

# Improving Children's Mental Health: The Bright Futures Approach



NIHCM  
FOUNDATION

One in five children in the U.S. suffer from mental illness, but only 20% receive treatment. The publication of "Bright Futures in Practice: Mental Health" is a major step in building partnerships to improve children's mental health. On February 5, 2002, the National Institute for Health Care Management (NIHCM) Foundation held a forum to introduce the Bright Futures guide and illustrate the incorporation of the Bright Futures concepts of mental health promotion and supervision into primary care. The forum was part of a series entitled "Bright Futures and Managed Care," which NIHCM Foundation is conducting under a cooperative agreement with the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB). This Action Brief summarizes key issues and discussion from the forum.

## OPENING PRESENTATIONS

**Trina Menden Anglin, MD, PhD, Chief, Office of Adolescent Health, Maternal and Child Health Bureau (Welcome)**

**Laura Sessions Stepp, MS, *The Washington Post* (Moderator for the Day)**

**Eve Moscicki, ScD, MPH, Senior Advisor, Office of the Surgeon General**

**Jeanne Ringel, PhD, Associate Economist, RAND**

**Dr. Trina Anglin** opened the forum by recounting the history of Bright Futures and providing an overview of MCHB activities in children's mental health. Bright Futures publications offer expert guidelines and a practical developmental approach to providing health supervision for children and adolescents. In 1995, recognizing that primary care health professionals were becoming increasingly

powerful frontline promoters of children's mental health, MCHB conceptualized *Bright Futures in Practice: Mental Health*. The guide, released at the forum, helps primary care providers realize their potential for enhancing children's and families' mental health and in providing appropriate services.

MCHB also supports other initiatives that address children's and parents' mental health through development of community model programs, technical assistance and training, and service provision:

- (1) *Integrated Health and Behavioral Health Care for Children, Adolescents, and their Families*. This program encourages communities to develop innovative models for delivering integrated health and behavioral healthcare for children, adolescents, and their families.
- (2) *Mental Health in Schools*. Two national training and technical assistance centers help schools, school districts, and health and mental health providers strengthen their abilities to address student mental health issues through training and

## TOPICS:

- National Agenda
- Data
- Bright Futures
- Psychosocial Issues
- Screening Tools
- State Models
- School Services
- Family's Role
- Family Perspectives
- Managed Care
- ADHD
- Depression/Suicide

*“I love the concept and title of Bright Futures because it means we focus not on what children cannot do, but what they can do, even in the midst of some severe problems.”*

*- Laura Sessions Stepp*

*“Primary care practitioners need tangible tools to help them assess children’s emotional and social needs, discuss mental health issues with families, and make appropriate referrals for intervention.”*

*- Eve Moscicki*

infrastructure development that fosters access to mental health services in schools.

- (3) *Leadership Training.* MCHB supports programs that train health professionals in behavioral pediatrics, public health social work, adolescent health care, and care of children with neuro-developmental disabilities.
- (4) *Healthy Start.* All sites (almost 100) provide clinical screening of women for perinatal depression and ensure that they receive mental health services.

**Laura Sessions Stepp** noted that most of her work focuses on reporting problems with children and the health care system, and she “love[d] the concept and the title of Bright Futures because it means we focus not on what children cannot do, but what they can do, even in the midst of some severe problems.” **Ms. Stepp** challenged the audience to think about ways in which Bright Futures and the information presented during the forum could be disseminated to the public at large.

### ***National Agenda for Children’s Mental Health***

**Dr. Eve Moscicki** provided a synopsis of federal initiatives, focusing primarily on the Surgeon General’s efforts to find workable solutions for mental health problems. Since 1999, the federal government has released *The Report of Surgeon General on Mental Health*, *The Report of Surgeon General on Youth Violence*, *The Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda*, *The National Strategy for Suicide Prevention*, and *Mental Health: Culture, Race, and Ethnicity*, and held several conferences.

The Surgeon General’s national agenda on children’s mental health calls for:

- (1) recognition of mental health as an essential part of child health;

- (2) integration of mental health services into all systems targeted at families and children;
- (3) incorporation of families’ and children’s perspectives in the development of all mental health care planning; and
- (4) development and enhancement of the public/private health care infrastructure to support efforts to the fullest extent possible.

Integrating mental health consultations into general health care may lead to early identification of problems and opportunities for prevention. Unlike immunization programs, mental health screenings are not typically included in primary care settings. “Primary care practitioners need tangible tools to help them assess children’s emotional and social needs, discuss mental health issues with families, and make appropriate referrals for intervention. They also need to be provided training opportunities to recognize early indicators of mental problems,” noted **Dr. Moscicki**.

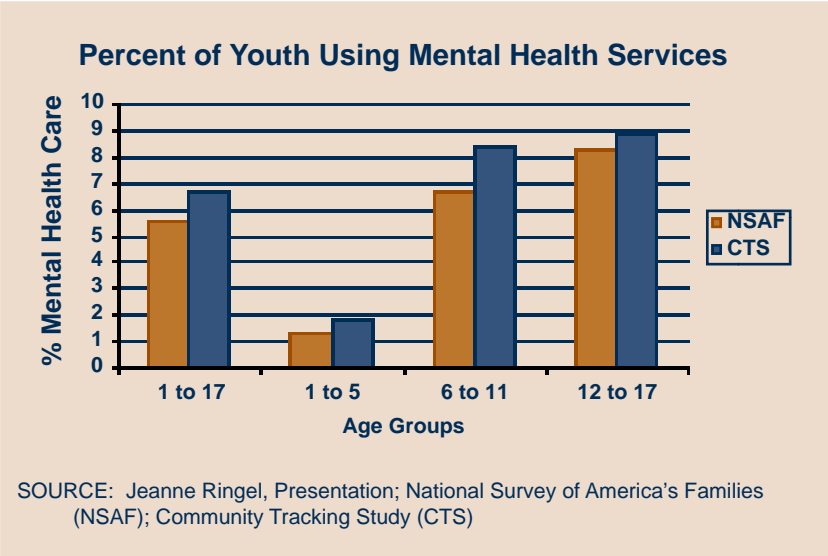
Because it does not provide universal, comprehensive, and continuous coverage, the current health care system inadequately addresses children’s mental health needs. Co-location of mental health services into primary care and school-based health centers, training of professionals, paraprofessionals, and family advocates, and creation of multidisciplinary programs may help increase access and improve continuity of services.

