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Policy Statement—The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care

abstract

Pediatric primary care clinicians have unique opportunities and a growing sense of responsibility to prevent and address mental health and substance abuse problems in the medical home. In this report, the American Academy of Pediatrics proposes competencies requisite for providing mental health and substance abuse services in pediatric primary care settings and recommends steps toward achieving them. Achievement of the competencies proposed in this statement is a goal, not a current expectation. It will require innovations in residency training and continuing medical education, as well as a commitment by the individual clinician to pursue, over time, educational strategies suited to his or her learning style and skill level. System enhancements, such as collaborative relationships with mental health specialists and changes in the financing of mental health care, must precede enhancements in clinical practice. For this reason, the proposed competencies begin with knowledge and skills for systems-based practice. The proposed competencies overlap those of mental health specialists in some areas; for example, they include the knowledge and skills to care for children with attention-deficit/hyperactivity disorder, anxiety, depression, and substance abuse and to recognize psychiatric and social emergencies. In other areas, the competencies reflect the uniqueness of the primary care clinician's role: building resilience in all children; promoting healthy lifestyles; preventing or mitigating mental health and substance abuse problems; identifying risk factors and emerging mental health problems in children and their families; and partnering with families, schools, agencies, and mental health specialists to plan assessment and care. Proposed interpersonal and communication skills reflect the primary care clinician's critical role in overcoming barriers (perceived and/or experienced by children and families) to seeking help for mental health and substance abuse concerns. *Pediatrics* 2009;124:410–421

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KEY WORDS
mental health, competencies, primary care, medical home, children, adolescents, education, training, substance abuse

ABBREVIATIONS
PCCs—primary care clinicians
DSM-PC—*Diagnostic and Statistical Manual for Primary Care*
DSM-IV—Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
CAM—complementary and alternative (integrative) medicine
AAP—American Academy of Pediatrics
ACGME—Accreditation Council for Graduate Medical Education
ADHD—attention-deficit/hyperactivity disorder

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INTRODUCTION

The purposes of this policy statement are to articulate competencies—skills, knowledge, and attitudes—needed by primary care clinicians (PCCs) to address the mental heath problems prevalent among children and adolescents in the United States and to promote use of the competencies in guiding residency education and continuing education of PCCs.

Definitions and Scope

The term "mental" throughout this statement is intended to encompass "behavioral," "neurodevelopmental," "psychiatric," "psychological," "emotional," and "substance abuse," as well as family context[1–6] and community-related concerns 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, and the grief and loss accompanying any of these issues or the illness or death of family members. The term also encompasses somatic manifestations of mental health issues, such as eating disorders and functional gastrointestinal symptoms. This is not to suggest that the full range or severity of all mental health problems falls within the scope of pediatric primary care 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, family physicians, pediatric nurse practitioners, and physician assistants provide a medical home.[7]

The *Diagnostic and Statistical Manual for Primary Care* (DSM-PC) classification system[8] distinguishes between developmental variations (behaviors that may raise concern but are within the range of expected behaviors for the age of the child), problems (behaviors serious enough to disrupt functioning but not to a level severe enough to warrant the diagnosis of a disorder), and disorders (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* [DSM-IV][9]). Because the PCC has a role in providing reassurance and/or care for children with behaviors in each of these categories, all fall within the scope of this document. Authors have used the term "concerns" when referring to behavioral issues not differentiated into 1 of these categories.

Many PCCs engage in mental health screening, assessment, diagnosis, and treatment. The term "mental health specialists" is intended to distinguish PCCs from those who specialize in the assessment and care of children and adolescents with mental health concerns. Thus, the term "mental health specialists," as used in this report, includes physicians and nonphysicians such as psychiatrists, clinical psychologists, clinical social workers, licensed professional substance abuse counselors, nurses with advanced psychiatric training, family therapists, neurologists, early intervention specialists, developmental-behavioral pediatricians, and adolescent medicine specialists. Each of these disciplines has specific training and licensing requirements. Other individuals outside the mental health profession who have an effect on the mental health of children include teachers, counselors, coaches, religious leaders, and community and extended family members. Providers of complementary and alternative (integrative) medicine (CAM), both licensed and unlicensed, also may address children's mental health, and a large number of families self-select CAM treatments for their children's mental health conditions.[10–14] A growing body of literature describes the potential benefits of CAM approaches[15–17] and risks of CAM therapies, including interactions of herbal remedies and dietary supplements with prescription medications.[18,19] Although 1 randomized, controlled trial of St John's wort was conducted with adolescents with depression,[20,21] most studies of herbal medication for mental health disorders have been completed in adults. These developments underscore the importance of knowing the medical evidence and considering CAM therapies and CAM providers in the context of pediatric mental health care.

