The Behavioral / Mental Health Crisis:
Preparing Future Pediatricians to Meet the Challenge

Association of Pediatric Program Directors (APPD)
2017 Annual Spring Meeting
Pre-Meeting Workshop

Wednesday,
April 5, 2017
8:30 am - 3:00 pm

Hilton Anaheim
Anaheim, California
July 2017

Dear Colleagues:

In recognition of the importance of ensuring that residency training prepares pediatricians to meet the growing behavioral and mental health needs of children, the American Board of Pediatrics (ABP) and the Association of Pediatric Program Directors (APPD) jointly sponsored a day-long Pre-Meeting Workshop entitled “The Behavioral/Mental Health Crisis: Preparing Future Pediatricians to Meet the Challenge” prior to the 2017 APPD Annual Spring Meeting.

This packet includes 3 items:

- **Minutes from the Pre-Meeting Workshop.** The minutes include comments generated in discussions with participants at the workshop and should not be interpreted as recommendations from either the APPD or the ABP. Rather, they represent a wealth of ideas from which program directors, chairs, and faculty or trainee champions may draw to improve training in behavioral/mental care. In addition, a PDF of all the slides from the workshop are included.

- **Resources Handout from the American Academy of Pediatrics (AAP).** Dr. Cori Green presented on behavioral/mental health resources available from the AAP at the Pre-meeting Workshop. The attached handout details these resources.

- **Article.** We also include a pdf copy of an article published in *Pediatrics* in January 2017 entitled “Pediatric Residency Education and the Behavioral and Mental Health Crisis: A Call to Action” calling for the pediatric community to partner around improving behavioral/mental health care.

We welcome your comments at abpfoundation@abpeds.org.

In hopes of a brighter future for children, adolescents, young adults, and their families!

Sincerely,

Laurel K. Leslie, MD, MPH
Vice-President, Research
American Board of Pediatrics

Julia McMillan, MD
Co-Chair, American Board of Pediatrics Strategic Planning Committee

Marshall Land, MD
Co-Chair, American Board of Pediatrics Strategic Planning Committee
1. Welcome and Introductions  Franklin Trimm, MD and Julia McMillan, MD

2. Background and Importance of Addressing B/MH in Education (Slide presentation appended)
   Dr. McMillan opened the workshop by reviewing the current state of children’s B/MH in the United States, explaining why the pediatric training community should be focused on B/MH care for children, and describing how the B/MH entrustable professional activity (EPA, #9) provides a framework for improving B/MH training.

3. The B/MH EPA (Slide presentation appended)
   Dr. Marshall (“Buzz”) Land discussed entrustable professional activities (EPAs) as a mechanism for trainee assessment.

4. TRIZ Exercise: “Stop Counterproductive Activities and Behaviors to Make Space for Innovation”
   Dr. Trimm summarized the B/MH EPA’s five functions. He then led an exercise to identify activities that impede improving B/MH training. In the first part of the exercise, he posed the question: “What could you do to ensure that your trainees will be incompetent to perform these functions?” Responses included:
   - Do not acknowledge, screen, or assess for B/MH problems
   - Focus outpatient efforts on documentation and productivity, ignoring the needs of patients
   - Allow faculty members to minimize the importance of B/MH—“That’s not our problem.”
   - Focus only on physical health issues in settings like the PICU and ED (e.g., focus only on the liver in a teenager with a Tylenol overdose)
   - Give residents rotations primarily in ICUs and emergency departments
   - Silo B/MH care by locating child psychiatry in a different place in the hospital, use separate medical records for physical and B/MH care, and manage B/MH issues exclusively in psychiatry clinics
   - Prioritize block rotations without moving toward longitudinal experiences that permit engaging with children and families over time
   - Eliminate or minimize the importance of adolescent medicine and developmental/behavioral rotations

   Dr. Trimm noted that these suggestions describe many of the current aspects of pediatric residency training, quoting Dr. Paul Batalden, a leader in quality improvement, who said: “every system is perfectly created to get the results it gets.”

   In the second part of the exercise, Dr. Trimm asked participants to write down one first step they could take back to their pediatric program to enhance B/MH training at their institution.

5. Breakout Session 1: Implementing the B/MH EPA
   Dr. Land introduced the first breakout session. Participants were asked to think through the following three questions, first individually, then with a partner, and then with their table member.
• Question #1- Which EPA #9 activities have you/your institution already implemented to train residents in B/MH?
• Question #2- Which EPA #9 activities could possibly be implemented in your program in the next 6 months?
• Question #3- What resources do you have at your institution (e.g., strategies, curriculum, assessment tools, faculty development, longitudinal experience, interprofessional training opportunities) that would facilitate implementing elements of EPA #9?

Following table discussions, Dr. Land then led a discussion of some of the barriers to implementation of EPA #9. These included the following:
• Effectiveness of co-location of pediatrician and B/MH providers depends on collaboration among staff
• Subspecialty faculty members may not see B/MH needs as “their problem”
• Need for assessment tools for both B/MH problems and for assessment of attainment of EPA #9
• Unfamiliarity with available B/MH resources
• Continuity clinic sites may be in community settings in which faculty members may prioritize efficiency and RVUs (relative value units) over teaching
• Faculty members may need education and training themselves around B/MH
• Need buy-in from leadership (e.g., department chairs, hospital CEOs)
• Inadequate interpreter availability in many communities and clinic/hospital settings for children and families from diverse settings

The group then shared results from their table discussion. Activities related to EPA #9 that some participants have already implemented in their programs (Question #1), included the following:
• Performing initial assessment for B/MH problems, including use of validated screening tools
• Initiating management for B/MH problems
• Co-managing B/MH problems with B/MH specialists
• Providing a B/MH coordinator in the continuity clinic to assist with access to B/MH services
• Identifying patients needing subspecialty B/MH services and transferring relevant information
• Identifying local resources and providing families with links to community resources, including resources for Latino patients
• Including families in decision-making
• Partnering with co-located B/MH providers
• Identifying and managing ADHD
• Screening mothers for B/MH problems
• Using simulations to teach culturally competent care
• Including social workers on multi-disciplinary rounds
• Working collaboratively with an eating disorders program
• Including psychiatry in care of inpatients
• Offering rotations and shadowing experiences in B/MH
• Including psychiatry exposure in developmental/behavior rotation
• Integrating B/MH providers in case conferences and grand rounds
• Including triple-boarded (pediatrics/psychiatry/child psychiatry) faculty in teaching program

Various participants felt that some of the following activities could be implemented in their programs in the next 6 months (Question #2), such as:
• Improving identification, management, co-management, and referral of children with B/MH problems
• Identifying B/MH services and support groups in the community
• Clarifying the roles of various B/MH providers
• Providing access to social workers in the outpatient clinic
• Integrating tools to facilitate identification/management of B/MH problems into the EMR (electronic medical record)
• Providing residents with experience with psychologists
• Teaching residents to initiate pharmacotherapy for anxiety and depression
• Providing substance abuse training
• Increasing resident knowledge of B/MH care, including cognitive behavioral therapy
• Engaging child psychiatry residency program to work with pediatric residency
• Developing a multidisciplinary autism program
• Improving relationship with schools related to IEP evaluations
• Organizing a grand rounds session with B/MH health practitioners to educate trainees on who these practitioners are, what they do, what is the wait time to be seen, what alternative resources are available, and how to fill “the gap” in treatment for children and families

Regarding Question #3, some participants indicated that they had access to resources that would facilitate implementing EPA #9, including the following:

- Access to patient assessment tools
- Access to B/MH providers
- Availability of inter-professional training opportunities
- An office of cultural competency
- Possible co-location of a B/MH provider in their general pediatric clinic
- A state-run B/MH hub that might provide tele-referral and management
- Possible faculty development opportunities with primary care faculty who are open to learning
- Buy-in from the hospital and/or clinic
- Adolescent medicine, developmental-behavioral, and child psychiatry faculty
- Improved the B/MH rotation through an enhanced outpatient experience
- Improved use of screening tools, including inpatient, outpatient, and emergency medicine
- Use of the American Academy of Pediatrics (AAP) B/MH curriculum
- Faculty to provide didactics related to B/MH care
- Triple-boarded faculty who could be imbedded in the teaching program

6. B/MH Resources - American Academy of Pediatrics (AAP) (*Slide presentation and AAP handout on training resources appended*)

Dr. Cori Green of Weill Cornell Medical College gave a brief presentation on B/MH resources available through the AAP, many of which are interactive. These resources are on the AAP website under the header “AAP Mental Health Initiatives” at www.aap.org/mentalhealth.

In discussion following the presentation, feedback around barriers to employing these resources identified several barriers:

- Lack of awareness
- “Overwhelming” number of resources makes it difficult to sort through and decide which to use
- Trainees have no time to learn and practice these skills

Suggestions included the following:

- Identify a formal faculty “champion” to sort through B/MH resources and serve as a resource to other faculty and residents
- Link faculty development to Maintenance of Certification (MOC) so that faculty receive credit for improving their teaching around B/MH and building their knowledge base regarding B/MH
• Increase practice opportunities, allowing for practice of new skills – many of the available tools are exceptional. How we train residents must change or we will not achieve our goals
• Develop a standardized national curriculum, with lesson plans, practice opportunities, and strong assessment tools (didactics alone will not be sufficient) that can be employed across disciplines

7. B/MH Training in U.S. Pediatric Residency Programs *(Slide presentation appended)*

Dr. Green shared some of her research regarding B/MH training in pediatric residency programs. She described the results of a recent AAP Periodic Survey demonstrating how few pediatricians are comfortable addressing B/MH issues. She then presented research with residents explaining their lack of interest and competence in addressing B/MH problems. Residents shared the following:

• Their comfort level is directly proportional to their faculty members’ comfort level
• Negative attitudes about caring for children and families with B/MH problems persist
• Limited opportunities exist to develop skills in continuity clinics and other sites

Dr. Green stated that the importance of co-location is increasingly recognized, and program directors whose residents participate in co-located care rate their residents as more knowledgeable about B/MH care. She pointed out, however, that this model can be problematic if residents and faculty simply refer cases to their co-located B/MH provider and never develop the skills needed to prevent, identify, and manage/co-manage B/MH issues.

Dr. Green noted that the Weil Cornell Medical College program has built on several available resources to improve training around B/MH, including the following:

• Faculty members have participated in New York’s REACH Institute curriculum, a three-day intensive educational program that includes role playing followed by six months of conference calls with a psychiatrist and pediatrician to build personal skills in managing B/MH issues. Participating faculty then become “trainers of the trainers”
• Identification of screening tools and incorporation into the organization
• Her own research, which has focused on the domains in the “unified theory of behavior change”, including intention and perception of responsibility, self-reported practices, organizational barriers, etc.

