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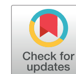
Responding to the Child Mental Health Emergency: Future Pediatricians to the Rescue?



Over the past decade, there has been an unprecedented surge in the rates of depression, anxiety, trauma, and suicide among children and adolescents.[1,2] The coronavirus disease 2019 pandemic has thrown fuel on the fire of mental health problems, especially among minoritized youth.[3,4] Data from a large meta-analysis of 29 studies including more than 80 000 children and adolescents from North America, Europe, and Asia indicate that the global prevalence of clinically significant symptoms of depression and anxiety has more than doubled during the pandemic, rising to approximately 25% and 20%, respectively.[3] In response to this public health crisis, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association have declared a national state of emergency in child and adolescent mental health.[5]

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This public mental health crisis occurs in the context of a critical national shortage of child behavioral and mental health specialists, with fewer than 10 child and adolescent psychiatrists for every 100 000 children.[6] Even before the pandemic, only one-half of the children with treatable mental health disorders received treatment from a mental health professional.[7] With limited access to specialty mental health care, who can help to meet the needs of the many children and adolescents suffering with mental illness? The American Academy of Pediatrics and the American Board of Pediatrics (ABP) have charged pediatricians to diagnose and treat children with mild-to-moderate attention-deficit/hyperactivity disorder, anxiety, and depression.[8,9] Pediatric primary care clinicians have become the de facto mental health providers as the sole physicians responsible for treatment of more than one-third of children with mental health problems.[10]

Yet, pediatricians in practice, including those who recently graduated from residency training, report limited competence in their ability to diagnose and treat children and adolescents with mental health problems.[11,12] A minority of senior pediatric residents and recent graduates surveyed report high competence in child mental health assessment (33%) and treatment (19%).[11] In recognition of this major gap in pediatric residency training, the ABP has exhorted residency programs to better prepare trainees to deliver mental health care.[13]

To inform pediatric residency curricular changes, it is important to understand how and in which clinical settings pediatric residents develop competence in child mental health care. Building on a previous finding that pediatric residents learned the most about child mental health in their continuity clinics,[14] Green et al sought to determine whether onsite (ie, colocated or integrated) behavioral and mental health (B/MH) clinicians in continuity clinics were associated with greater pediatrician competence in mental health assessment and treatment.[15] In this volume of *The Journal*, the authors defined integrated care as having a B/MH clinician onsite who plays an active role seeing patients with the resident and/or precepting for B/MH issues that arise during clinic.[15] In contrast, colocation was defined as having an onsite B/MH professional who sees patients in their own practice but does not precept or see patients with the resident. They analyzed data from a national, cross-sectional survey of more than 1500 pediatric trainees and recent graduates applying for the initial ABP examination. The authors hypothesized that pediatric residents who trained with B/MH professionals onsite would have greater self-reported competence in B/MH care compared with those without an onsite B/MH professional. Based on their adjusted logistic regression analyses, they found that those residents with an onsite B/MH professional in clinic were significantly more likely to report high competence in both assessment and treatment.

Surprisingly, there was no significant difference in composite competence in either assessment or management between those pediatricians who had integrated vs colocated B/MH clinicians. Unlike the colocated B/MH model, the integrated model includes a B/MH clinician to supervise residents and precept for B/MH issues in clinic. One would expect that residents with these experiential learning opportunities would have greater self-reported competence in mental health care. In contrast, a colocated model that facilitates mental health referrals but does not involve B/MH clinicians in precepting residents might shift mental health care away from the trainees and limit their chances to develop skills in assessment and treatment. The authors note that their survey did not clarify the extent of collaboration, communication, and didactic training that the colocated

ABP	American Board of Pediatrics
B/MH	Behavioral and mental health

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B/MH clinician provided. As such, it is possible that a colocated model could have included educational experiences beyond staffing patients with the resident that may have blurred the lines between the 2 onsite models. The authors acknowledge this as a limitation to the study.

According to the study, nearly one-half of the residents reported no onsite B/MH professional in continuity clinic. Given the limited availability/accessibility of child B/MH clinicians, future studies are needed to further clarify the amount of time and type of collaboration with an onsite B/MH clinician that is minimally necessary to help pediatric residents develop critical skills in child mental health care. The study authors defined the B/MH clinician broadly to include licensed clinical social workers, psychologists, and child and adolescent psychiatrists—each of whom may differentially affect trainee competence in aspects of assessment and treatment. For example, child and adolescent psychiatrists would play a particularly important role in helping residents develop competence in treatment using psychotropic medication for attention-deficit/hyperactivity disorder, anxiety, and depression. However, the study did not explore which types of B/MH professionals are required to develop pediatric resident competence in caring for children with B/MH problems.

An unprecedented number of youth are suffering from mental health problems. It is important to determine feasible, practical ways that pediatric residency training programs can collaborate with a limited supply of B/MH clinicians to provide experiential learning opportunities to identify, diagnose, and treat children with mild- to moderate-severity mental health problems. There is an urgent need to build and study models that help pediatric trainees develop these critical skills in child mental health care so that they may serve the millions of patients and their families in need. ■

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