**Dr. Moscicki** also highlighted the need to provide incentives for scientifically-proven, cost-effective preventive and treatment interventions and disseminate information on these programs. All of these action steps require partnerships in research, practice and policy to facilitate knowledge transfer. The Office of the Surgeon General is working with the Federal Interdepartmental Working Group on Children’s Mental Health, the Department of Health and Human Services, the Department of Education, and the Department of Justice to improve children’s mental health.

**Review of Data on Mental Health Care for Youth**

**Dr. Jeanne Ringel** analyzed the characteristics of youth using mental health services and the rate of unmet care among those who exhibit mental problems. Her research revealed:

- (1) Five to seven percent of youths use mental health services. Nearly two-thirds of children who needed mental health services did not receive them.
- (2) Compared to the privately insured and the uninsured, children enrolled in Medicaid use services at twice the national rate at around 10%. Over 81% of uninsured youth did not receive needed care.
- (3) Hispanic children have the lowest rates of mental health care utilization at 4% to 5% and the highest rate of unmet need (77%). Utilization rates for white children are between 6% and 7% and the rate of unmet need compared to other ethnicities was the lowest at 59%.
- (4) The use rate for mental health care services for youths with no parents is nearly five times greater than for children with two parents (15% vs. 3%). However, the highest rate of unmet need is found in youths with two biological parents (70%).



- (5) Youths with parents who have poor mental health are twice as likely to use services as their peers who have parents with good mental health.

**Dr. Ringel's** research found that \$11.7 billion was spent on children's mental health services in 1998. The costs were distributed unevenly across the age groups with 60% spent on children between the ages of 12 and 17. Reflecting the shift from inpatient to outpatient care, inpatient expenditures, which accounted for two-thirds of the total cost in 1986, dropped to nearly 40%. The total cost of pharmaceuticals was \$1.1 billion, an indication of the great advance in drug therapy.

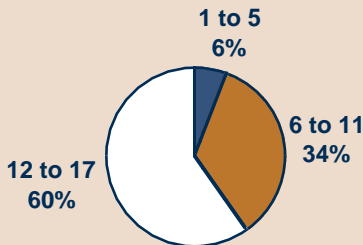
**Dr. Ringel's** cost-analysis of the privately insured indicates that a large proportion of children's mental health services are provided outside of the health system and primarily in the educational setting, not in the doctor's office. In addition, mental health services are increasingly being provided by primary care physicians.

**Dr. Ringel** remarked that while her "data on cost and utilization of mental health services gives you an idea of what services are being provided, it gives us no information about the quality and effectiveness of the care that is being provided." She stressed the tremendous need to better understand the quality of services provided in the fragmented health care delivery system.

*"Data on cost and utilization of mental health services gives you an idea of what services are being provided, [but] it gives us no information about the quality and effectiveness of the care that is being provided."*

*- Jeanne Ringel*

**Total Cost of Mental Health Care in Children and Adolescents, 1998**



**Total Costs in 1998 were \$11.7 billion**

- Costs per child per year:
- \$293 per adolescent
- \$163 per child age 6 to 11
- \$35 per pre-schooler

SOURCE: Jeanne Ringel, Presentation

## BRIGHT FUTURES: ASSESSMENT AND SUPERVISION IN PRIMARY CARE

**Michael Jellinek, MD, Chief, Child Psychiatry Service, Massachusetts General Hospital, and Professor, Psychiatry and Pediatrics, Harvard Medical School**

**Barbara Howard, MD, Co-Director, Center for Promotion of Child Development through Primary Care**

**J. Brad Ummer, Principal Partner, FliK**

### **Overview of Bright Futures in Practice: Mental Health**

**Dr. Michael Jellinek** introduced the *Bright Futures in Practice: Mental Health* guide. This book focuses on children's daily functioning, self-esteem, and interactions with school, family, and friends. The goals of the guide are to:

- (1) Promote mental and emotional health and well-being of children, adolescents, and families;
- (2) Provide prevention, early recognition, and intervention strategies in primary care settings; and
- (3) Encourage partnerships and collaboration between health professionals, families, and communities.

The guide consists of two volumes, a mental health practice guide and a tool kit. The practice guide contains the Introduction, Developmental Chapters, and Bridge Topics. The Introduction addresses issues such as making mental health supervision accessible, managing time and reimbursement issues, continuity of care, training, cultural competence, attitudes about mental health, and coordination and referral. **Dr. Jellinek** noted Dr. Kelly Kelleher's research, which revealed that "many offices have a rotating system of primary care doctors taking

care of patients which may be efficient for the office, but is not necessarily the best approach to caring for children and families."

The Developmental Chapters are organized by age group: infancy (newborn to 11 months); early childhood (1 to 4 years); middle childhood (5 to 10 years); and adolescence (11 to 21 years). Each chapter highlights the most important developmental issues within these functional areas such as attachment in infancy, mastery in early childhood, school functioning in middle childhood, and family communication in adolescence. The emphasis is on mental health as a positive construct. This section also highlights areas of concern such as insecure attachment, severe tantrums, difficulty forming friendships, bullying, academic difficulties, low self-esteem, and mood problems. The chapters provide developmental checklists for each well-child visit, as well as suggestions for office practices to promote family partnerships and for community practices to promote child mental health.

Bridge Topics lists key facts, symptoms of, and interventions for the most common mental health problems found in primary care settings such as attention deficit hyperactivity disorder (ADHD), anxiety, eating and mood disorders, learning disabilities, and substance abuse. This section of the guide forms a bridge between mental health promotion and illness prevention to early recognition and management.

The second volume is the Mental Health Tool Kit, which is designed to support primary care providers in screening, education, and health care management. It is comprised of screening measures and questionnaires, resource lists, interactive handouts, and forms to facilitate communication with schools for the health care practitioner. It also includes tools such as health education handouts and reading lists for families and children.

