

Pediatric Mental Health Competencies: A Detailed Outline for Use by Pediatric Educators

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

“Patient care”: clinicians providing care to children and adolescents can maximize the patient’s and family’s agency, sense of safety, respect, and partnership by developing competence in performing the following activities:

Promotion/Prevention

1. Promote healthy emotional development and resilience through reinforcing child and family strengths and counseling families in healthy lifestyles including nutrition, exercise, play, access to nature, limited screen time, sleep, family time, stress management, decreased exposure to environmental toxins, seeking support within the community, promotion of social capital, and positive parenting strategies.
2. Provide anticipatory guidance to families on managing the stress of illness and common behavioral problems; on coping with trauma and other adverse life events such as parental separation and illness, death of a loved one, and socioeconomic stressors; and on using mental health-related educational resources appropriate to their literacy level and cultural and individual need.

Identification

3. Recognize mental health emergencies such as suicide risk, severe functional impairment, and complex mental health symptoms that require urgent mental health specialty care.
4. Routinely gather an age-appropriate psychosocial history (eg, family routines, relationships with family members and peers, adverse childhood experiences, school performance, social determinants of health, family members’ mental health, family disruptions, and other traumatic events) to identify the strengths and challenges of the patient and family.
5. Recognize mental health risks faced by special populations such as children and adolescents exposed to adverse childhood experiences; those in foster care; those in military families; those living in poverty; those whose parents have separated or divorced; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth; children and adolescents with chronic medical conditions and developmental disabilities; and children and adolescents affected by racism and xenophobia.

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6. Select and use tools appropriate to the practice setting for purposes such as screening, surveillance, and psychosocial/behavioral assessment of family members for psychosocial strengths and risks to the patient's healthy emotional development.
7. Select and use tools appropriate to the practice setting for screening, surveillance, and psychosocial/ behavioral assessment of infants, children, and adolescents for strengths, risks, symptoms, and functional impairment.
8. Integrate a brief psychosocial update into acute care and chronic care visits.
9. Conduct history, physical assessment, and observations of parent-child attachment and interaction indicated by psychosocial concerns, positive screening test results, and information collected from collateral sources (eg, schools, agencies, juvenile justice system, and mental health professionals).
10. Routinely assess for suicidal risk factors, thoughts, and behaviors.
11. Identify clusters of mental health symptoms that may not reach the level of a *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* or *DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)* diagnosis, including, at a minimum:
 - a. signs and symptoms of social-emotional problems in infants and preschool children
 - experience of toxic stress
 - exposure to trauma
 - b. the following symptom clusters in school-aged children and adolescents:
 - anxious or avoidant behaviors
 - impulsivity and inattention, with or without hyperactivity
 - low mood or withdrawn behaviors
 - disruptive or aggressive behaviors
 - eating abnormalities
 - substance use
 - exposure to trauma or loss
 - learning difficulties
12. Identify potential behavioral, mental health, and/or learning differences/problems reflected in report cards, academic test results, individualized family service plans, individualized education programs, and 504 plans.
13. Recognize common mental health comorbidities in children with physical, developmental, and cognitive disabilities and chronic medical conditions.

Interpretation

14. Analyze results from mental health screening, history, physical assessment, observations, and response to previous interventions to determine a patient's/family's need for further mental health assessment and/or intervention.

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15. Recognize and differentiate normal behavioral variations, impairing symptoms, mental health disorders, physical conditions with mental health manifestations, and adverse medication effects.

Diagnostic Assessment

16. Conduct a full diagnostic assessment (eg, history from family members, collateral information from teachers, physical examination, observations of child and parent, disorder-specific rating scales, documentation of symptoms per DSM-5 criteria) of school-aged children and adolescents with symptoms suggesting the following disorders, at a minimum: ADHD, common anxiety disorders (eg, separation anxiety disorder, social phobia, generalized anxiety disorder), depression, and substance use.

Treatment

17. Apply office and community emergency protocols to the care of children with suicide risk and other mental health emergencies.
18. Develop a safety plan with patients and parents for children and adolescents who do not require immediate hospitalization and are depressed and/or suicidal.
19. Apply fundamental (common factors) communications skills to engage youth and families and overcome barriers to their help seeking for identified problems.
20. Apply common elements of evidence-based psychosocial treatment to initiate the care of:
 - a. children and youth with medical and developmental conditions who manifest comorbid mental health symptoms
 - b. infants and young children manifesting difficulties with communication and/or attachment or other signs and symptoms of emotional distress (eg, problematic sleep, eating behaviors)
 - c. children and adolescents presenting with:
 - anxious or avoidant behaviors
 - impulsivity and inattention, with or without hyperactivity
 - low mood or withdrawn behaviors
 - disruptive or aggressive behaviors
 - disordered eating
 - substance use
 - exposure to trauma or loss
 - learning difficulties
21. Integrate patient/family strengths, needs, and preferences; clinician's own skills; and available resources into development of a care plan for children and adolescents with mental health problem(s), alone, with the primary care team, or in collaboration with mental health specialists (including further assessment; patient/family education about the conditions; evidence-based psychosocial, complementary, and, if indicated, pharmacologic interventions; communication with family and collaborating professionals; monitoring mechanisms; preventive services; and, for adolescents, transition to adult care):

