# Introduction

**AUTHOR:** Jane Meschan Foy, MD, for the American Academy of Pediatrics Task Force on Mental Health

*Department of Pediatrics, Wake Forest University School of Medicine, Winston-Salem, North Carolina*

**ABBREVIATION**

AAP—American Academy of Pediatrics

www.pediatrics.org/cgi/doi/10.1542/peds.2010-0788C

doi:10.1542/peds.2010-0788C

Accepted for publication Mar 24, 2010

Address correspondence to Joy Meschan Foy, MD, Department of Pediatrics, Wake Forest University School of Medicine, Medical Center Blvd, Winston-Salem, NC 27157. E-mail: jmfoy@wfubmc.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).



**FINANCIAL DISCLOSURE:** *The authors have indicated they have no financial relationships relevant to this article to disclose.*

In 2004, the American Academy of Pediatrics (AAP) Board of Directors appointed the Task Force on Mental Health, charging it to assist pediatricians and other primary care clinicians* in enhancing the mental† health care that they provide to children and adolescents.

## BACKGROUND

The board's directive stemmed from its recognition that (1) pediatric primary care clinicians will play an increasingly important role in promoting the social-emotional health of children and providing treatment—or serving as an entry point to specialty treatment—for children and adolescents who have mental health and substance abuse problems and (2) the growth in this role will involve transformational changes in pediatric primary care practice, requiring new knowledge and skills, payment structures, collaborative relationships, office systems, and resources.

### The Growing Role of Pediatric Primary Care Clinicians in Mental Health Care

A compelling body of evidence demonstrates the enduring effects of early social and emotional experiences on the brain architecture and development of infants and young children. The evidence demonstrates the effects of these experiences, in turn, on behavior, biological stress reactivity, psychological resilience, and immunologic resistance throughout life.[1–3] Pediatric primary care clinicians have unique access to the families of young children before and after the birth of a child and, thus, are uniquely situated to foster effective nurturing by their caregivers and positive early experiences for the child. *Bright Futures* provides a framework for the integration of social-emotional care within the context of routine pediatric health supervision.[4] In addition to providing their own guidance, primary care clinicians play an important role in advocating for and linking families to parenting resources and to high-quality child care, preschool, and school pro-

*Throughout this document, the term "primary care clinicians" is intended to encompass pediatricians, family physicians, nurse practitioners, and physician assistants who provide primary care to infants, children, and adolescents.

†Throughout this statement, the term "mental" is intended to encompass "behavioral," "neurodevelopmental," "psychiatric," "psychological," "social-emotional," and "substance abuse," as well as adjustment to stressors such as child abuse and neglect, foster care, 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. It also encompasses somatic manifestations of mental health issues, such as fatigue, headaches, eating disorders, and functional gastrointestinal symptoms. This is not to suggest that the full range or severity of all mental health problems is primarily managed by pediatric primary care clinicians 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, just as children with special physical and developmental needs, are children for whom pediatricians, family physicians, nurse practitioners, and physician assistants provide a medical home.

grams, all of which may positively influence the social-emotional health of children.[5–8]

Primary care clinicians also encounter many families with concerns about their children's mental health and many children with mental health problems.

- In the United States between 9.5% and 14.2% of children from birth to 5 years of age experience social-emotional problems that cause suffering to the child and family and interfere with functioning.[9,10]
- An estimated 21% of children and adolescents in the United States meet diagnostic criteria for a mental health disorder and have evidence of at least minimal impairment[11]; approximately half of these children have significant functional impairment (severe emotional disturbance).[12]
- An estimated 16.1% of children and adolescents in the United States do not meet criteria for a disorder but have some impairment[13] ("problems" in the terminology of the *Diagnostic and Statistical Manual for Primary Care* [DSM-PC][14]).
- Fully half of the adults in the United States with a mental health disorder had symptoms by the age of 14 years.[15]
- Within primary care settings in the United States an estimated 13% of school-aged children and 10% of preschool-aged children have parents who present with "concerns" about their children, although their children are functioning reasonably well.[16,17]
- Unidentified mental health conditions such as anxiety and depression, particularly in children with chronic medical conditions, are a significant force that drives utilization of medical services.[18]