Her research results reinforced the comments workshop participants made earlier in the day, including the importance of:
• Committed preceptors
• Co-located B/MH staff who are committed to teaching and available to residents when they are seeing patients
• Incorporating programs like Healthy Steps into care
• Community resources to which patients can be referred

8. Panel Discussion: Incorporation of B/MH Training *(Slide presentations appended)*

Panelists: Lynn Garfunkel, MD, University of Rochester School of Medicine; Janet Serwint, MD, Johns Hopkins School of Medicine; Molly Broder, MD, Albert Einstein School of Medicine; and Keith Ponitz, MD, Case Western Reserve
Moderator: Laurel Leslie, MD

Panel members described how B/MH training is being incorporated into their programs.
Dr. Garfunkel (University of Rochester) described the co-training of pediatricians and clinical psychology trainees (a 2-year post-doc training in family systems) at her institution. Conferences include both trainee types as well as faculty, nursing staff, and others. The curriculum specifically addresses how to collaborate and how to refer. Psychology trainees can see patients short-term with the resident or long-term without the resident and “teach” in the moment. There is joint supervision by psychology and general pediatrics attendings. The evaluation results have demonstrated a positive impact on teaching. Additional changes implemented in response to evaluations have included: 1) use of a psychologist during the developmental-behavioral pediatrics (DBP) rotation, 2) monthly morning report facilitated by psychologist, 3) QI/research projects in DBP and B/MH, 4) incorporation into subspecialty practice, 5) mindfulness, 6) parent engagement, 7) faculty development, and 8) linkage to other efforts like “Autism Echo”, an interactive program that includes training and mentoring with an autism specialist.

Dr. Broder (Albert Einstein) highlighted several approaches implemented in her program, including in the continuity clinic, a longitudinal lecture series, inclusion of a weekly behavior clinic with co-located B/MH providers during the DBP rotation, an adolescent medicine rotation, and a two-week outpatient child psychiatry elective. One major initiative is the “Bronx Behavioral Health Integration Project” (BHIP), which is now found in all Montefiore Medical Group pediatric sites. Residents use screening tools that target children ages 0-21 and their parents, and a social worker triages the referral using an age-based protocol, making referrals to social work, psychology, or psychiatry. Child psychiatry co-manages the process along with the residents. Residents have inpatient and outpatient experiences in B/MH care, develop comfort working with other disciplines in a team, and, thus, ensure availability of B/MH services for their patients in clinic. Areas for improvement include 1) ensuring that all residents access inpatient opportunities, 2) scheduling residents and child psychiatry faculty together, and 3) ensuring that all continuity clinic faculty are comfortable with medications. To address the third concern, they have initiated collaborative B/MH office rounds for faculty.

Dr. Ponitz (Rainbow Babies and Children’s Hospital; Case Western Reserve) will launch a formal B/MH program for residents in July 2017. Rainbow used “asthma” to model the program by asking, “how is it that residents learn to manage asthma?,” and realized asthma is seen across the inpatient/outpatient settings and treated from the perspective of multiple generalists and specialists. With this in mind, the training plan includes enhancing the B/MH experience of residents in partnership with child psychiatry, exposing residents to inpatient psychiatry patients, including residents as integral members of the inpatient consult psychiatry service, embedding B/MH staff in resident continuity clinic, and providing an outpatient psychiatry longitudinal experience. A faculty champion for this effort has been identified (and funded). Other curricular elements include lectures/modules, a B/MH journal club, and scholarly activities and QI projects within B/MH. Dr. Ponitz acknowledged that evaluation of this program will be crucial to ensure its continued improvement toward the goal of improving B/MH care for children.

Dr. Serwint (Johns Hopkins) commented that the Johns Hopkins program builds on experiences during continuity clinic, DBP, and adolescent B/MH, highlighting the program’s 2-week B/MH rotation that involves multiple sites, including inpatient settings. The program has also added B/MH professionals to the morning report once each week, to highlight B/MH needs even for children admitted because of physical conditions. Co-integrated care models have been implemented, and the curriculum includes on-line training. Benefits of these measures include “de-mystifying” B/MH for residents and faculty, which increases the residents’ confidence and improves their skills regarding B/MH issues. Dr. Serwint shared their program’s evaluation data, which also included residents’ qualitative comments. The data showed that the residents had increased confidence regarding the referral process, screening for maternal depression, and other areas. Continuing challenges still needing to be addressed include: 1) ensuring residents have sufficient time to evaluate children with B/MH needs, 2) elevating the importance of B/MH issues to same level as physical health issues, 3) imbedding B/MH providers into as many settings as possible.
The discussion following the panel highlighted the need for more focus on B/MH across training settings. The following themes were noted:

- B/MH is not just a primary care issue. It needs to be addressed in intensive care units, the emergency department, and in subspecialty settings.
- If the goal is for all graduates to be able to manage B/MH issues, regardless of whether their goal is primary care or subspecialty care, a mandate will be necessary, as this training will require additional time. Without such a mandate, B/MH training can only be accomplished peripherally.
- There is a lack of clarity regarding which faculty should be responsible for teaching B/MH.
- Collecting information on what is and is not working across programs would be a good next step.
- Training child psychiatrists requires intense training and longitudinal blocks, which would make them valuable partners in learning what works best for training pediatricians.
- Residents should be provided an opportunity to learn from skilled B/MH professionals.

9. Lunch Presentation – Lawrence Wissow, MD, of the Johns Hopkins School of Medicine and Bloomberg School of Public Health (Slide presentation appended)

Dr. Wissow’s presentation focused on teaching and sustaining B/MH knowledge and skills. Dr. Wissow has received several NIMH-funded grants and developed an approach to teaching core B/MH skills efficiently to both doctors in practice and trainees. He has noticed that teaching these additional skills may in fact enhance efficient practice. He said that in his approach residents are taught to consider cases as paradigmatic problems rather than as diagnosis. He emphasized that proficiency and consistent application of these skills requires 1) the development of an underlying mindset, 2) demonstration and practice in specific situations, and 3) a clinical culture that supports the use of these skills and enables inter-professional work. Dr. Wissow pointed out that knowing about patients as individuals and engaging with them is motivating for physicians.

Dr. Wissow said that the core skills required to build/reinforce common factors in teaching include:

- Eliciting concerns
- Assessing level of function
- Addressing safety issues
- Developing a plan that the patient and family will commit to engage in

He said that the component of family engagement cannot be ignored, and that it may take some time to determine the actual underlying problem. Of those referred, he said, about half will comply with the referral, and only about half of those will return for a second visit to see a B/MH professional. Thus, engaging the family is a critical skill residents must learn. Universal interventions include:

- Psychoeducation (information, validation)
- Stress reduction and problem-solving
- Prescribing self-care that builds on strengths and resources
- Age-appropriate parenting advice

Screening: While there are benefits to screening protocols, it is important to acknowledge benefits and downsides of screening, including the potential for failure to engage and potential for misinterpretation of the results of the screen. A clinical culture that supports skill use and enables inter-professional work demonstrates the following attributes:

- Availability, responsiveness, continuity
- Mission-driven, results-oriented, participation-based
- Use of teamwork
- Flexibility
- Child life, chaplaincy, and other natural allies exist to build on as well

Nathan Blum, MD, Perelman School of Medicine, University of Pennsylvania; John Duby, MD, Wright State University Boonshoft School of Medicine; and Laura Richardson, MD, University of Seattle

Moderator: Julia McMillan, MD

Each speaker was asked to identify 3-4 steps that training programs could take to improve B/MH training. The steps identified included:

- Get commitment from the top. This can substantially improve access to key stakeholders and feasibility. Think of a story that is relevant to your chair’s specialty to encourage interest and perceived importance. Use buzzwords to get a chair’s attention: benefit to the community, patient experience, quality improvement (QI) principles (start small), value-based care
- Think broadly about how to integrate training across resident experiences, rather than in continuity clinics alone (for example, incorporating depression screening in the NICU)
- Fill the pipeline. Reconsider whether we are recruiting the appropriate people into pediatrics. Raise awareness that B/MH is a key component of pediatrics. Faculty development should not focus on generalists alone
- Know basic principles of behavior change and patient engagement; treatment will not be effective without effective engagement
- Employ evidence-based approaches to positive parenting. There are core principles of interventions for B/MH problems that should be incorporated into all residency training
- Behavior is often a form of communication. Therefore, the most effective interventions teach adaptive rather than maladaptive ways of communicating, which is often systematized into evidence-based parent training programs
- Teach consistent approaches to assessment and initial management of common B/MH conditions across primary care, inpatient, and subspecialty rotations. Consider parallels to the building blocks of asthma care. Components should be introduced as variations of the same skills rather than different skills altogether as presented in different settings. This can be facilitated with the use of common language throughout the training program
- Encourage skills in measurement and tracking of B/MH symptoms. Skills should be concrete, such as the use of screening tools like the PHQ-9, and residents should understand their role in ongoing follow-up management
- Recognize boundaries of care. Encourage trainees to ask for help and to understand boundaries and indications for subspecialty expertise. Psychiatrists do not receive as much training in normal development, which pediatricians should be able to employ to enhance care
- Provide opportunities for interdisciplinary learning

Discussion following the panel presentation included the following points:

- Advocacy cannot be emphasized enough. Lack of reimbursement is a significant barrier, and we all should feel a personal responsibility to improve this on both a state and federal level
- Modeling: Are we as physicians modeling how to take care of ourselves more effectively before we expect residents to incorporate this into practice?
- We should ensure that B/MH efforts are being directed at family-centered therapy, rather than child/patient centered treatment alone. The needs may be primarily arising from a parent, with the child’s behavior a manifestation of those problems. Health Leads is a program that screens all families for social determinants of health, and can then allow social workers to appropriately link the families to needed resources
- Maternal depression screening is common, but these efforts should be expanded
- Faculty development remains critical. How do we develop faculty who can better manage and address B/MH issues, perhaps to foster shared learning with residents across disciplines?
do we reduce stigma in which faculty fear acknowledgement of their own learning gaps and deficiencies?

- The diversity of children and families in the United States needs to be acknowledged. How can we improve care for families with limited English proficiency? This communication barrier is impairing our ability to optimally assess and engage these families in treatment.

- We need to address the fact that our residents are often learning B/MH issues with some of the most complicated patients/families in their continuity clinic settings. The solution to this level of difficulty seems to be around focusing on basic communication/interviewing skills so that residents can experience initial success prior to proceeding to addressing and managing more complicated issues.

- We must improve B/MH resilience and awareness in general among both faculty and residents.

- General pediatricians are becoming increasingly frustrated as board certification continues to become more specific and specialized, leaving us to wonder, “what am I supposed to be good at?” We need to more specifically carve out what is within the realm of general pediatrics not only for B/MH problems but in other areas as well.

- Focus on a few steps for implementing change, such as determining who are your coalition members at your institution.

- Mandates may be needed to encourage change and would need to permit flexibility.

- Not only should we focus on what residents/fellows need to learn, we should also focus on what is NOT essential for residents/fellows to learn to improve educational effectiveness and increase opportunities for face-to-face clinical care.


Participants then broke into table groups to brainstorm what was needed to implement the B/MH EPA. Following discussions, the following responses were shared in the report back.

**What do you need in your program?**

- Faculty development around B/MH
- Non-pediatric faculty involvement: making social workers, psychologists, and psychiatrists aware of the EPA and partnering with them to improve B/MH training.
- Milestones or developmental pattern for the skill sets and diagnoses in B/MH for residents, without specifying specific curricula or locus of training (e.g., could post the vignettes developed on the ABP website and possibly APPD website).
- Regional centers of excellence for pediatric B/MH training that would consult and provide formative assessment of residents/fellows in the region until the faculty have those skills.
- Faculty understanding of the milestones and EPAs and training on how to use these tools.
- All staff trained in B/MH.
- Allow staff who are not faculty (social workers, etc.) to evaluate and make observations; they may not have to “score” (the Clinical Competency Committee could), but they could provide feedback.

