

Access to Mental Health Services
Facilitated Listserv Topic Indian Health/Rural Health SIGS
Council on Community Pediatrics
January-February 2006

Introduction

Steve Holve, MD – Chair, Indian Health SIG

Those of us who work with American Indian and Alaska Native (AI/AN) youth recognize that mental health treatment is doubly difficult: AI/AN youth have a disproportionate burden of psychiatric illness yet access to trained mental health physicians and counselors is particularly problematic in poor, rural settings.

Improving mental health services is one of the priorities of Dr. Charles Grim, Director of the Indian Health Service. The facilitators of this listserv discussion work with AI/AN communities, but we know our colleagues in non-reservation rural communities face many of the same barriers in obtaining mental health services. Recognizing our shared concerns, we invite you to offer your worries and wisdom to this national listserv discussion that includes members of both the AAP Indian Health and Rural Health Special Interest Groups and the members of the American Academy of Child and Adolescent Psychiatry's Native American Child Committee. Jon Perez, PhD, Indian Health Service Behavioral Health Director, is also a participant in this listserv discussion.

Robert Holmberg, MD – Chair, Rural Health SIG

Difficult access to rural child mental health services continues to be the greatest disparity mentioned to me by rural pediatricians. Rural isolation, poverty, lack of health insurance, limited early child care programs and education, parental alcohol and methamphetamine abuse, etc. all compound the problems. Dr. Steve Holve and several colleagues in the Indian Health SIG have written this listserv discussion and survey to share with us.

PLEASE take the time to read, ponder your situation, share with us briefly your solutions, or dreams for solutions. I would add to their questions whether you have been able to integrate child mental health services into your rural peds practice. REMEMBER that we have MTAP grants (<http://www.aap.org/sections/socp/mtap.html>) quite available to help you get consultation and start a dream project to improve community-based rural peds services, including mental health, in your practice.

Topic

Access to Child and Adolescent Mental Health Services in Native American and Rural Communities

- While covering pediatric urgent care in your rural clinic, you are called to see a 14-year-old girl who is distraught and intoxicated. She reportedly has taken a Tylenol overdose as a suicide gesture. Who do you consult? What kind of triage/follow-up concerns do you have?

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- A grandparent brings her 8-year-old grandson to your Urban Indian Health Center Clinic reporting that he is struggling in school with his grades. He seems anxious to you. What supports are in your clinic to help serve this boy?
- The dental clinic refers a 12-year-old boy to you because, in addition to having multiple pressing dental care needs, he also seems depressed. His immunization records and general health data are not available to you. You understand that he had been placed in a far away Indian boarding school and have refused to return.

The above vignettes represent some of the challenges faced by primary pediatric care providers who serve the needs of AI/AN children and adolescents in rural and urban clinics. Because psychiatrists and psychologists are rare in poor and rural settings, primary care teams routinely provide the mental health care safety net for many children in rural communities, as well as for urban AI/AN youth. Unfortunately, AI/AN youth experience disproportionately high rates of psychological stress, learning difficulties, accidental and non-accidental injuries, depression, multi-generational post-traumatic stress disorders, suicide, and substance abuse. Issues of need and access to mental and behavioral health services are compounded by risks of rural and urban isolation, limitations with insurance coverage, poverty, cultural appropriateness of services, and other factors.

In addition, each year nearly 10,000 AI/AN students begin their school years living in boarding schools... sometimes in schools that are thousands of miles from home. A disproportionate number of AI/AN boarding school students have a history of family dysfunction, legal difficulties, and school failure. These students are a particularly high-risk population, but often have greater difficulty accessing mental health services because they are far from their medical home and often out of their home state.

Questions

Through this listserv discussion, we would like to explore the difficulties and frustrations, as well as satisfaction with model programs that are being experienced by primary pediatric care providers encountering mental and behavioral illness among AI/AN children and youth and children and youth who reside in rural settings.

- How are mental and behavioral health services being delivered in your various clinical and community settings?
- What works, and what else is needed to address these problems?
- What triumphs are experienced? What programs are out there that could be generalized more widely to meet the challenges?
- Do you have any suggestions for improving cross-specialty consultation processes?
- Any ideas regarding optimal electronic medical record (EMR) strategies for serving AI/AN youth?