"We've put together a very practical guide. It doesn't break down all the barriers of providing mental health services, but our hope is that it will walk pediatricians, school-based providers, and families through normal psychosocial development of a child as well as provide guidance if there are problems," **Dr. Jellinek** said. For example, Bright Futures gives step

*"[Bright Futures is] a very practical guide. It doesn't break down all the barriers of providing mental health services, but ... it will walk pediatricians, school-based providers, and families through normal psychosocial development of a child as well as provide guidance if there are problems."*

*- Michael Jellinek*

by step mental health supervision suggestions for adolescent depression.

Primary care practitioners can use promotion and prevention tips from the Developmental Chapters such as, "Obtain a history of psychiatric problems in the family including depression, suicide, and substance abuse," and "Reassure adolescents and their parents that depression is not their fault, that it has a biological basis, and that it can be treated successfully."

For more specific screening guidance, providers can turn to Bridge Topics, which includes potential questions to pose like: "What do you do when you feel really down and

depressed?"; and, "Have you ever felt bad enough that you wished you were dead?" They can also access numerous checklists, including a self-test to determine a youth's depression level, and handouts to distribute to families about recognizing depression symptoms. In addition, providers can use steps listed on page 10 in the Introduction to refer the youth to a specialist.

The mental health guide can assist health professionals in efficiently providing mental health services to children and adolescents in a primary care context. The *Bright Futures in Practice: Mental Health* guide may be viewed, downloaded, or ordered through the Internet at [www.brightfutures.org/mental\\_health](http://www.brightfutures.org/mental_health).

## BRIGHT FUTURES IN PRACTICE: MENTAL HEALTH AT-A-GLANCE

### Introduction

**Making Mental Health Supervision Accessible:** Managing time and reimbursement issues, continuity of care, training, cultural competence, attitudes about mental health, coordination and referral.

### Developmental Chapters

**Infancy:** Temperament, regulation, family formation, attachment, stimulation

**Early Childhood:** Self-control, self-esteem, cooperation, sibling relationships, socialization, school readiness

**Middle Childhood:** Self-esteem, inner life, what matters at home, school functioning

**Adolescence:** Self-esteem, mood, body image, sexuality, identity and independence, family relationships, roles, rules and responsibilities, friends and leisure activities, school functioning, injury prevention, violence perpetration and exposure, substance use and abuse

### Bridges

Anxiety Disorders

Attention Deficit Hyperactivity Disorder

Child Maltreatment

Domestic Violence

Eating Disorders

Learning Problems and Disorders

Mental Retardation

Mood Disorders: Depressive and Bipolar Disorders

Oppositional and Aggressive Behaviors

Parental Depression

Pervasive Development Disorders

Substance Use Problems and Disorders

### Appendix

Diagnostic Criteria of conditions described in Bridges.

SOURCE: *Bright Futures in Practice: Mental Health*

### ***Psychosocial and Family Issues in Child Health***

**Dr. Barbara Howard** addressed the role of the **American Academy of Pediatrics (AAP)** in promoting Bright Futures and introduced a new computer-based system to implement Bright Futures in primary care.

AAP, a cosponsor in the generation of guidelines for Bright Futures, is now responsible for the "Next Steps for Bright Futures." AAP will manage the Bright Futures Education Center, providing training and Continuing Medical Education on Bright Futures content and philosophy, help maintain and update tools and guidelines, and create private and public partnerships. "Next Steps" will also (1) encompass Bright Futures Pediatric Implementation projects; (2) analyze obstacles to mental health services; (3) provide medical homes to children; (4) develop strategies for Bright Futures implementation; (5) encourage multidisciplinary collaboration approaches to improve access; and (6) disseminate findings to a broad spectrum of stakeholders. "*Bright Futures in Practice: Mental Health* is a perfect document for helping people know what to do when you find concerns in the primary care setting," **Dr. Howard** stated.

A contributor to the Bright Futures Mental Health guide, **Dr. Howard** also co-directs the Center for Promotion of Child Development through Primary Care. The Center conducts and disseminates research on comprehensive child health care supervision as well as provides multidisciplinary training. One of the initiatives developed by the Center is a new, interactive screening and educational tool. The Child Health and Development Interactive System (CHADIS) utilizes concepts from Bright Futures and AAP's "Diagnostic and Statistical Manual: Primary Care Version" (DSM-PC) to provide education and information at times of need and support to teachers, researchers, and parents.

CHADIS, used in the primary care provider's office, assesses a child's strengths, family medical history, risk factors, and demographics through a simple computerized questionnaire. The provider will be equipped with not only the

usual medical measurements such as blood pressure readings, but also with information about factors such as parental concerns. Through this system, the provider can not only diagnose, but also provide handouts to families specific to their child's disorder.

The Center may disseminate CHADIS throughout the country for free. "It will be an opportunity to be sure that pediatricians have the tools they need right at their fingertips as part of using the Bright Futures approach," said **Dr. Howard**.

### ***Bright Futures Mental Health Screening***

The pediatric office is one of the most effective places to provide patient-specific information to a parent on the health and development of a child. Expanded demands on the clinician and staff, however, make conducting extensive and accurate screenings difficult. Time, paper and processing constraints faced by primary care providers led **Dr. Kelly Kelleher** and **Mr. Brad Ummer**, in conjunction with Children's Hospital of Pittsburgh, to develop EnterVue, a computer-based screening tool based on Bright Futures.

EnterVue has four basic objectives: (1) leverage the doctor-patient relationship by allowing clinicians and staff to spend more time on guidance and less time gathering information. **Mr. Ummer** explained that "it bolsters the doctor's relationship with the family when you can spend more time focused on the child's problem rather than asking a laundry list of questions"; (2) enable providers to use computer-based systems and the Internet to personalize and increase the delivery of anticipatory guidance; (3) use dynamic, rather than static, questionnaires to gather and provide information to the doctor. Question sets are updated and tailored to a specific child, while reporting is customized for the requirements of the office; and (4) incorporate parental involvement in a child's health care while promoting interaction with the clinician.

