ACTION BRIEF

MARCH 2005

Children's Mental Health

New Developments in Policy and Programs

NATIONAL INSTITUTE FOR HEALTH CARE MANAGEMENT

NIHCM FOUNDATION

The prevalence of mental health disorders in the United States continues to raise significant concerns about the associated short- and long-term health implications, particularly in children. On May 13, 2004, the National Institute for Health Care Management (NIHCM) Foundation held a forum to share information on new policies on the federal and state levels as well as on programs, research and evidence-based efforts, and successful prevention and treatment options. The forum was part of NIHCM Foundation's cooperative agreement with the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB).

OPENING PRESENTATIONS

Sybil Goldman, MSW, Senior Advisor on Children, Office of the Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA)

Karen VanLandeghem, MPH, Health Policy and Program Consultant, VanLandeghem, Inc.

In 2002, the President's New Freedom Commission on Mental Health was charged to conduct a comprehensive study of the nation's mental health service delivery system and to recommend improvements. The Commission created a series of subcommittees focused on key issue areas in different populations, including a subcommittee on children and families that identified the problems that underscore the recommendations made to the Commission. In the opening presentation, SAMHSA's **Sybil Goldman** provided background on the activities of the subcommittee and the Commission's "transformed system of care" in mental health, which she defined as "a continuous, complex process that involves new behaviors, new competencies, new ways of doing business and a new source of power." The six major goals of a transformed system of care (Figure 1) represent a vision for mental health care in the United States.

The Commission began with a vision for a future in which mental illnesses can be prevented or detected early, and everyone of all ages with a mental illness has access to effective treatment and supports that are essential for living, working, learning and participating fully in the community. **Ms. Goldman** highlighted the need for greater research on children's mental health, early intervention and individualized care, and greater federal collaboration with local communities. "If we are going to create these individualized plans of care, if we are going to have comprehensive plans at the state level, we at the federal level need to work more closely together—collaborating what we do and facilitating what happens at the state and the community level," **Ms. Goldman** stated.

SAMHSA, designated as the lead agency by the Department of Health and Human Services to review the Commission's final report and develop an action plan, is working in collaboration with several federal partners to develop a federal action agenda. SAMHSA's own program priorities include four key areas of focus:

(1) Transforming the mental health system,
(2) Implementing the strategic prevention framework,
(3) Building substance abuse treatment capacity and
(4) Addressing needs of youth and adults with co-occurring mental and substance abuse disorders.

"...We at the federal level need to work more closely, collaborating what we do and facilitating what happens at the state and the community level."

- Sybil Goldman

Figure 1: Goals of a Transformed System

1. Americans understand mental health is essential to overall health
2. Mental health care is consumer- and family-driven
3. Disparities in mental health care are eliminated
4. Early mental health screening, assessment and referral to services are common practice
5. Excellent mental health care is delivered and research is accelerated
6. Technology is used to access mental health care and information

"When we are talking about prevention and promotion, we mean promoting optimal social and emotional devleopment and emotional wellness in children and youth."

- Karen VanLandeghem

Key Considerations for Health System Stakeholders

The Surgeon General's report and the President's New Freedom Commision Report "Neurons to Neighborhoods" use statistics to detail the high prevalence of children's mental health disorders and the importance of early intervention. **Karen VanLandeghem** used these findings to provide a framework to understand key considerations for stakeholders. Factors that act as barriers to quality mental health services include race and ethnicity, geographic location, lack of insurance coverage, cost of services, stigma, provider shortages and fragmentation in the mental health system. **Ms. VanLandeghem** provided further context by highlighting trends in mental health care, particularly the shift from institutional and hospital care to community-based systems and primary care providers.

In discussing the comprehensive approach of health promotion, prevention, early intervention and treatment, **Ms. VanLandeghem** elaborated, "When we are talking about prevention and promotion, we mean promoting optimal social and emotional development and emotional wellness in children and youth, building resilience in children and youth and reducing stigma." A comprehensive and coordinated system is family-centered and integrated into the community, engages the multiple systems in place, accounts for multiple funding streams and focuses on quality improvement.

Ms. VanLandeghem highlighted Wrap-Around Milwaukee as a prototype of a behavioral health care carve-out, offering children and youth with mental health disorders and their families access to a comprehensive array of interventions, treatments and supports. Financed by multiple state and county agencies—child welfare, Medicaid, juvenile probation services and the county mental health system—this program involves families at all levels of the system and aggressively monitors quality and outcomes.

Concluding, **Ms. VanLandeghem** recommended that health plans and providers consider coordinating with public systems, especially schools. She added that the focus on child development services and screening and assessment should be strenghtened, more participation in research should be encouraged, and quality measures for improvement should be adopted to further address children's mental health.