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- Does your clinic utilize telemedicine/telepsychiatry supports? Perils and promises?
- Do you have experiences or resources to share, such as the Massachusetts Child Psychiatry Access Project (MCPAP)?
- Does your program have links to community-based projects and/or traditional/complementary healing practices (such as the Circles of Care projects)?

Responses

There were many responses to this listserv topic. The responses have been summarized by topic.

Reimbursement

- This situation is only worsened by poverty, reality, and isolation but here we are not better off as primary providers don't even get reimbursed for mental health codes!!! (*Gilbert Handal, MD, El Paso, TX*)
- For those interested in mental health, more courses to take to better help us in dealing with so many of our patients with these problems and no one knowledgeable to help except in a rudimentary way. I realize insurance companies would need to be involved as well. Perhaps they should sponsor the courses and certify the docs who complete these courses. In doing so reimbursement would be greater! (*Arnold Gold, MD, Yuba City, CA*)
- We need to make it worthwhile to obtain additional training in mental health. CPT codes need to be revised and reasonable reimbursement for those willing to take the extra time and effort. (*Arnold Gold, MD, Yuba City, CA*)
- Training is needed for pediatricians on how to appropriately bill for services. (*Steve Barnett, MD, Austin, TX*)
- Payor systems (e.g., insurance companies) need to be more policy directed by practitioners in order for services to be adequately reimbursed. (*Steve Barnett, MD, Austin, TX*)

Helpful Strategies

- We have resorted to the following strategies that have helped somewhat:
 - Telecounseling linking with places that have those services available.
 - Group practice (beyond counseling), DIGMAS Group Medical Appointments (reference: Group Practice Journal, Nov-Dec 2001)
 - Further training of primary care providers on psychopharmacology and approaches to the child with mental health problems. There are algorithms for depression, behavioral problems, and ADHD. We are in the process of developing our own that will better fit our reality.

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- Develop liaisons with the schools to develop counseling resources and other mental health providers that can train the teachers about early recognition and referral and develop culturally appropriate screening tools.
- Use your social services support from the clinic site and schools to work in concert to address some of the social problems that are the harbingers of psychological difficulties.
- Work with the community to develop support systems, such as after hour workshops with parents to deal with parenting, anger management, problem resolution, etc. (*Gilbert Handal, MD, El Paso, TX*)
- Telemedicine has been a valuable tool in Alaska and other places with big distances and few practitioners. The Medical College of Georgia has had considerable experience with telemedicine along with other centers around the country. (*Martin Greenberg, MD, Savannah, GA*)
- Those of us at IHS sites tend to be better off than rural folks in private practice in that IHS has historically done well with designating a provider at each site to obtain extra training in health topics. Perhaps Dr. Grim would consider hosting a good CME for the primary care physician, then insisting that each site send a trainee. (*Lori Byron, MD, Hardin, MT*)
- We have been blessed in the past to usually have one psychiatric nurse in one of our mental health slots, who has typically educated the physicians and we look to them to assist with or do medication management. We have none now, but we are using some of the psychiatrist salary (slot unfilled for 18 years) towards a mid-level with an interest in mental health. (*Lori Byron, MD, Hardin, MT*)
- I believe there are some interesting programs in mental health that are demonstrating impressive results over relatively short-term treatment times. At least one of these (trauma focused CBT) has a web-based training program that non-psych providers can go through. In Pittsburgh, we trained 2 of our social workers to provide training sessions to parent-child dyads with severe behavioral issues following concerns of abuse/neglect. I can't comment on outcomes, but anecdotally it seems to be doing well. (*Kristine A. Campbell, MD, Pittsburgh, PA*)
- I've been able to get "on the job training" by working with child psychiatrists in the non-profit sector and with local mental health early intervention programs and perinatal substance abuse treatment programs. Although I had a strong interest in developmental issues in med school and residency, nothing quite prepared me for the myriad of psychosocial issues that my patients and families experience. (*Pierrette Mimi Poinsett, MD, Modesto, CA*)
- I am fortunate enough to work for a facility that adopted telepsychiatry services through the Arizona Telemedicine Network 5 years ago and to have had (at least intermittently) mental health staff with reasonable to good pediatric and adolescent experience. We have been providing telepsychiatry in both local high schools (equipment permitting) for as long. Even so, we are only able to serve a limited number of teens on a weekly basis and usually have a waiting list for both telemedicine and hospital-based services. Unfortunately, we end up being firemen when we really want to be farmers. (*Jane Oski, MD, Tuba City, AZ*)

