



Achieving the Pediatric Mental Health Competencies

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Mental health disorders affect 1 in 5 children; however, the majority of affected children do not receive appropriate services, leading to adverse adult outcomes. To meet the needs of children, pediatricians need to take on a larger role in addressing mental health problems. The accompanying policy statement, “Mental Health Competencies for Pediatric Practice,” articulates mental health competencies pediatricians could achieve to improve the mental health care of children; yet, the majority of pediatricians do not feel prepared to do so. In this technical report, we summarize current initiatives and resources that exist for trainees and practicing pediatricians across the training continuum. We also identify gaps in mental health clinical experience and training and suggest areas in which education can be strengthened. With this report, we aim to stimulate efforts to address gaps by summarizing educational strategies that have been applied and could be applied to undergraduate medical education, residency and fellowship training, continuing medical education, maintenance of certification, and practice quality improvement activities to achieve the pediatric mental health competencies. In this report, we also articulate the research questions important to the future of pediatric mental health training and practice.

INTRODUCTION

Mental health disorders have surpassed physical conditions as the most common reasons children have impairments and limitations.¹ Mental health disorders affect 1 in 5 children; however, a shortage of mental health specialists, stigma, cost, and other barriers prevent the majority of affected children from receiving appropriate services.²⁻⁴ Pediatricians have unique opportunities and a growing sense of responsibility to promote healthy social-emotional development of children and to prevent and address their mental health and substance use problems. In 2009, the American Academy of Pediatrics (AAP) published a policy statement proposing mental health competencies for pediatric primary care and recommended steps toward achieving them.⁵ The policy statement

abstract

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“Mental Health Competencies for Pediatric Practice,”⁶ accompanying this technical report, affirms and, importantly, provides updates to incorporate new science on early brain development, to articulate the pediatrician’s role in addressing social determinants of health and trauma, and to consider mental health practice in subspecialty, as well as primary care, settings.

Currently, the majority of pediatricians do not feel prepared to achieve these mental health competencies.^{7,8} Furthermore, more than half of pediatric program directors (PDs) surveyed in 2011 were unaware of the 2009 competencies, making it unlikely that training programs have enhanced their curriculum to prepare future pediatricians to achieve them.⁹ With this technical report, we aim to stimulate efforts to address these gaps by summarizing educational strategies that have been applied and could be applied to undergraduate medical education, residency and fellowship training, continuing medical education (CME), maintenance of certification, and quality improvement activities to achieve the pediatric mental health competencies proposed in the accompanying policy statement. This report also articulates research questions important to the future of pediatric mental health training and practice.

HISTORY

Deficiencies in mental health training have been recognized for more than 4 decades, and in the 1980s, the AAP first called for improved education of pediatricians in the care of children with psychosocial and mental health problems.^{10,11} Pediatric trainees and graduates since the 1980s report feeling less prepared to care for these children than they do children with other pediatric conditions.^{12,13} Surveys over 3 decades have

documented little change in their reported preparedness, despite the considerable efforts described below.^{14–16}

In 1997, the Accreditation Council for Graduate Medical Education (ACGME) mandated that all pediatric residency programs include a 4-week developmental-behavioral pediatrics (DBP) rotation.¹⁷ Completion of all 4 weeks of this rotation has had a positive effect on pediatricians’ self-reported competence, practices, and willingness to accept responsibility for providing mental health care.^{18,19} However, change in mental health practice has been modest, as measured by the AAP’s periodic surveys of members, and mental health training is still not emphasized during residency and is considered to be suboptimal per PDs.^{8,9,20,21} Advances in science have continued to demonstrate the interplay between the environment—particularly the child’s social environment—and both physical and mental health; the pervasiveness of environmental influence makes it evident that mental health training needs to expand beyond a single rotation. Well-meaning efforts to address deficiencies in mental competencies by requiring DBP rotations and/or offering clinical rotations in psychiatry may have the unintended consequence of implying that mental health is primarily the domain of DBP subspecialists or child psychiatrists.²² Ideally, mental health content and practice experiences would be integrated throughout the pediatric curriculum, during both inpatient and outpatient experiences, conveying the message that mental health competencies are integral to all aspects of pediatric practice.

