Pediatric Mental Health and the Power of Primary Care: Practical Approaches and Validating Challenges

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ABSTRACT
Introduction: With over 300 school shootings in the past 5 years, the unprecedented use of online social media, and the growing demands of academia, mental illness is quickly becoming one of the top causes of morbidity and mortality in the pediatric population. In the past year, 90% of children in the U.S. visited their pediatric primary care provider (PCP), giving PCPs a unique opportunity to address the mental health needs of their patients.

Methods: The author conducted a comprehensive review of the literature.

Results: This clinical paper seeks to validate the mental health competency of pediatric PCPs, identifies current challenges, and outlines practical approaches to care.

Discussion: The consequences of untreated pediatric mental illness are indisputable. Pediatric PCPs have an obligation to address the growing pediatric mental health crisis directly. By utilizing standardized screening tools, referring to established clinical guidelines, seeking continuing education, and developing a comprehensive list of available resources, pediatric PCPs can incorporate mental health care into primary care. J Pediatr Health Care. (2019) XX, 1–9

KEY WORDS
Mental health, pediatrics, primary care, behavioral health

With more than 300 shootings in U.S. schools in the past 5 years, an unprecedented use of the internet and social media, and the growing demands of academia, the mental health of children and adolescents is significantly affected by the increased stressors in today’s society (Everytown for Gun Safety, 2018; Spies Shapiro & Margolin, 2014). Pressures from cyberbullying and endless exposure to highly curated, filtered versions of reality on social media make a substantial impact on the mental health of children and adolescents as they learn to develop their own identity (Cramer, 2017; Moreno & Whitehill, 2014). As the pressure from these stressors builds, it can lead to physical symptoms, such as disordered eating and sleeping, an inability to concentrate, irritability, and even hostility, leading to significant functional impairment and reduced performance in school, work, and extracurricular activities (Bedewy & Gabriel, 2015).

Untreated mental illness is the number one risk factor for suicide and the second leading cause of adolescent death for the sixth consecutive year (Heron, 2016). Suicide claims the lives of over 5,500 U.S. children and adolescents annually, with more youth dying from suicide than cancer, congenital abnormalities, and chronic heart and lung disease combined (Heron, 2016). Children and adolescents with mental health disorders account for 70% of those incarcerated in juvenile detention centers and up to 20% of those who do not finish grade school (Hjorth et al., 2016; National Institute of Mental Health, 2018). Research suggests that more than half of school shooters have underlying mental health disorders, and their actions leave a long-lasting impact on the students, school, and community as a whole (Beland & Kim, 2016). Furthermore, children and adolescents with mental health disorders experience disordered growth and development throughout childhood, often leading to long-term disability and impaired function in adulthood (Wissow, van Ginneken, Chandna, & Rahman, 2016).

Recent evidence suggests that over the next few years, mental illness will continue to rise, quickly becoming one of the five top causes of morbidity and mortality in the...
The worldwide prevalence of pediatric mental and behavioral disorders is between 17% and 20% (Centers for Disease Control and Prevention, 2017). In the United States alone, it is estimated that as many as one in five children will have a debilitating mental disorder at some point in their life, with 50% of mentally ill adults showing symptoms before the age of 14 years (Centers for Disease Control and Prevention, 2017). Mental and substance use disorders are the leading cause of disability worldwide, with 23% of all years lost and more than $2.5 trillion economic output lost annually because of disability caused by mental illness (Trautmann, Rehm, & Wittchen, 2016; WHO, 2015). A large cross-sectional study involving 17 countries and 47,609 participants showed a statistically significant association between the presence of mental illness and subsequent chronic physical conditions, including heart disease, chronic pain, and stroke, suggesting that a person's mental health has a direct impact on their physical health (Ohnberger, Fichera, & Sutton, 2017; Scott et al., 2016). Diagnosing and treating mental illness early can prevent long-term health consequences (Schatell, 2016).

DISCUSSION: WHY PRIMARY CARE?
Primary care is the initial setting where patients with mental health complaints present for evaluation and treatment (Olfson, Kroenke, Wang, & Blanco, 2014). The percentage of pediatric visits related to mental or behavioral disorders is increasing faster than any other type of primary care visit, with the top five “sick” visits related to behavioral concerns (Olfson et al., 2014; Yogman, Betjemann, Sagaser, & Brecher, 2018). Although children and families often seek care without framing it as a mental health visit, a quarter of patients seen in primary care settings meet the diagnostic criteria for at least one mental health disorder, with more than 40% experiencing functional issues at home or in school but not meeting the diagnostic criteria (AAP, 2018).