EnterVue uses a repository of over 350

*"Bright Futures in Practice: Mental Health is a perfect document for helping people know what to do when you find concerns in the primary care setting."*

*- Barbara Howard*

questions based on Bright Futures pediatric checklists and screeners. Utilizing cutting-edge technology, the screening is administered through multiple touchscreen web tablet devices, wirelessly connected to an Internet-based application server. Parents answer questions that are individually tailored to their child (on average 35 questions) while in the waiting room. The questions are then processed and two reports are generated: the doctor's report is based on a well-child encounter form that is augmented to highlight potential problems identified by EnterVue; and the patient's report details potential issues, brief instructions to remedy the problem, and outside resources.

Evaluations of EnterVue indicate that it has a positive effect on health supervision. Approximately 368% more topical screening questions and 1.26 times more topics are being addressed by the doctor. Also 48% of parents say that time spent with the doctor is more helpful. Fifty-seven percent say that visits with EnterVue are much more satisfying compared to prior visits without the system. No parent said that it was less effective or less satisfying.

EnterVue provides benefits to children, parents, doctors, and health care systems. Children benefit through increased time spent with the doctor, better tracking and identification of problems, and emphasis on healthy lifestyle and injury prevention. Parents have an increased sense of participation in their child's health and enjoy productive waiting room times. "EnterVue provides individualized advice to the parent, and it gives them an action plan for how they can address the potential problems of their child," said **Mr. Ummer**. Doctors can maximize time spent with patients, improve documentation of issues covered, and focus on problem areas. Insurers should also benefit from potentially reduced claims due to early detection of preventable problems. In addition, comparison of data across the health care system will allow physicians to identify outlier offices with a greater proportion of patients with mental health problems, evaluate success of interventions, report more accurately for NCQA evaluation, and generate a health profile of patients across the region.

## ADDRESSING CHILDREN'S MENTAL HEALTH NEEDS

**Jean N. Takenaka, MD, MPH, Child Health Medical Director, Maternal and Child Health Program, Office of Public Health, Louisiana Department of Health and Hospitals**

**Mark D. Weist, PhD, Associate Professor and Director, Center for School Mental Health Assistance, University of Maryland School of Medicine**

**A. Elaine Slaton, RN, MSA, Federation of Families for Children's Mental Health**

**C. Veree' Jenkins, MS, Family Involvement Coordinator, Family HOPE, and the Federation of Families of Palm Beach, Inc.**

### *Early Childhood Mental Health Systems and Models*

**Dr. Jean Takenaka** gave an overview of programs from the Louisiana Office of Public Health (OPH), which uses the Bright Futures approach to address children's mental health. "We felt that the Bright Futures supervision guidelines were really great for public health," **Dr. Takenaka** said.

To enhance its efforts in prevention of child abuse and neglect, OPH used Bright Futures' principles pertaining to social and emotional development, parent-child interactions, maternal and family functioning, and provider-family relationships. After initial training from the Bright Futures national staff, Louisiana's own team began training for public health professionals across the state. OPH stressed anticipatory guidance, and parenting and interviewing skills to improve children's social and emotional health.

OPH also revised its child health record by incorporating questions on psychosocial issues,

*"EnterVue provides individualized advice to the parent, and it gives them an action plan for how they can address the potential problems of their child."*

*- Brad Ummer*

*“We felt that the Bright Futures supervision guidelines were really great for public health.”*

*- Jean Takenaka*

created an age-specific assessment and record, and used the Bright Futures anticipatory guidance section to structure the questions.

The Bright Futures approach was also tied into the Infant Mental Health program. Infant mental health is defined as a state of emotional and social competence in young children who are developing appropriately with the interrelated context of biology, relationships, and culture. The focus is on addressing early experiences that may predispose children for maladaptation behaviorally, emotionally, socially, and cognitively. Dr. Paula Zeanah developed a five-session, 30-hour training program for public health professionals to improve knowledge and recognition of factors that place infants at risk for behavioral and psychosocial problems. OPH is now in the process of training all public health professionals across the state including nurses, physicians, nutritionists, and social workers.

Because Louisiana had few mental health services for children under six years of age and their families, OPH has also implemented the Nurse Home Visiting program (NHV) using elements of David Olds Nurse Family Partnership Program. NHV is a voluntary program that provides weekly visits to low-income families with children up to two years old.

The Healthy Beginnings Project, funded by the Institute of Mental Hygiene, provides mental health services within public health clinics. It addresses prenatal risk assessment and focuses on social and environmental factors such as lack of resources, domestic violence, substance abuse, depression, and other mental health problems that could interfere with later parental functioning as well as prenatal care.

*“Bright Futures provides a wonderful framework for training frontline providers in mental health.”*

*- Mark Weist*

### **School Mental Health Services**

**Dr. Mark Weist** presented the **Center for School Mental Health Assistance's (CSMHA)** Expanded School Mental Health (ESMH) framework. The core concept of ESMH is to build partnerships between schools and

community agencies to expand upon and develop a full array of mental health promotion and intervention efforts for use in education.

CSMHA, funded by MCHB, works closely with the Center for Mental Health in Schools at UCLA. The goals of the CSMHA are to:

- (1) provide national training and education;
- (2) provide technical assistance and consultation;
- (3) develop, maintain, and disseminate materials; and
- (4) promote local-state-national networking.

While more comprehensive mental health services in schools have existed for at least two decades, they have grown exponentially in the 1990s, partially due to increased access and documentation of the effectiveness of such programs.

Three critical issues in ESMH include: disaster preparedness; quality assessment and improvement; and building mental health promotion programs. The tragic events in September 2001 underscored the importance of mental health education and training prior to disasters. “There is a very significant need now for broad training in the schools on mental

### **EXPANDED SCHOOL MENTAL HEALTH**

#### *ESMH Services*

- Focused evaluation
- Referrals
- Tracking of referrals
- Preventive services
- Full range of treatment services

#### *Advantages of ESMH Services*

- Greatly enhanced accessibility
- Enhanced capacity for prevention
- Broadened roles of therapists
- Reduced referrals to special education
- Improved outreach to youth with “internalizing” problems
- Reduced stigma of mental health services
- Opportunities for global impacts in schools

SOURCE: Mark Weist, Presentation materials

health, not just on disorders, but on stress and protective factors, traumatization, coping, and staying mentally healthy,” said **Dr. Weist**.

