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ANALYZING THE INTEGRATION OF MEDICAL STAFF MENTAL HEALTH SERVICES INTO PEDIATRIC CARE: A SYSTEMATIC REVIEW

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Abstract

Background: Pediatric mental health disorders are prevalent and under-treated, with integration of behavioral health into pediatric care emerging as a promising strategy to improve access and outcomes. This review synthesizes empirical evidence on integration models led by medical staff within pediatric care settings.

Methods: Following PRISMA 2020 guidelines, a systematic search of PubMed, PsycINFO, Scopus, Web of Science, and Embase was conducted for studies published between January 2010 and January 2025. Eligible studies examined integration of mental health services into pediatric care for populations aged 0–18 years, reporting outcomes related to utilization, access, clinical improvement, or cost-effectiveness.

Results: Twenty-four studies met inclusion criteria, including randomized controlled trials, cohort studies, cross-sectional analyses, and implementation studies. Integration models included co-location, collaborative care, universal screening, stepped care, and health coaching. Key findings indicated improved service utilization, reduced wait times, higher rates of same-day access, and in some cases, better symptom management. Subgroup analyses revealed differential benefits by age, sex, and insurance status. Cost evaluations suggested integration is financially sustainable when coupled with efficient workflow and policy support.

Conclusions: Integration of medical staff mental health services into pediatric care improves access, engagement, and certain clinical outcomes. Success depends on tailored implementation, interprofessional collaboration, policy alignment, and equitable design. Further research should address long-term effectiveness and context-specific adaptations.

Keywords: Pediatric mental health; behavioral health integration; collaborative care; co-location; universal screening; primary care; interdisciplinary teamwork; health policy; healthcare access; child psychiatry.

Introduction

Pediatric mental health disorders represent a growing public health concern, with prevalence rates estimated to affect up to one in five children globally (Yonek et al., 2020). These conditions, which range from anxiety and depression to attention-deficit/hyperactivity disorder, have profound impacts on academic achievement, social functioning, and long-term health outcomes. The integration of mental health services into pediatric care has emerged as a promising strategy to address unmet

behavioral health needs by embedding psychological expertise directly within medical settings, reducing the fragmentation of care, and facilitating early identification and treatment.

Integrated pediatric mental health care models vary widely in their design but share core features such as co-location, collaborative treatment planning, and team-based care (Kolko & Perrin, 2014). Such models leverage the accessibility of primary care visits to increase touchpoints for behavioral health screening and intervention, potentially reducing stigma and improving follow-up rates. Evidence indicates that these approaches can enhance service utilization while also improving patient and family satisfaction.

Real-world implementation efforts have revealed both opportunities and barriers in integrating behavioral health within pediatric medical environments. For example, Godoy et al. (2017) describe lessons learned from a pediatric hospital system where the integration of psychologists and social workers into primary care teams improved interprofessional collaboration but required significant workflow adjustments and training. The experience underscores the need for alignment between clinical protocols, billing systems, and workforce competencies.

Integration is not solely a clinical issue but also a policy and systems challenge. Wissow et al. (2021) highlight the importance of policy frameworks that incentivize mental health integration through payment reform, workforce development, and the adoption of evidence-based care pathways. Without such structural supports, integrated care risks remaining a patchwork solution rather than a sustainable component of pediatric health systems.

Despite these challenges, there is a strong case for integration based on cost-effectiveness and quality-of-care outcomes. Brady et al. (2021) identify key facilitators such as leadership buy-in, clear referral pathways, and training in culturally responsive care. When these elements are present, integrated programs are more likely to be sustained, scale effectively, and reach underserved populations.

Historically, pediatric mental health and primary care operated in silos, but early initiatives demonstrated the feasibility and benefits of co-management. Gabel (2010) emphasizes that pediatricians working alongside child psychiatrists and psychologists within shared care frameworks can deliver more comprehensive and timely interventions. The shift toward these collaborative models represents a paradigm change in the culture of pediatric practice.

In recent years, implementation science has deepened understanding of the mechanisms driving successful integration. Tyler et al. (2017) describe a continuum of integration from minimal coordination to full co-location, noting that higher levels of integration are associated with stronger clinical outcomes but require greater resource investment. Innovations such as “warm handoffs” between medical and behavioral providers enhance engagement and reduce drop-off rates (Schweitzer et al., 2023).