AAP RESPONSES

In response to the needs of practicing pediatricians, the AAP Task Force on Mental Health (2004–2010) published a supplement to

*Pediatrics*²³ describing the rationale for enhancing pediatric mental health care, offering community-level and practice-level strategies to support enhanced pediatric mental health care, and presenting algorithms for integrating mental health care into the flow of primary care pediatric practice. The task force also published *Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit*,²⁴ providing an array of pragmatic tools to assess a practice’s capacity for providing mental health care, to build capacity when needed, and to operationalize the process laid out in the supplement. Also, within this toolkit, symptom “cluster” guidance offered a pragmatic clinical approach to addressing the common symptom constellations faced in pediatrics: anxiety, low mood, disruptive behavior and aggression, inattention and impulsivity, substance use, learning difficulty, and social-emotional symptoms in young children. This guidance has subsequently been incorporated into several publications of the AAP: *Signs and Symptoms in Pediatrics*,²⁵ *Textbook of Pediatric Care, Second Edition*,²⁶ *Pediatric Care Online*,²⁷ and *Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians*.²⁸ The AAP has also published or endorsed clinical guidelines, reports, or statements guiding the assessment and management of attention-deficit/hyperactivity disorder (ADHD),²⁹ depression,^{30,31} maladaptive aggression,^{32,33} early social-emotional problems,³⁴ early childhood trauma and toxic stress,³⁵ and substance use.³⁶

The AAP Mental Health Leadership Work Group (2011 to present), in collaboration with other AAP groups, has offered additional resources: a set of videos on using motivational interviewing (MI) to address mental health problems, e-mail notification about new publications relevant to pediatric mental health, Webinars,

a curriculum and course for continuity clinic preceptors (see below), and a Web site with mental health resources.^{37,38} Unfortunately, dissemination and evaluation of these approaches remain a challenge, and the mental health toolkit and other materials created to help pediatricians integrate mental health into their practice have not reached the majority of pediatricians.^{39,40}

RESPONSES OF ACCREDITING BODIES

Improving training and competence in mental health care for future pediatricians—subspecialists as well as primary care pediatricians—has increasingly received national attention and is now a priority of the American Board of Pediatrics (ABP).^{41,42} In 2013, the ACGME and ABP created the “Pediatric Milestones Project” to assess incremental achievement of pediatric competencies across the career span, from novice to expert.⁴³ Seventeen entrustable professional activities (EPAs)—professional units of work that define a specialty—were developed for general pediatrics.^{44,45} A number of EPAs have implications for mental health care, and one—number 9—specifically states that the general pediatrician should be able to “assess and manage patients with common behavior/mental health problems.”⁴⁵ This EPA lists the following functions expected of the pediatrician: (1) identify and manage common behavioral/mental health issues, (2) refer and/or manage patients with appropriate specialist(s), (3) know mental health resources available in one’s community, (4) know team member roles and/or monitor care, and (5) provide developmentally and culturally sensitive care. This EPA reinforces many of the mental health competencies from the 2009 AAP statement⁵ and the accompanying policy statement “Mental Health Competencies for Pediatric Practice.”

Pediatric medical subspecialty practices are at times the de facto medical home for children with chronic conditions who are at a higher risk than their peers for mental health problems.^{46,47} However, subspecialists often focus on their organ system, and studies have revealed that subspecialists are not routinely inquiring about psychosocial and mental health problems in children with chronic medical conditions or referring them for mental health care.^{48,49} Promisingly, the majority of PDs agree that all trainees, regardless of future career plans, need to be competent in identifying, referring, and managing children with mental health problems. However, only half of PDs believe trainees going into a subspecialty should be responsible for mental health treatment.⁴²

PURPOSE OF THIS REPORT

With this report, we identify gaps in mental health clinical experience and education across the training continuum and describe innovative strategies created and/or tested to improve pediatricians’ ability to care for children with mental health problems. As reflected in the material below, efforts to date have been focused mainly on pediatric residency training programs and CME efforts.