Current data relate the gap in mental health care to multiple factors, including a substantial lack of specialty providers, the stigma of mental illness, the high costs associated with receiving specialty services, and lack of insurance coverage (Younger, 2017). Integrating mental health into pediatric primary care has the potential to bridge this care gap by improving access, reducing stigma, lowering costs of care, and ensuring coverage for services.

A Case for Primary Care
Dilemma: Lack of access to specialty providers
It is estimated that only 8,500 child and adolescent psychiatrists actively practice in the United States, with a need exceeding 30,000 (American Academy of Child and Adolescent Psychiatry [AACAP] 2015). In 2015, the American Academy of Child and Adolescent Psychiatry published a nationwide workforce map, indicating that not one of the 50 states in the United States had an adequate supply of behavioral health specialists to meet their recommendation of 47 per 100,000 children (AACAP, 2015). In fact, 41 of the 50 states were classified as having a severe shortage, with only 1 to 17 practicing child—adolescent psychiatrists per 100,000 children (AACAP, 2015).

Solution in primary care: High rate of primary care visits
Current research identifies primary care as an untapped solution for helping address the growing mental health crisis in the pediatric population. The most current estimate reports there are more than 50,000 actively practicing pediatric PCPs in the United States who can deliver necessary preventative care and treatment to children and adolescents (American Medical Association, 2017; Petterson et al., 2012). Patients visit their PCP more than any other practitioner, and pediatric patients spend a significant amount of time in office visits before the age of 18 years, with an overall annual visit rate of 2.3 visits per person (Heron, 2016). In
a cross-sectional, population-level survey involving a sample of 16,731 participants, patients indicated a strong preference for their PCPs (Bitton, Baughman, Carlini, Weissman, & Bates, 2016). Research attributes this to patients believing that their providers know them well, and viewing their providers as knowledgeable, supportive, and trustworthy (Rhodes, Sanders, & Campbell, 2014). A small interview-based study by Rhodes et al. (2014) involving 38 participants with varied socioeconomic backgrounds found that patients feel confident with their PCP's medical expertise and believe the service quality is superior, facilitating a sense of psychosocial security. The family-centeredness of primary care provides a unique opportunity to address the needs of pediatric patients with mental and behavioral disorders on a population level (Rhodes et al., 2014).

Current literature also identifies a strong patient preference for primary care in mental health management. In a quasi-experimental study evaluating the effectiveness of primary care behavioral health treatment in 475 patients with depression and/or anxiety, more than half of the patients had a clinically significant reduction in their symptoms based on their PHQ-9 scores and a self-reported satisfaction survey (Balasubramanian et al., 2017). Patients in the study attributed this to the comfort and support they felt when receiving holistic care by their PCPs, who often incorporated medical management with mental health (Balasubramanian et al., 2017).

In an expansive study evaluating trends in the National Ambulatory Medical Care Survey from 1995 to 2010, it was found that 60% of patients with mental health disorders were initially diagnosed by their PCP (Olfson et al., 2014). A shift was also seen in visits from psychiatrists directly to PCPs, and most patients (73%) being treated for depression were managed by their PCP (Olfson et al., 2014). Patients also consider PCPs to be the second most helpful resource in terms of diagnosing and managing health care, even more than mental health specialists and second only to their families (Yap, Reavley, & Jorm, 2013).

Dilemma: Stigma of mental illness

The relationship between stigma and mental illness has a longstanding history and has been widely studied (Zeidler Schreiter et al., 2013). Patients who feel stigmatized generally feel a sense of shame, loss of self-esteem, and participate less in academic and vocational activities (Clement et al., 2015). Many people feel that having a mental health condition comes with a stigmatizing label, and patients often feel reluctant to accept a mental health referral when it is recommended (Zeidler Schreiter et al., 2013).

Stigma comes in many forms, including public, perceived, internalized, anticipated, experienced, or through association with mentally ill family members or friends (Clement et al., 2015). The stigma surrounding mental health disorders impedes necessary help-seeking behavior because many individuals delay or avoid seeking care for fear of being stigmatized (Clement et al., 2015). In a large interview-based study involving 3,021 young participants, stigma (self-perceived or public) surrounding mental health treatment was directly correlated to help-seeking behaviors (Yap et al., 2013). The more the participants were stigmatized and made to believe that mental illness was a sign of personal weakness rather than an medical condition, the less likely they were to seek help (Yap et al., 2013). Furthermore, in a retrospective chart review of 237 commercially insured adolescent patients referred out for mental health treatment, only 18% followed up on their referral, reflecting the stigma associated with getting mental health treatment (Hacker et al., 2014).

