strategies for system change in children’s mental health

a chapter action kit
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The recommendations contained in this kit and in the mentioned publications do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. This kit discusses titles published by organizations other than the American Academy of Pediatrics. Statements and opinions expressed in these publications are those of the authors and not necessarily those of the American Academy of Pediatrics.

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Strategies for System Change in Children’s Mental Health: A Chapter Action Kit was developed out of a need to strategize how the American Academy of Pediatrics (AAP) chapters can address the growing mental health needs of children and adolescents that pediatrics and other primary care clinicians who provide medical homes face. The strategies offered in this kit vary in time, effort, funding requirements, and collaboration with state, regional, and local partners. The Chapter Action Kit is a true collaborative effort, resulting in many hours of hard work, mainly by Jane Meschan Foy, MD, chair of the AAP Task Force on Mental Health (TFOMH); the TFOMH volunteers; our consultant, Karen J. VanLandeghem, MPH; Judith C. Dolins, MPH, director of the AAP Department of Community, Chapter, and State Affairs; and Aldina Hovde, MSW, manager, Mental Health Initiatives.

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Additional Contributors
Several individuals and organizations contributed materials that they, themselves, developed for inclusion in the Chapter Action Kit. We gratefully acknowledge their participation as well. They are as follows: the American Academy of Child and Adolescent Psychiatry Subcommittee on Healthcare Access and Economics; Marian Earls, MD, FAAP; and Darcy Gruttadaro JD, National Alliance on Mental Illness.

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About the External Review Group
To make sure the strategies, resources, and tools were appropriate to our constituents, an external review group was formed. Participants included a member of the AAP Board of Directors, Gary Q. Peck, MD, FAAP; a Chapter President, William Cotton, MD, FAAP (Ohio); and a Chapter Executive Director, Linda Lee, APR (Alabama).

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# Table of Contents

**Getting Started: Approaching Children’s Mental Health**
Overview .................................................................................................................. 1-1

**Strategies to Partner With Families**
Strategies to Partner With Families ................................................................. 2-1

*Tools and Resources*
Building Family and Community Connections .............................................. 2-7

The Role of the Primary Care Clinician in Providing Culturally Competent, Family-Centered Care .................. 2-11

**Strategies to Assess the Service Environment**
Strategies to Assess the Service Environment ............................................. 3-1

*Tools and Resources*
Community Mental Health Resource Directory Guidance and Template ........................................................................ 3-7

Mental Health Professionals Sample Letter and Survey ............... 3-11

Mental Health Professionals List Sample ........................................ 3-13

Considerations in Developing Community Children’s Mental Health Emergency Services Protocols .................. 3-15

**Strategies to Collaborate With Mental Health Professionals**
Strategies to Collaborate With Mental Health Professionals ........................................ 4-1

*Tools and Resources*
Overview of Confidentiality Statutes and Children’s Mental Health ......................................................................... 4-7

Physician Referral and Feedback Form Template ......................... 4-11

Working to Improve Mental Health Services: The North Carolina Advocacy Effort“ Pediatrics Article .................. 4-13
Illinois Children’s Mental Health Partnership: Executive Summary ............................................................................ 6-17

American Academy of Pediatrics Chapter Mental Health Initiatives ........................................................................... 6-37

“A Process for Developing Community Consensus Regarding the Diagnosis and Management of Attention-Deficit/Hyperactivity Disorder” Pediatrics Article .... 6-41

Strategies to Improve Children’s Mental Health Financing
Strategies to Improve Children’s Mental Health Financing ...... 7-1

Tools and Resources
How Children’s Mental Health Services Are Financed
Fact Sheet ........................................................................................................................................ 7-9

Chapter Pediatric Councils Overview ........................................ 7-15

Hassle Factor Form ........................................................................ 7-19

Pediatric Mental Health Coverage Template Letter and Survey ........................................................................... 7-23

Collecting Information for Chapter Advocacy: Mental Health
Public and Private Payer Matrix ...................................................... 7-25

Pediatric Mental Health Payment Strategies Targeting Payers ........................................................................... 7-31

American Academy of Pediatrics State Government Affairs
Issue Brief: Child and Adolescent Mental Health.................... 7-37

National Conference of State Legislatures Brief: Children and Mental Health Parity ...................................................... 7-45

Selected American Academy of Pediatrics Mental Health Policy Statements, Technical Reports, and Endorsed Policy Statements
Selected AAP Mental Health Policy Statements, Clinical Reports, Technical Reports, and Endorsed Policy Statements.......... 8-1

Additional Tools and Resources
National and State Data Sources on Children’s Mental Health ...................................................................................... 9-3
Internet Resource List for Child and Adolescent Mental Health

From Neurons to Neighborhoods: The Science of Early Childhood Development

The Federation of Families for Children’s Mental Health

2-1-1 Fact Sheet

Guiding Principles for Collaboration Between Mental Health and Public Health
getting started - approaching mental health
Children’s mental health is an intrinsic part of their overall health and well-being. At least one in 10 children—as many as 6 million youth—experience a mental illness that severely disrupts his or her daily functioning at home, in school, or in the community. Another 16% of children have symptoms that do not rise to the level of a diagnosis but have functional impairment, and another 9% have a mental health diagnosis without current impairment. Fewer than 20% of these children receive mental health services in any given year.

Numerous barriers prevent children and their families from obtaining needed services, including stigma, mental health professional shortages, inadequate coverage of mental health services in public and private health insurance programs, inadequately trained clinicians, and complex and fragmented service delivery systems. Primary care clinicians report their own challenges to providing mental health services. These barriers include a number of system-level issues:

- Lack of time to meet the “physical” health needs, let alone the mental health needs, of their patients
- Lack of comfort, training, and expertise to address mental health needs and problems
- Insufficient or no payment for mental health services provided by primary care clinicians
- Lack of knowledge about community-based mental health referral resources
- Inadequate referral resources (eg, shortages or limited pediatric expertise of mental health professionals)
- Insufficient referral feedback “loops” and shared decision making between primary care clinicians and mental health clinicians

How the American Academy of Pediatrics Chapters Can Help: Strategies for System Change

Efforts to enhance children’s mental health services must address every sector of the system – from the pediatric practice to community mental health agencies and private mental health providers – using a variety of strategies – from better integrated systems of care to changes in state policy. While the prospect of transforming the mental health system for children is overwhelming, there are many preliminary steps that the American Academy of Pediatrics (AAP) chapters can take to begin tackling this issue. Incremental steps will involve partnering with parents, building the requisite relationships with state and community agencies and organizations concerned about children’s mental health, educating policy makers about children’s mental health needs, and learning about the availability of existing services.

Toward this end, this Chapter Action Kit outlines numerous strategies that chapters can use to improve children’s mental health programs and services in their state. These range from the simple (eg, initiating dialogue with mental health professionals developing resource listings) to the more complex and time intensive (eg, changing coverage or payment for mental health services, building a children’s mental health
coalition). Many of these strategies are based on the experiences of several chapters of the AAP, including Connecticut, Massachusetts, North Carolina, and Texas.

As chapters begin working with mental health agencies and parent groups that are dedicated to children’s mental health, they are likely to find that many existing state and community-based advocacy efforts focus on addressing the needs of children with the most serious emotional disturbances. Just as many primary care clinicians may be unaware of these children’s needs and struggles, mental health agencies and consumer advocates may be unaware of the issues faced by the many children with mild-to-moderate mental health needs who are the very children who are being seen – often exclusively – by primary care clinicians. It will be important for pediatricians, mental health professionals, and parent groups to learn of each others’ interests in and perspectives on children’s mental health.

**Why This Chapter Action Kit Was Developed**
Recognizing that children’s mental health needs are significant, the AAP Board of Directors, together with grassroots interest from many primary care clinicians who were interested in enhancing their capacity to provide needed services to children, made children’s mental health a top AAP priority. In 2004, the AAP Board established the Task Force on Mental Health (TFOMH), charging its members to assist primary care clinicians in enhancing this capacity. The Board appointed a multidisciplinary, multi-organizational group, representing the AAP membership and national organizations that are concerned about children’s mental health (eg, National Alliance on Mental Illness, American Academy of Child and Adolescent Psychiatry, and American Psychiatric Association).

**How This Chapter Action Kit Is Organized**
This Chapter Action Kit is organized into 6 core action areas (eg, the tabbed sections) that each focus on a unique but interrelated overall strategy for improving children’s mental health programs and services. Also included are a section on AAP Mental Health Policies and a section for additional resources. The 6 core action areas are as follows:

1. Partner With Families
2. Assess the Service Environment
3. Collaborate With Mental Health Professionals
4. Educate Chapter Members
5. Partner With Child-Serving Agencies
6. Improve Children’s Mental Health Financing

Within each core action area, the AAP includes information on the overall issue, implications for chapter work, suggested chapter strategies, resources for further information, and selected tools that are related to the topic. It is important to note that, as chapters begin their effort and identify the children’s mental health issues specific to their state, additional strategies, resources, and tools may be identified in addition to what is included in this *Chapter Action Kit*. The information included here is not intended to be exhaustive, but rather to help serve as a starting point for chapter efforts. Each chapter will want to consider and tailor its activities and strategies specific to its own state issues and needs and chapter resources.
How Chapters Can Get Started

If chapter leadership and staff are unfamiliar with children’s mental health issues overall, they may wish to first review some key national reports on the topic, such as the Surgeon General’s Mental Health Report and the President’s New Freedom Commission on Mental Health Report. These and other salient reports provide a comprehensive overview of the existing mental health system in states and communities, including children’s mental health, and are a good foundational starting point for understanding key challenges with regard to this issue. (These and other resources are in the Additional Resources section. The President’s New Freedom Commission on Mental Health Report also can be found in the section for Strategies to Partner With Child-Serving Agencies.)

Chapter leaders may want to select a chapter member who is passionate about this issue to lead and champion the effort. This chapter member can help guide the effort, serve as the chapter “face” for the issue with state and community agencies and organizations, and help convey the needs, issues, and concerns of the chapter and its members. This chapter member also may be best in articulating the concerns of pediatricians using “real-world” terms and examples (eg, stories that highlight their own day-to-day struggles in addressing the mental health needs of the children they see in their practice.)

Chapters can undertake these and other actions even in states with little commitment to the issue or few resources to invest in children's mental health. Whatever the strategy or activity that is identified, clearly chapters can play a significant role in improving the mental health delivery system for children.

References
partner with families
Families play a central role in promoting and nurturing the overall health and well-being of their child, including their mental health. Families are a child’s “first teacher” and, as such, play a key part in promoting their child’s healthy social and emotional development. For children with mental health needs, families are not only critical partners in the care of their child (eg, development of child treatment plans) but also in areas such as informing policy and programmatic decisions at the system (eg, state mental health policies), health plan, and practice level. Because of these varied but essential roles, families are critical partners in efforts to improve the children’s mental health system. Indeed, the mantra “nothing about us without us” is a core tenet of family involvement in children’s mental health.

Within the mental health system, families (“consumers” in mental health terminology) are central to building and implementing an effective “system of care.” In fact, a guiding principle of the system of care philosophy states that services should involve families and youth as full partners. Effective systems of care actively involve, support, and engage families in a variety of roles, including the following:

- Asking families how they would like to be involved
- Providing supports for involvement such as transportation, translation, and child care assistance
- Using parents as trainers of other stakeholders
- Supporting families to be full partners by giving them the information and skills to partner through activities such as training and mentoring programs

Examples of Family Involvement in Mental Health Systems of Care

**Family Involvement at the Policy Level**
- Comprising the majority vote on state governance bodies
- Writing and reviewing state Requests for Proposals and contracts
- Participating in task forces, work groups, and other system entities to inform development of policies and programs

**Family Involvement at the Management Level**
- Participating in quality improvement processes and efforts
- Evaluating system performance
- Helping to recruit and select staff
- Participating as trainers in training activities
- Providing guidance to the development and dissemination of community resource guides

**Family Involvement at the Service Level**
- Providing active input to the care of their own child
- Serving as case managers, family support workers, and peer mentors
- Advocating for family needs
What Does This Mean for American Academy of Pediatrics Chapters?

Given the essential role of families, chapters may want to include and partner with family organizations in efforts to improve the children’s mental health system. These groups include state and local chapters of the Federation of Families for Children’s Mental Health, National Alliance on Mental Illness, Children and Adults with Attention-Deficit/Hyperactivity Disorder, Families with Depression, Family Voices, and Association of Retarded Citizens. (See Tools and Resources in this section, Building Family and Community Connections, for the Web sites of family organizations with state level affiliates.)

In identifying family organizations to engage in chapter activities, chapters also may want to consider partnerships with family groups that may not work directly on children’s mental health but care about children’s issues overall and have a stake in how the children’s mental health system is transformed. These groups can lend an important voice and unique perspective to the issue, may have broad-based constituencies for engagement of further partners, and can be powerful advocates with state and local policy makers. The National Parent-Teacher Association (PTA) is an excellent example of such a family organization.

Chapter Strategies for Building Partnerships With Families

Chapters may want to identify and consider a range of strategies for involving and building partnerships with family organizations to advance children’s mental health efforts. Key strategies include the following:

- Involve family representatives and family organizations from the beginning in the planning, development, and implementation of chapter activities.
- Identify contacts in family organizations that work on children’s mental health issues and begin a dialogue to explore common policy and advocacy goals. (See Tools and Resources in this section, Building Family and Community Connections, for a listing of these family organizations.)
- Identify and begin a dialogue with family organizations that do not specifically represent or work with mental health consumers (eg, PTA).
- Model “systems of care” principles for family involvement by identifying ways to support family involvement (eg, support for time to attend meetings, child care, and transportation) in chapter-led activities, where necessary and relevant. Some state and local chapters of family organizations may not have full or even part-time staff, but rather work with family volunteers to support and advance organizational activities. Support for family involvement in chapter-led activities would be helpful if not essential. (See Tools and Resources in this section, The Role of the Primary Care Clinician in Providing Culturally Competent, Family-Centered Care, for information on promoting culturally competent, family-centered pediatric mental health care.)

References

Resources for Further Information


Building Family and Community Connections
This resource provides chapters with guidance on ways to build community linkages and includes information on key national family advocacy organizations that focus on children’s mental health.

The Role of the Primary Care Clinician in Providing Culturally Competent, Family-Centered Care
This resource provides an overview of 10 core elements to promoting culturally competent, family-centered pediatric mental health care.
Families are pleased that pediatricians increasingly are becoming a resource for children and families with mental health treatment needs. The national shortage of child and adolescent psychiatrists can be a significant hardship for families who cannot access a child psychiatrist for either an evaluation or treatment.

There are many effective ways for pediatricians to raise awareness about their work in child and adolescent mental health care and to build community connections. The most logical place to start is with family mental health advocacy organizations and with schools and child care programs.

**National Family Advocacy Organizations**

There are a number of national family/consumer advocacy organizations that focus on children's mental health. These national organizations have local chapters in most communities across the country. Many of these organizations provide information and referrals to families that contact them in seeking mental health care for their child. They also provide information to families about community resources on their Web sites, in support groups, and as part of other programs offered to families.

As a result of long-standing community connections with child-serving organizations and agencies, these consumer advocacy organizations also can make recommendations to pediatricians about other organizations to contact to promote their work in child mental health care.

The following is a list of the major national mental health family advocacy organizations that pediatricians may wish to notify about their work in children’s mental health services:

- **Child and Adolescent Bipolar Foundation (CABF)—**A virtual organization with excellent Web-based resources for families, the Web site lists support groups in communities around the country. Pediatricians may wish to contact support group leaders ([www.bpkids.org](http://www.bpkids.org), click on “support groups”).

- **Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD)—**Local chapters are included on the CHADD Web site ([www.chadd.org](http://www.chadd.org), click on “Finding Support”).

- **Federation of Families for Children’s Mental Health (FFCMH)—**Local chapters are included on the Federation Web site ([www.ffcmh.org](http://www.ffcmh.org), click on “who we are”).

- **Mental Health America (MHA, formerly the National Mental Health Association)—**Local chapters are included on the MHA Web site ([www.nmha.org](http://www.nmha.org), click on “affiliate network”).

- **The National Alliance on Mental Illness (NAMI)—**Local chapters are included on the NAMI Web site ([www.nami.org](http://www.nami.org), click on “Find Support” and “State and Local NAMIs”).
• **Bright Futures**—Provides resources for families as well as guidance for pediatricians ([www.brightfutures.aap.org](http://www.brightfutures.aap.org)). Initiated by the Maternal and Child Health Bureau of the Health Resources and Services Administration, Department of Health and Human Services, and administered by the American Academy of Pediatrics.

In addition to the national family advocacy organizations, there also may be state and local family advocacy organizations that do not have a national presence but focus locally on children’s mental health. Often, the public mental health agency in a region has a child and family advisory committee, which welcomes participation by primary care physicians. Pediatricians can learn more about these organizations by talking with child mental health professionals and families in their communities.

**Schools/Child Care Programs**
School and child care professionals are another important community connection for pediatricians. Families often request referral information from school-based health and mental health professionals if their child is struggling with unexplained behavioral or academic challenges that suggest the need for a mental health evaluation. Schools and child care programs appreciate learning about pediatric offices that will serve as a resource for families in child mental health care.

In contacting schools and child care programs, pediatricians may wish to talk with the following professionals about their work in child mental health care:

• **Special Education or Exceptional Children’s Services Coordinator**—The title may vary by school district, this staff person works with families seeking specialized services for their child.

• **School Health and Mental Health Professionals**—This varies by school district and may include school psychologists, school guidance counselors, school social workers, school nurses, and a school physician (frequently organized under an associate superintendent for student support).