INTEGRATION AND COORDINATION OF BEHAVIORAL HEALTH

Rebecca Julian, MA, Coordinator of Child/ Adolescent Services, Unity Health System

Barbara Shaw, Director, Illinois Violence Prevention Authority

Paula Duncan, MD, Youth Health Director, Vermont Child Health Improvement Program

Thomas R. Kratochwill, PhD, Director, School Psychology Program, University of Wisconsin, Madison

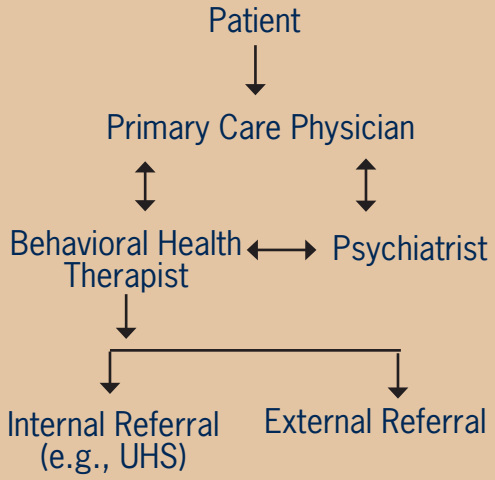
Integrating Behavioral Health in Primary Care

Rebecca Julian introduced Unity Health System (UHS), the smallest of three not-for-profit health systems in Rochester, New York, but the largest provider of child and adolescent behavioral health services. Unity's goal is to provide culturally-relevant, on-site evaluation and treatment to patients referred from their primary care physicians in participating practices. The anticipated outcomes are increased communication, improved access to mental health services and reduced stigma of seeking mental health treatment.

Integration in mental health varies (Figure 2). The lowest level, enhanced referral, is the improvement of the process by which a primary care physician refers to a specialty mental health clinic. Subsequent levels are: the training level, where education is provided to primary care providers on behavioral health concerns; the consultation or co-location level, where a therapist is located in the office; and the collaboration level, referred to as the apex of the model, where resources are shared in all respects and the behavioral health therapist is actually part of the treatment team.

There are four key components in developing an integrated mental health system (Figure 3). **Ms. Julian** explained that federal, state and local regulatory bodies are necessary for approval and acceptance for funding and reimbursement

Figure 2: Patient Flow in an Integrated System



Source: Adapted from Rebecca Julian Presentation

from third parties. In looking at organizational structure, it was important for UHS to have the involvement of the hospital administration, the administration of the medical practices they were serving, and the Administration of Behavioral Health and consumers. Behavioral health providers who are actually situated in the doctor's office should be a complement to the practice site. **Ms. Julian** stressed the importance of finding a therapist that has competencies in treating children, adolescents and adults.

Some of the challenges UHS faced include: acquiring competent child therapists; therapists feeling a sense of isolation at the practice sites; an electronic medical record system in which the therapists need to be trained; and coordinating the referral process, the multiple practice sites and office space in a primary care setting. In the future, UHS plans to partner with the local Healthy Start initiative to provide mental health treatment to pregnant women and women with children under the age of two. UHS also hopes to integrate chemical dependency services and to identify further venues for dissemination.

Figure 3: Components of an Integrated Model

- Regulatory Bodies
- Organizational Structure
- Providers
- Program Structure

Illinois Children's Mental Health Partnership

The Illinois Children's Mental Health Act of 2003 established the Children's Mental Health Partnership to develop a Plan for the state. **Barbara Shaw,** chairperson of the Partnership, highlighted the Plan and the framework for a comprehensive and coordinated chilldren's mental health system. Significant elements of the Act include expanding mental health funds to children under the age of three, requiring the Illinois Board of Education to develop social and emotional standards, requiring school districts to develop policies on social and emotional development, and improving the methods of obtaining Medicaid funds for mental health.

In developing a Children's Mental Health Plan, the Children's Health Partnership is taking a developmental approach that involves all systems that relate to children —family, education, child welfare, juvenile justice and other community programs. "Every one of those systems has a responsibility for helping build children's social and emotional strength," said **Ms. Shaw**. "We are really trying to shift away from an illness model to a positive developmental model in terms of social and emotional strength in children, and we need to, in our plan, recommend how we can create a quality-driven system with shared accountability." The plan will focus on developing coordinated systems of prevention, early intervention and treatment.

The Children's Mental Health Partnership has outlined several priorities:

(1) Prepare and submit the plan to the Governor and General Assembly;
(2) Develop and distribute the school policy format, guidance and technical assistance;
(3) Collaborate with the Illinois State Board of Education to develop Illinois Learning Standards;

"The goal of our program is to provide culturally relevant, on-site evaluation and treatment to patients referred from their primary care physicans in participating practices."

- Rebecca Julian

"We are really trying to shift away from an illness model to a positive development model in terms of social and emotional strength in children..."

- Barbara Shaw

(4) Develop a plan and guidance for public awareness campaign; and
(5) Finalize the pre-hospital screening process.

