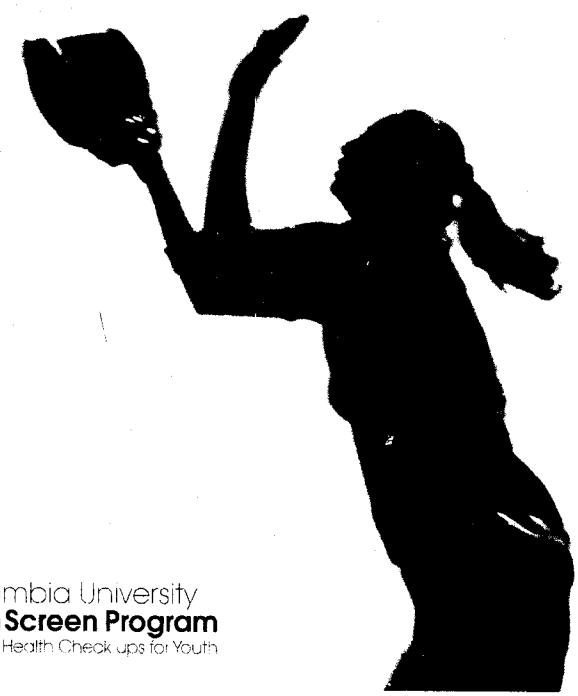
CATCH THEM BEFORE THEY FAIL

How to Implement Mental Health Screening Programs for Youth as Recommended by the President's New Freedom Commission on Mental Health

September 2003



PATH
Positive Action for Teen Health

Columbia University
Teen Screen Program
Mental Health Check ups for Youth

CATCH THEM BEFORE THEY FALL

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SEPTEMBER 2003

Suicide has been the third leading cause of death among young people ages 10-18 for the past 14 years. This statistic alone is cause for alarm. When you consider that each year an additional 520,000 youth require medical services as a result of suicide attempts, it's clear that something needs to be done.

In July 2003, President Bush's non-partisan New Freedom Commission on Mental Health issued a report stressing the crucial role mental health screenings can play in early detection and intervention. This public health approach spares troubled youth from what the Commission calls "a downward spiral that can include school failure, depression, and suicide."

A number of organizations now offer scientifically-based mental health screenings that catch youth before they fall. For example, the Columbia University TeenScreen® Program, outlined in the President's New Freedom Commission as a model program for early intervention, offers communities free assistance in developing screening programs that can find youth at risk for mental illness and suicide and refer them to treatment. Communities in 29 states have already partnered with the Columbia University TeenScreen Program. Positive Action for Teen Health, a national initiative also housed at Columbia University, is working with policy makers and national organizations to ensure all youth receive a mental health checkup before high school graduation.

What can you do? This report is designed to provide specific action steps for educators, health professionals and health plans, policymakers, community leaders, and parents who are trying to expand the availability of mental health screenings to children and teens. The suggestions come from extensive experience in the implementation and dissemination of teen mental health screening programs around the country. Sections of this report are highlighted with examples of exemplary practices that we hope will provide ideas and encouragement to others. It will take the effort of people like you to make mental health screenings for youth as commonplace as other preventive heath efforts like hearing and vision screenings. Please email teenscreen@childpsych.columbia.edu if you, or the organization you represent, would like to be part of this growing national effort to save lives.

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Acknowledgements

This report was produced by the Carmel Hill Center at Columbia University's Division of Child and Adolescent Psychiatry. The Carmel Hill Center is dedicated to the early detection and treatment of mental illness in youth. The Center houses the Columbia University TeenScreen Program, which has thus far established 91 teen mental health screening programs in 29 states, and the Parent Partners program, which is conducting research on how involving parents in treatment can greatly improve outcomes for adolescents with mental illness. The Carmel Hill Center receives generous support for its work from the Carmel Hill Fund and the Sallie Foundation. Their support makes this report possible.

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CHAPTER ONE

The Commission Report, Early Detection and the Road From Here

In 2002, President Bush announced the creation of a 22-member New Freedom Commission on Mental Health. He charged the Commission with studying our nation's mental health care system and recommending steps that would enable adults and children with serious mental health problems to live, work, learn, and participate fully in their communities. The Commission, chaired by Michael Hogan Ph.D., Director of the Ohio Department of Mental Health, included researchers, parents, advocates, and federal and state mental health officials.[1]

Key Commission Findings and Goals

The Commission's final report, issued in July 2003, contained numerous findings of importance for those working to identify and treat adolescents with mental health problems and suicide risk. These include:

- 5-9% of all children suffer from a mental, behavioral or emotional disorder that substantially interferes or limits one or more major life activity including academic performance and the ability to maintain interpersonal relationships.
- Children with serious mental health problems have the highest rates of school failure.
- There is a lack of a national priority given to suicide prevention, despite the existence of proven screening and treatment methods
- Early detection, assessment, and linkage to treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating.
- Early intervention and appropriate treatment can reduce pain and suffering for children who are at risk for frequently co-occurring mental and addictive disorders.
- Mental health problems of adolescents are not adequately addressed in primary care settings.

The Commission set as national goals:

- Early mental health screening, assessment, and referral to services.
- Screening for co-occurring mental and substance use disorders and linking with integrated treatment strategies.
- Quality screening and early intervention in readily accessible, low-stigma settings, such as primary health care facilities and schools.
- Screening and intervention in settings where there is a high level of risk for mental health problems such as in the child welfare and juvenile justice systems.

Suicide and Mental Illness in Youth

The Centers for Disease Control and Prevention (2000) reported that suicide is the third leading cause of death among youth aged 10-24 years. Each year in the United States, almost as many adolescents and young adults die from suicide than from all natural causes-such as leukemia, birth defects, pneumonia, influenza and AIDS-combined.

According to the Youth Risk Behavior Survey (2001), 8.8% of high school students make a suicide attempt, and 2.6% (or 520,000) make an attempt serious enough to require medical attention.

The United States Surgeon General (2001) reported that while one in ten youth in the United States suffers from a mental illness severe enough to cause some level of impairment, only one in five of these receive the needed mental health treatment.

The Substance Abuse and Mental Health Services Administration (1999) reported that

[1]For a list of Commission members, a summary of the final report and more information on the report's recommendations on mental health screening, please see the appendices.

almost 3 million youth were at risk for suicide but only 36% received any mental health treatment. Psychological autopsy studies have found that 90% of teenagers who committed suicide were suffering from a treatable mental illness at the time of death *(Shaffer, et al., 1996).*

(See Appendix D for citations to the research)

The Role of Screening in Improving and Protecting Lives

The Commission's call for the early screening of young people responds to a growing body of research that has found screening to be an effective way to find those who are suffering from mental health problems. Screening provides a way to find these youth before their lives have been permanently derailed by related poor academic achievement, substance use and even self-injury.

Screening is especially important because many conditions, especially adolescent depression, do not always exhibit easy to identify symptoms. Universal screening, when linked with referral to appropriate services, can significantly reduce the devastating impact of mental health problems on young lives.

The move to offer mental health screening to every teen in the United States is based on the findings of a psychological autopsy study published in 1996 by Dr. David Shaffer, Director of the Department of Child and Adolescent Psychiatry at Columbia University. The study provided key information about teenagers who commit suicide and how suicides could be prevented, revealing that teen suicide is not the unpredictable event we had once thought it to be. In fact, teens that commit suicide suffer from a very specific range of mental illnesses. Dr. Shaffer found that 90% of the teens that committed suicide had a psychiatric disorder at the time of their deaths. This finding has now been replicated in several national and international studies. In Dr. Shaffer's study, the majority of boys who committed suicide suffered from depression, abused alcohol or drugs, and/or had made a prior suicide attempt. Most girls who committed suicide either suffered from depression or had made a prior suicide attempt.

Dr. Shaffer hypothesized that if youth were screened for these disorders and those found to be at risk were treated, most suicides could be prevented. As a result the Columbia University TeenScreen Program was developed.