Yet, few of the children who need mental health and substance abuse services receive them—only ~20% do[12,19]—despite the fact that many psychosocial and some pharmacologic treatments have been found to be safe and effective for children.[20–23] Reasons that so few receive needed services include the shortage and inaccessibility of parenting programs and social-emotional interventions for families of children younger than 5 years[1–3,5,6,9,10,24–28]; the shortage of specialty mental health services,[29] especially in rural areas and for children from low-income families who do not fall within the target population for public/community mental health services; the shortage of school-based mental health programs and services, despite evidence of the effectiveness of many of these programs[30–32]; and the shortage or lack of awareness of emergency mental health services for children and adolescents in crisis, which causes these patients to rely on overcrowded emergency departments for care.[33,34] Minority populations suffer disproportionately from lack of access to mental health services.[35] Unmet childhood social-emotional, mental health, and substance abuse needs contribute to poor educational, social, and economic outcomes.[36–38]

As a consequence of these unmet needs, the mental health community, which is increasingly focusing its limited resources on the most severely impaired individuals, and families of children with mental health needs are looking to primary care clinicians as a source of mental health care and a gateway to mental health care. The opportunity—and urgency—for primary care clinicians to fulfill these roles was articulated in the President's New Freedom Commission report,[39] *Mental Health: A Report of the Surgeon General*,[12] and the Future of Pediatric Education II[40] study. In multiple resolutions to the AAP Annual Leadership Forum, AAP members expressed their need for assistance in fulfilling these roles.

## The Transformation of Primary Care Practice

The forces described above will transform pediatric primary care practice. The Task Force on the Vision of Pediatrics 2020 estimates that by the year 2020, mental health care will constitute a significant part of general pediatric practice. Primary care clinicians' role in mental health care will differ substantively from that of mental health specialists, many of whom may be unfamiliar with problems as they present in primary care. 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 often have not framed the visit as related to "mental health." They may be seeking routine health supervision, acute care for a physical complaint, help with a challenging behavior, or simply reassurance. Ideally, primary care clinicians would elicit psychosocial and mental health concerns from children and families in each of these situations. They would find ways to support and help families that are resistant to seeking psychosocial intervention or 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, primary care clinicians may choose to assess and manage the child themselves—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, primary care clinicians would ideally monitor the child and family's functioning and progress in care, applying chronic care principles

as they do to other children and youth with special health care needs. Primary care clinicians would ideally 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.

### Unique Strengths of Primary Care Clinicians

The AAP recognizes the unique strengths of primary care clinicians and the opportunities inherent in the pediatric primary care setting ("the primary care advantage"[41]):

- a longitudinal, trusting, and empowering therapeutic relationship with children and family members;
- the family-centeredness of the medical home[42–49];
- unique opportunities to prevent future mental health problems through promoting healthy lifestyles, reinforcing strengths in the child and family, recognizing adverse childhood experiences and stressors associated with social-emotional problems, offering anticipatory guidance, and providing timely intervention for common behavioral, emotional, and social problems encountered in the typical course of infancy, childhood, and adolescence (as described in *Bright Futures*)[4,50,51];
- an understanding of common social, emotional, and educational problems in the context of a child's development and environment[4];
- experience working with specialists in the care of children with special health care needs and serving as coordinator and care manager through the medical home; and
- familiarity with chronic care principles and practice-improvement methods.

### Barriers to Primary Care Change

Primary care clinicians experience many barriers to providing mental health services, including discomfort with their knowledge and skills, time constraints, poor payment, limited access to mental health consultation and referral resources, and administrative barriers in insurance plans.[52,53]

## WORK OF THE TASK FORCE ON MENTAL HEALTH

The task force set 3 goals toward its purpose of assisting primary care clinicians in enhancing their provision of mental health care.

### Goal 1: Facilitate System Changes

Improving children's mental health requires primary care clinicians and their respective professional organizations to adopt a population perspective, to work collaboratively with other stakeholders, and to understand and participate in changing system characteristics such as financing, availability of mental health specialty care, communication mechanisms, and stigma.