Building Coalitions to Improve Mental Health Services

"We are not going to change anything unless we have the data that is going to demonstrate how we are improving..."

- Dr. Paula Duncan

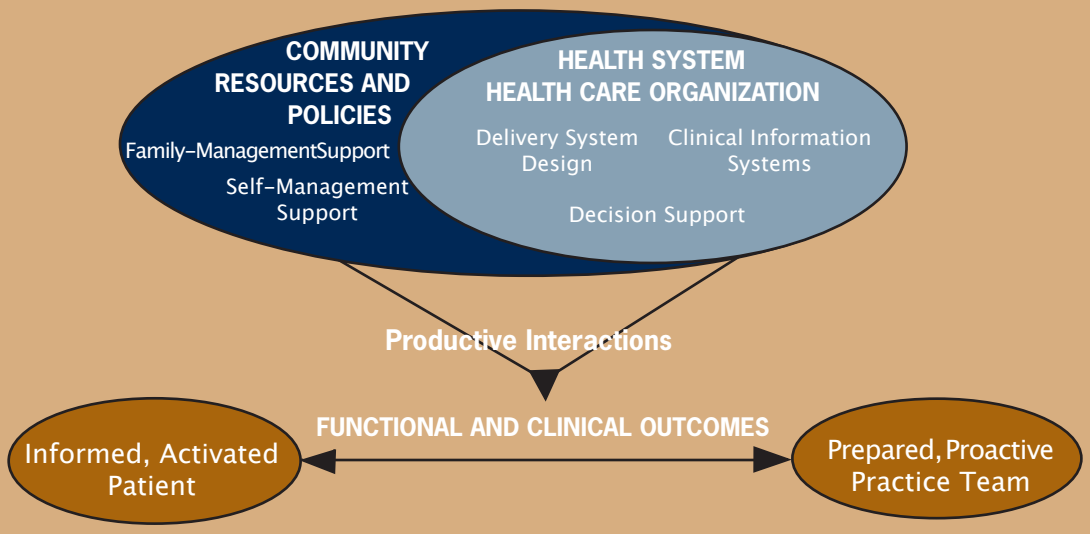
Presenting a state-level perspective of how to integrate services with community-based programs, **Dr. Paula Duncan** of the Vermont Child Health Improvement Program (VCHIP) described initiatives in that state. VCHIP has an outcomes-driven approach to improving mental health services for children and youth. VCHIP developed outcomes, adopted in state legislation, to measure improvement in services. "We are not going to change anything unless we have the data that is going to demonstrate how we are improving…" said **Dr. Duncan**. She stressed the importance of looking at best practices and including community partners in determining how to change the outcomes. To illustrate this point, **Dr. Duncan** referenced the Care Model for Child Health, an adaptation of the Chronic Care Model developed by Dr. Donald Berwick of the Institute for Healthcare Improvement (Figure 4).

Dr. Duncan directs the Vermont Youth Health Improvement Initiative, a program led by VCHIP and supported by many community partners, to screen children age 8 to18 in the primary care setting. The Initiative identifies community-based resources for referrals to promote coordinated care. The Initiative seeks to maximize the time a primary care physician spends with a child by developing a project called *Six Plus Four.* Six represents the major risks for adolescent and adult mortality based on the critical health behaviors identified by the Centers for Disease Control and Prevention (CDC):

(1) Alcohol and drug use,
(2) Injury and violence,
(3) Tobacco use,
(4) Nutrition,
(5) Physical activity and
(6) Sexual behaviors.

The Intitative also identifies child and parent strengths at each visit along four dimensions, a concept **Dr. Duncan** views as "probably the biggest mental health intervention we could do in terms of prevention." The four strengths used in the assessment are: generosity, independence, mastery and belonging. "If you have those four things in your life, you are much less likely to be involved with the risk behaviors, but you are also more likely to have healthy emotional development and thriving—even kids in very difficult situations," said **Dr. Duncan**.