"... a 14 year old boy who started experimenting with drugs to ease his severe depression. This former honor student became a drug addict. He dropped out of school, was incarcerated six times in 16 years. Only two years ago, when he was 30 years old, did the doctors finally diagnose his condition as bipolar disorder, and he began a successful program."

–President Bush from his speech announcing the formation of the Commission

The Columbia University TeenScreen Program uses a two-stage process to identify at-risk youth. First, all youth who consent to screening and obtain parental consent, complete the DISC Predictive Scales (DPS). The DPS is a 10-minute self-administered questionnaire that screens for social phobia, panic disorder, generalized anxiety disorder, major depression, alcohol and drug abuse, and suicidality. The DPS is not a diagnostic instrument, but it does indicate which students require further evaluation and it highlights the disorders for which students are likely to be suffering from. Youth who report no mental health problems on the DPS are dismissed from the screening, and youth who require further attention are advanced to the second stage, where they are assessed by a mental health clinician to determine if further evaluation or treatment would be beneficial. If professional services are recommended, the youth and his or her family are assisted with the referral process.

The original study of the Columbia TeenScreen Program on 2,004 high school students revealed the program's unique ability to uncover youth at risk for suicide, but unknown to have problems and not receiving professional help for them *(Shaffer et al, 1996).* Only 31 percent of those with major

depression, 26 percent of those with recent suicide ideation, and 50 percent of those who had made a past suicide attempt were known by school personnel to have significant problems and were receiving help.

Since 2001, the Carmel Hill Center at Columbia University has been providing free screening tools, training and technical assistance to help communities create mental health screening programs. All screenings require parental or guardian consent and student assent. All results are confidential and do not become part of a student's permanent academic record. Columbia University also operates a research initiative working in 14 states to implement screening as part of the standard intake process within the juvenile justice system. The Commission report highlighted the Columbia University TeenScreen Program as a model program in its report:

MODEL PROGRAM: Screening Program for Youth from the Commission Final Report

PROGRAM	Columbia University TeenScreen Program
GOAL	To ensure that all youth are offered a mental health check-up before graduating from high school. TeenScreen identifies and refers for treatment those who are at risk for suicide or suffer from an untreated mental illness.
FEATURES	All youngsters in a school, with parental consent, are given a computer-based questionnaire that screens them for mental illnesses and suicide risk. At no charge, the Columbia University TeenScreen Program provides consultation, screening materials, software, training, and technical assistance to qualifying schools and communities. In return, TeenScreen partners are expected to screen at least 200 youth per year and ensure that a licensed mental health professional is on-site to give immediate counseling and referral services for youth at greatest risk. The Columbia TeenScreen Program is a not-for-profit organization funded solely by foundations. When the program identifies youth needing treatment, their care is paid for depending on the family's health coverage.
OUTCOMES	The computer-based questionnaire used by TeenScreen is a valid and reliable screening instrument. The vast majority of youth identified through the program as having already made a suicide attempt, or at risk for depression or suicidal thinking, are not in treatment. A follow-up study found that screening in high school identified more than 60% of students who, four to six years later, continued to have long-term, recurrent problems with depression and suicidal attempts.
BIGGEST CHALLENGE	To bridge the gap between schools and local providers of mental health services. Another challenge is to ensure, in times of fiscal austerity, that schools devote a health professional to screening and referral.
HOW OTHER ORGANIZATIONS CAN ADOPT	The Columbia University TeenScreen Program is pilot-testing a shorter questionnaire, which will be less costly and time-consuming for the school to administer. It is also trying to adapt the program to primary care settings.
WEB SITE	www.teenscreen.org
SITES WHERE IMPLEMENTED	69 sites (mostly middle schools and high schools) in 27 states

There are a number of different mental health screening systems that have been developed by a variety of institutions *(see Appendix E)*. Communities choosing a screening instrument or program should examine whether the tools they are considering have been carefully evaluated and shown to properly identify youth at risk for specific mental disorders and suicide.

The Road From Here

Advances in neuroscience have dramatically increased our ability to diagnose and treat mental disorders. New therapies along with improvements in the efficacy of treatments make early detection and intervention more important than ever. We now know that mental illness is more prevalent in youth than previously known and that the key to successful treatment is early identification.

The United States is at a critical juncture in its effort to improve the health and welfare of its children. The significance of the Commission report is that it clearly and succinctly lays out a path to finding and treating young people in critical need of mental health services. The scientific knowledge it cites is conclusive. The tools it suggests are available. What is required is action at all levels of government, in every school, within health care systems and doctors' offices, and by parents and guardians nationwide.

There is growing support for the national goal of universal youth mental health screenings at all levels of government and among national organizations and advocacy groups. In the last six months, 17 national organizations have endorsed this goal *(see sidebar)*.

This report is intended to list a number of suggestions for action appropriate for a broad range of individuals–actions that will make a difference. Each chapter provides relevant findings and goals from the Commission's report and recommendations for specific audiences including educators, health professionals, policymakers, and community leaders.

Efforts have been made to illustrate suggested activities with real-world examples from all parts of the United States. Many parents, school officials, public health officials, and legislators are already hard at work on achieving the goal of providing universal mental health screening for teens.

National Organizations Endorsing Universal Mental Health Screening for Teens

The following are among a growing list of organizations that endorse the national goal:

"Every American teen should receive a mental health check-up before graduating from high school."

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

AMERICAN FEDERATION OF TEACHERS

AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

AMERICAN PSYCHIATRIC ASSOCIATION

ANXIETY DISORDERS ASSOCIATION OF AMERICA

GIRLS AND BOYS TOWN

CHILD AND ADOLESCENT BIPOLAR FOUNDATION

DEPRESSION AND BIPOLAR SUPPORT ALLIANCE

FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH

INTERNATIONAL SOCIETY OF PSYCHIATRIC-MENTAL HEALTH NURSES

NATIONAL ASSOCIATION OF BEHAVIORAL HEALTH DIRECTORS

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

NATIONAL ALLIANCE FOR THE MENTALLY ILL

NATIONAL EDUCATION ASSOCIATION

SCHOOL SOCIAL WORK ASSOCIATION OF AMERICA

TOURETTE SYNDROME ASSOCIATION

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

Parent Support and Involvement

The most important figures in improving the health of children and adolescents are their parents. A 2003 national study of parent attitudes (conducted by Columbia University and the Positive Action for Teen Health program) showed significant concern for youth mental health and significant support for universal mental health screening. The major findings of the study include:

Parents say depression and suicide are public health and safety issues that affect all families. While parents worry their kids may experience depression or consider suicide, they also worry their children might be endangered by another depressed or suicidal teen. Parents also worry a great deal about drug and alcohol use, often associated with teen depression and suicide.

- Four in five parents say they are concerned about teenage depression.
- Four in five parents say they are concerned about the problem of suicide among teenagers. Nearly 1 in 5 parents say they are concerned that their child may have thought about suicide and 1 in 10 say they have thought about contacting a medical professional because they were concerned their child had thought about taking his or her life.
- Nine in ten parents say they are concerned about drug and alcohol use among teens.

Parents think schools must play an important role in identifying students at risk. There is strong support among parents for a credible program that regularly screens high school students for depression and suicide. Most parents would consent to having their own child screened or tested.

- Nine in ten parents agree that schools must play an important role in identifying students who may be at risk for depression or suicide.
- Nearly three in four parents say it is important for high schools to regularly screen all students for risk of depression and suicide.
- Nearly two in three parents support having all high schools in their state regularly screen all students for risk of depression and suicide.
- More than two in three parents would give permission or consent for their child to be screened or tested for depression and suicide risk in school.

Although there are significant gaps in knowledge about teen suicide and depression, parents know this: Many teens are suffering and not nearly enough is being done.

- Eight in ten parents say that not enough is being done to treat mental illnesses that affect teenagers. In spite of what they don't know about the specifics of teen depression and suicide, parents know that millions of cases are going undiagnosed.
- Two in three parents know that a majority of teens who are clinically depressed do not receive treatment.
- Three in four parents know that fewer than one in five teens with depression get the help that they need. Seven in ten parents know that most teenagers that have thought about committing suicide do not seek help.

