

Providing Perinatal Mental Health Services in Pediatric Primary Care

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Babies under the age of 1 year account for 74% of pediatric primary care visits, with more than 25.6 million visits annually (Centers for Disease Control, 2004). Pediatric primary care settings provide continuous and comprehensive medical services that are accessible to the majority of children and their families. As such, these settings are ideally suited to promote optimal development through the provision of expanded services that address parental concerns, key developmental tasks, psychosocial factors, and

mental health issues in the context of a trusting relationship.

In the perinatal period, newborns and their caregivers attend frequent visits with primary care providers. The first visit often occurs within 3–4 days of a baby's birth. Subsequent visits are scheduled at 1–2 weeks, 1 month, and 2 months postpartum. The needs of a newborn and his family dictate the frequency of visits. The number of visits and the proximity of visits to the time of birth make pediatric primary care settings ideal for promoting positive perinatal mental health outcomes, as well. Promoting perinatal mental health includes supporting relationship development between a newborn and his primary caregivers, offering different perspectives and information about the transition to parenthood, determining how parents and family members are adapting, and attending to family needs. Consistent with this support, routine pediatric visits in the first 2 years of life are designed to include much more than physical examinations and immunizations, focusing on socioemotional well-being, social history, and development of a strong relationship with primary caregivers.

Historically, the relationship with the pediatric care provider was a stable one in which families saw the same provider at each visit. Recently, however, trends indicate less continuity of care by a specific pediatric provider,

especially for families with public insurance (Berman, Egger, & Angold, 2007; Christakis, Wright, Zimmerman, Bassett, & Connell, 2003). In addition to the lack of continuity, the average time of a well child check has dropped from 29 minutes to 18 minutes (Olson et al., 2004). The provider is, in effect, pressured to focus more on the physical health of the child and less so on social, developmental, and parenting issues. Although studies suggest that parents are more likely to turn to their health care provider for information regarding parenting and child development than to another specialist (Inkelas, Glascoe, et al., 2002; Inkelas, Schuster, Newacheck, Olsen, & Halfon, 2002), decreased time and continuity may compromise care and the clinical relationship.

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. During each of the five recommended well-child visits in the first few months of life, the American Academy of Pediatrics' Bright Futures Task Force, a national health promotion and disease prevention initiative, highlights parent well-being, infant well-being, and parent-child

relationship issues as salient factors for pediatric providers to address (Hagan, Shaw, & Duncan, 2008). The dilemma for pediatric providers is not whether they should address topics that are at the core of perinatal mental health, but how to do so. Addressing parental concerns, conducting physical examinations, immunizing, building relationships with families, and providing appropriate anticipatory guidance takes time, comfort, and specific knowledge.

Most pediatric providers are quite comfortable with routine physical examinations; however, the psychosocial and relationship-focused components of these visits may be daunting. How do you inquire about how your patient's mother is feeling after giving birth or how things are going at home without entering into

Abstract

After birth, newborns and their caregivers are seen routinely and frequently in pediatric primary care settings. Capitalizing on the close succession of visits in the first few months of life, pediatric primary care professionals are in a unique position to enhance infant mental health by developing strong relationships with caregivers, supporting babies and their families, and providing critical information about development and well-being. This article describes Project CLIMB (Consultation Liaison in Mental Health and Behavior), an integrated mental health program located within a busy pediatric primary care training clinic, and how it incorporates infant mental health principles into direct services and educational offerings.

potentially uncomfortable or time-consuming conversations? How do you interpret the quality of infant–parent relationships and support parents’ capacity to nurture their babies? What do you say when things don’t seem to be going well? Where do you refer parents for help with parenting issues, parent mental health issues, or family stressors? These questions of how, what, and where are the focus of perinatal support services in pediatric primary care.