Figure 4: Care Model for Child Health



SOURCE: Adapted from Paula Duncan Presentation

Prevention and Intervention for Children's Mental Health in Schools

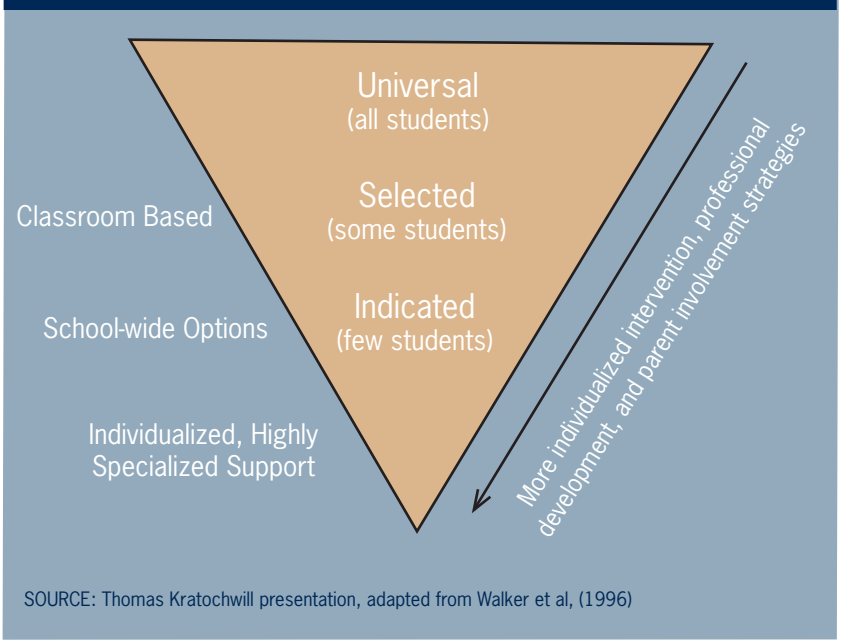
A broad range of evidence-based psychological practices are interfacing with schools on children's mental health, with an emphasis on prevention and intervention initiatives. One of the major efforts occurring in this area is a school psychology task force, chaired by **Dr. Thomas Kratochwill**, that is collaborating with a new American Psychological Association (APA) task force on evidence-based practice. The primary goal of this partnership is to communicate evidence-based practices and interventions to graduate training programs and practitioners.

A national initiative that "will likely serve as a blueprint for new models of special education in schools" is six K to 3 national intervention projects being funded by United States Department of Education's Office of Special Education and Rehabilitative Services (OSERS). Approximately $40 million is being used to pilot and demonstrate prevention programs for children in academic, behavioral and a combination of academic and behavioral interventions. Dr. Kratochwill suggested a prevention framework for student and system support in schools (Figure 5).

In Wisconsin, a pilot project is being designed with a mission of promoting prevention services—primarily, academic and mental health—in the state's schools. A critical part of this initiative is building principles that commit to the vision of prevention. One of the unique features in the pilot project in Wisconsin is that each school has a mentor specially trained in educational mental health interventions.

There are several ways for school professionals to be involved in this prevention initiative: early identification and screening, social and emotional behavior, academic assessment, and progress monitoring of students. **Dr. Kratochwill** noted challenges encountered when implementing evdience-based initiatives (EBIs) in schools: school attachment to inefficient but "pet" programs; contextual variables at the schools can limit the efficacy of EBIs and many programs require retraining of mental health professionals; and change in both the broad system and people's attitudes and beliefs is necessary to implement effective EBIs.

Figure 5: Prevention Framework for Student and System Support



SOURCE: Thomas Kratochwill presentation, adapted from Walker et al, (1996)

HEALTH PLAN AND PROVIDER INITIATIVES

Joseph Hagan, MD, American Academy of Pediatrics

Pilar Bernal, MD, Chief of Child and Adolescent Psychiatry, Kaiser Permanente Behavioral Health Case Management

Karen Lloyd, PhD, Senior Director, Behavioral Health Strategy, HealthPartners

Brian Kennedy, MD, Associate Medical Director, Southeast Region, Magellan Health Services

Bright Futures in Practice: The Mental Health Practice Guide and Tool Kit

In the late 1990s, it was reported that 20% of pediatric and adolescent primary care office visits identified a psychosocial problem. Mental health needs of children and adolescents are increasing while access to mental health

"If you look at the school reform literature and think about what it is that influences whether schools move forward on educational and mental health initiatives, there are three things: the building principle, the building prinicple, and the building principle."

- Dr. Thomas Kratochwill

services is decreasing, and most identification and care is occurring in primary care practices. **Dr. Joseph Hagan** explained that the American Academy of Pediatrics (AAP) is implementing the Bright Futures Health Supervision Guidelines and the Bright Futures in Practice: Mental Health Practice Guide and Tool Kit to provide resources to appropriately address children's mental health needs.

"Good studies are showing that the surveillance that we were all trained to count on, the surveillance that we thought would be adequate in terms of case findings and addressing needs before they present as acute needs, is just not as effective as we were taught and as we believe."

- Dr. Joseph Hagan

Dr. Hagan noted that pediatricians have traditionally relied on surveillance rather than screening for mental health issues, but it has not worked. "Good studies are showing that the surveillance that we were all trained to count on, the surveillance that we thought would be adequate in terms of case findings and addressing needs before they present as acute needs, is just not as effective as we were taught and as we believe," explained **Dr. Hagan**. Screening, however, uses tools that are tested and validated.

The Bright Futures Mental Health Guide has three parts: developmental chapters with health promotion, bridge topics of common childhood mental health problems, and the mental health tool kit. Of the many tools available, Bright Futures offers a shortened Pediatric System Checklist (PSC) that is faster and less expensive to administer.