Additional suggestions were made by participants on index cards provided at their tables. Those suggestions have been categorized in the following list:

**Leadership/faculty:**

- Faculty champion who is a general pediatrician with passion for B/MH and who receives support from the chair.
- Chair buy-in.
- Faculty development
  - Faculty awareness of B/MH EPA.
  - Faculty development for B/MH competence and assessment, including funds to support faculty development.
Development of faculty role models

MOC for faculty development and QI collaboratives

• Adolescent specialist
• Developmental/behavioral pediatrics faculty who are invested in teaching
• Faculty buy-in
  o Expansion of B/MH teaching/learning opportunities across all electives
  o Ensure social work and child psychiatry/psychology faculty understand EPA #9
  o Ensure DBP and adolescent medicine faculty know and understand EPA #9
• Empower social workers and psychologists as faculty
• Inter-disciplinary committee involving residents, pediatric faculty, B/MH professionals
• Administration buy-in
• Regional center for excellence in B/MH

Personnel:
• Translators
• Social workers and child psychology staff in continuity clinics and funds for their support
• Social worker in subspecialty clinic

Curriculum/Assessment:
• Evidence-based curricula
• Milestones for B/MH EPA
• Protected curriculum time with specific goals
  o Education regarding medications
  o Training in psychotherapy
  o Training to screen/recognize patients at risk
  o B/MH curriculum across specialty experiences
  o Clarity regarding roles of generalist versus B/MH professionals
  o Align current rotation activities
  o Integration of mental/physical health care, e.g., psychiatry elective, psychiatry consult-liaison service
• Assessment tools (formative and summative) linked to EPA #9 milestones
• Engagement with child psychiatry for resident and faculty education
• Enhanced collaboration with B/MH providers; inter-professional training
• Engage faculty/residents/faculty together to learn and teach B/MH
• Asset mapping of what is covered and where

Systems:
• Funds to support B/MH visits and time for B/MH visits
• Mid-levels to replace residents on redundant inpatient rotations
• Enhance resident time for direct patient care
• Coordination with community resources and providers
• Enhance expertise in billing for behavioral health services

Other:
• Publicize EPA #9 and export to MedHub/eValue for assessment
• Family engagement
• TIME
• Access to Mental Health Toolkit and Bright Futures without charge
• Change in culture—reduce stigma
• Add B/MH issues to the “review of systems"

What could the APPD and ABP do to help?
• Support for some sort of some mutual support network around implementing change (e.g., national collaborative (with Part 4 credit) to improve B/MH training; national monthly call with mentoring coach)
• The ABP certifying exam does not test whether you displayed empathy with a child and family; how do we assess this ability?
• Advocacy for payment for pediatrics, specifically around B/MH
• Research around evidence for assessing B/MH and pay-off
• Advocate for greater accessibility of AAP tools
• Encouragement that B/MH is both a primary care and subspecialty skill set
• Data collection regarding experience/competence in B/MH care in ACGME annual resident survey
• Faculty development toolkit developed that all programs could use
• Training in how to do assessments and implement the B/MH EPA, specifically, and all the EPAs generally

What changes in the Review Committee Requirements would help you?
• Continuity clinic: possibility of switching to the model that Internal Medicine is using which has intact inpatient/elective followed by a week of outpatient (continuity clinic, adolescent, DBP, B/MH) and permit more longitudinal experiences. Would need to change the requirement that continuity clinic be no less than 26 weeks or allow flexibility
• Value of assessing B/MH and well-being of patients and families across residency and fellowships. Grander vision is to move it across all ACGME and not just pediatrics
• Incorporate B/MH language into the subspecialty fellowship requirements
• How do we do encourage greater focus on B/MH without focusing on specific diagnoses? Could focus on staffing requirements for programs
• ACGME resident survey asks if comfortable with intubations. What about adding some additional questions about B/MH?
• Consider a flexible mandate

12. Wrap-up and Next Steps by Julia McMillan, MD
Participants were asked to contact Linda Paul (AAP) if interested in testing new AAP modules and Cori Green (Cornell) if interested in concept mapping around what needs to be incorporated into training. The ABP plans to study barriers and facilitators to implementing EPAs including the B/MH EPA to understand how to better embed them into the resident/fellow training experience. Participants may contact Carol Carraccio or Laurel Leslie if interested.

Respectfully submitted,

Laurel K. Leslie, MD, MPH
Vice President, Research

/lkl
Attachments
Appended Slides
The Mental Health Crisis: Preparing Future Pediatricians to Meet the Challenge

Sponsored by The American Board of Pediatrics Foundation and the Association of Pediatric Program Directors

The Mental Health Crisis: Background and Importance

Julia McMillan, MD
ABP/APPD Meeting
April 2017

Introductions

- Julia McMillan, MD
  - Pediatrician who served as residency program director at two institutions for over 25 years.
  - Professor Emerita at Johns Hopkins School of Medicine
  - ABP Consultant for the Mental Health Initiative

- Dr. Marshall Land, Jr., MD (Buzz)
  - General pediatrician who was in private practice for 40 years
  - Professor of Pediatrics at University of Vermont School of Medicine
  - ABP Consultant for Strategic Planning, Maintenance of Certification, Communication, and Testing

- Laurel K Leslie, MD, MPH
  - Developmental-behavioral pediatrician
  - Professor of Medicine and Pediatrics at Tufts University School of Medicine
  - ABP Vice President, Research

Disclosures:

- I have nothing to declare
- I have no relevant financial disclosures other than my consultancy with the ABP

Behavioral and Mental Health in Childhood: An Urgent Problem

- 10-14% of children <5 years experience social-emotional problems that interfere with functioning
- 20% of children and adolescents in the U.S. meet diagnostic criteria for a mental health disorder
- Half of adults in the U.S. with mental health disorder had symptoms by 14 years of age
- Hospitalization for mental health conditions increased by nearly 50% for 10-14 year olds between 2006 and 2011
From the mother of a child with hypoplastic left heart syndrome:

"In the 22 years of navigating a life-threatening, complex, and chronic medical condition with my son, I was never asked how my son or I was doing from a mental health perspective and was never proactively offered support in this area. It would have been profoundly helpful to have had those issues addressed and to have had the importance of mental health care normalized and integrated into his physical care..."

"...I can now say that having had such support and care might have prevented a great deal of heartache and challenges that we have and continue to struggle with, many of which have been far more difficult than having a single ventricle and immune deficiency. I believe that the individual in the best position to help us with these issues would have been his pediatrician..."

"...Yet, I cannot in any way expect even the most qualified pediatrician to be prepared to do so without proper training, something I can only imagine is woefully lacking in medical school and residence currently."

Behavioral and Mental Health in Childhood: An Urgent Problem

- During the decade between 2001 and 2011, childhood disability related to developmental or mental health conditions increased by 20.9%, while the prevalence of disability attributable to physical health conditions declined by 11.85%
- Suicide is the second leading cause of death among 10-25 year olds
- Suicide is the second leading cause of death among 10-14 year olds

Why is the gap in behavioral and mental health care important?

- Number of children and youth affected
- Effect on families
- Stigma
- Ineffective preparation of pediatricians
- Systems of pediatric practice don’t support mental health/behavioral health care
  - Time, reimbursement, personnel (including referral resources)
  - Inadequate number and distribution of non-pediatrician providers
AAP Periodic Survey, 2013

• 65% of the 512 pediatricians surveyed indicated they lacked training in the treatment of children and adolescents with mental health problems

• 40% lack confidence to recognize MH problems

• >50% lack confidence to treat MH problems

• 44% not interested in treating, managing, or co-managing child mental health problems

This is not a new problem!!!

• 1978: Future of Pediatric Education Task Force Report called for residency programs to provide more training in behavioral, developmental, and adolescent issues, to improve physicians’ skills in working with other health professionals.

• 2000: FOPE II, Pediatric Generalists of the Future Workgroup Report: “Extra training in children’s mental health must be provided, particularly with respect to the initial assessment, diagnosis, and treatment of common childhood psychiatric conditions and the use of pharmacotherapy and other modalities.”

Common Themes April 2016 Convening

• Pediatricians have a unique role as partners with parents to prevent, recognize and manage B/MH problems, but they need knowledge and skills and resources

• Inter-professional training models will be important, including integrated care models in clinics and other settings

• Innovative models of care have been developed, but they must be disseminated

• Available tools (eg from AAP) aren’t being utilized—why?

• Behavioral/mental health training must be a priority

Common Themes (cont)

• Non-pediatrician partners will be needed

• Faculty development will be needed

• Assessment strategies and tools will be needed

• Changing the training of pediatricians is difficult, will require innovation and significant resources

• Collaboration among societies/organizations is key

• ABP has a significant (though not the only) role in the education/training of pediatricians

Who Are You? (n=85 pre-survey respondents)

• Roles:
  • 88% Program/Associate Program Directors of Residency Training Programs
  • 31% CCC members

• Location: 85.9% rated programs as urban/urban-inner city

• Program Size (total number categorical residents):
  • 29% <30
  • 39% 31-60
  • 32% >60

• 88% interested in support network

Grading Residents and Common Childhood Mental Health Problems (CCMPS, n=80)

<table>
<thead>
<tr>
<th>Attitudes on Competencies</th>
<th>Percent Endorsing Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>If going into primary care, should be competent in identification of CCMPS</td>
<td>96%</td>
</tr>
<tr>
<td>Management of CCMPS</td>
<td>86%</td>
</tr>
<tr>
<td>Referral and co-management of CCMPS</td>
<td>96%</td>
</tr>
<tr>
<td>If going into subspecialty care, should be competent in identification of CCMPS</td>
<td>93%</td>
</tr>
<tr>
<td>Management of CCMPS</td>
<td>50%</td>
</tr>
<tr>
<td>Referral and co-management of CCMPS</td>
<td>76%</td>
</tr>
<tr>
<td>My training program is committed to ensuring graduating residents can address CCMPS</td>
<td>88%</td>
</tr>
</tbody>
</table>
### Perception of Graduating Residents’ Comfort Level *(n=77)*

<table>
<thead>
<tr>
<th>Examples of Mental Health Competency</th>
<th>Percent Endorsing Somewhat/Very Comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing anticipatory guidance around common behavioral health problems (eg, social-emotional difficulties, discipline)</td>
<td>75%</td>
</tr>
<tr>
<td>Eliciting parent/patient concerns in an empathetic manner</td>
<td>87%</td>
</tr>
<tr>
<td>Managing behavioral problems (eg, social-emotional difficulties, disciplinary issues)</td>
<td>53%</td>
</tr>
<tr>
<td>Using evidence-based tools like motivational interviewing to encourage engagement in treatment</td>
<td>36%</td>
</tr>
<tr>
<td>Identifying ADHD</td>
<td>90%</td>
</tr>
<tr>
<td>Treating depression and/or anxiety with medications</td>
<td>22%</td>
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</tbody>
</table>

### Goals for this Meeting

- Highlight the urgency of the mental health crisis and the need for action
- Identify barriers and facilitators for incorporating mental health into training programs
- Promote use of EPA #9 as the basis for program curriculum, resident experiences, and assessment

### Goals for this Meeting (cont)

- Provide examples and prompt ideas for innovative experiences
  - Incorporating parent/patient perspectives
  - Co-locating/integrating mental health professionals as part of training and care
- Encourage grass-roots networking effort by program directors to improve mental health training
- Hear your thoughts and ideas

### Envision the future for families:

“What we needed most was the physician recognition of patient/family mental health needs as part of our routine patient experience in the exam room. Then, after receiving that ‘life raft’, it would be nice to know how to get on board with tools, experts and other safe ways to help our child (and ourselves). It’s not a one-time conversation, but one that ebbs and flows over and through transition, ages and life changes. It should be normal, empathetic, and compassionate.”
Advancing Knowledge and Skills in Mental Health