Need for Statement

The need for this statement was driven by the following forces:

- the recognition that adverse psychosocial experiences in childhood have lifelong adverse effects on mental and physical health and on psychosocial status[22–25];
- the high prevalence of mental health disorders and substance abuse among children and adolescents: an estimated 10% to 11% of children and adolescents have both a mental health disorder and evidence of functional impairment[26];
- the prevalence of children who do not meet DSM-IV criteria for a disorder but who have clinically significant impairment ("problems" in DSM-PC terminology[8]), which is estimated to be equal to twice the prevalence of children with severe emotional disorders[26–28];
- the prevalence of mental health concerns in pediatric populations[29,30];
- the recognition that fully half of the adults in the United States with a mental health disorder had symptoms by the age of 14 years[31];
- the low percentage of children receiving care for their mental health or substance abuse problems (~20%)[26,32];
- the shortage and inaccessibility of specialty mental health services,[33] especially for underserved children from low-income families who do not fall within the target population of public/community mental health services;
- the disproportionate effects of unmet mental health needs on minority populations[34];

- the recognition that unidentified mental health comorbidities, such as anxiety and depression, are a significant force driving utilization of medical services[35]; and
- the growing realization (articulated in the President's New Freedom Commission Report[36]; *Mental Health: A Report of the Surgeon General*[26]; the Future of Pediatric Education II (FOPE II)[37] study; and *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition*[38]; and by American Academy of Pediatrics [AAP] members [annual leadership forum resolutions]) that PCCs have a critical role to play in meeting children's mental health needs; in fact, at least 1 state is now requiring, by court order, universal mental health screening by PCCs for all children on Medicaid in that state.[39]

RATIONALE FOR COMPETENCIES

Uniqueness of the PCC's Role

PCCs have a role in mental health care that differs substantively from that of mental health specialists, many of whom may be unfamiliar with problems as they present in primary care. The recommended competencies reflect these differences. Children and families who seek care from a mental health specialist do so because they have recognized a mental health need or because some crisis has compelled them. Children and families seeking care at primary care offices typically have not framed the visit as "mental health"–related. They may be seeking routine health supervision, acute care for a physical complaint, help with a challenging behavior, or simply reassurance. Ideally, PCCs would elicit psychosocial and mental health concerns from children and families in each of these situations. They would find ways to support and help the family that is resistant to seeking mental health care and to recognize those emergent situations that compel an immediate intervention. If and when a family is ready to address a problem, PCCs may choose to assess and manage the child himself or herself—in roles similar to those of mental health specialists—or they may choose to guide the family toward appropriate referral sources. Whether providing mental health services alone or collaboratively, PCCs would monitor the child and family's functioning and progress in care, applying chronic care principles as they would for other children and youth with special health care needs.[40] PCCs ideally would be able to provide these mental health services within the constraints of a busy practice without compromising the efficiency and financial viability of the practice.

The Primary Care Advantage

The AAP recognizes the unique strengths of PCCs and the opportunities inherent in the primary care setting—"the primary care advantage"[41]—on which mental health competencies can build:

- a longitudinal, trusting, and empowering therapeutic relationship with children and family members;
- the family-centeredness of the medical home[1–6,42,43];
- unique opportunities to prevent future mental health problems through promoting healthy lifestyles, anticipatory guidance, and timely intervention for common behavioral, emotional, and social problems encountered in the typical course of infancy, childhood, and adolescence (as described in *Bright Futures*)[38,44,45];
- understanding of common social, emotional, and educational problems in the context of a child's development and environment[38];
- experience working with specialists in the care of children with special health care needs and serving as coordinator and case manager through the medical home; and
- familiarity with chronic care principles and practice-improvement methods.