PROMISING APPROACHES ACROSS THE EDUCATIONAL CONTINUUM

Undergraduate Medical Education

Currently, the Liaison Committee on Medical Education includes communication skills as 1 of the 9 mandated areas of content.⁵⁰ Although there are no specifications as to which skills should be taught and how, medical school curricula offer opportunities to enhance physician-patient communication and professionalism. The first step in addressing any mental health concern is to engage the family and build a therapeutic relationship by using

communication skills such as MI and a “common-factors” approach, which builds on MI (see Discussion in accompanying policy statement⁶). These skills (eg, building hope, providing empathy, partnering with families, rolling with resistance, managing conflict) are necessary in all aspects of patient care and should be emphasized and taught throughout the continuum of medical education, starting with medical school.

It is essential that medical students choosing pediatrics be aware of and be prepared for their role in caring for pediatric mental health problems. The Council on Medical Student Education in Pediatrics does include pediatric behavior in its third-year competencies and objectives.⁵¹ However, whether this is emphasized and whether preceptors model the provision of care to children with mental health problems during pediatric rotations is unknown. These questions should be addressed in further study.

Graduate Medical Education

As of 2013, 68% of practicing pediatricians reported receiving no training in MI during residency training, and more than half reported receiving no training in other interviewing techniques.¹⁹ Until medical schools consistently provide this training, residency programs will need to provide it and ensure trainees’ competence in these skills, and regardless of when it is introduced, preceptors will need to model and reinforce evidence-based communication skills.^{21,42} Unfortunately, only 20% of PDs currently report that their residents receive optimal training in common-factors communication skills.²¹

It is promising that most residents believe they are responsible for identifying and referring children with mental health problems, yet few believe they are responsible for treating them.⁵² In the unified theory of health behavior change, intention is

what is most predictive of behavior;⁵³ yet for trainees and practicing pediatricians, perceived responsibility does not always lead to practicing in a way that is consistent with that perception.^{18,54} This discrepancy between intent and practice is likely the result of a learning environment that does not provide the teaching and support needed to practice the requisite skills.^{54,55} Trainees request experiential learning opportunities to care for children with mental health problems.⁵⁵ This request aligns with principles of andragogy (ie, to build self-efficacy, the clinical learning environment must provide opportunities to learn and practice skills guided by knowledgeable clinicians who can role model and demonstrate these skills).⁵⁶

In response, educational interventions have included not only curriculum development but also a variety of instructional methods: role plays,³⁸ videos,^{57,58} standardized patients (SPs),^{59,60} and training alongside mental health professionals and trainees.^{52,61,62} Successful interventions have used multimodal approaches, allowing trainees to gain knowledge and practice skills. Specifically, Fallucco et al⁵⁹ demonstrated that interns who received instruction using both didactics and SP trainings had increased knowledge and confidence in assessing for suicide compared with trainees who received only the lecture, those who received only the SP training, or controls who did not receive either of these experiences. Jee et al⁶⁰ had similar results combining case-based didactics with the use of SPs, leading to increased confidence among trainees in use of anxiety screening tools and later practices in performing a warm handoff (ie, an in-person, facilitated transfer of care from the trainee to another provider).

Additional examples highlight important caveats. One institution

created a multimodal instructional approach using role plays, cases, and SPs on screening for substance use, brief intervention, and referral to treatment, which increased trainees' knowledge and confidence in the screening technique; however, these gains declined over time.⁶³ Another institution successfully implemented a multimodal curriculum for addressing substance use using screening, brief intervention, and referral to treatment while also creating an assessment tool to measure performance. Residents improved in patient-centered discussions and identifying motives and plans when practicing skills with SPs.⁶⁴ At another institution, the combination of computer modules and SPs to teach how to assess and diagnose depression improved trainees' interpersonal skills, diagnostic skills, and confidence in treatment of depression; however, gaps in history taking and assessment for comorbidities remained.⁶⁵ These findings reinforce the need for ongoing assessment of trainees' skills and, importantly, their practice of skills to supplement curricular efforts.