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- a) Assist families in understanding, accessing, and using psychosocial treatment delivered by a mental health specialist, in an evidence-based electronic format, and/or by a facility that provides evidence-based services appropriate to a patient's/family's needs and preferences
 - b) Demonstrate capacity to manage, at a minimum, school-aged children and adolescents with the following disorders, applying available guidelines: ADHD, common anxiety disorders (separation anxiety disorder, social phobia, generalized anxiety disorder), depression, and substance use
 - c) Demonstrate proficiency in selecting, prescribing, and monitoring (for response and adverse effects) ADHD medications and selective serotonin reuptake inhibitors that have a safety and efficacy profile appropriate to use in pediatric care
 - d) Demonstrate proficiency in selecting, prescribing, and monitoring medications for any other condition(s) for which the clinician prescribes psychopharmacologic therapy
 - e) Develop a contingency or crisis plan for a child or adolescent
 - f) Apply strategies to actively monitor adverse and positive effects of nonpharmacologic and pharmacologic therapy
 - g) Facilitate a family's and patient's engagement with and transfer of trust (ie, "warm handoff") to a mental health professional
 - h) Comanage mental health care with other providers (primary care team members, medical and surgical subspecialists, mental health specialists) as appropriate to provider's level of mental health competence and the needs and preferences of the patient and family
 - i) Participate as a team member in coordinating and monitoring the multidisciplinary care of children and adolescents with complex medical and psychosocial needs
 - j) Make timely referrals to appropriate mental health specialists
22. Refer, collaborate, co-manage, and participate as a team member in coordinating mental health care with specialists and in transitioning adolescents with mental health needs to adult primary care and mental health specialty providers.

"Medical knowledge": clinicians providing care to children and adolescents can support mental health practice with evidence-informed guidance by developing competence in performing the following activities:

1. Apply knowledge of early brain development and the impact of toxic stress to identifying those patients and families at risk for social-emotional and mental health problems.

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2. Access and evaluate current data about efficacy of parenting programs for typically developing children and those with mental health problems to refer patients to the appropriate program.
3. Apply knowledge of safety and efficacy of common pharmacologic, psychosocial, mind-body, and other complementary interventions applicable to children and adolescents to patient care.
4. Access current data about interactions between prescription drugs, dietary supplements, folk remedies, and complementary and integrative medicine therapies commonly used for mental health problems to appropriately counsel families.
5. Apply DSM-5 or DC: 0–5 criteria for the diagnoses of ADHD, common anxiety disorders, depression, substance use, and any other disorder for which the clinician considers pharmacologic therapy when caring for patients.
6. Apply principles of behavior-change science to mental health practice.
7. Identify existing mental health and social resources (eg, human service agencies, parenting programs, early intervention programs, therapists who provide cognitive behavioral therapy, mental health practitioners, school-based social and mental health services) in one's network and community to appropriately refer patients.

“Practice-based learning and improvement”: clinicians providing care to children and adolescents can improve the quality of their practice’s mental health services by developing competence in performing the following activities:

1. “Identify strengths, deficiencies, and limits in one’s own [mental health] knowledge and expertise.”
2. “Set learning and improvement goals.”
3. “Identify and perform appropriate learning activities.”
4. “Locate, appraise, and assimilate evidence from scientific studies related to their patients’ [mental health] problems.”
5. Systematically analyze practice using quality improvement methods with the goal of [mental health] practice improvement.
6. Establish a practice environment that normalizes integration of mental health into its primary and secondary prevention efforts; incorporate principles of trauma-informed practice; and apply chronic care methods to the care of children and adolescents with psychosocial risks, undifferentiated mental health problems, and identified mental health disorders.
7. Identify parents and youth, including those who have lived with mental health problems, to advise the practice on its mental health services and patient and family friendliness.

