewed communicating with pediatricians as a logical and expected part of the care they provided. In addition, one of these mental health providers stated that communicating with pediatricians was grounded in a "sense of [professional] community" that transcended professional identification.

Similarly, many respondents ($n = 6$) reported the belief that communicating with PCPs is essential to collaborative care. This belief, and the experiences that contributed to it, appeared to shape the way the respondents thought about interdisciplinary collaboration and, in turn, influenced their decisions to initiate conversations with the child's interdisciplinary providers. For example, one provider noted:

"If I was a pediatrician and one of my patients was in behavioral health treatment, I would want to know that. It completes a picture that is important" (Provider #1)

On the other hand, a minority of providers ($n = 2$) did not hold the view that increased communication between mental health providers and pediatricians was needed. These providers cited access to care as a more significant issue, did not see pediatricians as interested to receive mental health information, and were unaware of how regular collaboration with pediatricians could be helpful.

Perceptions of and Past Experiences with Pediatricians

Mental health providers' perceptions of PCPs also influenced their decisions to communicate with them. When describing successful communication exchanges with PCPs, almost all ($n = 8$, 88%) of the mental health providers mentioned that a pediatrician had demonstrated receptivity to working with, and hearing from, mental health providers. Pediatricians were described as doing so by consulting with mental health providers about medication prescriptions ($n = 2$), being accessible on the phone ($n = 2$), providing information regarding their reason for referral to mental health services and observations of family interactions in advance of the patient's first visit ($n = 2$), and/or maintaining contact regarding a shared patient's progress ($n = 2$). For example,

"...each time I have called his office, his secretary says hold on and he gets on the phone." (Provider #7)

“...he would call and follow-up...and so that one worked really well.” (Provider #2)

“...the collaborations with those pediatricians went very well. They would call me and tell me that they were referring somebody and why” (Provider #6)

In contrast, the perception that PCPs were not interested in collaboration or too busy to communicate with mental health providers dissuaded some providers from initiating contact, even if they regularly communicate with other professionals, as exemplified by these statements:

“I routinely interact with schools and I think it’s so important to have that overlap. I just never thought of [pediatricians] as another interested party that might have something to contribute or to receive.” (Provider #2)

“For some reason I think of doctors as so busy, though, that they don’t have time to communicate with us... I would never call unless I felt it was a case where I was extremely concerned about safety issues, health, and then I would call.” (Provider #3)

Professional Relationships With Specific Pediatric Colleagues

More than half of the providers interviewed ($n = 5$) viewed their professional relationships with specific pediatricians as an important factor that facilitated communication. Respondents discussed their belief that pre-existing professional relationships are key to effective communication and that familiarity makes it easier for them to contact a PCP. In particular, as mentioned in the previous category, knowing the PCP has a collaborative attitude invites them to initiate contact. Additionally, respondents noted that once a working relationship has been established with a pediatrician, communication becomes more efficient:

“That this is somebody that I kind of know and trust and that I’m interested in their input and their feedback because they have something to offer. I think the personal connection was really important.” (Provider #8)

“[Communications] have been more streamlined and easier because we have worked together on a few instances and had more of a relationship” (Provider #9).

Discussion

This qualitative study investigated interprofessional communication experiences, practices and preferences from the perspective of mental health providers who were in free-standing practice groups unaffiliated with any pediatric provider. Participants were never directly asked during the interviews what determined their decisions to communicate with pediatricians; rather the themes identified in this analysis emerged from a more general discussion of communication experiences and practices. All the more salient, then, is the fact that the decision whether or not to initiate communication was made for each individual client emerged repeatedly throughout the interviews, without interviewer prompting.