Several countries have comprehensive school mental health programs that focus on youth mental health promotion. For example, Australia’s Mind Matters uses a global approach to understand school mental health issues, map resources, and provide school-wide training for teachers, administrators, students, and families. Topics addressed by this program include resilience, bullying and harassment, grief and loss, and understanding mental illness.

In contrast, the U.S. prevention model is a patchy network of tertiary care, rather than focusing on primary population-wide prevention and secondary prevention through early intervention. Mental health care is primarily accessed through schools and community mental health centers that serve children and adolescents with more serious problems. Many effective prevention and promotion initiatives for schools are only implemented when connected with university programs. There is a need to move beyond this limited landscape of prevention and health promotion efforts toward a public mental health promotion and intervention system that involves collaboration among all child-serving agencies, and guidance by youth, families, and other community stakeholders.

“Bright Futures provides a wonderful framework for training frontline providers in mental health,” concluded **Dr. Weist**.

### ***The Family’s Role in Mental Health Care***

**Ms. Elaine Slaton**, who was trained as a psychiatric nurse and whose child grew up with an emotional disorder, spoke about the family’s role in prevention, early identification, and treatment of children’s mental health conditions. Her experience with the **Federation of Families for Children’s Mental Health** has shown the value of fostering partnerships between health professionals and families.

Families are central to the prevention, identification, and treatment of their child’s mental, emotional, or behavioral disorders. “Families are the context of our children’s lives - the past, present, and the future. No matter how much we love our pediatricians and our other health care providers, they are temporary consultants to us,” **Ms. Slaton** stated.

Families advocate for the right services and supports for children. They connect the multiple providers and services their children access, and as **Ms. Slaton** noted, they encounter many providers beyond the health care system, such as educators and police officers. Since they speak in many different professional languages, family members must translate and link all of the information together.

The Center for the Study of Social Policy, the National Resource Network, Georgetown University, and the Federation conducted focus groups comprised of families and professionals to learn about fostering partnerships. They found that families and professionals share the same goal of wanting to find and implement what is best for children. “Most mental health practitioners are about treating illness and disease, so they understandably approach a person, child or family with looking for what might be wrong,” **Ms. Slaton** remarked. As a result, many families have had negative experiences when health professionals have not fully understood their situations.

With these challenges, **Ms. Slaton** enumerated steps that families and providers can take to nurture partnerships:

- (1) take personal responsibility to communicate in a way that can be heard;
- (2) distinguish the roles of families and providers in children’s mental health care;
- (3) understand the values and goals of both the family and provider;
- (4) understand each other’s constraints;
- (5) take time to talk with parents;
- (6) make sure that families have the opportunity and the support they need to play a strong role in their child’s care; and

*“No matter how much we love our pediatricians and our other health care providers, they are temporary consultants to [families].”*

*- A. Elaine Slaton*

*“[Families] truly want a partnership. We need the expertise of providers and schools. We really believe that we are equal partners and we need you to listen to us.”*

*- C. Veree’ Jenkins*

*“There are lots of opportunities to look at data and improve care, but really working collaboratively [with primary care providers] is what we think distinguished us in Virginia.”*

*- Anthony Pelonero*

- (7) train and sensitize medical staff to work respectfully with families.

**Ms. Slaton** applauded the efforts of everyone responsible for the Bright Futures’ approach to children’s mental health, and asked for help in fighting stigma, discrimination, and parental blame for children’s mental health problems, connecting families for peer-to-peer support, and seeking parity for mental health services.

### **Perspectives from a Family Member**

**Ms. Veree’ Jenkins** gave a moving testimony about raising a son, Joel Hosea, with mental health problems. She described her joy at his birth, the sadness she endured after learning of her son’s emotional problems, and the struggles she faced maneuvering through the mental health care system.

**Ms. Jenkins** highlighted the frustration of having practitioners, educators, and others label her son as suffering from ADHD, being gifted and special, having bipolar disorder, or being spoiled. But she would remind him that Joel Hosea meant strength and salvation. “I tried to give him that gift so that he would hold onto it and not the other labels that were given to him,” said **Ms. Jenkins**.

During her son’s childhood, **Ms. Jenkins** felt helpless and confused trying to access the services Joel needed. She noted that “twenty years ago, I didn’t have a Bright Futures approach.” Instead of guidance, she was told what to do. “No one listened to me regarding what I thought I needed,” said **Ms. Jenkins**.

Eight years ago **Ms. Jenkins** took the initiative to not only become spiritually, emotionally, and physically whole, but also to move forward and be aggressive in attaining the support she and her son needed. Because pediatricians and teachers would not listen to her about Joel’s needs, she wrote down all of her questions prior to their meetings, hoping that at least three or four would be answered. “Parents need someone to listen to them more than anything. They need validation and support. They need

to know that they are doing the best things they can with the resources that they have at hand. They need practical information, resources, and how to get help,” **Ms. Jenkins** explained. In particular, parents need and value partnerships with practitioners, schools, and communities. “We truly want a partnership. We need the expertise of providers and schools. We really believe that we are equal partners and we need you to listen to us,” she said.

Now, as the Founder and Executive Director of the Federation of Families of Palm Beach County, **Ms. Jenkins** reaches out to other families who are experiencing the difficulties that she had. The organization provides families with practical information and resources on getting necessary services for their children. The Federation stresses to families the importance of listening to children and partnering with providers and schools. **Ms. Jenkins** asked the medical community to “Partner with the family. Get the Bright Futures information out to the family organizations. We can help parents talk to doctors and the medical community about getting these resources in their office.”

## INNOVATIONS IN MANAGED CARE

**Anthony Pelonero, MD, Medical Director, Trigon Behavioral Healthcare**

**Maria-Pilar Bernal, MD, Chief of Child and Adolescent Psychiatry, Kaiser Permanente, Santa Teresa, Medical Center**

**Laura Maxon, RN, Senior Quality Improvement Specialist, Magellan Behavioral Health**

**Damona Fisher, Community Integration and Public Relations Coordinator, Arkansas Blue Cross and Blue Shield (Reactor)**

### ***Collaborating with Practitioners to Improve Care for Children***

Seven years ago, executives at **Trigon Blue Cross Blue Shield** in Virginia made the decision to provide mental health services directly rather than through an outside vendor. Trigon recruited numerous clinicians, many who served in the public sector and in academia, to develop a managed care model for behavioral health care. **Dr. Anthony Pelonero** stated that of Trigon's 1.8 million members, 40% of PPO, 29% of HMO, and 76% of Medicaid HMO members are children.