Marshall Land, Jr. MD
ABP/APPD Meeting
April, 2017

Disclosures
• I have nothing to declare
• I have no relevant financial disclosures other than my consultancy with the ABP

Collaborating with APPD: Trainee Assessment
• Trainee assessment is key to determining if we are achieving our desired outcome for improving mental health care of children and youth
• Fortunately, when the Entrustable Professional Activities (EPAs) were developed, behavioral and mental health identified as 1 of the required 17
• Thanks to APPD members who wrote curricular components and reviewed and made suggested edits with input from AAP

Use of EPAs in Residency Program (n=71)

<table>
<thead>
<tr>
<th>At my residency program,</th>
<th>Percent Endorsing Agree/Strongly Agree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty who assess resident performance understand EPAs</td>
<td>28%</td>
</tr>
<tr>
<td>We have introduced EPAs into trainee assessment</td>
<td>33%</td>
</tr>
<tr>
<td>We are using EPAs to inform our CCC reviews &amp; decisions</td>
<td>27%</td>
</tr>
<tr>
<td>We are using the mental health EPA to assess residents' readiness for practice with respect to common childhood mental health problems</td>
<td>7%</td>
</tr>
</tbody>
</table>
Use of EPAs in Residency Program (n=71)

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<td>7%</td>
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</tbody>
</table>

Entreatable Professional Activities (EPAs)

- Agreed-upon list of activities within a given specialty or subspecialty that a physician should be expected to be able to perform competently and without supervision
- Milestones assessed within the context of each of those activities
- EPA #9 (of 17 EPAs for general pediatricians): Assessment and management of patients with common behavioral and mental health problems

Rationale for Using EPAs

- Provide a practical framework for assessment of competence
  - Competencies: Focus on a single task but care delivery requires task integration
  - EPAs: Focus on integration of competencies needed to deliver care
  - Bring the concept of entrustment (ready to practice without supervision) to workplace-based assessment

Five Functions needed to Carry Out MH EPA

- Identify & manage common behavioral and mental health issues including the initiation and monitoring of treatment effects for psychosocial interventions and when indicated for certain disorders, pharmacotherapy
- Refer & co-manage patients with the appropriate specialist(s) when indicated to match the patient’s needs, including pharmacotherapy

Five Functions Needed to Carry Out MH EPA

- Know the mental health resources available to patients in one’s community and utilizing the appropriate resources for each patient’s needs
- Know the role of each member of the interprofessional team and coordinate and monitor care provided outside one’s practice to optimize patient care
- Provide care that is developmentally and culturally sensitive
Competencies Critical for Making an Entrustment Decision

- Interviewing patients
- Developing management plans
- Counseling patients and families
- Demonstrating knowledge
- Communicating with health professionals
- Demonstrating cultural competence
- Coordinating care

Addressing Common Behavioral/Mental Health Issues

- Common behavioral issues
- ADHD with or without hyperactivity
- Depression or dysthymia
- Anxiety disorders
- Autism
- Normal adolescent developmental issues and conflict
- Substance use in adolescents

We Need Your Help

- Multiple challenges to address mental health care, but multiple opportunities to provide both better care and training
- Seven programs are currently trying to implement the mental health EPA so we have much to learn from them
- Some programs have attended to teaching and assessing mental health to a greater extent and we need to know what pieces can be generalized

Summary of 5 MH EPA (#9) Functions

- Identify and manage common behavioral/mental health issues
- Refer/co-manage patients with appropriate specialist(s)
- Know mental health resources available in one’s community
- Know team member roles/monitor care
- Provide developmentally and culturally sensitive care
American Academy of Pediatrics: Mental Health Initiatives

DISCLOSURES
• Residency Curriculum and Motivational Interview Video Development, AAP’s Friends of Children Fund
• Trauma Materials, Dave Thomas Foundation for Adoption and Jockey Being Family
• Resilience Project, Department of Justice Office of Victims of Crimes
• Star Center, Early screening, JBP Foundation

Personal Knowledge about AAP Mental Health Resources (n=71)

Policy Statement on Mental Health Competencies
Residency Curriculum on Mental Health
Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit

American Academy of Pediatrics
ACGME Framework: Systems-based Practice Patient Care Medical Knowledge Practice-Based Learning and Improvement Interpersonal and Communication Skills Professionalism

Mental Health Toolkit
Symptom Clusters Readiness Checklists Screening Tools Algorithms

www.aap.org/mentalhealth
**Motivational Interviewing**

**AAP Mental Health Curriculum**

**Module 1: Brief Intervention**

Utilize evidence-based approaches to engage patients and families in managing mental health concerns.

**Module 2: Anxiety**

Recognize and provide initial management for children and youth with mild to moderate anxiety in the primary care setting.

**Modules in progress**

- Low Mood
- Inattention
New project focused on screening, TA, and resources for developmental milestones, social determinants of health, and maternal depression.


Early Brain and Child Development Web site: www.aap.org/ebcd

Poverty Web site: www.aap.org/poverty


Poverty & Child Health:

Practice Tips

Screening for Basic and Social Needs and Connecting Families to Community Resources

Practice Tips can use simple screening tools that help identify families with unmet needs and referrals will help to access community resources and services.

To get started with screening:

- Simple profiles are not screening tools for basic needs, social problems, or other types of needs.
- Use this resource to help identify families with unmet needs and referrals will connect families with small community resources.

Supported Screening Tools

- The Screening Tool is not a specific tool, but it will help identify families with unmet needs and referrals will make sure that small community resources are available.

Preceptors can access materials to help in training residents to address mental health issues in their patients. [www.aap.org/mentalhealth](http://www.aap.org/mentalhealth)

These online training simulations are free to AAP members and provide participants with effective brief intervention techniques for addressing substance use and mental health concerns with adolescents.

To access, visit [kognito.com/aap](http://kognito.com/aap)

1. Create a new account
2. Follow the onscreen instructions
3. Choose your course
   Click “LAUNCH”

The Screening in Practices Initiative offers information and resources, including screening recommendations, practice tools, and individualized assistance, to help pediatric health care providers implement effective screening, referral, and follow-up for developmental milestones, maternal depression, and social determinants of health.

[www.aap.org/screening](http://www.aap.org/screening)

This required 8-hour training qualifies physicians for the waiver to prescribe Buprenorphine for treating opioid use disorder. Free for AAP members. [www.aap.org/mat](http://www.aap.org/mat)
Policy Statement—The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care

The purposes of this policy statement are to articulate competencies—skills, knowledge, and attitudes—needed by primary care clinicians to address the mental health 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 primary care clinicians.

http://pediatrics.aappublications.org/content/124/1/410.full

Free CME course

Research-Based Clinical Strategies to Prevent and Address Adolescent Substance Use and Prescription Medication Misuse—Being Part of the Solution

www.drugabuse.gov/nidamed/adolescent-substance-use-rx-drug-misuse-cmeces

AAP Toolkits

- Addressing Mental Health Concerns in Primary Care
- Autism: Caring for Children With Autism Spectrum Disorders
- Caring for Children With ADHD: A Resource Toolkit for Clinicians

https://shop.aap.org/deluxe-mental-health-toolkit-package

Mental Health Initiatives

www.aap.org/mentalhealth

Committee on Substance Use and Prevention

www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/substance-use/Pages/home.aspx

AMEERICAN ACADEMY OF PEDIATRICS

Julius B. Richmond Center of Excellence

www.aap.org/richmondcenter

Eliminating Tobacco Use and Exposure to Secondhand Smoke

Residency programs can help satisfy QI requirements with this EQIPP course. The course ensures residents receive an equal education and shared QI experience.

shop.aap.org/eqipp-eliminating-tobacco-use-and-exposure-to-secondhand-smoke
How Can We Use Education To Improve The Mental Health of Today’s Children?

Cori Green, MD, MS
Assistant Professor of Pediatrics

Disclosure
I have no financial disclosures or conflicts other than part of this work was funded by:
• The American Academy of Pediatrics CATCH grant
• APPD Special Projects Grant and a
• Weill Cornell Medical College Department of Pediatrics Clinical Pilot Grant

Future of Pediatric Education, 1978

“The 1978 Report was pivotal in addressing necessary changes for pediatric training in the late 1970s. It anticipated the need to … to incorporate more training in behavioral, developmental and adolescent issues; and to improve physicians’ skills in working with other health professionals.”

Further recommendations
ACGME, 1997
• Mandated Development and Behavior Rotation

FOPE II, 2000
• “Extra training in children’s mental health must be provided, particularly with respect to the initial assessment, diagnosis, and treatment of common childhood psychiatric conditions and the use of pharmacotherapy and other modalities.”

“1. Residency Training programs should reflect in their curricula psychosocial issues that affect children and their families.”

“5. Pediatricians are strongly encouraged to establish side-by-side practice with mental health professionals...”
What do we know about the impact of current educational interventions?

Developmental and Behavioral Pediatrics (DBP) Rotation: Training in specific skills Increases perceived responsibility and self-reported competence
Stein, et. al. 2007, 2016

Training with on-site mental health professionals: 35% per CORNET study, identified more mental health (MH) issues, no impact on treatment, Bunik et. al., 2013

AAP Periodic Survey: On-site MH providers do not ALONE change practices
Education and interest associated with co-management practices, Horwitz 2016, Green in press
**Focus Group Theme: Comfort**

A few residents described MH as “gross” or “scary.” Another resident stated, “We don’t enjoy [MH]. Just like I don’t like taking trips to the adult side.”

**Focus Group Theme: Organizational Capacity**

Residents noted that “[their] comfort level often reflects [their] attendings’ comfort levels” and that perhaps MH training needs to “start . . . higher up [with general pediatricians] and then it will trickle down to [residents].”

**Focus Groups Theme: Education**

“the most bang for our buck with . . . our own [continuity clinic] and gen[eral] ped[iatric] attendings start to manage things like that more and teach it to us . . . That certainly is the most effective way that we learn.”
**Objectives**

1) To evaluate whether perceived responsibility for inquiring and treating common MH problems (ADHD, depression, anxiety, and behavioral problems) is associated with self-reported practices.

2) To examine the relation of psychosocial orientation and perceived barriers with perceived responsibility and self-reported behaviors.

3) To examine trainee characteristics, practice characteristics, and learning experiences with perceived responsibility and practices.