Parents are key partners in our effort to ensure a mental health check-up for every teen in America. This report contains numerous recommended activities for parents to assist in reaching the Commission's goals. These activities are discussed in the context of recommendations for schools, health professionals, policymakers, and community leaders.

CHAPTER TWO

Implementation Agenda for Schools

The Commission devoted extensive attention to the important role that schools play in providing critical health screenings and mental health services. The Commission makes the important point that mental illness is often the underlying cause of poor academic performance and high drop-out rates. Adolescent suicide attempts and completions are acts of violence, as we have seen in numerous school shootings in America. Substance abuse, another critical challenge for schools, is often a symptom of mental illness. The Commission also highlights the link between student mental health and the ongoing effort to provide students with a safe and drug-free school environment.

Key Commission Findings and Goals

The Commission's final report contained findings of importance to educators and those working in school settings. These include:

• Schools are in a unique position to identify mental health problems early and to provide a link to appropriate services. Every day more than 52 million students attend over 114,000 schools in the U.S. When combined with the six million adults working at those schools, almost one-fifth of the population passes through the nation's schools on any given weekday.

• Mental health is essential to learning.

• 50% of students with serious emotional impairments drop out of school.

• A substantial number of children and adolescents have co-occurring mental illness and substance abuse disorders.

The Commission listed a number of national goals for schools:

• Schools should work with parents, local providers, and local agencies to promote screening, assessment, and early intervention.

• School and mental health programs must provide any screening or treatment services with full attention to confidentiality and privacy of children and families.

• Mental health services should be part of school health centers. There should be a national effort to improve and expand school mental health programs. Schools must be partners in the mental health care of children.

• To fulfill the promise of the President's major educational reform effort, the No Child Left Behind Act of 2001, schools must work to remove the emotional, behavioral, and academic barriers that interfere with student success in schools. Consequently, it is critical that schools improve and expand school mental health programs.

• Schools should build in the recommendations from the President's Commission on Excellence in Special Education and implement empirically supported prevention and early intervention approaches at the school district, local school, classroom, and individual student level.

Implementation Steps

Increasingly, school personnel and administrators are recognizing that mental health screenings are vital to find the youth who are struggling with mental illness. The Carmel Hill Center at Columbia University has been working nationwide with schools since 2001 to design and implement mental health screening and treatment referral programs. This work has taken place with an enormously diverse student population in urban, suburban, and rural areas, in every region of the country, and with students and parents of African, Asian, European, Hispanic, Native American, and Pacific Islander descent.

On average, 20% of young people screened in a school setting are found to require some type of mental health assistance, ranging from a single session with a mental health professional to more comprehensive treatment. Invariably, 1-2 per cent of all students screened are found to be in crisis, often contemplating an act of self-injury. When students are asked by mental health professionals why they did not share their symptoms earlier with a parent or another adult, the almost universal answer is "nobody ever asked."

Five years of program experience in schools has demonstrated that there are a number of paths educators can take to establish successful programs that confidentially identify and refer students in need. The following case studies illustrate the creative and diverse approaches schools have taken to implement screening programs:

1. Add screening to the responsibilities of student health centers and utilize existing school personnel to conduct screening and referrals.

One of the most successful TeenScreen Program implementations is in a school-based health center in Juneau, Alaska. The major benefits of adding mental health and suicide screening to this school-based health center are the time it saves and the abundance of information it provides about students who are new to the health center staff. Students who are found by the screening to need further evaluation or treatment are then referred out to a community agency or, in some instances, offered short-term treatment at the school-based health center.

2. Attract outside grant funding to support and expand in-school screening staff.

The TeenScreen site in Fond du Lac,

Screening Success Stories

Words from a student who had been screened:

"Being depressed made going to school difficult. My grades suffered, I was cutting myself regularly. I had a definite plan to kill myself. Then the Columbia TeenScreen Program came to my high school and I thought this program might be able to help me. TeenScreen gave me an adult to talk to – someone to listen-and then connected me with a counselor that I could see regularly. I am in college (now) and I have not hurt myself or thought about suicide since."

A clinician talks about cases that were found through screening:

"Students were referred to me after a thorough screening process and the approval of their parent or guardian. Most of the students presented as mentally stable at the time of our first appointment, but it became apparent that many of them struggle with chronic mental and emotional issues. One success story involved a 14-year-old girl battling major depression. She had previously tried to drown herself at age 12. She began opening up and sharing her feelings of unworthiness and low self esteem. She admitted that the occasional suicidal thought had become more frequent and powerful in the recent days. She didn't trust her ability to protect herself from self-harm. I told her that I had to intervene and call her mother, which brought a sigh of relief. Through the actions of her mother she was able to receive prompt attention and begin treatment for her mental illness. The Colorado Link project provided a safe environment for the young girl to explore her tormenting issues, reveal herself, and ask for help. In this particular case, that connection may have saved her life."

Wisconsin ran the first year of its screening program entirely with volunteers and existing school staff. At the end of the year, they took their results to local funding agencies and were awarded funds that will enable them to hire a part-time screening coordinator for the 2003-2004 school year. These funds will also enable them to expand their screening efforts to other arenas, such as primary care. In addition, news of their success has spread throughout the state and other districts are now also working to implement the program.

3. Develop a partnership with a local non-profit health agency.

In Tulsa, Oklahoma the TeenScreen program is run by the community's Mental Health Association, which is a non-profit mental health advocacy organization. Through a variety of grants, the Mental Health Association is able to staff a full-time screening coordinator/clinician and a case manager, and this team of two travels from school to school screening students. The school district is a partner in their TeenScreen Program. The Mental Health Association of Tulsa that conducts and oversees the program.

4. Partner with local city or county government.

In Arizona, the City of Tempe Counseling Services were able to secure a grant from a local foundation to hire a part-time screener/clinician to screen students at the district's alternative school throughout the school year. This partnership between the city and school district has worked well and efforts are currently underway to expand the program to three additional schools in the area.

5. Collaborate with a local suicide prevention program.

The TeenScreen site in Dallas, Texas is run by the local Suicide and Crisis Center. The Center provides screening services to several schools and the Dallas County Juvenile Justice Alternative Education Program. The Center provides the screeners while clinicians provide treatment for identified youth.

Parents and Schools

Parents have a tremendous amount of influence in their communities and their opinions are highly regarded by education leadership. Among the steps parents can take to help establish screening programs are:

- Bring information about screening programs, depression, and suicide directly to school health personnel, including school nurses, social workers, guidance counselors, and psychologists. These individuals are often in the best position to understand how screening can help them perform their professional responsibilities and providing them with useful information can engage them to become effective advocates for screening within schools.

- Bring information to the local PTA to develop a screening outreach effort to local schools. PTAs are very interested and active in initiatives that help promote academic performance and that ensure schools provide a safe learning environment.

- Contact local principals, superintendents, and school boards. These individuals have the greatest authority and, if committed to adolescent mental health, will become valuable allies. It should be noted that the larger the responsibilities of school officials, the more constituencies they must deal with and sometimes the more cautious they become.

Community Foundations, United Ways and Civic Groups

The Carmel Hill Center has noted the important role local philanthropic institutions and civic groups can play as catalysts to help launch and maintain mental health screening programs in schools. In conversations with school superintendents, it has often been repeated that the visible involvement of a local charitable group, such as the United Way, the Red Cross, the PTA, or a community foundation, can provide the support needed to make mental health screening a priority in the schools. Community philanthropic institutions can also play a critical role in bringing mental health service providers together to design an effective referral and treatment system for youth in need.

CHAPTER THREE

Implementation Agenda for Primary Care, Health Plans and the Mental Health System

A major theme of the Commission's work is the failure of our health care system to meet our children's mental health needs. It is an area ripe for aggressive action by health professionals working in primary care and mental health care settings, as well as health plans.