Framework for Behavioral and Mental Health Competencies

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) initiated the Outcome Project.[46] Through it, the ACGME established competencies to serve as the framework for residency curricula, organized into 6 domains: systems-based practice; patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; and professionalism. The competencies proposed in this report build on the ACGME framework with the expectation that they will be useful in setting goals for personal and professional growth in pediatric practice, for future board certification and recertification, and for residency training. Because achievement of system changes necessarily precedes other enhancements in mental health practice, the table of proposed mental health competencies for pediatric PCCs (Appendix 1) departs from the usual ACGME sequence, which includes systems-based practice as the final set of competencies, and instead begins with competencies for systems-based practice.

Assumptions

Traditional concepts of mental health care build on the assumption that treatment must follow diagnosis of a disorder; however, this approach offers only partial help for most children with mental health problems seen in primary care—those with significant dysfunction in the absence of a specific diagnosis.[27] The primary care setting

offers the unique opportunity for patient-clinician interaction to positively influence the clinical outcome of emerging problems, problems that do not meet the criteria of a DSM-IV disorder, and mild or undiagnosed disorders ("problems" in the DSM-PC classification[8]). The proposed competencies assume that PCCs can, in many instances, have a positive effect on a child's mental health problems without knowing precisely the child's diagnosis and in situations in which the child's symptoms do not meet the criteria of a DSM-IV disorder.[47–49]

"Generic" mental health skills proposed in this report are drawn from the literature on "common factors" in mental health care—techniques used to increase patients' optimism, feelings of well-being, and willingness to work toward improvement, regardless of the specific diagnosis or problem identified.[50–56] Other skills target symptoms that occur commonly across multiple mental health problems—feelings of anger, ambivalence, and hopelessness—and the family conflicts frequently associated with these problems. These skills come from family therapy,[6] cognitive therapy,[57] motivational interviewing,[52] family engagement,[58] family-focused pediatrics,[42,43] and solution-focused therapy.[59]

The proposed competencies further assume that collaboration—among PCCs and staff members within the primary care practice and between the PCC/practice and families, mental health specialists, educators, case managers, social service workers, juvenile justice staff, and other agency personnel—is a central requirement in caring for children with mental health problems. Collaboration between PCCs and mental health specialists may take the form of a referral with formal exchange of information, a special referral relationship with regular communication, meeting(s) to discuss cases, meeting(s) of both the PCC and mental health specialist(s) with patients, or full integration of mental health and primary care services.[60] Models in which a licensed mental health specialist is integrated into a primary care practice have shown promise in improving access to services and treatment adherence, increasing efficiency and effectiveness of care, decreasing medical costs, increasing patient functioning and productivity, and improving patient and provider satisfaction.[61–64] A regional network of child psychiatrists[65] offering real-time telephone consultation and referral to PCCs in Massachusetts enhances the capacity of PCCs to care for children with diagnostic comorbidity, complicated attention-deficit/hyperactivity disorder (ADHD), anxiety, and depression. The proposed competencies reflect the importance of clinicians' staying abreast of collaborative approaches applicable to their particular setting and applying the growing body of evidence evaluating the effectiveness of various models.

A final assumption is that PCCs can expand their capacity beyond managing ADHD to care effectively for children with other commonly occurring pediatric mental health problems: anxiety, depression, and substance abuse.[63,66–68] By routinely screening for mental health problems, recognizing symptoms early, educating children and families about self-management strategies, and offering first-line treatment, PCCs have the potential to improve the lives of many children and their families who might otherwise not receive mental health care or receive care only after problems become more severe and impairing.[38] In the case of children with a chronic medical condition and comorbid anxiety and depression, mental health care may also result in improvements in their physical health and decreases in their utilization of emergency department and hospital services.[35]

PROPOSED COMPETENCIES

The proposed competencies are detailed in Appendix 1. A summary follows.

Systems-Based Practice

Systemic changes will necessarily precede other enhancements in mental health practice. Competencies in this area will empower clinicians to work with other mental health advocates toward improving the organizational and financial base of care and, with that base in place, to establish effective coding and billing practices that will sustain mental health services.[69,70]

Another skill set involves building collaborative relationships with individuals and agencies that provide mental health services and with organizations that represent youth and families who are experiencing mental illness. These relationships will enable clinicians to address service gaps, define respective roles, and coordinate services. A final set of systems-based competencies involves selecting tools and establishing systems within the practice to normalize and systematize integration of mental health and to apply medical home principles and the chronic care model to children with mental health problems.