Dr. Hagan emphasized that common challenges for clinicians performing mental health screening in pediatrician offices of time and costs persist. Bright Futures has a modified PSC with 17 questions that focus on depression, attention and aggression, which could replace the current 35-question version, and an Attention-Deficit/Hyperactivity Disorder (ADHD)-specific screen. Better reimbursement for mental health screening is also being addressed through proper screening and billing. The AAP is working to help providers choose what is important to do in well-child visits and acute care, which may encourage doctors to perform the screenings.

"We have a model that coordinates and integrates care. We also have a model that was developed in intense collaboration with the community to include family clinicians, schools and communities."

- Dr.Pilar Bernal

As the AAP develops the third edition of the Bright Futures Health Supervision book, the approach focuses on a set of principles, strategies and tools that are theory-based, evidence-driven and systems-oriented. These can be used to improve the health and well-being of children through culturally-appropriate interventions that address current and emerging health promotion issues at the policy, community, health system and family levels.

Best Practices in Autism Spectrum Disorders and Depression

According to the National Institutes of Health (NIH), there has been a 281% increase in diagnosed cases of Autism Spectrum Disorders (ASD) in the last 10 years. The estimated total of the ASD population in Kaiser Permanente Northern California is 3,750 with an expected presentation of 200 new cases per year. An average number of visits to a primary care physican for a non-ASD child was 3.5 visits per year in 2001. The children with ASD used an average of eight visits per year. These and other reasons prompted implementation of Kaiser Permanente's ASD Pilot project.

Dr. Bernal described the three levels of the ASD care model (Figure 6). Level 1 recommends that generalist clinicians use evidence-based tools to routinely screen all children, using the Bright Futures system at well-baby checkups, the Modified Checklist for Autism in Toddlers (M-CHAT) for children up to five years, and the Social Communication Questionnaire for children over five years.

Level 2, which encompasses diagnosis and evaluation of autism, recommends referring children with ASD to specialized centers, where

Figure 6: Overview of ASD Model

Level 1:	Routine Developmental Surveillance by all clinicians at every well-child visit
Level 2:	Diagnosis and Evaluation of Autism by ASD specialists
Level 3:	Assessment for treatment and case management by ASD specialists in collaboration with community resources

efficiencies will be monitored to replicate the centers across the region. A multidisciplinary team will review standardized instruments, provide feedback to parents and send them back to the generalist/primary care provider or the mental health provider.

Assessment for treatment and case management occur in Level 3. The treatment plan includes Kaiser services and community services. In all of the child and adolescent clinics, care managers implement recommendations for the treatment plan in collaboration with the schools and the regional centers. "Again, the goal is to provide support for the family… but also to collaborate with the community to avoid what is very common in these children, that is, redundancies, repetitions and reevaluations in their care," added **Dr. Bernal**.

The ASD process of referral is the basis for screening in primary care and for tracking outcomes and efficiencies. Developmental screens happen in all baby checks, embedded with chart questions, and M-CHAT occurs at either 15 or 18 month well-baby checks.

Dr. Bernal also presented on adolescent depression and Kaiser's treatment continuum, including a depression overview education class. The first session of this class addresses the prevalence of depression in teens and the science behind depression. The second session describes the cycle and biology of depression. The third session addresses management of depression—what parents and professionals can do, possible medications for depression and a saftey plan. Session four addresses self-care for depression, including stress management and physical, emotional and mental well-being.

Behavioral Health Case Management

Dr. Karen Lloyd summarized behavioral case management for high-risk members of HealthPartners, a Minnesota-based health care organization, and its five behavioral health program components: identification, enrollment engagement, stabilization and "soft discharge" (Figure 7).

During identification, predictive modeling is used to identify members at risk for hospitalization, based on algorithms developed from patterns of care reflected in the member administrative, claims and pharmacy data. This stage presents the greatest challenge to HealthPartners. Once identified, members' parents receive an introductory letter, emphasizing that enrollment in the program is free, confidential and voluntary.

Figure 7: HealthPartners Behavioral Health Case Management

1. Identification
2. Enrollment
3. Engagement
4. Stabilization
5. Soft Discharge

The engagement level is determined by the acuteness of the clinical and social situations, which in turn determines the intensity of the telephone contact. Also at the engagement level, which ranges from four to nine months or more, the parents' and member's personal goals are identified and later linked with the treatment plan goals develop by the provider.

One of the first goals of the stabilization period is to identify and remove barriers to treatment. Modeling and coaching good problem-solving skills is an important element later in the stabilization period. **Dr. Lloyd** stressed the need for communication between practitioners, providers and HealthPartners. "We are the first to know sometimes that a crisis is beginning, that the patient isn't taking their medicine, or has missed a couple of sessions with one of the practitioners."

Soft discharge, the final stage, is defined as tapering contact over time and inviting members to call back if they think they could

"We are the first to know sometimes that a crisis is beginning, that a patient isn't taking their medicine, or has missed a couple of sessions with one of the practitioners."

