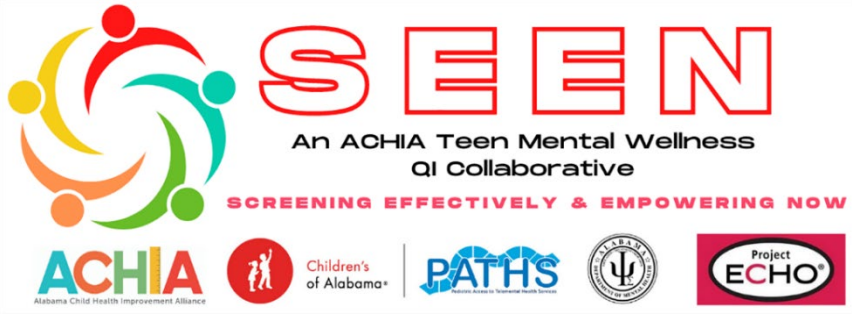


November 17, 2023

Dear SEEN participants,

Welcome to our teen mental wellness collaborative! In this packet you will find several items to get you started, including:

- Prework documents: Checklist, Important Dates, Key Driver, Measures Definitions, Datasets 1 and 2 (PDF version), Mental Health Algorithm
- Articles/Tools: *Mental Health Competencies*, PHQ-9 (Modified for Teens), PHQ-A Combined
- QI Tools: PDSA Model for Improvement, PDSA worksheet, sFMEA
- Other: Sticky notes (for process map team activity in January), ACHIA Measuring Tape, ACHIA buttons

We are looking forward to working and learning with you in this new collaborative!

Best regards,

Rachel Latham

*Project Manager, ACHIA*

rlatham@alaap.org

**Core Team Pre-Work**
Complete before **December 1, 2022**

Review Emailed Information

- ❒ *Selecting a Core Team*
- ❒ *Core Team and Physician Expectations*
- ❒ *Practice Readiness Assessment Survey*
- ❒ *Timeline and Important Dates*

Establish a Core Team

- ❒ Establish Core Team based on *Selecting a QI Core Team* job descriptions

Core Team and Provider Expectations

- ❒ Review *Core Team and Physician Expectations* with core team and physicians seeking MOC Part 4
- ❒ Collect signatures
- ❒ Email signed and scanned copy to Rachel Latham at rlatham@alaap.org

Complete Pre-Survey

- ❑ Complete one Pre-Survey for each practice. Practices with multiple sites, complete one per site.
- ❑ Attached Pre-Survey PDF provided to facilitate completion **(do NOT return PDF):**
  - Meet with practice core team meeting to discuss current clinical practice
  - Collect of number of patients seen annually and by payor %
- ❑ Complete REDCap Pre-Survey via link emailed from Rachel Latham

Establish protected time for collaborative work (see Timeline and Important Dates)

- ❒ Place SEEN Teen WellnessQI webinars on the core team member calendars
- ❒ Place PATHS ECHO Webinars on calendars of physicians seeking MOC **(Physicians seeking MOC Part 4 must participate in webinars in real-time; recorded sessions not available.)**
- ❒ Place task due dates on team members' calendar responsible for task(s)
- ❒ Establish data entry back up plans that accommodate vacations/illnesses
- ❒ Schedule core team meetings at least bi-weekly (consider using huddles)

Purchase AAP Mental Health Toolkit

- ❑ Purchase the online AAP Mental Health Toolkit if you do not currently have access. ACHIA will reimburse up to $150 for each practice. If you have a subscription to Pediatric Care Online, your toolkit is included in your subscription. AAP Mental Health Toolkit information is here.

Test communication streaming/camera/audio prior to Kick-Off Webinar

- ❒ Download the ZOOM app to your computer desktop
- ❒ Test ZOOM access, audio, and ability to mute audio source (landline or computer microphone) https://learning.zoom.us/learn
- ❒ Update ZOOM each month prior to webinar to ensure full functionality

Physicians seeking MOC complete NICHQ QI by December 6, 2022 (see ACHIA website.)

Note: Past practice participants will notice ACHIA is testing several innovative approaches.