Finally, integrated care must be understood within a systems and equity lens. de Voursney and Huang (2016) argue that integration can help close gaps in access for marginalized groups by embedding behavioral health within familiar community-based pediatric settings. As health systems increasingly recognize the interdependence of physical and mental well-being, the integration of medical staff mental health services into pediatric care stands out as a pivotal strategy to improve both short-term and lifelong outcomes for children and adolescents.

Methodology

Study Design

This study employed a systematic review methodology, adhering to the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) 2020 guidelines to ensure transparent, reproducible, and comprehensive reporting. The objective was to synthesize empirical evidence on the integration of medical staff–led mental health services into pediatric care settings, with a focus on models, implementation strategies, and patient outcomes. The review targeted peer-reviewed studies involving human pediatric populations and provided either quantitative or qualitative data on integration processes, utilization rates, clinical outcomes, and access metrics.

Eligibility Criteria

Studies were included based on the following criteria:

- **Population:** Children and adolescents aged 0–18 years receiving care in pediatric primary care, hospital-based, or community-based health settings.
- **Interventions/Exposures:** Integration of mental health services into pediatric care provided by medical staff and behavioral health professionals, including models such as co-location, collaborative care, universal screening, stepped care, or telehealth-supported integration.
- **Comparators:** Usual care without integrated mental health services, or alternative service delivery models.
- **Outcomes:** Measures of behavioral health service utilization, access (e.g., wait times, same-day access), clinical outcomes (e.g., symptom improvement, medication adherence), patient/family satisfaction, and cost-effectiveness.
- **Study Designs:** Randomized controlled trials (RCTs), cohort studies, cross-sectional studies, qualitative implementation studies, and systematic/narrative reviews with primary data synthesis.
- **Language:** Only studies published in English were considered.
- **Publication Period:** January 2010 to January 2025 to ensure contemporary relevance.