- Dr. Karen Lloyd

use HealthPartners services again, even after the case is closed.

"What we are trying to do is not only educate the parents who are already depressed about the possibility of depression in their kids, but we are also trying to educate primary care doctors who see adult depressed patients, pediatricians, and also behavioral health providers."

- Dr. Brian Kennedy

Some early lessons from HealthPartners' experience include wider use of administrative data for quality improvement, using thoughtful strategies by practices to maximize enrollment and staff managing large caseloads over extended periods. A challenge HealthPartners faces is the identification of patients at all stages of the disease process.

Offspring Depression Prevention Program

Magellan Behavioral Health works to identify the population of children at risk for depression as early as possible to introduce interventions. **Dr. Brian Kennedy** explained that children of depressed parents are at highest risk for developing depression, yet only about 25% of depressed children of depressed adults receive treatment. Magellan's Offspring Depression Prevention Program focuses on this risk group. Once a child is identified, the program seeks to detect early signs of depression, promote appropriate care and evaluation, and educate parents and providers about risk and protective factors for these children.

Magellan uses claims data from the adult population to identify depressed parents. They are then sent a package with an introductory letter, a screening tool to identify depression in a child, and educational information to encourage families to become involved in the program. When the screens are returned, positive scores are identified. Magellan then contacts the families and provides assistance to get treatment, including arranging a provider and helping schedule appointments. Follow-up calls are made at three, six and nine months to assess treatment outcomes

"One of the decisions early on with this was that we needed not only to come out with the guidelines but come out with a process of how to help clinicians on how they do it."

- Dr. Mark Wolraich

Dr. Kennedy pointed to the response rate to the initial mailing as key to improvement. Educating practitioners to encourage patient participation and providing information to members through a newsletter and website are other intervention strategies, as well as making the preventive health care manager available on a 24-hour basis.

PROGRAMS AND STRATEGIES FOR PREVENTION AND TREATMENT

Mark Wolraich, MD, CMRI/Shaun Walters Professor of Pediatrics, Oklahoma University Child Study Center

Steven Evans, PhD, Associate Professor of Psychology and Director, Alvin V. Baird Attention & Learning Disabilities Center, James Madison University

Laurie Flynn, Director, Carmel Hill Center for Early Diagnosis and Treatment, Columbia University, Division of Child & Adolescent Psychiatry

Improving Primary Care Services for Children with ADHD

Current estimates show that 4% to 12% of all school-age children may be affected by Attention-Deficit/Hyperactivity Disorder (ADHD). In addition, 65% of children with ADHD have problems with ADHD as adults. As a chronic condition, ADHD should be monitored and followed over time, including both psychosocial and pharmaceutical interventions for children. According to **Dr. Mark Wolraich,** some studies have shown there was a problem with how primary care clinicians were managing children with ADHD and that there "was a great variety in the quality of care that was being provided."

As a result, the AAP developed guidelines for diagnosis and treatment of ADHD and a systematic way of trying to change physician

Fact: 65% of children with ADHD have problems with ADHD as adults.

Figure 8: AAP Diagnosis and Treatment Guidelines for ADHD

Diagnostic Guidelines

1. Children 6 to 12 years old who present inattention, hyperactivity, impulsivity, academic underachievement or behavior problems should be evaluated for ADHD.
2. The diagnosis of ADHD must meet DSM-IV criteria.
3. The assessment requires evidence obtained directly from parents or caregivers regarding core symptoms, age of onset, duration of symptoms and degree of impairment.
4. The assessment requires evidence from teachers or other school personnel, particularly in elementary schools, for core symptoms, duration of symptoms, degree of impairment and coexisting conditions.
5. Evaluation of children with ADHD should include assessment for coexisting conditions.
6. Other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD.

Treatment Guidelines

1. Physicians should establish treatment that recognizes ADHD as a chronic condition.
2. The treating clinicians, parents and child, in collaboration with school personnel, should specify appropriate target outcomes to guide management.
3. The clinician should recommend stimulant medication and/or behavior therapy as appropriate to improve target outcomes.
4. When the selected management has not met target outcomes, clinicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan and presence of coexisting conditions.
5. The clinician should periodically provide a systematic follow-up. Monitoring should be directed to target outcomes and adverse effects, with information gathered from parents, teachers and the child.

behavior (Figure 8). "One of the decisions early on with this was that we needed to not only come out with the guidelines, but come out with a process of how to help clinicians on how they do it," said **Dr. Wolraich.**

The guidelines were published and a toolkit was developed, in part, by the national collaborative of 30 practices from 19 states. The practices, which participated over a 14-month period, used the Plan-Do-Study-Act (PDSA) cycle that the National Initiative for Children's Healthcare Quality (NICHQ) uses, to identify problems within their practice, think about how they could deal with the problems, plan a new strategy, try out the strategy and see if it worked. The outcomes, which are harder to measure and take longer, do not show as robust a change but considerable improvement—from about 5% to 40% in terms of the outcomes in the children that were being seen.