- Baseline data are collected December-February rather than retrospectively
- Interventions/Change Ideas begin in March
- Data are entered into REDCap rather than QIDA/Qualtrix/SurveyMonkey
- QI Coaching takes place during the SEEN Webinars rather than individual practice meetings
- Educational teen depression content begins in March and is delivered via PATHS ECHO sessions rather than SEEN online modules and webinars

# SEEN: An ACHIA QI Learning Collaborative
# December 2022 to August 2023

SEEN
An ACHIA Teen Mental Wellness QI Collaborative
SCREENING EFFECTIVELY & EMPOWERING NOW

## Action Period 1

### Nov/Dec 2022

- SEEN Webinar: Orientation 12/6/2022
- SEEN Webinar: Data 12/13/2022
- Practice Meeting
- Complete Practice Readiness Assessment Survey 12/1/2022
- Physicians seeking MOC complete Orientation and NICHQ QI by 12/6/22

### Jan 2023

- SEEN Webinar: Process Maps 1/17/2023
- Practice Meeting
- Baseline Data Due 1/31/2023
- Office Hours *optional for any questions practices have 1/25/2023 12-1 pm

### Feb 2023

- SEEN Webinar: Aim statements/ Key Drivers 2/21/2023
- Practice Meeting
- Baseline Data And Monthly Survey Due 2/28/2023
- Office Hours *optional for any questions practices have 2/21/2023 1-1:30 pm

## Action Period 2

### March 2023

- SEEN Webinar: PDSA 3/21/2023
- Practice Meeting
- Data and Monthly Survey Due 3/31/2023
- PATHS ECHO Webinar 3/2/23
- PATHS ECHO Webinar 3/30/23

### April 20223

- SEEN Webinar: PDSA ramps 4/18/2023
- Practice Meeting
- Data and Monthly Survey Due 4/28/2023
- PATHS ECHO Webinar 4/27/23

### May 2023

- SEEN Webinar: Run Charts/ Annotation 5/16/2023
- Practice Meeting
- Data and Monthly Survey Due 5/31/2023
- PATHS ECHO Webinar 5/25/23

## Action Period 3

### June 2023

- SEEN Webinar: SFMEA 6/13/2023
- Practice Meeting
- Data and Monthly Survey Due 6/30/2023
- PATHS ECHO Webinar 6/22/23

### July 2023

- SEEN Webinar: Spread/ Implementation 7/25/2023
- Practice Meeting
- Data and Monthly Survey Due 7/31/203
- PATHS ECHO Webinar 7/13/23

### Aug 2023

- SEEN Webinar: Celebration 8/15/2023
- Practice Meeting
- Post Survey Due: 9/15/2023
  Attestations Due: 9/15/2023

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An ACHIA Teen Mental Wellness QI Collaborative
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## Important Dates

**SEEN QI Webinar:** Mostly monthly on Tuesdays

Who Participates: Core Team Members

Dec 2022 - Aug 2023 @ 12 – 1 PM Zoom meeting link emailed monthly

2022: 12/6 (Kick-Off), 12/13, (Data Orientation)
2023: 1/17, 2/21, 3/21, 4/18, 5/16, 6/13, 7/25, 8/15

**PATHS ECHO Webinar:** Mostly every 4 weeks on Thursdays

Who participates: Core Team clinical members and Physicians seeking MOC Part 4

March – July 2022 @ 12:15-1:1:15PM

2023: 3/2, 3/30, 4/27, 5/25, 6/22, 7/13

**REDCap Data Due Dates:** last day of each month

Baseline data: 1/31, 2/28
Intervention data and PDSA reports: 3/31, 4/28, 5/31, 6/30, 7/31

**QI Online Module**

Who Participates: Core Team and Physicians seeking MOC Part 4

Before December 6, 2021

- ❒ NICHQ Quality Improvement (1 hour approx.) https://static.nichq.org/quality-improvement-101
- ❒ NICHQ Quality Improvement 102: (The PDSA Story – 30 min.) https://static.nichq.org/quality-improvement-102/story_html5.html

If you have any questions, please feel free to contact Rachel Latham at rlatham@alaap.org

SEEN

An ACHIA Teen Mental Wellness QI Collaborative

SCREENING EFFECTIVELY & EMPOWERING NOW

ACHIA Alabama Child Health Improvement Alliance | Children's of Alabama | PATHS Pediatric Access to Telemental Health Services | Project ECHO

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2.09 million, with 20% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government

# 2023 SEEN Key Driver Diagram

## SMART AIM

By August 2023 we will do the following:

- Increase the percentage of teens in clinic for well- child check-ups ages 12-18 years with appropriately completed validated depression screen to 80 percent
- Increase the percentage of screens positive for major depression with a follow up plan to 80 percent
- Increase the percentage of teens with a screen positive for major depression followed up within 30 days by five percent over baseline.