As an attempt to stimulate mental health training nationally, the AAP created a curriculum and training for pediatric continuity clinic preceptors and trainees in the common-factors approach.³⁸ This curriculum was created with various teaching modalities, including videos and role plays, with flexibility in implementation so that it can be adapted regardless of program characteristics. A faculty guide was included as an attempt to provide guidance for preceptors who may not have learned these concepts already. The curriculum has been disseminated by the AAP online and at national meetings as an attempt to train preceptors to deliver the modules. However, this curriculum has yet to be evaluated, and the majority of PDs are not familiar with the contents of the AAP curriculum.⁴⁰

Trainees have stated that the most effective way they will learn to provide mental health care is for their own pediatric preceptors to model the mental health practices,⁵⁵ yet many pediatricians, including continuity preceptors, do not feel competent to serve as role models for mental health practice.^{8,20,55} As an attempt to fill this gap, more than half of residency continuity clinics have an on-site developmental-behavioral pediatrician, social worker, child psychiatrist, psychologist, or other mental health specialist.^{21,42} Although the role of these mental health specialists is not clear and likely varies between sites, PDs and residents trained in clinics with enhanced mental health services do report increased confidence and competence in systems-based practice and in coordinating and collaborating with mental health specialists.^{9,52,61,62}

One study revealed that residents training on-site with mental health professionals were more likely to identify and refer patients with ADHD and reported that having the support of an on-site professional made them more comfortable to delve into their patients' problems.⁵² However, as stated in the accompanying policy statement, pediatricians should be able to manage common mental health problems themselves, and having an on-site mental health provider has not been shown to increase trainees' practice of treating mental health problems. It is necessary to clarify the role of on-site mental health professionals as teachers rather than simply referral sources; their purpose is to increase the knowledge and skills of trainees and preceptors rather than offer them a way to avoid caring for mental health issues that are within pediatricians' scope of practice. Further study is needed to delineate how an on-site mental health professional can best impact practices because there are currently no

financial structures to support them as preceptors without direct patient care responsibilities.

Study of successful integrated models has underscored the importance of preparing behavioral health providers to work within a primary care culture—for example, accommodating interruptions for consultation, participating in interdisciplinary meetings for peer-to-peer problem solving, and allowing unscheduled time for collaboration with other team members on unanticipated behavioral health issues.⁶⁶

Educational resources, including well-developed competencies, are available to guide mental health/substance use professionals in serving as primary care team members, comanagers, or consultants.⁶⁷ Some psychiatry residency programs and a number of other mental health professional programs have started training licensed mental health trainees in integrated programs (ie, programs that combine mental health and primary care services in a single site).^{68,69} One innovative program providing interdisciplinary training is the “buddy system,” in which pediatric and mental health trainees were paired to teach skills in integration and collaboration; its premise is that interdisciplinary team meetings help clinicians from different backgrounds to develop and understand each other’s work and services.⁷⁰ Impacts of this program are currently unknown, but it will likely lead to improved skills in collaboration between primary care pediatricians and mental health specialists. In 1 pediatric residency program, having pediatric and mental health trainees see patients in the same clinic has improved collaboration skills.⁷¹

The ACGME requires 6 months of individualized learning for pediatric residents; because subspecialty-bound residents are likely to focus on their future subspecialty during this

time, this requirement may result in their receiving less training in caring for mental health problems.⁷²

Currently, the ACGME guidelines for subspecialty training in pediatrics do specify communication and interpersonal skills that are expected of all fellows, regardless of specialty, including working and collaborating as a team member, but there is no mention of providing fully integrated care that would include addressing psychosocial and mental health concerns.⁷³ Many pediatric subspecialty clinics incorporate a mental health professional as a team member, and there is likely some crossfertilization of the fellows and subspecialists who participate in these models; however, the mental health professional typically has a clinical rather than an educational role and is often stretched thin with inpatient duties.⁴⁹ Additional research is needed to address how best to prepare future specialists to integrate mental health care into their practice.

The need to improve pediatric graduates’ training in mental health has been established, and the initiatives discussed above reveal promise. However, at this point, evaluation of educational interventions has mainly been limited to self-reported confidence, competence, and practices.^{18,19,52} More assessment tools to measure competence are needed to evaluate the impact of educational innovations.⁴² It will also be important to study actual practices and patient outcomes related to educational interventions.