Based on feedback from practices, the tools were revised to address practical issues. The experience from the national collaborative was also used to develop a web-based continuing medical education (CME) activity, called eQIPP, which can be used by any physician. To develop a more systematic approach to the management of ADHD by changing physicians' ADHD management behaviors, an initiative to spread the web-based CME program across the country has connected eQIPP with CME workshops in local AAP chapters.

School-based Mental Health

Dr. Steven Evans presented the Challenging Horizons Program (CHP), a school-based treatment program for middle school age youth with ADHD in the Shenandoah Valley, Virginia. CHP organized three community development teams comprised of teachers, parents, physicians and mental health providers in the community. Each team focused on a particular area: psychosocial, medication and care coordination. "What we wanted to do was not just have an add-on after-school program but be able to take the techniques we have been working on over the last few years and get them to a point where we could train teachers to do them during the regular class..." **Dr. Evans** clarified.

"What we wanted to do was to take the techniques we have been working on over the last few years and get them to a point where we could train teachers to do them during the regular class."

- Dr. Steven Evans

The psychosocial techniques used in CHP were largely developed in an initial after-school program and were modified for integrated use in the classroom by teachers. The community development team's primary question when examining various psychosocial interventions was "Is this something a teacher, special education teacher or school counselor could do on a regular school day? If so, what resources are required?"

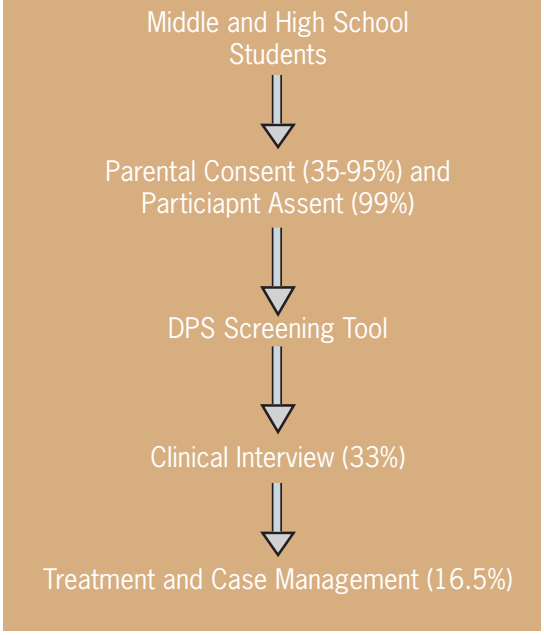
"Suicide is not really as unpredictable as we once thought it was."

- Laurie Flynn

The second community development team focused on medications for children with ADHD, which developed a modified version of procedures found in the literature to be implemented in actual practice. The medical team also established guidelines for determining the need to modify medication.

Coordination is a critical element of CHP. The third community development team created a web-based system with information that enables coordination between teachers, parents and physicians. The child is identified only by a unique username and password. Any authorized user (parents, teachers or pediatricians) can look at the child's web page and identify problem areas and treatments occuring for the child. In addition, parents, teachers and doctors have the opportunity to rate children on dimensions such as inattention, social skills, etc.

Figure 9: How does TeenScreen Work?



The CHP web pages include an algorithm that determines a threshold for success—exceeding the algorithm indicates a child is not dealing well with his or her ADHD. Parents are notified when a child exceeds the threshold, and can choose between increasing psychosocial interventions at school or conducting a medication evalution with the physican. CHP has found that parents usually choose psychosocial interventions .

Teen Depression and the Columbia University TeenScreen Program

TeenScreen is a national depression program founded on early identification, suicide prevention and treatment coordination. Headquartered in New York, TeenScreen provides free of charge to the site: (1) site development and consultation, (2) training, (3) the screening instrument, (4) technical support and (5) analysis of aggregate screening results. "Suicide is not really as unpredictable as we once thought it was. In fact, only 4% of cases have psychiatric symptoms developed in the last three months. That says this is something we can find, this is something we can treat, this is something we can actually do a lot to prevent," said **Ms. Laurie Flynn.**

The program works with middle and high school students. The Diagnostic Predictive Scale (DPS), a self-administered, computer-based assessment that takes 10 to15 minutes, is used for screening. Parental and participant assent must be granted to take the DPS. If a teen screens positive, he or she participates in a clinical interview to determine whether further assessment and treatment is necessary. If additional treatment is recommended, the individual who provides the clinical assessment in the school is committed to staying with the teen and family until the first appointment is kept. The various levels of screening are highlighted in Figure 9.

Because the screening tool is computer-based, results are automatically reported at the end of the interview. It is based on the Diagnostic and Statisical Manual for Mental Disorders (DSM) and rates not only the symptoms but also potential for disability or interference with performance. The DPS screens for social phobias, anxiety,

panic, obsessive compulsive disorder, major depression and substance abuse.