Recognizing that financing is a central issue in improving mental health care, the task force worked with committees and staff within the AAP to incorporate mental health issues into an advocacy agenda that targets federal government policy makers, major private insurers, and major insurance purchasers. The AAP played an active role in influencing the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. This law requires parity of mental health and physical health benefits in group health plans that provide mental health or substance abuse benefits and insure 50 or more employees, regardless of whether the plans are self-funded (regulated under the Employee Retirement Income Security Act) or fully insured (regulated under state law). Together with a number of partner organizations, the AAP also addressed problems such as policies that prevent primary care clinicians, developmental-behavioral pediatricians, and adolescent specialists from serving as mental health providers in insurance plans; absent or insufficient payment to primary care clinicians for mental health screening and assessment, treatment of children with emerging problems or impairing mental health problems that do not rise to the level of a diagnosis, and, in many plans, even for treatment of children with mental health diagnoses; lack of payment to primary care clinicians (and other mental health providers) for time spent with parents or teachers and for the many non–face-to-face aspects of mental health care and consultation; lack of pediatric expertise among mental health providers in insurance plans; and the absence of policies that require communication from mental health providers to primary care clinicians about children in their mutual care. The task force worked with colleagues from the American Academy of Child and Adolescent Psychiatry to develop an article that was published in *Pediatrics* in April 2009.[53] It provided recommendations to insurance purchasers, payers, and managed behavioral health organizations and addressed a set of key impediments that primary care and specialty clinicians encounter when providing mental health services to children and adolescents. This article was disseminated to public and private health plan carriers and employer groups. The AAP also continues to advocate to payers for coverage and appropriate payment for developmental screening as recommended in *Bright Futures*.

To facilitate chapter- and state-level efforts to effect systemic changes, the task force disseminated the *Strategies*

*for System Change in Children's Mental Health: A Chapter Action Kit*[54] (also available at www.aap.org/mentalhealth) to AAP chapter leaders in September 2007.

In the first article of this supplement,[55] the task force proposes strategies that primary care clinicians can use with their partners at the community level, collectively, to foster resilience in children, to address factors that increase children's risk of developing mental health problems, to enhance or expand services, and to facilitate systemic changes that foster collaboration between primary care clinicians and others who are important to children's mental health and care.

### Goal 2: Build Skills

Enhancing mental health practice in primary care settings will depend on primary care clinicians' and their staff's acquiring not the same skill set of mental health professionals but, rather, complementary skills, built on primary care clinicians' unique strengths, role, opportunities, and setting. To coordinate efforts toward this goal, the task force collaborated with the AAP Committee on Psychosocial Aspects of Child and Family Health to identify the competencies requisite to providing mental health services in the primary care setting. A policy statement that outlines the recommended competencies was published in *Pediatrics* in July 2009.[56] By highlighting these mental health competencies, the task force hopes, over the long-term, to provide educational goals for residency training and recertification; in the near term, the task force has developed a number of educational programs keyed to the competencies (eg, educational sessions for the AAP National Conference and Exhibition and a PediaLink module).

### Goal 3: Incrementally Change Practice

The task force envisions that primary care clinicians, by achieving changes in community systems and acquiring (or honing) skills, will gain the capacity to make practice enhancements necessary for effective mental health care. These enhancements are described in the second article of this supplement.[57] They involve, first and foremost, the application of "medical home" or chronic care principles to the care of children with identified psychosocial problems and mental health disorders, as they would to the care of children with other special health care needs such as asthma or diabetes. Mechanisms include support for self-management and family management; registries of children with mental health conditions; office protocols to guide decision-making, care, and monitoring of these children; and effective, appropriate use of validated functional assessment and mental health screening tools.

With practice enhancements in place, primary care clinicians can implement a process for mental health care that builds on their unique opportunities to assist families in building strength and resilience in their children; to recognize psychosocial stressors and emerging social-emotional and mental health problems; to provide mental health services in the medical home; to serve as an entry point for youth and families seeking, or in need of, parent training, social-emotional support, early intervention services, or specialty care; and to coordinate care for those children with chronic mental health conditions, as they would for other children with special health care needs. This process, represented in algorithms annotated with the procedure codes applicable to each step, is the subject of the final article in this supplement.[58]

In addition to its publications, the task force maintains a Web site at www.aap.org/mentalhealth. Through this site, readers will find descriptions of innovative primary care practices that incorporate mental health services, educational and funding opportunities relevant to mental health, up-to-date clinical guidance for the primary care practice of common mental health and substance abuse conditions, information about the clinical toolkit created to complement the task force publications, and other resources.