Education of Experienced Clinicians

Educational efforts have successfully reached experienced pediatricians, building on skills they have developed over years of working with children and families. For instance, Wissow et al⁷⁴ have demonstrated that experienced primary care clinicians (PCCs) can acquire

common-factors skills (described in the accompanying policy statement and above) and that the skills are helpful across a range of mental health conditions.^{75,76} Children treated by PCCs trained in the common-factors techniques have shown modest but significant improvement in mental health functioning, and their parents have shown reduction in distress compared with children treated by clinicians who did not receive this training.^{75,76}

Practicing pediatricians often feel that treating mental health problems is outside their scope of practice and often report that they do not have time to effectively implement psychosocial interventions.^{8,18} Brief interventions that pediatricians can learn readily and implement in a short time period may offer a solution. See the accompanying policy statement for a full discussion.⁶ Research will be necessary to develop and hone strategies for training residents and fellows in these approaches.

Several groups of mental health educators have successfully developed comprehensive training and CME programs to prepare mental health specialists and primary care professionals for their respective roles in collaborative practice.^{77–79} The AAP is collecting information about such trainings on its Mental Health Initiatives Web site (<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Collaborative-Projects.aspx>). The following are several examples:

The Resource for Advancing Children’s Health Institute offers a 3-day mini-fellowship for primary care physicians using active learning methods to teach how to improve skills in recognition, diagnosis, and treatment of children with mental health disorders. This is followed by 6 months of biweekly case

conferences. This program has changed physicians' practice patterns, as measured by an increase in the quality of referrals and a decrease in emergency department referrals, both of which can lead to decreased health care costs.⁸⁰ In New York, Project Training and Education for the Advancement of Children's Health uses the Resource for Advancing Children's Health mini-fellowship to train primary care physicians and offers a telepsychiatry consult line for support in diagnosis and management and to help find appropriate referrals. This program has trained more than 600 primary care physicians and consulted on over 8000 children and adolescents using telepsychiatry. Trained physicians felt more confident in addressing mental health problems with their patients and were motivated by the supportive and positive interactions with mental health specialists.^{77,81}

In Massachusetts, a regional network of child psychiatrists offering real-time telephone consultation and referral to PCCs in Massachusetts enhanced the capacity of PCCs to care for children with diagnostic comorbidity, complicated ADHD, anxiety, and depression.⁸²⁻⁸⁵ The Massachusetts Child Psychiatry Access Program has the resources to provide consultation and care coordination to 95% of the state's children, and in 2013, it had already served more than 10 500 children.⁸⁶ This program has been well received by pediatricians and now has expanded to offer support for mothers with depression.⁸⁷ At least 27 states have such consultation networks.⁸⁸ Congress authorized Pediatric Mental Health Care Access grants (§10002) that are modeled after the Massachusetts Child Psychiatry Access Program to support the development of new or improvement of existing pediatric mental health care telehealth access programs.⁸⁹

Clinicians may also work toward enhancing mental health competence

in maintenance of certification by using such quality improvement programs as Education in Quality Improvement for Pediatric Practice, AAP chapter-led quality improvement learning collaboratives, and development of relevant pay-for-performance and quality indicators for health plans. A growing number of educational resources developed by the AAP, the ABP, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners, the American Psychiatric Association, the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, and the American Psychological Association are available on each organization's Web site.

Even when practicing pediatricians acquire the knowledge and skills needed to integrate mental health into primary care, time and other practice barriers (culture, processes) may impede intentions from becoming practices. Building Mental Wellness was a state initiative developed by the Ohio Chapter of the AAP as a way to engage practices and primary care physicians in integrating mental health.⁹⁰ This initiative successfully taught physicians skills in prevention, identification, and management of mental health problems using online educational sessions. Importantly, this program also addressed organizational climate, culture, and care processes. Study of uptake of this program revealed that practice organization and culture were associated with the uptake of interventions, suggesting that education alone will not transform pediatricians' practices, but focus on office processes, culture, and climate is needed as well.⁹¹

The American Medical Association has suggested 10 steps to improve office culture including first diagnosing team culture by using measurement tools and brainstorming improvements and

creating processes to improve teamwork and communication to change a practice's culture.⁹² As discussed in the policy statement, thinking of a mental health concern (eg, inattention and impulsivity) similarly to fever may help clarify processes: an initial visit to assess severity and offer symptomatic care (antipyretic for fever or brief common-elements intervention such as helping parents apply effective behavioral management techniques for inattention and impulsivity), follow-up visits and further assessment possibly using objective measures if symptoms persist (a complete blood cell count for fever or a rating scale such as the Vanderbilt to assess for ADHD), targeted treatment if a diagnosis is made (antibiotics for a pneumonia or stimulants and behavioral therapy for ADHD), and referral if first-line treatment fails and/or severity worsens (the emergency department for respiratory distress or mental health specialist for complicated ADHD).

