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GUEST EDITORIAL

Pediatric Mental Health Crisis: Propelling the Surgeon General's Advice to Action

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The nation is facing a pediatric mental health crisis that is years in the making. The pandemic potentiated the crisis by isolating youth and compounding family stressors. In response, the US Surgeon General issued an advisory in late 2021 recommending actions that health care and other sectors should take to improve youth well-being. Integrated care has a critical role to play in both implementing and moving beyond the Surgeon General's recommendations. The Collaborative Family Healthcare Association's Pediatric Special Interest Group (SIG) meets monthly to provide support and learning experiences and to promote dissemination of innovations to address the pediatric mental health crisis. In this article, we share recommendations, informed by the conversations in the CHFA Pediatric SIG, to propel the Surgeon General's advice into actions. We prioritize and emphasize structural changes that are needed in the health care system and highlight practical and actionable steps individual providers can take to increase cross sector collaboration.

Keywords: pediatrics, behavioral health, integrated care

Our youth are in crisis, and it started long before the COVID-19 pandemic. As leaders within the Pediatrics Special Interest group in the nation's leading integrated care organization (Collaborative Family Healthcare Association [CFHA]), it is critically important for us to underscore the severity of this crisis and the need for action. Youth Risk Behavior Survey data show that youth mental health significantly worsened from 2009 to 2019. In a typical classroom of 30 high school students in the year before the pandemic, 11 would be experiencing persistent feelings of sadness or hopelessness, around 6 seriously considering attempting suicide, and around 3 attempted suicide (Centers for Disease Control and Prevention, 2019). The suicide rate among young people increased by 47% between 2007 and 2018 (Curtin, 2020) and is in the top three leading causes of death for youth aged 10 to 19 (National Vital Statistics System, 2020a, 2020b). Dr. John Ackerman (Nationwide Children's, 2018) put the enormity of youth suicide into context by explaining that, prior to the pandemic, the number of deaths from youth suicide was the equivalent to the terrorist attacks on September 11, 2001 occurring every 18 months.

The pandemic has certainly exacerbated this ongoing crisis. The percentage of ED visits with eating disorders among adolescent females doubled and emergency department visits for suicide attempts rose 51% between 2019 and 2022 (Radhakrishnan et al., 2022). This exacerbation is not just experienced by youth with clinical diagnoses; during the pandemic, almost half of all high

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school students have felt persistently sad or hopeless (Adolescent Behaviors and Experiences Survey, 2021). Additionally, more than 140,000 children have lost a parent or grandparent to COVID as of June 2021; with children of color being the most impacted (Hillis et al., 2021). When pandemic stressors hit caregivers, it often increases negative parenting approaches (e.g., yelling, focus on harsh punishments) thereby increasing emotional and behavioral difficulties of youth, particularly when caregivers have a history of adverse experiences themselves (Hails et al., 2021).

The Surgeon General's Advisory

On the heels of multiple pediatric professional organizations' calls to action (see American Academy of Pediatrics, 2021), in late 2021 the US Surgeon General, Dr. Vivek H. Murthy, issued an advisory that officially declared a national youth mental health crisis. The aims of the advisory are to describe the severity of the crisis and provide guidance on how numerous entities, including schools, media organizations, governments, companies, caregivers, and others can work together to support youth mental health. The advisory outlines five recommendations for health care systems and providers: (1) focus on prevention and trauma-informed care principles, (2) routinely screen for mental health problems and risk factors, (3) address the mental health needs of caregivers, (4) form community partnerships, and (5) build multidisciplinary teams (Office of the Surgeon General, 2021). Integrated care was specifically cited as a critical component to addressing the crisis.

Five Responses

In addition to highlighting the state of youth mental health and making others aware of the plan set forth by "the nation's doctor," this article contextualizes the Surgeon General's recommendations within ongoing development of pediatric integrated care. Specifically, we share recommendations, informed by the conversations in the CHFA Pediatric Special Interest group (SIG), to propel the Surgeon General's advice into actions. We prioritize and emphasize structural changes that are needed in the health care system and include exemplar practices that are consistent with the Surgeon General's recommendations. For those seeking immediate actionable steps individual providers can take to increase cross sector collaboration, we have provided some initial ideas in Figure 1.