Key Commission Findings and Goals

The Commission's final report contained findings of importance to all segments of the nation's healthcare system. These include:

- Of individuals who die by suicide, approximately 90% had a mental disorder and 40% of these individuals had visited their primary care doctor within a month before their suicide.
- A significant percentage of patients in primary care shows signs of depression, yet up to half go undetected and untreated.
- Of all the children they see, primary care physicians identify about 19% with behavioral and emotional problems. While these providers frequently refer these youth for mental health treatment, 59% of them never actually see the specialist.
- Children and adolescents are among those particularly unlikely to receive care for mental disorders.

The Commission listed national goals for the healthcare system:

- Screening for mental health disorders should occur in primary health care settings across the life span.
- Individuals with disorders should be connected to appropriate treatment and supports.
- Public and private insurers should reimburse case management, which is the link between screening and treatment.
- Mental health and substance abuse treatment should be seamless.

Implementation Steps

Seventy percent of youth aged 10-18 visit a primary care provider each year, with an average of three visits per year. Evidence-based mental health screening tools can be utilized to assess a youth's mental health similar to the way physicians use diagnostic tools, such as chest x-rays and blood tests, to assess a youth's physical health. Available mental health screening tools are accurate and reliable. Yet, except in a handful of isolated settings, these tools are not being used by physicians or being promoted by health plans.

We acknowledge the time constraints placed on many primary care visits, however, mental health screens offer a rapid method of identifying youth at risk that could be utilized at intake or in the waiting room.

IMPLEMENTATION STEPS FOR PRIMARY CARE PHYSICIANS

- Every primary care physician in the United States should administer a brief mental health check-up to every patient between the ages of 10-18. Because symptoms of depression and other mental health disorders often have no external symptoms, physicians should offer screening to all youth as part of a routine exam.
- Given the hereditary nature of many mental health disorders, primary care physicians treating adult patients for depression or other mental illness should make screening their patient's children a priority.

• The American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association are already supporting efforts to integrate screening into the healthcare system. Medical professional organizations that represent primary care health professionals should take a leadership role in promoting the use of screening.

IMPLEMENTATION STEPS FOR HEALTH PLANS AND EMPLOYEE ASSISTANCE PROGRAMS

• Evidence-based mental health screenings and referral programs, such as The Columbia University TeenScreen Program, should be reimbursed in a manner similar to other screening tests.

• Health plans should evaluate the costs and outcomes of traditional primary health care check-ups for adolescents with substituting screening as the first step in a physical for adolescents. For example, one of the leaders in the field of primary care based mental health screening, Kaiser Permanente of Hawaii, has found that comprehensive physical and mental health screening using a survey instrument produces better health outcomes for patients and lower overall costs for health plans (see sidebar).

• Employee Assistance Programs (EAPs) should offer mental health screenings for the family of employees.

• Eligible children should receive mental health screenings and treatment under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

• Behavioral health plans should explore connecting services to screening programs and offer comprehensive and coordinated care for co-occurring mental health and substance abuse disorders.

IMPLEMENTATION STEPS FOR MENTAL HEALTH CARE PROVIDERS

Psychiatrists and psychologists should work actively in their communities to assist schools and primary care settings in implementing mental health screening programs. A few ways to accomplish this are:

• Volunteering and organizing staffing of

KAISER PERMANENTE IN HAWAII

Comprehensive Adolescent Screening

Kaiser Permanente in Hawaii has developed a computer-assisted system of screening youth for high-risk health behaviors as part of their annual check-up. They have designed an interactive computerized program which facilitates greater reporting of high-risk psychosocial and health risk behaviors and allows timely professional intervention. Upon taking the computerized assessment, youth receive individual feedback and view automatically selected videos on a laptop computer. In addition, the computer program generates a prioritized list of problem areas for the health counselor to review with the adolescent.

Research on their program analyzing feedback from over 5,000 youth showed that the screening questions found 58% of teens required more in-depth evaluation of possible suicidal ideation and of those, 16% had thought about suicide within the last month. 14% had made a previous suicide attempt (9.8% of males and 17.8% of females). Computer-assisted preventive visits are very inexpensive when compared with traditional clinical services, with a cost analysis showing a total cost of $70 per visit for a standard preventive visit, compared to $15 per visit for a computer assisted health visit.

(Paperny, D.M. et al., 1997, 1999)

school and other community-based screening programs.

• Identifying mental health services available to handle referrals.

• Where necessary, working with schools and parents groups to advocate for the addition of new services.

Parents and the Healthcare System

Parents can be a critical voice and catalyst for change in the healthcare system. Simple actions can produce significant change, including:

• Requesting a mental health screening for your child as part of his or her next visit to a primary care physician.

• Downloading a copy of the President's New Freedom Commission Report, or this report, and giving it to your physician and health plan with a formal request that they implement screening and/or provide coverage for mental health screenings for youth.

• Helping to establish a Parent Partners program in your community that creates opportunities for parents to play a key role in the case management system that links mental health screening to treatment.[2]

• Contacting your employer or health insurance company to insist that they support and reimburse mental health screenings for teens.

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[2] For more information on these types of programs, please contact: durstk@childpsych.columbia.edu

CHAPTER FOUR

Implementation Agenda for Policymakers

While this report encourages schools, health-care professionals, and parents to play a significant role in expanding mental health screening opportunities for children and adolescents, much of the responsibility for instituting screening programs lies with policymakers at the federal, state, and local level.

Key Commission Findings and Goals

The Commission draws attention to the fact that "currently no agency or system is clearly responsible or accountable for young people with mental illness." Therefore, many federal, state, and even local agencies must play a role in expanding mental health screening for children and adolescents. Elected officials and advocates must encourage these agencies to act quickly.

The Commission's report makes some suggestions that can serve as the first building blocks of an implementation agenda in the policy arena. These include:

• In order to fulfill the promise of the No Child Left Behind Act of 2001, we must ensure that mental health services are part of school health centers and that these services are federally funded as health, mental health, and education programs.

• Create a state-level structure for school-based mental health services to provide consistent leadership and collaboration between education, general health and mental health systems.

• Improving coordination of the federal funding and clinical care provided by publicly funded community health clinics.

• Facilitating coverage for case management, a key component linking screening to treatment via Medicare, Medicaid, the Department of Veterans Affairs, and other federal and state-sponsored health insurance programs.

Implementation Steps for Federal Policymakers

Elected officials and key agency personnel have been working to expand the availability and funding of mental health check-ups for children and adolescents. Some of the key initiatives required for the expedited expansion of screening include:

DEPARTMENT OF EDUCATION

• Make implementation of universal school-based mental health screenings a key strategic goal in the Department of Education's next annual fiscal year plan.

• Through the Office of Safe and Drug-Free Schools website, conference, newsletters, and professional mailings, increase awareness that Safe and Drug-Free Schools program dollars can and should be used to support mental health services and suicide prevention activities.

• Increase funding for Safe and Drug-Free Schools State Programs to specifically support applicants who propose to implement school-based mental health screenings.

• Give priority to Safe and Drug-Free School state formula grant applicants and Safe Schools/Healthy Students grant applicants who propose to implement school-based mental health-screenings.

• Request the full funding of the Integration of Schools and Mental Health Systems grant as authorized under the No Child Left Behind Act.

• Reauthorize the Safe, Disciplined, and Drug-Free Schools Expert Panel to formally

establish school-based mental health screenings as an exemplary school-based program that promotes safe, disciplined and drug-free schools.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

- Earmark funds for school-based and community-based mental heath screening.
- Disseminate successful screening models through the Bureau of Primary Health's Center for School-Based Health, and provide technical assistance to schools implementing and operating screening efforts.

THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION (SAMHSA)

- Incorporate mental health screenings into substance use disorder diagnostic and treatment strategies.
- Facilitate cooperation between local teen drug prevention and mental health screening initiatives.
- Include evidence-based mental health screening programs in the National Registry of Effective Programs.
- Make funding streams available for research and demonstration projects designed to improve the effectiveness of community based mental health screening programs.

NATIONAL INSTITUTE FOR MENTAL HEALTH (NIMH)

- Fund research to improve accuracy and ease of mental health screening.
- Evaluate screening tools.
- Prioritize research on identifying risk factors, pre-cursors to mental illness and effective interventions for mental illness in youth.