• **Parent Training and Information Centers and Community Parent Resource Centers (PTI)**—Each state has at least one parent center that serves families of children with disabilities, including mental illnesses. These centers connect children with disabilities and their families to community resources that address their needs (the PTI national Web site lists state and community offices at [www.taalliance.org/centers/index.htm](http://www.taalliance.org/centers/index.htm)).

At the school level, there is often a committee called a Student Assistance Team or equivalent name, usually chaired by a guidance counselor. Such a committee serves as an entry point for students who experience academic difficulties, referred by either teachers or parents. Collecting contact information for these committees within a given school system can facilitate communication between clinicians and the schools about students in their mutual care. The table, Educational Terminology/Abbreviations/Acronyms that follow provides a list of terms and abbreviations that are common in educational parlance.
Mental Health Professionals and Other Agencies
Of course, building community connections also includes contact with child- and family-serving community mental health professionals (eg, child psychiatrists, child therapists, social workers, and others), faith-based community leaders, child welfare agencies, child care providers, and other child-serving professionals.

Pediatricians play an essential role in the health and well-being of children and families. Family mental health advocacy organizations and community child-serving professionals will welcome the opportunity to build stronger community connections with pediatricians to improve the lives of children and adolescents with mental health treatment needs.

Educational Terminology/Abbreviations/Acronyms
Laws that protect students with disabilities require free and appropriate public education (FAPE) in the least restrictive environment (LRE).

IDEA is the Individuals with Disabilities Act of 1997, a Special Education Law

- **EI—Early Intervention Program (Ages 0-3 years)**
  - I-T: Infant Toddler (0-3 years, delayed or diagnosed, no fees)
  - Preschool Program: (3-5 years, delayed or diagnosed, no fees)
  - LICC: Local Interagency Coordinating Council Consortium
  - IFSP: Individualized Family Service Plan

- **LEA—Local Education Authority (Public School System)**

  Exceptionality categories/abbreviations:
  - DB: Deaf Blind
  - MU: Multi-handicapped
  - OI: Orthopedically Impaired
  - TMD: Trainable Mentally Disabled
  - EMD: Educable Mentally Disabled
  - SP: Severe Profound (Mental Retardation)
  - TBI: Traumatic Brain Injury
  - BED: Behaviorally Emotionally Disabled
  - SLD: Specific Learning Disability
  - AU: Autistic
  - HI: Hearing Impaired
  - DD: Developmentally Delayed
  - SI: Speech-Language Impaired
  - VI: Visually Impaired
  - OHI: Other Health Impaired
    - Chronic or acute health problem
    - Limited alertness to the educational environment
    - Adverse effect on educational performance
    - Special educational needs defined in IEP: Individualized Education Plan

Section 504 of the Rehabilitation Act of 1973
- Civil rights statute
- Reasonable accommodations (general education)
- Related aids and services
Pediatricians have long been an important first resource for parents who are worried about their children’s behavioral problems, and, today psychosocial problems are the most common chronic condition for pediatric visits, eclipsing asthma and heart disease. Given the increase in pediatric visits centered on psychosocial issues, the need for the provision of culturally competent, family-centered care becomes more evident. Following are the 10 elements of culturally competent, family-centered pediatric mental health care adapted from the National Center of Medical Home Initiatives for Children with Special Needs.1 “Every Child Deserves a Medical Home” training program that may assist the primary care clinician in engaging families:

Element 1: Recognize the family as the constant in the child’s life. Health care providers may change over time.

- Acknowledge who the key family members are.
- Ask families what they value.
- Identify family routines.
- Recognize the expertise of families; listen to their ideas and opinions.
- Invest in teaching families what they need to know to care for their child.
- Mold the care plan to match family strengths, needs, concerns, and resources.
- Share decision-making.

Element 2: Facilitate family and professional collaboration at all levels in health care.

- Listen to families and follow their lead.
- Be accessible to families.
- Build confidence in families, and tell them often what they do well.
- Support families in their role as an advocate for their child.
- Create win-win solutions.
- Create family options; be sensitive to energy and resources.
- Assist families in learning how to be good historians, keepers of information, and care coordinators.
- Provide families with information and resources.
- Involve families in designing, implementing, and evaluating a care plan for their child.

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1 Adapted from the National Center of Medical Home Initiatives for Children with Special Needs. Every Child Deserves a Medical Home Training Program. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2004
Element 3: Honor the diversity of families.

- Learn about other cultures; ask questions.
- Be aware of your own values and beliefs and how they shape your actions and decisions.
- Respect family values and beliefs, including interest in alternative remedies.
- Be nonjudgmental.
- Consider ways to sensitize the entire office staff about the diversity of families.
- Provide educational materials in multiple languages as needed, and offer translation and interpreter services.
- Decorate the office to reflect cultural diversity.
- Recognize what nonverbal behaviors are communicating to the family and vice versa.

Element 4: Recognize family strengths.

- Look for and identify strengths in communication skills, participation, interest, knowledge, parenting style, support systems, culture, and spiritual values.
- Ask families:
  - What are your strengths? Concerns?
  - What are your child’s likes? Dislikes?
  - What is the best way to approach your child?
  - What do you want? Need?
  - What has worked in the past? What might work now?
  - What are your opinions and needs in the current situation?
- Be sensitive to questions that might be construed as blame.
- Develop the plan of care to build on family strengths.

Element 5: Share complete and unbiased information.

- Encourage families to write down information, questions, and suggestions before an office visit.
- Avoid making assumptions or speaking in jargon.
- Offer opinions, but be sure the family understands all options.
- Repeat critical information, expectations, and next steps.
- Invite questions and expressions of concern.
- Provide written information, videotapes, audiotapes, or illustrations when possible as a backup.
- Be available for follow-up discussions.
- Schedule adequate time to talk with families.

Element 6: Promote family-to-family support and networking.

- Be sensitive to family needs and the need for support.
- Validate the value of family-to-family support.
- Provide information about resources.
- Be informed about area support groups and/or encourage families to create support groups if possible.
• Recognize the child’s need for support.
• Recognize the support needs of other family members (eg, grandparents, siblings).

Element 7: Incorporate developmental and behavioral needs.

• Ask questions about developmental and behavioral issues at each visit.
• Listen for family concerns, past experiences with developmental/behavioral issues, use of complementary therapies, stigma, and differences among family members about perceived needs and interest in help-seeking behaviors.
• Conduct developmental and behavioral surveillance and appropriate screenings.
• Assist families to understand and support the developmental and behavioral needs of their children.
• Create relationships with referral sources, including developmental specialists, behavioral health professionals, and agencies providing support services.
• Become informed about special education programs and services and mental health/substance abuse services.
• Make certain that treatment is adapted and adjusted for the developmental stage of the child.
• Encourage family advocacy.
• Encourage families to model self-advocacy skills for their child.
• Design office space to accommodate developmental needs of children.
• Plan for and support developmental transitions.

Element 8: Implement comprehensive policies and programs.

• Ask families what they need (a checklist can help).
• Inform families of available programs and resources. Keep brochures and applications on hand.
• Develop a resource library for families and children with mental health concerns.
• Develop a parent advisory group to assist in designing and implementing care, services, and programs.

Element 9: Design accessible health care systems that are flexible, culturally competent, and responsive to family needs.

• Be available (eg, flexible hours, evening hours, and weekend hours).
• Consider transportation needs and options for families who are seeking care.
• Eliminate financial barriers to the greatest extent possible (eg, flexible payment options, and assist families to apply for services such as Medicaid, State Children’s Health Insurance Program (SCHIP), SSI, Title V, or public mental health programs).
• Use community-based care coordination services to help families gain access to needed community-based services.
Element 10: Family-professional collaboration.

- Promote a relationship in which family members and professionals work together to ensure the best services for the child and the family.
- Recognize and respect the knowledge, skills, and experience that families and professionals bring to the relationship.
- Identify and acknowledge differences of opinion among family members about the child’s needs and approaches to care.
- Acknowledge that the development of trust is an integral part of a collaborative relationship.
- Facilitate open communication so that families and professionals feel free to express their concerns about both medical and psychosocial issues.
- Create an atmosphere in which the cultural traditions, values, and diversity of families are acknowledged and honored.
- Recognize that negotiation is essential in a collaborative relationship.
- Include some acknowledgment of mutual respect for each others’ culture, values, and traditions.
- Recognize, and adapt to, the family’s level of readiness to address a problem, accept a type of treatment, or change a behavior.
- Express interest in collaborating with other health care providers who are involved in the child and family’s care.
- Communicate the expectation of a continuing relationship with the child and family when the child is referred for behavioral or subspecialty care.
assess the service environment
strategies to assess the service environment

strategies for system change in children's mental health: a chapter action kit

Because mental health problems are common in primary care settings, information on the availability of mental health professionals and referral resources is important to pediatricians and other primary care clinicians who serve children with mental health needs. However, navigating complex health and social service delivery systems to identify available mental health services and resources can be a challenging and time-consuming task.

The delivery of mental health services is complex—it is primarily organized at the local level, can differ for public and private insurance coverage, and, for public services, may be provided by numerous community agencies. As a result, the availability of mental health services varies by community, county, and region. Adding to these complexities, there is a significant shortage of mental health professionals within mental health care, particularly child psychiatrists. The shortage is most significant in rural areas and for mental health professionals who serve children and adolescents.

Because of the widespread recognition that mental health professional shortages exist and services can be hard to access, many state and local mental health agencies and other organizations are working to address access to, and the availability of, mental health services. These efforts, however, vary by state and by community. They may include 2-1-1 Information and Referral Systems (see the following text), activities by state mental health agencies and other entities (eg, universities) to study or “map” the availability of providers and provider shortage areas, and community mental health professionals’ information and resource listings. For example, many community mental health agencies and other related organizations likely will have information on available providers in a given community or region, and whether these providers serve publicly and/or privately insured children.

2-1-1 Information and Referral Call Centers

Health and human services Information and Referral telephone call centers exist or are in development in several states and in many communities across the country. Accessed by 2-1-1 dialing codes, these centers (“2-1-1 centers”) are staffed by trained specialists who link callers to a variety of health and social services, including mental health services. The centers are available for no charge, 24 hours/7 days a week, and have multilingual capabilities. Implementation of 2-1-1 centers is being spearheaded by United Way and comprehensive and specialized information and referral agencies in states and local communities. They are funded through local and state funding sources, including local United Ways and other nonprofit organizations, foundations, businesses, and state and local governments.

Currently, every operational 2-1-1 center consists of a single, centralized call center servicing a locality or a very small state. With the exception of Connecticut, Hawaii, and Minnesota, no state currently provides statewide access to 2-1-1 centers. However, many local systems have goals for eventual statewide coverage. Implementation of these systems can be met with numerous challenges, including lack of support from state regulatory bodies, prohibitively high phone rates from local telephone companies.
for the delivery of 2-1-1 service, and opposition from other potential service providers (eg, providers of 9-1-1 coverage).4

What Does This Mean for American Academy of Pediatrics Chapters?
Chapters can provide a significant service to their members by assessing whether key groups (eg, state and community mental health agencies, mental health associations, local United Ways, and universities) have undertaken efforts to identify, "map," and/or provide information on the availability of mental health services and resources in a state and/or given locality. Because the mental health delivery system is so complex, it may be more realistic for chapters to initially assess existing state and/or local efforts in this area rather than conduct an independent analysis of their own. This baseline information can help chapters know whether they need to take further steps to identify available mental health services and resources, issues regarding provider availability and shortages statewide and at the community level, implications for primary care clinicians, and related key strategies.

Finally, chapters may want to consider providing their members with guidance on how to develop a community mental health resource guide, if one does not exist in their community. (See the Community Mental Health Resource Guide Template in this section.)

Chapter Strategies for Assessing the Availability of Mental Health Services
Chapters may want to identify and consider a range of strategies for assessing and improving the availability of mental health services in their state and at the community level. Key strategies include the following:

- Collaborate with state mental health agencies and other key state agencies (eg, public health agencies) to fund and conduct statewide and community-based studies that examine the availability of mental health professionals (eg, psychiatrists, psychologists, social workers) who serve children and their families, provider shortage areas, and the implications of the findings for the primary care system. (See Additional Tools and Resources in this Chapter Action Kit for National and State Data Sources on Children’s Mental Health.)
- Recommend that state mental health agencies and other relevant state agencies (eg, public health agencies) include information about how to access community-based mental health services for children on their Web sites and in other relevant materials and dissemination mechanisms.
- Encourage the development of community-based mental health service and resource directories by working with community mental health agencies and other key mental health organizations to inform, develop, and maintain such directories, and to include information about mental health and substance abuse treatment referral sources that are relevant to primary care clinicians. (See the Tools and Resources of this section for the Community Mental Health Resource Directory Guidance and Template.)
- Partner with local United Way agencies and other groups to support advocacy and programmatic efforts to implement and maintain 2-1-1 Information and Referral Centers, and to include information about mental health and substance abuse treatment referral sources that are relevant to primary care clinicians.
- Inventory the psychiatrists, psychologists, social workers, and community-based organizations (eg, community mental health agencies, local public health
departments, school health clinics, and schools) that see children and take referrals. (See the Mental Health Professional Sample Letter and Survey, and Mental Health Professionals List in the Tools and Resources section for a sample survey instrument, cover letter, and provider listing.)

- Since many families are unsure where to turn when their child has a serious behavioral or substance abuse episode, where the child poses a serious threat to themselves or others, particularly at night, families bring their child to the emergency room for help. Emergency rooms are not always equipped to handle children in immediate need of mental health or substance abuse services. Having a community protocol for emergency situations is an important service to have available and known by primary care clinicians.

References
strategies to assess the service environment

tools and resources

strategies for system change in children’s
mental health: a chapter action kit

Community Mental Health Resource Directory Guidance and Template
This resource provides an overview of key considerations and a template for developing a community resource guide.

Mental Health Professionals Sample Letter and Survey
This tool is a sample survey and cover letter for obtaining information from mental health professionals on their practice, interest in referrals from primary care clinicians, and interest in a co-location model.

Mental Health Professionals List Sample
This tool is a sample chart for summarizing key information on mental health that accept referrals.

Considerations in Developing Community Children’s Mental Health Emergency Services Protocols
This tool outlines key issues to consider in developing children’s mental health emergency service protocols in communities. Information on a similar protocol developed by the Idaho Council on Children’s Mental Health, Task Force on Crisis Response, is included.
Information on available community mental health programs and services is important both to families seeking services and to primary care clinicians. It can provide a critical link to needed services, identify the range of community resources available for children with mental health needs, and help facilitate critical links between families and mental health professionals and primary care clinicians. Moreover, a comprehensive community mental health resource directory can provide critical information not only about mental health professionals that serve children but also about other available community mental health resources, such as local support groups, child care programs, respite care, and parenting groups.

Many community mental health agencies, local health departments, local hospitals, and other related mental health organizations may have information on available mental health professionals, programs, and other resources in a given community or region. Since the mental health delivery system is so complex, chapters may want to first determine the availability and scope of existing community mental health resource guides. Once an initial assessment of existing guides is completed, chapters may then determine whether development of a guide is needed and, if so, the focus and scope of the guide, particularly in cases where existing guides are limited to a specific geographic area or mental health specialty. Finally, chapters may wish to partner with a community mental health professional or agency in the development and maintenance of the guide.

Assess the Availability and Scope of Existing Community Mental Health Resource Guides

- Contact and consult with representatives from the community mental health agency, community hospitals, local health departments, child care programs, schools, and other child-serving entities with an interest in children’s mental health to determine the availability of a community mental health resource guide.
- Assess the comprehensiveness and scope of existing mental health resource guides, considering whether information, including, but not limited to, the following is listed:
  - Mental health professionals that serve children, their area(s) of specialty, payment type accepted (eg, Medicaid or private insurance), office hours, and location.
  - Public community mental health services (eg, community mental health agency).
  - Community mental health programs and resources (eg, support groups, respite care, parenting education).
- Determine the availability of existing guides.
  - Is the guide readily available to all families and primary care clinicians or just certain subgroups (eg, families with private insurance or clinicians that serve infants, children, and adolescents enrolled in Medicaid)?
• Determine the **accessibility** of existing guides.
  o Is information provided in Spanish and/or other prominent languages that are spoken by families living in a local community or region?
  o Is information written at a reasonable readable level?

• Determine the **reliability** of the resource guide information.
  o How often is the resource guide updated and by what means (eg, community surveys or electronic updates)?
  o What types of mental health professionals (eg, all mental health professionals or only providers that pay for a listing) are listed and how is that determined and by whom?