## Global AIM

Teens will be SEEN and have mental health needs addressed

## Key Drivers

### Universal Reliable Screening for Depression and Suicide

- Select validated standardized screen(s) for practice
- Standardize workflow to complete screen
- Complete screen confidentially
- Review responses with teen

### Standardized Management for Positive Screens for Depression and Suicidal Ideation

- Discuss management options with teen and caregiver utilizing evidence-based communication approaches
- Develop a shared plan of care with teen and caregiver
- Initiate treatment per shared plan of care:
  - Provide behavioral education
  - Prescribe psychopharmacological medications
  - Provide culturally appropriate educational materials for teen/ family
  - Create a safety plan
  - Establish urgent care for active suicidal ideation
  - Refer to mental health providers

### Timely and Reliable Follow Up Depression and Suicidal Ideation

- Follow up positive screens within 30 days
- Establish reminder/recall processes for positive screens
- At follow up review shared plan of care:
  - Assess efficacy of behavioral recommendations
  - Adjust medication based on side effects and level of improvement
- Track medication changes (dose and reason for change)
- Utilize tele-mentoring between PCP and mental health professional when appropriate and available
- Establish two- way communication with mental health referrals

## Change Ideas/Innovations

# SEEN Adolescent Depression Screening and Follow Up Measure Definitions

- **Exclusions for all SEEN Measures:**

  (1) Patient has an active diagnosis of depression prior to any encounter during the measurement period;

  (2) Patient has a diagnosis of bipolar disorder prior to any encounter during the measurement period;

  (3) Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

**Dataset #1**

**Measure Name: Depression Screen with Validated Tool**

- **Definition of Measure:** Proportion of adolescents 12 through 18 years of age seen for a well visit who are screened for depression using an age-appropriate validated screening tool.
- **Type of Quality Measure:** Process measure.
- **Improvement Target Value:** 80% of eligible adolescents.
- **Calculation:**
    - **Target population:** Adolescents 12 through 18 years of age (up to 19th birthday).
    - **Numerator:** Number of adolescents 12 through 18 years of age (up to 19th birthday) screened for depression using a validated screening tool.
    - **Denominator:** Number of adolescents 12 through 18 years of age (up to 19th birthday) who present for a well visit.
- **Inclusion:** Adolescents 12 through 18 years of age seen for a well visit
- **Data Source:** Patient charts (paper or EMR).
- **Collection Frequency:** All available charts per month for 7 months entered online via REDCap link.
- **Measurement timeframe**: 22nd of prior month through 21st of current month December 22, 2022-July 21, 2023
- **Data due date**: Enter data by the last day of the month.
- **Is the measure validated or endorsed?** Yes. NQF 0418.

**1B. Measure Name: Documentation of a Follow-up Plan for Depressed Adolescents**

- **Definition of Measure:** Proportion of adolescents 12 through 18 years of age who screen positive for depression using an age-appropriate valid tool and have a documented follow up plan for their depression.
- **Type of Quality Measure:** Process measure.
- **Improvement Target Value:** 80% of adolescents who screen positive for depression using an age-appropriate valid tool will have a documented follow-up plan of care for their depression.
- **Calculation:**
    - **Target Population**: Adolescents 12 through 18 years of age (up to 19th birthday) who screen positive for depression using an age-appropriate valid tool.
    - **Numerator:** Number of adolescents 12 through 18 years of age (up to 19th birthday) who screen positive for depression using an age-appropriate valid tool and have a documented follow-up plan of care for their depression.
    - **Denominator:** Number of adolescents 12 through 18 years of age (up to 19th birthday) who screen positive for depression at a well visit using an age-appropriate valid tool.
- **Inclusions:** Charts abstracted for 1A.
- **Data Source:** Patient charts (paper or EMR) or immunization registry.
- **Collection Frequency:** Sample all available charts from Measure 1A each month for 8 months entered online via REDCap link.
- **Measurement timeframe**: 22nd of prior month through 21st of current month December 22, 2022-July 21, 2023
- **Data due date**: Enter data by the last day of the month
- **Is the measure validated or endorsed?** Yes, based on NQF 0418.

**Dataset#2**

**2. Measure Name: Follow Up for Depression within 30 days**

- **Definition of Measure:** Proportion of adolescents 12 through 18 years of age who are followed up within 30 days after screening positive for depression.
- **Type of Quality Measure:** Process measure.
- **Improvement Target Value:** 5% above baseline
- **Calculation:**
    - **Target population:** Adolescents 12 through 18 years of age (up to 19th birthday).
    - **Numerator:** Number of adolescents 12 through 18 years of age (up to 19th birthday) who completed follow up within 30 days with either an in-person or telehealth visit with primary care or a mental health provider or had a primary care phone visit with a qualified professional (MD, NP, RN, MSW, PA).
    - **Denominator:** Number of 12 through 18 years of age (up to 19th birthday) with a positive screen AND a follow up plan from the health supervision visit.
- **Inclusions:** All adolescents 12 through 18 years seen for a well visit who screened positive for depression and have a follow up plan
- **Data Source:** Patient charts (paper or EMR).
- **Collection Frequency:** All eligible charts entered monthly for 7 months online via REDCap link.
- **Measurement timeframe**: 22nd of prior month through 21st of current month December 22, 2022-July 21, 2023
- **Data due date**: Enter data by the last day of the month
- **Is the measure validated or endorsed?** No, but this measure is based on NQF 0418. Our measure allows for assessing if follow-up plan was completed

