

**Minnesota Society of Child and Adolescent Psychiatry
September 20, 2010 Summit Report**

Background

Introduction

There has been a longstanding critical shortage of child psychiatrists in the state of Minnesota. From March through August, 2010, MSCAP convened a multi-disciplinary planning committee to plan and host a statewide forum on September 20. We held the statewide forum to begin to address these problems, highlight, and develop innovative solutions. The forum highlighted several organizations' innovative ideas for enhancing outreach, building networks, and utilizing technology to meet the growing mental health needs of Minnesota's children. We drew on Summit participants to form an ongoing interdisciplinary collaborative pediatric workgroup to develop protocols for effective consultation and quality care in pharmacy, family medicine, psychiatry, and pediatrics.

The following is a summary of information shared at the Summit along with information gathered using survey tools.

September 20, 2010 Summit

Overall Program Objective: Participants will be able to:

- Identify examples of successful integrated care models, and describe the strategies use by each.
- Discuss how inpatient care has changed, and list alternatives to hospitalization that could provide a similar level of care

Title of Presentation: Welcome, Summit History Speakers: Sanjiv Kumra, MD Learning Objective(s): Participants will be able to describe MSCAP Summit History.
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Title of Presentation: A Day in the Life of a Parent Speaker: Susan O'Neil Learning Objective(s): Participants will be able to describe a day in the life of a parent whose child has a mental illness
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Title of Presentation: Meeting the Need Speaker: Read Sulik, MD Learning Objective(s): Participants will be able to List actions Minnesota is taking to address children's mental health needs and improve the current system..

Title of Presentation: Communicating about Collaboration Panel. How has inpatient care changed? Speakers: Stephen Setterberg, MD; Joel Oberstar, MD; Frances Go, MD; Lloyd Wells, MD Learning Objective(s): Participants will be able to: <ul style="list-style-type: none">• Describe how inpatient care has changed, and how the statewide shortage of beds has impacted services.• List services provided in inpatient settings, and name alternatives to hospitalization that provide a similar level of care.
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Title of Presentation: DHS State Consultation Project and State Operated Services Speakers: Read Sulik, MD; George Realmuto, MD Learning Objective(s): Participants will be able to: Describe the new Consultation Project, and SOS resources available in Willmar.
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Title of Presentation: Improving Care through Health IT: The Time Is Now Speakers: Susan Severson Learning Objective(s): Participants will be able to: <ul style="list-style-type: none">• Describe ways to improve clinical care and efficiency by incorporating HIT in your practice setting.• Identify state and national requirements and available funding sources for Minnesota practices related to health information technology.

Title of Presentation: Federal Health Care Reform, Parity, and Federal Support for Quality Care Speakers: April Shaw Learning Objective(s): Participants will be able to: Describe how federal health reform and parity implementation have the potential to improve access to mental health care.

Title of Presentation: Teams: Roles and Funding

Speakers: Steve Sutherland, MD; Susan Jenkins, MD

Learning Objective(s): Participants will be able to:

- Describe integrated care team roles and how consultants and clinics can improve collaboration to improve the economic viability of the mental health system with efficiencies gained through integration.

Roles of Professionals on the Child Mental Health Treatment Team

Sept. 21, 2010

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Introduction: This is a work in progress. The author invites input and feedback.

This draft is offered as an attempt to articulate the various roles of members of the treatment team. It has been written from the view of a child psychiatrist; in its present form it is limited and likely biased.

Role of the Team as a Whole:

1. Promote the mental health and well-being of the child with a goal of helping that child to become an independent and mentally healthy adult.
2. The team should attempt to do this work with the child in the context of the family of origin if possible.
3. Accordingly, a secondary goal of the team is to promote the understanding and ability of the parents (caregivers) to care for the child and to manage the child's mental illness.

Roles Shared by All Members of the Team:

1. Monitor safety and report child abuse promptly.
2. Do everything in service to the best interests of the child and the child's family.
3. Contribute your perspective. Represent your profession well.
4. Encourage each other with this difficult work; offer constructive feedback and educate each other as needed; "We're all in this together." Assume the best – then ask questions.
5. Keep other team members honestly informed of difficulties in completing the tasks associated with your role -- i.e., limited time to meet with the family; no funds for the services requested; caseload too large to manage, etc. – to allow the team to shift responsibilities or adjust the treatment plan
6. Recognize that different professions have different ethical standards and different understandings of what it means to provide services. Respect these differences. Be alert to different uses of professional jargon and even apparently "English" words.
7. Agree on confidentiality and file sharing practices.
8. Beware of conflicts resulting from taking protective ownership of the case; beware of projecting the child's pathology onto other members of the team; do not minimize or ignore feedback from other team members because it conflicts with your perspective.