RECENT FEDERAL LEGISLATIVE ACTIVITY

Labor HHS Appropriations

During the fiscal year 2004 appropriations process, both the House of Representatives and the U.S. Senate included language in their reports on the Departments of Labor, Health and Human Services, and Education appropriations bill that recognizes the importance of youth mental health check-ups. The reports call on the Department of Education and the Substance Abuse and Mental Health Services Administration to collaborate to make the availability of screening programs more widely known and to help school districts and other groups provide voluntary mental health check-ups to all school-aged youth. Both must provide a report on their progress to the House and Senate Appropriations Committee before next year's appropriations process begins.

H.R. 3063 The Children's Mental Health Screening and Prevention Act

In September 2003, Congresswoman Rosa DeLauro (D-CT) reintroduced the Children's Mental Health Screening and Prevention Act. This bill was first introduced by the Congresswoman in the 107th Congress. The bill creates a federal grant program to fund a demonstration project to implement "evidence-based preventive screening programs to detect mental illness and suicidal tendencies in school-aged children." Grants would be made to any facility serving at-risk youth, such as a school, school-based health center, juvenile justice facility, homeless shelter, or a youth outreach organization, to name a few. The bill also creates an advisory panel, consisting of mental health professionals, advocates, and academics, among others, charged with making recommendations on the use or improvement of these screening models based upon information collected by grantees. This legislation will allow the federal government to collect "proof" that preventive screening efforts work and to endorse these efforts as sound federal policy.

CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS)

• Provide reimbursement for screening and related case management.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

• The Division of Adolescent and School Health (DASH) of the National Center for Chronic Disease Prevention and Health Promotion should integrate mental health screening into tobacco prevention, violence and sexual health social marketing and behavioral health strategies.

• The National Center for Injury Prevention and Control (NCIPC) should include mental health screening as a core strategy in their work to raise awareness of suicide as a serious public health problem and focus on science-based prevention strategies to reduce injuries and deaths.

THE SURGEON GENERAL

• The landmark "Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda" was one of the first federal calls for universal screening. The Office of the Surgeon General should make an ongoing effort to promote this recommendation.

• Convene state medical officers to promote the goal of reducing youth suicide by establishing universal screening programs in primary care and school settings.

DEPARTMENT OF JUSTICE

• The Department of Justice's Office of Juvenile Justice and Delinquency Policy (OJJDP) should encourage and fund mental health screenings as a routine part of intake in every juvenile justice program in the United States.

• Follow the recommendations for best practices for screening and assessing youth in the juvenile justice system reached using the expert consensus method during a conference in 2002, hosted by Columbia University's Center for the Promotion of Mental Health in Juvenile Justice. These recommendations included: providing an evidence-based, scientifically sound screening for risks to self and others within the first 24 hours of a youth's arrival at a facility; providing a multi-component, evidence-based, scientifically sound screening and/or assessment for mental health needs, including diagnostic status, for all youths in justice system contact; and providing screening for mental health needs on a regular basis while in the juvenile justice facility and before re-entering the community.

Implementation Steps for State and Local Policymakers

• Adapt and introduce a resolution endorsing youth mental health screenings. Georgia and Pennsylvania have introduced such resolutions and provide a model for other state legislatures.

• Convene a state level hearing to review a state's suicide prevention plan and policy and to encourage the statewide implementation of school-based mental health screenings.

• The National Governors Association and the National Conference of State Legislatures should highlight youth mental health screenings as a best practice and disseminate information on screenings to our nation's governors, legislators, and their policy advisors.

Resolutions in the Georgia House of Representatives and the Pennsylvania Senate

Leaders in both the Georgia House and the Pennsylvania Senate introduced resolutions, HR 563 in Georgia and SR 52 in Pennsylvania, endorsing mental health screenings for youth. Both bills state that "every child should be screened for mental illness once in their youth in order to identify mental illness and prevent suicide among youth." This is a major step towards recognizing such check-ups as a best practice for identifying mental illness and preventing suicide in those states. It has also helped pave the way for future program activities in those and other states.

(To obtain the full text of either of these bills, please visit: www.teenscreen.org)

Excerpt from the Oregon State Suicide Prevention Plan

"Screen youth and young adults for suicide risk and refer identified individuals for further evaluation and intervention. Screening and referral is appropriate for youth in any setting but may be particularly warranted for those in subgroups known to be at higher risk for suicide. These include: incarcerated youth, youth with history of juvenile justice and/or protective service involvement; American Indians; white males; depressed youth; substance abusers; high-striving, perfectionist youth; potential dropouts; runaways; gay and lesbian youth; victims of assault and/or abuse; and pregnant teens. Screening can identify youth with symptoms of depression, suicidal ideation, and behavior, thus providing a means to determine which of them are in need of further assessment and care."

(For the full text of the Oregon State Youth Suicide Prevention Plan please visit: http://www.ohd.hr.state.or.us/ipe/2000plan)

• All states should adopt mental health screening as a core strategy of their state suicide prevention plan. States should follow Oregon's lead in recommending screening as a core strategy to prevent suicide in youth.

• State health, education and juvenile justice programs should increase funding for mental health screening and increase flexibility of current funding streams so they can be used for screenings in schools, primary care settings, and community settings (boys and girls clubs, drop-in centers, etc.).

• State and local governments should urge consolidation and cooperation between the Department of Education, the Department of Child Welfare, and the Department of Health to work together to further the goal of offering mental health screenings to all youth. Parents, Advocates, and Public Policy Parents and advocates are the most compelling spokespersons for changes in public policy.

Action steps for those eager to change federal, state and local policies include:

• Sign the Positive Action for Teen Health Petition (at www.pathnow.org) which calls for universal mental health screening for every teen. Encourage others in your community to sign it, too.

• Contact your federal legislators to encourage them to play an active role in increasing the availability of youth mental health screenings.

• Encourage state and local health and mental health officials to hold public hearings to examine how current programs and resources can be better targeted to support mental health screening and treatment for youth.

• Contact your state legislators and ask them to introduce a resolution endorsing youth mental health screenings and to include youth mental health screenings in the state's suicide prevention plan or policy.

• Build an advocacy network by working with other families to encourage universal screening in schools and primary healthcare settings.

Conclusion

The President's New Freedom Commission on Mental Health has challenged our nation to enact significant and critical changes in the way we deliver child and adolescent mental health care. This implementation report suggests that multiple sectors and many individuals are needed to take the next steps. The good news is that many educators, policy makers, health plans, parents, and advocates around the country have already created examples of successful approaches and models. This should provide confidence that nationwide success is practical and possible. Science dictates that mental health screenings can be a powerful tool to improve health and save lives. The combined efforts of people like you will decide how quickly these available tools are implemented and consequently, how quickly troubled youth can be caught before they fall.

If you would like to support the work of the Carmel Hill Center in encouraging the development of universal mental health screenings and treatment for children and teens please contact:

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Website
www.teenscreen.org

Appendix A

Summary of Goals and Recommendations From The President's New Freedom Commission on Mental Health

In a Transformed Mental Health System...

GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health.

RECOMMENDATIONS

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

GOAL 2: Mental Health Care Is Consumer and Family Driven.

RECOMMENDATIONS

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

2.3 Align relevant Federal programs to improve access and accountability for mental health services.

2.4 Create a Comprehensive State Mental Health Plan.

2.5 Protect and enhance the rights of people with mental illnesses.

GOAL 3: Disparities in Mental Health Services Are Eliminated.

RECOMMENDATIONS

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

RECOMMENDATIONS

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

GOAL 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated.

RECOMMENDATIONS

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

GOAL 6: Technology Is Used to Access Mental Health Care and Information.

RECOMMENDATIONS

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

Appendix B

Michael F. Hogan, Ph.D.
Chairman, President's New Freedom Commission on Mental Health

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Deanna F. Yates, Ph.D.

Appendix C

Goal 4: Early Mental Health Screening, Assessment and Referral to Services Are Common Practice

RECOMMENDATIONS

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Understanding the Goal

EARLY ASSESSMENT AND TREATMENT ARE CRITICAL ACROSS THE LIFE SPAN

For consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience mental health problems.

