



Mental Health Competencies for Pediatric Practice

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Pediatricians have unique opportunities and an increasing sense of responsibility to promote healthy social-emotional development of children and to prevent and address their mental health and substance use conditions. In this report, the American Academy of Pediatrics updates its 2009 policy statement, which proposed competencies for providing mental health care to children in primary care settings and recommended steps toward achieving them. This 2019 policy statement affirms the 2009 statement and expands competencies in response to science and policy that have emerged since: the impact of adverse childhood experiences and social determinants on mental health, trauma-informed practice, and team-based care. Importantly, it also recognizes ways in which the competencies are pertinent to pediatric subspecialty practice. Proposed mental health competencies include foundational communication skills, capacity to incorporate mental health content and tools into health promotion and primary and secondary preventive care, skills in the psychosocial assessment and care of children with mental health conditions, knowledge and skills of evidence-based psychosocial therapy and psychopharmacologic therapy, skills to function as a team member and comanager with mental health specialists, and commitment to embrace mental health practice as integral to pediatric care. Achievement of these competencies will necessarily be incremental, requiring partnership with fellow advocates, system changes, new payment mechanisms, practice enhancements, and decision support for pediatricians in their expanded scope of practice.

INTRODUCTION

A total of 13% to 20% of US children and adolescents experience a mental* disorder in a given year.¹ According to the seminal Great Smoky Mountain Study, which has followed a cohort of rural US youth since 1992, 19% of youth manifested impaired mental functioning without meeting the criteria for diagnosis as a mental disorder (ie, subthreshold

abstract

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symptoms).² The authors of this study have since shown that adults who had a childhood mental disorder have 6 times the odds of at least 1 adverse adult outcome in the domain of health, legal, financial, or social functioning compared with adults without childhood disorders, even after controlling for childhood psychosocial hardships. Adults who had impaired functioning and subthreshold psychiatric symptoms during childhood—termed “problems” in this statement—have 3 times the odds of adverse outcomes as adults.³ These findings underscore the importance to adult health of both mental health disorders and mental health problems during childhood.

The prevalence of mental health disorders and problems (collectively termed “conditions” in this statement) in children and adolescents is increasing and, alarmingly, suicide rates are now the second leading cause of death in young people from 10 to 24 years of age.^{4–6} Furthermore, nearly 6 million children were considered disabled in 2010–2011, an increase of more than 15% from a decade earlier; among these children, reported disability related to physical illnesses decreased by 11.8%, whereas disability related to neurodevelopmental and mental health conditions increased by 20.9%.⁵ Although the highest rates of reported neurodevelopmental and mental health disabilities were seen in children living in poverty, the greatest increase in prevalence of reported neurodevelopmental and mental health disabilities occurred, unexpectedly, among children living in socially advantaged households (income \geq 400% of the federal poverty level).⁵

Comorbid mental health conditions often complicate chronic physical conditions, decreasing the quality of life for affected children and increasing the cost of their care.^{7–12} Because of stigma, shortages of

mental health specialists, administrative barriers in health insurance plans, cost, and other barriers to mental health specialty care, an estimated 75% of children with mental health disorders go untreated.^{13–16} Primary care physicians are the sole physician managers of care for an estimated 4 in 10 US children with attention-deficit/hyperactivity disorder (ADHD) and one-third with mental disorders overall.¹⁷

In 2009, the American Academy of Pediatrics (AAP) issued a policy statement, “The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care,” proposing competencies—skills, knowledge, and attitudes—requisite to providing mental health care of children in primary care settings and recommending steps toward achieving them.¹⁸ In the policy, the AAP documented the many forces driving the need for enhancements in pediatric mental health practice.

Updates to the Previous Statement

In the years since publication of the original policy statement on mental health competencies, increases in childhood mental health morbidity and mortality and a number of other developments have added to the urgency of enhancing pediatric mental health practice. A federal parity law has required that insurers cover mental health and physical health conditions equivalently.^{19,20} Researchers have shown that early positive and adverse environmental influences—caregivers’ protective and nurturing relationships with the child, social determinants of health, traumatic experiences (ecology), and genetic influences (biology)—interact to affect learning capacities, adaptive behaviors, lifelong physical and mental health, and adult productivity, and pediatricians have a role to play in addressing chronic stress and adverse early childhood experiences.^{21–24} Transformative

changes in the health care delivery system—payment for value, system- and practice-level integration of mental health and medical services, crossdiscipline accountability for outcomes, and the increasing importance of the family- and patient-centered medical home—all have the potential to influence mental health care delivery.^{25–27} Furthermore, improving training and competence in mental health care for future pediatricians—pediatric subspecialists as well as primary care pediatricians—has become a national priority of the American Board of Pediatrics^{28,29} and the Association of Pediatric Program Directors.³⁰

In this statement, we (1) discuss the unique aspects of the pediatrician’s role in mental health care; (2) articulate competencies needed by the pediatrician to promote healthy social-emotional development, identify risks and emerging symptoms, prevent or mitigate impairment from mental health symptoms, and address the mental health and substance use conditions prevalent among children and adolescents in the United States; and (3) recommend achievable next steps toward enhancing mental health practice to support pediatricians in providing mental health care. The accompanying technical report, “Achieving the Pediatric Mental Health Competencies,” is focused on strategies to train future pediatricians and prepare practices for achieving the competencies.³¹

Uniqueness of the Pediatrician’s Role in Mental Health Care

Traditional concepts of mental health care as well as mental health payment systems build on the assumption that treatment must follow the diagnosis of a disorder. However, this diagnostic approach does not take into account the many opportunities afforded pediatricians, both in general and subspecialty practice, to promote mental health and to offer primary

and secondary prevention. Nor do these traditional concepts address the issue that many children have impaired functioning although they do not meet the diagnostic criteria for a specific mental disorder.

Consequently, pediatric mental health competencies differ in some important respects from competencies of mental health professionals. The unique role of pediatricians in mental health care stems from the “primary care advantage,” which is a developmental mind-set, and their role at the front lines of children’s health care.³² Primary care pediatricians typically see their patients longitudinally, giving them the opportunity to develop a trusting and empowering therapeutic relationship with patients and their families; to promote social-emotional health with every contact, whether for routine health supervision, acute care, or care of a child’s chronic medical or developmental condition; to prevent mental health problems through education and anticipatory guidance; and to intervene in a timely way if and when risks, concerns, or symptoms emerge. Recognizing the longitudinal and close relationships that many pediatric subspecialists have with patients and families, the authors of this statement have expanded the concept of primary care advantage to the “pediatric advantage.”

Pediatric subspecialists, like pediatric primary care clinicians, need basic mental health competencies. Children and adolescents with somatic manifestations of mental health problems often present to pediatric medical subspecialists or surgical specialists for evaluation of their symptoms; awareness of mental health etiologies has the potential to prevent costly and traumatic workups and expedite referral for necessary mental health services.³³ Children and adolescents with chronic medical conditions have

a higher prevalence of mental health problems than do their peers without those conditions; and unrecognized mental health problems, particularly anxiety and depression, often drive excessive use of medical services in children with a chronic illness and impede adherence to their medical treatment.³⁴ Furthermore, children and adolescents with serious and life-threatening medical and surgical conditions often experience trauma, such as painful medical procedures, disfigurement, separation from loved ones during hospitalizations, and their own and their loved ones’ fears about prognosis.³⁵ For these reasons, mental health competencies involving clinical assessment, screening, early intervention, referral, and comanagement are relevant to pediatric subspecialists who care for children with chronic conditions. Subspecialists have the additional responsibility of coordinating any mental health services they provide with patients’ primary care clinicians to prevent duplication of effort, connect children and families to accessible local resources, and reach agreement on respective roles in monitoring patients’ mental health care.