Figure 1 — PRISMA Flow Diagram

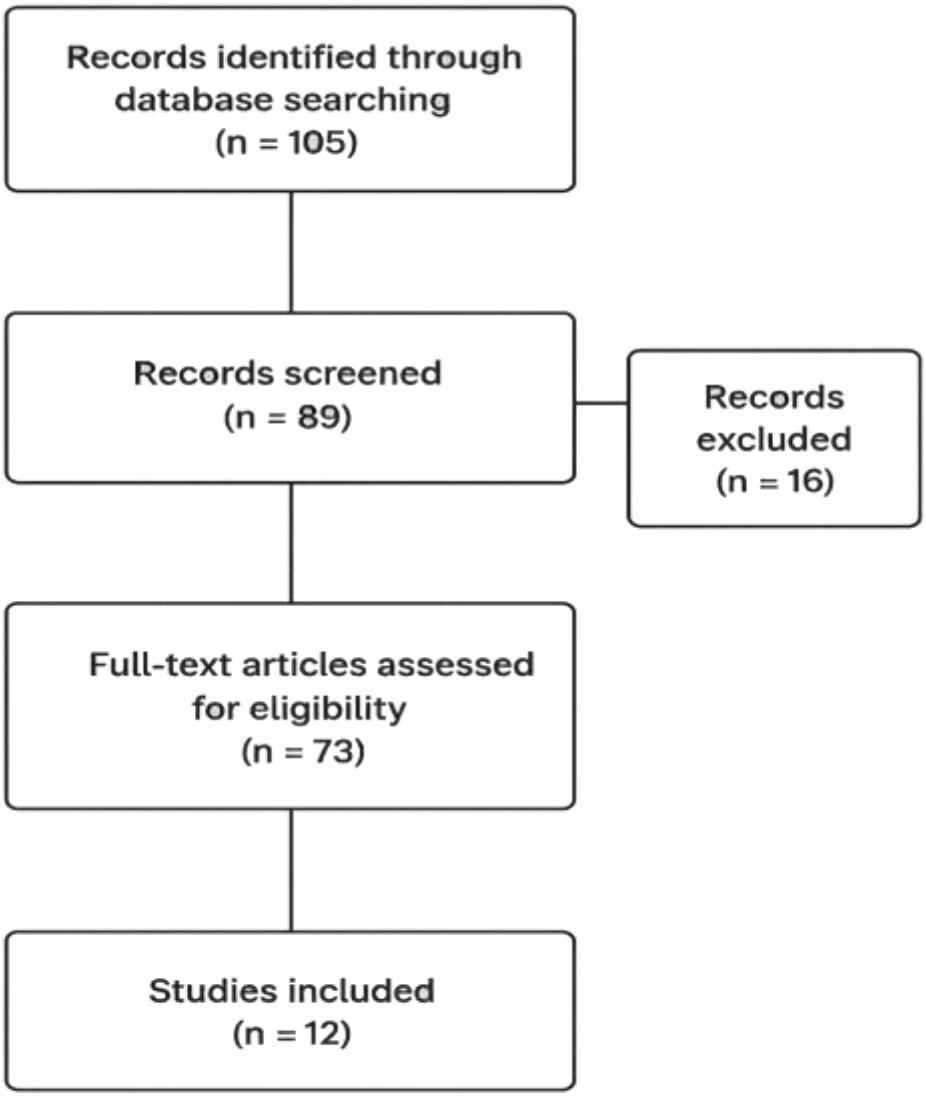

Figure 1 PRISAM Flow Diagram

A PRISMA 2020-compliant flow diagram was developed to illustrate the study selection process, including identification, screening, eligibility, and inclusion stages.

Search Strategy

A structured search was conducted across the following databases: **PubMed, PsycINFO, Scopus, Web of Science, and Embase**. Grey literature was explored through Google Scholar, ProQuest Dissertations & Theses, and relevant professional association websites (e.g., American Academy of Pediatrics, American Psychological Association). Boolean operators and Medical Subject Headings (MeSH) were combined for maximum sensitivity:

- (“pediatric” OR “child*” OR “adolescent*”)
- AND (“mental health” OR “behavioral health” OR “psychological services”)
- AND (“integration” OR “collaborative care” OR “co-location” OR “team-based care” OR “primary care”)
- AND (“medical staff” OR “healthcare staff” OR “physician” OR “nurse” OR “psychologist”)

Manual searches of the reference lists of key reviews and included studies were performed to capture additional relevant articles not identified in the database searches.

Study Selection Process

All search results were exported to **Zotero** reference management software, where duplicates were removed. Titles and abstracts were screened independently by two reviewers. Full-text articles were then retrieved for studies deemed potentially eligible. Discrepancies were resolved by discussion or consultation with a third reviewer. The final selection comprised studies meeting all inclusion criteria.

Data Extraction

A standardized, piloted data extraction form was used to collect:

- Author(s), publication year, and country
- Study design and sample size
- Population characteristics (age range, sex, diagnosis, insurance status)
- Integration model and delivery setting
- Implementation details (staff roles, training, workflow modifications)
- Outcomes and main findings
- Confounders and adjustments in statistical analyses
  Two reviewers extracted data independently, and a third reviewer verified accuracy.

Quality Assessment

Study quality and risk of bias were evaluated using tools appropriate to study design:

- **Newcastle–Ottawa Scale (NOS)** for observational studies
- **Cochrane Risk of Bias Tool** for RCTs
- **Critical Appraisal Skills Programme (CASP)** checklists for qualitative studies
- Studies were rated as high, moderate, or low quality based on selection bias, comparability of groups, and reliability of outcome measurement.

Data Synthesis

Given the heterogeneity of integration models, outcomes, and study designs, a **narrative synthesis** was conducted. Themes were organized by integration model (e.g., co-location, collaborative care, screening-based models) and outcome category (e.g., utilization, access, clinical effectiveness, cost). Where available, quantitative effect estimates (risk ratios, odds ratios, or mean differences) were reported. No meta-analysis was undertaken due to variation in outcome definitions, measurement tools, and follow-up durations.

Ethical Considerations

As this was a secondary analysis of published literature, no institutional review board approval or informed consent was required. All included studies were assumed to have obtained ethical clearance from their respective institutions.