Role of the Parents (Guardians/ Caregivers):

1. Provide a safe and loving environment.
2. Take care of your own mental health.
3. Ask questions.
4. Discipline with appropriate understanding of child development and with informed care.
5. Supply accurate and complete information about the child and family's situation. Leave shame and blame outside.
6. Become informed about child development, the child's illness and treatments.
7. Follow the treatment plan (i.e., follow directions) and be willing to access services as advised.
8. Notify the appropriate member of the team when there are changes in the child's status that may necessitate a change in the treatment plan.
9. Advocate for your child.
10. Notify the team when obstacles arise that will interfere with your ability to stick with the plan or complete the treatment.

Role of the Child and Adolescent Psychiatrist (CAP):

1. CAPs presume that they are the member of the team with the broadest and deepest knowledge of childhood mental illness and treatment. They will assume responsibility.
2. Complete a thorough and careful diagnostic assessment, using referrals to other experts as necessary, and integrating multiple sources of information. The assessment will include bio-psycho-social data and one or more direct contacts with the child and the parents (caregivers).

3. Clearly state priorities in treatment planning to address the most serious concerns first without losing track of other treatment goals.
4. Coordinate an effective treatment plan. Track progress at regular intervals, using standardized methods, and adjust treatment as necessary. Monitor for safety and side effects.
5. Be available to other members of the team and assist their efforts with prompt completion of forms or by supplying records and reports.
6. Educate other members of the team (or refer them to sources of good information).
7. Advocate for the child's needs with other members of the team or system.
8. Provide for continuity of care when the child leaves the area or becomes an adult.

Role of the Pediatrician or Family Practice Physician:

1. Provide ordinary well-child check-ups and vaccinations.
2. Provide education to parents/caregivers regarding development and major milestones.'
3. Initiate and manage treatment for uncomplicated behavior problems and habit disorders of childhood.
4. Initiate and coordinate evaluations when children fail to meet expected developmental milestones.
5. Begin and manage treatment for ADHD, anxiety, and depression.
6. Assist with coordinated evaluation for children with somatization disorders, sleep disorders, and medically caused disorders of emotions and behavior.
7. Assist with careful search for organic causes of mental illness.
8. Assist with access to other services such as laboratories, medical specialists, etc.
9. Provide feedback to the child psychiatrist and other team members as necessary.
10. Supply medical records promptly when requested.
11. Do not prescribe psychotropics (including pain medications) without notifying the CAP.

Role of the Children's Mental Health Case Manager:

1. Be informed on available services within the geographic region and volunteer that information as relevant to other members of the team
2. Assist the family in obtaining necessary services, advocating strenuously.
3. Coordinate communication among members of the team and support them as you are able in completing their duties.
4. Keep informed about children's mental illness and treatments
5. Have a crisis plan and communicate this to other members of the team.
6. Be creative and flexible; aim to solve problems.
7. Honestly complete the CAS-II and ECS-II without reference to budget issues.

Role of the School:

1. Provide an appropriate education .
2. Provide a safe learning environment that is free of bullying and harassment.
3. Be informed about appropriate accommodations for children with mental illness.
4. Attempt to provide the best possible special education services or appropriate accommodations (and be honest about what services are available).
5. Provide a competent and complete assessment by the Child Study Team.
6. Promptly complete the IEP or 504 plan and see that it is implemented
7. Promptly provide an educational alternative when a child must be pulled from mainstream classes.
8. Maintain an atmosphere that works to limit stigma and secondary damage from mental illness.
9. Provide discipline in a manner that does not cause trauma to the child.
10. Promptly inform other members of the team of unexpected developments.

Role of the Psychologist (Consultant):

1. Provide appropriate cognitive, academic, personality, and basic neuropsychological testing.
2. Provide a succinct summary to treating professionals.
3. Provide the raw data upon request (if not with the original report!).
4. Follow the data – i.e., if a memory problem is suspected, do additional testing or suggest how to go about this.
5. Design an appropriate behavioral modification plan if requested.
6. After designing a behavioral plan, designate appropriate tracking and follow-up.
7. Supply contact information.