## Data Set #1 : 12-18 yo WCC and Depression Screening

Track all 12-18 yo WCC in your practice for each cycle. Document whether a depression screening was completed, the results of the depression screening and if a follow up plan was documented with each positive depression screen.

Enter data by the last day of each month. Each cycle will go from the 22nd of the prior month through the 21st of the current month. **Example: The January cycle will be from 12/22-1/21. Enter data by January 31st**

**1a:** Total # of adolescents 12-18 yo who complete a WCC in each cycle

**1b:** Total # of adolscents 12-18 yo screened for depression using an age-appropriate valid tool.

**1c:** Total # of adolescents 12-18 yo who screen positive for depression using an age-appropriate valid tool.

**1d:** Total # of adolescents 12-18 yo who screen positive for depression and have a follow up plan documented.

**Exclusions for all SEEN Measures:**

(1) Patient has an active diagnosis of depression prior to any encounter during the measurement period;

(2) Patient has a diagnosis of bipolar disorder prior to any encounter during the measurement period;

(3) Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

**Please refer to the chart below for the data due each month. This tracker correlates with the information in the bracket**

| | Data Entry Month | Jan | Feb | Mar | Apr | May | Jun | July |
|---|---|---|---|---|---|---|---|---|
| | Dates | 12/22-1/21 | 1/22-2/21 | 2/22-3/21 | 3/22-4/21 | 4/22-5/21 | 5/22-6/21 | 6/22-7/21 |
| | | Baseline | | | | Intervention | | |
| Run Chart Data | Dataset 1 Cycle # | #1 | #2 | #3 | #4 | #5 | #6 | #7 |
| | Depression screen completed and follow- up plan documented for positive screens **All visits current cycle* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Dataset 2 Cycle # | | #1 | #2 | #3 | #4 | #5 | #6 |
| | Follow Up Completed **For positive screens from previous cycle* | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Annotate run charts **optional* | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| PDSA | P-upcoming cycle | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| | D-S-A current cycle | | | ✓ | ✓ | ✓ | ✓ | ✓ |

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# Monthly Data Set 1

| Patient Name | 1a. Patient MRN # | 1b. Was a screen for depression completed? | 1c.Was the depression screen positive? | 1d. If positive, was a follow up plan documented? |
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| Enter the information from the boxes below into REDCap | |
|---|---|
| 1a: Total # of 12-18 yo WCC | |
| 1b: Total # of 12-18 yo screened for depression | |
| 1c: Total # of 12-18 yo w/positive depression screening | |
| 1d: Total # of 12-18 yo with positive depression screenings who have a follow up plan documented | |

# Dataset #2: Measure 2-Follow Up Visit Tracking Spreadsheet

Track Follow Up Visits with Primary Care Practice for screens positive for depression

Track all patients with screens positive for depression **(Do not put negative screens in the spreadsheet)**

Cycle is from 22nd of previous month through 21st of current month. Enter data by last day of current month.
**Example: For all patients with positive screens from Dec 22- Jan 21, track if had follow up completed within 30 days of screen through Feb 21. Enter data by February 28th.**

**Denominator:** Total # of screens positive for concern of depression from previous cycle

**Numerator:** Follow up completed with 30 days of the screen (Number of adolescents 12 through 18 years of age (up to 19th birthday) who completed follow up within 30 days with either an in-person or telehealth visit with primary care or a mental health provider or had a primary care phone visit with a qualified professional (MD, NP, RN, MSW, PA).)