Emerging research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability. New understanding of the brain indicates that early identification and intervention can sharply improve outcomes and that longer periods of abnormal thoughts and behavior have cumulative effects and can limit capacity for recovery.

IF UNTREATED, CHILDHOOD DISORDERS CAN LEAD TO A DOWNWARD SPIRAL

Early childhood is a critical period for the onset of emotional and behavioral impairments. In 1997, the latest data available, nearly 120,000 preschoolers under the age of six – or 1 out of 200 – received mental health services. Each year, young children are expelled from preschools and childcare facilities for severely disruptive behaviors and emotional disorders.

Since children develop rapidly, delivering mental health services and supports early and swiftly is necessary to avoid permanent consequences and to ensure that children are ready for school. Emerging neuroscience highlights the ability of environmental factors to shape brain development and related behavior. Consequently, early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening.

Without intervention, child and adolescent disorders frequently continue into adulthood. For example, research shows that when children with co-existing depression and conduct disorders become adults, they tend to use more health care services and have higher health care costs than other adults. If the system does not appropriately screen and treat them early, these childhood disorders may persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. No other illnesses damage so many children so seriously.

One of the many factors that can affect the emotional health of young children is the mental health status of their parents. For example, depression among young mothers has been shown to influence the mental health of their young children. These findings are significant because mental disorders that occur before the age of six can interfere with critical emotional, cognitive, and physical development, and can predict a lifetime of problems in school, at home, and in the community.

Early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening.

Schools Can Help Address Mental Health Problems

Currently, no agency or system is clearly responsible or accountable for young people with serious emotional disturbances. They are invariably involved with more than one specialized service system, including mental health, special education, child welfare, juvenile justice, substance abuse, and health.

The mission of public schools is to educate all students. However, children with serious emotional disturbances have the highest rates of school failure. Fifty percent of these students drop out of high school, compared to 30% of all students with disabilities. Schools are where children spend most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children.

Schools are in a key position to identify mental health problems early and to provide a link to appropriate services. Every day more than 52 million students attend over 114,000 schools in the U.S. When combined with the six million adults working at those schools, almost one-fifth of the population passes through the Nation's schools on any given weekday. Clearly, strong school mental health programs can attend to the health and behavioral concerns of students, reduce unnecessary pain and suffering, and help ensure academic achievement.

People with Co-occurring Disorders Are Inadequately Served

Early intervention and appropriate treatment can also reduce pain and suffering for children and adults who have or who are at risk for co-occurring mental and addictive disorders. Seven to ten million people in the United States have at least one mental disorder in addition to an alcohol or drug abuse disorder. Too often, these individuals are treated for only one of the two disorders – if they are treated at all.

In his speech announcing the Commission, the President used an example that affirms this point. The President spoke of: *"... a 14-year-old boy who started experimenting with drugs to ease his severe depression. This former honor student became a drug addict. He dropped out of school, was incarcerated six times in 16 years. Only two years ago, when he was 30 years old, did the doctors finally diagnose his condition as bipolar disorder, and he began a successful program ..."*

Co-occurring substance use and mental disorders can occur at any age. Research suggests that as many as half of the adults who have a diagnosable mental disorder will also have a substance use disorder at some point during their lifetime.

A substantial number of children and adolescents also have co-occurring mental illnesses and substance use disorders. If one co-occurring disorder remains untreated, both usually get worse. Additional complications often arise, including the risk for other medical problems, unemployment, homelessness, incarceration, suicide, and separation from families and friends.

Older adults are at risk of developing both depression and alcohol dependence for perhaps the first time in their lives. This phase of the life cycle has new risk factors for both of these disorders. The number of older adults with mental illnesses is expected to double to 15 million in the next 30 years. Mental illnesses have a significant impact on the health and functioning of older people and are associated with increased health care use and higher costs. The current mental health service system is inadequate and unprepared to address the needs associated with the anticipated growth in the number of

older people requiring treatment for late-life mental disorders.

Individuals with co-occurring disorders challenge both clinicians and the treatment delivery system. They most frequently use the costliest services (emergency rooms, inpatient facilities, and outreach intensive services), and often have poor clinical outcomes. The combination of problems increases the severity of their psychiatric symptoms and the likelihood for suicide attempts, violent behaviors, legal problems, medical problems, and periods of homelessness.

Studies show that few providers or systems that treat mental illnesses or substance use disorders adequately address the problem of co-occurring disorders. Only 19% of people who have co-occurring serious mental illnesses and substance dependence disorders are treated for both disorders; 29% are not treated for either problem. For people with less serious mental illnesses and substance dependence problems, the pattern of under-treatment is even worse. Most (71%) receive no treatment; only 4% receive treatment for both disorders. The same pattern of undertreatment holds for youth with co-occurring disorders.

Widespread barriers impede effective treatment for people with co-occurring disorders at all levels, including Federal, State, and local governments, and individual treatment agencies.

Mental Health Problems Are Not Adequately Addressed in Primary Care Settings

People with mental health disorders are routinely seen in primary care settings. The Epidemiologic Catchment Area Study, conducted in the early 1980s, found that while people with common mental illnesses had some contact with primary care services, few received specialty mental health care. About half of the care for common mental disorders is delivered in general medical settings. Primary care providers actually prescribe the majority of psychotropic drugs for both children and adults. While primary care providers appear positioned to play a fundamental role in addressing mental illnesses, there are persistent problems in the areas of identification, treatment,and referral.

Despite their prevalence, mental disorders often go undiagnosed, untreated, or under-treated in primary care. Primary care providers' rates of recognition of mental health problems are still low, although the number identified is increasing.

When mental illnesses are identified, they are not always adequately treated in the primary care setting, and referrals from primary care to specialty mental health treatment are often never completed.

While effective treatments exist for most common mental disorders, studies have shown that many consumers seen in primary care settings do not receive them. Even in the 1990s, most adults with depression, anxiety, and other common mental disorders did not receive appropriate care in primary care settings. Older adults, children and adolescents, individuals from ethnic minority groups, and uninsured or low-income patients seen in the public sector are particularly unlikely to receive care for mental disorders.

Of individuals who die by suicide, approximately 90% had a mental disorder, and 40% of these individuals had visited their primary care doctor within the month before their suicide. During visits in the primary care setting, the question of suicide was seldom raised.

A significant percentage of patients in primary care shows signs of depression, yet up to half go undetected and untreated. This is especially problematic for women, people with a family history of depression, the unemployed, and those with chronic disease, all of whom are at increased risk for depression.

Despite their prevalence, mental disorders often go undiagnosed, untreated, or under-treated in primary care.

A significant percentage of patients in primary care shows signs of depression, yet up to half go undetected and untreated.

Of all the children they see, primary care physicians identify about 19% with behavioral and emotional problems. While these providers frequently refer children for mental health treatment, significant barriers exist to referral, including lack of available specialists, insurance restrictions, appointment delays, and stigma. In one study, 59% of youth who were referred to specialty mental health care never made it to the specialist.

Finally, it is noteworthy that there is a parallel problem in specialty mental health care. Specialty mental health providers often have difficulty providing adequate medical care to consumers with co-existing mental and physical illnesses. Given that individuals with serious mental illnesses, such as schizophrenia, have high levels of nonpsychiatric medical illnesses and excess medical mortality, this is also a troubling situation.

Achieving the Goal

RECOMMENDATION

4.1 Promote the mental health of young children.

EARLY DETECTION CAN REDUCE MENTAL HEALTH PROBLEMS

Early detection and treatment of mental disorders can result in a substantially shorter and less disabling course of illness. As the mental health field becomes increasingly able to identify the early antecedents of mental illnesses at any age, interventions must be implemented, provided in multiple settings, and connected to treatment and supports.

Early interventions, such as the Nurse-Family Partnership *(See Figure 4.1.)*, and educational efforts can help a greater number of parents, the public, and providers learn about the importance of the first years of a child's life and how to establish a foundation for healthy social and emotional development.

Quality screening and early intervention should occur in readily accessible, low-stigma settings, such as primary health care facilities and schools, and in settings where a high level of risk for mental health problems exists, such as juvenile justice and child welfare.