TeenScreen works with 110 sites in 35 states, Guam, Panama and Canada. It also works in partnership with national organizations and federal and state agencies. "We think that there is a demand that can be created as we build sites, for a more organized federal and state policy, and importantly, resources to support the ongoing problem of access to treatment and treatment that is sustained when needed," concluded **Ms. Flynn**. To this end, TeenScreen partners have been working on Capitol Hill, introducing several pieces of legislation.

NIHCM Foundation distributed a paper, "Children's Mental Health: An Overview and Key Considerations for Health System Stakeholders," which contains a list of health care, school and community programs in addition to web-based resources. See http://www.nihcm.org to download a copy of the issue paper.

Below is a list of additional resources for children's mental health information.

NAME	WEBSITE
American Academy of Child and Adolescent Psychiatry -Clinical Parameters	**www.aacap.org** **www.aacap.org/clinical/parameters/index.htm**
American Academy of Pediatrics	**www.aap.org**
Association of Maternal and Child Health Programs	**www.amchp.org**
Association of State and Territorial Health Officials	**www.astho.org**
Bazelon Center for Mental Health Law	**www.bazelon.org**
Center for Health and Healthcare in Schools	**www.healthinschools.org**
Center for Health Care Strategies	**www.chcs.org**
Center for Health Services Research and Policy at the George Washington University	**www.gwumc.edu/sphhs/healthpolicy/chsrp**
Centers for Disease Control and Prevention -Division of Adolescent and School Health	**www.cdc.gov/healthyyouth**
Centers for Medicare and Medicaid Services -New Freedom Initiative	**www.cms.hhs.gov/newfreedom**
Challenging Horizons Program	**http://chp.cisat.jmu.edu**
Child and Adolescent Health Measurement Initiative	**www.cahmi.org**
Children and Adults with Attention-Deficit/Hyperactivity Disorder	**www.chadd.org**
Children's Defense Fund	**www.childrensdefense.org**
The Commonwealth Fund	**www.cmwf.org**

NAME	WEBSITE
The Federation of Families for Children's Mental Health	**www.ffcmh.org**
Florida Mental Health Institute -Research and Training Center	**http://rtckids.fmhi.usf.edu**
Health Resources and Services Administration (HRSA) - Maternal and Child Health Bureau (MCHB) - "Take a Stand. Lend a Hand. Stop Bullying Now!"	**www.mchb.hrsa.gov** **www.stopbullyingnow.hrsa.gov** **1-800-ASK-HRSA**
Illinois Children's Mental Health Partnership	**http://www.ivpa.org/child-rensmhtf/**
Mental Health in Schools Program - Center for Mental Health in Schools at UCLA - Center for School Mental Health Assisstance at U. Maryland, Baltimore	**www.smhp.psych.ucla.edu** **http://csmha.umaryland.edu**
National Academy for State Health Policy - Assuring Better Child Health and Development (ABCD) Initiative	**www.nashp.org**
National Adolescent Health Information Center	**http://nahic.ucsf.edu**
National Assembly on School Based Health Care	**www.nasbhc.org**
National Association of School Nurses	**www.nasn.org**
National Association of School Psychologists	**www.nasponline.org**
National Association of State Mental Health Program Directors	**www.nasmhpd.org**
National Center for Children in Poverty	**www.nccp.org**
National Center for Education in Maternal and Child Health	**www.ncemch.org**
National Conference of State Legislatures	**www.ncsl.org**
National Governors Association	**www.nga.org**
National Initiative for Children's Health Care Quality	**www.nichq.org**
National Institute of Mental Health	**www.nimh.nih.gov/**
National Techinical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development	**http://gucchd.georgetown.edu/programs/ta_center/index.html**
President's New Freedom Commission	**www.mentalhealthcommission.gov**
Promising Approaches Series, part of the Health Care Reform Tracking Project - Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems	**http://rtckids.fmhi.usf.edu/study05.cfm**

NAME	WEBSITE
Substance Abuse and Mental Health Services Administration (SAMHSA) - Center for Mental Health Services - National Mental Health Information Center	**www.samhsa.gov** **http://mentalhealth.samhsa.gov** **www.mentalhealth.org/child/childhealth.asp**
Society for Adolescent Medicine	**www.adolescenthealth.org**
Surgeon General's Report on Children's Mental Health	**www.surgeongeneral.gov/topics/cmh/childreport.htm**
U.S. Department of Education **- Office of Special Education and Rehabilitative Services**	**http://www.ed.gov/about/offices/list/osers/osep/index.html?src=mr**
US Food and Drug Administration - Question and Answer Session on Anti-Depressant Use in Children, Adolescents, and Adults	**www.fda.gov/cder/drug/antidepressants/Q&A_antidepressants.htm**
Vermont Child Health Improvement Program	**www.vchip.org**

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