Trigon executives and managers invited practitioners to join the **Trigon Behavioral Healthcare** provider network to provide appropriate, high quality care to Trigon members. In sharing historical utilization and quality data, they stressed the elimination of micromanagement, authorizations, and primary care physician referrals.

One of Trigon Behavioral Healthcare's highest priorities is improving quality of care for members. An example is the ADHD Assessment Guideline. Practitioners were using various assessment and testing techniques that sometimes led to inadequate evaluations or incorrect psychological diagnoses. Therefore, the company consulted with providers and examined available guidelines from the American Academy of Child and Adolescent Psychiatry and others to develop the ADD/ADHD Assessment Guideline. This guideline has been disseminated to all behavioral health and family practitioners. Trigon has since endorsed practice guidelines for depression, bipolar disorder, and panic disorder. **Dr. Pelonero** remarked that these publications have been well-received not only by specialty providers but also by primary care practitioners.

To better coordinate the delivery system, Trigon Behavioral Healthcare encourages mental health specialists to link with primary care providers to facilitate transitions between primary and specialty care. In addition, after a member is hospitalized for a psychiatric condition, Trigon practitioners schedule

appointments prior to discharge. This is done because Trigon data indicates that members are more likely to keep appointments if scheduled prior to leaving the hospital and are less likely to be hospitalized again.

"There are lots of opportunities to look at data and improve care, but really working collaboratively is what we think has distinguished us in Virginia," said **Dr. Pelonero**.

### ***Pediatric Mental Health Initiatives***

**Dr. Pilar Bernal** presented two studies from **Kaiser Permanente** that examine the utilization and cost of children's mental health services and subsequent initiatives for emotionally disturbed children. The first study, conducted in 1996, detected the prevalence of psychosocial dysfunction in primary care to establish a baseline of displaced utilization and services. Approximately 13% of preschool children (2 to 5 years old) and 13% of school age children (6 to 18 years) had mental problems. Analysis of the data indicated that mentally ill children were more likely to utilize services and their health care costs were higher. Parents of mentally ill children were also more likely to use health services. "We were able to ascertain that the burden of having a sick child impacts the family's care and their own sense of well-being," **Dr. Bernal** said. The research also showed that cost of treatment for children who internalized their disorders was more expensive than for externalizers, or children who act out their problems. In addition, externalizers were more likely than internalizers to have earlier diagnoses.

The second study documented the effectiveness of an intervention using parent education programs. Preliminary data shows that parental education interventions decrease total costs of health care from \$735 to \$690, but increase psychiatric and psychotropic drug costs. **Dr. Bernal** remarked that while the results are a good indication that children are getting the right care, "we are spending an inordinate and significant amount of dollars in psychotropic medications."

*"We were able to ascertain that the burden of having a sick child impacts the family's care and their own sense of well-being."*

*- Maria-Pilar Bernal*

*“The next steps are to maintain the momentum of [the] national agenda [on mental health], embrace the Bright Futures concepts, think multidisciplinary foundations for health care, value scientific-based research validated methods, and be mindful of partnerships to manage mental health needs of health plan members.”*

*- Laura Maxon*

As a result of these studies, Kaiser Permanente has proposed and created a number of initiatives for emotionally disturbed children. One is a quality improvement pilot for primary care clinics that is being proposed to leadership for review and final approval. The program will aim to improve utilization of services, increase access by coordinating care and facilitating referrals to specialists, and control costs. The pilot will place a treatment coordinator at each test site to collaborate with clinicians and families.

The TOTS program is an early intervention program based on results from temperament studies developed by Kaiser Permanente 15 years ago. Pediatricians, mental health specialists, and gynecologists make initial evaluations and refer parents and children to TOTS. The curriculum includes 10 sessions that focus on temperament and positive parenting. Parents learn about the DRIP (Define, Reflect, Imitate, and Praise) technique and engage in interactive play and behavioral therapy with their children. Pre- and post-test data reveals that TOTS significantly reduces the number of mental health problems in children.

### **Primary Care Physician Education**

**Magellan Behavioral Health**, a managed behavioral health organization, acts as an administrator for various health plans, including Blue Cross Blue Shield plans and Aetna. Magellan has helped implement prevention programs in 16 states across the nation. These programs focus on early identification of behavioral and psychosocial disorders through education, screening, and treatment of not only children with mental problems but also their siblings and parents. Magellan also provides community-based education on topics such as raising healthy children for depressed mothers, and the impact of primary care physician education on screening and referral rates for adolescents with depressive disorders.

**Ms. Laura Maxon** described a prevention program developed by a Connecticut insurer

and Magellan's New Jersey Regional Service Center. The program aims to:

- (1) increase depression screening of adolescents in the primary care setting;
- (2) increase the use of validated screening of adolescents in primary care; and
- (3) increase treatment and/or referral for adolescent depression.

Both Magellan and the Connecticut insurer wanted to create an evidence-based program to encourage practitioners to participate. Therefore, the parties conducted literature reviews and consulted AAP policy statements on suicide in adolescents as well as the National Institute of Mental Health publication review, *Teens: Let's Talk about Depression*. Using accepted guidelines, Magellan placed screening tools in providers' offices.

The program was implemented by targeting various stakeholders such as pediatricians, family practice physicians, behavioral health providers, and adolescent members of the health plan along with their parents. Magellan sent letters and educational materials to primary care physicians that included validated screening tools, information to support the use of these tools, tips on how to interact with the depressed teen, and how and when to refer the youth to a behavioral health specialist. Magellan also sent a letter to its behavioral health providers announcing the program, the potential for increased referrals, access needs, and primary care partnerships. Magellan and the Connecticut insurer sent members such as parents of eligible adolescents announcements about the program and a brochure on adolescent depression and screening. Evaluation of the intervention will be conducted by measuring pre- and post-intervention outcomes as well as a comparative claims analysis.