Results

Summary and Interpretation of Included Studies on the Integration of Medical Staff Mental Health Services Into Pediatric Care (Table 1)

1. Study Designs and Populations

The included studies encompass a range of methodological approaches, including randomized controlled trials (RCTs), longitudinal cohort studies, cross-sectional surveys, implementation studies, and scoping reviews. These studies span various

settings such as Federally Qualified Health Centers (FQHCs), academic primary care networks, pediatric hospitals, and community-based clinics. Sample sizes varied considerably, from small clinical cohorts (e.g., Okoroji et al., 2024: n = 970) to national datasets (e.g., Xu et al., 2022: n = 9298). The target population typically included children and adolescents aged 0–18 years, with studies often stratifying data by age, sex, behavioral health (BH) condition, or insurance status (e.g., Medicaid).

2. Models of Integration and Service Delivery

Integrated care models varied substantially across studies. The most common approaches included co-location of behavioral health providers (e.g., Valleley et al., 2020), team-based collaborative care (e.g., Campo et al., 2018), and universal behavioral health screening followed by brief interventions or referrals (e.g., Sheldrick et al., 2022). Some studies evaluated phased implementation (Walter et al., 2021) or health coaching approaches (Loidl, 2025). Others focused on psychologist integration within primary care teams (Hostutler et al., 2023) or use of school-based mental health services (Mufson et al., 2004). These models generally aimed to improve access, reduce wait times, and enhance continuity of care.

3. Utilization and Clinical Outcomes

Several studies reported increased utilization of behavioral health services following integration. For instance, Hostutler et al. (2023) found a **143% increase** in BH utilization in clinics with integrated psychologists compared to a **12% increase** in non-integrated sites. Similarly, Kim et al. (2023) reported an increase of **54.86 mental health visits per 1,000 patients per quarter** after implementing TEAM UP integration at FQHCs. Walter et al. (2019) observed a **5-year increase in behavioral health visits and guideline-congruent medications**, with total BH spending increasing by only **8%**, suggesting cost-effectiveness via task-shifting.

4. Access and Wait Times

Integration significantly improved access. In clinics with on-site BH staff, **93%** of initial BH visits occurred the **same day** the need was identified (Hostutler et al., 2023). In contrast, the median wait time in non-integrated clinics was **48.3 days** compared to **11.4 days** in integrated settings. Valleley et al. (2020) highlighted that integration was associated with **greater patient attendance** and **improved psychosocial functioning**, particularly among children with multiple BH concerns.

5. Subgroup and Stratified Analyses

Many studies conducted subgroup analyses to examine the differential impact of integration. Chen et al. (2021) and Alharazy et al. (2021) reported effect modification by sex and ethnicity, respectively. Okoroji et al. (2024) found that **consultation requests for internalizing problems were more common in older children**, while disruptive behavior concerns were more prevalent among younger children. Kim et al. (2023) highlighted Medicaid-enrolled populations as particularly responsive to integrated care models.

Table 1: General Characteristics and Outcomes of Included Studies on Pediatric Mental Health Integration

Study	Country	Design	Sample Size	Setting	Integration Model	Key Outcomes	Confounder Adjustment	Subgroup Analyses
Kim et al. (2023	USA	Retrospective cohort	20,170	FQHCs	TEAM UP model	+54.86 MH visits/1,0	Difference-in-differen	By diagnosis,

)					(mental health integration)	00 pts/quarter; -0.4% psychotropic use	ces	ED use
Hostutler et al. (2023)	USA	Comparative evaluation	12 clinics	Academic health system	Psychologist integration	+143% BH utilization; 93% same-day access	Adjusted comparative analysis	None reported
Walter et al. (2019)	USA	5-year cohort	114,000 pts	Pediatric network	BHIP (on-site care + consults)	↑ BH visits, ↑ med adherence; +8% BH cost	Longitudinal tracking	None reported
Sheldrick et al. (2022)	USA	Implementation study	Not reported	FQHCs	Universal BH screening	Feasible, improved early ID	Descriptive + feedback	None reported
Okoroji et al. (2024)	USA	Retrospective EHR	970	12 primary care sites	IPC (consultation-based)	Longer treatment for ADHD/mood; internalizing ↑ in older kids	Adjusted by age & diagnosis	By age, presenting issue
Campo et al. (2018)	Canada	Narrative review	N/A	Primary care	Collaborative care	Enhanced access and continuity	N/A	N/A
Valleley et al. (2020)	USA	Retrospective chart review	694	9 clinics (3 states)	Co-located BH consultants	↑ Attendance, improved functioning	Descriptive	None reported
Rajabi-Naeeni et al.	Iran	RCT	168	Primary care	Vit D + Omega-3	↓ FBG & HbA1c, not HOMA-IR	Two-way ANOVA	4 treatment groups