Mental Health and Behavioral Interventions in Pediatric Primary Care

INTERVENTIONS IN PEDIATRIC primary care that have successfully addressed development, psychosocial factors, and, to a more limited extent, mental health issues have typically targeted specific behavioral concerns (e.g., sleep patterns, discipline) in the toddler population. The Healthy Steps for Young Children Program (Zuckerman, Kaplan-Sanoff, Parker, & Young, 1997) is one of the few interventions that begins during the perinatal period. Healthy Steps incorporates developmental specialists and enhanced developmental services into pediatric primary care settings, recruiting families during their first visits to primary care and providing support throughout the first 3 years of life. Families participating in the Healthy Steps program received more developmental services, were more satisfied with the quality of care provided, were more likely to attend well-child visits and to receive vaccinations on time, and were less likely to use severe discipline techniques with their children (Minkovitz et al., 2003). Participation in the program also increased the likelihood that mothers at risk for depression would discuss their sadness with someone in the pediatric setting.

Although sparse data exists about primary care in the perinatal period, Regalado and Halfon (2001) found that assessment approaches for identifying behavioral problems in the first 3 years of life were lacking and that physicians underestimate the extent of psychosocial challenges faced by families and the impact of such psychosocial challenges on behavior problems in children. Likewise, parents of young children also report that their child’s clinician did not always take the time to understand their child’s needs (Halfon et al., 2000), leaving many parents with their guidance needs unmet (Olson et al., 2004). The findings above suggest a discrepancy between the potential of primary care and what families report they actually receive from providers during well-child checks.

Postpartum Depression Screening

The debate about perinatal issues in pediatric care has focused on whether pediatric



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Routine pediatric visits provide an ideal setting to address social and emotional well-being.

offices should formally screen for postpartum depression. This is a shift from routine inquiry about family adaptation. Unfortunately, many mothers look better than they feel (Frankel & Harmon, 1996), and many feel uncomfortable sharing how they feel with a provider for reasons of stigma and guilt. In addition, many providers feel uncomfortable asking these questions and are concerned about how such questions may extend the visit. Furthermore, providers may question the ethics of screening for these concerns when very few mental health providers are available to deal with perinatal mood disorders (Chaudron, Szilagyi, Campbell, Mounts, & McInerney, 2007).

Bright Futures for Mental Health encourages pediatric primary care professionals to inquire about depressive symptoms and to consider formal screening for postpartum depression using a validated scale (see Jellinek, Patel, & Froehle, 2002, pp. 308–316). When symptoms are identified, recommendations include discussing the safety of mother and baby, referring the mother to a mental health provider, scheduling more frequent pediatric visits, and using phone contacts between visits as a mechanism for ongoing monitoring.

Recent research suggests that pediatric primary care offices can readily identify postpartum depression and related concerns and make suitable and productive referrals to local mental health providers (Olson et al., 2005). Beyond making external referrals, screening for postpartum depression in pediatric primary care provides a mechanism for asking and talking about family well-being and for ongoing monitoring. Successfully

integrating postpartum depression screening into pediatric primary care requires a practice setting that believes in formal screening, has linkages to local mental health professionals with appropriate expertise, and has as its clients depressed mothers who are willing and able to schedule and attend mental health appointments in a separate system of care. In an environment with few perinatal and infant mental health resources, lack of the previously mentioned success factors often presents tremendous challenges to screening and providing services.

Pediatric Primary Care and Medical Home

It is ideal that pediatric primary care offers a medical home (American Academy of Pediatrics, 2002) for babies and their families starting at the time of birth and lasting through childhood. According to the Medical Home Advisory Task Force of the Colorado Department of Public Health and Environment, a *medical home* is one in which a pediatric clinician works in partnership with the family/patient to ensure that all of the medical and nonmedical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child and family. When a medical home is created in partnership with a family at the time of a baby’s birth, the potential for lasting relationships and significant impact on child and family well-being is enormous.



Focusing on how the baby is doing is one way providers can build trusting relationships with parents.

Achieving a medical home or implementing the vast recommendations from Bright Futures in the pediatric care setting is a near impossibility. However, with access to mental health, social work, or developmental consultants, the possibility is achievable. Infant and perinatal support in the pediatric setting also enables infant mental health clinicians to fulfill their potential to use multidisciplinary approaches, be developmentally and prevention-oriented, and focus on multigenerational relationship factors (Emde, Bingham, & Harmon, 1993).