The Commission suggests a national focus on the mental health needs of young children and their families that includes screening, assessment, early intervention, treatment, training, and financing services. The national focus will:

- Build on coordination mechanisms already in place, such as Part C of the Individuals with Disabilities Education Act (IDEA); and
- Expand the coordination of services for children ages 3 through 21 for those who qualify for services under Part B of IDEA, thus building capacity for improved and increased services in communities.

A coordinated, national approach to these issues will help eliminate social and emotional barriers to learning and will promote success in school and in other community settings for young children. This effort may involve collaborations among parents, mental health providers, and early childhood and child care programs. Other important dimensions of the approach will include:

- Training a workforce skilled in treating young children and their families;
- Training primary health providers to screen for and recognize early signs of emotional and behavioral problems and to offer connections to appropriate interventions;
- Eliminating barriers to coverage, such as a required psychiatric diagnosis when an alternative diagnosis that minimizes labeling and stigma is more appropriate; and
- Including "social and emotional check-ups" in primary health care.

The IDEA specifically provides for a statewide, comprehensive, interagency system for early prevention services for children with disabilities from birth to 3 years old who

FIGURE 4.1. MODEL PROGRAM: Intervening Early to Prevent Mental Health Problems

PROGRAM	Program Nurse-Family Partnership
GOAL	To improve pregnancy outcomes by helping mothers adopt healthy behavior, improve child health and development, reduce child abuse and neglect, and improve families' economic self-sufficiency.
FEATURES	A nurse visits the homes of high-risk women when pregnancy begins and continues for the first year of the child's life. The nurse adheres to visit-by-visit protocols to help women adopt healthy behaviors and to responsibly care for their children. In many states, Nurse-Family Partnership programs are funded as special projects or through State appropriations.
OUTCOMES	*For mothers*: 80% reduction in abuse of their children, 25% reduction in maternal substance abuse, and 83% increase in employment. *For children (15 years later)*: 54% to 69% reduction in arrests and convictions, less risky behavior, and fewer school suspensions and destructive behaviors. This is the only prevention trial in the field with a randomized, controlled design and 15 years of follow-up. The program began in rural New York 20 years ago and its benefits have been replicated in Denver and in minority populations in Memphis.
BIGGEST CHALLENGE	To preserve the program's core features as it grows nationwide. The key feature is a trained nurse, rather than a paraprofessional, who visits homes. A randomized, controlled trial found paraprofessionals to be ineffective.
HOW OTHER ORGANIZATIONS CAN ADOPT	Modify requirements of Federal programs, where indicated, to facilitate adopting this successful, cost-effective model.
SITES	Sites 270 communities in 23 states.
FOR ADDITIONAL INFORMATION	http://www.nccfc.org/nurseFamilyPartnership.cfm

have a developmental delay and physical, cognitive, communication, social or emotional, or adaptive development problem, or have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

More effort is needed to heighten public awareness of the developmental requirements for children's social and emotional well-being – just as public awareness of the early developmental and educational needs for reading skills has been increased through public and private initiatives. When children with disabilities reach age 3, they may be eligible for services under Part B of IDEA if they have one of the specified impairments andif, because of the impairment, they need special education and related services. However, services and other resources for children who have emotional and mental health issues are sometimes less readily available with respect to workforce, interventions, and financing, than other services, such as speech and language therapy or physical therapy.

Addressing the mental health of young children may also involve providing information, supports, and treatment for parents. For the young child, treating the parents' mental health problems also benefits the child.

Schools Should Have the Ability to Play a Larger Role in Mental Health Care for Children

RECOMMENDATION

4.2 Improve and expand school mental health programs.

Growing evidence shows that school mental health programs improve educational outcomes by decreasing absences, decreasing discipline referrals, and improving test scores. The key to improving academic achievement is to identify mental health problems early and, when needed, provide appropriate services or links to services. The extent, severity, and far-reaching consequences make it imperative that our Nation adopt a comprehensive, systematic approach to improving the mental health status of children. Clearly, school mental health programs must provide any screening or treatment services with full attention to the confidentiality and privacy of children and families. The Columbia University TeenScreen® program provides a

FIGURE 4.2. MODEL PROGRAM: Screening Program for Youth

PROGRAM	Columbia University TeenScreen® Program
GOAL	To ensure that all youth are offered a mental health check-up before graduating from high school. TeenScreen® identifies and refers for treatment those who are at risk for suicide or suffer from an untreated mental illness.
FEATURES	All youngsters in a school, with parental consent, are given a computer-based questionnaire that screens them for mental illnesses and suicide risk. At no charge, the Columbia University TeenScreen® Program provides consultation, screening materials, software, training, and technical assistance to qualifying schools and communities. In return, TeenScreen® partners are expected to screen at least 200 youth per year and ensure that a licensed mental health professional is on-site to give immediate counseling and referral services for youth at greatest risk. The Columbia TeenScreen® Program is a not-for-profit organization funded solely by foundations. When the program identifies youth needing treatment, their care is paid for depending on the family's health coverage.
OUTCOMES	The computer-based questionnaire used by TeenScreen® is a valid and reliable screening instrument. The vast majority of youth identified through the program as having already made a suicide attempt, or at risk for depression or suicidal thinking, are not in treatment. A follow-up study found that screening in high school identified more than 60% of students who, four to six years later, continued to have long-term, recurrent problems with depression and suicidal attempts.
BIGGEST CHALLENGE	To bridge the gap between schools and local providers of mental health services. Another challenge is to ensure, in times of fiscal austerity, that schools devote a health professional to screening and referral.
HOW OTHER ORGANIZATIONS CAN ADOPT	The Columbia University TeenScreen® Program is pilot-testing a shorter questionnaire, which will be less costly and time-consuming for the school to administer. It is also trying to adapt the program to primary care settings.
WEBSITE	www.teenscreen.org
SITES WHERE IMPLEMENTED	69 sites (mostly middle schools and high schools) in 27 states

model for early intervention. *(See Figure 4.2.)*

The Commission recommends that Federal, State, and local child-serving agencies fully recognize and address the mental health needs of youth in the education system. They can work collaboratively with families to develop, evaluate, and disseminate effective approaches for providing mental health services and supports to youth in schools along a critical continuum of care. This continuum includes education and training, prevention, early identification, early intervention, and treatment.

The No Child Left Behind Act of 2001 is designed to help all children, including those with serious emotional disturbances reach their optimal potential and achievement. To fulfill the promise of this Act, schools must work to remove the emotional, behavioral, and academic barriers that interfere with student success in school. Consequently, it is critical to strengthen mental health programs in schools. This effort may involve:

- Working with parents, local providers, and local agencies to support screening, assessment, and early intervention;
- Ensuring that mental health services are part of school health centers;
- Ensuring that these services are Federally funded as health, mental health, and education programs;
- Building on a recommendation from the President's Commission on Excellence in Special Education to implement empirically supported prevention and early intervention approaches at the school district, local school, classroom, and individual student levels; and
- Creating a State-level structure for school-based mental health services to provide consistent State-level leadership and collaboration between education, general health, and mental health systems.

Since the IDEA requires that a variety of professionals collaborate in the school and in the community, the Commission urges that coordinating services be regarded as a "related service" in the child's Individual Education Plan (IEP). In developing the IEP, there should be a stronger family focus and youth involvement and support. The training and research funds designated in this Act should be considered for use to train teachers, related services professionals, and parents to recognize signs of emotional and behavioral problems in children, make appropriate referrals for assessment and services and classroom accommodations, and implement and evaluate evidence-based school mental health interventions.

On a related topic, the Commission recognizes the particular challenges for youth in transition from adolescence to adulthood. IDEA has transition requirements beginning at age 14, but to date, these requirements have not resulted in acceptable post-school outcomes.

Studies show that approximately 42% of students with serious emotional disturbances graduate from high school as opposed to 57% of students with other disabilities. Schools and local mental health agencies could improve their collaboration and use of evidence-based practices to develop transition-to-work services so that children with serious emotional disorders can move successfully from school to employment or to post-secondary education.