Integration of Mental Health Care Into Pediatric Workflow

The AAP Task Force on Mental Health (2004–2010) spoke to the importance of enhancing pediatricians’ mental health practice while recognizing that incorporating mental health care into a busy pediatric practice can be a daunting prospect. The task force offered an algorithm, the “Primary Care Approach to Mental Health Care,” depicting a process by which mental health services can be woven into practice flow, and tied each step in the algorithm to *Current Procedural Terminology* coding guidance that can potentially support those mental health-related activities in a fee-for-service environment.³² The AAP Mental Health Leadership Work

Group (2011–present) recently updated this to the “Algorithm: A Process for Integrating Mental Health Care Into Pediatric Practice” (see Fig 1). The AAP has a number of resources to assist with coding for mental health care.

The pediatric process for identifying and managing mental health problems is similar to the iterative process of caring for a child with fever and no focal findings: the clinician’s initial assessment of the febrile child’s severity of illness determines if there is a serious problem that urgently requires further diagnostic evaluation and treatment; if not, the clinician advises the family on symptomatic care and watchful waiting and advises the family to return for further assessment if symptoms persist or worsen. Similarly, a mental health concern of the patient, family, or child care and/or school personnel (or scheduling of a routine health supervision visit [algorithm step 1]) triggers a preliminary psychosocial assessment (algorithm step 2). This initial assessment can be expedited by use of previsit collection of data and screening tools (electronic or paper and pencil), which the clinician can review in advance of the visit, followed by a brief interview and observations to explore findings (both positive and negative) and the opportunity to highlight the child’s and family’s strengths, an important element of supportive, family-centered care. Finding a problem that is not simply a normal behavioral variation (algorithm step 3) necessitates triage for a psychiatric and/or social emergency and, if indicated, immediate care in the subspecialty or social service system (algorithm steps 9 and 10). In making these determinations, it is important to understand the family context, namely, the added risks conferred by adverse social determinants of health, which may exacerbate the problem and precipitate an emergency.

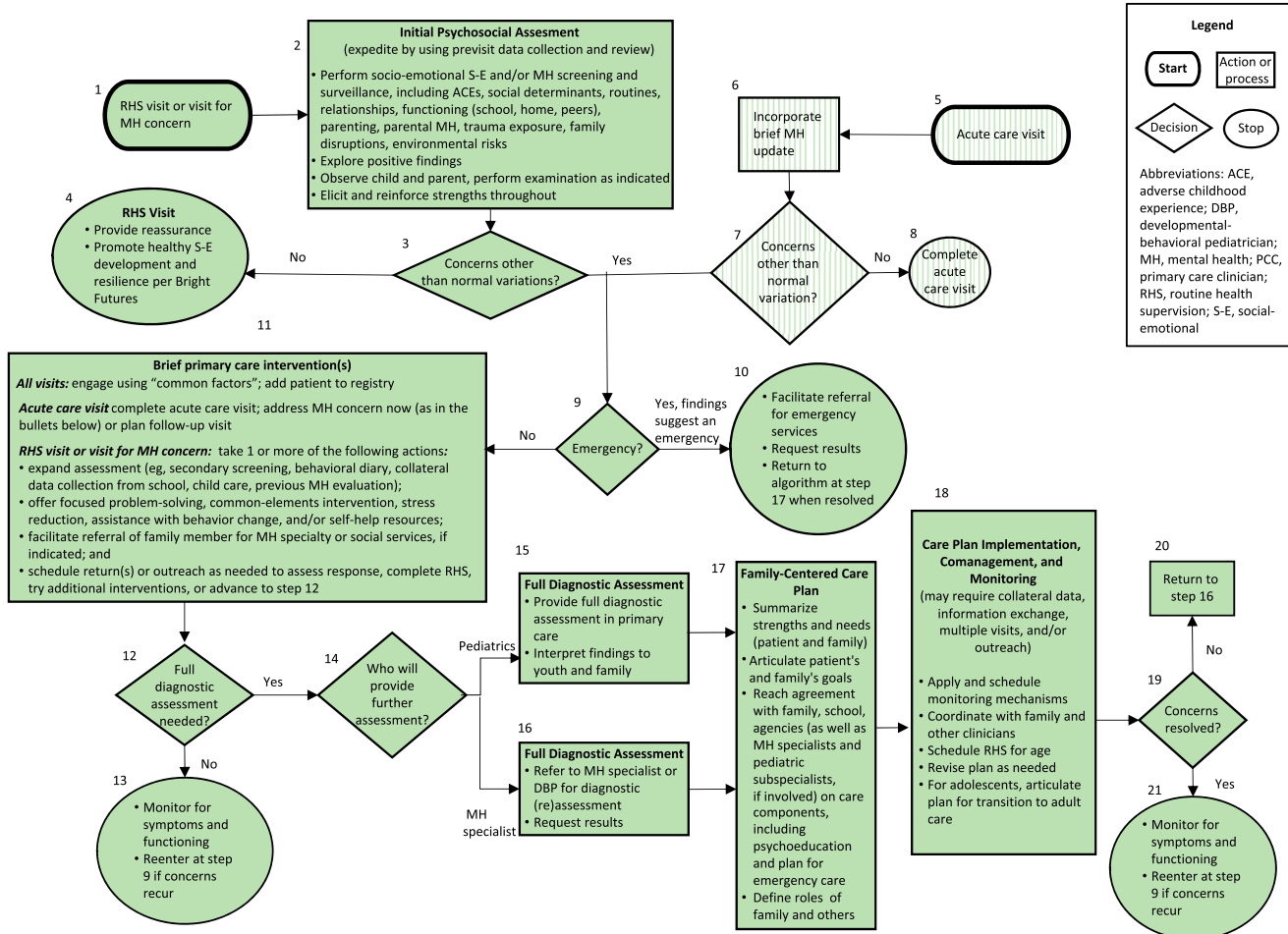


FIGURE 1 Mental health (MH) care in pediatric practice. ACE, adverse childhood experience; RHS, routine health supervision; S-E, social-emotional.

Intervention will need to include supports to address social determinants.

If an identified problem is not an emergency, the clinician can undertake 1 or more brief interventions, as time allows, during the current visit or at follow-up visit(s) (algorithm step 11). These interventions may include iteratively expanding the assessment, for example, by using secondary screening tools, gathering information from school personnel or child care providers, or having the family create a diary of problem behaviors and their triggers. Brief interventions may also include referral of a family member for assistance in addressing his or her

own social or mental health problems that may be contributing to the child's difficulties. In addition, brief interventions may include evidence-informed techniques to address the child's symptoms, as described in the section immediately below.

When indicated by findings of the assessment and/or by failure to respond to brief therapeutic interventions, a full diagnostic assessment can be performed, either by the pediatrician (algorithm step 15) at a follow-up visit or through referral to a specialist (algorithm step 16), followed by the steps of care planning and implementation, comanagement, and monitoring the child's progress (algorithm steps 17 and 18).