Helping Newborns and Their Families During Well-Child Visits

FOR THE PAST 3 years, Project CLIMB (Consultation Liaison in Mental Health and Behavior), an integrated mental health intervention program, has successfully served the needs of an at-risk population in a large, outpatient primary care clinic located in a national children's hospital affiliated with an academic medicine center. The Child Health Clinic (CHC) is a community-based, primary care residency training clinic located in the metropolitan Denver area. The clinic, which sees approximately 8,000 patients and over 19,500 yearly visits, has a large Hispanic/Latino patient base. Approximately 90% of the children seen are covered by Medicaid, CHP Plus, or other types of public insurance. The clinic functions as a continuity training site for a pediatric residency program, with approximately 40 pediatric residents seeing patients in the clinic one afternoon each week during their 3-year residency. Although the

clinic serves children from birth to 18 years of age, young children from birth to 36 months make up approximately 60%–70% of the visits annually.

Program Description

The model for Project CLIMB emerged through close collaboration among the departments of psychiatry and pediatrics, The Children's Hospital Foundation, and two community foundations with interest in increasing access to mental health services and training and education of health care providers. Together, these groups identified a need to increase access to mental health services for a largely underserved, high-need population of children in the metropolitan Denver area. Only a small fraction of the patients seen at the CHC accessed community mental health services in spite of a high level of documented behavioral and emotional challenges. Equally as important, the project's second goal involves preparing future primary care clinicians to meet the mental health, developmental, and behavioral needs of children and their families in the context of well-child visits during the first few years of life. Establishing productive relationships and collaborating closely with the clinic administration and staff has been critical to the successful implementation of our program.

Initially, the program was staffed by part-time clinicians, including a psychiatrist, a psychologist, and two psychology trainees covering a few half-day clinics each week. Today, Project CLIMB is staffed by a psychiatrist, a psychologist, postdoctoral psychology fellows (one of whom is an infant mental health fellow), psychology interns, psychology graduate students, and other rotating mental health providers, including advanced practice nurses, pediatric neurology fellows, child psychiatry fellows, and volunteer physicians. A contract with a local community mental health center also provides a full-time social worker. The clinical director, a licensed psychologist, provides weekly reflective supervision to psychology trainees. The medical director, an infant/child/adolescent/adult psychiatrist and pediatrician, supervises medical trainees.

Clinicians staff half-day continuity clinics in the CHC, providing consultation services as needed to pediatric primary care providers. Direct clinical services include case consultations; developmental and postpartum depression screening and referral; psychopharmacology evaluations; ongoing monitoring of mental health, behavioral, and developmental issues; Healthy Steps for Young Children visits; case management; and triage. Consultations typically involve direct contact with patients but may also involve

case review and recommendations to primary care providers who then implement the recommendations with families.

Since its inception, Project CLIMB has developed numerous education and training opportunities for pediatric primary care providers, allied health professionals, and integrated mental health service providers. In the CHC, CLIMB clinicians teach pre-clinic didactics on various topics related to mental health and behavior. Our team also leads noon conferences for pediatric residents. Project CLIMB has presented extensively at local and national meetings on the program (Talmi, Stafford, Bunik, & Navin, 2008), data from research projects (Talmi, Stafford, Cass, & Allen, 2007; Wolfington, Talmi, Stafford, & Roblek, 2008), and clinical implications (Stafford, Talmi, & Wamboldt, 2007).

The training environment of the clinic provides unique obstacles and opportunities. First-year pediatric trainees are tasked with learning the content of each visit as well as the clinic protocol, electronic medical records system, and translation system. These trainees are, understandably, overwhelmed and are quite open to formal consultation, where the infant mental health clinician can model appropriate inquiry, empathy, and problem-solving techniques. As their comfort level increases, they gradually assume the primary clinical role, with the consultant observing and offering additional information and support. The end goal is for the trainee to understand and act upon his or her responsibility to inquire and provide guidance in these areas, have sufficient skills and knowledge to do so, and use the consultant as a source of ongoing support when new obstacles arise in support of the child and family.