## ACKNOWLEDGMENTS

The task force acknowledges with gratitude the involvement of a number of other organizations in developing and disseminating its products: American Academy of Child and Adolescent Psychiatry, American Psychological Association, Centers for Disease Control and Prevention, Child Neurology Society, Health Resources and Services Administration's Maternal and Child Health Bureau, National Alliance on Mental Illness, National Association of Pediatric Nurse Practitioners, National Association of Social Workers, National Medical Association, Society for Adolescent Medicine, Society for Developmental-Behavioral Pediatrics, and Substance Abuse and Mental Health Services Administration.

The 2005–2009 AAP Task Force on Mental Health included Jane Meschan Foy, MD (chairperson, lead author), Paula Duncan, MD, Barbara Frankowski, MD, MPH, Kelly Kelleher, MD, MPH, Penelope K. Knapp, MD, Danielle Laraque, MD, Gary Peck, MD, Michael Regalado, MD, Jack Swanson, MD, and Mark Wolraich, MD; the consultants were Margaret Dolan, MD, Alain Joffe, MD, MPH, Patricia O'Malley, MD, James Perrin, MD, Thomas K. McInerny, MD, and Lynn Wegner, MD; the liaisons were Terry Carmichael, MSW (National Association of Social Workers), Darcy Gruttadaro, JD (National Alliance on Mental Illness), Garry Sigman, MD (Society for

Adolescent Medicine), Myrtis Sullivan, MD, MPH (National Medical Association), and L. Read Sulik, MD (American Academy of Child and Adolescent Psychiatry); and the staff were Linda Paul and Aldina Hovde.

## REFERENCES


1. Knapp LK, Mastergeorge AM. Clinical implications of current findings in neurodevelopment. *Psychiatr Clin North Am.* 2009; 32(1):177–197
2. Middlebrooks JS, Audage NC. *The Effects of Childhood Stress on Health Across the Lifespan.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008. Available at: www.cdc.gov/Ncipc/pub-res/pdf/Childhood_Stress.pdf. Accessed January 7, 2010
3. Shonkoff JP, Phillips DA, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Academy Press; 2000
4. Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
5. Nelson CA, Zeanah CH, Fox NA, Marshall PJ, Smyke AT, Guthrie D. Cognitive recovery in socially deprived young children: the Bucharest Early Intervention Project. *Science.* 2007;318(5858):1937–1940
6. Dozier M, Manni M, Gordon MK, et al. Foster children's diurnal production of cortisol: an exploratory study. *Child Maltreat.* 2006; 11(2):189–197
7. Knitzer J, Lefkowitz J. *Resources to Promote Social and Emotional Health and School Readiness in Young Children and Families: A Community Guide.* New York, NY: National Center for Children in Poverty; 2005. Available at: www.nccp.org/publications/pdf/text_648.pdf. Accessed January 8, 2010
8. Yannacci J, Rivard JC. Matrix of Children's Evidence-Based Interventions. Alexandria, VA: National Association of State Mental Health Program Directors Research Institute, Inc; 2006. Available at: http://systemsofcare.samhsa.gov/headermenus/docsHM/MatrixFINAL1.pdf. Accessed December 9, 2009
9. Egger HL, Angold A. Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. *J Child Psychol Psychiatry.* 2006;47(3–4): 313–337
10. Brauner CB, Stephens CB. Estimating the prevalence of early childhood serious emotional/behavioral disorder: challenges and recommendations. *Public Health Rep.* 2006;121(3):303–310
11. Shaffer D, Fisher P, Dulcan MK, et al. The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): description, acceptability, prevalence rates, and performance in the MECA study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *J Am Acad Child Adolesc Psychiatry.* 1996;35(7):865–877