Patient Care

Competencies in this area include clinical skills to build resilience, promote healthy lifestyles, and prevent or mitigate mental health problems in children; identify risk factors and emerging mental health problems in children and their families; screen for mental health issues; conduct an assessment of a child presenting with mental health concerns or a positive screening test; overcome barriers (perceived and/or experienced by children and their families) in seeking help for mental health

concerns; provide guidance to families on managing common behavioral problems and coping with adverse life events; and recognize mental health emergencies. A critical patient care skill is integrating child and family strengths, needs, and preferences; the use of clinicians' own skills (interpersonal, relational, assessment, diagnosis and management); and available resources into developing a care plan for children with mental health problems, involving mental health specialists when appropriate. The proposed competencies suggest that PCCs develop the capacity to provide care to children with ADHD, anxiety, depression, and substance abuse.

Medical Knowledge

This set of competencies focuses on applying current science to the mental health screening and assessment process and to decision-making about pharmacologic and psychosocial interventions in primary care. Foundational elements include the diagnostic classification of mental health variations, problems, and disorders in primary care (DSM-PC)[8] and the evidence base for screening, therapeutic interventions, and behavior change science, as applied to mental health practice.

Practice-Based Learning and Improvement

This skill set enables the clinician to set and achieve learning and practice-improvement goals. Components include development of office protocols for the assessment and care of children with mental health problems and implementation of a quality-improvement program.

Interpersonal and Communication Skills

These skills are central to effective mental health practice within the rapid pace of a primary care practice, including common-factors approaches that are effective across a range of mental health conditions (see "Assumptions"). They also encompass effective exchange of information between PCCs and others involved in the care of the child and family.[71]

Professionalism

These skills build on respect for children and their families and sensitivity to cultural differences. In addition to facilitating child-clinician and family-clinician empathic relationships, which are the heart of effective mental health practice, they enable the clinician to discuss such issues as confidentiality and his or her own professional limitations.[72,73]

RECOMMENDATIONS

PCCs should:

- partner with parents, mental health specialists, and AAP chapter and national leaders to achieve competencies in systems-based practice, such as advocating with insurers for appropriate payment, and with policy makers for funding of mental health services[74,75];
- build relationships with mental health specialists with whom they can collaborate in enhancing their mental health knowledge and skills;
- with necessary system changes in place (eg, payment, collaborative relationships), adopt the goal of achieving the full complement of mental health competencies outlined in Appendix 1;
- advocate for innovations in residency training and continuing medical education activities to increase the knowledge base and skill level of PCCs in accordance with these competencies; and
- pursue educational strategies suited to their own learning style and skill level for achieving the mental health competencies.

EDUCATIONAL STRATEGIES AND IMPLEMENTATION CHALLENGES

These competencies are put forward as goals for all clinicians who serve children. Some clinicians have achieved many, if not most, of these competencies through development of their own knowledge and skills. Some achieve competence through collaborative practice with mental health specialists, as described above. Some are just setting out to achieve competence in mental health practice.

The AAP recognizes the serious maldistribution of mental health resources for children and their families. There are many areas of the country where specialty mental health services are unavailable or inaccessible; in these settings, clinicians may feel a sense of urgency to achieve and apply the full set of mental health competencies. Where mental health specialty services are more readily available, PCCs have the opportunity to establish collaborative relationships with mental health specialist(s), such as a mental health specialists colocated within the primary care setting, a psychiatrist consulting via telephone or videoconference, a mental health specialist providing cognitive behavioral therapy to a child being treated by the PCC with an antidepressant drug, or any number of other collaborative models.[60–63] Such relationships serve to educate the PCC and enhance services to children in their mutual care.

Achieving the proposed competencies will require new educational approaches as well as systems changes. With the exception of ADHD,[76,77] little evidence is available to guide PCCs in the unique aspects of their role as mental health care providers, and few experts in mental health/substance abuse have experience practicing in busy primary care settings within the context of primary care's average 16.3-minute[78] visits and payment realities.

Strategies for Residency Education

Just as mental health practice in primary care settings is collaborative, the process of training PCCs for primary care practice will necessarily be collaborative. Content experts (eg, developmental-behavioral pediatricians, child psychiatrists, adolescent medicine specialists, clinical psychologists, nurses with advanced psychiatric training, social workers) can join with primary care experts—clinicians who are effective in delivering primary medical care and managing children's chronic conditions in partnership with families—to train the next generation of PCCs. For academic generalists who have not received mental health training, collaboration with mental health specialist(s) to train PCCs will be particularly important. This training might take the form of coprecepting in residency continuity clinics, partnering to conduct inpatient rounds, and codeveloping didactic programs. While benefiting from the content expertise of their mental health colleagues, pediatric academicians will have the opportunity to model the collaborative, multidisciplinary relationships that underlie effective mental health practice.