Solution in primary care: Normalizing mental health care

PCPs can play a huge role in helping to reduce stigma, and managing mental illness in primary care offers the “normalcy” and comfort of the primary care setting (Corrigan et al., 2014; Zeidler Schreiter et al., 2013). Accessing mental health care within primary care allows patients to receive services from their trusted provider in a familiar environment (Zeidler Schreiter et al., 2013). In a qualitative research study involving 166 health care providers and a separate review of literature, it was found that the better the relationship between a patient and health care provider, and the more the providers felt comfortable and confident discussing mental illness with their patients and the less likely the patients felt stigmatized when seeking care for mental health concerns (Corrigan et al., 2014; Rössler, 2016). Discussing mental health concerns and treatment using a similar method to any other disorder a child may experience helps reduce stigma and enhances access (Corrigan et al., 2014).

Dilemma: Significant mental health care expenditures

It is estimated that $247 billion is spent annually on the management and treatment of pediatric mental health disorders, largely related to hospitalizations and emergency room visits to treat acute symptoms, as well as costs associated with premature mortality (National Institute of Mental Health, 2018). Mental illness that is not addressed early on is costly to patients, their families, and society, and mental illness is among the top chronic medical conditions driving health care costs in the United States (National Institute of Mental Health, 2018).

Solution in primary care: Primary care cuts costs

The enactment of the Affordable Care Act in 2009 brought attention to the valuable role of primary care in lowering costs of health care with its ability to offer comprehensive and preventative care (Cuellar, 2015). The Institute of Medicine defines health care comprehensiveness as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs” (Institute of Medicine (US) Committee on the Future of Primary Care, 1994, p. 16). In a large study involving the patients of 3,652 physicians, it was found that receiving comprehensive care by PCPs lowered health-related expenditures and led to fewer
hospitalizations (Bazemore, Pettersen, Peterson, & Phillips, 2015).

Substantial evidence suggests that preventative care and early intervention leads to better outcomes and decreased costs, specifically in the mental health care of pediatric patients (Cuellar, 2015). A randomized controlled trial study of 321 pediatric patients revealed that costs associated with mental health treatment in primary care settings were lower than in both specialty and acute care settings, while at the same time having positive effects on patient outcomes and decreasing parental distress rates (Yu, Kolko, & Torres, 2017). In another large study that reviewed the difference between inpatient and outpatient costs, it was found that behavioral health integration in primary care using a collaborative care approach saves an average of $3,363 per patient over 4 years, with returns of $6.50 for every $1 invested in integration (Unützer, Harbin, Schoenbaum, & Druss, 2013). Preventing mental health problems before they occur, or addressing them early, prevents long-term health consequences, significant financial burdens, and disability (Cuellar, 2015).

**APPROACHES TO DATE**

In 2007, to meet the growing need, the AAP released a “mental health toolkit” for providers to use as a blueprint for treating mental illness in primary care, offering techniques and competencies that address childhood mental health problems head on (AAP, 2009). Approaches to standardizing the integration of mental health into primary care were also made relevant in 2007 when the World Health Organization published the “Service Organization Pyramid for an Optimal Mix of Services for Mental Health,” a global model on integrating mental health into primary care. Although this model was created over a decade ago, key points from it can and should still be considered, including the PCPs’ ability to address childhood mental illness early, as well as identifying concerns that do not meet diagnostic criteria according to the DSM-V but continue to affect healthy growth, development, and life functioning (AAP, 2009). Since then, various strategies have been explored to further improve access and mental health care in the pediatric population (Njoroge et al., 2016).

The most popular models for managing mental health in primary care include collaborative care management and colocation, both of which involve coordination between behavioral health specialists and PCPs (Njoroge, Hostutler, Schwartz, & Mautone, 2016).

