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Please break the silence: Parents' views on communication between pediatric primary care and mental health providers

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Abstract

Introduction—The purpose of this study was to gain a better understanding of parents' preferences regarding the sharing of information between their children's primary care and mental health providers.

Methods—Fifty-five parents with a child who was actively engaged in mental health treatment completed an anonymous survey while accompanying their child to either a primary care or mental health clinic appointment. This brief measure elicited parents' experiences with and preferences for treatment coordination across their children's primary care and mental health providers, with a focus on communication practices.

Results—Parents consistently described communication amongst their children's primary care and mental health providers as important, yet frequently reported that such communication was not currently taking place. Further, parents reported that they were often called upon to act as "communication bridges" between professionals caring for their children.

Discussion—Implications for the collaborative pediatric and mental health care of children as well as recommendations for improving communication between mental health and pediatric providers are discussed.

Keywords

collaborative care; communication; parent perceptions; mental health; pediatric primary care

Collaborative pediatric and mental health care requires efficient inter-professional communication in order to ensure continuity and coordination of services (Williams, Palmes, Klinepeter, Pulley, & Foy, 2005). Otherwise, clinical information is exchanged on an *ad hoc* basis, if at all. Parents may be put in the position of serving as communication "bridges," relaying information from one provider to another (Stille, Primack, McLaughlin,

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& Wasserman, 2007), undermining the timely sharing of accurate and complete data and potentially compromising the child's medical and mental health care. The American Academy of Pediatrics (2014) recommends “family input in all aspects of coordinated pediatric care” (American Academy of Pediatrics, 2014, p. e1452). Therefore, the current study surveyed parents’ opinions regarding communication and care coordination for their children by pediatric and mental health professionals.

METHOD

Parents and other adult guardians (*N*=157) attending appointments with their children at a pediatric medical (with 10 pediatricians) or two mental health (with 16 and 7 clinicians) practices were surveyed anonymously during a two-week period in 2013 using a protocol approved by the University of Connecticut Health Center Institutional Review Board. Because the survey did not ask respondents to specify their relationship to the children they were accompanying, the term “parent” is used throughout the paper to refer to all of the respondents. Twenty-seven parents at a mental health site and 28 at the pediatric practice who indicated that their child was currently receiving mental health care comprised the final sample.

A brief measure was developed for this study asking parents to use a 5-point Likert scale (1 = *Strongly Disagree*, 5 = *Strongly Agree*) rating their level of agreement with three statements about communication between pediatricians and mental health providers (“It is important that pediatricians and mental health providers communicate to coordinate children's care,” “In my experience, mental health and pediatric providers work closely together when they both treat a child,” and “Usually the parent has to convey information between mental health and pediatric providers.”). Parents also selected the types of information they deemed important for pediatricians and mental health providers to share. Finally, age of oldest child in the home, presence of chronic medical illnesses, and insurance type (private, Medicaid, none) were obtained.

RESULTS

Table 1 describes sample characteristics overall and separately for parents surveyed in the mental health or pediatric practices. The two groups did not differ on age of the oldest child in the home, a child with chronic illness, or type of insurance. The only difference identified was that parents at mental health practices were more likely than those at the pediatric practice to have a single child, $U = 268.5$, $p = .04$. Independent samples *t* tests showed no differences between parents from mental health versus pediatric practices on any survey item (p>.13-.62). Therefore, subsequent analyses were conducted with the full sample.

Pearson bivariate correlations revealed a relationship between parents’ beliefs that inter-provider communication is important and that it actually occurs ($r = .35$, $p = .01$), but these beliefs were uncorrelated with viewing themselves as a “communication bridge” ($r = -.26$ - .19, $p > .06$). A paired samples *t* test showed that parents rated the importance of inter-professional communication ($M = 4.36$, $SD = 0.91$) higher than their rating of actual collaborative care ($M = 3.09$, $SD = 1.31$), $t(54) = 7.20$, $p < .001$). Most (>85%) parents

endorsed inter-professional communication about diagnoses, treatment plans, medication recommendations, and progress updates as important (Table 2).