Role of the Therapist:

1. Be able to clearly state the nature of the problem, the target symptoms to be addressed, the type of therapy method employed, the frequency of contacts, and the expected duration of therapy required to resolve the concern.
2. See the patient at the required frequency and for the required duration.
3. Set a date at which one might expect to be able to judge whether the therapy used is beginning to show efficacy. Then assess. Modify the therapy if necessary.
4. Notify the psychiatrist or treatment team of significant changes in the child's status.
5. Supply routine updates (once or twice per year) without being asked.
6. Supply summary reports when services are completed.
7. Don't stop services without terminating services – i.e., don't just let therapy lapse. Make an effort to find out what's happening and notify the case manager or responsible medical professional.
8. Have a crisis plan and inform other members of the team of your plan.
9. Take an appropriate level of responsibility and communicate with team members what that is.

Role of the Inpatient Unit:

1. Rapidly assess and stabilize the patient
2. Request information from the treating medical professional and therapist; invite input
3. Assume that the outpatient professionals have a reason for the diagnosis and treatment plan. Remember that families don't always understand and frequently can't explain the clinical reasoning of the professionals. Be mindful that patients generally appear more organized and less symptomatic in the highly structured hospital milieu than they do in the community.
4. Notify the outpatient team of the anticipated dismissal date before the dismissal.
5. Promptly supply a dismissal summary with copies of laboratories, imaging studies, and any/all psychological testing and medical consultations. Include in the dismissal summary: a) notes about any medications which were tried and discontinued due to adverse reactions. b) the inpatient treatment team's plans for outpatient tapering or adjustment of medications and necessary monitoring laboratories. c) the quantity of medication supplied and the number of refills.
6. Notify the treating professional if the patient is being transferred to another facility.

What Doesn't Work:

1. Being left without information when the patient is in crisis on Friday night.
2. Suggesting that the family access other sources of care or obtain second opinions without at least trying to understand what's happening with the current treating professional
3. Attempting to solve all of the child's problems yourself
4. Disparaging or showing contempt for other members of the team.
5. Offering opinions outside your area of training or expertise
6. Ignoring recommendations by other members of the team
7. Being affronted when questioned
8. Delaying or refusing to complete required reports

Title of Presentation: Clinics in the Schools **Speakers: Mark Sander, PsyD, LP**
Learning Objective(s): **Participants will be able to: Describe how clinics in the schools work and how joint funding and supervision supports effective integration to improve access.**

Title of Presentation: Panel Reflections of Successful, Experienced Integrated Care: Why does it work well?
Speakers: Dave Einzig, MD; Pamela GiGi Chawla, MD; Susan Jenkins, MD; Anne Edwards, MD; Michael Feldman, MD
Learning Objective(s): **Participants will be able to: Identify keys to successful integrated care.**

Title of Presentation: Interdisciplinary Workgroup Speakers: Joel Oberstar, MD
Learning Objective(s): Participants will be able to:
• Describe purpose and goals of the interdisciplinary workgroup.

List two distinct things you have learned from this activity that you can apply to your clinical practice:

- Look into electronic records and also lobbying help for psychologists
- Need to do a better job with collaboration of the medical and mental health community
- Complexities of interdisciplinary teaming
- Needs of primary care physicians
- Nothing that was said or discussed was relevant to my practice
- What other states are doing
- The different hospitals
- School clinic in Minneapolis
- Improvement of family care
- Resources available
- Commitment to better communication with other providers
- More services for school based-needs for continued funding –models
- Consultative model
- New policy for hospital
- Collection of pediatrics and child psychiatry
- Parents perspective on mental illness
- I'll soon be "rejoining" the word of CAP proactive and feel grateful for eye opener on what does exist for integrated care. Happy to know that practitioners other than me are disgruntled with role. We've practiced in "med doler" rather than global outlook of our work. Good to be part of movement to change.
- Family focus
- IT/ECTR information

Suggestions to improve the meeting:

- Psychologists and psychiatrists would benefit from working together
- More time or less topics
- Need a new location-poor room for breakouts-lack of technical equipment
- Better breakout rooms
- More time for work group activities
- It was very hard to hear in small break out meetings-a lot of background noise-more handouts
- Limited opportunities to network
- Too many topics
- Great meeting-like the short presentation format
- More clear outline of topics. Provision of contact/info/web sites from related speakers-resources.
- Stick with format and continue ECTR emphasis too as very timely and will increase collaboration and long-term cost. Liked this summit better than first one as more focused and information/status oriented.
- Enhanced collaboration with PCP's. School based

Survey Results showing suggested models of effective collaboration were collected and are posted online with Summit presenter handouts. The interdisciplinary workgroup has also collected additional information and that data is posted as well. Interdisciplinary workgroup minutes are available upon request.