Also included is a blank data sheet that you can copy if you choose to collect data after the collaborative

**Please refer to the chart below for the data due each month. This tracker correlates with the information in the bracket**

| | Data Entry Month | Jan | Feb | Mar | Apr | May | Jun | July |
|---|---|---|---|---|---|---|---|---|
| | Dates | 12/22-1/21 | 1/22-2/21 | 2/22-3/21 | 3/22-4/21 | 4/22-5/21 | 5/22-6/21 | 6/22-7/21 |
| | | Baseline | | | | Intervention | | |
| Run Chart Data | Dataset 1 Cycle # | #1 | #2 | #3 | #4 | #5 | #6 | #7 |
| Run Chart Data | Depression screen completed and follow- up plan documented for positive screens *All visits current cycle | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Run Chart Data | Dataset 2 Cycle # | | #1 | #2 | #3 | #4 | #5 | #6 |
| Run Chart Data | Follow Up Completed *For positive screens from previous cycle | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Run Chart Data | Annotate run charts *optional | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| PDSA | P-upcoming cycle | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| PDSA | D-S-A current cycle | | | ✓ | ✓ | ✓ | ✓ | ✓ |

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| Patient Name | Patient MRN | Screen Concerning for Depression, Suicide, or Both | Date of Screen/Visit | **Primary Care Follow Up Plan** (in person, telehealth, phone call with qualified clinician, no 30 day plan documented, family declined follow up) | Date follow-up Scheduled | Date Follow up completed | Number of Days between follow up | Follow Up Completed within 30 days | **Contact Info** (Name of Caregiver, Phone Number) |
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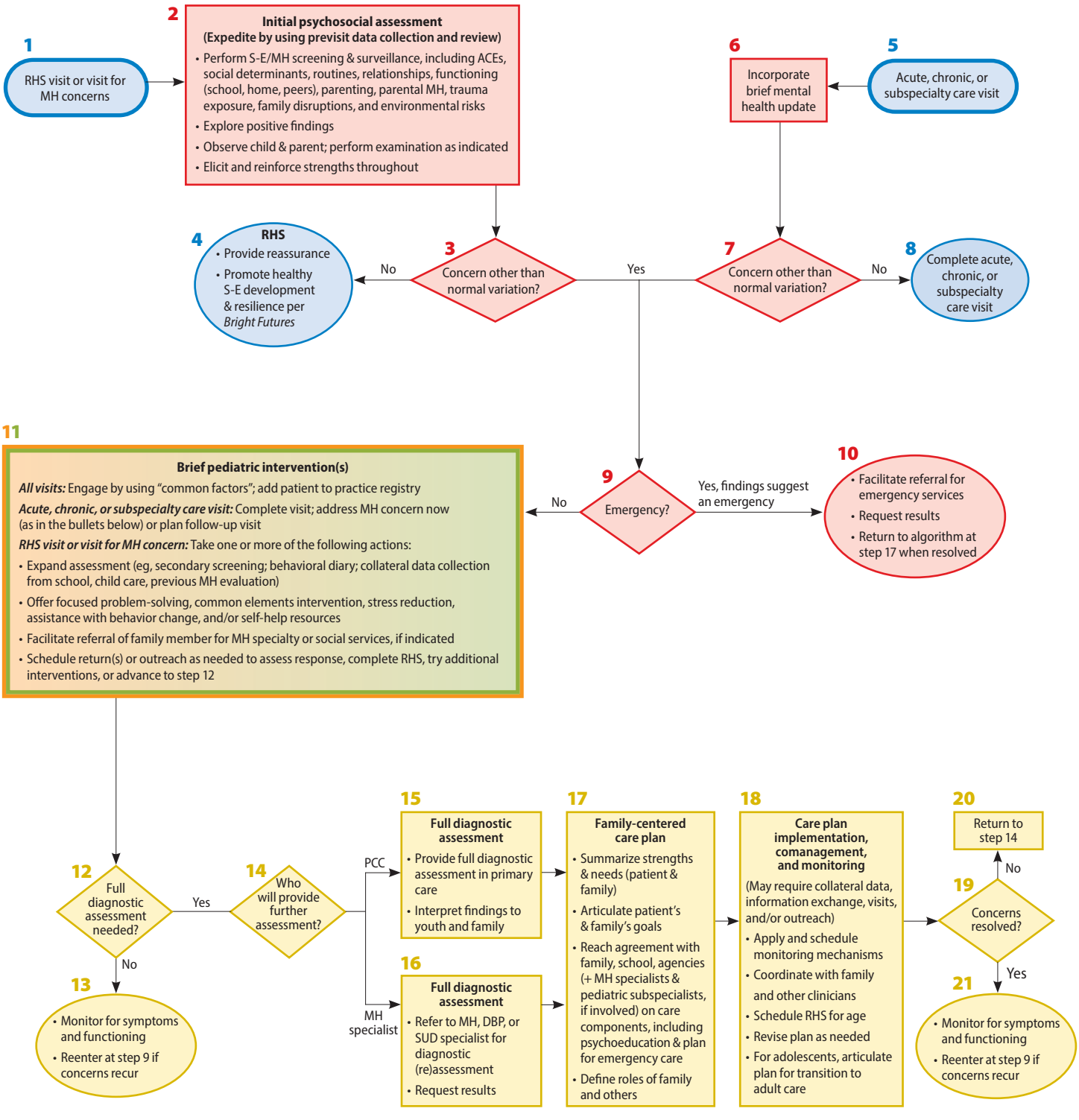
|---|---|---|
| **Numerator** | Follow Up Completed within 30 days | |
| **Denominator** | Total Positive Screens | |
| | | |