**Community Mental Health Resource Guide Template**

The following template provides an overall guide to key information for inclusion in a community resource guide:

1. **Type of provider** *(please check one)*:
   - [ ] Mental health professional
     - Please specify type (eg, psychiatrist, psychologist, or licensed clinical social worker):
   - [ ] Community mental health agency
   - [ ] Hospital
   - [ ] Local health department
   - [ ] Other, please specify:

2. **Age groups of children served** *(please check all that apply)*:
   - [ ] Birth to 11 months
   - [ ] 1 to 4 years
   - [ ] 5 to 10 years
   - [ ] 11 to 21 years

3. **Types of evidence-based child and adolescent psychosocial interventions** provided to children and their families *(please check all that apply)*:
   - [ ] Cognitive behavioral therapy
   - [ ] Behavior therapy
   - [ ] Parent training
   - [ ] Educational support
   - [ ] Interpersonal therapy
   - [ ] Family therapy
   - [ ] Applied behavioral analysis
   - [ ] Other, please specify:
4. Any programs provided to children and their families (please check all that apply):

☐ Consultation to child-serving organizations and providers (eg, early childhood programs or primary care clinicians)
☐ Home visiting
☐ Parenting education
☐ Respite care
☐ Outpatient treatment
☐ Day treatment
☐ Others*

5. Payment type accepted (please check all that apply):

☐ Private insurance (list all that are applicable)
☐ Medicaid
☐ Self-pay
☐ Sliding scale
☐ Other:

6. Hours of operation (please list):

7. Office location(s) (please list):

8. Any targeted services provided (eg, multilingual speaking staff, interpreters, or outreach to underserved families):

9. Other pertinent information:

References


* For examples of other programs to list, please visit the Web site of the Department of Pediatrics at Wake Forest University Health Sciences and the Northwest Area Health Education Center at: http://northwestahec.wfubmc.edu/mhi/index.cfm
Mental Health Professional
Address

Dear mental health professional:

I am writing to you at the request of our clinical staff here at __________. Describe the practice demographics, insurance accepted, services provided, and professionals on staff, and what other professionals/organizations your practice collaborates with outside of the office.

Our clinical staff is keenly aware of, and concerned about, the mental health needs of our patients and families, and we are very interested in collaborative and/or co-location arrangements with mental health professionals.

We would like to know more about your practice and your interest in referrals from our practice, as well as any interest you may have in a co-location model. Please complete the enclosed survey to better assist us in making appropriate referrals. I would be glad to communicate with you further if desired, and would be glad to arrange an introduction to our pediatricians and nurse practitioners.

Thank you in advance for your response.

Sincerely,
Name of Professional ____________________________________________________
Professional Degrees __________________________________________________
Name of Practice _______________________________________________________
Address _______________________________________________________________
Ages Served
Birth to 5 years ______  6 to 12 years ______  13 to 19 years ______
Specialty Areas _________________________________________________________
Therapy Types _________________________________________________________
Office Hours __________________________________________________________
Type of Insurance _____________________________________________________
Payment Accepted ______________________________________________________
Office Contact for Referrals
Name ________________________________________________________________
Phone ________________________________________________________________
Fax ________________________________________________________________
Please Fax To:  
Name of practice
Attn: Name of primary care clinician
Fax number
<table>
<thead>
<tr>
<th>Names and Addresses</th>
<th>Ages Served</th>
<th>Specialty Areas</th>
<th>Therapy Types</th>
<th>Office Hours</th>
<th>Types of Insurance Accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe, LPC</td>
<td>6-12 years</td>
<td>Addictions, PTSD, Childhood abuse, ACOA, depression, anxiety</td>
<td>Individual, group, couples</td>
<td>Monday–Wednesday 8:00 am–3:00 pm Thursday–Friday 3:00 pm–8:00 pm</td>
<td>Medicaid and most other insurances</td>
</tr>
<tr>
<td></td>
<td>13-19 years</td>
<td>Adult Geriatric</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18 years</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Adult</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Geriatric</td>
<td></td>
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</tr>
</tbody>
</table>
Emergency mental health services are a critical component of a comprehensive children's mental health system. These services typically are provided to children younger than 18 years whose mental or emotional state (1) poses a significant threat to self, (2) poses a significant threat to the safety of others, or (3) poses a significant risk of substantial deterioration in the child’s condition. Within the public mental health system, community mental health agencies are required to establish 24-hour, 7-days-a-week, emergency/crisis care services for all children and adults, regardless of their ability to pay.

Protocols for the provision of children’s emergency mental health services can provide important guidance to primary care clinicians and other professionals who serve children and their families. Because numerous systems serve children and their families, these protocols are best developed by and among the multiple systems that serve this population (eg, primary care clinicians, schools, mental health agencies, public health agencies, child welfare agencies, and juvenile justice systems). Chapters could provide a significant service to their members by providing information on strategies for establishing and strengthening children’s mental health emergency service protocols. This template provides general guidance on key considerations in the development of these protocols.

**Assess the Existing Policy Environment for Children’s Mental Health Emergency Services**

- Consult with representatives in the child and adolescent services program of the state mental health agency regarding state rules, regulations, and/or requirements for provision of children's mental health emergency services in general and in community mental health agencies.
- Consult with representatives in the state mental health agency regarding any programs, policies, and/or guidelines related to emergency mental health services (eg, pre-screening policies and services and efforts to promote access to services in the least restrictive environment and to minimize or prevent hospitalizations).
- Review state mental health code regarding regulations for development of children’s mental health emergency services.
- Contact community mental health agencies to obtain information and a copy of agency protocols for provision of emergency mental health services.
- Review state confidentiality statutes for information on state minor consent laws and their relevance for children’s mental health emergency services.

* The Community Mental Health Services Block Grant, administered by the Substance Abuse and Mental Health Services Administration, requires that states agree to provide a core set of community mental health services, including 24-hour emergency care.
• Engage in dialogue with mental health professionals about professional and ethical standards for provision of emergency mental health services to children and adolescents.

**Identify and Develop Core Components of the Emergency Mental Health Services Protocol**

- Educate chapter members about the epidemiology of psychiatric emergencies (e.g., suicide rates, homicides involving youth as victims or perpetrators, psychiatric hospitalization rates, and emergency room utilization), clinical guidelines, and service algorithms (e.g., suicide prevention) related to the provision of emergency children's mental health services.
- Guide members in convening regional task forces of stakeholders to develop the protocol or offer a statewide conference, inviting teams of stakeholders from each region. Regions may be defined by the mental health system's state, regional and/or community administrative units, emergency room catchment areas, or a combination of the two. Stakeholders include representatives of child-serving systems and agencies, including, but not limited to, mental health (especially the medical director and those involved in screening, triage, and referral services and mobile crisis response), public health, juvenile justice, child welfare, law enforcement, education, hospitals (especially emergency room staff), mental health professional groups, child advocates, primary care physicians, and consumers. Involvement of an Area Health Education Center may facilitate meeting logistics and, ultimately, dissemination of the protocol.
- Identify a common mission and set of core values for the system.
- Establish program goals (e.g., timeliness, cost-effectiveness, provision of services in least restrictive environment, and minimize hospitalization) for development of the system.
- Identify and address ethical standards, confidentiality statutes, and other federal and state laws regarding provision of emergency mental health services.
- Specify the target population who will receive mental health emergency services.
- Identify points of access to emergency children's mental health services (e.g., where, when, and how services are accessed) and by whom (e.g., self-referral, parent referral, third-party referrals).
- Identify an emergency/crisis intervention model outlining steps to be taken in an emergency or crisis situation.
- Establish the continuum of children's mental health services (e.g., hotline, education on warning signs, mobile crisis response) and/or identify needs and a systematic plan to address them.
- Develop administrative procedures, including forms for exchange of information between primary care physicians and sources of emergency services.
- Disseminate the protocol to members and other interested groups and offer continuing medication education on its use.

**References**

1. Center for Mental Health Services. *Transforming Mental Health Care in America. Community Mental Health Services Block Grant Application Guidance and Instructions, FY 2007.* Washington, DC: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration. Available at:

Resources for Further Information


State Mental Health Agency Contact Information

collaborate with mental health providers
strategies to collaborate with mental health professionals

strategies for system change in children’s mental health: a chapter action kit

Children’s mental health needs are addressed by a variety of providers and caregivers who work in a range of diverse and loosely organized public and private settings. Approximately 21% of US children and adolescents are served by this “de facto mental health service system” each year. This patchwork of providers and services is typically categorized into 4 components: (1) specialty mental health (eg, psychiatrists, psychiatric nurses, psychologists, and social workers), (2) primary care (eg, pediatricians, family physicians, and nurse practitioners), (3) human services (eg, social services and school-based counseling services), and (4) voluntary support networks (eg, self-help groups). In turn, these providers work within public and private service delivery systems.

A quality children’s mental health service delivery system relies on the ability of providers to collaborate, coordinate services and activities, and share health information related to the treatment of a patient. In the absence of this integration, services can become fragmented and duplicated, and children’s access to care can be compromised. Several factors can impact the provision of children’s mental health care. At the minimum, it is important for primary care clinicians to be able to communicate and share health information with mental health professionals regarding the treatment of children with mental health problems. However, differences in practice culture between provider groups, lack of knowledge about professions, differences in use of terminology, and federal and state laws and policies can hinder effective communication and collaboration between providers.

Numerous federal and state laws protect the privacy of health care information, creating significant barriers for collaborative practices between primary care clinicians and mental health professionals. Recent federal privacy rules permit a health care provider to disclose protected health information about an individual, without his or her authorization, to another health care provider for that provider’s treatment of the individual. However, state privacy laws (eg, informed consent laws) may place further protections on health privacy. (See Tools and Resources in this section, Overview of Confidentiality Statutes and Children’s Mental Health, for more information.)

What Does This Mean for American Academy of Pediatrics Chapters?

Chapters may want to engage the range of mental health professionals who provide mental health services in dialogue and efforts to improve the children’s mental health system. At the minimum, conversations with the various state organizations representing mental health professionals can illuminate issues related to better integration of primary care and mental health systems, and specific mechanisms for improving communication and information sharing at the practice level. Informational meetings with mental health professional organizations are an important overall “starting point” to identifying and better understanding the opportunities and challenges to effective collaboration, and in determining mutual concerns and interests in improving the children’s mental health system. Some mental health organizations may not even know of the primary care’s interest in working together. Finally, with regards to information sharing between providers, chapters may want to first understand the federal and state laws and policies...
that impact information sharing between providers. (See Tools and Resources in this section, Overview of Confidentiality Statutes and Children’s Mental Health, for more information.)

Chapter Strategies
Chapters may want to identify and consider a range of strategies for collaborating with mental health professionals. Key strategies include the following:

- Initiate a dialogue with the leaders of the state organizations of social workers, psychologists, psychiatrists, school psychologists, school counselors, family physicians, and other providers who serve children by convening a meeting to discuss mental health services for children. Such a dialogue can bring together all stakeholders in children’s mental health who typically do not work together, share the same professional culture, or even know each other. Additionally, this dialogue can be the basis for building a coalition to educate policy makers about the need for system changes. (See Internet Resource List for Child and Adolescent Mental Health in the Additional Resources section for further information.)

- Identify the key provider barriers to providing comprehensive and integrated children’s mental health services. Issues to consider and address include (1) universally accepted guidelines for information sharing that work within confidentiality laws and consistent reporting forms and (2) standards for certification of non-physician therapy providers. (See Tools and Resources in this section, Template Referral and Feedback Form for Referrals Between Primary Care Clinicians and Mental Health Professionals, for a sample referral form.)

- Consult with multiple sources to obtain information about state-specific privacy laws and rules related to sharing of health information, including a minor’s consent for services. Provide a synopsis of federal and state privacy laws to chapter members. (See Tools and Resources in this section, Overview of Confidentiality Statutes and Children’s Mental Health, for general information on federal and state confidentiality statutes related to sharing of health information.)

- Identify the key barriers to the sharing of health information between primary care clinicians and mental health professionals. In doing so, determine whether these barriers are the result of state law, informed consent laws and policies, and/or the culture of mental health practice in the state and/or community.

- Identify mechanisms for improving communication among and between primary care clinicians and mental health professionals who serve children with mental health needs. Improved communications between primary care physicians and mental health professionals could help alleviate one of the problems created when managed care carves out behavioral health care services, as is the case in some states. Chapters that have established “pediatric councils” to engage with private insurers can consider enhancing communication between mental health professionals and primary care clinicians as part of their agenda. (See Tools and Resources in this section, Working to Improve Mental Health Services: The North Carolina Advocacy Effort, for an example of one state’s advocacy efforts to improve children’s mental health services.)
References

Resources for Further Information


The Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University provides health care stakeholders with information and tools related to greater protection of health information through research studies, policy analyses, Congressional testimony, extensive work with the media, and a Web site. Available at: http://www.healthprivacy.org/ Accessed January 8, 2007


Overview of Confidentiality Statutes and Children’s Mental Health
This policy brief provides an overview of federal and state confidentiality statutes and related issues regarding sharing of health information between primary care clinicians and mental health professionals.

Physician Referral and Feedback Form Template
This tool is a sample referral and feedback form that primary care clinicians can adapt for use with mental health professionals.

Working to Improve Mental Health Services: The North Carolina Advocacy Effort
Reprinted with permission from Pediatrics. This article discusses the efforts of the North Carolina chapter of the American Academy of Pediatrics to organize an advocacy initiative designed to improve children’s mental health services in the state.
Numerous federal and state laws protect the privacy of health care information. In particular, at least 3 types of laws affect the ability of pediatricians and mental health professionals (eg, psychiatrists and psychologists) to share information about a patient in their care. These laws are (1) federal medical privacy rules issued under the federal Health Insurance Portability and Accountability Act (HIPAA), (2) state privacy laws, and (3) state minor consent laws. In addition, there are specific federal confidentiality rules that govern facilities deemed to be federal alcohol and drug abuse treatment programs.

Confidentiality statutes are complex, subject to federal and/or state oversight and jurisdiction, and typically vary by state depending on the law. It is beyond the scope of this Chapter Action Kit to provide an in-depth analysis of these statutes. However, general information, chapter strategies for obtaining state-specific information about the laws, and resources for further information are outlined below.

**Health Insurance Portability and Accountability Act Privacy Rules**

In 1996, Congress passed HIPAA to establish national standards to protect the privacy of health care data, and to promote more standardization and efficiency in the health care industry. The HIPAA Privacy Rules, which are enforced by the US Department of Health and Human Services, Office for Civil Rights, took effect on April 14, 2003, and represent a uniform, federal floor of privacy protections for consumers.1

The HIPAA Privacy Rules limit the ways that health plans, pharmacies, hospitals, doctors, and other health care providers can use patients’ medical information (eg, information that is in medical records, communicated orally, or on computers). They are designed to govern disclosure of patient protected health information while protecting patient rights. With regard to sharing of health information between providers, the HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without their authorization, to another health care provider for that provider’s treatment of the individual. Indeed, consulting with another health care provider about a patient is within the HIPAA Privacy Rule’s definition of “treatment” and, therefore, is permissible.2

**State Privacy Laws**

In addition to these federal rules, many states have enacted state privacy laws (informed consent laws) that place further protections on health privacy. The HIPAA standards do not affect state privacy laws that may be more restrictive regarding privacy protections. Any state law providing additional protections would continue to apply.2

**Health Insurance Portability and Accountability Act and Minor Consent**

While the HIPAA rules permit sharing information between providers, there are unique considerations for minors who have legally consented to care. In general, HIPAA allows a parent to have access to the medical records for his or her minor child, when the access is not inconsistent with State or other law. Three exceptions to the HIPAA Privacy Rule are as follows:
1. When a minor has consented for the care and the consent of the parent is not required by state or other applicable law
2. When a minor obtains care at the direction of a court
3. When a parent agrees that a health care provider and minor may have a confidential relationship

In the case of consenting minors, parents do not necessarily have the right to access the minor’s health information and whether they can do so is dependent on state laws. Health care and mental health professionals need to examine state laws to determine whether they specifically address the confidentiality of a minor’s health information and, if not, professionals can typically determine whether or not to grant access. The next section provides an overview of key considerations regarding state minor consent laws.

**Health Insurance Portability and Accountability Act and Federal Substance Abuse Confidentiality Requirements**

Federal confidentiality regulations for substance abuse treatment programs (42 CFR Part 2 or Part 2) establish confidentiality requirements for patient records that are part of any federally assisted alcohol and drug abuse treatment program. Overall, Part 2 confidentiality requirements parallel the HIPAA Privacy Rule requirements in many areas. However, the “general rules” established by Part 2 and the Privacy Rule regarding use and disclosure of patient health information are very different. In general, federally subsidized substance abuse treatment programs must abide by Part 2 and cannot disclose information without written consent. This is more restrictive than the HIPAA Privacy Rule, which, as previously mentioned, permits disclosure of health information for treatment, payment, and health care operations without prior written authorization.

Furthermore, with regard to disclosure of health information of a minor, the HIPAA Privacy Rule defers to other applicable state and federal laws. In this case, Part 2 requires that a minor always sign the consent form for a program to release health information, even to his or her parent or legal guardian. (For further information, see The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs listed in the references at the end of this section.)

**State Minor Consent Laws**

State minor consent laws govern whether minors can give their own consent for health care (eg, care obtained without the consent of a parent or guardian). Every state has enacted these laws, which fall into 2 overall categories: (1) laws that are based on the status of the minor—minors who are emancipated, living apart from parents, married, pregnant, and/or parenting, and (2) laws that are based on the type of care that is sought (eg, emergency, family planning, drug/alcohol, and mental health). With regard to mental health services, at least 31 states have enacted laws that allow minors to consent for mental health services but with limitations (eg, age of minor, type of care, health professionals who are covered, and number of visits), depending on the state. Nearly all states have enacted some type of law that allows minors to consent for care related to drug and alcohol use.
Examples of State Minor Consent Laws for Mental Health Services

- In California, a minor 12 years or older may consent for outpatient mental health treatment or counseling if the minor, according to the attending professional, is mature enough to participate in the outpatient mental health treatment or counseling and the minor either would present a danger of serious physical or mental harm to self or others without the treatment, or is the alleged victim of incest or child abuse.

- In Illinois, any minor 12 years or older (eg, younger than 17 years) may request and receive counseling services or psychotherapy on an outpatient basis without parental consent. These services are limited to 5 sessions with a session not lasting more than 45 minutes.

- In North Carolina, any minor may consent to a physician for medical health services for prevention, diagnosis, and treatment of emotional disturbance.