**Ms. Maxon** stressed the importance of partnerships between managed behavioral health organizations, health plans, and other stakeholders. “The next steps are to maintain the momentum of this national agenda as it is being presented today, embrace the Bright Futures concepts, think multidisciplinary foundations for health care, value scientific-

based research validated methods, and be mindful of partnerships to manage mental health needs of health plan members,” said **Ms. Maxon**.

### Panel Reactor

**Ms. Damona Fisher** coordinates **Arkansas Blue Cross and Blue Shield’s** health and safety education program for school age children, “**Blue and Youth**.” The program addresses topics like nutrition, physical activity, and injury prevention. The company is currently developing a curriculum component for “emotions,” and **Ms. Fisher** hopes to use Bright Futures mental health materials as its foundation.

**Ms. Fisher** was encouraged by the efforts of health plans and was particularly interested in developing partnerships with schools, families, and providers. Arkansas BCBS works closely not only with the state health and human services agency, but also with schools throughout the state. **Ms. Fisher** noted, “The Bright Futures materials could be a definite resource in the schools and because we’re in a position to reach out to them, we’re going to be exploring opportunities to get those materials in the hands of our constituents.”

## BRIGHT FUTURES BRIDGES

**Charles Homer, MD, MPH, Executive Director, National Initiative for Children’s Health Care Quality, and Chair, Steering Committee on Quality Improvement and Management, American Academy of Pediatrics**

**David Shaffer, MD, Irving Philips Professor of Child Psychiatry, Columbia University**

**Howard Spivak, MD, Professor of Pediatrics and Community Health, Tufts University School of Medicine**

**Michael Faenza, MSSW, President and CEO, National Mental Health Association (Reactor)**

### Attention Deficit Hyperactivity Disorder

**Dr. Charles Homer** summarized the activities of AAP in support of widespread implementation of their guidelines for diagnosis and treatment of ADHD and presented specific strategies from the **National Initiative for Children’s Healthcare Quality (NICHQ)** to improve health care for children with ADHD.

“The current estimates of children who have ADHD are between 4 and 12%. In the first half of the last decade, use of stimulants for treatment rose by about 250%,” noted **Dr. Homer**. Evidence of the serious morbidity that this condition inflicts upon children, their families, and their communities, as well as the costs, are compelling.

While effective, evidence-based therapies exist, substantial gaps exist between optimal care and care currently practiced. To address this gap, the AAP first created clinical practice guidelines addressing ADHD diagnosis and treatment. Following the development of the guidelines, the AAP has embarked on a systematic program to enable practice consistent with guideline recommendations. This program includes development of a practical tool kit to facilitate ADHD treatment, follow-up, and side-effect assessment in practice; distance learning programs for pediatricians including practice assessments and feedback about performance; both brief and extensive education materials for parents on appropriate care and resources; and policy initiatives to enable appropriate reimbursement for pediatricians. AAP and Bright Futures recommendations are similar in emphasizing the importance of primary care providers in ADHD evaluation and treatment.

The diagnostic guideline requires evidence from parents or school teachers to diagnose ADHD, “something that at least half of the time is not done in routine clinical practice,” said **Dr. Homer**.

*“The Bright Futures materials could be a definite resource in schools and because we’re in a position to reach out to them, we’re going to be exploring opportunities to get those materials in the hands of our constituents.”*

*- Damona Fisher*

*“The current estimates of children who have ADHD are between 4 and 12%. In the first half of the last decade, use of stimulants for treatment rose by about 250%.”*

*- Charles Homer*

The AAP treatment guideline highlights several important points:

- (1) ADHD should be recognized as a chronic condition, which entails a longitudinal and engaged perspective.
- (2) A joint identification of the target outcome should be made between the treating clinician and the family.
- (3) A treatment plan should be designed to achieve family and clinician-based outcomes.

NICHQ recently launched a national collaboration focused on improving care for children with ADHD in 30 primary care sites in 19 states. NICHQ's ADHD initiative seeks to help the participating practices maximize quality of life for children with ADHD, provide support to families, and make sure that each clinician has confidence in the ability to monitor, treat, and coordinate care. The specific aims are to implement in these sites a system-wide model of care that assures the delivery of evidence-based clinical care and supports self-management. To achieve these goals, primary care clinicians need to embed the diagnostic and treatment guidelines into their clinical practice tools, design delivery systems to manage care as a team, use clinical registries to keep track of and work in concert with families, schools, and mental health providers. Preliminary evaluations from participants at the test sites for the ADHD program have been positive.

**Depression and Teen Suicide**

When **Dr. David Shaffer** began his practice, suicide was thought to be a random event. "But we now know that it's by no means random, but nearly always a fatal complication of an undertreated, mistreated, or untreated condition," explained **Dr. Shaffer**.

Suicide is the third leading cause of death in 15 to 19 year olds in the U.S., exceeded only by accidental death and homicides. The prevalence of suicide is rare with 1,600 cases per year. However, the Youth Risk Behavior

Survey shows that the rate of suicide ideation is 19%, or 2.7 million teenagers.

Research has been able to provide clinicians with tools to predict whether an adolescent will commit suicide. Age and gender are important risk factors. The trend in suicide rates among females is relatively low and constant. In males, however, the rate increases with age, particularly after age 15. This rise may be due to complications of alcohol and substance abuse. Another factor that accounts for suicide is depression prevalence. While depression is relatively rare before the age of 12, it becomes more common in early and late adolescence. Also, approximately 5% to 10% of teens commit suicide after a peer has done so or after reading a book or seeing a film.

Research also links suicide to low levels of serotonin in the behavior control area of the brain. Serotonin, which functions as a buffer of emotional extremes or impulsivity, is lower in males after alcohol consumption and in the elderly. "The trigger for suicide completion is probably this neurobiological difficulty in containing behavior or mood or self-control," **Dr. Shaffer** explained.