Brief Interventions: Addressing Mental Health Symptoms in the Context of a Busy Pediatric Practice

Although disorder-specific, standardized psychosocial treatments have been a valuable advance in the mental health field generally, their real-world application to the care of children and adolescents has been limited by the fact that many young people are "diagnostically heterogeneous"; that is, they manifest symptoms of multiple disorders or problems, and their manifestations are variably triggered by events and by their social environment. These limitations led researchers in the field of psychotherapy to develop and successfully apply "transdiagnostic" approaches to the care of children and adolescents, addressing multiple

disorders and problems by using a single protocol and allowing for more flexibility in selecting and sequencing interventions.³⁶

A number of transdiagnostic approaches are proving to be adaptable for use as brief interventions in pediatric settings. The goals of brief therapeutic interventions for children and adolescents with emerging symptoms of mild to moderate severity are to improve the patient's functioning, reduce distress in the patient and parents, and potentially prevent a later disorder. For children and adolescents identified as needing mental health and/or developmental-behavioral specialty involvement, goals of brief interventions are to help overcome barriers to their accessing care, to ameliorate symptoms and distress while awaiting completion of the referral, and to monitor the patient's functioning and well-being while awaiting higher levels of care. Brevity of these interventions, ideally no more than 10 to 15 minutes per session, mitigates disruption to practice flow. Although formal evaluation of these adaptations is in its early stages, authors of studies suggest that they can be readily learned by pediatric clinicians and are beneficial to the child and family.³⁷ Table 1 is used to excerpt several of these adaptations from a summary by Wissow et al.³⁷

All of these approaches feature prominently in the pediatric mental health competencies; 2 require further explanation.

“Common-factors” communication skills, so named because they are components of effective interventions common to diverse therapies across multiple diagnoses, are foundational among the proposed pediatric mental health competencies. These communication techniques include clinician interpersonal skills that help to build a therapeutic alliance—the felt bond between the clinician and patient and/or family, a powerful factor in facilitating emotional and psychological healing—which, in turn, increases the patient and/or family's optimism, feelings of well-being, and willingness to work toward improved health. Other common-factors techniques target feelings of anger, ambivalence, and hopelessness, family conflicts, and barriers to behavior change and help seeking. Still other techniques keep the discussion focused, practical, and organized. These techniques come from family therapy, cognitive therapy, motivational interviewing, family engagement, family-focused pediatrics, and solution-focused therapy.³⁸ They have been proven useful and effective in addressing mental health symptoms in pediatrics across the age spectrum and can be readily acquired by experienced clinicians.³⁹ Importantly, when time is short, the clinician can also use them to bring a visit to a supportive close while committing his or her loyalty and further assistance to the patient and family—that is, reinforcing the therapeutic alliance, even as he or she accommodates to the rapid pace of the practice.

See Table 2 for the HELP mnemonic, developed by the AAP Task Force on

Mental Health to summarize components of the common-factors approach.

“Common-elements” approaches can also be used as brief interventions. They differ from common factors in that instead of applying to a range of diagnoses that are not causally related, common elements are semisppecific components of psychosocial therapies that apply to a group of related conditions.⁴⁰⁻⁴³ In this approach, the clinician caring for a patient who manifests a cluster of causally related symptoms—for example, fearfulness and avoidant behaviors—draws interventions from evidence-based psychosocial therapies for a related set of disorders—in this example, anxiety disorders. Thus, as a first-line intervention to help an anxious child, the pediatrician coaches the parent to provide gradual exposure to feared activities or objects and to model brave behavior—common elements in a number of effective psychosocial treatments for anxiety disorders. Such interventions can be definitive or a means to reduce distress and ameliorate symptoms while a child is awaiting mental health specialty assessment and/or care. Table 3 is used to summarize promising common-elements approaches applicable to common pediatric primary care problems.

Certain evidence-based complementary and integrative medicine approaches may also lend themselves to brief interventions: for example, relaxation and other self-regulation therapies reveal promise

TABLE 1 Promising Adaptations of Mental Health Treatment for Primary Care

Pediatric Settings	Parallels in Mental Health Services
Emphasis on patient-centered care and joint decision-making building trust and activation	Common-factors psychotherapeutic processes promoting engagement, optimism, alliance
Initial treatment often presumptive or relatively nonspecific	Stepped-care models with increasing specificity of diagnosis and intensity of treatment
Treatment based on brief counseling focused on patient-identified problems	“Common elements”
Links with community services, advice addressing family and social determinants	Peer and/or family navigators

Adapted from Wissow LS, van Ginneken N, Chandna J, Rahman A. Integrating children's mental health into primary care. *Pediatr Clin North Am.* 2016; 63(1):101.

TABLE 2 Common-Factors Approach: HELP Build a Therapeutic Alliance

H = Hope	Hope facilitates coping. Increase the family's hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the child and family. Encourage concrete steps toward whatever is achievable.
E = Empathy	Communicate empathy by listening attentively, acknowledging struggles and distress, and sharing happiness experienced by the child and family.
L ² = Language, Loyalty	Use the child or family's own language (not a clinical label) to reflect your understanding of the problem as they see it and to give the child and family an opportunity to correct any misperceptions. Communicate loyalty to the family by expressing your support and your commitment to help now and in the future.
P ³ = Permission, Partnership, Plan	Ask the family's permission for you to ask more in-depth and potentially sensitive questions or make suggestions for further evaluation or management. Partner with the child and family to identify any barriers or resistance to addressing the problem, find strategies to bypass or overcome barriers, and find agreement on achievable steps (or simply an achievable first step) aligned with the family's motivation. The more difficult the problem, the more important is the promise of partnership. On the basis of the child's and family's preferences and sense of urgency, establish a plan (or incremental first step) through which the child and family will take some action(s), work toward greater readiness to take action, or monitor the problem and follow-up with you. (The plan might include, eg, keeping a diary of symptoms and triggers, gathering information from other sources such as the child's school, making lifestyle changes, applying parenting strategies or self-management techniques, reviewing educational resources about the problem or condition, initiating specific treatment, seeking referral for further assessment or treatment, or returning for further family discussion.)

Adapted from Foy JM; American Academy of Pediatrics, Task Force on Mental Health. Enhancing pediatric mental health care: algorithms for primary care. *Pediatrics*. 2010;125(suppl 3):S110.

in assisting children to manage stress and build their resilience to trauma and social adversities.⁴³ Other brief interventions include coaching parents in managing a particular behavior (eg, "time-out" for disruptive behavior⁴⁴) or, more broadly, strategies to reduce stress in the household and to foster a sense of closeness and emotional security, for example, reading together,⁴⁵ sharing outdoor time,⁴⁶ or parent-child "special time"—a regularly scheduled period as brief as 5 to 10 minutes set aside for a one-on-one, interactive activity of the child's choice.⁴⁷ Self-help resources may also be useful (eg, online depression management).⁴⁸ Encouragement of healthy habits, such as sufficient sleep (critically important to children's mental health and resilience as well as their parents'), family meals, active play, time and content limits on media exposure, and prosocial activities with peers can be used as "universal" brief interventions across an array of

presenting problems as well as a means to promote mental wellness and resilience.⁴⁹

For a more detailed summary of psychosocial interventions and the evidence supporting them, see PracticeWise Evidence-Based Child and Adolescent Psychosocial Interventions at www.aap.org/mentalhealth. Psychosocial interventions that have been studied in primary care are listed in Common Elements of Evidence-Based Practice Amenable to Primary Care: Indications and Sources at www.aap.org/mentalhealth. With training, pediatricians can achieve competence in applying brief interventions such as these in primary care or, potentially, subspecialty settings.^{37,50-52}

MENTAL HEALTH COMPETENCIES

The Accreditation Council for Graduate Medical Education has organized competencies into 6

domains: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice.⁵³ We have used this framework to develop a detailed outline of pediatric mental health competencies for use by pediatric educators; this outline is available at www.aap.org/mentalhealth. Competencies most salient to this statement are listed in Tables 4 and 5.

Clinical Skills

All pediatricians need skills to promote mental health, efficiently perform psychosocial assessments, and provide primary and secondary preventive services (eg, anticipatory guidance, screening). They need to be able to triage for psychiatric emergencies (eg, suicidal or homicidal intent, psychotic thoughts) and social emergencies (eg, child abuse or neglect, domestic violence, other imminent threats to safety).