Sub-group comparisons (Table 3) showed parents of teenagers were more likely than those with only younger children to view pediatric and mental health providers as actually collaborating, $t(53) = -2.42$, $p=.02$. Parents whose children's healthcare insurance was Medicaid only were more likely to view mental health and pediatric providers as collaborating than parents with private insurance, $t(51) = -2.49$, $p = .02$. Finally, having a child with a chronic physical illness did not influence parents' views on any survey item.

Discussion

Parents with children in mental health treatment who were surveyed either at a pediatric primary care practice or at their child's mental health practice considered collaboration and communication between mental health and pediatric providers important for the care of their children. Overwhelmingly, they endorsed communication not only for purposes of initial referral (e.g., diagnoses) but also for ongoing collaboration (e.g., treatment plan, prescriptions, progress updates). However, parents also described a gap between the degree of importance they assign to this inter-professional communication and the extent to which it actually occurs. In addition, parents tended to view themselves as responsible for conveying information between mental health and pediatric primary care providers. These results underscore the importance of bidirectional communication between pediatric medical and mental health providers and confirm previously identified barriers to integrated mental health care (e.g., Kainz, 2002; Pidano, Marcaly, Ihde, Kurowski, & Whitcomb, 2011; Sarvet & Wegner, 2010; Williams et al., 2005).

However, this is the first empirical study to our knowledge of parents' views about collaborative pediatric medical and mental health care. Parents' perceptions and preferences regarding collaborative care for their child were consistent regardless of whether they were surveyed at their child's pediatric medical or mental health practice. Thus, study findings are relevant for both pediatric medical and mental health practitioners when providing care to children with mental health problems. The findings also apply equally for children who have minimal or acute versus chronic physical illnesses.

A possible developmental difference in collaborative care for adolescents versus younger children was identified, with parents of teenagers more frequently reporting inter-professional coordination. This may reflect the often-greater complexity and severity of mental health problems in adolescence. However, parents with only younger children equally valued provider-to-provider communication as did those with adolescents, suggesting that providers be alert to the need for collaborative coordination even when the behavioral health problems seem less complex or severe in earlier childhood.

In addition, the child's type of health insurance may influence collaborative medical and mental health care. Parents whose children were insured by Medicaid only were equally as likely as those with private insurance to endorse communication between pediatric and mental health providers as important, but the Medicaid sub-group was more likely than the

private insurance group to report that provider-to-provider communication genuinely was occurring. These findings suggest that Medicaid requirements for collaborative care may be increasing the actual coordination of care. Alternatively, or perhaps conjointly, the disincentives created by private insurance requirements and limitations on reimbursement may be working against collaborative communication between mental health and pediatric providers.

One implication of these findings is that the development of standardized and efficient collaborative communication practices could help providers to achieve the coordination of pediatric medical and mental health care that parents strongly value. Currently, such guidelines are largely non-existent, and consequently the collaborative practices between primary and mental health care differ from the standardized practices that occur between primary care and most other health specialties (Massa, Miller, & Kessler, 2012). As a result of separate training and treatment protocols (Kessler, Stafford, & Messier, 2009), pediatric primary care and mental health providers tend to have different expectations regarding frequency of communication and the content of information to be shared.

Limitations of this study warrant notation. First, the data were collected from a small self-selected sample of parents in a single pediatric practice and two mental health practices in one geographic region (the Northeast United States). Second, the brief survey employed to minimize the burden on parents and increase the likelihood of completion was not psychometrically validated and may have omitted factors that could influence parents' beliefs about their children's health care, such as their own experiences with mental health care. Although the practice sites served families from a range of backgrounds who lived in rural, suburban, and urban communities, it is not possible to state whether the opinions expressed are those of an ethnically, racially and/or socioeconomically diverse sample of parents, potentially limiting the generalizability of the findings. However, there is some indication of a range of socioeconomic levels given that nearly one third of the sample had public insurance.