The rate of suicide in 15 to 19 year olds in the U.S. increased steadily between 1964 and

*"We now know that [suicide is] by no means random, but nearly always a fatal complication of an undertreated, mistreated, or untreated condition."*

*- David Shaffer*

**Leading Causes of Death in 15 to 19 Year Olds in the U.S., 2000**

Cause	# of Deaths
Accidents	6573
Homicide	1861
Suicide	1574
Cancer/Leukemia	759
Heart Disease	372
Congenital Anomalies	213
Lung Disease	151
Stroke	60
Diabetes	40
Blood Poisoning	36
HIV	36

1631

SOURCE: David Shaffer, Presentation; NCHS 2001, preliminary

1988, with the rate tripling among whites. Since 1988, however, the suicide rate, as well as ideation and attempts, has declined at a rapid pace. A number of pharmacologic and therapeutic treatments have been shown to be effective in reducing depressive symptoms - fluoxetine, paroxetine, Cognitive-Behavioral Therapy, and Interpersonal Psychotherapy. However, intensive or long-term therapy and family or group problem-solving have not shown effectiveness.

**Dr. Shaffer** stressed that the role of pediatricians in suicide prevention is key. Pediatricians should conduct systematic annual screenings during routine examinations, learn when to change dosages and medications, seek psychotherapy or a specialized evaluation, and provide psycho-educational materials to parents and teens.

### ***Stress, School Violence, and Terrorism***

Despite a significant decline, the epidemic of youth violence is far from over. Instead, it has spread from inner cities to middle-class suburban and rural communities and from male perpetrators to female. While the U.S. has seen a decrease in violent deaths in the past several years, homicide rates are still far too high. The current rates are similar to those in the 1980s when the Surgeon General first declared violence a public health problem, and self-reported rates of high school students' involvement in violence has not fallen in the past several years.

**Dr. Howard Spivak** sees many opportunities for the health care system to curb youth violence. But this will require a different approach than practitioners treating injuries due to youth violence and domestic abuse without addressing the root of the problem. "Youth who show up in emergency rooms with weapon-related injuries have rates of subsequent violent injuries and violent death that are appalling. Yet we don't even ask people how the injury happened or assess any underlying risk or mental health issues for those kids when they show up for treatment for their injury," explained **Dr. Spivak**. Providers need to screen for risk

and early warning signs and educate parents that youth and domestic violence are preventable and major health issues for children today. Practitioners also need to be able to refer children and families to available community resources.

A grant from the Department of Justice (Office of Juvenile Justice and Delinquency Prevention) to AAP will fund the development of a youth violence prevention protocol in pediatric practice. The protocol will be comprised of prevention education on such things as alternatives to verbal and physical punishment, the link between violent media exposure and aggressive behavior, bullying, access to handguns, and other risk factors.

Youth violence can be reduced by implementing programs that have proven to be effective, such as:

- (1) mentoring programs (e.g. Big Brother Big Sister);
- (2) home visit programs for parents;
- (3) skill building programs to help children learn to get along and relate to one another; and
- (4) multidisciplinary and wraparound programs versus isolated programs.

**Dr. Spivak** also highlighted programs that have not been as successful as anticipated such as: arming schools; punitive, no tolerance policies; boot camp; the DARE program; and isolated mental health programs such as peer counseling and peer mediation.

For more information on treating stress, anxiety, and violence, **Dr. Spivak** recommended *Bright Futures in Practice: Mental Health*, the CDC's *Best Practices in Youth Violence Prevention*, and the Surgeon General's Report on Youth Violence.

### ***Panel Reactor***

**Mr. Michael Faenza** praised the panel for drawing attention to the advances in the science of prevention and treatment of mental health

*"Youth who show up in emergency rooms with weapon-related injuries have rates of subsequent violent injuries and violent death that are appalling. Yet we don't even ask people how the injury happened or assess any underlying risk or mental health issues for those kids when they show up for treatment for their injury."*

*- Howard Spivak*

*“If the risk to individuals and communities warrants the kind of expenditures that we’re making in security, then it warrants preparing our communities to support and treat the consequences of terrorism.”*

*- Michael Faenza*

needs. But he stressed that much more ground remains to be covered, especially in the realm of public policy. The majority of states are facing cutbacks in public mental health programs for children as a result of Medicaid budget shortfalls. While the federal government has appropriated billions of dollars to address terrorism, he urged the health care community to advocate the importance of these mental health services. “If the risk to individuals and communities in this country warrants the kind of expenditures that we’re making in security, then it warrants preparing our communities to support and treat the consequences of terrorism,” concluded **Mr. Faenza**.

### **Disseminating Bright Futures**

Some of the challenges in improving children’s mental health include: fragmentation of the health care system for mental health services; lack of partnerships among health care providers, families, schools, and other community organizations; and reliance upon the disease model rather than a prevention model. Resources such as the *Bright Futures in Practice: Mental Health* guide are invaluable in educating providers, families, and community leaders like police officers and religious

organizations on mental health supervision and promotion. Disseminating this kind of information to those who most need it is critical.

**Ms. Stepp** revisited her challenge to the audience to find ways to disseminate the Bright Futures approach to the public. Participants suggested:

- Educating all health care professionals who care for or interact with children and fostering partnerships and collaborations among them as well as families, schools, public programs, and communities.
- Presenting Bright Futures materials to hospitals using programs like grand rounds to familiarize staff on this approach.
- Promoting Bright Futures at community functions such as Town Hall meetings focused on health issues.
- Highlighting mental health issues at local chamber of commerce and worksite meetings to promote mental health in the workplace and educate employees about children’s mental health care.
- Encouraging additional forums that educate managed care companies on Bright Futures and other prevention models.



**NIHCM**  
FOUNDATION

1225 19th Street, NW  
Suite 710

Washington, DC 20036

TEL 202.296.4426

FAX 202.296.4319

WEB [www.nihcm.org](http://www.nihcm.org)

## A PUBLICATION OF THE NIHCM FOUNDATION

### **About The NIHCM Foundation**

The National Institute for Health Care Management Research and Educational Foundation is a non-profit organization whose mission is to promote improvement in health care access, management and quality.

### **About This Action Brief**

This Brief was written with support from the Health Resources and Services Administration’s Maternal and Child Health Bureau, Public Health Service, U.S. Department of Health and Human Services, under cooperative agreement No. 5 U93 MC 00143-04. Its contents are solely the responsibility of the author and do not necessarily represent the official views of the Maternal and Child Health Bureau. Amy Chung, NIHCM Foundation, prepared the Brief.