TABLE 3 Most Frequently Appearing Common Elements in Evidence-Based Practices, Grouped by Common Presenting Problems in Pediatric Primary Care

Presenting Problem Area	Most Common Elements of Related Evidence-Based Practices
Anxiety	Graded exposure, modeling
ADHD and oppositional problems	Tangible rewards, praise for child and parent, help with monitoring, time-out, effective commands and limit setting, response cost
Low mood	Cognitive and/or coping methods, problem-solving strategies, activity scheduling, behavioral rehearsal, social skills building

Adapted from Wissow LS, van Ginneken N, Chandna J, Rahman A. Integrating children's mental health into primary care. *Pediatr Clin North Am*. 2016; 63(1):103.

TABLE 4 Core Pediatric Mental Health Competencies: Clinical Skills

Pediatricians providing care to children and adolescents can maximize the patient's and family's health, agency, sense of safety, respect, and partnership by developing competence in performing the following activities:

Promotion and primary prevention

- Promote healthy emotional development by providing anticipatory guidance on healthy lifestyles and stress management
- Routinely gather an age-appropriate psychosocial history, applying appropriate tools to assist with data gathering

Secondary prevention

- Identify and evaluate risk factors to healthy emotional development and emerging symptoms that could cause impairment or suggest future mental health problems, applying appropriate tools to assist with screening and refer to community resources when appropriate (ie, parenting programs)

Assessment

- Recognize mental health emergencies such as suicide risk, severe functional impairment, and complex mental health symptoms that require urgent mental health specialty care
- Analyze and interpret results from mental health screening, history, physical examination, and observations to determine what brief interventions may be useful and whether a full diagnostic assessment is needed
- Diagnose school-aged children and adolescents with the following disorders: ADHD, common anxiety disorders (separation anxiety disorder, social phobia, generalized anxiety disorder), depression, and substance use

Treatment

- Apply fundamental (common factors, motivational interviewing) communications skills to engage youth and families and overcome barriers to their help seeking for identified social and mental health problems
- Apply common-factors skills and common elements of evidence-based psychosocial treatments to initiate the care of the following:
 - Children and youth with medical and developmental conditions who manifest comorbid mental health symptoms
 - Depressed mothers and their children
 - Infants and young children manifesting difficulties with communication and/or attachment or other signs and symptoms of emotional distress (eg, problematic sleep, eating behaviors)
- Children and adolescents presenting with the following:
 - Anxious or avoidant behaviors
 - Exposure to trauma or loss
 - Impulsivity and inattention, with or without hyperactivity
 - Low mood or withdrawn behaviors
 - Disruptive or aggressive behaviors
 - Substance use
 - Learning difficulties
- When a higher level of care is needed for symptoms listed above, integrate patient and/or family strengths, needs, and preferences, the clinician's own skills, and available resources into development of a care plan for children and adolescents with mental health problem(s), alone, with the practice care team, or in collaboration with mental health specialists
- Demonstrate proficiency in selecting, prescribing, and monitoring (for response and adverse effects) ADHD medications and selective serotonin reuptake inhibitors that have a safety and efficacy profile appropriate to use in pediatric care
- Develop a contingency or crisis plan for a child or adolescent
- Develop a safety plan with patients and parents for children and adolescents who are suicidal and/or depressed
- Apply strategies to actively monitor adverse and positive effects of nonpharmacologic and pharmacologic therapy
- Facilitate a family's and patient's engagement with and transfer of trust (ie, "warm handoff") to a mental health professional
- Demonstrate an accurate understanding of privacy regulations
- Refer, collaborate, comanage, and participate as a team member in coordinating mental health care with specialists and in transitioning adolescents with mental health needs to adult primary care and mental health specialty providers

Pediatricians need to be able to establish a therapeutic alliance with the patient and family and take initial action on any identified mental health and social concerns, as described above. All pediatricians also need to know how to organize the care of patients who require mental health specialty referral or consultation, facilitate transfer of trust to mental health specialists, and coordinate their patients' mental health care with other clinicians, reaching previous agreement on respective roles, such as who will prescribe and monitor medications and how

communication will take place. The care team might include any of the individuals listed in Table 6, on- or off-site. For a discussion of collaborative care models that integrate services of mental health and pediatric professionals, see the accompanying technical report.³¹

The clinical role of the pediatrician will depend on the patient's condition and level of impairment, interventions and supports needed, patient and family priorities and preferences, pediatrician's self-perception of efficacy and capacity,

and accessibility of community services.

Disorders such as maladaptive aggression^{54,55} and bipolar disorder⁵⁶ may require medications for which pediatricians will need specialized training or consultation from physician mental health specialists to prescribe (eg, antipsychotics, lithium). Comanagement—formally defined as “collaborative and coordinated care that is conceptualized, planned, delivered, and evaluated by 2 or more health care providers”⁵⁷—is a successful

TABLE 5 Core Pediatric Mental Health Competencies: Practice Enhancements

Pediatricians providing care to children and adolescents can improve the quality of their practice's (and network's) mental health services by developing competence in performing the following activities

- Establish collaborative and consultative relationships—within the practice, virtually, or off-site—and define respective roles in assessment, treatment, coordination of care, exchange of information, and family support
- Build a practice team culture around a shared commitment to embrace mental health care as integral to pediatric practice and an understanding of the impact of trauma on child well-being
- Establish systems within the practice (and network) to support mental health services; elements may include the following:
 - Preparation of office staff and professionals to create an environment of respect, agency, confidentiality, safety, and trauma-informed care;
 - Preparation of office staff and professionals to identify and manage patients with suicide risk and other mental health emergencies;
 - Electronic health record prompts and culturally and/or linguistically appropriate educational materials to facilitate offering anticipatory guidance and to educate youth and families on mental health and substance use topics and resources;
 - Routines for gathering the patient's and family's psychosocial history, conducting psychosocial and/or behavioral assessment;
 - Registries, evidence-based protocols, and monitoring and/or tracking mechanisms for patients with positive psychosocial screen results, adverse childhood experiences and social determinants of health, behavioral risks, and mental health problems;
 - Directory of mental health and substance use disorder referral sources, school-based resources, and parenting and family support resources in the region;
 - Mechanisms for coordinating the care provided by all collaborating providers through standardized communication; and
 - Tools for facilitating coding and billing specific to mental health.
- Systematically analyze the practice by using quality improvement methods with the goal of mental health practice improvement

approach for complex mental conditions in children and adolescents. Both general pediatricians and pediatric subspecialists will benefit from these collaborative skills. These skills also enable pediatricians to help adolescents with mental health conditions and their families transition the adolescent's care to adult primary and mental health specialty care at the appropriate time, as pediatricians do other patients with special health care needs.

Misperceptions about privacy regulations (eg, the Health Insurance Portability and Accountability Act of 1996,⁵⁸ federal statutes and regulations regarding substance

abuse treatment [42 US Code § 290dd-2; 42 Code of Federal Regulations 2.11],⁵⁹ and state-specific regulations) often impede collaboration by limiting communication among clinicians who are providing services. In most instances, pediatricians are, in fact, allowed to exchange information with other clinicians involved in a patient's care, even without the patient or guardian's consent. Pediatricians need an accurate understanding of privacy regulations to ensure that all clinicians involved in the mutual care of a patient share information in an appropriate and timely way (see <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/>

HIPAA-Privacy-Rule-and-Provider-to-Provider-Communication.aspx).

Other necessary clinical skills are specific to the age, presenting problem of the patient, and type of therapy required, as described in the following sections.