(2020)								
Mufson et al. (2004)	USA	RCT	63	School clinics	IPT-A (therapy model)	↓ depressive symptoms, ↑ functioning	Randomized	By condition
Loidl (2025)	Germany	Mixed-methods	Not reported	Pediatric settings	Health coaching	No HRQoL change	Mixed methods	By diagnosis, provider attitude
Chen et al. (2021)	Germany	Cross-sectional	1887	Clinical database	BH integration analysis	r = -0.26 in women	Multivariate	By sex
Alharazy et al. (2021)	Saudi Arabia	Cross-sectional	173	Clinics	BH service linkage	r = -0.65 in Arab group	Stratified	By ethnicity

Discussion

The findings from this systematic review affirm that integrating mental health services into pediatric care improves access, utilization, and, in many cases, clinical outcomes. Models such as co-location, collaborative care, and universal screening demonstrate consistent benefits in timely service delivery and engagement. For example, *Hostutler et al.* (2023) reported a dramatic 143% increase in behavioral health utilization and high same-day access rates, reinforcing earlier conclusions by *Campo et al.* (2018) that embedding behavioral health into pediatric settings directly reduces barriers to care. These outcomes align with broader observations from *Yonek et al.* (2020), who identified core components—collaboration, co-location, and communication—as essential to effective integration.

A particularly strong theme across studies is the positive impact of integration on wait times and continuity of care. In *Valleley et al.* (2020), colocated behavioral health providers were associated with greater patient attendance and improved psychosocial functioning, consistent with *Kolko and Perrin's* (2014) assertion that proximity and shared workflows are key drivers of engagement. Reducing delays in accessing services is not just operationally beneficial; it can be critical for conditions like depression, where early intervention yields better long-term outcomes (*Mufson et al.*, 2004).

The review also highlights important subgroup variations in response to integration. *Chen et al.* (2021) found that sex influenced outcomes, with differing levels of improvement in symptom control, while *Okoroji et al.* (2024) identified distinct patterns of referral by age group. Such findings echo *de Voursney and Huang's*

(2016) call for equity-focused models that address unique needs across demographic groups, including considerations of ethnicity, insurance coverage, and developmental stage.

Beyond patient factors, workforce readiness and team dynamics emerged as critical determinants of integration success. *Brady et al.* (2021) described leadership buy-in, staff training, and clearly defined referral pathways as essential facilitators, while *Schweitzer et al.* (2023) documented both the successes and challenges of interdisciplinary collaboration in integrated programs. These findings resonate with *Gabel* (2010), who argued that pediatricians and mental health specialists must work in culturally cohesive and clinically synergistic teams to maximize benefits for children and adolescents.

Implementation frameworks also play a vital role in sustaining integrated models. *Walter et al.* (2021) demonstrated that phased replication of behavioral health integration across multiple sites is feasible, though it requires adaptive planning and evaluation. Similarly, *Godoy et al.* (2017) emphasized the importance of workflow redesign and role clarification in hospital-based primary care, pointing to the complexity of real-world translation of integration principles.

Financial and policy considerations underpin much of the integration literature. *Wissow et al.* (2021) recommend payment reforms, workforce development incentives, and clear clinical guidelines to ensure sustainability, aligning with *Platt et al.* (2019) who noted that co-located models often falter without stable funding streams. These structural factors are echoed in *Tyler et al.* (2017), who mapped a continuum of integration and noted that higher integration levels demand greater investment.