In conclusion, the results of the present study indicate that parents desire collaboration between mental health and pediatric primary care providers but often experience gaps in inter-professional communication amongst their children's pediatric and mental health providers that they feel responsible for bridging. While requiring replication, these results suggest that pediatric and mental health providers may need to be particularly vigilant (and possibly better incentivized) in order to provide truly collaborative care. Finally, while parents' thoughts about confidentiality and HIPAA were not collected in this study, their overwhelming support for the sharing of information between their children's providers suggests that regulations and procedures that embody ethical and responsible handling of patient information, while facilitating the efficient coordination of care, would be looked upon favorably by all parties involved.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Characteristics of the Study Sample

Characteristics	Child in Mental Health Care (*n* = 55)	Parent at Mental Health Clinic (*n* = 27)	Parent at Pediatric Office (*n* = 28)	*Test Statistic*[a]	
	***n* (%)**	***n* (%)**	***n* (%)**		***p***
# Children in Family				$U = 268.50$	.04
1	30 (55)	18 (67)	12 (43)		
2	18 (33)	8 (29)	10 (36)		
3	6 (11)	1 (4)	5 (18)		
4	1 (2)	0 (0)	1 (3)		
Age of oldest child				$\chi^2(1) = 0.50$	.48
Young (0-12 years old)	23 (42)	10 (37)	13 (46)		
Adolescent (13-21 years old)	32 (58)	17 (63)	15 (54)		
Child with chronic illness	20 (36)	11 (41)	9 (32)	$\chi^2(1) = 0.44$	.51
Insurance type				$\chi^2(2) = 1.88$	.39
Medicaid	23 (42)	11 (41)	12 (43)		
Private	28 (51)	14 (52)	14 (50)		
Both	2 (4)	0 (0)	2 (7)		

[a] Comparisons of parents who completed the survey at a mental health clinic with parents who completed the survey at a pediatric office.

Table 2

Parents' preferences for information to be shared between their children's primary care and mental health providers.

	Yes	No
	***n* (%)**	***n* (%)**
Diagnoses	52(94.5)	3(5.5)
Treatment Plans	48(87.3)	7(12.7)
Prescriptions	51(92.7)	4(7.3)
Ongoing Updates	47(85.5)	8(14.5)

Table 3

Parents' beliefs about communication between their children's primary care and mental health providers.

	Total Sample	Comparisons by Sub-Groups											
		Chronic Physical Illness				Insurance				Oldest Child			
		Yes	No			Private	Public			Age ≤ 12	Teen		
	n = 55	*n* = 20	*n* = 35			*n* = 30	*n* = 23			*n* = 23	*n* = 32		
	M (SD)	*M (SD)*	*M (SD)*	t(df)	*p*	*M (SD)*	*M (SD)*	*t*(df)	*p*	*M (SD)*	*M* (SD)	*t*(df)	*p*
Importance Providers Collaborate	4.36 (0.91)	4.35 (1.09)	4.37 (0.81)	−0.08 (53)	.93	4.50 (0.86)	4.13 (0.97)	1.47 (51)	.15	4.17 (1.15)	4.50 (0.67)	−1.32 (53)	.19
Providers Actually Collaborate	3.09 (1.31)	3.10 (1.37)	3.09 (1.29)	0.04 (53)	.97	2.67 (1.16)	3.52 (1.34)	−2.49 (51)	.02	2.61 (1.34)	3.44 (1.19)	−2.42 (53)	.02
Parents Act as Bridge	3.78 (1.11)	3.85 (1.09)	3.74 (1.14)	0.36 (52)	.72	3.97 (0.85)	3.50 (1.37)	1.51 (50)	.14	3.77 (1.07)	3.78 (1.16)	−0.03 (52)	.98