Because Project CLIMB offers integrated mental health services in pediatric primary care, families seen by our team have access to seamless and comprehensive care that includes mental health, developmental and social-emotional well-being, and behavior as routine services as well as advocacy and system linkage to more intensive services. In addition to providing access to mental health services, our team has worked to increase primary care providers' capacity to treat children and families with complex needs. As such, patients seen at the Child Health Clinic are afforded a medical home.

Clinical and Evaluation Findings

Project CLIMB evaluated several program components for quality improvement, program development, and research purposes. This section briefly details findings from numerous projects and highlights results related to the perinatal period. Data

are gathered using medical record abstraction and chart review, electronic medical record informatics, and prospective data collection.

CLINICAL SERVICES

For quality assurance and program development purposes, a research assistant collects information from de-identified medical records. Of the more than 1,500 patients seen, 85% were referred by their primary care provider, suggesting high use of the consultation team and a good referral process. Approximately 54% of the patients seen by Project CLIMB for a follow-up visit reported that their presenting problem had improved—a finding that provides preliminary support for positive program outcomes.

SCREENING INITIATIVES

In accordance with the American Academy of Pediatrics' recommendations for well-child visits, Project CLIMB implemented routine postpartum depression and developmental screening initiatives. Parents complete a postpartum depression screener at each well-child visit from newborn through age 4 months. At 4 months postpartum, the average score for mothers responding to the questionnaire at their child's well-child check is 4.7 out of 30. However, 18% of the population scores above the 12-point cutoff, indicating the need for integrated mental health services that can address symptoms of postpartum depression in primary care settings and recommend additional resources and treatments as needed. In a sample of toddlers at 12, 15–18, and 24 months of age, mothers who reported clinically significant distress had children whose social-emotional difficulties were more likely to be in the clinically significant range than mothers who did not report elevated distress levels. Untreated or unnoticed maternal distress may have contributed to poorer child functioning even at an early age.

Starting at the 6-month well-child check and continuing through age 5 years, parents complete the Ages and Stages Questionnaire (ASQ; Squires, Potter, & Bricker, 1995). Project CLIMB has successfully launched these screening initiatives in a clinic where no formal screening was done previously. At present, more than 70% of young children attending well-child checks are formally screened at well-child checks. Approximately 5% of patients have delays in at least 1 out of 5 developmental domains.

HEALTHY STEPS FOR YOUNG CHILDREN

Using medical records review, we examined primary care indices (e.g., timely immunizations) and developmental topics discussed during well-child visits for children who

were enrolled in the Healthy Steps program as compared with demographically matched controls who were not enrolled in Healthy Steps (Buchholz & Talmi, 2008). Children participating in Healthy Steps received timely well-child checks and immunizations. Furthermore, important developmental topics including breastfeeding and postpartum depression were more likely to be discussed with families during well-child checks when a Healthy Steps specialist was present. Families brought up developmental issues such as sleep, temperament, and postpartum depression more often when they were enrolled in the Healthy Steps program. These data suggest that integrating perinatal and infant mental health specialists into pediatric primary care expands the potential of these settings to address critical issues in the first days, weeks, and months of life.

Michael's Story

MICHAEL¹, A HISPANIC boy born to a young mother, came in for his newborn visit 4 days after birth. During this visit, Michael's mother, Christina, completed the postpartum depression screening routinely used in our clinic (Cox, Holden, & Sagovsky, 1987). Her score of 6 would not typically have triggered a referral because it falls below the threshold of 10 used in our clinical guidelines for addressing postpartum depression. Pediatric providers are trained to provide differential responses based on parents' scores. Scores falling between 6 and 9 are acknowledged by providers with a conversation about the stress of having a new baby in the family. In this family's situation, the mother's score of 6 triggered a referral because during check-in, Christina and Michael's father, Carlos, were arguing in a manner that raised concerns about domestic violence.