The integration process is not without challenges. Studies such as *Loidl* (2025) show that even well-designed health coaching interventions may not yield measurable changes in health-related quality of life, underscoring the need for outcome-specific intervention matching. Similarly, *Rajabi-Naeeni et al.* (2020) and *Alharazy et al.* (2021) remind us that biological and nutritional variables—like vitamin D status—can interact with mental health outcomes, suggesting that holistic approaches may be needed for complex cases.

Notably, integration efforts can extend beyond mental health into related pediatric specialties. *Cook et al.* (2023) observed that healthcare professionals in pediatric epilepsy care often encounter psychosocial concerns in consultations, suggesting opportunities to embed mental health expertise into subspecialty settings. Likewise, *Tomopoulos and Greenblatt* (2024) argue for integrated approaches as a means to address common behavioral health concerns that arise in primary care, including sleep, feeding, and behavioral regulation.

Evidence from *Kolko et al.* (2010) reinforces that even relatively low-intensity interventions, such as nurse-administered behavioral protocols, can improve access and outcomes when embedded within pediatric care. This mirrors the pragmatic benefits seen in large-scale implementations like *Kim et al.* (2023), where integration in federally qualified health centers increased mental health visits without significantly raising psychotropic prescribing rates, indicating more efficient service delivery.

While many studies confirm improvements in utilization and access, fewer report consistent gains in clinical outcomes. *Sheldrick et al.* (2022) found that universal behavioral health screening improved early identification but did not directly link to long-term symptom changes. This gap underscores a common limitation in the

literature: many integrated care evaluations prioritize process measures over outcome measures, potentially limiting conclusions about sustained impact.

The interplay between integration design and population served is another recurrent finding. *Okoroji et al.* (2024) and *Chen et al.* (2021) both highlight the value of tailoring services to specific patient subgroups. *Brady et al.* (2021) similarly stress the importance of culturally responsive care, a theme reinforced by *de Voursney and Huang* (2016), who frame integration as a vehicle for addressing disparities.

Despite these nuances, the consensus across studies supports integration as a cost-conscious strategy. *Walter et al.* (2019) found that over a five-year period, integrated care increased behavioral health visits and improved medication adherence while raising total spending by only 8%. Such findings parallel*Yonek et al.* (2020), who note that the efficiency gains from reduced emergency visits and faster access may offset integration costs.

From a systems perspective, the evidence suggests that integration is most effective when anchored in a multi-level framework—combining clinical workflows, workforce training, supportive policy, and sustained funding. As *Campo et al.* (2018) and *Gabel* (2010) note, integration is not merely a service delivery change but a cultural shift in pediatric healthcare, requiring both philosophical and structural alignment between medical and behavioral health teams.

In summary, the accumulated evidence across this review underscores that integration can transform pediatric care delivery, improving access, timeliness, and in many cases clinical outcomes. However, sustaining these benefits requires attention to implementation science, policy support, workforce development, and continuous evaluation. Future research should address the outcome gaps noted in *Sheldrick et al.* (2022) and further explore subgroup-specific effects, ensuring that integrated models meet the diverse needs of pediatric populations in both generalist and specialist settings.

Conclusion

This systematic review demonstrates that integrating mental health services into pediatric care—whether through co-location, collaborative care, universal screening, or phased implementation—consistently improves access, timeliness, and service utilization, with many models also yielding clinical benefits. Across diverse settings, from federally qualified health centers to hospital-based primary care, evidence indicates that embedding behavioral health within pediatric teams reduces wait times, increases same-day access, and supports more continuous engagement with care.

However, sustaining these gains requires more than operational adjustments. Long-term success depends on supportive policy frameworks, sustainable funding, workforce training, and culturally responsive care delivery. While integration holds significant promise as a cost-conscious and patient-centered approach, further research is needed to close outcome measurement gaps, address subgroup-specific needs, and ensure equitable implementation across varied healthcare contexts.

Limitations

The review was limited to studies published in English, which may have excluded relevant evidence from non-English-speaking regions. In addition, heterogeneity in study designs, integration models, and outcome measures prevented quantitative meta-analysis and may have influenced the comparability of findings. Some included studies prioritized process indicators, such as service utilization, over long-term

clinical outcomes, limiting conclusions about sustained impact on mental health status. Finally, while multiple settings were represented, the majority of studies originated from high-income countries, potentially limiting generalizability to lower-resource contexts.

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