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- Co-location of services. We have become so frustrated in our practice that we have hired 2 MSW trained mental health professionals to do counseling in our office. Telemedicine is another technique for co-location of services. Patients like coming to the office for therapy rather than going to the mental health center. (*Francis Rushton, Jr., Beaufort, SC*)
- We've had a "mental health" conference as part of our training program each month for the past 3 years. We don't do a block rotation, but we communicate that the combined peds/mental health session is AT LEAST as important as our monthly Peds/OB and Peds/ED and Peds/Surg conferences. (*Greg Blaschke, MD, MPH, San Diego, CA*)

Long-term Solutions/Ideas for Improvement

- Recruitment/Partnership
 - Recruiting greater numbers of ethnic minorities into professional training is essential, but difficult. It is hard to develop this untapped resource when the schools in rural and high-minority regions suffer the same economic disadvantage as the populations they are charged to educate. (*Douglas Esposito, MD, Fort Defiance, AZ*)
 - A call to the American Academy of Child and Adolescent Psychiatry (AACAP) and other guilds to augment their efforts to help recruit/encourage psychiatrists, ARNPs, and other mental health providers to AI/AN and rural communities. AACAP also has specific committees that address serving rural health challenges. (*Mick Storck, MD, Lakewood, WA*)
 - Fostering enhanced collaboration between the Indian Health Service and the Bureau of Indian Affairs in the effort to better serve the daunting healthcare needs of the nearly 10,000 AI/AN youth in boarding schools. (*Mick Storck, MD, Lakewood, WA*)
 - Increased presence of physical/occupational/speech and language therapists in AI/AN and rural communities. (*Mick Storck, MD, Lakewood, WA*)
 - Need for partnership with state and /or regional collaborative organizations, pediatric societies, university peds departments/divisions, and office of rural health. (*Steve Barnett, MD, Austin, TX*)
- Advocacy
 - Developing a position statement that encourages more extensive primary mental health care training in pediatrics/family medicine. (*Mick Storck, MD, Lakewood, WA*)
 - Specific strategies are needed to advocate for and engage with community/state population-based mental health interventions including home visiting, quality early education /child care, school-based mental health promotion and treatment, family support programs, and documented efficacy of interventions. (*Steve Barnett, MD, Austin, TX*)
- Education

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- We need to update ourselves on psychiatric issues, whether by mini-fellowships or CME. Hopefully, residency programs are already starting to address the need by scheduling in more psychiatry. (*Lori Byron, MD, Hardin, MT*)
- Course offerings that are specifically geared toward the primary care pediatrician. (*Douglas Esposito, MD, Fort Defiance, AZ*)
- IHS could support more specific training of individuals in the area of child and adolescent psych. One difficulty is the transience of the general IHS provider. (*Douglas Esposito, MD, Fort Defiance, AZ*)
- If we use a small part of our time teaching primary providers about basic diagnosis and psychopharmacology, I believe we could improve the level of basic care delivery to more kids, and enhance primary providers' identification of kids with mental health problems. Even if we only hang on to child psychiatry staff for a short time, if they do some teaching, their time can have some lasting effect. (*Elise L. Fatimi*)
- Increasing the required amount of child psychiatry training in pediatrics residency would be vital, but is maybe not the highest priority on the AAP or Board's screen. (*Elise L. Fatimi*)
- I think it is much more than providing an "elective" or rotation in child psych or a few lectures a year about psychopharmacology. That is just the tip of the iceberg. I think we as pediatricians need more skills in cooperative work with other disciplines (not just child psychiatrists and psychologists, but also teachers, community counselors, elders in the community, principals). (*Pierrette Mimi Poinsett, MD, Modesto, CA*)
- Increasing the availability of training for us rural folk – and our urban and suburban colleagues – would be a great first step. Increasing the amount of residency education would be helpful – either as an elective or a mandate – but it would mean that some other desperately needed piece of education would be marginalized. (*Jane Oski, MD, Tuba City, AZ*)
- Updating not only psychiatrists, but pediatricians about the new psychoactive medicines even if they are not recommended for children. We all know they are used frequently by the psychiatrists for children and we need to be comfortable prescribing them. (*Arnold Gold, MD, Yuba City, CA*)
- Enhanced training for primary care providers on mental health issues. Specifically attention disorders, attachment disorders, depression, anxiety disorders, conduct disorder, oppositional defiant disorder, and obsessive-compulsive disease. (*Francis Rushton, Jr., MD, Beaufort, SC*)
- An emphasis on prevention: Many of the mental health conditions we see can be either prevented, or at least more adequately contained with the appropriate support for families in the first years of life. This means advocacy for home visitation programs, outreach with in our office to families who are stressed, and screening families who are at risk for poor outcomes as part of routine care. (*Francis Rushton, Jr., MD, Beaufort, SC*)