12. US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999. Available at: www.surgeongeneral.gov/library/mentalhealth/home.html. Accessed January 8, 2010
13. Burns BJ, Costello EJ, Angold A, et al. Children's mental health service use across service sectors. *Health Aff (Millwood).* 1995l;14(3):147–159
14. Wolraich ML, Felice ME, Drotar D, eds. *The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC), Child and Adolescent Version.* Elk Grove Village, IL: American Academy of Pediatrics; 1996
15. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry.* 2005;62(6):593–602
16. Costello EJ, Edelbrock C, Costello AJ, Dulcan MK, Burns BJ, Brent D. Psychopathology in pediatric primary care: the new hidden morbidity. *Pediatrics.* 1988;82(3 pt 2): 415–424
17. Jellinek MS, Murphy JM, Little M, Pagano ME, Comer DM, Kelleher KJ. Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: a national feasibility study. *Arch Pediatr Adolesc Med.* 1999;153(3):254–260
18. Bernal P. Hidden morbidity in pediatric primary care. Pediatr Ann. 2003;32(6):413–418
19. Kataoka SH, Zhang L, Wells K. Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *Am J Psychiatry.* 2002;159(9):1548–1555
20. Evidence-Based Child and Adolescent Psychosocial Interventions. American Academy of Pediatrics Children's Mental Health in Primary Care Web site. Available at: www.aap.org/mentalhealth. Accessed April 28, 2010
21. Substance Abuse and Mental Health Services Administration. National Registry of Evidence-Based Programs and Practices (NREPP). Available at: www.nrepp.samhsa.gov. Accessed January 8, 2010
22. Evidence-Based Services Committee. Evidence-based child and adolescent psychopharmacology. Available at: http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs023.pdf. Accessed January 8, 2010
23. APA Working Group on Psychoactive Medications for Children and Adolescents. Report of the Working Group on Psychoactive Medications for Children and Adolescents: Psychopharmacological, Psychosocial, and Combined Interventions for Childhood Disorders—Evidence Base, Contextual Factors, and Future Directions. Washington, DC: American Psychological Association; 2006. Available at: www.apa.org/pi/families/resources/child-medications.pdf. Accessed April 27, 2010
24. Barnett WS. *The State of Preschool 2008: State Preschool Yearbook.* New Brunswick, NJ: National Institute for Early Education Research, Rutgers Graduate School of Education; 2008
25. Briggs-Gowan MJ, Carter AS. Social-emotional screening status in early childhood predicts elementary school outcomes. *Pediatrics.* 2008;121(5):957–962
26. Barlow J, Parsons J. Group-based parent-training programmes for improving emotional and behavioural adjustment in 0–3 year old children. *Cochrane Database Syst Rev.* 2003;(1):CD003680
27. Coren E, Barlow J. Individual and group-based parenting programmes for improving psychosocial outcomes for teenage parents and their children. *Cochrane Database Syst Rev.* 2001;(3):CD002964
28. Jones K, Daley D, Hutchings J, Bywater T, Eames C. Efficacy of the Incredible Years Basic parent training programme as an early intervention for children with conduct problems and ADHD. *Child Care Health Dev.* 2007; 33(6):749–756
29. Thomas CR, Holzer CE III. The continuing shortage of child and adolescent psychiatrists. *J Am Acad Child Adolesc Psychiatry.* 2006;45(9):1023–1031
30. National Assembly on School-Based Health Care. *Creating Access to Care for Children and Youth: School Based Health Center Cen-*