**Unified Theory Of Behavior Change**

![Unified Theory Of Behavior Change Diagram]

**Methods**

**Study Design:**

- Mixed Methods

- Web-based survey of convenience sample of pediatric residents

- Focus Groups

**Setting/Sample:**

- Urban academic center where 60 pediatric residents are trained a year

- 3 continuity clinic sites, 1 with co-located psychologist for children ages 0-5
Session 7 - B/MH Training in U.S. Pediatric Residency Programs

04/05/2017

Methods Quantitative

Variables
• Provider Characteristics
• Practice Location
• Perceived Barriers in providing MH care
• Attitude
• Educational Experiences

Methods Quantitative

• Perceived Provider Responsibility in Inquiring and Treating
• Self-Reported Behaviors in Inquiring and Treating
• Mental Health Conditions
  ADHD, Depression, Behavioral Problems, Anxiety

Methods: Analysis

Descriptive statistics
Spearman’s Correlations, Non-parametrics to compare means

Quantitative Results: Subject Characteristics

n=45 (75% response rate)

Year of training
• 5 PGY1, 40 PGY2 and PGY3

Post-Residency Plans
• 56% Fellowship
• 44% Gen Peds/Other

Continuity Clinic
• 58% Main Academic Center
• 42% Community Sites

Perceived Responsibility

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>52%</td>
<td>20%</td>
<td>28%</td>
</tr>
<tr>
<td>Depression</td>
<td>98%</td>
<td>40%</td>
<td>12%</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>100%</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>100%</td>
<td>59%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Self-Reported Practices

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Inquire</th>
<th>Treat</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>60%</td>
<td>56%</td>
</tr>
<tr>
<td>Depression</td>
<td>73%</td>
<td>24%</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>84%</td>
<td>38%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>44%</td>
<td>20%</td>
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</table>
### Educational Settings

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<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
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<tbody>
<tr>
<td>Community Sites</td>
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<td>Inpatient Unit</td>
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<td>Adolescent Rotation</td>
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<td>DBP Rotation</td>
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<td>Continuity Clinic</td>
<td>-</td>
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### Influential Faculty

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<tr>
<th>Influence Source</th>
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<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
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<tr>
<td>MH professional</td>
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<tr>
<td>Social Workers</td>
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<td>Child Psych faculty</td>
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<td>Child Psychiatry Residents</td>
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<td>Gen Peds Faculty</td>
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<td>DBP Faculty</td>
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### Objective 1

- To evaluate whether perceived responsibility for inquiring and treating common MH problems (ADHD, depression, anxiety, and behavioral problems) is associated with self-reported practices.
  - Inquire ADHD
  - Treat ADHD
  - Treat Behavioral Problems

### Objective 2

- To examine the relation of psychosocial orientation and perceived barriers with perceived responsibility and self-reported behaviors
  - Psychosocial Orientation and Perceived Responsivity for treating MH Problems
  - No association with practices

### Objective 3

- To examine trainee characteristics, practice characteristics, and learning experiences with perceived responsibility and practices.
  - Positive association with PGY Level
  - No association between future plans and responsibility or practices
Objective 3

- To examine trainee characteristics, practice characteristics, and learning experiences with perceived responsibility and practices.
- Learn for child psychiatry resident less likely responsibility
- No other educational experiences associated with perceived responsibility

Objective 3

- To examine trainee characteristics, practice characteristics, and learning experiences with perceived responsibility and practices.
- Learning from a general pediatrician, social worker, MH specialist, and adolescent attending associated with practices

Methods - Qualitative

Data Collection: 3 focus groups
14 open-ended questions asking about experiences, attitudes, perceived role in MH care, and experiences with collaborating with MH providers

Data Management: Audio recorded and sent for transcription

Data Analysis: Coded by 2 independent researchers using grounded theory lead by a qualitative research expert

Codes organized into categories using qualitative software, later themes identified

Results: Qualitative

- 3 focus groups of 31/60 residents
- Residents represented from each year of training: 15 PGY1, 8 PGY2, 6 PGY 3

Results: Themes

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>Rewarding</td>
</tr>
<tr>
<td></td>
<td>Accepting responsibility</td>
</tr>
<tr>
<td></td>
<td>Mental health is different than physical health (stigma, definitions, more challenging)</td>
</tr>
<tr>
<td></td>
<td>Lack of knowledge and skills</td>
</tr>
<tr>
<td></td>
<td>Role ambiguity</td>
</tr>
<tr>
<td>External</td>
<td>Support from MH professionals</td>
</tr>
<tr>
<td></td>
<td>Parental barriers</td>
</tr>
<tr>
<td></td>
<td>Environmental (time, continuity, lack of resources)</td>
</tr>
</tbody>
</table>

Internal Facilitators: Rewarding Experiences

“It can really impact...all areas of their life, whether it’s school, home environment, friends and if you can... change or improve that, you’re affecting everything.”

“...just starting him on the medication ... was able to ... really turn around and really just start doing well in school. ... they were seeing that change and that it can happen also relatively quickly for some of these kids.”
Internal Facilitators: Perceived Responsibility

“...huge role in the screening process and also like the referral process...”

“And by virtue of our relationship with pediatric patients, we have the longest and closest follow up with them, so if we were to feel comfortable managing their different aspects of their mental health disorder then we would be the home base.”

“And providing care for... if - depression, ADHD, I think that [is the] most bread and... can be easily managed with the primary care provider first...”

Internal Barriers: MH Is Different

“The part where they don’t get better. It’s much easier to treat someone with an ear infection when you give them antibiotics versus a lot of that psychiatric stuff, they just don’t get better, or they don’t get better in a timeframe that you seek, and that can just be very disheartening...”

“...it’s hard to sort of talk about some of that stuff with some of these adolescents who... there’s a lot of stigma around it...”

Internal Barrier: Role Ambiguity

“...the ER, which I think is the most frustrating mental health experience where you have ten kids every single day that come in with a... a mental health complaint and we do... basically nothing for every single one of them, other than call Psych and Social Work and have them sit in a bed for 72 hours...”

“I don’t feel comfortable with medications at all.”

“... it’s hard to know, especially for kids that are already seeing... a psychiatrist or a therapist...I have trouble figuring out... sort of what my role is in sort of helping with their mental health care.”

Internal Barriers: MH Is Different

“...it’s hard to sort of talk about some of that stuff with some of these adolescents who... there’s a lot of stigma around it...”

External Facilitators: Support

“...at the end of the visit we actually did start him on an SSRI, ... but we used [CAP PC/Telepsychiatry]... you could speak with the psychiatrist over the phone and it was certainly really helpful.”

“...sometimes the psychologists are even like in the... workrooms so like – we get...uncomfortable during the visit, but having them as a resource to talk to and get advice from.”

External Barriers: Lack of Support

“...I think the problem is... we know that we can treat constipation. If it gets really bad, then we can refer them to GI... we can manage asthma until it becomes really hard to control, and then we refer them to Pulm. But with Psych, we make it to that point where we can’t do anything anymore comfortably and we don’t have anyone to send that patient to. And no one’s gonna want to put themselves in that situation if they don’t know that there’s a backup plan.”

External Barriers: Lack of Support

“...I think the problem is... we know that we can treat constipation. If it gets really bad, then we can refer them to GI... we can manage asthma until it becomes really hard to control, and then we refer them to Pulm. But with Psych, we make it to that point where we can’t do anything anymore comfortably and we don’t have anyone to send that patient to. And no one’s gonna want to put themselves in that situation if they don’t know that there’s a backup plan.”
Limitations

One Program, small sample size
Behavioral Problems not well defined
Confidence, competence not measured

Conclusions

Perceived Responsibility and Intent are there
Learning environment not supportive of practices
All disorders are not created equally
Preceptors, role models, working with MH specialists are important in building skills

Next Steps: Grant

Concept mapping project to multiple stakeholders
National data collection on programs, models of care, curriculum
CORNET

Thank you

AAP, APPD, ABP
Larry Wissow
Janice Hanson
Susan Bostwick
John Walkup
William Trochim
Session 8- Incorporation of B/MH Training- Garfunkel

Not Just Integrated: Psychology Fellows and Pediatric Residents Training Together in Primary Care
Lynn C. Garfunkel, MD
APPD April 5, 2017

Training Comparison

**PEDIATRICS**
- College
- Medical School (MD, DO)
- 4 years courses/clinical
- Pediatric Residency
  - 1st year intern
  - 3 years total

**CLINICAL PSYCHOLOGY**
- College
- Graduate School (PhD, PsyD)
- 5 years total courses/clinical
- 5th year internship – clinical, testing
- Practice
- Post Doc Fellowship
  - 1-2 years

20% of Didactic presentations include Behavior and Mental Health Topics
- Developmental delay, screening
- Speech/Language screening, evaluation, management
- Depression, suicide
- Anxiety
- ADHD
- Motivational interviewing
- School problems
- Aggression/aggressive behaviors
- Learning Disability
- Intellectual Disability
- Drugs, ETOH use and abuse
- Maternal depression
- Autism/ADD
- Collaboration, referral

Teaching and Training
- Didactic – Pre-Continuity Clinic Conference
  - 3 year schedule
- Residents, APPs, Faculty/Attendings, Psychologists, Psychiatrist, Psychology post-doctorate clinical fellows,
- Guests – billing staff, community (VN, tobacco coalition, legal rep, LC, etc.)

Resident(s), Pediatric Preceptor, Psychologist

Disclosure
- I have nothing to declare
- I have no relevant financial disclosures
Session 8 - Incorporation of B/MH Training - Garfunkel

Psychology Fellow Training
- See patients - in consultation
- Follow either short term or long term
- Advise pediatricians in the moment
- Meet and Greet (warm hand over)
- Refer back to PCP/JAPP
- Receive supervision and staffing with psychologists and psychiatrist

“Engaged in joint treatment planning with BMH professional during continuity clinic”

“Continuity clinic experience prepared me for collaborating with mental health professionals”

Other Program Advances
- DBP
  - Jointly run by DBP and psychologists
  - Additional psychology teaching sessions
  - Clinical sessions with psychologists
- Monthly morning report facilitated by Psychologist
  - Residents bring case(s) – informal presentation
  - Post Doc Fellow
  - Pediatric Faculty
  - Review data gathering needed
  - Discuss Common Factors N.H.E.L.P.
  - Learn and use s-t-o tools or strategies in office (or in hospital) with patient family
- Ambulatory Pediatrics rotations – additional sessions with psychologist
- Projects (IQ, research, education)

Other opportunities
- Increase MH provider availability
- For care and collaboration
- For training
- Include inpatient and subspecialty practices
- Mindfulness curriculum and programming
- Family of Origin
- Faculty Development
- Autism ECHO
- CAP PC
Thank you!
Session 8- Incorporation of B/MH Training- Broder

Training Residents in Managing Mental Health Disorders at the Children's Hospital at Montefiore

Molly C. Broder, MD
Associate Program Director, Pediatric Residency

Behavioral and Mental Health Curriculum

- Child Psychiatry elective
  - 2 week inpatient elective for PGY-2s or PGY-3s
- Longitudinal Lecture series (Noon conference)
  - All residents
- Continuity Clinic
  - Longitudinal lecture series
  - Co-management with mental health providers
- Behavior and Development rotation
  - 4 week required rotation for all PGY-1s
  - Weekly behavior clinic, weekly sessions with co-located mental health providers
- Adolescent Medicine
  - 4 week inpatient required rotation for all PGY-1s/2s; 2 week OP elective

Who Teaches Our Residents?

- Child Psychiatry elective
  - Child Psychiatry faculty and team members
- Longitudinal Lecture series
  - Child Psych faculty
  - Adolescent medicine faculty
- Continuity Clinic
  - General Pediatrics faculty
  - Co-located mental health providers
- Behavior Clinic
  - Developmental Behavioral Pediatric faculty
  - Co-located mental health providers

Bronx Behavioral Health Integration Project (BHIP)

- Co-located social workers, child psychologists, child psychiatrists
- Continuity Clinic
  - Residents identify patients that need to be referred to SW for triage
  - Screening tools (ages 0-21)
  - Residents refer patient to appropriate BHIP provider per protocol
  - BHIP team decides which mental health provider is appropriate
  - Child psychiatrist co-manages psychiatrist medications with residents

Formal Curriculum

- Child Psychiatry elective
  - Daily learning sessions with the fellows and faculty including lectures and journal club
  - Individualized precepting on inpatient consults
- BHIP curriculum
  - Continuity clinic lecture series
  - Modules and lectures for interns on behavior and development rotation

I have nothing to disclose.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>What Can We Do Better?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient and outpatient experiences</td>
<td>• Not all residents opt to do Child Psychiatry elective</td>
</tr>
<tr>
<td>• Develop comfort in managing routine behavior and mental health issues in outpatient settings</td>
<td>• Residents on Child Psychiatry rotation do not have opportunity to do ED or outpatient intakes</td>
</tr>
</tbody>
</table>
| • Opportunity to work in multidisciplinary teams, appreciate value of, and learn from each team member | • Continuity clinic:  
  – Difficulty in coordinating joint visits with residents and child psychiatrist  
  – General pediatric faculty have variable comfort level in prescribing psychiatric medications hindering continuation of treatment by resident  
  • Collaborative office rounds with faculty                       |
| • In continuity clinic, patients able to get mental health services |                                                                         |
Rainbow Babies and Children’s Hospital
Mental Health Program
Keith Ponitz, M.D.
Residency Program Director

Disclosures

• I have nothing to declare
• I have no relevant financial disclosures

Rainbow Mental Health Program

• Based on Asthma Model
• Building Blocks Strategy
• Rainbow Ambulatory Practice (Continuity Clinic)
  – Mental Health Embedded
• Outpatient Psychiatry Elective and Longitudinal Experience
• Developmental Behavior Pediatrics Rotation
• Inpatient Psychiatry Consultative Service Elective
• Inpatient Psychiatry Unit Elective
• Inpatient Hospital Units
• Director of the Program

Who Teaches Mental Health?