The finding that the decision to engage in interprofessional communication was case-specific but nonsystematic, and thus occurred sporadically, is consistent with previous findings within healthcare (Bramesfeld et al., 2012; Clancy et al., 2013; Kalman et al., 2012; Nair et al., 2012). Bramesfeld et al. (2012), for example, found that good cooperation among mental health providers happened “by chance.” Likewise Nair et al. (2012) found that decision making on the care of patients occurred infrequently between doctors and nurses. Similarly, psychopharmacologists and psychotherapists often provide collaborative treatment to shared patients, yet communication often does not take place between these professionals (Kalman et al., 2012).

This study adds to this literature by identifying the factors that contribute to providers’ decisions to initiate communication. Determinants of communication fell into four categories: severity of client concerns, mental health providers’ own positive beliefs about collaborative/integrative mental health-pediatric care, perceptions of and past experiences with the primary care providers with whom they interact, and professional relationships with specific primary care providers.

There was fairly strong consensus that certain categories of client characteristics leaned themselves to interprofessional communication with the child’s PCP. Most of the mental health providers noted that they had contacted a pediatric PCP in reference to their clients with physical illness or symptoms, more severe or complex presentations, or psychopharmacological medicine use. These findings suggest that, despite time constraints, mental health providers found it important to initiate communication with pediatricians when there was a clear medical or safety concern. It appears that for more complex client presentations, the mental health providers’ communication practices were consistent with reports of pediatricians’ desire for input from mental health providers (Pidano et al., 2011; Ross et al., 2011; Williams et al., 2005).

The mental health providers’ belief system about collaborative/integrative care emerged as another determinant of their decision to engage in communication with pediatricians. In addition to communicating for specific pressing medical or safety issues, several providers viewed interprofessional communication as necessary from a holistic mind-body perspective. This belief appeared to motivate these mental health providers to communicate with their interdisciplinary partners. The idea of motivation as an important characteristic for interdisciplinary communication is supported by prior research (Odegard & Strype, 2009).

Consistent with the extant literature on interprofessional collaboration, which suggests that collaborative care among interagency providers of mental health services is facilitated by mutual valuing, respect, and trust (Bramesfeld et al., 2012; Cooper et al., 2016), these providers indicated that when they had an established relationship or familiarity with a PCP they were more likely to contact them about a shared client and the exchange of information was more efficient. Further, several mental health providers evaluated the success of past communication exchanges based upon the pediatrician’s response to them. It seems that receiving a message from pediatricians that their feedback was valued shaped the mental health providers’ evaluation of the exchange, and possibly increased the likelihood of engaging in future communication with pediatricians. However, those messages and other

opportunities for an ongoing interprofessional relationship were described as occurring essentially by chance when a pediatric provider fortuitously signaled an interest in or appreciation of collaborative care.

Implications for Clinical Practice

Interviews with mental health practitioners suggest that even though there are numerous advantages to collaborative communication with pediatric providers, a number of practitioner-level hurdles to engaging in collaborative communication still remain. Indeed, in a recent study of the co-management of pediatric depression and anxiety, communication between mental health and primary care providers occurred for only 6% of patients, despite the provision of communication templates (Rubin et al., 2014). In addition to addressing the infrastructure of collaboration, practitioners' motivation to engage in interprofessional communication needs to be addressed. Consistent with this view, in a study of healthcare professionals, including psychologists and physicians, Odegard and Strype (2009) found that motivation was among the most important determinants of interprofessional collaboration.

Numerous theories of behavior change assert that an individual's attitudes and beliefs influence their behavioral choices. Most notably the Theory of Reasoned Action (TRA) posits that an individual's decision to conduct a behavior is predicted by a combination of their attitude toward the behavior and their perception of social norms (Ajzen & Fishbein, 1980). Thus it is not surprising that in the current study mental health providers discussed their decision to initiate interprofessional communication in the context of a holistic mind-body perspective (attitude), a belief that communication with pediatricians could be helpful to their clients (attitude), and a perception that their input is valued by pediatricians (social norm).