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8. Use information technology to access data for population management of patients with mental health conditions.
9. Implement a patient-/family-centered care team, including on-site clinicians, staff, and key off-site collaborators, all trained in care of children and adolescents affected by trauma and other social adversities and supportive in meeting team members' own psychosocial needs.
10. Establish systems within the practice to support mental health services; elements may include:
 - a. preparation of office staff and professionals to create an environment of respect, agency, confidentiality, safety, and trauma-informed care, beginning with the family's first contact
 - b. preparation of office staff and professionals to identify and manage patients with suicide risk and other mental health emergencies
 - c. anticipatory guidance to promote mental health within the context of the practice's primary care or subspecialty services
 - d. routines for gathering patient's and family's psychosocial history, conducting psychosocial/behavioral assessment (per *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition) and, as indicated in the practice setting, performing and interpreting family and patient psychosocial screens
 - e. registries, evidence-based protocols, and monitoring/tracking mechanisms for patients with positive psychosocial screens, adverse childhood experiences and social determinants of health, behavioral risks, and mental health problems (including patients/families not prepared to take action on mental health concerns, patients with medical comorbidities, and patients for whom psychopharmacologic agents have been prescribed by the practice or by a collaborating mental health specialist)
 - f. culturally and linguistically appropriate educational materials on mental health and substance use topics for children and families
 - g. directory of mental health and substance use disorder referral sources, school-based resources, and parenting and family support resources in the region
 - h. tools for facilitating coding and billing specific to mental health
 - i. tools for coordinating the care provided by mental health, surgical, and medical specialists

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“Interpersonal and communication skills”: clinicians can optimize their interactions with children, adolescents, and their families by developing competence in performing the following activities:

1. Elicit mental health concerns from a child or adolescent and family.
2. Use a strengths-based approach when gathering a history and counseling a family.
3. Explore the cultural context of a patient’s and family’s symptoms or concerns.
4. Collaborate with child/adolescent and family to establish the agenda for an outpatient visit involving a mental health issue.
5. Apply motivational interviewing techniques and family engagement strategies to addressing psychosocial risks and behaviors, planning further assessment as needed, developing a differential diagnosis for mental health concerns, seeking consensus on a mental health plan of action, and preparing the family for a mental health consultation.
6. Identify and address barriers preventing a patient and/or family from seeking or accepting help for a mental health problem (eg, sense of hopelessness, inadequate insurance or financial resources, family conflict, stigma) or adhering to a plan of care.
7. Manage resistance or anger in child/adolescent and/or family.
8. Interpret to families current evidence related to the safety and efficacy of relevant therapeutic options.
9. Promote healthy lifestyles that contribute to mental health.
10. “Communicate effectively with physicians, other health professionals, health-related agencies” and educators in the mutual care of children and adolescents.
11. Convey, clarify, and discuss psychological test results, mental health findings, and concerns with children, adolescents, and families in a nonjudgmental manner, in language that is appropriate for age, education level, and cultural norms.
12. Close a mental health visit in a supportive, efficient manner.

“Professionalism”: clinicians can work toward realizing their full potential as providers of mental health care to children and adolescents by developing competence in performing the following activities:

1. “Demonstrate compassion, integrity, and respect” for all children, adolescents, and family members.
2. Reflect on one’s own limitations, cultural biases, or perceived stigma in thinking about social and mental health problems.
3. Demonstrate understanding that promoting emotional wellness is an integral part of the pediatric profession.
4. Assume responsibility for assessing and managing children and adolescents with common and uncomplicated mental health problems.

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5. Demonstrate sensitivity to cultural differences and family preferences in addressing mental health concerns.
6. Establish clear expectations in children, adolescents, and their families about conditional confidentiality (specific to state laws), exchange of protected health information, and business practices.
7. Discuss one's professional limitations in knowledge and skills as part of the referral process.
8. Recognize one's own symptoms of stress and compassion fatigue and take steps to address them.

“Systems-based practice”: clinicians can maximize their impact on child and adolescent mental health by developing partnerships with parents, youth, school personnel, and other child advocates; mental health, adolescent, and developmental-behavioral specialists; health and human service agency representatives; and/or AAP chapter and national leaders by developing competence in performing the following activities:

1. Establish collaborative relationships with mental health professionals, Early Intervention and school personnel; and/or health and human service agencies involved in supporting and treating children and families with psychosocial problems; and define respective roles in assessment, treatment, coordination of care, exchange of information, and family support.
2. Demonstrate awareness that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits exchange of information among treating clinicians, even from substance use disorder and mental health specialists, with the exception of written psychotherapy notes and substance abuse treatment records that are maintained by a licensed substance abuse program (42 USC § 290dd-2; 42 CFR 2.11).
3. Participate in multidisciplinary meetings, appropriately applying such skills as reflective listening, mediation, and consensus building.
4. Contribute to development of public health, child care-based, and school-based initiatives that promote the resilience and healthy social-emotional development of children and adolescents and reduce the precipitants of toxic stress.

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