# Mental Health Care in Pediatric Practice




**Legend**

Start | Action/ Process | Decision | Stop

**Abbreviations:**
ACE, adverse childhood experience; DBP, developmental-behavioral pediatrician; MH, mental health; PCC, primary care clinician; RHS, routine health supervision; S-E, social-emotional; SUD, substance use disorder.

Foy JM, Green CM, Earls MF, AAP COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, MENTAL HEALTH LEADERSHIP WORK GROUP. Mental Health Competencies for Pediatric Practice. Pediatrics. 2019; 144(5):e20192757

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

# Mental Health Competencies for Pediatric Practice

Jane Meschan Foy, MD, FAAP,[a] Cori M. Green, MD, MS, FAAP,[b] Marian F. Earls, MD, MTS, FAAP,[c] COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, MENTAL HEALTH LEADERSHIP WORK GROUP

## abstract

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

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*Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.*

*Drs Foy, Green, and Earls contributed to the drafting and revising of this manuscript; and all authors approved the final manuscript as submitted.*

*The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.*

*All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.*

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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 ≥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.

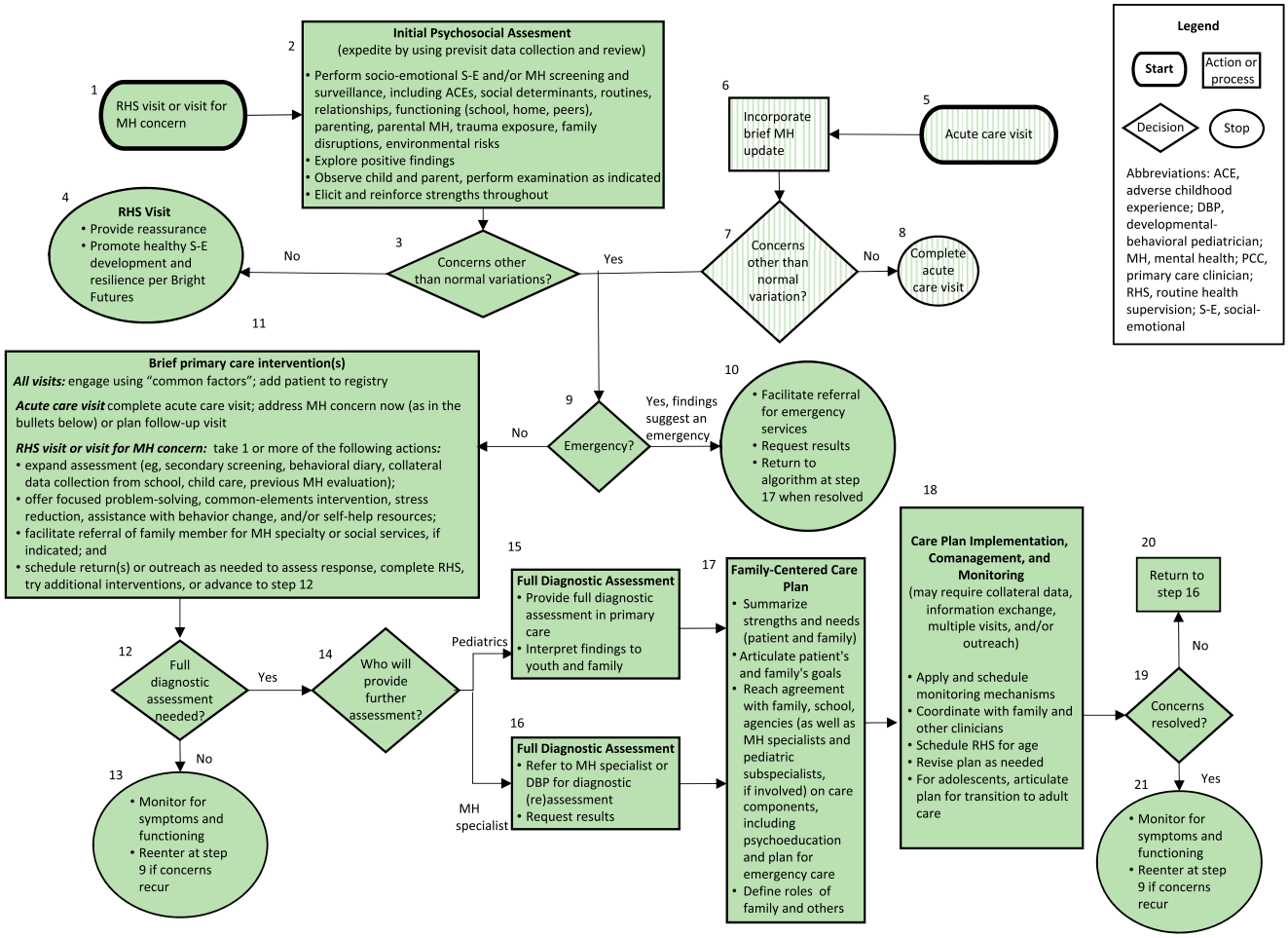


**FIGURE 1**
Mental health (MH) care in pediatric practice. ACE, adverse childhood experience; RHS, routine health supervision; S-E, social-emotional.

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 semispecific 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 behavior[44]) 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 disorder[56] 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).

**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.

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

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 statement[18] 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 report[31]). 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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# PHQ-9: Modified for Teens

Name _____

Clinician _____ Date _____

**Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.**

| | (0) Not At All | (1) Several Days | (2) More Than Half the Days | (3) Nearly Every Day |
|---|---|---|---|---|
| 1. Feeling down, depressed, irritable, or hopeless? | | | | |
| 2. Little interest or pleasure in doing things? | | | | |