The AAP mental health toolkit, as mentioned previously, offers tools to support mental health processes in practices. Other tools have been developed and studied, such as a brief intervention for anxiety using an anxiety action plan.⁹³ Study of this tool, which is comparable to an asthma action plan, has shown it to be feasibly implemented into primary care and helpful in reducing children's symptoms. Maternal depression screening was successfully implemented into practice in North Carolina by Community Care of North Carolina through a guided Maintenance of Certification Part 4 activity that reached over 100 PCCs (www.communitycarenc.org). Outreach by regional quality improvement coordinators in 14 regions across the state and "1-pagers" for practices resulted in high rates of implementation of perinatal

depression screening (87% at all 1-month well visits, as of quarter 4, 2018). Technical assistance to practices included use of the screening tool, support resources for mothers, evidence-based dyadic therapies, referral, and follow-up. Similar progress has been seen with adolescent depression screening. Lastly, approaching mental health concerns through a stepwise approach as described through the AAP algorithm (see accompanying policy statement) can make it more feasible to implement in busy practices.

Expansion of the medical home team to include a mental health provider is financially feasible in some payment environments and clinically beneficial to patients and families.⁹⁴⁻⁹⁷ In addition, it offers PCCs the benefit of crossdisciplinary learning through experiences such as collaborative care planning, clinical problem solving, and comanagement of patients with mental health morbidities and comorbidities.⁹⁸⁻¹⁰⁰ These integrated models of care in which a licensed mental health specialist is on-site in a primary care practice have shown promise in improving access to mental health care for patients, improving patient functioning and productivity, and improving patient and provider satisfaction.^{94,100-103} The majority of mental health care is provided during well-child visits and spans the continuum from promotion, to screening, to initiation of medications.²⁸ However, simply placing a mental health specialist on-site in pediatric practices may not necessarily enhance pediatricians' own mental health skills or practice; the roles of both the mental health specialist and pediatrician(s) must be well thought out and clear to avoid inappropriate referral to the on-site mental health specialist of patients ideally managed by the PCC.¹⁰⁴ In addition, there are barriers to sustaining integrated models of care in fee-for-service plans because

productivity of the mental health professional is variable.^{102,105} As mentioned in the accompanying policy statement, systems changes are needed for pediatricians to achieve the proposed mental health competencies.

For some subspecialties, guidelines have specified inclusion of a mental health professional as a team member. For example, the International Society for Pediatric and Adolescent Diabetes "Clinical Practice Consensus Guidelines 2014" for care of children and adolescents with type 1 diabetes mellitus state "Resources should be made available to include professionals with expertise in the mental health and behavioral health of children and adolescents within the interdisciplinary diabetes health care team. These mental health specialists should include psychologists, social workers, and psychiatrists."¹⁰⁶ A recent supplement to *Pediatric Blood and Cancer* outlined 15 evidence-based standards for the psychosocial care of children with hematologic and oncologic conditions and their families, including 1 on integrating a mental health team member.¹⁰⁷ Even when such standards exist, however, there is no assurance that an integrated model can be implemented or sustained in a given clinical setting.¹⁰⁸ Additional research is needed to assess whether these models of care better integrate mental health into the care of children with chronic physical conditions.