Infants and Preschool-aged Children

For infants and preschool-aged children, the signs and symptoms of emotional distress may be varied and nonspecific and may manifest themselves in the child, in the parent, or in their relationship. When consistently outside the range of normal development, these young children and families typically require specialized diagnostic assessment (based on the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*⁶⁰), intensive parenting interventions, and treatment by developmental-behavioral specialists or mental health specialists with expertise in early childhood. Consequently, pediatric mental health competencies for the care of this age group involve overcoming any barriers to referral, guiding the family in nurturing and stimulating the child, counseling on parenting and behavioral management techniques, referring for diagnostic assessment

TABLE 6 Potential Mental Health Care Team Members

- Patient and family
- One or more PCC
- Any other pediatric team member who has forged a bond of trust with the family (eg, nurse, front desk staff, medical assistant)
- Mental health medical consultant (eg, child psychiatrist, developmental-behavioral pediatrician, adolescent specialist, pediatric neurologist), directly involved or consulting with PCC by phone or telemedicine link
- Psychologist, social worker, advanced practice nurse, substance use counselor, early intervention specialist, or other licensed specialist(s) trained in the relevant evidence-based psychosocial therapy
- School-based professionals (eg, guidance counselor, social worker, school nurse, school psychologist)
- Representative of involved social service agency
- Medical subspecialist(s) or surgical specialist
- Parent educator
- Peer navigator
- Care manager

PCC, primary care clinician.

and dyadic (attachment-focused) therapy as indicated, and comanaging care. When social risk factors are identified (eg, maternal depression, poverty, food insecurity), the pediatrician's role is to connect the family to needed resources.

School-aged Children and Adolescents

The AAP Task Force on Mental Health identified common manifestations of mental health problems in school-aged children and adolescents as depression (low mood), anxious and avoidant behaviors, impulsivity and inattention (with or without hyperactivity), disruptive behavior and aggression, substance use, and learning difficulty and developed guidance to assist pediatric clinicians in addressing these problems.⁶¹ Recognizing that 75% of children who need mental health services do not receive them, the AAP went on to publish a number of additional educational resources on these topics, specifically for pediatricians.⁶²⁻⁶⁴ Additional tools are available online at www.aap.org/mentalhealth. Children and adolescents who have experienced trauma may manifest any combination of these symptoms.^{65,66} Children and adolescents with an underlying mental condition may present with somatic symptoms (eg, headache, abdominal pain, chest pain, limb pain, fatigue) or eating abnormalities.^{67,68} Furthermore, children and adolescents may experience impaired functioning at home, at school, or with peers, even in the absence of symptoms that reach the threshold for a diagnosis.^{2,69,70}

Once a pediatrician has identified a child or adolescent with 1 or more of these manifestations of a possible mental health condition (collectively termed "mental health concerns" in this statement, indicating that they are undifferentiated as to disorder, problem, or normal variation), the pediatrician needs skills to differentiate normal variations from

problems from disorders and to diagnose, at a minimum, conditions for which evidence-based primary care assessment and treatment guidance exists—currently ADHD,⁷¹ depression,^{72,73} and substance use.⁷⁴ Pediatricians also need knowledge and skills to diagnose anxiety disorders, which are among the most common disorders of childhood, often accompany and adversely affect the care of chronic medical conditions, and when associated with no more than mild to moderate impairment, are often amenable to pediatric treatment.⁶⁶ A number of disorder-specific rating scales and functional assessment tools are applicable to use in pediatrics, both to assist in diagnosis and to monitor the response to interventions; these have been described and referenced in the document "Mental Health Tools for Pediatrics" at www.aap.org/mentalhealth.

Although the diagnostic assessment of children presenting with aggressive behaviors often requires mental health specialty involvement, pediatricians can use a stepwise approach to begin the assessment and offer guidance in selecting psychosocial interventions in the community for further diagnosis and treatment, as outlined in the guideline, "Treatment of Maladaptive Aggression in Youth (T-MAY)," available at www.ahrq.gov/sites/default/files/wysiwyg/chain/practice-tools/tmay-final.pdf.

Pharmacologic and Psychosocial Therapies

Many pharmacologic and psychosocial therapies have been proven effective in treating children with mental health disorders. Pharmacologic therapies may be more familiar to pediatricians than psychosocial therapies; however, psychosocial therapies, either alone or in combination with pharmacologic therapies, may be more effective in some circumstances.

For example, American Academy of Child and Adolescent Psychiatry guidelines recommend at least 2 trials of psychosocial treatment before starting medication in young children up to 5 years of age.⁷⁵ Studies involving children and adolescents in several specific age groups have revealed the advantage of combined psychosocial and medication treatment over either type of therapy alone for ADHD in 7- to 9-year-old children,⁷⁶ common anxiety disorders in 7- to 9-year-old children,⁷⁷ and depression in 12- to 17-year-old children,⁷⁸ and benefits of combined therapy likely go well beyond these age groups. Furthermore, many children with mild or subthreshold anxiety or depression are likely to benefit from psychosocial therapy, mind-body approaches, and self-help resources without medication.^{48,66,79} Although pediatricians may feel pressured to prescribe only medication in these and other situations because it is generally more accessible and/or expedient,⁸⁰ knowledge of these other approaches is necessary to offer children these choices. If needed community services are not available, pediatricians can use common-elements approaches in the pediatric office and advocate for evidence-based therapies to be offered by the mental health community.

Certain disorders (ADHD, common anxiety disorders, depression), if associated with no more than moderate impairment, are amenable to primary care medication management because there are indicated medications with a well-established safety profile (eg, a variety of ADHD medications and certain selective serotonin reuptake inhibitors).⁸¹ Ideally, pediatric subspecialists would also be knowledgeable about these medications, their adverse effects, and their interactions with medications prescribed in their subspecialty practice. Necessary

clinical skills are summarized in Table 4.

Practice Enhancements

Effective mental health care requires the support of office and network systems. Competencies requisite to establishing and sustaining these systems are outlined in Table 5.

PROGRESS TO DATE

Despite many efforts to enhance the competence of pediatric residents and practicing pediatricians (see accompanying technical report "Achieving the Pediatric Mental Health Competencies"³¹), change in mental health practice during the last decade has been modest, as measured by the AAP's periodic surveys of members. National data reveal that in 2013, only 57% of pediatricians were consistently treating ADHD and less than a quarter were treating any other disorder.⁸² Although fewer barriers were reported in 2013 than in 2004, most pediatricians surveyed in 2013 reported that they had inadequate training in treating child mental health problems, a lack of confidence to counsel children, and limited time for these problems.⁸³

In the accompanying technical report, we address the barriers of training and confidence.³¹ The barrier of limited time for mental health care may one day become an artifact of volume-based care and the payment systems that have incentivized it. Value-based payment, expanded clinical care teams, and integration of mental health care into pediatric settings may provide new incentives and opportunities for mental health practice, improve quality of care, and result in improved outcomes for both physical and mental health conditions. In the interim, the AAP recognizes that although the proposed competencies are necessary to meet the needs of children, pediatricians will necessarily achieve them through incremental steps that rely on improved third-party payment

for their mental health services and access to expertise in mental health coding and billing to support the time required for mental health practice.