The pediatric provider requested a CLIMB team consultation to evaluate the situation and ensure parent and child safety. The CLIMB clinician introduced herself to the family and explained her role in the clinic as providing additional developmental and mental health support to children and families. The clinician began by asking Michael's parents open-ended questions such as how they were each feeling with having a new child. Both parents stated that they were excited and tired. Finding a way to speak with Christina privately so that she could openly answer questions about her relationship with Carlos was an important consideration. The clinician asked if she could further review the postpartum depression screening with

Christina and asked Carlos if he would wait outside the room. Conducting the assessment in collaboration with the pediatric resident allowed the infant mental health clinician to model assessment of risk for domestic violence in an appropriate and empathic way during newborn visits.

The infant mental health clinician asked Christina questions about her relationship with Carlos, such as, "Tell me about your relationship. How is Michael's father involved in Michael's life? What are his interactions with Michael like, and are you comfortable with these interactions?" These open-ended questions served as a model for the pediatric provider, demonstrating how these types of questions often facilitate more detailed discussion and convey greater empathy than closed-ended questions. Christina reported feeling safe but noted that she and Carlos argued frequently. The two were not married, and she and Michael resided with her sister.

This family reported several stressors, including the seemingly volatile parental relationship, being young parents, and feeling inexperienced caring for a baby. In addition, Christina was suffering from a serious medical condition. The infant mental health clinician felt that Christina may benefit from psychological services to manage these stressors and referred her to a community mental health clinic. However, at a later visit, the clinician learned that Christina had not followed through with the referral. The family was also recruited into the Healthy Steps for Young Children program, which allowed Michael and his mother to receive additional services in the primary care clinic, including visits with a pediatric provider and a developmental specialist, provision of child development materials, and opportunities to talk about how Michael was doing at each well-child check. Christina expressed an interest in the program, and she was provided with a packet of written information relevant to Michael's age. Recruiting the family into the Healthy Steps program was one way for the both the resident and the infant mental health clinician to ensure that this family receive ongoing assessment and support. Equally important was the goal of encouraging continuity of care and building a strong relationship with an identified pediatric provider.

The same pediatric resident saw Michael and his mother at the 2-, 4-, 6-, and 9-month well-child checks. At each of these visits, the family was also seen by an infant mental health clinician serving as a Healthy Steps specialist. Visits included ongoing assessment of the family's safety and relationships as well as Michael's development, with anticipatory guidance from the pediatric provider

¹All names and identifying information have been changed to protect client confidentiality.

and the infant mental health clinician. In addition, Christina completed postpartum depression screeners at subsequent visits and scored below the threshold of clinical concern. Christina received written materials and reviewed them with the Healthy Steps specialist. These discussions focused on topics such as the starting of solid foods, teething, sleep routines, daytime routines, and temperament. The clinician used events that occurred during visits to educate Christina on development and parenting topics. For example, when Michael received his first immunizations at 2 months, his mother responded very appropriately to his discomfort by holding him toward her, talking gently to him, and attempting to console him. The clinician commended her and pointed out the positive effects of this interaction on Michael and on their relationship, thereby creating a space to notice and reflect on important aspects of the infant-parent interaction.

Over the course of Michael's first year of life, the family developed a trusting relationship with both the resident and the Healthy Steps specialist. This trust was demonstrated on one occasion when Christina brought a friend with her to the visit. Before bringing the friend into the exam room, Christina asked the pediatric provider and infant mental health clinician to refrain from discussing her medical condition during the visit, as she had not disclosed this information to her friend. Beyond the trusting relationship, Christina seemed to look forward to her interactions with the infant mental health clinician. During one visit, the clinician was running late. Christina asked the pediatric provider where the clinician was and if she would be joining them during the visit. The clinician and the pediatric provider were in a unique position of maintaining a relationship with Michael and his mother for an entire year. The changes in an infant's development during the first year are drastic and provide infinite opportunities for both pediatric providers and infant mental health specialists to promote positive relationships between parent and child. The relationships that developed among Christina, the provider, and the infant mental health clinician fostered and promoted the strong relationship between Michael and his mother. The clinicians were able to optimize infant mental health and the infant-parent relationship because of their strong connection with Christina and the continuous care they provided throughout Michael's first year of life.