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- Beginning planning for an NCE or other national meeting focusing on survival skills for the primary care provider, as well as highlighting model treatment programs and highlighting existing success stories with communities that are solving their challenges. (*Mick Storck, MD, Lakewood, WA*)
- Enhanced efforts to orient psychiatrists who provide consultation and/or direct service to AI/AN and rural settings to methods of consultation that are most useful for primary clinicians. (*Mick Storck, MD, Lakewood, WA*)
- Training is needed in the following areas:
 - Promotion of mental health
 - Early identification of problems and what are the best screening tools for various age groups as well as for common problems
 - Diagnosis of common disorders (e.g., learning disabilities, mood disorders, autistic spectrum disorders, anxiety disorders, and behavioral disorders)
 - Office management of common mental/behavioral problems
 - Psychopharmacology for non-complicated diagnoses
 - How to set up a practice with a community team for referral and consultation (*Steve Barnett, MD, Austin, TX*)
- More CME offerings that focus on practical problems of dealing with mental health issues in practice that successfully provide the pediatrician with take home skills to make a difference. (*Steve Barnett, MD, Austin, TX*)
- Alternative Practice Options
 - Finding a way for psychiatrists to work with primary care docs via phone should greatly amplify the mental health expertise available. If I see a child for depression, discuss it with a psychiatrist, prescribe a SSRI, and do the follow-up that one conversation may help me provide 5 follow-up visits to a child. This will free the psychiatrist to see five new patients. (*Steve Holve, MD, Tuba City, AZ*)
 - Phone consults and telemedicine can help fill some of the gaps, but there are times when it has taken more than just a few phone calls to reach one of my child psychiatrist back up people with a child in crisis. (*Pierrette Mimi Poinsett, MD, Modesto, CA*)
 - It is vital that we have access to Ped/Adol Psychiatry colleagues to help us to manage these sometime difficult patients. If we could adopt a rotating consultation service that could help us to respond to our questions and concerns, we could all breathe a bit more easily. (*Jane Oski, MD, Tuba City, AZ*)
 - Better back up by tertiary-based psychological services. (*Francis Rushton, Jr., MD, Beaufort, SC*)
- Tools
 - Having internet sites to retrieve information on common mental health problems. We need a central site where we can elaborate problems