| 3. Trouble falling asleep, staying asleep, or sleeping too much? | | | | |
| 4. Poor appetite, weight loss, or overeating? | | | | |
| 5. Feeling tired, or having little energy? | | | | |
| 6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down? | | | | |
| 7. Trouble concentrating on things like school work, reading, or watching TV? | | | | |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual? | | | | |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? | | | | |

In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

For Office Use Only Score_____



American Academy of Pediatrics
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# PHQ-9 modified for Adolescents (PHQ-A)

**Name:** _____ **Clinician:** _____ **Date:** _____

**Instructions:** How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

| | (0) Not at all | (1) Several days | (2) More than half the days | (3) Nearly every day |
|---|---|---|---|---|
| **1.** Feeling down, depressed, irritable, or hopeless? | | | | |
| **2.** Little interest or pleasure in doing things? | | | | |
| **3.** Trouble falling asleep, staying asleep, or sleeping too much? | | | | |
| **4.** Poor appetite, weight loss, or overeating? | | | | |
| **5.** Feeling tired, or having little energy? | | | | |
| **6.** Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down? | | | | |
| **7.** Trouble concentrating on things like school work, reading, or watching TV? | | | | |
| **8.** Moving or speaking so slowly that other people could have noticed?<br><br>Or the opposite – being so fidgety or restless that you were moving around a lot more than usual? | | | | |
| **9.** Thoughts that you would be better off dead, or of hurting yourself in some way? | | | | |

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

**Office use only:** **Severity score:** _____

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

asQ
Ask Suicide-Screening Questions

**Ask the patient:**

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO

If yes, how? _____ When? _____

**If the patient answers yes to any of the above, ask the following question:**

(5) Are you having thoughts of killing yourself right now? YES NO

If yes, please describe: _____

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

**Provide resources to all patients: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
**24/7 Crisis Text Line: Text "HOME" to 741-741**

# MODEL FOR IMPROVEMENT

What are we trying to accomplish?

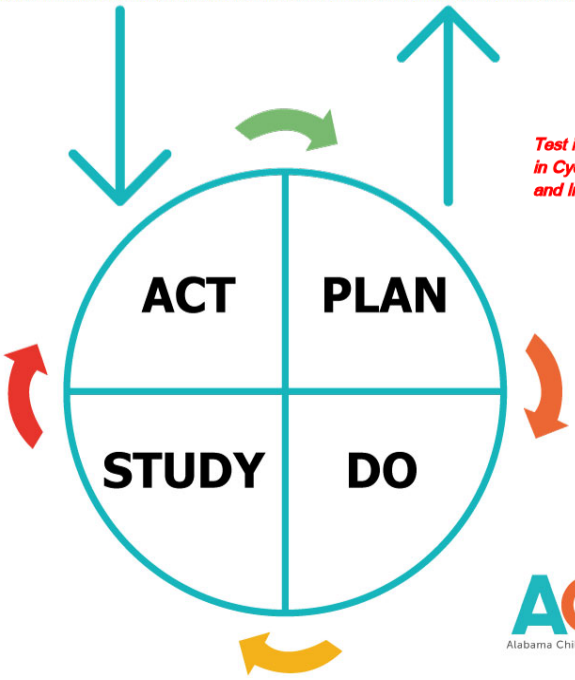
***AIMS***

How will we know that a change is an improvement?