*sus 1998–1999*. Washington, DC: National Assembly on School-Based Health Care; 2000

31. Hahn R, Fuqua-Whitley D, Wethington H, et al; Centers for Disease Control and Prevention (CDC); Task Force on Community Preventive Services. The effectiveness of universal school-based programs for the prevention of violent and aggressive behavior a report on recommendations of the Task Force on Community Preventive Services. *MMWR Recomm Rep*. 2007;56(RR-7):1–12
32. Wilson SJ, Lipsey MW. School-based interventions for aggressive and disruptive behavior: update of a meta-analysis. *Am J Prev Med*. 2007;33(2 suppl):S130–S143
33. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, and Pediatric Emergency Medicine Committee. Pediatric mental health emergencies in the emergency medical services system. *Pediatrics*. 2006;118(4):1764–1767
34. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Access to optimal emergency care for children. *Pediatrics*. 2007;119(1):161–164
35. US Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001. Available at: www.surgeongeneral.gov/library/mentalhealth/cre. Accessed January 8, 2010
36. Kessler RC, Foster CL, Saunders WB, Stang PE. Social consequences of psychiatric disorders, I: educational attainment. *Am J Psychiatry*. 1995;152(7):1026–1032
37. Kessler RC, Berglund PA, Foster CL, Saunders WB, Stang PE, Walters EE. Social consequences of psychiatric disorders, II: teenage parenthood. *Am J Psychiatry*. 1997;154(10):1405–1411
38. Kessler RC, Walters EE, Forthofer MS. The social consequences of psychiatric disorders, III: probability of marital stability. *Am J Psychiatry*. 1998;155(8):1092–1096
39. Presiden'ts New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America: Final Report*. Rockville, MD: US Department of Health and Human Services; 2003. DHHS publication No. SMA-03-3832. Available at: www.mentalhealthcommission.gov/reports/FinalReport/toc.html. Accessed January 8, 2010
40. American Academy of Pediatrics, Future of Pediatric Education II (FOPE II) Project. The Future of Pediatric Education II: organizing pediatric education to meet the needs of infants, children, adolescents, and young adults in the 21st century. *Pediatrics*. 2000;105(1 suppl):163–212
41. Harris M. Rural Private Pediatric Practice Ownership and Management of a Mental Health Practice [teleconference audio file]. Elk Grove Village, IL: American Academy of Pediatrics; October 25, 2006. Available at: www.aap.org/commpeds/dochs/mentalhealth. Accessed January 4, 2010
42. Schor EL; American Academy of Pediatrics, Task Force on the Family. Family pediatrics: report of the Task Force on the Family. *Pediatrics*. 2003;111(6 pt 2):1541–1571
43. Wertlieb D. Converging trends in family research and pediatrics: recent findings for the American Academy of Pediatrics Task Force on the Family. *Pediatrics*. 2003;111(6 pt 2):1572–1587
44. Blanchard LT, Gurka MJ, Blackman JA. Emotional, developmental, and behavioral health of American children and their families: a report from the 2003 National Survey of Children's Health. *Pediatrics*. 2006;117(6). Available at: www.pediatrics.org/cgi/content/full/117/6/e1202
45. Kim HH, Viner-Brown SI, Garcia J. Children's mental health and family functioning in Rhode Island. *Pediatrics*. 2007;119(2 suppl):S22–S28
46. Beardslee WR, Gladstone TR, Wright EJ, Cooper AB. A family-based approach to the prevention of depressive symptoms in children at risk: evidence of parental and child change. *Pediatrics*. 2003;112(2). Available at: www.pediatrics.org/cgi/content/full/112/2/e119
47. Allmond BW, Tanner JL, Gofman HF. *The Family Is the Patient: Using Family Interviews in Children's Medical Care*. 2nd ed. Baltimore, MD: Williams & Wilkins; 1999
48. Coleman WL, Howard BJ. Family-focused behavioral pediatrics: clinical techniques for primary care. *Pediatr Rev*. 1995;16(12):448–455
49. Coleman WL. Family-focused pediatrics: solution-oriented techniques for behavioral problems. *Contemp Pediatr*. 1997;14(7):121–134
50. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE Project. *Pediatrics*. 2007;120(3):547–558
51. Ginsburg KR; American Academy of Pediatrics, Committee on Communications and Committee on Psychosocial Aspects of Child and Family Health. The importance of play in promoting healthy child development and maintaining strong parent-child bonds. *Pediatrics*. 2007;119(1):182–191
52. Horwitz SM, Kelleher KJ, Stein RE, et al. Barriers to the identification and management of psychosocial issues in children and maternal depression. *Pediatrics*. 2007;119(1). Available at: www.pediatrics.org/cgi/content/full/119/1/e208
53. American Academy of Pediatrics, Task Force on Mental Health; American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics. Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration [published correction appears in *Pediatrics*. 2009;123(6):1611]. *Pediatrics*. 2009;123(4):1248–1251
54. American Academy of Pediatrics, Task Force on Mental Health. Strategies for system change in children's mental health: a chapter action kit. Available at: www.aap.org/mentalhealth/mh2ch.html. Accessed January 8, 2010
55. American Academy of Pediatrics, Task Force on Mental Health. Enhancing pediatric mental health care: strategies for preparing a community. *Pediatrics*. 2010;125(3 suppl):S75–S86
56. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health. The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics*. 2009;124(1):410–421
57. American Academy of Pediatrics, Task Force on Mental Health. Enhancing Pediatric mental health care: strategies for preparing a primary care practice. *Pediatrics*. 2010;125(3 suppl):S87–S108
58. American Academy of Pediatrics, Task Force on Mental Health. Enhancing Pediatric Mental Health Care: Algorithms for Primary Care. *Pediatrics*. 2010;125(3 suppl):S109–S125

# Introduction

Jane Meschan Foy and for the American Academy of Pediatrics Task Force on Mental Health

*Pediatrics* 2010;125;S69
DOI: 10.1542/peds.2010-0788C

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

# Introduction

Jane Meschan Foy and for the American Academy of Pediatrics Task Force on Mental Health

*Pediatrics* 2010;125;S69
DOI: 10.1542/peds.2010-0788C