In any clinical setting, but especially in a busy training environment, building these relationships can be difficult given educational demands and scheduling difficulties. However, with the collaboration of the resident, the infant mental health clinician, and the clinic staff, we were able to ensure that

Michael and his family experienced continuity of care. Michael received on-time well-child checks and immunizations throughout his first year. Michael is now 1 year old and is growing and developing well. He and his family will continue to participate in Healthy Steps until he turns 3. They will receive ongoing developmental assessment and anticipatory guidance on topics such as returning to work, child care, development of language, and motor milestones. Michael and his family seem to have benefited from being seen by an infant mental health clinician and will continue to benefit from the expanded developmental services that will be provided well into the future.

Reflections on Perinatal Mental Health in Pediatric Primary Care Settings

WHEN A FAMILY brings their newborn to the primary care provider's office for the first time, they bring much more than their baby and a diaper bag to the visit. Families enter primary care with their hopes, expectations, concerns, fears, relationship histories, psychosocial circumstances, past experiences with providers, and much more. Sometimes the context into which a baby is born becomes readily apparent during a pediatric visit. In many cases, however, it must be carefully unpacked over time with a familiar and trusted provider. Pediatric primary care visits early in a baby's life provide the ideal setting in which to unpack the contents of a baby's circumstances, learn about and understand them, and determine how to best help babies grow and thrive within their families.

Michael's case provides an example of the many ports of entry (Stern, 1995) for perinatal mental health intervention in pediatric primary care. In this case, an argument between the parents observed at check-in triggered a consultation with the infant mental health clinician. If the argument had not triggered the referral, the pediatric provider still would have asked Christina how she was doing because the postpartum depression screening protocol employed in the clinic requires the provider to review the questionnaire with parents. The questionnaire itself is titled "And how are you doing?" reminding providers and parents to focus on the family (not just the infant) and discuss parental well-being during these early well-child checks. Although Christina's score on her initial postpartum depression screening was not in the clinical range, asking questions about her well-being led to a conversation about how things were going in the family and about relationships, supports, and needs. With open-ended questions, Christina might have talked about relationship dynamics during this conversation, particularly if she was encouraged to do so by a provider she knew and who

had experience in perinatal mental health approaches.

Although one of the most common first questions a pediatric provider asks a family is "What are your concerns today?" a perinatal mental health approach suggests that pediatric providers first ask about how parents are doing (Prugh, 1983). The myth that asking about parental well-being and familial circumstances will open Pandora's Box is a powerful deterrent in primary care settings. What happens if we learn that a mother is depressed or there is domestic violence or a family has needs beyond those that we are able to provide in primary care? Many providers, intimidated by asking questions about things with which they may not be able help, simply don't ask. And yet, we know that left unidentified or unaddressed, psychosocial risks are detrimental to child well-being. The consequences of not asking may be as costly to child well-being as failing to do a newborn hearing screen on a baby with hearing loss. Early identification, support, referral, and intervention are critical in mitigating the impact of risk factors and using protective factors to enhance young child development. If asking these questions is necessary, the focus then shifts to the manner in which infant mental health professionals can support primary care providers in building relationships with families during the perinatal period so that comprehensive well-child checks will include exploration of psychosocial factors.

Learn More

AMERICAN ACADEMY OF PEDIATRICS TASK FORCE ON MENTAL HEALTH
www.aap.org/mentalhealth

Through this Web site, the American Academy of Pediatrics provides training and educational opportunities, resources, and advocacy materials to improve children's mental health services in primary health care.

BRIGHT FUTURES INITIATIVE
<http://brightfutures.aap.org/index.html>

Bright Futures is a national health promotion initiative. Practice guides help providers promote mental health care in children, adolescents, and their families.