**Collaborative Care**

A widely recognized model for behavioral health integration is the evidence-based collaborative care model, with the first positive effectiveness trials published in the early 1990s (McGough, Bauer, Collins, & Dugdale, 2016). In collaborative care, the PCP works with other members of a primary care-based team, which can include specialty trained nursing staff, social workers, and care managers. Emphasis is also placed on behavioral health specialists helping PCPs manage patients with mental health disorders in their own environment, leaving the referrals for the more severe, acute cases that require intensive specialty care (Zeidler Schreiter et al., 2013). Other key elements of this model emphasize collaboration with community resources and the involvement of patients taking an active role in treatment-related decision making (Goodrich, Kilbourne, Nord, & Bauer, 2013). It supports a “team-building” culture, whereby regular contact (by telecommunication or in person) is established between PCPs and specialists to build professional relationships, open lines of communication, and strengthen the continuity of care (Kim et al., 2015). It is the typical model used when PCPs work with providers of other specialties and has extensive research supporting its implementation and practice (Kolko & Perrin, 2014). In a meta-analysis of results from 79 studies involving patients with depression and anxiety, it was found that patients and providers both favored the collaborative care approach in short-, medium-, and long-term care (Katzelnick & Williams, 2015). Despite these promising statistics, critics argue that truly collaborative care is difficult to achieve because it requires a fundamental change in the system of care (Katzelnick & Williams, 2015). In addition, some studies suggest that although collaborative care is effective, it is often more expensive (Jolly et al., 2016).

**Colocation**

In colocation models, behavioral health specialists including psychiatrists, psychologists, and specialty trained nurse practitioners or physician assistants work directly on-site with PCPs to manage mental health concerns (McGough et al., 2016). Although the attraction to this model is growing, the literature leaves many unanswered questions and suggests that colocation alone does not improve mental health outcomes (McGough et al., 2016). The severe shortage of mental health specialists simply limits the feasibility of this model (Wener & Woodgate, 2016).

**VALIDATING CHALLENGES**

Although PCPs are optimally positioned to address the mental health needs of pediatric patients, several challenges have been identified in current literature, including cultural, structural, and financial barriers (Guerrero et al., 2017). The burden of additional training, finding time to provide routine mental health care in primary care settings, and issues with reimbursement are proven challenges to behavioral health integration (Kolko & Perrin, 2014).

**Time Constraints**

The most common barrier identified in existing literature is the current organizational structure of primary care practices, which limits the amount of time available to adequately screen, diagnose, and treat the complexities of mental and behavioral disorders (Arora et al., 2017). Time constraints in primary care often result in treatment being limited to psychotropic medication, because providers lack the time and/or training to also deliver the necessary psychosocial counseling (Olfson et al., 2014). Primary care visits are generally shorter than psychiatrist visits, and the time allotted to mental health care is even more constrained in a primary
In a study of primary care residency programs at two large teaching hospitals in the United States, it was found that doctors undergo insufficient training in mental health care and subsequently report low comfort levels and confidence in treating patients with mental illness (Olsson et al., 2014). Similarly, in a 2015 comprehensive review of literature, advanced practice nurses specializing in primary care had little to no additional training in mental health care, with no current published literature identifying the current mental health training practices of masters’- or doctoral-level primary care nurse practitioners (Theophilos, Green, & Cashin, 2015). There is also great variability in the interest level of PCPs in treating mental illness. The results of a study by Iskander et al. (2014) suggest that although more training in mental health care increased the physicians’ comfort level in treating mental illness, it did not change their practice (Iskander et al., 2014). In fact, 90% of the residents indicated that they would prefer to treat less patients with mental illness, or none at all (Iskander et al., 2014). Although most pediatric providers endorse responsibility of identifying mental health concerns, far less claim their role in treating them (Dempster et al., 2015).

PRACTICAL APPROACHES FOR INDIVIDUAL PROVIDERS

The most common models of care for children with behavioral health disorders highlight referrals and collaboration with behavioral health specialists (Yogman et al., 2018). However, in a large systematic review of reviews, the effectiveness of practice change in primary care using complex interventions was evaluated, with a common finding that of all the interventions applied, more improvements were seen when the strategies targeted individual providers (Lau et al., 2016). This is indicative of the provider’s potential to create change on a broader level, starting with their own personal practices and altering their current routines. With the shortage of external mental health resources, practical and self-directed approaches for pediatric PCPs should be explored.

EVIDENCE-BASED STEPS

Use Available Screening Tools

One of the key findings in an extensive research study by the U.S. Secret Service examining 37 incidents of targeted violence and mass shootings in schools found that the incidents were rarely impulsive acts, but rather the result of comprehensive planning and cumulative events, with the attackers exhibiting multiple signs of mental illness before the incident (Vossekuii, Fein, Reddy, Borum, & Modzeleski, 2004). The research suggested that there was no pattern or “profile” of students who engaged in these attacks, but that key characteristics including demographics, personality, and social and academic history varied substantially (Vossekuii et al., 2004). In addition, 78% of the attackers never received a formal mental health evaluation despite showing multiple signs of mental illness including suicidal thoughts or attempts (Vossekuii et al., 2004). These findings support universal screening and surveillance of all pediatric patients, regardless of perceived or self-reported risk factors. Using screening
tools is one way to standardize care and identify at-risk patients who may not be otherwise showing signs or symptoms of mental illness before their condition escalates to the point of violence or self-inflicted harm.