We Need an Enhanced Focus on Prevention

We were glad to see that the Surgeon General's advisory recognized that the prevention of mental health challenges is an essential priority. We should continue our focus on developing innovative ways to engage in prevention work on a population-based level. One promising program that is strengths-based, prevention focused, and addresses the call for family and caregiver health is HealthySteps (Zero to Three, 2022). HealthySteps specialists provide brief support for families with children up to age three in the context of their pediatric visit, with a focus on primary prevention. The program screens families for needs and provides risk stratified services addressing child development and behavior. HealthySteps could be delivered as a stand-alone service or within the context of a Primary Care Behavioral Health or similar integrated care program. As of 2022; the program operates in 25 states and 214 pediatric primary care practices. Families who received services through the program had higher odds of attending health surveillance visits and completing vaccines at five months (Ammerman et al., 2022); lower rates of obesity and improved social-emotional functioning (Gross et al., 2015), including for caregivers who have experienced maternal trauma (Briggs et al., 2014). For more on HealthySteps, see www.healthysteps.org and Rahil Briggs et al.' (2016) implementation guide.

Screening is Important, and We Cannot Screen for Everything

The Surgeon General report highlights the important role that routine screening for youth mental health challenges plays within and beyond health care settings, particularly when that screening is linked to appropriate and equitable treatment. A multitude of studies show that we can effectively implement mental health and developmental screening in primary care (e.g., Beck et al., 2022; Lipkin et al., 2020; Sokol et al., 2019); for a list of pediatric screeners appropriate for primary care, refer to the Screening Technical Assistance and Resource Center (American Academy of Pediatrics, 2022).

However, we need to carefully consider screening fatigue and thus screening economy in pediatric primary care. While we can screen for mental

Figure 1

Actions You Can Take Now

- Join the Collaborative Family Healthcare Association Pediatric Special Interest Group and attend our meetings where we provide resources, opportunities for networking, and discussion on the topics of youth behavioral health and pediatric integrated care.
- Set up a meeting (or have clinic leadership set up a meeting) with at least one cross-sector partner to coordinate care for youth you serve. In our experience, beginning with schools yields the largest return.
- Consider joining a local government task force, elected position, or advisory board working to improve youth wellbeing and/or behavioral health workforce development in your area. Start by staying up to date about what is occurring in your community by reading the local paper, identifying your elected representatives (https://myreps.datamade.us/index.html), attending city or county commission meetings, and discussing how your community contributes to both wellness and stress with the families you serve to identify potential areas of support.
- Identify and map your screening processes to find overlaps in content or outcome and potential gaps. Additionally, ask your team, "How are we making this data actionable?" If screening data is not currently actionable, determine how to make it actionable and develop evidence-based protocols to respond to screening; this will improve efficiency and outcomes. If you cannot make it actionable, evaluate whether it is necessary and adds incremental value.
- Ask your families and patients about the crisis and what they think would make the biggest difference in your community.
- Advocate for protected time in your job to conduct quality improvement, program development, and cross-sector collaborations. Articulate a clear plan about how this work aligns with the needs of the clinic, values of your healthcare team or system, and will improve efficiency and/or outcomes.
- Collect outcomes data in your practice and leverage that data to negotiate competitive rates and/or the funding of novel pilot projects (e.g., projects focused on prevention) with your payors.
- Identify gaps in your team and work with your clinic's leadership to consider what additional professionals could be added to fill those gaps (e.g., community health workers, family peer mentors). Include return on investment analyses in your pitch to hire new team members.

health problems, social determinants, caregiver well-being, health behaviors, developmental milestones, adverse childhood experiences (ACEs), and protective factors, the list can quickly become overwhelming for both families and primary care teams. We need further research to better understand and develop screening economy. Specifically, it is essential that we investigate and prioritize screeners that are efficient, accurately stratify a patient's risk at the individual level, target malleable factors, are matched to the needs of the community, are incrementally valid, and lead to improved outcomes when implemented in pediatric primary care. For example, the recently updated policy statement by the American Academy of Pediatrics (AAP) on the impact of toxic stress on youth seeks to shift clinical and research frameworks from a primarily problem centered focus on toxic stress (e.g., ACEs screening) to a strengths-based focus on relational health and building "safe, stable, and nurturing relationships" for children given the poor predictive validity of ACEs at the individual level (Garner & Yogman, 2021). Given protective factors are often malleable and can be screened in primary care, we need more research comparing the predictive accuracy between risk and resilience screeners and incremental validity screening to determine if it is more effective to screen for risk versus protective factors or if there is clinically meaningful value to screening for both. As practices make choices about which screeners to use, they should consider that emerging evidence promotes screening and intervening around protective factors.