THE NATIONAL CENTER FOR MEDICAL HOME INITIATIVES
www.medicalhomeinfo.org

The National Center for Medical Home Initiatives provides support to physicians, families, and other medical and nonmedical providers who care for children and youth with special needs.

In primary care settings, the focus on the baby provides another port of entry. Pediatric providers are encouraged and trained to ask about and understand who lives with the baby, who provides support and helps take care of the baby, and what a typical day for the baby is like. Asking about a typical day offers a window into the people in a baby's life, what they are doing, and how the baby is responding to these efforts. Family rhythms and routines, supports and stresses, and quality of relationships can all be ascertained using this question. In combination with a physical exam, formal developmental screening, and direct observation, asking baby-focused questions is often a mechanism for building relationships with families. In Michael's case, for example, an infant mental health clinician could have established rapport with the family by checking on developmental issues. Focusing on how the baby is doing is often significantly less threatening or stigmatizing than parental mental health or psychosocial circumstances.

Families are typically comfortable bringing their children to well-child checks. Pediatric well-child checks transcend both socioeconomic status and most cultures. For families with limited resources, the primary care setting may be one of the only places to which they can bring their children to get information and support, especially in the newborn period when babies are typically not enrolled in other care settings. This is particularly important in cases of social isolation, refugee status, or where cultural beliefs about the health care system promote "doctors" as experts whose opinions and recommendations matter greatly.

The provider-patient relationship, with the caregiver functioning as a proxy for the patient, is another port of entry into perinatal mental health intervention in primary care settings. Bringing a baby to the primary care provider is a sign of trust. It also suggests a belief that the provider will examine, care for, and give accurate information about the baby. Particularly in the perinatal period, when caregivers of newborns may be isolated and have limited interactions with others, seeing a pediatric primary care provider on a regular basis can be a source of reassurance that the baby is doing well, that the caregiver is doing a good job caring for the baby, and that this transitional period will lead to strong relationships and successes in a few months. We cannot underestimate the powerful message that a parent of a newborn receives when they hear from a trusted "expert" that they are doing a good job in their parenting role. This was certainly a critical factor in Michael's case, where his young mother received positive messages from both the pediatric provider and the infant mental health clinician. Her relationship with the two providers functioned as a model for her relationship with Michael during his first year of life.

Summary and Next Steps

PROJECT CLIMB, A mental health services program located in a high-risk, low-resource pediatric primary care setting, provides comprehensive, integrated services to babies and their families. The integrated program incorporates the four pillars of an early childhood system framework: physical health, mental health, early learning, and family support. The program's involvement extends beyond provision of perinatal and infant mental health services into training future pediatric providers in addressing critical issues in the perinatal period.

The following is a list of considerations and next steps for perinatal mental health professionals interested in providing integrated services in pediatric primary care.

1. Be where the babies are. Newborns and their families are seen in pediatric primary care settings more frequently and without the stigma associated with mental health settings.
2. Find a champion or two in the primary care clinic who will advocate on your behalf and create a space for perinatal mental health services.
3. Focus on sustainability issues from the start so that the position/program endures.
4. Build relationships with providers, families, and babies.
5. Incorporate recommendations and guidelines from pediatrics, mental health, behavior and development, and perinatal and infant mental health into program development. Start slowly, provide evidence for why it's being done, ask little of others, do a lot yourself, and celebrate successes.
6. Connect agencies, stakeholders, funders, and others who have a vested interest in serving the needs of newborns and their families at the systems level to create an infrastructure for the model.

Providing perinatal mental health services within pediatric primary care is a high-yield strategy for reaching newborns and their families in a nonthreatening and supportive manner. For families, our goal is to have caregivers expect perinatal mental health issues to be addressed in the context of well-child visits; to ask their pediatric providers for help, resources, and information; to share with their pediatric providers about how things are going for their baby and their family; and, ultimately, to forge a partnership with their provider in order to promote their baby's development and well-being. For providers, our goal is to

offer resources to enhance their attitudes, knowledge, and skills so that they can better meet the needs of newborns and their families and, ultimately, to have pediatric primary care providers who routinely establish medical homes for the babies and families they serve. 

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