This suggests, at least from the mental health providers' perspective, that an approach grounded in TRA which addresses both the providers' underlying attitudes about interprofessional communication as well as their perceptions of pediatricians' receptivity to information exchange could increase participation in collaborative communication. Such an approach might begin with curricula at the graduate or medical school level that provide a holistic perspective on mental and physical health and educate students on the role of the mental health provider and the pediatrician in collaborative coordination of their patients' physical and mental health care. For practicing clinicians, increased opportunities for cross-disciplinary interactions and consultation, such as planned breakfast case conferences or lunchtime discussion sessions, could serve to build familiarity and improve relationships among mental health providers and pediatricians and ultimately promote an exchange of information (Greene et al., 2016).

The question of who initiates interprofessional communication is also important. The responses of the mental health providers in this study suggest that they are most often the ones to initiate – or not initiate – communication, despite the fact that pediatricians have been tasked by the PCMH standards to coordinate their patients' mental health care. Further inquiry into the flow of communication among interprofessional providers in children's mental health care is needed from the perspective of both mental health providers and

pediatricians. Given what is already known about barriers to interprofessional collaborative practice (Cooper et al., 2016; Interprofessional Education Collaborative Expert Panel, 2011), it is likely that such inquiry will reveal that clarification of roles and expectations is warranted. Indeed, care pathways that organize the care process in healthcare have been found to improve communication among team members (Deneckere et al., 2012).

Our study has some limitations. Our sample size was small and selected by convenience, which makes it difficult to generalize our results to all mental health providers in outpatient settings. Nevertheless, it provides a valuable perspective on interprofessional collaborative care that is underrepresented in the literature: that of the mental health provider. Because communication between mental health providers and pediatricians is a reciprocal process, understanding pediatrician views about communication with mental health providers also is important. While existing research on physician attitudes toward interprofessional communication exist (Pidano et al., 2011; Ross et al., 2011; Williams et al., 2005), future research would benefit from capturing similar information reported here from the pediatric perspective. That is, when do pediatricians decide to communicate with mental health providers, what facilitates or hinders this process, and what are their preferences for collaborative communication?

Research documenting how collaborative care and interprofessional communication affect children's mental health care and treatment outcomes is still nascent. However, in the broader healthcare literature interprofessional communication has been identified as a cornerstone of effective collaborative care (Interprofessional Education Collaborative Expert Panel, 2011), while also frequently cited as a significant barrier to interagency collaboration in children's mental health services (Cooper et al., 2016). Better understanding the views and beliefs of providers from both the mental health and pediatric healthcare disciplines is imperative to developing approaches to enhancing ongoing interprofessional communication that can move all child-serving providers toward truly collaborative care.

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Research Highlights

- Systematic communication is essential to collaborative mental health-pediatric care.
- These providers initiated communication on a nonsystematic, “case-by-case,” basis.
- Positive beliefs about collaboration guided providers’ communication practices.
- Quality of professional relationships with PCPs guided communication practices.
- Enhancing interprofessional attitudes and relationships may promote collaborative care.

Table 1

Themes developed from interviews

Themes	Categories within each theme
Factors influencing the decision to communicate with pediatric PCPs	<ul style="list-style-type: none"> • Severity of client concerns • Positive beliefs about collaborative/integrative mental health-pediatric care • Perceptions of and past experiences with PCPs • Professional relationships with specific PCPs
Barriers to collaboration	<ul style="list-style-type: none"> • Time constraints • Communication problems • Patient privacy • Unclear provider roles • Billing constraints • Professional/cultural differences
Interventions to improve collaboration	<ul style="list-style-type: none"> • Monthly/quarterly meetings • Clear communication procedures • Clear workflow design • Communication coordinator • Specifying roles among providers • Participation in a list-serv
Communication Preferences	<ul style="list-style-type: none"> • Communication content • Communication method • Communication frequency
Referral practices	<ul style="list-style-type: none"> • Referral process • Referral sources, appropriateness, and timeliness • Privacy releases