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- beyond our ability and then revisit our diagnosis, perhaps using psychiatrists around the country to help us answering our questions. (Arnold Gold, MD, Yuba City, CA)
- We need help with evaluation forms to make a diagnosis of a specific mental illness similar to the Connors form on ADHD. (Arnold Gold, MD, Yuba City, CA)
 - Better tools: The Vanderbilt as opposed to the Connors does a pretty good job of looking for depression, anxiety, and oppositional behavior... but perhaps we need more. (Francis Rushton, Jr., MD, Beaufort, SC)
 - Perhaps a new PREP-like journal again for those interested in mental health so they can keep up to date on drugs and new diagnostic criteria for their patients suspected of mental health problems. (Arnold Gold, MD, Yuba City, CA)
 - Resources and toolkits to deal with the following issues:
 - How to work with distressed families, foster families, and group homes
 - Assessment tools (checklists and questionnaires for neurodevelopmental and psychiatric variables)
 - Psycho pharmacotherapy prescriber survival strategies
 - Guidance on evidence-based therapies such as Trauma-based Cognitive Behavioral Therapy and Motivational Interviewing
 - Skills for triaging
 - Telemedicine/telepsychiatry
 - Augmentations of electronic medical recordkeeping (Mick Storck, MD, Lakewood, WA)
 - A national (preferably regional) consultation line for providers to get immediate perspective on a specific mental health treatment quandary. (Mick Storck, MD, Lakewood, WA)
 - Models of mental/behavioral models for rural communities that can address common, but varying demographics, office practices, and community collaboration with counselors, social workers, psych nurses, psychologists, and psychiatrists. (Steve Barnett, MD, Austin, TX)

Resources Shared

- American Indians and Suicide: A Neglected Area of Research, *Trauma Violence Abuse*. 2006 Jan; 7(1):19-33. A good overview of what is known and unknown about mental health issues for Native Americans. While this article appears on the surface to be specifically geared toward the ever-pervasive problem of suicide, it is actually a very thoughtful overview of the broader topic of mental health.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16332979&query_hl=1&itool=pubmed_DocSum (Douglas Esposito, MD, Fort Defiance, AZ)

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- <http://www.ihs.gov/NonMedicalPrograms/DirInitiatives/index.cfm> Dr. Charles Grim, Director of the Indian Health Service, Behavioral Health Initiative. Four strategies are offered to help address the mental and behavioral health needs of the AI/AN communities. (Douglas Esposito, MD, Fort Defiance, AZ)
- *Mental Health: A Report of the Surgeon General*, 1999
<http://www.surgeongeneral.gov/library/mentalhealth/home.html> & the supplement *Mental Health: Culture, Race, and Ethnicity*, 2001
<http://www.surgeongeneral.gov/library/mentalhealth/cre/> (Douglas Esposito, MD, Fort Defiance, AZ)
- *Family-Focused Behavioral Pediatrics* by Bill Coleman. Good resource for those who want to enhance their counseling skills. (Francis Rushton, Jr., MD, Beaufort, SC)
- Training curricula that are out there already including:
www.pediatricsinpractice.org and www.brightfutureseducation.org (Greg Blaschke, MD, MPH, San Diego, CA)
- Community Pediatrics Training Initiative (CPTI) at AAP is trying to focus on many topics that have been brought up in this list serv discussion. The *Community Pediatrics Curriculum Manual and Community-based Resident Projects Toolkit* can both be found at <http://www.aap.org/commpeds/CPTI/resources.htm>. (Greg Blaschke, MD, MPH, San Diego, CA)
- New Bright Futures materials coming out in Jan 2007 have tried to include a 'practice improvement tool' to have all members involved in health care contribute to finding workable solutions to implement a Bright Futures practice. Also, the guidelines for health care supervision will include practical TOOL kits to help busy practitioners (in a culturally friendly, literacy level considered type way.) *Bright Futures in Practice: Mental Health Volumes I & II* is a wonderful book with good non-copywrited tools. <http://brightfutures.aap.org/web/> (Greg Blaschke, MD, MPH, San Diego, CA)
- Model Indian community development programs sponsored by US-HHS SAMHSA Circles of Care Program (http://www.uchsc.edu/ai/coc/coc_index.htm) (Mick Storck, MD, Lakewood, WA)
- AAP Task Force on Mental Health (<http://www.aap.org/commpeds/dochs/mentalhealth/taskforce.cfm>) is conducting the following activities:
 - Develop continuing medical education teleconferences or videoconferences on evidence-based mental health practices.
 - Coordinate presentations by mental health experts at AAP chapter and district meetings.
 - Develop and monitor an electronic discussion forum for pediatricians and other primary care professionals to discuss the care of children with mental health disorders in the medical home.
 - Provide training to 5 pilot practices on how to implement the AAP mental health tool kit.