Conclusion
The sharing of health information is complicated and subject to state and federal laws, rules, and regulations. Chapters may want to consult with multiple sources to obtain information about the privacy laws and rules specific to their state. These sources include the following:

- **State Minor Consent and Privacy Laws.** State mental health agencies and associations will have information on the privacy and confidentiality laws and rules that apply for mental health services in their state. State-by-state resource lists and contacts in state mental health agencies, state protection and advocacy agencies, and state mental health associations are available on the Web site of the Substance Abuse and Mental Health Services Administration (SAMHSA) at: [http://mentalhealth.samhsa.gov/publications/Publications_browse.asp?ID=185&Topic=State%20FTerritory+Resources](http://mentalhealth.samhsa.gov/publications/Publications_browse.asp?ID=185&Topic=State%20FTerritory+Resources).


- **HIPAA Privacy Rules.** Further information about the HIPAA Privacy Rules is available from the HHS Office for Civil Rights, SAMHSA, and other federal agencies (see Resources for Further Information).

In addition, chapters may want to determine whether barriers to the sharing of information between primary care clinicians and mental health professionals are the result of state law, informed consent laws and policies, and/or the culture of mental health practice. The American Psychiatric Association clearly supports the sharing of information between physicians when it is related to a patient’s treatment. Chapters could meet with mental health professional groups to explore these issues further and to determine strategies for improving information sharing as it relates to children’s mental health care. (See Strategies to Collaborate With Mental Health Professionals in this Chapter Action Kit for related chapter strategies.)

For more information on state consent and confidentiality laws, please contact the American Academy of Pediatrics Division of State Government Affairs at 800/433-9016, ext 7799, or stgov@aap.org.
References


Resources for Further Information

The Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University provides health care stakeholders with information and tools related to greater protection of health information through research studies, policy analyses, congressional testimony, extensive work with the media, and a Web site. Available at: [http://www.healthprivacy.org/](http://www.healthprivacy.org/) Accessed March 2, 2007


Physician Referral and Feedback Form Template

Strategies for System Change in Children’s Mental Health: A Chapter Action Kit

Date: ________________  ( ) Initial  ( ) Follow Up

Referring Physician Name:
_____________________________________________________________________

Address:
(Street/PO Box)              City              State
Zip
Fax: (____) ___________________________ Phone: (_____) __________________

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Parent’s Name: ________________ Address: ________________ Phone: ________________

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Any Specific Questions or Requests:
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Physician Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please mail or fax this completed form to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

☐ Patient did not make appointment
☐ Patient made an appointment but did not keep appointment
☐ Patient not seen within 60 days
Initial Diagnoses:
1. __________________________________________________________________
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Recommendations:
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Medications Prescribed:
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Follow-up Planned:
- Medication management
- Individual therapy
- Family therapy
- Medical lab requests
- Referral for additional diagnostic testing
- Return to your care for medication management
- Recommend follow-up in _____ weeks
- Other ________________________

Name (type or print) ____________________________ Signature ____________________________

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4-12
SPECIAL ARTICLE

Working to Improve Mental Health Services: The North Carolina Advocacy Effort

Jane Meschan Foy, MD∗; Marian F. Earls, MD‡; and David A. Horowitz, MD§

ABSTRACT. Poor reimbursement of pediatricians for behavioral and developmental services and the disarray of children’s mental health services in the state led leaders of the North Carolina chapter of the American Academy of Pediatrics to organize an advocacy effort with the following objectives: 1) to articulate pediatricians’ perspective on the current crisis in delivering and coordinating children’s behavioral health services; 2) to represent the collective voice of both academic and community pediatricians in dialogue with mental health providers, Medicaid leaders, and the health and mental health segments of state government; 3) to build consensus about an achievable plan of action to address pediatricians’ reimbursement and systems issues; 4) to develop a full and appropriate role for pediatricians as providers and, potentially, coordinators of behavioral health care; and 5) to facilitate implementation of Medicaid changes, as a first step in carrying out this plan. This article describes the 24-month process that achieved these objectives. Pediatrics. 2002;110:1232–1237; mental health, advocacy, Medicaid.

ABBREVIATIONS. NC, North Carolina; MH, mental health; AAP, American Academy of Pediatrics; SCHIP, State Children’s Health Insurance Program; SHP, state health plan; DMA, Division of Medical Assistance.

NORTH CAROLINA’S SETTING AS DESCRIBED IN DECEMBER 1998

In North Carolina (NC), as in many other states, mental health (MH) services are in disarray. Inadequate reimbursement has undermined the capacity of virtually every source of MH care, with the end result being that children of all income levels have limited access to behavioral health services. Many communities have no child psychiatrists and an inadequate number of MH providers trained and credentialed to care for children. Medicaid’s low reimbursement for office visits, requirement of a definitive diagnosis, and lack of reimbursement for the many nonface-to-face aspects of delivering behavioral health services have contributed significantly to many providers’ reluctance or inability to serve publicly insured children. Table 1, an excerpt from the position paper developed as a tool in NC’s advocacy effort, provides an example. Disparate deductibles, co-payments, and caps for MH services in private health plans have created access barriers for privately insured children as well.

Primary care pediatricians, faced with these barriers and with the estimated 30% of children who require MH intervention,1 frequently experience pressure to prescribe psychiatric medications and deliver services for which they feel inadequately trained. Some have attempted to expand their expertise and involve themselves in these new areas. Others, already frustrated by inadequate compensation for the many behavioral services they provide in the context of comprehensive pediatric care, refer children with behavioral problems through available channels, knowing that only 21% of children with MH problems receive MH services,2 70% to 80% of these through the meager resources of public schools,2 where MH professionals are focused primarily on testing and attendance issues.

In NC, as elsewhere in the country, there is an artificial schism between behavioral health systems and medical systems of care. Poor coordination and poor integration of MH services with children’s pediatric care further diminish accessibility and quality of the care that is provided in both the public and private sectors. Inadequately funded public MH facilities experience high turnover of staff and difficulty with recruitment; those MH professionals who are on staff usually are anonymous to community pediatricians. Because NC Medicaid does not allow social workers and psychologists to bill Medicaid unless they are employed or credentialed by a state-funded, state-administered MH program, collegial relationships between pediatricians and Medicaid MH providers are virtually nonexistent in most communities. In many private health plans, families self-refer children for behavioral services; here also there are often inadequate or absent procedures for communication between MH providers and primary care physicians, who often do not have access to the list of behavioral health providers. Reimbursement for MH services is frequently allowed only to MH providers, eliminating any financial incentive for primary care physicians to share in the care of children with MH conditions.

For all these reasons, pediatricians are frequently...
unaware of medications prescribed by MH providers and of therapeutic efforts important to the ongoing management of a child’s emotional and family problems. An additional factor contributing to poor coordination is the paucity of care coordination programs in NC for children with behavioral problems and mental illness: the state-funded Child Services Coordination Program serves children with developmental and medical problems from birth to age 5; neither the Child Services Coordination Program nor the state-supported Developmental Evaluation Centers serve school-aged children. Low ratios of school nurses in the state—1:2451 statewide, 1:5000 or more in some areas—prevent most nurses from playing a role in coordination. Public school psychologists and guidance counselors, who deliver the majority of MH services to youth, function virtually outside the health care system.

Compounding these reimbursement and coordination issues in NC, as elsewhere, are the problems arising from the compartmentalized training of MH and medical professionals and the separate administrative structures that perpetuate this compartmentalization. As a result, MH professionals and community pediatricians typically do not work in the same buildings, utilize the same terminology or diagnostic approach, attend the same educational programs, use the same forms or reimbursement codes, or sit at the same tables to address their concerns. At the level of state government, 2 separate systems, functioning largely in parallel and funded by separate streams, oversee medical programs in 1 building, MH programs in another. This separation posed significant challenges for the process of addressing NC’s problems.

**NC’s ASSETS**

NC has an active chapter of the American Academy of Pediatrics (AAP) and 5 academic pediatric programs whose chairs are closely involved in the chapter’s educational and advocacy efforts. The chapter has a long history of effective collaboration with state government, enhanced by the tenure of David Bruton, MD, a community pediatrician from Pinehurst, North Carolina, who served as secretary of the Department of Health and Human Services from 1997–2001. The primary setting for the chapter’s collaboration has been an open forum, convened 3 times yearly by the chapter, which brings together pediatricians, child advocates, and representatives of state government to update each other on important developments affecting the health of children and to address mutual concerns. The former Director of Medicaid, Richard Perruzzi, was among the attendees. Secretary Bruton and Mr. Perruzzi worked closely with chapter leaders in developing a non-Medicaid State Children’s Health Insurance Program (SCHIP) built around the State Health Plan (SHP) for state employees. The SHP experience in MH coverage had been especially positive: in 1992, NC introduced into the SHP full coverage parity of MH and non-MH conditions, a single insurance deductible, full freedom of choice of MH providers, and only moderate management of generous benefits through a contract with Value Behavioral Health. With MH parity in place, by 1998 NC had seen the following changes:

- MH payments as a percentage of total health payments decreased from 6.4% to 3.1%.
- MH hospital days decreased by 70%.
- Actual per member/per month cost for MH benefits (including administrative overhead) went from $5.43 in fiscal year 1990 to $4.11 in fiscal year 1998.
- Actual utilization patterns remained constant and modest: 6% to 7% of enrollees sought outpatient services per year; half went for only 3 to 4 sessions, three-fourths completed treatment within 11 to 13 sessions; utilization >26 visits remained constant and low (0.40%–0.75%).

Although MH parity did not increase overall costs, and although it brought about a marked reduction in inpatient MH days (an outcome also documented by Sturm, who studied insurance plans that offered parity in behavioral health spending limits), these data were insufficient to persuade state legislators to pass MH parity legislation on multiple annual attempts. However, the SHP experience was sufficient to open dialogue that could not have otherwise occurred in NC’s fiscally conservative political climate.

**THE PROCESS**

1) Articulating Pediatricians’ Perspective: The Position Paper

A critical first step was bringing together pediatricians to form a task force of NC’s AAP chapter. Key members felt passionate about the MH issue, had expertise and experience, and were already involved in chapter leadership: a community pediatrician who chairs the chapter’s Mental Health Committee and is the parent of a child with special developmental needs; an academic developmentalist from the chapter’s Committee on Disabilities; a developmental pediatrician who serves as medical director of a community health program for low-income children in...
an urban county, former chair of the local Board of Mental Health, Developmental Disabilities, and Substance Abuse, and Chair of the chapter’s School Health Committee; and an adolescent specialist in combined community and academic practice, former chair of the chapter’s Committee on Adolescence. The chair of the group, which was named the Task Force on Mental Health Care Access and Reimbursement, is an academic generalist, formerly in private and public health settings, involved in developing school-based health services and serving as NC’s AAP chapter president.

As the group began meeting to discuss the problem, anecdotal experiences and discussion about our sources of frustration dominated the discussion. It became evident that, to move forward, we needed to find expression for the angst, educate each other about unfamiliar aspects of the issues, and prepare to speak in one, understandable voice to fellow child advocates and policymakers. We settled on the idea of writing a position paper, which went through many iterations and served to focus our efforts during our first few months. This document appears on the Web site of the NC chapter of the AAP, which is available at: www.ncpeds.org.

2) Including Other Stakeholders: Consensus Plan

Having reached consensus on the position paper, we began expanding our Task Force to include other MH advocates, including the executive directors of the state’s organizations for social workers, psychologists, and psychiatrists and the president of the state’s Council of Child and Adolescent Psychiatrists. These individuals brought with them their experience in lobbying the state legislature and state government on MH issues, linkage to other advocacy groups such as the Alliance for the Mentally Ill, and their own expressions of anger and frustration, which the Task Force processed and discussed over several meetings. With their input, the Task Force developed a plan of action, which served mutual goals; this plan became a second chapter of the position paper, which is available at: www.ncpeds.org.

3) Working With Medicaid

With this document complete, we made the decision to approach Medicaid leadership. The group’s optimism was greatly increased by a surprise legislative response to years of chapter advocacy, facilitated by Secretary Bruton, to increase Medicaid rates to parity with Medicare, effective January 1, 1999, and to allow clients 1 year of Medicaid eligibility, rather than month-to-month. Although these measures were not specific to MH and did not solve other problems, such as the absence of reimbursement for nonface-to-face activities and barriers to collaboration with Medicaid MH providers, they were enormously helpful to the cause and signaled a mood of receptiveness to physician concerns.

The Task Force approached the Director of Medicaid, and he agreed to meet with the group about its access and reimbursement concerns. We decided to locate the meeting in his conference room at the Division of Medical Assistance (DMA) building and have met there regularly since, frequently involving other members of the DMA staff and consulting with them about wording of new regulations resulting from our negotiations, as well as unrelated topics such as preventive dental programs, for which they needed our advice and support. We soon pulled in other members of state government, leaders from the Department of Mental Health, Developmental Disabilities and Substance Abuse Services, who had not previously interacted with our pediatric leadership, and began to address MH systems issues, as well as reimbursement. These new relationships continue to be of great value to the chapter.

4) Outcomes

Advocacy is not science; consequently, outcomes cannot be attributed tidily to any 1 factor in the complex environment of that period. Generations of chapter leaders gave this advocacy effort their legacy of credibility and effective relationships with state government. Secretary Bruton’s powerful position and supportive posture toward the Task Force undoubtedly helped to get Medicaid leaders to the table and to facilitate progress. Other MH advocacy groups worked in parallel with the Task Force, invigorated by the support of pediatricians. To these ingredients the Task Force added focus, persistence, a consensus voice, a framework for negotiation, and access to the clinical expertise of pediatricians motivated to participate in a change effort.

Results came about laboriously. Several contentious issues required discussions by telephone or in small groups outside Task Force meetings. Occasionally, impacted groups (eg, physicians in local area MH programs) requested a hearing of their concerns, which were all heard first by Task Force representatives, then considered and addressed by the Task Force as a whole. Meticulous notes of meetings (an essential component of an advocacy effort) recorded agreements and reminded the group of unfinished business. Snags sometimes required data-gathering, outside expertise, and special visitors to Task Force meetings, occasionally including Secretary Bruton himself or other members of the Department of Health and Human Services staff. Periodically, the Task Force revised the position paper to clarify a point and then recirculated it to Secretary Bruton and other government leaders.

The following Medicaid changes resulted from this collaborative effort:

Reimbursement for up to 6 visits to a MH/substance abuse provider without assigning a diagnosis and up to 26 unmanaged visits in a calendar year for Medicaid recipients up to age 21.6 DMA confirmed on October 12, 2001 that this policy also applies to physicians performing behavioral assessment and treatment.

We anticipate that the steps in bold print will facilitate pediatricians’ collegial relationships with, employment of, and/or co-location with MH professionals. We believe that these changes will, in turn, improve access to MH services for Medicaid-enrolled children and increase the likelihood that these services will be provided within or coordinated with a child’s medical home.
MH visits annually for children under the age of 21.7 MH providers are educated to communicate at regular intervals with the primary care provider.

✓ Expansion of “incident to” rules,8 allowing physicians employing licensed clinical social workers, and clinical nurse specialists with psychiatric certification to bill for the services of these MH professionals if the physician provides on-site supervision.8

✓ Expansion of “incident to” rules,8 allowing health departments who employ licensed clinical social workers, licensed psychologists, and advanced practice nurses to bill for their services in school-based health centers, if a physician provides supervision by phone or beeper.9

✓ Direct Medicaid enrollment of independently practicing licensed clinical social workers, licensed psychologists, and advanced practice nurses allowing them to bill for services delivered in their offices.10,11,12

✓ An additional provision allowing independently enrolled MH professionals to bill for services delivered in school sites.13

We were not successful in achieving Medicaid reimbursement for non-face-to-face services. Nor were we successful in achieving an enhanced fee for services performed by pediatricians with subspecialty training. Both these approaches created troubling complications for DMA outside the realm of pediatrics. Although we were successful in enabling new categories of MH professionals to deliver services in school sites without on-site physician supervision, we were unsuccessful in expanding this opportunity to those employed by private physicians or universities.

We should add that some of these changes created new challenges for NC’s area MH programs. For the first time, they must compete for physician referrals of low-income patients. A positive outcome has been their heightened interest in streamlining their own referral processes and enhancing communication with referring physicians. A negative outcome has been the growing phenomenon of split therapy, a name they have given to the circumstance that develops when a nonphysician community MH professional delivers a portion of a patient’s therapy and a physician without an established relationship with that professional is expected to deliver the other (e.g., emergency hospitalization or psychopharmacologic therapy). The latter problem appears amenable to relationship-building among the concerned parties and may prove an additional incentive to collaboration.

5) Educating Our Membership

To bring the membership of our chapter along in the process and to expand pediatricians’ capacity to deliver and coordinate behavioral and MH services, we planned educational sessions around the topics our Task Force identified as most critical, including developmental and behavioral health screening, psychopharmacology, and coding for MH services and special needs health care. The session on coding received the highest evaluation of any offering. Future offerings will focus on expansion of other MH skills important to primary care pediatricians: use of the Diagnostic and Statistical Manual for Primary Care, family assessment, management of attention-deficit/hyperactivity disorder and depression, collaboration with schools and other community agencies, referral to MH professionals, and behavioral therapy.

We met with the leadership of our NC area health education centers to plan regional grand rounds on MH topics. NC’s Council of Child and Adolescent Psychiatrists is participating in this effort. The Northwest Area Health Education Center, which serves 17 counties, has undertaken a project to assist selected communities in organizing systems of care for children with attention problems. This effort will be patterned after a successful model in Guilford County, which developed a community protocol for the assessment of children with classroom inattention and behavior problems; established roles for school personnel, public health nurses, primary physicians, and MH agencies in the assessment and management of these children; created communication forms and procedures for each step of these processes; and implemented an educational plan for introducing these new procedures to physicians and school personnel.