Bright Futures, developed by the AAP, is one of the most widely accepted and used guidelines for pediatric preventative health care in the United States, and identifies screening and surveilling patients at every opportunity as an invaluable tool for health promotion (Finnell, Stanton, & Downs, 2014; Hagan, Shaw, & Duncan, 2008). The guidelines discuss the importance of promoting and supporting not only physical health but also cognitive, social, and emotional well-being, all of which contribute to healthy growth and development (Fussell, Rodgers, & Connors Edge, 2016).

Although standardized screening tools are readily available to providers and are proven methods to identify patients with mental health concerns, studies show they are significantly underused (Dempster et al., 2015). In a study involving 69 PCPs, it was found that although most PCPs agree that addressing mental health is important for the patient’s overall health, less than half routinely screened for or assessed their patient’s current behavioral or developmental status (Dempster et al., 2015). To address this, the AAP offers a comprehensive listing of screening and assessment tools for use in the pediatric population (AAP, 2012). This includes the highly specific 17-item Pediatric Symptom Checklist and the more comprehensive 35-item Pediatric Symptom Checklist, both freely accessible, easy to complete, and quick to score. Forms can be mailed before the visit or given at the point of care and are an inexpensive and effective way to get the opinions of multiple observers, including parents, teachers, and even siblings (Augustyn, Zuckerman, & Caronna, 2011). When a patient screens positive during a well-child examination, it is then possible, if needed, to schedule a longer “problem visit” to address any concerns appropriately (Augustyn et al., 2011).

Making these screenings a routine part of practice will normalize common mental health concerns and has the power to reduce related stigma (Schell, 2016). In a narrative synthesis of 45 papers describing 38 studies, Wissow; van Ginneken, Chandna, & Rahman (2016) revealed that screenings framed as universal and confidential were the most widely accepted, and even negative screenings initiated further discussions and increased the number of mental health referrals. Just as providers plot height and weight measurements on a growth chart as a marker for current physical health status, surveilling mental health over time can be done by using standardized screening tools. Screening tools are an effective and inexpensive way to integrate mental health screenings into a variety of practice settings at every wellness examination.

Refer to Established Clinical Guidelines

The availability of established guidelines specific to PCPs is limited but includes the Guidelines for Adolescent Depression in Primary Care. This first-ever guideline was designed to assist providers in identification and initial management of depression in adolescents in the primary care setting (Zuckerbrodt, Cheung, Jensen, Stein, & Laraque, 2018).

Furthermore, providers can use current interventions such as those highlighted in the behavioral skills building program, Creating Opportunities for Personal Empowerment. This program was developed by Nurse Practitioner Bernadette Melnyk and allows clinicians who undergo a 4-hr training workshop to deliver time-limited, Cognitive Behavioral Skills Building Therapy sessions during their brief, 20- to 30-min primary care visits. This easy-to-implement program can be administered in both group and individual sessions and is supported by evidence to reduce symptoms of depression and anxiety in adolescents (Lusk & Melnyk, 2013).

Seek Relevant CME or Specialty Certification

Although CME/CE (Continuing Medical Education/Continuing Education) emerged to help providers disseminate information, it has been widely used to boost providers’ confidence and help shift behaviors in clinical practice (Filipe, Silva, Stulting, & Golnik, 2014). Obtaining CME promotes provider accountability and plays a role in improving management, team building, and interpersonal communication and can be individually tailored based on the needs of the provider (Filipe et al., 2014). In a study of the effectiveness of a continuing education program on the mental health management skills of psychiatric PCPs (n = 7,582), it was found that providers who participated in continuing education treated their patients more confidently and effectively, making more appropriate referrals and leaving the emergency room referrals to only the most clinically severe cases (McCaffrey, Chang, Farrelly, Rahman, & Cawthorpe, 2017). CME is an indispensable part of maintaining competency in practice and helps providers stay up to date on relevant clinical issues (Davies, Lello, Downey, & Friedman, 2017). CME credits to aid in the management of pediatric mental illness in primary care are available through professional organizations, universities, and online websites dedicated to providing ACCME-accredited CME credits.