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- Promote and disseminate educational material on state Early Intervention programs and 211 systems.
- Collaborate with national primary care organizations and with mental health specialist organizations to develop and endorse models of collaborative practice that can be utilized in communities with limited mental health resources.
- Create and disseminate an AAP chapter resource guide to assist chapters in establishing meaningful state-level partnerships. Include with this guide will be a coding fact sheet related to mental health.
- Provide resources and technical assistance to at least 3 select states that do not have an operational state mental health plan.
- Facilitate culturally diverse parent and youth focus groups in order to identify barriers to seeking and engaging in mental health treatment in primary care settings.
- Develop educational material and public service announcements emphasizing the importance of early mental health care and the primary care professional's role in providing this care. (*Linda Paul, MPH, AAP Manager, Mental Health Initiatives*)

Other issues to address

- Staffing Issues
 - I have seen frequent turnover, poor levels of education, a lack of professionalism, and low levels of staffing/funding of agencies charged with child protection services. I have also seen frequent turnover and low staffing levels, even with highly professional staff, in the realm of mental health services. (*John Ratmeyer, MD, Gallup, NM*)
 - Until local Native communities and governments becomes involved with encouraging the education and retention of a professional class of Native people, our current patchwork of services will persist. (*John Ratmeyer, MD, Gallup, NM*)
 - There is a severe national shortage of well-trained, competent, and dedicated mental health professionals. We have been unable to identify an individual willing to come to this rural area to staff our brand new, state-of-the-art residential Adolescent Care Unit. Either general psychiatrists refuse to see adolescents or children, or else will not agree to take call. (*Douglas Esposito, MD, Fort Defiance, AZ*)
- Common background
 - It's difficult to develop health continuity in therapeutic relationships when counselors share so little of their experience and heritage with Native patients. (*John Ratmeyer, MD, Gallup, NM*)
 - There is certainly a disconnect between our Native populations and many of the providers who serve them. Study after study documents the specific vulnerabilities of our culturally distinct and racial minorities.

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Definite problems arise when “outsiders” find themselves caring for these populations. This is especially true with regard to mental and behavioral health. (*Douglas Esposito, MD, Fort Defiance, AZ*)

- We need more pediatricians that “look like their patients” in communities of need. (*Pierrette Mimi Poinsett, MD, Modesto, CA*)
- Community Involvement
 - We have to find ways to positively articulate messages about the positive ways in which Native people were traditionally raised to respect interconnectedness of all things and to value their children and the future they represent. This could motivate effective lifestyle change for entire communities. (*John Ratmeyer, MD, Gallup, NM*)
- Training for the primary care pediatrician
 - As a pediatrician, I received as little mental and behavioral health training as ER and family physicians received in pediatric-specific training. (*Douglas Esposito, MD, Fort Defiance, AZ*)
 - Even though most of us feel comfortable with ADHD, sleep disorders, bedwetting, psychosomatic pain, and other debilitating mental health topics, we did not receive adequate training in bipolar, depressive, and explosive disorders. (*Lori Byron, MD, Hardin, MT*)
 - Current training appears to assume that young men and women leaving pediatric residency will do what, in fact, most of them actually do: go into group practices in the suburbs. This training, I think, PRE-supposes that there will be adequate access to 1) mental health services and 2) pediatric sub-specialists. Neither is true in rural areas. As the population of pediatric sub-specialists ages (with no good pipeline to replace them), #2 will become less true in suburban areas too. (*James Jarvis, MD, Oklahoma City, OK*)
- Health Care Disparities
 - Healthcare disparities (especially mental health) continue to persist despite the dedication and hard work of many providers. I truly believe it is a systemic problem fueled by a “healthcare system” that continues to prioritize acute care medicine over psychosocial issues. The irony is that even in adult medicine a large portion of out patient care is due to the effects of stress, mental health issues, chemical dependency. The systems may present as physical but often there are underlying psychosocial issues. (*Pierrette Mimi Poinsett, MD, Modesto, CA*)