The next phase of our educational effort will be workshops for pediatricians on collaboration with MH providers, explaining new reimbursement opportunities. We will be distributing the names of newly enrolled MH providers (>400 statewide as of this writing), information about their training and scope of practice, and recommended referral procedures. A new brochure under development by NC’s representatives on the AAP’s Committee on Psychosocial Aspects of Child and Family Health will facilitate this process.

6) Other Advocacy Efforts

The chapter joined with our colleagues in social work, psychology, and psychiatry for yet another failed effort to pass legislation requiring parity of MH benefits in insurance plans. Our chapter’s resolution to address MH parity specifically in the AAP’s Universal Health Insurance proposal was passed by the 2000 AAP Annual Chapter Forum. Our chapter’s resolution to provide assistance to chapters on MH issues was adopted by the 2001 Annual Chapter Forum.

Private insurers lag well behind in improving MH benefits. The chapter formed a group, the Managed Care Solutions Committee, to move the chapter’s advocacy efforts into the private sector. Medical directors of NC’s major managed care organizations met to discuss an agenda that is jointly developed by our chapter leadership and a health maintenance organization medical director, who is also a pediatrician. Modest first steps in relation to MH include

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8 Incidental to” rules govern billing for services delivered by a physician’s employee in the name of the physician. Before August 2000, NC’s rules restricted “incident to” billing to PhD psychologists. Before September 2000, NC’s rules required the physician to be on-site at the time the employee delivered the service.

9 An additional provision allowing independently enrolled MH professionals to bill for services delivered in school sites.

13 We were not successful in achieving Medicaid reimbursement for non-face-to-face services.
an agreement to share behavioral health provider lists with pediatricians and attention-deficit/hyperactivity disorder coding guidelines specific to each of the plans.

Perhaps the Task Force’s most long-lasting accomplishment will be the inclusion of pediatricians on state government committees and MH planning groups that previously did not include any primary care physicians.

NEXT STEPS

There is much left to do. Evaluation of NC’s progress toward improving access to MH services for Medicaid-enrolled children will be a challenge. Medicaid has only claims data. In these data, MH services delivered by employed MH professionals under new “incident to” policies are so far indistinguishable from those delivered by their supervising physicians. On the other hand, we will be able to track the number and type of services delivered by newly enrolled independent providers and the total number of MH services delivered. Individual providers will be able to analyze their changes in reimbursement. Other measures will require a separate evaluation effort.

We remain hopeful that improvements in Medicaid will place pressure on private insurers if and when we achieve a buy-in option for children who are financially ineligible for Medicaid and SCHIP. If, as we suspect from experience in the SHP, improved MH benefits in Medicaid and SCHIP do not have adverse cost implications, there may be incentives for expanding private MH benefits, even without the buy-in option.

LESSONS LEARNED ABOUT WORKING WITH STATE GOVERNMENT

The following principles drawn from NC’s experience may be helpful to pediatricians in their advocacy efforts:

1. Advocates must take advantage of political opportunities that present themselves. One such opportunity is a sympathetic person in a key government role; this might be a physician, a parent, or grandparent of a child with mental illness, or a child advocate. Full advantage is gained only if pediatricians with the requisite clinical expertise position themselves to be accessible and well-organized during this person’s period of empowerment, with clearly articulated consensus positions on important policy areas.

2. State government administrators often view subspecialty care, especially that which is delivered at academic centers, as exotic and expensive. There may also be an adversarial relationship between the governmental agency and the medical center. Efforts by academic pediatricians to lobby state government on their own behalf appear self-serving and suffer from this baggage. Academic pediatricians will benefit from joining with community pediatricians in their AAP state chapter to approach Medicaid and other state agencies. The community pediatrician can speak to the value of subspecialty services in the care of their patients. This reframes the academics’ problems in terms of access to care for children in need, rather than survival of tertiary hospital infrastructure (a cause that few government officials will find appealing).

3. Personal relationships with state government leaders are at the heart of successful negotiations. These grow over time. Many AAP state chapters have developed these relationships over a long period, adding to their value as partners in any advocacy effort. Parents and grandparents of patients may also have relationships with administrators or with legislators, as well as passion and experience to bring to an advocacy effort.

4. State government leaders weary of listening to splinter perspectives of various advocacy groups. All advocates are best served by participating in a coalition, which agrees on a common agenda. If there are issues outside this common agenda—especially if they are in conflict with the common agenda—there should be advance understanding by all partners in the coalition. One partner’s end run around a process and agenda developed by a coalition is very destructive to trust and credibility.

5. A government official will have little sympathy for enhancing physicians’ income, especially because it probably far exceeds his own. The fundamental issue when seeking increased reimbursement should always be access. The AAP Members Only Channel provides links to a number of documents that make the case for the association between access and reimbursement (available at: www.aap.org/moc/medlegal2.CFM).

6. Child advocates must seek out opportunities to understand the perspective of state government administrators and, when possible, to assist them with their problems. Frequently, these opportunities enable advocates to address their own concerns in an unexpected way. In the present economic environment, opportunities for cost-saving are particularly powerful. The state DMA will likely have a medical director—possibly a pediatrician—who is a good initial contact. By linking DMA to pediatricians with expertise in the management of complex and expensive conditions, advocates can assist Medicaid in reducing cost and improving quality, while laying the groundwork for a productive problem-solving relationship.

7. Child advocates must pursue strategies that are compatible with the political and economic environment. Administrators of state government agencies serve political leaders. They are looking for opportunities to align themselves with their constituents’ interests.

8. Specific strategies most beneficial in negotiating with Medicaid will necessarily vary from state to state. The following section suggests some approaches that may yield results.

APPROACHES TO MEDICAID

The exact approach a state uses to negotiate with Medicaid will depend on the particular shortcom-
ings of that Medicaid program. Examples might include the following:

- Codes reimbursed by Medicare but not Medicaid
- Absence of reimbursement for visits not resulting in a diagnostic code (ie, screening, testing, multi-visit assessment)
- Absence of reimbursement for nonface-to-face services (telephone consultation, record review, parent or school conferences, etc)
- Restrictions built into the “incident to” policy (supervision requirements, failure to reimburse categories of MH professionals)
- Impediments to reimbursement for MH services delivered on school premises
- Failure to recognize advanced credentials of physicians (ie, no enhanced fee for a more complex service delivered by a more highly trained professional)
- Failure to reimburse categories of MH professionals and MH professionals in certain employment arrangements
- Monopolies of state MH programs
- Managed care policies excluding the primary care physician from referral/management decisions
- Monthly renewal of Medicaid eligibility (as opposed to yearly)
- Across-the-board inadequacies in reimbursement

The negotiation process involves exploring the feasibility of each of these strategies with Medicaid leaders. Some will have more appeal than others, depending on that Medicaid agency’s history and political climate. Child advocates dealing with tight state budgets must fight the perception that increasing access will balloon costs. NC’s experience with its SHP (see above) and the experience of other plans that provide MH parity contradict this perception: total expenditures for MH care have, at most, modestly increased with parity; furthermore, plans with parity have experienced the very positive outcome of decreased inpatient days. There are undoubtedly other needed MH care reforms, such as those that build the capacity of neglected systems, that will be financially costly; advocates for these changes must build their case around the human and economic costs of untreated behavioral problems.

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WORKING TEENAGERS

“American teenagers are an atypically industrious lot. In most developed countries, teenagers work only if the family needs income. Yet the American teens most likely to work have historically been white, and (perhaps most surprisingly of all) had a family income above $40 000 a year. By contrast, poor inner-city kids have been much less likely to hold jobs. A new report by the Center for Labor Market Studies at Northeastern University in Boston points out that this has been the toughest summer-job market for teenagers in 37 years.”

The Economist. August 24, 2002

Noted by JFL, MD
educate chapter members
Primary care clinicians play a central role in the prevention, identification, and treatment of mental health problems in children. They can help promote children’s mental health (e.g., anticipatory guidance and parent education) and identify children who may be experiencing mental health issues (e.g., screening for developmental delays, and depression). They also play an essential role in the treatment of mental health problems. Approximately half the care for common mental health disorders is delivered in primary care settings. Moreover, primary care clinicians prescribe the majority of psychotropic medications for both children and adults.1

Given the prevalence of mental disorders in primary care settings and the ever-increasing shortage of mental health providers, particularly those who serve children, primary care clinicians are assuming more significant roles in children’s mental health. Pediatricians are challenged to place greater focus on the social, developmental, and behavioral needs of children—issues that are now considered a core element of pediatric care.2 Families who have questions or concerns about a mental health need in their child often first seek help from their primary care clinician. Primary care settings are where many families go regarding general health and other related concerns for their child, they are often perceived as less stigmatizing than mental health settings, and they can often best prevent, promote, and identify mental health issues (e.g., identification of developmental delays through well child visits).

In spite of the opportunities for addressing mental health issues in primary care settings, primary care clinicians are often ill equipped to assume extensive roles in the care of children’s mental health. Many primary care clinicians lack the time, training (e.g., interviewing, counseling, and diagnostic skills) and decision-making support (e.g., when to manage a mental health disorder vs when to refer) to provide care to children with mental health needs.2 Indeed, mental health problems are often undiagnosed, untreated, and under treated in primary care settings.1

When mental health conditions are identified, primary care clinicians may feel pressured by families or teachers to prescribe psychopharmacologic therapies. This phenomenon may be exacerbated in regions where pharmaceutical companies’ aggressive marketing to primary care physicians has substituted for legitimate continuing medical education (CME) about these therapies. Even formal CME activities may be overly influenced by pharmaceutical company interests.3

System barriers to integration between primary care and behavioral health care further compound these clinical barriers. These challenges include inadequate reimbursement for mental health services, rules and regulations that can limit the kinds of mental health services that primary care clinicians can provide, and poor integration of services between primary care clinicians and mental health professionals. Psychiatric specialty education provides insufficient training in primary care and the interactions and effects of coexisting medical disorders and psychiatric conditions.4 Furthermore, medical schools do not emphasize working as part of an interdisciplinary team—primary care clinicians and psychiatrists receive little training in collaborative practice arrangements.
What Does This Mean for American Academy of Pediatrics Chapters?
Given these issues, national reports and studies have called for better integration between primary care and behavioral health care in addressing children’s mental health needs. States and communities have begun developing initiatives to promote and foster better integration between these service delivery systems. In addition, models of integrated care are being developed in primary care practices across the country.

Chapters can play a significant role and service by educating their members on the prevention, early identification, and treatment of children’s mental health issues. Furthermore, chapters can help advance initiatives, strategies, and practice models to address better integration of primary and behavioral health care.

Chapter Strategies for Educating Chapter Members
Chapters may want to identify and consider a range of strategies for educating chapter members on the prevention, identification, and treatment of mental health problems in children. Key strategies include the following:

- Hold CME sessions on mental health prevention, early identification (eg, use of valid mental health screening tools), and diagnosis; psychiatric medications; and mental health case management. The American Academy of Pediatrics (AAP) Task Force on Mental Health has suggested guidelines for educational activities about psychopharmacology. (See the Tools and Resources in this section for: The Warning Signs Project Summary and a Glossary of Mental Health and Substance Abuse Terms.)
- Provide CME sessions on care integration; behavioral health management approaches; and reimbursement, coding, and other documentation issues.
- Provide guidance to members and their staff (eg, office managers) on how to appropriately code for mental health visits. (See the Tools and Resources in this section for the following related information: Commonly Reported Codes for Primary Care Clinicians and Mental Health Professionals, Coding for Primary Care Clinicians and Mental Health Professionals, and Developmental Screening/Testing: Coding Fact Sheet for Primary Care Clinicians).
- Use AAP resources such as the coding tips on attention-deficit/hyperactivity disorder in chapter newsletters.
- Develop a speaker’s bureau and write an article and/or other informational strategy on successful integrated practice models and collaborations between primary care and mental health professionals.
- Facilitate the sharing of effective models of integration with mental health professionals. For example, pediatric practices have had success with employing, co-locating with, and collaborating with social workers, psychologists, and nurse practitioners with specialized training to provide mental health services for children. Successful experiences could be shared at chapter meetings and through other dissemination mechanisms. (See Tools and Resources in this section for the following related information: Collaborative Models Sample Survey and Template Letter; Primary Care and Mental Health: Collaborative Projects; Health Plan Policies Fostering Co-location and Other Forms of Collaboration in the Care of Children With Mild to Moderate Mental Illness; and “Co-Location of Mental Health Professionals in Primary Care Settings: Three North Carolina Models.”)
• Develop peer-mentoring programs to assist primary care clinicians with less experience in integrated practices.

• Convene collaborative, cross-disciplinary meetings between behavioral health and primary care clinicians to address gaps in services and promote treatment protocols and adherence to evidence-based practices. (See Tools and Resources in this section for the Evidence-based Child and Adolescent Psychosocial Interventions Matrix).

• Work with pediatric residency programs to ensure that children’s mental health is addressed in medical training. The overall mental health and social and emotional development of children is a major part of the future of pediatrics. Current and future medical residents need to be prepared to address the mental health needs of children. More information is available from the Association of Pediatric Program Directors, a national associated dedicated to promoting excellence in pediatric medical education to ensure the health and well-being of children, at http://www.appd.org.

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Resources for Further Information


The AAP Division of Chapter and District Relations. Available at: http://www.aap.org/member/chapters/chapoverview.htm Accessed March 21, 2007


Bright Futures. Available at: http://brightfutures.aap.org/web/ Accessed March 21,
2007. Bright Futures, initiated by the Maternal and Child Health Bureau (MCHB) over a decade ago and managed by the American Academy of Pediatrics, is a philosophy and approach that is dedicated to the principle that every child deserves to be healthy, and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community.


The Improving Mental Health in Primary Practice Through Access, Collaboration and Training (IMPACT) program is a grant from the federal Maternal and Child Health Bureau (MCHB) to the AAP to improve children's mental health by offering pediatricians and other primary care professionals the tools and support they need to provide community-based, collaborative care. Available at: http://www.aap.org/mentalhealth/mh1a.html Accessed March 28, 2007


Mental Health: The Cornerstone of Health contains mental health information related to US Department of Health and Human Services research, programs, policies, and media campaigns and highlights the latest research findings and policy efforts. Available at: http://mentalhealth.samhsa.gov/cornerstone/ Accessed March 28, 2007

strategies to educate chapter members
tools and resources

strategies for system change in children’s mental health: a chapter action kit

The Warning Signs Project Summary
Reprinted with permission from Peter Jensen MD, Center for the Advancement of Children’s Mental Health. This resource is an overview of a project developed by the Center for the Advancement of Children’s Mental Health at Columbia University that is designed to provide clinicians, including pediatricians, with the skills and tools that are needed to recognize early signs of mental health problems in children.

Glossary of Mental Health and Substance Abuse Terms

Commonly Reported Codes for Primary Care Clinicians and Mental Health Professionals
This resource outlines common diagnosis codes that are used by primary care clinicians and mental health professionals for mental health problems in children and adolescents.

Coding for Primary Care Clinicians and Mental Health Professionals
This resource contains comprehensive listings of codes for services such as case management, office or other outpatient service codes, prolonged physician service codes, and mental health services codes.

Developmental Screening/Testing: Coding Fact Sheet for Primary Care Pediatricians
This resource provides guidance to primary care clinicians on developmental screening for children, and information on diagnostic codes that can be used for developmental testing (eg, comprehensive developmental assessments).

Collaborative Models Survey Sample Letter and Template
This template and cover letter may be used by chapters to obtain information from mental health and substance use/abuse professionals regarding effective collaborative practices between primary care clinicians and mental health professionals.

Primary Care and Mental Health Collaborative Projects
This resource highlights examples from across the country of collaborative and co-location models between primary care clinicians and mental health professionals. It also lists the contact names, address, and phone numbers for more information.

Health Plan Policies Fostering Co-location and Other Forms of Collaboration in the Care of Children With Mild to Moderate Mental Illness
This tool is a checklist of policies to consider in support of co-location and collaboration between primary care clinicians and mental health professionals.
Co-location of Mental Health Professionals in Primary Care Settings: Three North Carolina Models
Reprinted with permission from Sage Publications. This article describes 3 North Carolina practice models in which mental health professionals are co-located with pediatric primary care clinicians, and outlines how advocacy efforts can impact the success of co-location models.

Evidence-based Child and Adolescent Psychosocial Interventions Matrix
Reprinted with permission from the State of Hawaii, Department of Health, Child and Adolescent Mental Health Division. This tool was developed to guide teams (eg, youth, family, educators, and mental health practitioners) in developing appropriate plans using psychosocial interventions.
the warning signs project summary
strategies for system change in children's mental health: a chapter action kit

Reliable studies have shown that about 75-80% of children and adolescents with mental health treatment needs fail to be identified and to receive treatment. Stigma and lack of awareness about mental health concerns contribute significantly to the problem.

In January 2001, US Surgeon General David Satcher issued the “Call to Action” report on children’s mental health which discussed the urgent need to identify children with mental health treatment needs and to find effective ways to communicate to the public that certain behaviors in children warrant professional attention.

In response to the call to action, the Center for the Advancement of Children’s Mental Health at Columbia University created The Warning Signs Project, with support from the National Institute of Mental Health and the Center for Mental Health Services. The project is designed to give frontline clinicians, including pediatricians, the skills and tools needed to recognize early symptoms of mental disorders. The project is modeled after the “Seven Warning Signs of Cancer” – created as part of the war on cancer in the 1970s.