• Director of the Program – Developmental Behavioral Pediatrician
• General Academic Pediatrics & Adolescent Medicine Faculty
  ➢ Building Mental Wellness – Ohio AAP Collaborative
  ➢ REACH program
• Mental Health Embedded Faculty - Psychologist and Psychiatrist
• Developmental Behavior Pediatric Faculty
• Psychiatry Faculty
  – Outpatient Psychiatry Elective and Longitudinal Experience
  – Inpatient Psychiatry Consultative Team
  – Inpatient Psychiatry Unit Attendings
• Hospitalists/Specialists – medical clearance and co-morbid mental health problems associated with their respective specialties

Program Curriculum

• Clinical
• Traditional didactic sessions
• BMW Lectures and Modules - http://ohioaap.org/BMWLearning
• Interdisciplinary lectures with pediatric and psychiatry residents
• Mental Health Journal Club
• Scholarly Activity and QI projects within mental health arena

Benefits

• Formal program for interested residents
• Increased exposure to interdisciplinary approaches to mental health for all residents
  ➢ Training comes from general pediatricians, psychologists, psychiatrists, and developmental and behavioral pediatricians
• Demystify diagnosis and treatment of mental health as different than other pediatric illnesses
• Improved readiness for diagnosing and treating mental health problems post residency
What could we do better?

- Patient base of our Continuity Clinic has limited school age children and our adolescents tend to go to adolescent clinic
- Enhancing education regarding screening tools for mental health disorders
- Many experiences are only observational
- Inpatient rarely focus on the mental health component of hospitalization and suicide attempts are more focused on medical clearance
- Develop practice guidelines – similar to asthma care paths
- Evaluation will be critical - No evidence that this will provide better training for mental health problems than our current structure
Mental Health Curriculum in the Johns Hopkins Residency Training Program

Barry Solomon, MD, MPH¹
Emily Frosch, MD²
Jami Margolis, LCPC
Tracy Carter
Samantha Meilman, LCSW

Johns Hopkins School of Medicine
¹Division of General Pediatrics & Adolescent Medicine
²Division of Child & Adolescent Psychiatry

Disclosures:
- I have nothing to declare
- I have no relevant financial disclosures.

Where is the program implemented?
- 2-week Mental Health Rotation
- 4-week Community Advocacy/MH Block
- PGY-2 or PGY-3

Settings:
- Harriet Lane Clinic/HLC (Continuity/Acute Care)
- Children’s Mental Health Center/CMHC (community-based)
- Child & Adolescent Psychiatry Day Hospital Program
- Inpatient Child Psychiatry Unit
- Others based on resident preference (e.g., Eating Disorders Unit, Early Psychosis Intervention Clinic)

Inpatient exposure – mental health providers attend senior morning report once per week, inpatient services

Who teaches them?
HLC Mental Health Team

Harriet Lane Clinic
- Mental Health Consultant (Licensed Counselor)
  - Conducts real-time mental health evaluations for children, adolescents and caregivers
- Weekly Mental Health Team Meetings
  - General Pediatrics and Child Psychiatry Faculty
  - Maternal Mental Health Therapist (LCSW)
  - Maternal & Infant Case Manager
- CMHC, Day Hospital, Inpatient
- Child Psychiatry Residents, Faculty and Therapists

Educational Program

Continuity Clinic
- ‘Mental Health in Primary Care’ module included in on-line teaching curriculum (Physician Education and Assessment Center/PEAC)

Mental Health Rotation
- Experiential training in a variety of inter-professional settings
- Weekly team meetings in HLC including journal club, reflective exercise and in-depth case-based discussions
Benefits for residents and their future patients

• Improve Clinical Care Delivery
  • Demystify referral process and enhance awareness of resources

• Improve comfort, competence and confidence in handling behavioral and mental health issues

• Build inter-professional relationships

• Resident Reflection: “It has become even more evident how important it is that after you do uncover mental health concerns that an appropriate referral and treatment can truly change lives. I think the most concrete thing I learned was the importance of reaching out to work with our mental health colleagues more closely. This collaboration and shared learning process is vital to the health of our patients.”

Impact of On-Site Mental Health Providers

Annual Resident Survey 2008-2011:

- 130 participants
- 78% with on-site MHP vs. 22% in traditional clinic
- Even distribution across training levels
- 63% mental health training prior to residency
- 47% plan to pursue specialty

Results:

- On-site MHP residents
  • Report services available in clinic
  • More likely to inquire about and refer children with ADHD
  • More likely to refer for depression and behavior problems

- Opportunity to enhance inter-professional education and improve patient care

Raguntinghan, B, Frosch E, Solomon BS. On-site mental health professionals and pediatric residents in continuity clinic. Clinical Pediatrics. Dec 1 2016 [Epub ahead of print]

Evaluation: Residents’ Perceptions & Reported Practices

<table>
<thead>
<tr>
<th>Perceptions/Practices</th>
<th>2006 (n=47)</th>
<th>2008 (n=45)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible for identifying ADHD</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Responsible for identifying Depression</td>
<td>100</td>
<td>95</td>
</tr>
<tr>
<td>Usualy inquires about ADHD</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td>Usualy inquires about Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inquires about symptoms of maternal depression</td>
<td>48</td>
<td>77</td>
</tr>
<tr>
<td>Uses a screening tool for maternal depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(more than ½ the interventional visits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confident in ability to identify maternal depression (Agree/Strongly Agree)</td>
<td>11</td>
<td>70</td>
</tr>
<tr>
<td>Confident in ability to make an effective referral for maternal depression (Agree/Strongly Agree)</td>
<td>40</td>
<td>63</td>
</tr>
<tr>
<td>Things we wish we could do better:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Ensure timing so residents can accompany mental health provider during outpatient visits
- More inter-professional training in all parts of residency
- Embed mental health providers in other pediatric settings
- Place pediatric residents in mental health settings with specific roles
- Elevate mental health issues to same level as all medical issues

Mental Health Rotation Reflections by Residents

- “During my last 2 weeks, I have seen excellent examples of mental healthcare providers deftly tackle these issues with relative ease. I almost envy their ability and poise. And even if I did feel uncomfortable with a mental health issue, I would have liked to know such healthcare providers existed – instead of just a ‘black box’…”

- “I saw them kill him in front of me. I mean he just died right there. He said it so casually as if he were talking about children playing football in the street. It is just part of his reality…. It was striking how quickly the psych resident I was working with unlocked this portion of him that I had been unable to surface. It was something more than just asking the right questions, it was the way that she asked the skillfully framed questions, the time that she gave him to answer and the safety that seemed to be palpable in the room.”

Mental Health Rotation Reflections by Residents

- “It has become even more evident how important it is that after you do uncover mental health concerns that an appropriate referral and treatment can truly change lives. We cannot do it alone. There can be a ripple effect that addressing the mental health of a child can change the dynamics of a family”.

Things we wish we could do better
Components and context for skills-based pediatric mental health training

Larry Wissow, MD MPH
Center for Mental Health and Pediatric Primary Care
Johns Hopkins School of Medicine

Financial Disclosures

• No relevant financial relationships with any commercial interests.

Team effort (partial list)

• Jonathan Brown, Melissa King, Waleed Zafar
• Anne Gadomski (Bassett Healthcare)
• Kate Fothergill, Susan Larson, and Debra Roter (JHU)
• Peter Salmon (University of Liverpool)
• Marc Karver (USF); Marian Earls (NC)
• Karen Hacker (Cambridge Health Alliance)
• Special thanks to Jane Foy (Wake Forest)
• Funding from NIMH, SAMHSA, State of Maryland

Outline

• Crosswalks from mental health to primary care
• Some training content
  – An abbreviated assessment
  – Underlying interactional skills
  – Near universal therapeutic interventions
  – Brief evidence-informed interventions for common problems
• Organizational culture, interprofessional, and community work

Conclusion first

• It is possible to efficiently teach core mental health skills and see uptake
• Sustained use and clinical impact likely require
  – Uptake of an underlying mindset
  – Demonstration and practice in specific situations in which skills need to be used
  – A clinical culture that supports skill use and enables inter-professional work

The mindset: Expanded definition of mental health

• Positive sense of self
• Ability to form social bonds
• Sense of reward from learning and interactions
• Reasonable ability to regulate mood and behavior
• Reasonable ability to sustain attention
• Basic cognitive capacity on which to build

Dwamena F. Interventions for providers to promote a patient-centred approach in clinical consultations. Cochrane Reviews 2012; issue 12
Table 1

<table>
<thead>
<tr>
<th>Community and General Medical Settings</th>
<th>Parallels in Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasis on patient-centered care and joint decision making building trust and activation</td>
<td>“Common factors” in psychotherapeutic processes promoting engagement, optimism, alliance</td>
</tr>
<tr>
<td>Treatment delivered in pulses with follow-up for monitoring or as needed</td>
<td>“Single session” treatment models</td>
</tr>
<tr>
<td>Initial treatment often prescriptive or relatively nonspecific</td>
<td>Stepped care models with increasing specificity of diagnosis and intensity of treatment</td>
</tr>
<tr>
<td>Treatment based on brief counseling focused on patient-identified problems</td>
<td>“Common elements”</td>
</tr>
<tr>
<td>Links with community services, advice addressing family and social determinants</td>
<td>Peer/family navigators</td>
</tr>
</tbody>
</table>


Paradigmatic problems vs. “diagnosis”

- Hear family concerns
- Place in one of a relatively smaller number of categories
- Assess function in key areas (family, school, peers)
- Assess safety issues
- Develop problem-focused plan and benchmarks
- Agree on likely next steps if required

“Common factor” influences on mental health outcomes

- Aspects of treatment that influence
  - Patient-provider relationship
    - Affective bond between patient and provider
    - Agreement on problem and direction of treatment
  - Change in patient behavior
    - Optimism about outcome
    - Engagement in treatment
    - Maintaining focus on achievable goals
- Predict outcome in child as well as adult studies

Trial of CF training in community pediatrics

- Agenda setting
  - Engaging both child and parent
- Problem formulation and solving
  - Agreement and steps forward
- Responding to anger and demoralization
  - Promoting optimism
  - Fostering affect regulation
- Advice giving
  - Avoiding and managing resistance; building partnership
- Time management
  - Managing rambling and interruptions