RECOMMENDATIONS

The recommendations that follow build on the 2009 policy statement¹⁸ and assumptions drawn from review of available literature; the recognized, well-documented, and growing mental health needs of the pediatric population; expert opinion of the authoring bodies; and review and feedback by additional relevant AAP entities. There are striking geographic variations in access to pediatric mental health services from state to state and within states, from urban to rural areas.⁸⁴ By engaging in the kind of partnerships described in the first point below, pediatricians can prioritize their action steps and implement them, incrementally, in accordance with their community's needs. With the pediatric advantage in mind, the AAP recommends that pediatricians engage in the following:

partner with families, youth, and other child advocates; mental health, adolescent, and developmental specialists; teachers; early childhood educators; health and human service agency leaders; local and state chapters of mental health specialty organizations; and/or AAP chapter and national leaders with the goal of improving the organizational and financial base of mental health care, depending on the needs of a particular community or practice; this might include such strategies as:

advocating with insurers and payers for appropriate payment to pediatricians and mental health specialists for their mental health services (see the Chapter Action Kit in Resources);

using appropriate coding and billing practices to support mental health

services in a fee-for-service payment environment (see Chapter Action Kit in Resources);

participating in development of models of value-based and bundled payment for integrated mental health care (see the AAP Practice Transformation Web site in Resources); and/or

identifying gaps in key mental health services in their communities and advocating to address deficiencies (see Chapter Action Kit in Resources);

pursue quality improvement and maintenance of certification activities that enhance their mental health practice, prioritizing suicide prevention (see Quality Improvement and/or Maintenance of Certification in Resources);

explore collaborative care models of practice, such as integration of a mental health specialist as a member of the medical home team, consultation with a child psychiatrist or developmental-behavioral pediatrician, or telemedicine technologies that both enhance patients' access to mental health specialty care and grow the competence and confidence of involved pediatricians (see AAP Mental Health Web site in Resources);

build relationships with mental health specialists (including school-based providers) with whom they can collaborate in enhancing their mental health knowledge and skills, in identifying and providing emergency care to children and adolescents at risk for suicide, and in comanaging children with primary mental health conditions and physical conditions with mental health comorbidities (see Chapter Action Kit in Resources);

pursue educational strategies (eg, participation in a child psychiatry consultation network, collaborative office rounds, learning

collaborative, miniature fellowship, AAP chapter, or health system network initiative) suited to their own learning style and skill level for incrementally achieving the mental health competencies outlined in Tables 4 and 5 (see accompanying technical report for in-depth discussion of educational strategies);

advocate for innovations in medical school education, residency and fellowship training, and continuing medical education activities to increase the knowledge base and skill level of future pediatricians in accordance with the mental health competencies outlined in Tables 4 and 5; and

promote and participate in research on the delivery of mental health services in pediatric primary care and subspecialty settings.

In the accompanying technical report,³¹ we highlight successful educational initiatives and suggest promising strategies for achieving the mental health competencies through innovations in the training of medical students, pediatric residents, fellows, preceptors, and practicing pediatricians and through support in making practice enhancements.

CONCLUSIONS

The AAP recognizes pediatricians' unique opportunities to promote children's healthy socioemotional development, strengthen children's resilience to the many stressors that face them and their families, and recognize and address the mental health needs that emerge during childhood and adolescence. These opportunities flow from the pediatric advantage, which includes longitudinal, trusting, and empowering relationships with patients and their families and the nonstigmatizing, family friendliness of pediatric practices. Fully realizing this advantage will depend on

pediatricians developing or honing their mental health knowledge and skills and enhancing their mental health practice. To that end, this statement outlines mental health competencies for pediatricians, incorporating evidence-based clinical approaches that are feasible within pediatrics, supported by collaborative relationships with mental health specialists, developmental-behavioral pediatricians, and others at both the community and practice levels.

Enhancements in pediatric mental health practice will also depend on system changes, new methods of financing, access to reliable sources of information about existing evidence and new science, decision support, and innovative educational methods (discussed in the accompanying technical report³¹). For this reason, attainment of the competencies proposed in this statement will, for most pediatricians, be achieved incrementally over time. Gains are likely to be substantial, including the improved well-being of children, adolescents, and families and enhanced satisfaction of pediatricians who care for them.

RESOURCES

AAP Clinical Tools and/or Tool Kits

AAP clinical tools and/or tool kits include the following:

Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit;

Health Insurance Portability and Accountability Act of 1996 Privacy Rule and Provider to Provider Communication;

Mental Health Initiatives Chapter Action Kit; and

AAP Coding Fact Sheets (AAP log-on required).

AAP Policies

AAP policies include the following:

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and

Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (November 2011);

Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management (endorsed by the AAP March 2018);

Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management (endorsed by the AAP March 2018);

Policy Statement: Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice (January 2019);

Technical Report: Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice (January 2019);

Policy Statement: Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health (January 2012; reaffirmed July 2016);

Technical Report: The Lifelong Effects of Early Childhood Adversity and Toxic Stress (January 2012; reaffirmed July 2016);

Clinical Report: Mind-Body Therapies in Children and Youth (September 2016);

The Prenatal Visit (July 2018);

Clinical Report: Promoting Optimal Development: Screening for Behavioral and Emotional Problems (February 2015);

Policy Statement: Substance Use Screening, Brief Intervention, and Referral to Treatment (July 2016); and

Clinical Report: Substance Use Screening, Brief Intervention, and Referral to Treatment (July 2016).

Quality Improvement and/or Maintenance of Certification

Quality improvement and/or Maintenance of Certification resources include the following:

Education in Quality Improvement for Pediatric Practice: Bright Futures - Middle Childhood and Adolescence; Education in Quality Improvement for Pediatric Practice: Substance Use - Screening, Brief Intervention, Referral to Treatment; and American Board of Pediatrics Quality Improvement Web site.

AAP Publications

AAP publications include the following:

AAP Developmental Behavioral Pediatrics, Second Edition;

Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians;

Promoting Mental Health in Children and Adolescents: Primary Care Practice and Advocacy;

Pediatric Psychopharmacology for Primary Care;

Quick Reference Guide to Coding Pediatric Mental Health Services 2019; and

Thinking Developmentally.

AAP Reports

AAP reports include the following:

Improving Mental Health Services in Primary Care: A Call to Action for the Payer Community (AAP log-on required); and

Reducing Administrative and Financial Barriers.

Web Sites

Web site resources include the following:

AAP Mental Health Web site;

AAP Practice Transformation Web site;

National Center for Medical Home Implementation;

The Resilience Project; and

Screening Technical Assistance and Resource Center.

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ABBREVIATIONS

AAP: American Academy of Pediatrics

ADHD: attention-deficit/hyperactivity disorder

*The term “mental” throughout this statement is intended to encompass “behavioral,” “psychiatric,” “psychological,” “emotional,” and “substance use” as well as family context and community-related concerns. Accordingly, factors affecting mental health include precipitants such as child abuse and neglect, separation or divorce of parents, domestic violence, parental or family mental health issues, natural disasters, school crises, military deployment of children’s loved ones, incarceration of a loved one, and the grief and loss accompanying any of these issues or the illness or death of family members. Mental also is intended to encompass somatic manifestations of psychosocial issues, such as eating disorders and gastrointestinal symptoms. This use of the term is not to suggest that the full range or severity of all mental health conditions and concerns falls within the scope of pediatric practice but, rather, that children and adolescents may suffer from the full range and severity of mental health conditions and psychosocial stressors. As such, children with mental health needs, similar to children with special physical and developmental needs, are children for whom pediatricians provide care in the medical home and in subspecialty practice.