In developing the warning signs, those leading the project used rigorous research, Diagnostic and Statistics Manual (DSM) criteria, and focus group input from diverse groups of families, physicians, school professionals and youth. The warning signs are designed to be easily communicated and understood by persons with diverse backgrounds, training, and education. Although these warning signs appear to be on the severe end of the spectrum, they were designed to differentiate between behaviors that may be a part of normal adolescence. While one adolescent may be exhibiting behaviors that are a part of normal development, others may exhibit behaviors or actions that suggest that there is a mental health concern.

The following are the 11 warning signs:

- Feeling very sad or withdrawn for more than 2 weeks
- Trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involvement in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
• Drastic changes in your behavior or personality

The project also included the development of a toolkit with a variety of resources, materials and training guidelines for various stakeholders, including physicians, teachers, parents, advocacy organizations, and the media. The following tools are available for pediatric practices:

• A sample poster (copy attached);
• A list of the 11 warning signs (copy attached);
• Fact sheets for each warning sign for parents and youth;
• Self-adhesive stickers for use in a medical chart to guide doctors in asking youth and families about the presence of the warning signs (copy attached);
• Sample scripts on how best to use the warning signs in clinical settings;
• Sample scripts and guidelines on how best to discuss the warning signs and issues related to making a mental health referral with youth and families; and
• Materials to educate and inform families about mental illnesses when a child is identified as needing treatment or a referral.

This project promises to help address the public health reality that far too many children and adolescents with mental health treatment needs fail to be identified. The tools developed for the warning signs project, when used in pediatric offices, will help to open the door to broader communication between youth and families and between families and the pediatric office staff about mental health related concerns.

Using the project tools communicates to youth and families that pediatricians are concerned with all aspects of a patient’s health and well-being, including their mental health. It also alerts youth and families that the circumstances listed in the warning signs warrant action and provides pediatricians with tools on how best to discuss the warning signs and mental health related issues with youth and families.

Pediatricians interested in learning more about the Warning Signs project and/or those interested in obtaining the tools developed for this project should contact:

Peter S. Jensen, MD, e-mail: psjensenmd@gmail.com,

or

c/o the Center for the Advancement of Children’s Mental Health
341 West 87th Street
Suite 4F
New York, NY 10024
ACTION Signs: Your Youngster’s Behavioral Health Thermometers

Wouldn’t it be great if a thermometer could tell you if your child was not feeling well emotionally?

Just as a thermometer measures if your child has a temperature, these action signs will tell you if your child has an emotional problem. The signs indicate when your child may be in need of professional evaluation.

If you think that your child may have any of the following warning signs, tell your family physician. Take action and help your child feel better!

- Feeling very sad or withdrawn for more than 2 weeks
- Seriously trying to harm or kill him/herself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involved in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt him/her or others
- Not eating, throwing up, or using laxatives to make him/herself lose weight
- Intense worries or fears that get in the way of his/her daily activities
- Extreme difficulty in concentrating or staying still that puts him/her in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in his/her behavior or personality

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is being provided with the understanding that the authors are not engaged in rendering medical or other professional services. If medical advice or other expert assistance is required, the services of a competent professional should be sought.

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Action Signs for Helping Kids in Your Setting

*Your behavioral health is an important part of your physical health. If you are experiencing any of these feelings, let your doctor know. You are not alone...not 1 in a 1000, but 1 in 10, because many kids have similar problems! Getting help is what counts. Help is available, and treatments work! Don’t wait. Talk with a helpful adult, such as your family, doctor, school nurse or counselor, or religious leader, if you have one.*

- Feeling very sad or withdrawn for more than 2 weeks
- Seriously trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involvement in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in your behavior or personality
Sticker Example:

Warning Signs for Mental Health

Instructions: Use this sticker as a reminder to ask the child about the following behaviors; follow-up on positive responses. Refer to the expanded information sheet.

- Feeling very sad or withdrawn; 2 weeks or more
- Seriously trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with racing heart or fast breathing
- Involved in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in danger or causes school failure
- Repeated use of drugs and alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in your behavior or personality
The following is a list of key concepts and terms that are commonly used in the fields of mental health and substance abuse. Many of these terms have been defined by federal agencies, particularly the Substance Abuse and Mental Health Services Administration. This is not an exhaustive list, but it represents many of the concepts, services, and models of care that are used by mental health and substance abuse programs, services, and systems that serve children, adolescents, and their families.

Assessment
An assessment is a professional, comprehensive, and individualized review of child* and family needs that is conducted when services are first sought from a mental health professional (e.g., psychiatrist, psychologist, or social worker). The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behavior in the community. An assessment also evaluates the strengths and resources of the child and family. Any decisions about treatment and supports should be made by the family and mental health professional together.

Case management
Case management is a service that helps people arrange for appropriate services and supports (e.g., health, mental health, educational, vocational, transportation, respite care, and recreational). Case managers typically organize and coordinate services and supports for children with mental health problems and their families. While numerous case management models exist, case management can involve assessment of child and family needs, development of service plans, contact with service providers on a child or family’s behalf, and work with the child and/or family to facilitate access to needed services.

Co-location
Co-location is one strategy for integrating primary and behavioral health care services to address issues of access, quality, and fragmented delivery systems in children’s mental health. Generally, this term refers to models whereby mental health professionals are co-located within primary care settings, or primary care clinicians are co-located within mental health programs, typically public programs. In cases where primary care settings co-locate mental health professionals, examples of models include large co-located multispecialty group practices (e.g., behavioral care and primary care), community-governed nonprofit health centers, and traditional private primary care offices. In the latter, business arrangements may include an employee of a mental health agency who is “out-stationed” in the primary care office, a self-employed mental health professional who is renting or using space in the primary care office, or a mental health professional who is employed by the primary care practice. (See Resources for Further Information for information on co-location models in primary care settings.)

* For purposes of this Glossary, the term “child” is used to refer to children and adolescents from birth through 21 years of age.
Consumer
“Consumer” is the term used in the mental health system to describe a person who is a client or user of mental health services. This term embodies principles of self-determination, choice, and child/family-centered care—central to the recent movement toward “reform” or “transformation” of the public mental health system. Mental health consumers often convey these principles in the expression, “Nothing about us without us.”

Crisis residential treatment services
This term refers to short-term, 24-hour care provided in a nonhospital setting during a mental health crisis. For example, when a child becomes aggressive and uncontrollable, despite in-home supports, a parent can temporarily place the child in a crisis residential treatment service. This care is designed to avoid inpatient hospitalization, help stabilize the child, and determine the next appropriate step.

Cultural competence
Cultural competence refers to a set of congruent practice skills, attitudes, policies, and structures that come together in a system, in an agency, or among professionals and enable that system or those professionals to work effectively in cross-cultural situations. Cultural competency is the acceptance and respect for difference, continuing self-assessment regarding one’s own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources, and flexibility within service models to work toward better meeting the needs of diverse populations. These areas can be along the dimensions of race, ethnicity, gender, gender identity, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies.

Culturally competent organizations
Culturally competent organizations have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally. The organizations have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve. They incorporate these components into policy-making, administration, practice, service delivery, and systematically involve consumers, key stakeholders, and communities.

Day treatment
Day treatment includes special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy, lasting at least 4 hours a day. These programs work in conjunction with, and may be provided by, mental health, recreation, and education organizations.

Diagnostic evaluation
The goals of a diagnostic evaluation (general psychiatric evaluation) are (1) to establish a psychiatric diagnosis, (2) to collect data that are sufficient to permit a case formulation, and (3) to develop an initial treatment plan, with particular consideration of any immediate interventions that may be needed to ensure the patient's safety, or, if the
evaluation is a reassessment of a patient in long-term treatment, to revise the plan of treatment in accord with new perspectives gained from the evaluation.

**Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)**

The *DSM-IV* is the official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems. Insurance companies and health care providers also use the terms and explanations in this book when categorizing or describing mental health problems.

**Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version**

The *DSM-PC Child and Adolescent Version* provides a step-by-step guide for the primary care clinicians to help assess, diagnose, and refer mental health conditions. It includes symptom listings for simple, comprehensive diagnoses, mental/physical disorder differential diagnosis for psychosocial problems, enhanced communication between colleagues by DSM-IV compatibility, and easy-to-use charts, tables, and text.

**Dual diagnosis**

A person who has both an alcohol or drug problem and an emotional/psychiatric problem is said to have a dual diagnosis.

**Early intervention**

Early intervention is a process used to recognize mental, emotional, behavioral, and/or learning problems and to respond to factors that put individuals at risk of developing mental health problems before they become established and more difficult to treat. Early intervention can help children get better in less time and can prevent problems from developing or becoming worse. Early intervention processes use validated screening tools to identify children with or at risk for mental health problems; include consultation by trained professionals with parents, teachers, and other caregivers; and work with children in their natural environments to provide needed supports and guidance.

**Early Intervention (EI) program**

The Early Intervention program was created as a result of the Individuals with Disabilities Education Act (IDEA), originally passed by Congress in 1986. States subsequently passed legislation to support and operationalize the system. There are two separate EI programs for young children who have or are at risk of having a disability or other special need that may affect their development, health, or education: the Infant-Toddler program covers children from birth through age two; the Preschool program covers children from three to five (or until the child enters kindergarten). Primary responsibility for each of these programs is assigned to a lead agency; these assignments vary from state to state.

Children participating in the Infant-Toddler Program are eligible for such services as a multi-disciplinary evaluation, service coordination, individualized family service plan (IFSP), and an array of assistive and supportive services. Agencies may render a charge for some of these services, though services cannot be denied because of a family’s inability to pay. Children participating in the Preschool Program are entitled to free and
appropriate special education service in the least restrictive environment through the local school system. Services may include a multi-disciplinary evaluation, individualized education program (IEP), and an array of assistive and supportive services.

Emergency and crisis services
Crisis intervention services are used in emergency situations to provide immediate intervention or care when children are, or are at high risk of becoming, a danger to themselves or others, or are experiencing acute psychotic episodes or other emergency events (eg, suicide). Such services are available 24 hours a day, 7 days a week, and provide screening, psychiatric evaluation, emergency intervention and treatment, stabilization services, and referral to community services and resources. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams, and crisis respite care.

Evidence-based programs
Evidence-based programs incorporate significant and relevant practices based on scientifically based research that obtains reliable and valid knowledge by (1) employing systematic, empirical methods that draw on observation or experiment; (2) involving rigorous data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn; (3) relying on measurements or observational methods that provide reliable and valid data across evaluators and observers, across multiple measurements and observations, and across studies by the same or different investigators.

Evidence-based practices
These are practices that research has shown to produce consistently good outcomes and applicable across varied populations.

Family-centered care
Family-centered care means that families have a primary decision-making role in the care and education of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. The term typically is used when describing mental health systems of care. Family-driven care includes the following:

- Choosing supports, services, and providers
- Promoting the inclusion of current, innovative treatments and therapies
- Setting goals
- Designing and implementing programs
- Supporting the youth/consumer to guide care as appropriate
- Monitoring outcomes
- Determining the effectiveness of all efforts to promote the mental health of children and youth

Family self-help
Self-help groups are based on the premise that people who share a condition have similar concerns, or have a family member with a condition also share common experiences and, therefore, can help each other by providing information, as well as practical and emotional support. Self-help groups are peer led and range from small,
informal groups to well-organized national networks. Family-run organizations may include drop-in centers and case management, employment, housing, crisis, and family support programs.

**Family support services**
Family support services refer to help designed to keep the family together, while coping with the mental health problems that affect them. These services may include consumer information workshops, in-home supports, family therapy, parenting training, crisis services, and respite care.

**Inpatient hospitalization**
This term refers to intensive mental health treatment that is provided in a hospital setting 24 hours a day. Inpatient hospitalization provides (1) short-term treatment in cases where a child is in crisis and may be a danger to self or others and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

**Intake/Screening**
These services are designed to briefly assess the type and degree of a child’s mental health condition to determine whether services are needed and to link a child to the most appropriate and available service. Services may include interviews, psychological testing, physical examinations, including speech/hearing, and laboratory studies.

**Integrated care**
This term refers to a range of strategies and models to integrate primary and behavioral health care in to improve children’s access to mental health services and supports, reduce duplication and fragmentation of services, and improve the quality of care. These models can include, but are not limited to, the following:

- Initiatives to improve collaboration between independent, office-based primary care clinicians and mental health professionals (eg, referrals by primary care clinicians to mental health professionals);
- Embedding primary care clinicians within public mental health programs; comprehensive programs that offer primary and behavioral health care through one administrative entity;
- Co-location of behavioral health providers in primary care offices. (See Resources for Further Information for information on integrated care.)

**Linguistic competence**
Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a way that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competence involves policy, structures, practices, procedures, and dedicated resources, including the following:

- Bilingual/bicultural or multilingual/multicultural staff
- Sign language interpretation services
TTY and other assistive technology devices
Print materials in easy-to-read, low-literacy, picture and symbol formats

Mental health
Mental health is the state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.

Mental health parity
Mental health parity refers to providing the same insurance coverage for mental health treatment as that offered for medical and surgical treatments. The federal Mental Health Parity Act was passed in 1996 and established parity in lifetime benefit limits and annual limits. Many mental health advocates have recently substituted the term “equity” for parity.

Mental illness
Mental illness collectively refers to all mental disorders, defined as health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination) associated with distress and/or impaired functioning. Mental disorders feature abnormalities in cognition, emotion or mood, and the highest integrative aspects of human behavior, such as social interactions.

Mental health problems
This term refers to signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder.

Person-centered plan (PCP)
This term, or such similar terms as plan of care and plan of service, refers to a document that is developed through a process focused on and directed by the individual (consumer) and his or her family or advocate. It identifies the consumer’s desired outcomes and determines the supports and services needed to achieve the desired outcomes (Michigan Mental Health Code, 1995). In the case of child and adolescent consumers, the PCP is developed with input from the child, family, mental health professional(s), and representatives of involved agencies and schools. Many public mental health systems require development and documentation of such a plan and incorporate a review of the plan into periodic audits of service providers.

Residential treatment centers
Residential treatment centers provide services 24 hours a day for children with serious emotional disturbances who require constant supervision and care, and can usually serve more than 12 children at a time. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than inpatient hospitalization. Residential treatment centers also are known as therapeutic group homes. The primary purpose of residential treatment is to improve overall functioning, including social and behavioral skills, so the individual can function adequately in the community, either at home or independently.
**Respite care**

Respite care is a service that provides a break for families who have a child with a serious emotional disturbance. Trained parents or counselors take care of the child for a brief period of time to give families relief from the strain of caring for the child. This type of care can be provided in the home or in another location. These services may be offered to families on a periodic or routine basis.

**Screening**

Screening is a process used to inform parents and professionals about the physical, cognitive, and emotional strengths and needs of a child. It is designed to determine whether children may be at-risk of having behavioral or emotional conditions that warrant further review and/or intervention. Mental health screening is designed to identify social and emotional development needs in children as early as possible to prevent potential mental health problems from developing or worsening. Screening is conducted by an adequately trained professional (eg, health care provider, social worker, psychologist, or counselor) and uses objective, accurate, reliable, and validated instruments and methods. Screening does not result in definitive statements about a child’s problem nor does it draw a conclusion about a mental health disorder or diagnosis.

**Serious emotional disturbances**

Serious emotional disturbances are diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. Serious emotional disturbances may include depression, ADHD, anxiety, bipolar disorder, conduct disorder, eating disorders, or other conditions contributing to severe functional impairment.

**System of Care**

System of Care is an evidence-based approach to the care of children and adolescents with serious emotional disturbances and their families. It incorporates a broad array of services and supports that are organized into a coordinated network, integrate care planning and management across multiple levels, are culturally and linguistically competent, and build meaningful partnerships with families and youth at service delivery and policy levels. Guiding principles in a System of Care specify that services should be:

- Comprehensive, incorporating a broad array of services and supports
- Individualized
- Provided in the least restrictive, appropriate setting
- Coordinated both at the system and service delivery levels
- Involve families and youth as full partners
- Emphasize early identification and intervention

**Treatment**

Treatment is a type of service, support, or clinical intervention that is designed to address identified emotional, psychological, and social needs of a child and/or family. The term often refers to therapy and counseling that is repeated over a course of time, as determined by the child and/or family (depending on the age of the child) together with a service provider. Treatment includes, but is not limited to, hospitalization, partial hospitalization, outpatient services, evaluation, various psychotherapies, and medication monitoring.
Treatment plan
A treatment plan is a plan of care that is designed specially for each child and family, based on individual strengths and needs. Ideally, mental health professionals develop the plan with input from a child’s family. (See Person-centered plan.) The plan establishes goals and summarizes appropriate treatment and services to meet the special needs of the child and family.

Wrap-around services
Wrap-around services refer to a package of unique community services and natural supports that are flexible and tailored to meet the unique needs of children with serious emotional disturbances. Wrap-around services are based on a definable planning process and are designed for children and their families to achieve a positive set of outcomes in the home setting. Services are provided by multidisciplinary teams that may include case managers, psychiatrists, nurses, social workers, vocational specialists, substance abuse specialists, community workers, and family members or caregivers.