Universal interventions

- Psychoeducation (information, validation)
- General stress reduction and problem solving
  - How can the overall load be reduced on the child or family
  - What concrete needs could be filled?
- Prescribing self-care that builds on strengths and resources
- Age-appropriate parenting advice
Practice elements for treating childhood anxiety

“Common elements” for child mental health

<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>Most common elements of related Evidence-Based Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Graded exposure, modeling</td>
</tr>
<tr>
<td>ADHD and oppositional problems</td>
<td>Tangible rewards, praise for child and parent, help with monitoring, time out, effective commands and limit setting, response cost</td>
</tr>
<tr>
<td>Low mood</td>
<td>Cognitive/coping methods, problem-solving strategies, activity scheduling, behavioral rehearsal, social skills building</td>
</tr>
</tbody>
</table>

“Single session” therapy

- Improvement can happen after one session
  - But additional sessions possible now or later
- Immediate focus on problems and solutions
- Each contact attempts to be self-contained
- Therapist active in establishing goals, developing intervention, keeping focus
- Clients encouraged to keep working on their own


Importance of clinical culture and context

- Organizing visits so mental health fits in
- Inter-professional work
  - Mutual understanding of roles and talents
  - Willingness to engage in task-shifting and sharing
  - Effective use of huddles and team meetings to plan collaborative care
- Being data and outcomes driven

Organizing visits: We make it harder

- Children (and parents) may not know what to expect in packed well visits
- When children don’t understand the motivation for a question, they may react with:
  - Evasive answers
  - Silence
  - Embarrassment, irritation

Recall interview:
- Interviewer: Were you paying attention to your mom and the doctor talking?
  - Child: No.
- Interviewer: Since you weren’t paying attention, was there anything in particular you were thinking about?
- Child: Like, is the doctor going to do anything? Or, why did I come to the doctor? They were talking more about my health and my behavior problems instead of like, giving me a shot, taking my blood pressure, and then I leave... I wasn’t expecting that.

Balancing protocols and relationships

<table>
<thead>
<tr>
<th>Integration task</th>
<th>Process interventions</th>
<th>Relationship interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly biomedical (e.g.: immunizations) - low patient control over outcome - very standardized treatment - few providers involved</td>
<td>More likely to be effective; standard QI approaches effective.</td>
<td>Less likely to be effective than process-based. Consider only for additive effects.</td>
</tr>
<tr>
<td>Highly behavioral (e.g.: mental health) - high patient control over outcomes - highly individualized treatment - multiple inter-reliant providers, many handoffs</td>
<td>Less likely to be sufficient. Can even be off-putting when not properly framed.</td>
<td>More likely to be required for successful change. Consider huddles, facilitation, collaboratives.</td>
</tr>
</tbody>
</table>

Adapted from Leykum Tables 5 and 6. Implementation Science 2014, 9:155

Problems with screening

- Lack of attention to engagement
  - Purpose of screen
  - Privacy while completing
  - Who will see results
  - Help with literacy or language issues
- Failure to adhere to good screening practice
  - No training in second stage interpretation
  - Misunderstanding of “valid screen”
  - Overestimation of predictive value

Benefits of screening

- Signposts and anticipates mental health content of visit
- Engages parents and youth
- Helps parents and youth organize concerns
- Serves as natural point of initiation of mental health discussion
- Gives something to track over time

Glisson “ARC” trial in CMHC’s

- “Availability, responsiveness, and continuity”
- How to be mission-driven, results-oriented, participation-based
- Use of teamwork to identify and address service barriers
- Promotion of provider flexibility, openness to change, commitment

New York State consultation line

Conclusions

• It is possible to efficiently teach core mental health skills and see uptake
• Sustained use and clinical impact likely require:
  – Uptake of an underlying mindset
  – Demonstration and practice in specific situations in which skills need to be used
  – A clinical culture that supports skill use and enables inter-professional work

Dwamena F. Interventions for providers to promote a patient-centred approach in clinical consultations. Cochrane Reviews 2012; issue 12
Pediatric Residency Education and the Behavioral and Mental Health Crisis: A Call to Action

Julia A. McMillan, MD, FAAP, a Marshall Land Jr, MD, FAAP, b Laurel K. Leslie, MD, MPH, FAAP c

For at least 4 decades, the need for improved pediatric residency training in behavioral and mental health has been recognized. The prevalence of behavioral and mental health conditions in children, adolescents, and young adults has increased during that period. However, as recently as 2013, 65% of pediatricians surveyed by the American Academy of Pediatrics indicated that they lacked training in recognizing and treating mental health problems. Current pediatric residency training requirements do not stipulate curricular elements or assessment requirements in behavioral and mental health, and fewer than half of pediatric residents surveyed felt that their competence in dealing with mental health problems was good to excellent. It is time that pediatric residency programs develop the capacity to prepare their residents to meet the behavioral and mental health needs of their patients. Meeting this challenge will require a robust curriculum and effective assessment tools. Ideal training environments will include primary care ambulatory sites that encourage residents to work longitudinally in partnership with general pediatricians and behavioral and mental health trainees and providers; behavioral and mental health training must be integrated into both ambulatory and inpatient experiences. Faculty development will be needed, and in most programs it will be necessary to include nonpediatrician mental health providers to enhance pediatrician faculty expertise. The American Board of Pediatrics intends to partner with other organizations to ensure that pediatric trainees develop the competence needed to meet the behavioral and mental health needs of their patients.

Twice within the past 40 years, comprehensive reports from task forces on the Future of Pediatric Education (FOPE and FOPE2) have emphasized the need to enhance residency training in behavioral, developmental, and adolescent issues.1,2 Nevertheless, the challenges related to behavioral and mental health among the nation’s children have only grown since the second report was issued in 2000.

The Behavioral and Mental Health Crisis

During the decade between 2001 and 2011, childhood disability related to developmental or mental health conditions increased by 20.9%, while the prevalence of disability attributable to physical health conditions declined by 11.85%.3 It is estimated that ~50% of Americans will experience a mental health concern at some point in their lives, and most will originate by guest on April 28, 2017Downloaded from
in childhood. More than 15% of US parents report a clinician-diagnosed mental, behavioral, or developmental disorder among 2- to 8-year-olds. One of every 13 high school students attempts suicide, the second leading cause of death among youth ages 10 to 14 and 15 to 24 after unintentional injury. Table 1 highlights specific data regarding these challenges. All of these conditions are more prevalent for children raised in poverty and exposed to environmental and community circumstances, often referred to as adverse childhood experiences.

Pediatricians are in a position to see and understand the toll behavioral and mental health problems take on individual children and on families. By virtue of their ongoing trusted relationship with families, their understanding of the context of their patients' development, and their familiarity with their available referral network, pediatricians have the opportunity to recognize behavioral and mental health problems, to intervene themselves in many cases, and to coordinate referral to specialists and other services when that is necessary.

**PERSISTENT INADEQUACIES IN BEHAVIORAL AND MENTAL HEALTH TRAINING AND PRACTICE**

There is little evidence, however, that residency training prepares pediatricians to care for behavioral and mental health issues, the most common group of problems likely to affect their patients. In a recent periodic survey by the American Academy of Pediatrics (AAP), 65% of the 512 responding primary care and specialty pediatricians indicated they lacked training in the treatment of children and adolescents with mental health problems, almost 40% responded they lacked confidence in their ability to recognize those problems, and >50% lacked confidence in their ability to treat them. Insufficient time during office visits and inadequate reimbursement are reported as significant barriers to diagnosis and management of mental health problems, but inadequate preparation and confidence likely contributed to responses from 44% of those surveyed, who indicated they were not interested in treating, managing, or comanaging child mental health problems. Adding to inadequate reimbursement and incomplete preparation of pediatricians to provide care themselves is the lack of availability of mental health specialists in many localities and practice patterns that do not incorporate mental health professionals alongside pediatric medical providers or support effective collaboration.

The accreditation requirements for pediatric residency training programs have evolved over time in an attempt to address training and health care needs. It was not until 1990 that the program requirements for pediatric residency training in the United States included a requirement for "evidence of structured educational experiences in adolescent medicine, child development, child psychology, and the care of the handicapped child." Beginning in 2000, each program was required to include a 1-month block experience in behavioral and developmental aspects of pediatrics, as well as an integrated experience incorporating child behavior and development, psychosocial screening and behavioral counseling, and referral as a part of ambulatory and inpatient experiences throughout the 3 years of training. These requirements, like all other Accreditation Council for Graduate Medical Education (ACGME) program requirements, did not stipulate competencies to be achieved or assessment methods to be used, and in the current version of the program requirements, even those general curricular descriptions have been omitted.

The ACGME, which oversees the Pediatric Review Committee (PRC), has now moved away from stipulating specific curricular content for residency training. Instead the ACGME is encouraging programs to innovate to achieve overall competencies as described in the Pediatric Milestones Project. Program requirements now mandate only that each program have at least 1 faculty member who is certified in developmental and behavioral pediatrics and that each resident complete a 1-month or 200-hour experience in developmental and behavioral pediatrics. In practice, the requirements, their interpretation, and their implementation have not resulted in an adequately trained pediatric workforce in the areas of developmental and behavioral health.

Subspecialty certification of developmental and behavioral pediatricians by the American Board of Pediatrics (ABP), first offered in 2002, was expected to provide well-trained faculty who would enhance the education of future pediatricians as well as to help foster research and clinical care. According to the ABP, there are now 775 board-certified pediatric developmental/behavioral subspecialists scattered unevenly throughout the country. Availability of these subspecialists ranges from 1 for every 59,000 children in some states to 1 per 300,000 in others; there are no developmental/behavioral counseling, and referral as a part of ambulatory and inpatient experiences throughout the 3 years of training. These requirements, like all other Accreditation Council for Graduate Medical Education (ACGME) program requirements, did not stipulate competencies to be achieved or assessment methods to be used, and in the current version of the program requirements, even those general curricular descriptions have been omitted.

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**TABLE 1 Lifetime Prevalence of Mental Health Diagnoses Among 18-Year-Olds**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>18.6%</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>19.9%</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>12.5%</td>
</tr>
<tr>
<td>Social phobia</td>
<td>8.5%</td>
</tr>
<tr>
<td>Attention-deficit/hyperactivity disorder</td>
<td>8.1%</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>6.8%</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>4.7%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

behavioral pediatricians in 2 states. The degree to which these subspecialists interact with pediatric residents in their continuity clinics or inpatient experiences is limited by a variety of factors including (1) the need to generate clinical income, (2) large volumes of complex referral patients, and (3) pressure on faculty to generate research needed for academic promotion. As pointed out by Dr Ruth Stein in a commentary published last year, many of those developmental/behavioral faculty members are “sequestered and siloed off-campus and are increasingly seen only as people who take care of children who have special needs, children who are unfortunately undervalued by society, rather than as key faculty, essential to the central departmental educational mission and critical to the successful delivery of care in all venues.”

In 2010 fewer than half of surveyed US pediatric residents rated their competence in mental health skills, such as diagnosing ADHD, depression, or anxiety, and managing or treating those conditions, as good to excellent; 28% reported that vacation time was permitted during their required 1-month developmental/behavioral pediatrics rotation. A 2014 survey of pediatric residency directors found that the majority of pediatric training programs did not emphasize mental health training and were unaware of the recently published mental health competencies for pediatricians developed by the AAP Committee on Psychosocial Aspects of Child and Family Health and the Task Force on Mental Health. The majority of program directors also rated their residents’ knowledge about psychosocial and pharmacological interventions as average or below average.