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REFERENCES

1. Perou R, Bitsko RH, Blumberg SJ, et al; Centers for Disease Control and Prevention (CDC). Mental health surveillance among children—United States, 2005–2011. *MMWR Suppl.* 2013; 62(2):1–35
2. Burns BJ, Costello EJ, Angold A, et al. Children's mental health service use across service sectors. *Health Aff (Millwood)*. 1995;14(3):147–159
3. Copeland WE, Wolke D, Shanahan L, Costello EJ. Adult functional outcomes of common childhood psychiatric problems: a prospective, longitudinal study. *JAMA Psychiatry*. 2015;72(9): 892–899
4. Slomski A. Chronic mental health issues in children now loom larger than physical problems. *JAMA*. 2012;308(3): 223–225
5. Houtrow AJ, Larson K, Olson LM, Newacheck PW, Halfon N. Changing trends of childhood disability, 2001–2011. *Pediatrics*. 2014;134(3):530–538
6. Heron M. Deaths: Leading causes for 2016. National Vital Statistics Reports; Vol 67. No 6. Hyattsville, MD: National Center for Health Statistics. 2018. Available at: https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_06.pdf. Accessed September 22, 2019
7. Suryavanshi MS, Yang Y. Clinical and economic burden of mental disorders among children with chronic physical conditions, United States, 2008–2013. *Prev Chronic Dis*. 2016;13:E71
8. Barlow JH, Ellard DR. The psychosocial well-being of children with chronic disease, their parents and siblings: an overview of the research evidence base. *Child Care Health Dev*. 2006;32(1):19–31
9. Perrin JM, Gnanasekaran S, Delahaye J. Psychological aspects of chronic health conditions. *Pediatr Rev*. 2012;33(3): 99–109
10. Hood KK, Beavers DP, Yi-Frazier J, et al. Psychosocial burden and glycemic control during the first 6 years of diabetes: results from the SEARCH for Diabetes in Youth study. *J Adolesc Health*. 2014;55(4):498–504
11. Shomaker LB, Tanofsky-Kraff M, Stern EA, et al. Longitudinal study of depressive symptoms and progression of insulin resistance in youth at risk for adult obesity. *Diabetes Care*. 2011; 34(11):2458–2463
12. Roy-Byrne PP, Davidson KW, Kessler RC, et al. Anxiety disorders and comorbid medical illness. *Gen Hosp Psychiatry*. 2008;30(3):208–225
13. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics Task Force on Mental Health. Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration. *Pediatrics*. 2009;123(4):1248–1251
14. Merikangas KR, He JP, Brody D, et al. Prevalence and treatment of mental disorders among US children in the 2001–2004 NHANES. *Pediatrics*. 2010; 125(1):75–81
15. Merikangas KR, He JP, Burstein M, et al. Service utilization for lifetime mental disorders in U.S. adolescents: results of the National Comorbidity Survey-Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry*. 2011; 50(1):32–45
16. Whitney DG, Peterson MD. US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *JAMA Pediatr*. 2019;173(4):389–391
17. Anderson LE, Chen ML, Perrin JM, Van Cleave J. Outpatient visits and medication prescribing for US children with mental health conditions. *Pediatrics*. 2015;136(5). Available at: www.pediatrics.org/cgi/content/full/136/5/e1178
18. Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health. Policy statement—The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics*. 2009;124(1):410–421
19. Centers for Medicare & Medicaid Services (CMS), HHS. Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the application of mental health parity requirements to coverage offered by Medicaid managed care organizations, the Children's Health Insurance Program (CHIP), and alternative benefit plans. Final rule. *Fed Regist*. 2016;81(61):18389–18445
20. Cauchi R, Hanson K; National Conference of State Legislators. Mental health benefits: state laws mandating or regulating. 2015. Available at: www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx. Accessed September 8, 2017
21. Garner AS, Shonkoff JP; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012;129(1). Available at: www.pediatrics.org/cgi/content/full/129/1/e224
22. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and

- Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1). Available at: www.pediatrics.org/cgi/content/full/129/1/e232
23. McLaughlin KA, Greif Green J, Gruber MJ, et al. Childhood adversities and first onset of psychiatric disorders in a national sample of US adolescents. *Arch Gen Psychiatry*. 2012;69(11): 1151–1160
 24. Levine ME, Cole SW, Weir DR, Crimmins EM. Childhood and later life stressors and increased inflammatory gene expression at older ages. *Soc Sci Med*. 2015;130:16–22
 25. Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee. Patient- and family-centered care coordination: a framework for integrating care for children and youth across multiple systems. *Pediatrics*. 2014;133(5). Available at: www.pediatrics.org/cgi/content/full/133/5/e1451
 26. Croghan TW, Brown JD. *Integrating Mental Health Treatment Into the Patient Centered Medical Home*. Rockville, MD: Agency for Healthcare Research and Quality; 2010
 27. Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services. Final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; technical amendment to external review for multi-state plan program. Final rules. *Fed Regist*. 2013;78(219):68239–68296
 28. Leslie L; American Board of Pediatrics. Finding allies to address children's mental and behavioral needs. 2016. Available at: <https://blog.abp.org/blog/finding-allies-address-childrens-mental-and-behavioral-needs>. Accessed September 12, 2017
 29. McMillan JA, Land M Jr, Leslie LK. Pediatric residency education and the behavioral and mental health crisis: a call to action. *Pediatrics*. 2017;139(1): e20162141
 30. McMillan JA, Land ML Jr, Rodday AM, et al. Report of a joint Association of Pediatric Program Directors-American Board of Pediatrics workshop: Preparing Future Pediatricians for the Mental Health Crisis. *J Pediatr*. 2018; 201:285–291
 31. Green CM, Foy JM, Earls MF; American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health; Mental Health Leadership Work Group. Technical report: achieving the pediatric mental health competencies. *Pediatrics*. 2019;144(5): e20192758
 32. Foy JM; American Academy of Pediatrics, Task Force on Mental Health. Enhancing pediatric mental health care: report from the American Academy of Pediatrics Task Force on Mental Health. Introduction. *Pediatrics*. 2010;125(suppl 3):S69–S74
 33. Samsel C, Ribeiro M, Ibeziako P, DeMaso DR. Integrated behavioral health care in pediatric subspecialty clinics. *Child Adolesc Psychiatr Clin N Am*. 2017;26(4): 785–794
 34. Bernal P. Hidden morbidity in pediatric primary care. *Pediatr Ann*. 2003;32(6): 413–418–422
 35. Janssen JS. Medical trauma. Available at: https://www.socialworktoday.com/news/enews_0416_1.shtml. Accessed November 3, 2018
 36. Marchette LK, Weisz JR. Practitioner Review: empirical evolution of youth psychotherapy toward transdiagnostic approaches. *J Child Psychol Psychiatry*. 2017;58(9):970–984
 37. Wissow LS, van Ginneken N, Chandna J, Rahman A. Integrating children's mental health into primary care. *Pediatr Clin North Am*. 2016;63(1):97–113
 38. Wissow L, Anthony B, Brown J, et al. A common factors approach to improving the mental health capacity of pediatric primary care. *Adm Policy Ment Health*. 2008;35(4):305–318
 39. Wissow LS, Gadomski A, Roter D, et al. Improving child and parent mental health in primary care: a cluster-randomized trial of communication skills training. *Pediatrics*. 2008;121(2): 266–275
 40. Chorpita BF, Daleiden EL, Weisz JR. Identifying and selecting the common elements of evidence based interventions: a distillation and matching model. *Ment Health Serv Res*. 2005;7(1):5–20
 41. Chorpita BF, Daleiden EL, Park AL, et al. Child STEPs in California: a cluster randomized effectiveness trial comparing modular treatment with community implemented treatment for youth with anxiety, depression, conduct problems, or traumatic stress. *J Consult Clin Psychol*. 2017;85(1):13–25
 42. Tynan WD, Baum R. *Adapting Psychosocial Interventions to Primary Care. Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians*. Itasca, IL: American Academy of Pediatrics; 2018
 43. Kemper KJ, Vora S, Walls R; Task Force on Complementary and Alternative Medicine; Provisional Section on Complementary, Holistic, and Integrative Medicine. American Academy of Pediatrics. The use of complementary and alternative medicine in pediatrics. *Pediatrics*. 2008; 122(6):1374–1386. Reaffirmed January 2013
 44. Sanders MR, Bor W, Morawska A. Maintenance of treatment gains: a comparison of enhanced, standard, and self-directed Triple P-Positive Parenting Program. *J Abnorm Child Psychol*. 2007;35(6):983–998
 45. High PC, Klass P; Council on Early Childhood. Literacy promotion: an essential component of primary care pediatric practice. *Pediatrics*. 2014; 134(2):404–409
 46. Yogman M, Garner A, Hutchinson J, Hirsh-Pasek K, Golinkoff RM; Committee on Psychosocial Aspects of Child and Family Health; Council on Communications and Media. The power of play: a pediatric role in enhancing development in young children. *Pediatrics*. 2018;142(3):e20182058
 47. Howard BJ. Guidelines for Special Time. In: Jellinek M, Patel BP, Froehle MC, eds. *Bright Futures in Practice: Mental Health—Volume II. Tool Kit*. Arlington, VA: National Center for Education in Maternal and Child Health; 2002
 48. van Straten A, Cuijpers P, Smits N. Effectiveness of a Web-based self-help intervention for symptoms of depression, anxiety, and stress:

- randomized controlled trial. *J Med Internet Res*. 2008;10(1):e7
49. Foy JM, ed. *Promoting Mental Health in Children and Adolescents: Primary Care Practice and Advocacy*. Itasca, IL: American Academy of Pediatrics; 2018
 50. Weersing VR, Brent DA, Rozenman MS, et al. Brief behavioral therapy for pediatric anxiety and depression in primary care: a randomized clinical trial. *JAMA Psychiatry*. 2017;74(6): 571–578
 51. Walkup JT, Mathews T, Green CM. Transdiagnostic behavioral therapies in pediatric primary care: looking ahead. *JAMA Psychiatry*. 2017;74(6):557–558
 52. Leslie LK, Mehus CJ, Hawkins JD, et al. Primary health care: potential home for family-focused preventive interventions. *Am J Prev Med*. 2016;51(4 suppl 2): S106–S118
 53. Accreditation Council on Graduate Medical Education. ACGME core competencies. Available at: <https://www.ecfmg.org/echo/acgme-core-competencies.html>. Accessed March 9, 2018
 54. Knapp P, Chait A, Pappadopoulos E, Crystal S, Jensen PS; T-MAY Steering Group. Treatment of maladaptive aggression in youth: CERT guidelines I. Engagement, assessment, and management. *Pediatrics*. 2012;129(6). Available at: www.pediatrics.org/cgi/content/full/129/6/e1562
 55. Scotto Rosato N, Correll CU, Pappadopoulos E, Chait A, Crystal S, Jensen PS; Treatment of Maladaptive Aggressive in Youth Steering Committee. Treatment of maladaptive aggression in youth: CERT guidelines II. Treatments and ongoing management. *Pediatrics*. 2012;129(6). Available at: www.pediatrics.org/cgi/content/full/129/6/e1577
 56. Shain BN; Committee on Adolescence. Collaborative role of the pediatrician in the diagnosis and management of bipolar disorder in adolescents. *Pediatrics*. 2012;130(6). Available at: www.pediatrics.org/cgi/content/full/130/6/e1725
 57. Stille CJ. Communication, comanagement, and collaborative care for children and youth with special healthcare needs. *Pediatr Ann*. 2009; 38(9):498–504
 58. American Academy of Pediatrics. Mental health initiatives: HIPAA privacy rule and provider to provider communication. Available at: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/HIPAA-Privacy-Rule-and-Provider-to-Provider-Communication.aspx>. Accessed March 9, 2018
 59. Office of the Federal Register. Confidentiality of substance use disorder patient records. Available at: <https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records>. Accessed March 9, 2018
 60. Zero to Three. *DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. Washington, DC: Zero to Three; 1994. Available at: <https://www.zerotothree.org/our-work/dc-0-5>. Accessed November 1, 2017
 61. American Academy of Pediatrics. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*. Elk Grove Village, IL: American Academy of Pediatrics; 2010
 62. Adam H, Foy J. *Signs and Symptoms in Pediatrics*. Elk Grove Village, IL: American Academy of Pediatrics; 2015
 63. McInerney TK, Adam HM, Campbell DE, eds, et al. *Textbook of Pediatric Care*, 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2016
 64. American Academy of Pediatrics. Pediatric care online. Available at: <https://pediatriccare.solutions.aap.org/Pediatric-Care.aspx>. Accessed November 3, 2018
 65. Knapp P. The Iterative Mental Health Assessment. In: Foy JM, ed. *Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians*, vol. Vol 1. Itasca, IL: American Academy of Pediatrics; 2018:pp 173–226
 66. Wissow LS. Anxiety and Trauma-Related Distress. In: Foy JM, ed. *Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians*, vol. Vol 1. Itasca, IL: American Academy of Pediatrics; 2018:pp 433–456
 67. Baum R, Campo J. Medically Unexplained Symptoms. In: Foy JM, ed. *Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians*, vol. Vol 1. Itasca, IL: American Academy of Pediatrics; 2018:pp 649–659
 68. Schneider M, Fisher M. Eating Abnormalities. In: Foy JM, ed. *Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians*, vol. Vol 1. Itasca, IL: American Academy of Pediatrics; 2018:pp 477–506
 69. Angold A, Costello EJ, Farmer EM, Burns BJ, Erkanli A. Impaired but undiagnosed. *J Am Acad Child Adolesc Psychiatry*. 1999;38(2):129–137
 70. Lewinsohn PM, Shankman SA, Gau JM, Klein DN. The prevalence and comorbidity of subthreshold psychiatric conditions. *Psychol Med*. 2004;34(4): 613–622
 71. Wolraich M, Brown L, Brown RT, et al; Subcommittee on Attention-Deficit/Hyperactivity Disorder; Steering Committee on Quality Improvement and Management. ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. *Pediatrics*. 2011;128(5): 1007–1022
 72. Zuckerbrot RA, Cheung A, Jensen PS, Stein REK, Laraque D; GLAD-PC Steering Group. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): part I. practice preparation, identification, assessment, and initial management. *Pediatrics*. 2018;141(3): e20174081
 73. Cheung AH, Zuckerbrot RA, Jensen PS, Laraque D, Stein REK; GLAD-PC STEERING GROUP. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): part II. Treatment and ongoing management. *Pediatrics*. 2018;141(3): e20174082
 74. Levy SJ, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics*. 2016;138(1):e20161211
 75. Gleason MM, Egger HL, Emslie GJ, et al. Psychopharmacological treatment for very young children: contexts and guidelines. *J Am Acad Child Adolesc Psychiatry*. 2007;46(12):1532–1572

76. The MTA Cooperative Group. Multimodal Treatment Study of Children with ADHD. A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Arch Gen Psychiatry*. 1999;56(12):1073–1086
77. Walkup JT, Albano AM, Piacentini J, et al. Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *N Engl J Med*. 2008;359(26):2753–2766
78. March J, Silva S, Petrycki S, et al; Treatment for Adolescents With Depression Study (TADS) Team. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. *JAMA*. 2004;292(7):807–820
79. Wissow LS. Low Mood. In: Foy JM, ed. *Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians*, vol. Vol 1. Itasca, IL: American Academy of Pediatrics; 2018: pp 617–636
80. Smith BL. Inappropriate prescribing. *Monit Psychol*. 2012;43(6):36
81. Riddle MA, ed. *Pediatric Psychopharmacology for Primary Care*. Elk Grove Village, IL: American Academy of Pediatrics; 2015
82. Stein RE, Storer-Isser A, Kerker BD, et al. Beyond ADHD: how well are we doing? *Acad Pediatr*. 2016;16(2):115–121
83. Horwitz SM, Storer-Isser A, Kerker BD, et al. Barriers to the identification and management of psychosocial problems: changes from 2004 to 2013. *Acad Pediatr*. 2015;15(6):613–620
84. Hudson CG. Disparities in the geography of mental health: implications for social work. *Soc Work*. 2012;57(2):107–119