Data from the 2007 AAP Graduating Residents Survey suggest that completion of an elective child psychiatry rotation and more training in mental health assessment, education, and treatment related to children are associated with greater confidence in identifying and treating pediatric mental health problems.[79] Additional research will be necessary to determine which educational methodologies are associated with the best outcomes. These findings have significant implications for the apportionment of time to mental health training within pediatric residency programs. Clearly, the 1-month developmental-behavioral pediatric rotation (often shortened by vacation time) is insufficient to accommodate necessary additions to the curriculum.

Strategies for Education of Experienced Clinicians

Experienced PCCs will benefit from approaches that build on skills they have developed over years of working with children and families. Wissow et al[49] have demonstrated that experienced PCCs can, in appropriate circumstances, provide evidence-based care of children with mental health and substance abuse problems or disorders of mild severity and functional impairment across diagnostic categories. Children treated by PCCs trained in mental health communication techniques have shown modest but significant improvement in mental health functioning, and their parents showed reduction in distress, compared with children treated by clinicians who did not receive training in mental health care.[49] Additional research will be necessary to adapt these techniques to the training of less-experienced clinicians.

Collaborative office rounds have been established in various communities for the purpose of enhancing mental health knowledge and skills of PCCs and their communication with mental health specialists.[80,81] One- to 2-hour sessions typically involve psychiatrists and/or developmental-behavioral pediatricians and PCCs in a case-based discussion.

Several groups of mental health educators have developed comprehensive training to prepare mental health specialists and primary care professionals for their respective roles in collaborative practice.[82,83] The AAP Task Force on Mental Health is collecting information about such trainings on its Web site (www.aap.org/mentalhealth) and has begun the process of keying proposed educational sessions at the National Conference and Exhibition and other AAP events to the mental health competencies put forward in this document. Clinicians may also work toward enhancing mental health competence by monitoring their psychosocial care in maintenance of certification by using such quality-improvement programs as eQIPP (Education in Quality Improvement for Pediatric Practice) and developing relevant pay-for-performance and quality indicators for health plans.

The most fundamental of all the proposed mental health competencies is the capacity to assess one's own knowledge and skills in mental health care and to establish a mechanism to update them, addressing the gaps that inevitably accompany gains in science. A growing number of educational resources developed by the AAP, 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 their respective Web sites (Appendix 2). A powerful educational strategy is the cross-fertilization that occurs through a PCC's relationship with mental health specialists—authentic collaboration in the assessment and management of children in their mutual care and regular exchange of information about the child's and family's progress. This type of collaboration, together with openness to applying new science, will be essential for achieving and maintaining competence in mental health practice.

CONCLUSIONS

Attainment of the mental health competencies proposed in this report is a future goal, not a current expectation. It will require systemic changes,

new methods of financing, practice enhancements, new (or honed) skills, access to reliable sources of information about existing evidence and new science, and innovative educational methods. These changes will be incremental and will require substantial investments by the AAP and its partner organizations and by clinicians working at both the community and practice levels. Gains are also likely to be substantial, including the improved well-being of children and their families and enhanced satisfaction of PCCs.

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APPENDIX 1 Proposed Mental Health Competencies for Pediatric PCCs

"Systems-based practice": clinicians providing primary care to children and adolescents should be able to do the following

"Improve the organizational and financial base of care"

1. Apply collaborative strategies applicable to advocating with insurers and payers for appropriate payment to PCCs and mental health specialists for their mental health services
2. Utilize appropriate coding and billing practices to support mental health services

"Build community collaborations"

3. Establish collaborative relationships with support groups; professionals available within the community (eg, early intervention specialists, school personnel, child care professionals, mental health specialists); and/or community agencies (eg, departments of social services, juvenile justice system, nonprofit agencies providing mental health and substance abuse services to children and families) and define respective roles in assessment, treatment, coordination of care, exchange of information, and family support
4. Participate in multidisciplinary meetings, appropriately applying such skills as reflective listening, mediation, and leadership skills
5. Apply collaborative approaches involving parents and mental health specialists to advocate for services and educational resources relevant to the full range of children's/adolescents' and families' mental health needs, including those of special populations, such as abused children, children in foster care, homeless children, children of international political refugees and other recent immigrants, children with physical or mental disabilities, children displaced by disasters, children of separated and divorced parents, children of parents deployed for military service, and youth involved in the juvenile justice system