Resources for Further Information

Koyangi C, Carty L. Get it together: how to integrate physical and mental health care for people with serious mental disorders. Washington, DC: Bazelon Center for Mental Health Law; 2004


Abuse and Mental Health Service Administration, National Mental Health Information Center, Center for Mental Health Services. Available at: http://mentalhealth.samhsa.gov/publications/allpubs/Ca-0005/default.asp Accessed April 3, 2007


commonly reported codes for primary care clinicians and mental health professionals

PROCEDURE CODES (CPT)
Physician Services:
Office or other outpatient services 99201-99215
Office or other outpatient consultations 99241-99245
Prolonged physician services 99354-99359
Case management services 99361-99362 & 99371-99373
Central nervous system assessments/tests 96110(screening); 96111(testing)

Modifier 25: Must be appended to the evaluation and management (E/M) code if 96110 or 96111 is reported at that same visit.

Non-physician Services:
Health & behavior assessment/intervention 96150-96155
Education & training for patient self-management 98960-98962

DIAGNOSIS CODES (ICD-9-CM)
Before a mental health condition is diagnosed, do not use “rule out” codes as the diagnosis. Use as many diagnosis codes that apply to document the patient’s complexity and report the patient’s symptoms and/or adverse environmental circumstances. Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses. Counseling diagnosis codes can be used when patient is present or when counseling the parent/guardian(s) when the patient is not physically present. The most correct coding accurately describes the condition requiring the service.

“V” codes are used to report circumstances other than a disease or injury and are recorded as “diagnoses” or “problems.” If appropriate, a numeric ICD-9-CM code should be reported before V codes are reported.

NOTE: ICD-9-CM codes in the 290-319 range are located in the “Mental Disorders” chapter of the nomenclature and, as such, payers’ claims adjudication systems may reject use of such codes when linked to E/M CPT codes.

ABUSE
303.00 Alcohol intoxication
305.00 Alcohol abuse; unspecified
305.20 Cannabis abuse; unspecified
305.70 Amphetamine abuse
305.90 Other, mixed, or unspecified drug abuse (drug/substance abuse/polysubstance abuse)
969.9 Psychotropic agents overdose (E855.9 accidental; E950.3 intentional)
989.89 Glue sniffing (E950.9 intentional)
995.51 Child abuse, emotional/psychological
995.52 Child maltreatment syndrome; child neglect (nutritional)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>V15.41</td>
<td>Physical abuse, history of (child/physical/sexual abuse/rape)</td>
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<tr>
<td>V15.42</td>
<td>Emotional abuse, history of</td>
</tr>
<tr>
<td>V61.22</td>
<td>Counsel perpetrator parental child abuse</td>
</tr>
<tr>
<td>V61.11</td>
<td>Counsel victim spousal abuse</td>
</tr>
<tr>
<td>V61.41</td>
<td>Alcohol abuse, family history of</td>
</tr>
</tbody>
</table>

**ANXIETY**

<table>
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<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tr>
<td>300.00</td>
<td>Anxiety state, unspecified</td>
</tr>
<tr>
<td>300.01</td>
<td>Panic disorder (panic attack)</td>
</tr>
<tr>
<td>300.20</td>
<td>Phobia, unspecified</td>
</tr>
<tr>
<td>300.23</td>
<td>Social phobia</td>
</tr>
<tr>
<td>307.59</td>
<td>Other and unspecified disorders of eating; loss of appetite of nonorganic</td>
</tr>
<tr>
<td></td>
<td>origin (feeding disorder of infancy or early childhood)</td>
</tr>
<tr>
<td>307.6</td>
<td>Enuresis</td>
</tr>
<tr>
<td>307.7</td>
<td>Encopresis</td>
</tr>
<tr>
<td>308.0</td>
<td>Acute reaction to stress; predominant disturbance of emotions</td>
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<tr>
<td>309.21</td>
<td>Separation anxiety disorder</td>
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<tr>
<td>309.24</td>
<td>Adjustment reaction with anxious mood</td>
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<tr>
<td>309.3</td>
<td>Adjustment disorder with disturbance of conduct</td>
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<tr>
<td>309.81</td>
<td>Posttraumatic stress disorder</td>
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<tr>
<td>309.89</td>
<td>Adjustment disorder, other (homesickness)</td>
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<tr>
<td>780.59</td>
<td>Sleep disturbances; other</td>
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<tr>
<td>786.05</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>789.00</td>
<td>Abdominal pain; unspecified site</td>
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<tr>
<td>V15.49</td>
<td>Other personal history presenting hazards to health; psychological trauma</td>
</tr>
<tr>
<td></td>
<td>(history of psychological trauma)</td>
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<tr>
<td>V40.2</td>
<td>Mental and behavioral problems; anxiety problem</td>
</tr>
<tr>
<td>V62.82</td>
<td>Bereavement, uncomplicated</td>
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<tr>
<td>V62.89</td>
<td>Other psychological or physical stress, not elsewhere classified</td>
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<tr>
<td>V79.0</td>
<td>Special screening for depression</td>
</tr>
</tbody>
</table>

**DEPRESSION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.20</td>
<td>Major depressive disorder, single episode; unspecified</td>
</tr>
<tr>
<td>300.11</td>
<td>Conversion disorder (hysteria, conversion reaction)</td>
</tr>
<tr>
<td>300.4</td>
<td>Neurotic depression; anxiety depression, dysthymic disorder (depression</td>
</tr>
<tr>
<td></td>
<td>with anxiety)</td>
</tr>
<tr>
<td>300.9</td>
<td>Self-mutilation (suicide attempt/risk)</td>
</tr>
<tr>
<td>309.0</td>
<td>Brief depressive reaction; adjustment disorder with depressed mood</td>
</tr>
<tr>
<td>V40.2</td>
<td>Mental and behavioral problems; depression</td>
</tr>
<tr>
<td>V62.82</td>
<td>Bereavement, uncomplicated</td>
</tr>
<tr>
<td>V62.89</td>
<td>Other psychological or physical stress, not elsewhere classified</td>
</tr>
<tr>
<td>V79.0</td>
<td>Special screening for depression</td>
</tr>
</tbody>
</table>

**EATING DISORDERS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>307.1</td>
<td>Anorexia nervosa</td>
</tr>
<tr>
<td>307.50</td>
<td>Eating disorder, unspecified</td>
</tr>
<tr>
<td>307.51</td>
<td>Bulimia nervosa</td>
</tr>
</tbody>
</table>

**LEARNING/DEVELOPMENTAL/ATTENTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>299.80</td>
<td>Asperger syndrome</td>
</tr>
<tr>
<td>299.00</td>
<td>Autistic disorder, current</td>
</tr>
<tr>
<td></td>
<td>or active</td>
</tr>
</tbody>
</table>
314.00  Attention deficit disorder, without mention of hyperactivity
314.01  Attention deficit disorder, with mention of hyperactivity
315.00  Reading disorder, unspecified
315.1  Mathematics disorder
315.2  Other specific learning difficulties (disorder of written expression)
315.32  Mixed receptive-expressive language disorder
315.39  Developmental speech or language disorder; other (developmental speech delay/articulation disorder)
315.4  Developmental coordination disorder (clumsiness syndrome)
315.9  Unspecified delay in development (learning disorder unspecified/NOS)
319  Mental retardation, unspecified
783.42  Late talking or late walking (delay in developmental milestones)
784.5  Other speech disturbance (speech articulation disorder/speech disturbance)

V40.0  Problems with learning
V40.1  Problems with communication (including speech)
V40.9  Unspecified mental or behavioral problem
V65.49  Other specified counseling
V79.3  Special screening for developmental delays in childhood
V79.9  Unspecified mental disorder and developmental handicap

OTHER CONDITIONS/DISORDERS
300.3  Obsessive-compulsive disorder
300.81  Somatization disorder
307.20  Tic disorder, unspecified
307.23  Tourette syndrome
307.3  Repetitive movements (head banging/spasmus nutans)
312.10  Temper tantrums
312.81  Conduct disorder, childhood onset type
312.82  Conduct disorder, adolescent onset type
313.81  Oppositional defiant disorder
NOTE: This resource contains comprehensive listings of codes that may not be utilized by your practice on a regular basis. We recommend that you identify the codes most relevant to your practice and include those on your encounter form/billing sheet.

CPT (Procedure) Codes
Initial assessment usually involves a lot of time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most pediatricians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor* or a consultation code for the initial assessment:

Office or Other Outpatient Service Codes
99201/99202/99203/99204/99205: Use for new** patients only; require 3 of 3 key components or greater than 50 % of the visit spent in counseling or coordinating care.

99212/99213/99214/99215: Use for established patients; require 2 of 3 key components or greater than 50 % of the visit spent in counseling or coordinating care.

Office or Other Outpatient Consultation Codes
99241/99242/99243/99244/99245: Use for new or established patients; appropriate to report if another physician or other appropriate source (ie, school nurse, psychologist) requests an opinion regarding a patient. Require 3 of 3 key components or greater than 50 % of the visit spent in counseling or coordinating care.

NOTE: Use of these codes requires the following:
  a) Written or verbal request for consultation is documented in the patient chart.
  b) Consultant’s opinion as well as any services ordered or rendered are documented in the patient chart.
  c) Consultant’s opinion and any services that are performed are prepared in a written report, which is sent to the requesting physician or other appropriate source.

Prolonged Physician Services Codes
99354/99355 Use for outpatient face-to-face prolonged services.
99358/99359 Use for non-face-to-face prolonged services in any setting.

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- Can only be reported in conjunction with codes that contain “typical times” as part of their descriptors (eg, 99201-99215, 99241-99245).
- Time spent does not have to be continuous.
- Codes are “add-on” codes, meaning they are reported separately in addition to the appropriate code for the service provided (eg, office or other outpatient E/M codes, 99201-99215).

*Time can be used as the key factor in determining a level of service when counseling and/or coordinating care constitute more than 50% of the encounter.

**A new patient is defined as one who has not received any professional services from a physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years. (Principles of CPT Coding (second edition), American Medical Association, 2001).
• If the physician spends at least 30 and no more than 74 minutes over the typical time associated with the reported E/M code, he/she can report 99354 (for face-to-face contact) or 99358 (for non-face-to-face contact). Codes 99355 (each additional 30 minutes of face-to-face prolonged service) and 99359 (each additional 30 minutes of non-face-to-face prolonged service) are used to report each additional 30 minutes of service beyond the first 74 minutes.
• Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is not reported separately.

Case Management Services Codes
99361/99362: Use to report a medical conference between the physician and an interdisciplinary team of health professionals to coordinate activities of patient care (patient not present).

99371/99372/99373: Use to report telephone calls made by the physician to patient/parent or for consultation or medical management or for coordinating medical management with other health care professionals.

Central Nervous System Assessments/Tests Codes
96110: Use to report limited developmental testing with interpretation and report (eg, Early Language Milestone Screen).
96111: Use to report extended developmental testing with interpretation and report (eg, Woodcock-Johnson Test).

NOTE: For mini-mental status examination performed by a physician, see evaluation and management codes.

Health and Behavior Assessment/Intervention Codes
96150/96151: Use to report health behavior assessment/re-assessment.
96152/96153/96154/96155: Use to report health behavior intervention (individual/group/family).

• Used to report services provided by non-physician providers. If physicians provide these services, report evaluation and management codes.
• Primary purpose is not psychiatric diagnosis but rather as a way for non-physician providers (eg, psychologists, social workers, nurses) to report behavioral assessments and/or interventions with patients who have medical (not psychiatric) illness.
• Health behavior assessment/intervention procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.
• Describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient’s health status.
• These services do not represent preventive medicine counseling and risk factor reduction interventions.
• These services are offered to patients who present with established illness or symptoms, who are not diagnosed with mental illness, and may benefit from evaluations that focus on the biopsychosocial factors related to the patient’s physical health status.
• Focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.
• Focus of the intervention is to improve the patient’s health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.
• For patients who require psychiatric services as well as health behavior assessment/intervention on the same date of service, report the predominant service provided; do not report these codes in conjunction with psychiatric codes 90801-90899.
• Cannot be reported on the same date of service as evaluation and management codes.

**Education and Training for Patient Self-Management Codes***

98960: Use to report education and training for patient self-management to an individual patient.

98961/98962: Use to report education and training for patient self-management to a group of patients.

• Used to report services provided by non-physician providers. If physicians provide these services, report evaluation and management codes or 99078.
• Used to report educational and training services prescribed by a physician and provided by a qualified, non-physician healthcare professional using a standardized curriculum for treatment of established illness(s)/disease(s) or to delay co-morbidity(s).
• Standardized curriculum must be used in order to report these codes but can be modified as necessary for the clinical needs, cultural norms, and health literacy of the patient(s).
• For health and behavior assessment/intervention that is not part of a standardized curriculum, see codes 96105-96155.
• Purpose is to teach the patient/caregiver how to effectively self-manage the patient’s illness(s)/disease(s) or delay disease comorbidity(s) in conjunction with the patient’s professional healthcare team.
• Education and training related to subsequent reinforcement or due to changes in the patient’s condition or treatment plan are reported in the same manner as the original education and training.
• The type of education and training provided for the patient’s clinical condition will be identified by the appropriate diagnosis code(s) reported.
• The qualifications of the non-physician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, non-physician healthcare professional society/association, or other appropriate source.

*The Education and Training for Patient Self-Management codes are new for 2006 and have an effective date of January 1, 2006. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that “the version of the medical data code sets specified in the implementation specifications must be the version that is valid at the time the health care is furnished.” This means that HIPAA covered entities must start recognizing the new codes as of January 1, 2006. However, physicians should contact their carriers regarding coverage for the new codes.
ICD-9-CM (Diagnosis) Codes

- Before a mental health condition is diagnosed, do not use “rule out” codes as the diagnosis. Use as many diagnosis codes that apply to document the patient’s complexity and report the patient’s symptoms and/or adverse environmental circumstances.
- Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses.
- Counseling diagnosis codes can be used when patient is present or when counseling the parent/guardian(s) when the patient is not physically present.
- “V” codes are used to deal with occasions when circumstances other than a disease or injury are recorded as “diagnoses” or “problems.” While some carriers may request supporting documentation for the reporting of V codes, others may not pay for them at all. In the latter case, a numeric ICD-9-CM code must be listed as the primary diagnosis.
- NOTE: ICD-9-CM codes in the 290-319 range are located in the “Mental Disorders” chapter of the nomenclature and, as such, payors’ claims adjudication systems may reject use of such codes when linked to E/M CPT codes.

ABUSE

303.90  Alcohol dependence
303.00  Alcohol intoxication
304.6  Inhalant dependence/phencyclidine dependence
304.20  Cocaine dependence
304.30  Cannabis dependence
304.40  Amphetamine dependence
304.80  Polysubstance dependence
304.90  Drug dependence
305.00  Alcohol abuse; unspecified
305.20  Cannabis abuse; unspecified
305.30  Hallucinogen abuse; unspecified
305.60  Cocaine abuse; unspecified
305.70  Amphetamine abuse
305.90  Other, mixed, or unspecified drug abuse (drug/substance abuse/polysubstance abuse)
760.71  Noxious influences affecting fetus or newborn via placenta or breast milk; alcohol
760.72  Noxious influences affecting fetus or newborn via placenta or breast milk; narcotics
760.75  Noxious influences affecting fetus or newborn via placenta or breast milk; cocaine
969.9  Psychotropic agents overdose (E855.9 accidental; E950.3 intentional)
977.9  Drug overdose, unspecified (E858.9 accidental; E950.4 intentional)
989.89  Glue sniffing (E950.9 intentional)
995.51  Child abuse, emotional/psychological
995.52  Child maltreatment syndrome; child neglect (nutritional)
995.53  Child maltreatment syndrome; child sexual abuse
995.54  Child maltreatment syndrome; child physical abuse
V15.41  Physical abuse, history of (child/physical/sexual abuse/rape)
V15.42 Emotional abuse, history of
V61.22 Counsel perpetrator parental child abuse
V61.83 Counsel perpetrator sexual abuse
V61.12 Counsel perpetrator spousal abuse
V61.21 Counsel victim child abuse
V61.11 Counsel victim spousal abuse
V61.41 Alcohol abuse, family history of

ANXIETY
293.84 Organic anxiety syndrome
300.00 Anxiety state, unspecified
300.01 Panic disorder (panic attack)
300.02 Generalized anxiety disorder
300.09 Other neurotic disorders
300.20 Phobia, unspecified
300.21 Agoraphobia with panic attacks
300.22 Agoraphobia without mention of panic attacks
300.23 Social phobia
300.29 Other isolated or simple phobias
300.4 Neurotic depression; anxiety depression
300.5 Neurasthenia
300.7 Hypochondriasis
300.10 Hysterical reaction
306.4 Cyclical vomiting
306.1 Hyperventilation syndrome
307.54 Psychogenic vomiting
307.59 Other and unspecified disorders of eating; loss of appetite of non-organic origin (feeding disorder of infancy or early childhood)
307.6 Enuresis
307.7 Encopresis
307.80 Psychogenic pain, site unspecified
307.81 Tension headache
307.89 Other psychalgia
307.9 Other and unspecified special symptoms or syndromes, NEC; behavior activities
308.0 Acute reaction to stress; predominant disturbance of emotions
308.1 Acute reaction to stress; predominant disturbance of consciousness
308.2 Acute reaction to stress; predominant psychomotor disturbance
308.3 Other acute reactions to stress
308.4 Mixed disorders as a reaction to stress
308.9 Unspecified acute reaction to stress
309.21 Separation anxiety disorder
309.24 Adjustment reaction with anxious mood
309.28 Adjustment reaction with mixed emotional features; anxiety and depression
309.81 Posttraumatic stress disorder
698.4 Dermatitis factitia
780.59 Sleep disturbances; other
780.95 Other excessive crying of child, adolescent, or adult
780.99 Other general symptoms
786.01 Hyperventilation
786.05 Shortness of breath
787.01 Nausea with vomiting
787.02 Nausea alone
787.1 Heartburn
787.3 Flatulence, eructation, and gas pain
787.91 Diarrhea
787.99 Other symptoms involving digestive system
789.00 Abdominal pain; unspecified site
799.2 Nervousness
V15.49 Other personal history presenting hazards to health; psychological trauma
    (history of psychological trauma)
V40.2 Mental and behavioral problems; anxiety problem
V65.49 Other specified counseling; anxious variation
V69.5 Problems related to lifestyle; behavioral insomnia of childhood