PROPOSED SOLUTIONS

It is time that pediatric residency programs develop the capacity to prepare their residents to meet the behavioral and mental health needs of their patients. We must, as a profession, recognize the large gap between the needs of children, adolescents, and their families and the preparation of pediatricians to meet those needs. Our goal should be to train pediatricians who can counsel parents to prevent behavioral and mental health problems and promote physical and emotional wellness, to identify those problems when they occur, to treat many common problems, and to refer and coordinate care when additional expertise is needed. These pediatricians may serve as primary care clinicians or as subspecialists caring for children with chronic medical conditions who often have coexisting mental health needs. We can no longer deny that behavioral and mental health concerns are morbidities that threaten the health, and in some cases the lives, of large numbers of children, their families, and society. If the education of general pediatricians and subspecialists does not advance to meet this need, it will be difficult to assert, as the second Future of Pediatric Education Task Force did, that “the pediatrician is the best trained professional to provide quality health care services” for the nation’s children.

Meeting this goal will not be easy. It will require a robust curriculum and effective assessment tools. Table 2 summarizes proposed solutions, participants, currently available resources, and a possible timeline. The mental health competencies for pediatric primary care developed under the auspices of the AAP should be adopted as a guide for an initial curriculum along with the residency curriculum on mental health that the AAP has already begun to post online. This curriculum could be used for building faculty capacity as well. Certain common, core, evidence-based skills such as communication, motivational interviewing, and parent-mediated behavior training should be included in that curriculum. Medical students considering pediatrics as a career could also take advantage of this training, and they should be made aware that these foundational skills will be an important part of their anticipated career.

So, what opportunities currently exist to improve residency training in behavioral and mental health care? Recent efforts by the ACGME and the American Board of Medical Specialties have encouraged the use of preidentified milestones in each specialty to assess trainees’ attainment of fundamental competencies. These behavioral milestones (eg, “gather essential and accurate information about the patient”; “communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds”) have been developed for pediatric trainees, and reporting of milestones assessment is now required by the ACGME. However, the context for assessment, that is, whether the milestones are assessed in an ICU, the emergency department, or the resident’s continuity clinic, is not specified.

Another recent assessment framework in medical education, which addresses this need for context, is the entrustable professional activity (EPA). EPAs presume that there are activities within a given specialty or subspecialty that a physician should be expected to be able to perform competently and without supervision. The concept of EPAs applies the general behavioral milestones to the context of each of those specialty-specific activities. The EPA should define the skills, knowledge, and other competencies that will be needed to achieve “entrustment,” or the ability to
effectively carry out a given activity independently. The EPAs put goals for training into the context of the activity in which they are taught and assessed. In accordance with those goals, a curriculum would be created with appropriate functions and competencies in mind, and assessment would occur to ensure that the trainee or pediatrician is developing appropriate competence. One of the activities proposed as defining the competent pediatrician is “assessment and management of patients with common behavioral and mental health problems.” The goal of using EPAs in training would be for each graduating pediatric resident to be competent in preventive counseling as well as the recognition of common behavioral and mental health problems. The graduating pediatric resident would then be able to provide knowledgeable, effective, efficient, coordinated care of common behavioral and mental health problems without need for supervision. This is a training goal that previously has not been articulated explicitly.

Future pediatricians will need immersion in environments where they will be taught by experienced clinicians with expertise in the promotion of well-being and the identification and treatment of mental health risk factors and problems and who are also skilled in educating others. Ambulatory experiences, including resident continuity clinics, and rotations in developmental/behavioral pediatrics, adolescent medicine, and community pediatrics in patient-centered medical home sites will likely be the primary venues for training in behavioral and mental health. Ideal training environments will include primary care ambulatory sites that encourage residents to

### Table 2: Proposed Approaches for Enhancing Residency Training in Behavioral and Mental Health

<table>
<thead>
<tr>
<th>Proposed Solution</th>
<th>Necessary Participants</th>
<th>Existing Resources</th>
<th>Proposed Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robust behavioral and mental health curriculum</td>
<td>Residency program directors, Faculty (e.g., general academics, developmental/behavioral, adolescent medicine, other subspecialty), Community practitioners, Child and adolescent psychiatrists, Child psychologists, Social workers, Pediatric Review Committee of the ACGME, ABP</td>
<td>AAP’s Mental Health Competencies for Pediatric Primary Care, AAP Mental Health Curriculum, Existing curricula at local institutions</td>
<td>2 y and ongoing</td>
</tr>
<tr>
<td>Tools aimed at assessing entrustment for unsupervised practice as described in the EPAs</td>
<td>Residency program directors, Faculty (e.g., general academics, developmental/behavioral, adolescent medicine, other subspecialty), Child and adolescent psychiatrists, Nonphysician mental health faculty, ABP</td>
<td>Existing assessment instruments at local institutions</td>
<td>3–5 y and ongoing</td>
</tr>
<tr>
<td>Appropriate training environments</td>
<td>Department chairs, Program directors, Pediatrician and nonphysician faculty, Community practitioners, Child and adolescent psychiatrists</td>
<td>Continuity clinics, Adolescent medicine clinics, Community pediatrician offices, Behavioral and mental health services, Schools, Community mental health services, Tele–mental health</td>
<td>2–3 y and ongoing</td>
</tr>
<tr>
<td>Faculty development for pediatrician faculty</td>
<td>Department chairs, Residency program directors, General pediatric faculty, Subspecialty pediatricians, Community pediatricians</td>
<td>Developmental/behavioral pediatrician faculty, Child and adolescent psychiatry faculty, Opportunities offered through the Association of Pediatric Program Directors, Society for Adolescent Health and Medicine, Society for Developmental and Behavioral Pediatrics, AAP, ABP, and ABP Lifelong Learning and Self-Assessment Modules, Psychologists, Social workers</td>
<td>2–3 y and ongoing</td>
</tr>
<tr>
<td>Collaboration with nonpediatric clinicians and trainees</td>
<td>Child and adolescent psychiatrists and trainees, Child psychologists and trainees, Social workers and trainees, Other providers (e.g., parent or peer mentor)</td>
<td>Colocated and integrated mental health services in some programs</td>
<td>2–3 y and ongoing</td>
</tr>
</tbody>
</table>
work over extended periods of time in partnership with general pediatricians as well as behavioral and mental health trainees and providers. Community practices that integrate or colocate mental health providers into their practice would appear to be especially desirable training environments. Some examples of these combined and colocated clinics already exist in current residency training programs.19,21

Because behavioral and mental health are interlinked with virtually every condition pediatricians treat, responsibility for identifying problems, counseling families, and coordinating needed care also must be integrated into inpatient, critical care, and subspecialty experiences. Children cared for in subspecialty clinics and inpatient units often have coexisting mental health problems, so training opportunities should not simply focus only on primary care. In fact, subspecialty clinics with integrated mental health providers may provide training opportunities for both residents and fellows. Subspecialty trainees, as well as pediatric residents, should understand that development of a communication strategy for building a therapeutic alliance with patients and families is critical, particularly for those with chronic diseases. Resources, personnel, and available training sites vary greatly among programs, and innovation will be needed. To achieve the goals of providing collaborative or integrated care, some programs will likely need to include schools, telemental health, and experiences involving residents working with skilled community faculty. Clear documentation of behavioral and mental health curricular elements and assessment of resident acquisition of skill during these experiences should even allow for accumulation of the 200 hours of developmental and behavioral pediatrics required by the PRC without need for, or in addition to, a block rotation. Some flexibility on the part of the PRC would be required, so that programs avoid penalties for including developmental/behavioral pediatrics curricular elements during other rotations. In most residency programs, faculty development will be needed, and it will be necessary to incorporate nonpediatrician mental health providers, including child psychiatrists, child psychologists, social workers, and counselors, to enhance pediatric faculty expertise and experience.

Recognition of behavioral and mental health problems cannot be the only goal in residency training. Prevention, through promotion of effective parenting and behavioral guidance, as well as development of confidence in treatment of many common mental health conditions, would be expected to reduce the need for referral to more specialized providers, who are often unavailable, have long waiting lists, and may not be adequately reimbursed. Communication training for pediatric providers has been shown to be effective in reducing mental health impairment among their minority patients as well as mental health symptoms suffered by their parents.20 Similar skills training should be included in pediatric residency education and applied in all settings in which residents care for patients.

The American Academy of Child and Adolescent Psychiatry (AACAP) is well aware that the 8700 child and adolescent psychiatrists in the United States, many of whom do not engage in full-time clinical practice, are not able to meet all the mental health needs of America’s children. They have expressed willingness to partner with pediatric organizations and training programs to enhance the capacity of pediatricians to provide mental health care for common problems. In 2014, the AACAP issued its own Call to Action to promote collaborative mental health partnerships between child and adolescent psychiatrists and primary care providers, including ensuring that child and adolescent psychiatry trainees gain experience in collaborative care paradigms.22 Colocation of pediatric and child psychology trainees already exists in some primary care settings, enhancing the training of both groups of trainees, and serving as a model for other programs as well as for their future practice.19 Integration of behavioral health care within primary care is promoted by the Patient Protection and Affordable Care Act,23 and research indicates that integrated care can improve behavioral health outcomes for pediatric patients.24 Development of integrated care models for pediatric resident continuity clinics would make behavioral and mental health specialists available as educators and help prepare future pediatricians for the practice patterns they are likely to encounter in the future.

The ABP can create expectations for education and certification, but it cannot make these essential changes in training happen alone. The ABP intends to use its influence and to partner with other organizations, such as the AAP, the Association of Pediatric Program Directors, the Academic Pediatric Association, the Society for Developmental and Behavioral Pediatrics, the Society for Adolescent Health and Medicine, the Council of Pediatric Subspecialties, the Association of Medical School Pediatric Department Chairs, the National Academy of Medicine, the AACAP, and the ACGME, to catalyze current and future efforts to ensure that future residency graduates develop competence to address the cognitive and behavioral wellness dimensions of child health and development; to prevent, identify, and treat common behavioral and
mental health conditions; and to ensure that future pediatric residency graduates are trained to engage with mental health colleagues in consultation and referral of children and youth with more serious behavioral and mental health problems. A meeting convened by the ABP in April 2016, including representatives from all of these organizations, helped set the framework for needed efforts to achieve this goal and allowed participants to share information about current activities their organizations have initiated. The ABP will also collaborate with these organizations to foster Maintenance of Certification efforts to enhance the effectiveness of diplomates in preventing, identifying, and treating mental health needs of children, adolescents, and young adults. Recognizing that addressing these needs takes time, it will also be important to continue advocacy efforts, including those led by the AAP, for adequate reimbursement to support effective models of care. 

For example, payers will need to be convinced that intervention helps even in the absence of a diagnosable disorder; dissemination of the burgeoning evidence base for children’s behavioral and mental health and well-being will be needed to persuade insurers as well. To the degree that these ongoing efforts are successful, it will be important for pediatricians and pediatric practices to be prepared.

Pediatricians have responded to crises in child health care in the past. We again have an opportunity to define ourselves in relation to the needs of America’s children. If we do not now ensure that graduates of our training programs are prepared to meet those needs, they will continue to be unmet, and the relevance of pediatric care to the health of children will be significantly diminished.

ACKNOWLEDGMENTS

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ABBREVIATIONS

AAP: American Academy of Pediatrics  
AACAP: American Academy of Child and Adolescent Psychiatry  
ABP: American Board of Pediatrics  
ACGME: Accreditation Council for Graduate Medical Education  
EPA: entrustable professional activity  
PRC: Pediatric Review Committee

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