In addition, providers may seek specialty certification in the area of mental health. The Pediatric Nursing Certification Board offers a Pediatric Mental Health Specialist certification for advanced practice nurses. The role of Pediatric Nurse Practitioners (PNPs) is expanding, and PNPs make up 4% of pediatric PCPs, with 51.6% of PNPs working in outpatient settings (American Association of Nurse Practitioners, 2019; Ortiz et al., 2018). PNPs are uniquely qualified to provide cost-effective care and play an instrumental role in improving access to mental health in the pediatric population. Obtaining specialty certification further validates the nurse practitioner’s expertise and commitment to providing comprehensive mental health care.

A subspecialty certification, Developmental-Behavioral Pediatrics, is also available to pediatricians who possess the special skills for, and advanced knowledge of, treating developmental difficulties and behavior problems in pediatric patients (American Board of Pediatrics, 2018). Similarly,
physician assistants can obtain a Certificate of Added Qualification in psychiatry, which highlights their knowledge of the diagnosis and treatment of behavioral and mental health conditions. Specialty certifications are linked to increased provider confidence in their clinical skills, professional credibility, and, in turn, improved patient outcomes (Lindgren & Lancaster, 2016).

**Develop a Resource List**

In a study of training methods in seven primary care practices, it was found that provider training alone is not enough to increase their confidence level or improve health outcomes for patients with behavioral disorders (Chew-Graham et al., 2014). Instead, it discusses “active linking” as one of the most important components in providing comprehensive mental health care, which involves mapping out local mental health organizations and resources for both patient and provider use (Chew-Graham et al., 2014). Research shows that with an increase in routine mental health screening, increased rates of positive screens and subsequent need for treatment or referral will inevitably occur (Hacker et al., 2015). However, PCPs may not be aware of the resources available to them and may misperceive services as being inconvenient or unavailable to their patients (Dempster et al., 2015). By developing and tailoring a list of resources that fit the local needs and priorities of individual practices, the confidence level of providers and readiness to adapt and treat mental illness in all of its complexities may increase (Chew-Graham et al., 2014). Being aware of and using additional resources available in the local community is supportive of holistic, patient-centered care (McGough et al., 2016).

**CONCLUSION**

On average, one in five children and adolescents experience mental health concerns, and mental illness will quickly become one of the leading causes of pediatric morbidity and mortality in this population if left unaddressed (Njoroge et al., 2016). Targeted school violence including mass shootings, high rates of suicide and self-harm, and decreased functioning in school and family life are all linked to untreated mental illness (Hjorth et al., 2016; Wissow et al., 2016). With barriers to care including a nationwide shortage of specialty providers, concerns about stigma, and high costs of treatment, patients with mental health concerns are falling through the cracks, and up to 85% of them do not receive timely, evidence-based care (WHO, 2015). Fortunately, 90% of children in the United States visit their PCP each year, offering a huge opportunity for PCPs to provide much needed mental health services early to prevent long-term consequences (Tyler et al., 2017). Pediatric patients and their families trust their PCPs, and therefore, managing mental health disorders in a primary care setting has the power to reduce stigma, decrease health care costs, and significantly improve access (Younger, 2017).

The AAP endorses the PCP’s role in addressing common mental health conditions and promotion of healthy growth and development throughout childhood and adolescence (AAP, 2017). To meet the mental health crisis head on, pediatric PCPs must appreciate the centrality of mental health to sustained physical health and overall well-being (Wissow et al., 2016). By using the easily accessible mental health screening forms, developing a list of local mental health resources, and continuing to seek additional education, training, and certification in the area of mental health, providers have the tools necessary to improve long-term health outcomes in patients with mental health disorders. Although challenges to integrating behavioral health will remain, including time constraints of primary care, concerns with reimbursement, and lack of interest or experience in mental health, no change in practice comes easy. The failure of incorporating mental health care into primary care will result in significant delays in diagnosis, complications from lack of treatment, and, most alarmingly, an increased risk of premature mortality (Kim et al., 2015; Kolko & Perrin, 2014). Pediatric PCPs can no longer ignore the care gap that is contributing to the pediatric mental health crisis. Instead, PCPs should endeavor to use every opportunity to adequately screen, diagnose, and manage mental health issues in primary care and deliver the care their patients so desperately need and are trusting them to provide.

**SUPPLEMENTAL MATERIALS**

Supplemental material associated with this article can be found, in the online version, at https://doi.org/10.1016/j.jpeds.2019.09.013.

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