RECOMMENDATION

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Treatment for Co-occurring Disorders Must Be Integrated

Integrated treatment is a means of coordinating both substance abuse and mental health interventions to treat the whole person more effectively. From studies and first-hand expe-

A key challenge to developing integrated treatment programs is overcoming the traditional separation between mental health and substance abuse treatment.

riences, many researchers and clinicians in these fields believe that both disorders must be addressed as primary illnesses and treated as such. Integrated treatment can improve client engagement, reduce substance abuse, improve mental health status, and reduce relapses for all age groups.

Integrated services should appear seamless to the individual who seeks and receives care. Mental health and substance abuse treatment can be integrated by one clinician, two or more clinicians working together, one program, or a network of services.

Integrated treatment often involves other systems as well, because individuals with co-occurring disorders typically have a wide range of health and social service needs. For example, children in the juvenile justice system are at high risk for co-occurring mental and substance abuse disorders. Similarly, in the child welfare system, research strongly demonstrates that children in foster care at a high-risk for maladaptive outcomes, including socio-emotional, behavioral, and psychiatric problems warranting mental health treatment and supports.

A key challenge to developing integrated treatment programs is overcoming the traditional separation between mental health and substance abuse treatment. At least 36 States are attempting some change to their systems by addressing this problem through creative leadership with a sustained vision and by engaging strong local stakeholder support – including consumers and families – in program design and advocacy. However, much remains to be accomplished. Studies of these efforts have shown that State and local regulatory issues and impediments to multiple State and local funding streams continue as major barriers to changing the systems. The Commission commends the Substance Abuse and Mental Health Services Administration (SAMHSA) for its Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders and supports the five-year blueprint for action contained in the report.

The Commission supports implementing systematic screening procedures to identify mental health and substance use problems and treatment needs in all settings in which children, youth, adults, or older adults are at high risk for mental illnesses or in settings in which a high occurrence of co-occurring mental and substance use disorders exists. In addition to specialty mental health and substance abuse treatment settings, screening for co-occurring disorders should be implemented when an individual enters the juvenile or criminal justice systems, child welfare system, homeless shelters, hospitals, senior housing, long-term care facilities, nursing homes, and other settings where populations are at high risk. Screening should also occur periodically after an individual enters any of these facilities.

Expanded screening and collaborative care models could save lives.

When mental health problems are identified, children, youth, adults, and older adults should be linked with appropriate services, supports, or diversion programs. Additionally, given the high incidence of substance use disorders among parents of children in the child welfare system, where indicated, these parents should be screened for co-occurring disorders and linked with appropriate treatment and supports.

The Commission supports coordinated and, where appropriate, integrated mental health and substance abuse screening, assessment, early intervention, and treatment for co-occurring disorders in all Federally funded adult and child health and human services, criminal and juvenile justice programs, and veteran's services. Health and mental health training programs that receive HHS funding should include co-occurring disorders in curriculum design and training experiences.

The Center for Medicare and Medicaid Services (CMS) should be encouraged to develop and implement policy guidance to promote access and use of covered services by Medicaid and Medicare beneficiaries with co-occurring mental and substance use disorders.

RECOMMENDATION

4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

FIGURE 4.3. MODEL PROGRAM: Collaborative Care for Treating Late-Life Depression in Primary Care Settings

PROGRAM	IMPACT–Improving Mood: Providing Access to Collaborative Treatment for Late-Life Depression
GOAL	To recognize, treat, and prevent future relapses in older patients with major depression in primary care. About 5% -10% of older patients have major depression, yet most are not properly recognized and treated. Untreated depression causes distress, disability, and, most tragically, suicide.
FEATURES	Uses a team approach to deliver depression care to elderly adults in primary care setting. Older adults are given a choice of medication from a primary care physician or psychotherapy with a mental health provider. If they do not improve, their level of care is increased by adding supervision by a mental health specialist.
OUTCOMES	The intervention, compared to usual care, leads to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission.
BIGGEST CHALLENGE	To ensure that the intervention is readily adapted from the research setting into the practice setting.
HOW OTHER ORGANIZATIONS CAN ADOPT	Be receptive to organizational changes in primary care and devise new methods of reimbursement.
SITES	Study sites in California, Texas, Washington, North Carolina, Indiana

Expand Screening and Collaborative Care in Primary Care Settings

The Commission suggests that collaborative care models should be widely implemented in primary health care settings and reimbursed by public and private insurers. Numerous studies have documented the effectiveness of collaborative care models.[160-162] Expanded screening and collaborative care models, such as the Collaborative Care Model for treating late-life depression in primary care settings *(See Figure 4.3.)*, could save lives.

The Commission notes that the Federal government could better coordinate the funding and the clinical care provided by publicly funded community health clinics to consumers with multiple conditions, including physical, mental, and co-occurring substance use disorders. This effort would include improved coordination of care between Health Resources and Services Administration-funded community health clinics and SAMHSA- or State-supported community mental health centers. Expanded screening and collaborative care models could save lives. The Commission recommends that Medicare, Medicaid, the Department of Veterans Affairs, and other Federal and State-sponsored health insurance programs and private insurers identify and consider payment for core components of evidence-based collaborative care, including:

- Case management,
- Disease management,
- Supervision of case managers, and
- Consultations to primary care providers by qualified mental health specialists that do not involve face-to-face contact with clients.

Appendix D

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Appendix E

National Mental Health Screening Program Resources

American Foundation for Suicide Prevention
120 Wall Street, 22nd Floor
New York, New York 10005
fax: (212) 363-6237
Phone: (212) 363-3500
Email: inquiry@afsp.org
www.afsp.org

Columbia University TeenScreen Program
The Carmel Hill Center for Early Diagnosis and Treatment
Division of Child and Adolescent Psychiatry
1775 Broadway, Suite 715
New York, NY 10019
Phone: (866).TeenScreen (1866-833-6727)
Fax: (646) 443-8190
Email: teenscreen@childpsych.columbia.edu
www.teenscreen.org

Kaiser Permanente Adolescent Clinic
1010 Pensacola Street
Honolulu, HI 96814
Phone: (808) 432-2000
Email: davidpaperny@kp.org

Kaiser Permanente
Teen Choices and Challenges
1950 Franklin, 13th Floor
Oakland, CA 94612
Phone: (510) 987-2356
Email: Veenu.Aulakh@kp.org

Screening for Mental Health, Inc.
One Washington Street, Suite 304
Wellesley Hills, MA 02841
Phone: (781) 239-0071
Fax: (781) 431-7447
Email: mailbox@mentalhealthscreening.org
www.mentalhealthscreening.org

The Jed Foundation
583 Broadway, Suite 8B
New York, NY 10012
Phone: (212) 343.0016
Fax: (212) 343.1141
E-mail emailus@jedfoundation.org
www.thejedfoundation.org

National Resources on Youth Mental Health and Suicide Prevention

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, Va. 22209-3901
Phone: (703) 907-7300
Email: apa@psych.org
www.psych.org

American Psychological Association
750 First Street, NE,
Washington, DC 20002-4242
Telephone: (800) 374-2721 or (202) 336-5500
www.apa.org

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Ave., NW
Washington, D.C. 20016-3007
Phone: (202) 966-7300
Fax: (202) 966-2891
www.aacap.org

The National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
Phone: (703) 524-7600
Fax: (703) 524-9094
www.nami.org

The National Institute of Mental Health
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-4513 or 1-866-615-NIMH (6464)
Fax: (301)443-4279
Email: nimhinfo@nih.gov
www.nimh.nih.gov

The National Mental Health Association
National Mental Health Association
2001 N. Beauregard Street, 12th Floor
Alexandria, Virginia 22311
Phone: (800) 969-NMHA (6642)
www.nmha.org

SPAN USA
P.O. Box 73368
Washington, D.C. 20056-3386
Fax: (202) 387-3187
Email: info@spanusa.org
www.spanusa.org

Substance Abuse and Mental Health Services Administration
Room 12-105 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0001
Fax: (301) 443-1563
www.samhsa.gov