"Enhance the practice"

6. Establish systems within their practice to support mental health services; elements include
   a. a directory of mental health and substance abuse referral sources and family support resources in the region
   b. established procedures for
      promoting healthy lifestyles, including exercise, sleep, optimal nutrition, stress management, decreasing exposure to environmental toxins and stressors, and seeking support within the community
      eliciting a history of patients' involvement in mental health specialty care
      requesting consent to collect information from collateral sources such as mental health professionals, schools, and social service agencies
      obtaining and documenting the child's and family's psychosocial history
      managing psychiatric emergencies
      screening for occult mental health problems
   c. registries of patients with mental health problems (including children for whom psychopharmacologic agents have been prescribed and children/families not prepared to take action on mental health concerns)
   d. evidence-based protocols and monitoring/tracking mechanisms for the care of children with mental health problems
   e. culturally and linguistically appropriate educational materials on mental health topics for children and families
   f. tools for facilitating coding and billing specific to mental health
7. Establish a practice environment that normalizes integration of mental health and incorporates medical home principles for the care of children with mental health concerns as for children and youth with other special health care needs

"Patient care": clinicians providing primary care to children and adolescents should be able to do the following

1. Promote mental health resilience through reinforcing child and family strengths and counseling families in healthy lifestyles (eg, nutrition, exercise, play, limited screen time, sleep, family time, stress management, decreased exposure to environmental toxins, and promotion of social capital)
2. Integrate a brief psychosocial update into acute care visits
3. Select, use, and interpret tools appropriate to the primary care setting for such purposes as screening for mental health problems, functional assessment of children and families, collection of information from collateral sources (eg, schools, agencies, juvenile justice system, other health professionals), and diagnostic assessment
4. Conduct history, physical assessment, and observations of parent-child interaction indicated by presenting mental health concerns and/or positive screening test(s) results
5. Differentiate normal behavioral variations, mental health problems and disorders, physical conditions with mental health manifestations, and adverse medication effects
6. Identify potential behavioral, mental health, and/or learning differences/problems reflected in report cards, academic test results, Individualized Family Service Plans, or Individualized Education Plans
7. Recognize common mental health comorbidities in children with physical and cognitive disabilities, chronic medical conditions, and mental health disorders
8. Plan diagnostic assessment, alone or in collaboration with mental health specialists, of children and youth with special health care needs who have comorbid mental health issues; infants and young children manifesting difficulties with communication and/or attachment; and children and adolescents presenting with anxious or avoidant behaviors, inattention and hyperactivity, depressive or withdrawn behaviors, oppositional or aggressive behaviors, problems with eating, substance use, exposure to trauma or loss, learning differences, and poor academic performance
9. Analyze results from mental health screening, history, and physical assessment to determine a child's/family's need for further assessment and/or intervention
10. Provide guidance to families on managing common mental health problems; on coping with adverse life events such as parental separation and illness or death of a loved one; and on use of educational resources appropriate to their literacy level and cultural and individual needs
11. Recognize mental health emergencies, severe functional impairment, and complex mental health symptoms that require mental health specialty care
12. Assist families in seeking and using care of a mental health specialist and/or facility that provides evidence-based services appropriate to a child's/family's needs and preferences
13. Develop a contingency or crisis plan for a child or adolescent with an urgent mental health problem
14. Apply strategies to monitor adverse and positive effects of nonpharmacologic and pharmacologic therapy
15. Integrate child/family strengths, needs, and preferences; clinician's own skills; and available resources into development of a care plan for children with mental health problems, alone or in collaboration with mental health specialists (including further assessment; child/family education about the condition[s]; evidence-based nonpharmacologic and, if indicated, pharmacologic interventions; communication with family and collaborating professionals; monitoring mechanisms; and routine health supervision)

APPENDIX 1 Continued

16. Initiate the process of care, alone or in collaboration with other clinicians, for children experiencing functional impairment from ADHD, anxiety, depression, or substance use/abuse, as desired by the child or family

"Medical knowledge": clinicians providing primary care to children and adolescents should be able to do the following