We Need to Consider Broadening Our Multidisciplinary Teams

We were happy to see that multidisciplinary and integrated care is being highlighted as a solution to the pediatric mental health crisis, in addition to larger child-serving systems integration. We know that teamwork in health care can lead to better outcomes (Rosen et al., 2018), and we should consider who else we should invite to our teams, regardless of the model of integrated care we use. While workforce availability may drive the formation of some teams, we should be open to broadening our sense of "team" to extend our reach. For example, (Chacko et al., 2020) demonstrated that psychologist-trained Family Peer Advocates (in this case, women of color with high school education) could successfully deliver behavioral parent training components to caregivers of children with ADHD.

Broadening our team can also include partnerships with systems outside of health care. Cross sector collaborations are important, and communication across sectors can be difficult but not impossible. For example, Community Health Workers (CHWs) can help patients coordinate services across sectors, increase access to services, and improve some health outcomes, particularly for underserved patients (Johnson & Gunn, 2015; Pinto et al., 2020). In addition to being a member of the team, CHWs can be an organizer and conduit of information from other systems (e.g., school, community resource, juvenile justice) to the health care team. CHWs may also be able to take on the bulk of resource management within a primary care clinic, allowing a Behavioral Health Consultant more time to address clinical needs. Overall, emerging technologies such as care-portals (Epstein et al., 2016) may make the Surgeon General's recommendations easier to incorporate into the busy workflows of integrated health care teams by establishing a HIPPA/FERPA compliant conduit for asynchronous communication across sectors such as medical clinics and schools.

We Need to Make Progress While Mitigating Burnout

The Surgeon General's report acknowledges that health care worker well-being must be supported while working to improve the pediatric mental health crisis. This is important, given that rates of health care worker burnout are a significant problem that the pandemic has worsened (Rehder et al., 2021). As health care organizations work to address burnout (for an example, see (Stanford Medicine, 2022), priority should be given to addressing systems level issues that could create or exacerbate workforce burnout and taking steps to prioritize creating jobs that are meaningful and sustainable. Compared to treating work exhaustion, mitigating burn out does not always mean working less, but rather experiencing more control, agency, and effectiveness in one's work. For example, quality improvement (QI) activities, particularly those targeting the cross-sector approaches defined in this advisory, may help address burnout (Rotenstein & Johnson, 2020). For example, integrated clinicians may find value in using QI to build cross-sector partnerships to help spread the work of caring for the large numbers of children needing behavioral health supports, even though this may require an

initial lift. Financial reimbursement for these activities would also help to address burnout.

We Need Scalable, Value-Based, and Sustained Integrated Care Funding

Many of the recommendations within the Surgeon General's advisory fall under the value-added, but largely nonbillable types of services within fee for services payment models (e.g., prevention, cross-sector collaboration). While value-based payment models are needed across the life span, the advisory rightly recognizes that the rapid development as well as the multitude and interdependence of cross-sector systems (e.g., schools, daycare, protective services, legal, athletic) throughout childhood makes value-based funding of particularly important for pediatric integrated models.

The advisory does acknowledge this and recommends that the government ensures adequate payment for pediatric mental health services, invests in innovative payment models for integrated and team-based care, ensures compliance with mental health parity laws, invests in prevention programs, and supports expansion of the mental health workforce. It also mentions the Centers for Medicare & Medicaid Services Innovation Center's Integrated Care for Kids (InCK) model, which funds six states to develop alternative payment models. While grants and pilot programs are helpful and important, we need systemic, scalable, and sustaining improvements to how integrated care is funded to effect change on the population level nationally and accomplish the aims of the Surgeon General's report that are as easily accessed by community pediatric offices as they are academic health centers.

Conclusion

The growing youth mental health crisis has been exacerbated by the pandemic. Recommendations from the Surgeon General can be a guiding framework for how we can begin to respond. Significant structural changes are needed to achieve the wide-spanning recommendations in the report, enhance our focus on prevention, screen effectively and efficiently, broaden and interconnect our teams, mitigate workforce burnout, develop sustainable integrated care funding pathways, and address societal drivers of this crisis; though there are some small steps individuals can take to start moving down this path (see Figure 1). Pediatric primary care is on the front line of taking care of youth's physical, mental developmental, and academic health, and it will take an intentional, team-based, and cross-sector approach to address the significant challenges that fuel and result from the mental health crisis. Despite its power and potential, we agree with the Surgeon General's conclusion that primary care cannot remediate all contextual societal ills that are contributing to this crisis within 15- to 30-min appointments a few times per year. It is this dialectic that we must attend to with intention and compassion: Integrated health care teams and the actions of the individual team-members alone will not resolve this crisis; and this crisis will not resolve without intentional, multidisciplinary, and effective integrated health care teams. We believe we must understand and embrace this dialectic to recognize the potential for burnout in assuming sole responsibility for resolving this crisis. Integrated health care teams are only a part, though an important part, of the solution to this crisis.

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