PROMISING DIRECTIONS

Achieving the proposed competencies will require new educational approaches and evaluation of their effectiveness, as well as significant enhancement in the interest and competence of pediatric faculty members who serve as teachers and role models. On the basis of experiences described above and the

opinion of experts, the following strategies seem most promising and are offered here for the consideration of pediatric educators:

- prioritize training in common-factors communication skills for all pediatric faculty and for learners at all levels;
- incorporate the mental health competencies into curricular objectives, as described in the ABP EPA number 9, "assess and manage patients with common behavior/mental health problems,"⁴⁵ in accordance with the level of training;
- incorporate the promotion of healthy social-emotional development into the residency curriculum, including reinforcing strengths in the child and family and identifying risks to healthy social-emotional development and emerging symptoms to prevent or mitigate impairment from future mental health symptoms;
- prepare medical educators and preceptors to model, teach, and assess mental health competencies;
- consider including mental health specialists and/or developmental specialists as copreceptors and team members in teaching clinics (both general pediatric and subspecialty), inpatient rounds, and other clinical teaching settings, taking care to ensure that learners participate in mental health care, not just refer to specialists;
- consider incorporating trainees in psychology, social work, child psychiatry, DBP, and other specialties as team members in continuity and subspecialty clinics;
- consider addition of clinical experience(s) in child psychiatry to pediatric residency programs, either as a block rotation or, preferably, a longitudinal experience;
- monitor their learners' success in achieving the mental health

competencies and ensure ongoing opportunities to practice skills; and

- participate in and/or support research to answer such questions as:
 - What do medical students know about the role pediatricians play and will play in caring for children with mental health problems?
 - How much exposure is there during the pediatric clerkship to mental health promotion, primary and secondary prevention, and care of pediatric mental health problems?
 - What are the best educational strategies to change attitudes and encourage the pediatric community that mental health care is within their scope of practice?
 - What are the most effective ways to teach foundational communication skills to inexperienced as well as experienced clinicians?
 - How can common elements of evidence-based psychosocial treatments be most effectively adapted for pediatric practice? What impact do they have? How can they be incorporated into residency training and CME?
 - Which competencies are most relevant to subspecialty pediatric practice and therefore necessary to residency and/or fellowship training?
 - How can achievement of competence in providing mental health care be assessed within the context of residency and fellowship training?
 - How can practicing subspecialists be engaged in enhancing their mental health practice and improving coordination with PCCs and mental health specialists around the mental health needs of their patients?
 - Which collaborative models are most effective with respect to outcomes for children? Which are

most effective for enhancing pediatricians' competence?

- ○ How can pediatricians not currently able or motivated to enhance their mental health competence or practice best be engaged?
- ○ Will better preparing pediatricians to care for mental health problems in their practice improve the mental health care of children and reduce the societal burden of untreated mental health problems?

CONCLUSIONS

Attainment of the mental health competencies proposed in the accompanying AAP policy statement will require innovative educational methods and research as described in this report. Significant enhancement in pediatric faculty competence, medical education, pediatric residency and fellowship training, and practicing pediatricians' own educational efforts will also be needed, along with effective assessment methods to document learners' progress toward achieving the competencies. These changes will continue to require investments by the AAP and its partner organizations, pediatric educators, and pediatricians working at both the community and practice levels.

AAP RESOURCES

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;
Common Elements;
Hope, Empathy, Loyalty, Language, Permission, Partnership, Plan ("HELP") mnemonic;
Mental Health Algorithm; and
Mental Health Symptom Cluster Guidance.

Education, Training Materials, and/or Videos

AAP education, training materials, and/or videos include the following: Mental Health Residency Curriculum; and
Implementing Mental Health Priorities in Practice video series.

PUBLICATIONS AND/OR BOOKS

AAP publications and/or books include the following:

Developmental Behavioral Pediatrics; Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians; and Pediatric Psychopharmacology for Primary Care.

Reports

AAP reports include the report "Reducing Administrative and Financial Barriers."

Web Site

Web site resources include the AAP mental health Web site.

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MENTAL HEALTH LEADERSHIP WORK GROUP, 2017–2018

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ABBREVIATIONS

AAP: American Academy of Pediatrics

ABP: American Board of Pediatrics

ACGME: Accreditation Council for Graduate Medical Education

ADHD: attention-deficit/hyperactivity disorder

CME: continuing medical education

DBP: developmental-behavioral pediatrics

EPA: entrustable professional activity

MI: motivational interviewing

PCC: primary care clinician

PD: program director

SP: standardized patient

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Achieving the Pediatric Mental Health Competencies
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