1. Access current data about the safety and efficacy of common pharmacologic and psychosocial interventions in children and adolescents
2. Access current data about interactions between prescription drugs and dietary supplements commonly used for mental health problems
3. Apply the DSM-PC criteria for the diagnoses of ADHD, major depressive disorder, and other disorders for which the clinician considers pharmacologic therapy
4. Use evidence-based interventions for children and adolescents with anxiety disorders (including posttraumatic stress disorder), ADHD, depression, and substance abuse
5. Apply principles of behavior-change science to mental health practice

"Practice-based learning and improvement": clinicians providing primary care to children and adolescents should be able to do the following

1. "Identify strengths, deficiencies, and limits in one's own knowledge and expertise" concerning mental health and substance abuse assessment and care
2. "Set learning and improvement goals"
3. "Identify and perform appropriate learning activities"
4. "Locate, appraise, and assimilate evidence from scientific studies related to their patients' problems"
5. "Use information technology to optimize learning"
6. Apply learning to development of office protocols for the assessment and care of children with mental health disorders
7. "Systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement" in mental health care

"Interpersonal and communication skills": clinicians providing primary care to children and adolescents should be able to do the following

1. Elicit mental health concerns from a child or adolescent and family
2. Explore the cultural context of a child and family's symptoms or concerns
3. Collaborate with child/adolescent and family to establish the agenda for an outpatient visit involving a mental health issue
4. Identify and address barriers preventing a child and/or family from seeking or accepting help for a mental health problem (eg, sense of hopelessness, inadequate insurance or financial resources, family conflict, stigma)
5. Manage resistance or anger in child/adolescent and/or family
6. Apply motivational interviewing techniques, family engagement strategies, and behavioral contracts to seek consensus on a mental health plan of action and to prepare the family for a mental health consultation
7. Interpret to families current evidence related to the safety and efficacy of relevant therapeutic options
8. Promote healthy lifestyles that contribute to mental health
9. "Communicate effectively with physicians, other health professionals, health-related agencies" and educators in the mutual care of children and adolescents
10. Clarify and discuss psychological test results, mental health findings, and concerns to children, adolescents, and families in language that is appropriate for age, education level, and cultural norms
11. Bring a mental health visit to a close in a supportive, efficient manner

"Professionalism": clinicians providing primary care to children and adolescents should be able to do the following

1. "Demonstrate compassion, integrity, and respect" for all children and family members
2. Demonstrate sensitivity to cultural differences and family preferences in addressing mental health concerns
3. Establish clear expectations in children, adolescents, and their families about conditional confidentiality (specific to state laws), exchange of protected health information, and business practices
4. Discuss one's professional limitations in knowledge and skills as part of the referral process

The ACGME has published "general competencies," which in some cases overlap those outlined in this document but bear restatement in the context of mental health care. ACGME wording is shown in quotes. The AAP recognizes that achievement of the competencies proposed in this table is a long-term goal, requiring training and resources that have yet to be developed. The AAP is committed to the development of the resources and training needed to assist pediatricians in achieving these competencies.

APPENDIX 2 Web Resources for Treatment and Referral Decisions for Primary Care

1. American Academy of Pediatrics Children's Mental Health in Primary Care Web site. Available at: www.aap.org/mentalhealth.
2. National Institute on Drug Abuse (NIDA) (provides resources on substance abuse and mental health issues). Available at: www.nida.nih.gov.
3. American Academy of Child and Adolescent Psychiatry (AACAP) (access to practice parameters on a variety of mental health topics). Available at: www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters.
4. Hawaii State Department of Health (evidence-based child and adolescent psychosocial interventions). Available at: www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html.
5. GeneralPediatrics.com (many links, especially to child psychiatry and practice parameters). Available at: www.generalpediatrics.com.
6. National Guideline Clearinghouse (a public resource for evidence-based clinical practice guidelines; an initiative of the Agency for Healthcare Research and Quality, US Department of Health and Human Services). Available at: www.guideline.gov.
7. University of Buffalo School of Social Work (provides a description of the signs and symptoms of disorders that affect children and adolescents, as well as current evidence-based practices for each disorder). Available at: www.socialwork.buffalo.edu/conted/EBP/index.htm.
8. Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices (a searchable online registry of mental health and substance abuse interventions reviewed and rated by independent reviewers). Available at: www.nrepp.samhsa.gov.

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