***MEASURES***

What change can we make that will result in improvement?

***IDEAS***

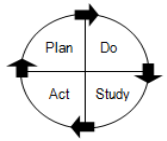


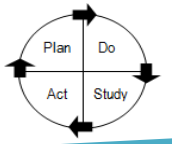

***Test ideas & changes in Cycles for Learning and Improvement***

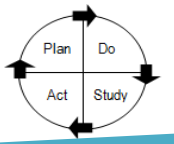
ACHIA
Alabama Child Health Improvement Alliance

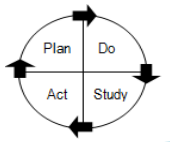
# Ramp Plan

**August 2020 version**



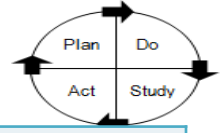




| *<Enter Intervention>* | **Test Cycle 1** | **Test Cycle 2** | **Test Cycle 3** | **Test Cycle 4** |
|---|---|---|---|---|
| **Test Cycle Description, including changes in scale/time:** | | | | |

# PDSA Worksheet




| | |
|---|---|
| **Project Title:** | **Screening Effectively & Empowering Now (SEEN): An ACHIA Teen Mental Wellness QI Collaborative** |
| **Intervention Name:** | |
| **What key driver does this test impact?** | ❑ Universal Screening for Depression and Suicide<br>❑ Standardized Management for Concerning Screens<br>❑ Practice Follow Up Visits |

| | | | | | |
|---|---|---|---|---|---|
| **Test Cycle #:** | | **Test Cycle Start Date:** | | **Test Cycle Completion Date:** | |

**Describe the intent and structure of the test cycle:**

**What would the successful test look like? Include how you will measure success for this test cycle:**

**What do you predict will happen? This should be your realistic prediction.**

**Action steps to carry out the test cycle (who, what, where & when):**

**Describe your observations and data. Was there anything that occurred that was not part of the plan?**

## STUDY:

**How did the results compare to your prediction? What did you learn?**

## ACT: *(to be completed after the test cycle)*

**Adapt** ☐

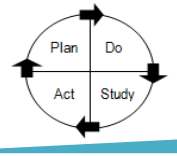
**Adopt** ☐

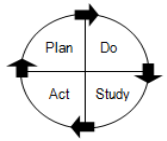
**Abandon** ☐

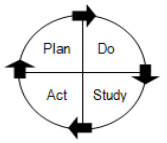
What will you change in the next test if "adapt". *(Modify intervention to reflect learning and/or increase scale)*

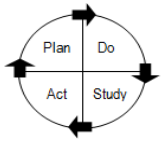
# Ramp Summary

**August 2020 version**




| | *<Enter Intervention>* | Test Cycle 1 | Test Cycle 2 | Test Cycle 3 | Test Cycle 4 |
|---|---|---|---|---|---|
| **Plan** | **Describe the intent and structure of the test cycle.** | | | | |
| **Do** | **What changed from the previous test cycle?** | | | | |
| **Study** | **Results: Data and Observations** | | | | |
| **Act** | **Action (Adapt, Adopt or Abandon):** | | | | |

# Data Collection and Entry Guidance

| | Data Entry Month | Jan | Feb | Mar | Apr | May | Jun | July |
|---|---|---|---|---|---|---|---|---|
| | Dates | 12/22-1/21 | 1/22-2/21 | 2/22-3/21 | 3/22-4/21 | 4/22-5/21 | 5/22-6/21 | 6/22-7/21 |
| | | Baseline | | | | Intervention | | |
| **Run Chart Data** | Dataset 1<br>Cycle # | #1 | #2 | #3 | #4 | #5 | #6 | #7 |
| | Depression screen completed and follow up plan documented for positive screens<br>**All visits current cycle* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Dataset 2<br>Cycle # | | #1 | #2 | #3 | #4 | #5 | #6 |
| | Follow Up Completed<br>**For positive screens from previous cycle* | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Annotate run charts<br>**optional* | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| **PDSA** | P-upcoming cycle | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| | D-S-A current cycle | | | ✓ | ✓ | ✓ | ✓ | ✓ |

# Measure Populations