DEPRESSION
296.20 Major depressive disorder, single episode; unspecified
296.21 Major depressive disorder, single episode; mild
296.22 Major depressive disorder, single episode; moderate
296.23 Major depressive disorder, single episode; severe, without mention of
    psychotic behavior
296.24 Major depressive disorder, single episode; severe, specified as with
    psychotic behavior
296.25 Major depressive disorder, single episode; in partial or unspecified
    remission
296.26 Major depressive disorder, single episode; in full remission
296.30 Major depressive disorder, recurrent episode; unspecified
296.31 Major depressive disorder, recurrent episode; mild
296.32 Major depressive disorder, recurrent episode; moderate
296.33 Major depressive disorder, recurrent episode; severe, without mention of
    psychotic behavior
296.34 Major depressive disorder, recurrent episode; severe, specified as with
    psychotic behavior
296.35 Major depressive disorder, recurrent episode; in partial or unspecified
    remission
296.36 Major depressive disorder, recurrent episode; in full remission
296.80 Manic-depressive psychosis, unspecified
298.0 Depressive type psychosis
300.11 Conversion disorder (hysteria, conversion reaction)
300.4 Neurotic depression; anxiety depression, dysthymic disorder (depression
    with anxiety)
300.5 Neurasthenia
300.9 Self-mutilation (suicide attempt/risk)
301.12 Chronic depressive personality disorder
307.59 Other and unspecified disorders of eating; loss of appetite of non-organic
    origin
307.6 Enuresis, non-organic
307.7 Encopresis, non-organic
307.80 Psychogenic pain, site unspecified
307.81 Tension headache
307.89 Other psychalgia
307.9 Other and unspecified special symptoms or syndromes, NEC; behavior
    activities
308.0 Acute reaction to stress; predominant disturbance of emotions
308.1 Acute reaction to stress; predominant disturbance of consciousness
308.2 Acute reaction to stress; predominant psychomotor disturbance
308.3 Other acute reactions to stress
308.4 Mixed disorders as a reaction to stress
308.9 Unspecified acute reaction to stress
309.0 Brief depressive reaction; adjustment disorder with depressed mood
309.1 Prolonged depressive reaction
309.21 Separation anxiety disorder; anaclitic depression
309.28 Reaction with mixed emotional features; anxiety and depression
311 Depressive disorder, not elsewhere classified
313.1 Misery and unhappiness disorder
780.59 Sleep disturbances; other
780.79 Other malaise and fatigue
780.95 Other excessive crying of child, adolescent, or adult
780.99 Other general symptoms
787.99 Other symptoms involving digestive system
789.00 Abdominal pain; unspecified site
V15.49 Other personal history presenting hazards to health; psychological trauma
V40.2 Mental and behavioral problems; depression
V62.82 Bereavement, uncomplicated
V62.84 Suicidal ideation
V62.89 Other psychological or physical stress, not elsewhere classified
V65.49 Other specified counseling; depression variation
V69.5 Problems related to lifestyle; behavioral insomnia of childhood
V79.0 Special screening for depression

EATING DISORDERS
307.1 Anorexia nervosa
307.50 Eating disorder, unspecified (atypical)
307.51 Bulimia nervosa
307.52 Pica
307.53 Rumination disorder
307.54 Psychogenic vomiting
307.59 Other and unspecified disorders of eating (feeding disorder of infancy or early childhood/infantile feeding disturbances of non-organic origin/loss of appetite of non-organic origin)

FAMILY/ENVIRONMENT
V60.0 Lack of housing
V60.1 Inadequate housing
V60.2 Inadequate material resources
V60.8 Other specified housing or economic circumstances
V61.10 Counsel marital/partner problem
V61.20 Counseling for parent-child problem, unspecified
V61.29 Parent-child problems; other (foster care)
V61.49 Health problems with family; other
V61.8 Health problems within family; other specified family circumstances (mental disorder of parent/substance abusing parent)
V61.9 Health problems within family; unspecified family circumstances
V62.0 Other psychosocial circumstances; unemployment
V62.3  Other psychosocial circumstances; educational circumstances (illiteracy of parent)
V62.4  Other psychosocial circumstances; social maladjustment (cultural deprivation/language barrier)
V62.5  Other psychosocial circumstances; legal circumstances
V62.81  Interpersonal problems, NEC
V62.89  Other psychological or physical stress, not elsewhere classified; other (domestic violence)
V65.2  Malingering

LEARNING/DEVELOPMENTAL
299.80  Asperger syndrome
299.00  Autistic disorder, current or active
307.0  Stuttering
307.46  Sleep arousal disorder (night terrors/sleepwalking)
307.9  Other and unspecified special symptoms or syndromes, NEC (masturbation, nail biting, thumb sucking)
309.0  Adjustment disorder with depressed mood (grief reaction)
309.22  Adjustment disorder, adolescent
309.3  Adjustment disorder with disturbance of conduct
309.3  Adjustment reaction; with predominant disturbance of conduct
309.89  Adjustment disorder, other (homesickness)
309.82  Adjustment disorder with physical symptoms
312.00  Undersocialized conduct disorder, aggressive type; unspecified
312.30  Impulse control disorder, unspecified
312.81  Conduct disorder, childhood onset type
312.82  Conduct disorder, adolescent onset type
312.9  Unspecified disturbance of conduct
313.22  Introverted/withdrawal disorder
313.81  Oppositional defiant disorder
313.83  Academic underachievement disorder
314.00  Attention deficit disorder, without mention of hyperactivity
314.01  Attention deficit disorder, with mention of hyperactivity
314.1  Hyperkinesis with developmental delay
314.2  Hyperkinetic conduct disorder
314.8  Other specified manifestations of hyperkinetic syndrome
314.9  Unspecified hyperkinetic syndrome
315.00  Reading disorder, unspecified
315.01  Alexia
315.02  Developmental dyslexia
315.09  Specific reading disorder; other (spelling difficulty)
315.1  Mathematics disorder
315.2  Other specific learning difficulties (disorder of written expression)
315.31  Expressive language disorder
315.32  Mixed receptive-expressive language disorder
315.39  Developmental speech or language disorder; other (developmental speech delay/articulation development disorder)
315.4  Developmental coordination disorder (clumsiness syndrome)
315.5  Mixed developmental disorder
315.8  Other specified delay in development
315.9  Unspecified delay in development (learning disorder unspecified/NOS)
317  Mental retardation, mild, IQ 50-70
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>319</td>
<td>Mental retardation, unspecified</td>
</tr>
<tr>
<td>781.3</td>
<td>Lack of coordination (graphomotor disorder/dysgraphia)</td>
</tr>
<tr>
<td>783.40</td>
<td>Unspecified lack of or inadequate physiological development</td>
</tr>
<tr>
<td>783.41</td>
<td>Failure to thrive</td>
</tr>
<tr>
<td>783.42</td>
<td>Late talking or late walking (delay in developmental milestones)</td>
</tr>
<tr>
<td>783.43</td>
<td>Short stature</td>
</tr>
<tr>
<td>784.5</td>
<td>Other speech disturbance (speech articulation disorder/speech disturbance)</td>
</tr>
<tr>
<td>784.61</td>
<td>Dyslexia</td>
</tr>
<tr>
<td>V11.9</td>
<td>Mental disorder, history of</td>
</tr>
<tr>
<td>V40.0</td>
<td>Problems with learning</td>
</tr>
<tr>
<td>V40.1</td>
<td>Problems with communication (including speech)</td>
</tr>
<tr>
<td>V40.3</td>
<td>Mental and behavioral problems; other behavioral problems (hyperactive/impulsive behavior problem/inattention problem)</td>
</tr>
<tr>
<td>V40.9</td>
<td>Unspecified mental or behavioral problem</td>
</tr>
<tr>
<td>V62.89</td>
<td>Other psychological or physical stress NEC; other</td>
</tr>
<tr>
<td>V62.9</td>
<td>Unspecified psychosocial circumstance</td>
</tr>
<tr>
<td>V65.49</td>
<td>Other specified counseling</td>
</tr>
<tr>
<td>V69.1</td>
<td>Problems related to lifestyle; inappropriate diet and eating habits</td>
</tr>
<tr>
<td>V69.5</td>
<td>Problems related to lifestyle; behavioral insomnia of childhood</td>
</tr>
<tr>
<td>V71.02</td>
<td>Observation for suspected mental condition; childhood or adolescent antisocial behavior (negative emotional behavior problem/oppositional aggressive problem)</td>
</tr>
<tr>
<td>V71.09</td>
<td>Observation for suspected mental condition</td>
</tr>
<tr>
<td>V77.0</td>
<td>Special screening for thyroid disorders</td>
</tr>
<tr>
<td>V79.2</td>
<td>Special screening for mental retardation</td>
</tr>
<tr>
<td>V79.3</td>
<td>Special screening for developmental delays in childhood</td>
</tr>
<tr>
<td>V79.9</td>
<td>Unspecified mental disorder and developmental handicap</td>
</tr>
<tr>
<td>V80.0</td>
<td>Special screening for neurological condition</td>
</tr>
<tr>
<td>V82.5</td>
<td>Special screening for lead poisoning</td>
</tr>
</tbody>
</table>

**OTHER CONDITIONS/DISORDERS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>300.3</td>
<td>Obsessive-compulsive disorder</td>
</tr>
<tr>
<td>301.9</td>
<td>Personality disorder</td>
</tr>
<tr>
<td>302.70</td>
<td>Psychosexual dysfunction</td>
</tr>
<tr>
<td>302.6</td>
<td>Psychosexual identity disorder</td>
</tr>
<tr>
<td>299.90</td>
<td>Psychosis/schizophrenia of childhood</td>
</tr>
<tr>
<td>307.3</td>
<td>Repetitive movements (head banging/spasmus nutans)</td>
</tr>
<tr>
<td>302.9</td>
<td>Sexual deviation</td>
</tr>
<tr>
<td>313.21</td>
<td>Shyness disorder, childhood</td>
</tr>
<tr>
<td>300.81</td>
<td>Somatization disorder</td>
</tr>
<tr>
<td>312.10</td>
<td>Temper tantrums</td>
</tr>
<tr>
<td>307.21</td>
<td>Tic disorder, transient</td>
</tr>
<tr>
<td>307.20</td>
<td>Tic disorder, unspecified</td>
</tr>
<tr>
<td>307.23</td>
<td>Tourette syndrome</td>
</tr>
<tr>
<td>760.77</td>
<td>Noxious influences affecting fetus or newborn via placenta or breast milk; anticonvulsants</td>
</tr>
</tbody>
</table>
I. CODING

Developmental screening, surveillance, and assessment are often complemented by the use of special tests, which vary in length. This Coding Fact Sheet provides guidance on how pediatricians can appropriately report limited and extended developmental screening and testing services.

A. How To Report Developmental Testing

96110 Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

The use of developmental screening instruments of a limited nature (eg, Developmental Screening Test II, Early Language Milestone Screen, PEDS, Ages and Stages, and Vanderbilt ADHD rating scales) is reported using CPT code 96110 (developmental testing; limited). Code 96110 is often reported when performed in the context of preventive medicine services, but may also be reported when screening is performed with other evaluation and management (E/M) services such as acute illness or follow-up office visits. On the 2005 Medicare Fee Schedule (Resource-Based Relative Value Scale or RBRVS), the Centers for Medicare and Medicaid Services (CMS) published a total relative value unit (RVU) of 0.36 for 96110, which amounts to a Medicare payment of $13.64 (0.36 x $37.8975 {Medicare 2005 conversion factor} = $13.64). Because an office nurse or other trained non-physician personnel typically performs the service, this relative value reflects only the practice expense of the office staff and nurses, the cost of the materials, and professional liability -- there is no physician work value published on the Medicare physician fee schedule for this code.

On the less common occasion where a physician performs this service, it may still be reported with code 96110 but the time and effort to perform the testing itself should not count toward the key components (history, physical exam, and medical decision making) or time when selecting an E/M code for a significant, separately identifiable service performed during the same patient encounter. When a limited screening test is performed along with any E/M service (eg, preventive medicine or office outpatient), both services should be reported and modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

96111 Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report

Extended developmental testing using standardized instruments (eg, Bayley Scales of Infant Development, Woodcock-Johnson Tests of Cognitive Abilities (Third Edition) and Clinical Evaluation of Language Fundamentals (Fourth Edition) are reported using CPT
code 96111. This service may be reported independently or in conjunction with another code describing a separate patient encounter provided on the same day as the testing (eg, an evaluation and management code for outpatient consultation). A physician or other trained professional typically performs this testing service. Therefore, there are physician work RVUs published on the Medicare physician fee schedule (Resource-Based Relative Value Scale or RBRVS) for this code. In 2005, code 96111 has 3.83 total RVUs, which calculates to a Medicare payment of $145.15 (3.83 x $37.8975 (Medicare 2005 conversion factor) = $145.15).

When 96111 is reported in conjunction with an E/M service, the time and effort to perform the developmental testing itself should not count toward the key components (history, physical exam, and medical decision making) or time for selecting the accompanying E/M code. Just as discussed for 96110, if the E/M code is reported with 96111, modifier –25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be appended to the E/M code or modifier –59 (distinct procedural service) should be appended to the developmental testing code, showing that the services were separate and necessary at the same visit.

In 2005, the CPT code descriptor of 96111 was revised to reflect the deletion of the test examples as well as the "per hour" designation. Thus, starting January 1, 2005, physicians will report the service without regard to time. The typical testing session, including the time to perform the interpretation and report, was found in the American Academy of Pediatrics (AAP) survey used to value the service to be slightly over an hour.

B. When To Report Developmental Testing

96110

The frequency of reporting 96110 is dependent on the clinical situation. The AAP “Recommendations for Preventive Pediatric Health Care” schedule recommends developmental/behavioral assessment at each preventive medicine visit, and the AAP “Developmental Surveillance and Screening of Infants and Young Children” policy statement recommends that physicians use validated developmental screening tools to improve detection of problems at the earliest possible age to allow further developmental assessment and appropriate early intervention services.

Thus, the use of screening tests of a limited nature seems to enhance the task of developmental assessment typically done in the preventive medicine setting. The exact frequency of testing therefore depends on the clinical setting and the provider’s judgement as to when it is medically necessary. When physicians ask questions about development as part of the general informal developmental survey or history, this is not a "test" as such, and is not separately reportable. Examples of validated limited screening tests along with clinical vignettes are provided below.

96111

Longer, more comprehensive developmental assessments of patients suspected of having problems are typically reported using CPT code 96111 (developmental testing; extended). These tests are typically performed by physicians or psychologists and
require upwards of an hour of time. They also are accompanied by an interpretation and formal report, which may be completed at a time other than when the patient is present.

Like code 96110, the frequency of reporting code 96111 is dependent on the needs of the patient and the judgment of the physician. When developmental surveillance or screening suggests an abnormality in a particular area of development, more extensive formal objective testing is needed to evaluate the concern. In contrast to adults, the limited ability of children to maintain focused selective attention and testing speed may mean that several sessions are needed to properly evaluate the problem. Code 96111 is reported only once the testing and its accompanying report are completed.

Additionally, subsequent periodic formal testing may be needed to monitor the progress of a child whose skills initially may have not been “significantly low,” but who was clearly at risk for maintaining appropriate acquisition of new skills.

II. CLINICAL VIGNETTES

96110 Vignette #1
At a 24-month well child check, the mother describes her toddler as "wild," completes the PEDS (Parent Evaluation of Developmental Status), and responds positively to the question "Do you have concerns about your child’s language skills?" The nurse scores the PEDS and places the answer sheet on the front of the chart with a red arrow sticker next to it. When the pediatrician examines the child, he is alerted to ask the mother about her observations of the child’s language ability. He then confirms the delay in language, and makes a referral to a local speech pathologist.

CPT
99392-25 Preventive medicine service; established patient, age 1-4 (appended with modifier –25)  
96110 Developmental testing; limited

ICD-9-CM
V20.2 Routine infant or child health check
315.31 Expressive language disorder

If the pediatrician spent significant extra time evaluating the language problem, then an E/M service office/outpatient code from the 99201-99215 series may be reported using a modifier –25, linked to the appropriate ICD-9-CM code(s) as appropriate (eg, 315.31, Expressive language disorder; 315.32, Mixed receptive-expressive language disorder; 315.39, Other developmental speech or language disorder).

96110 Vignette #2
At a five-year health maintenance visit, a father discusses his daughter’s difficulty “getting along with other little girls.” “Doctor, she wants friends, but she doesn’t know how to make — much less keep — a friend.” Further questioning indicates the little girl is already reading and writing postcards to relatives, but has not learned how to ride her small bicycle, is awkward when she runs and she avoids the climbing apparatus at the playground. Her father wondered if her weaker gross motor skills affected her ability to play successfully with other children. She seems very happy to sit and look at books about butterflies — her all consuming interest! The child’s physical exam consistently fell in the range of ‘normal for age’ in previously health maintenance visits. The pediatrician asks her nurse to administer the Australian Scale for Asperger’s Syndrome
and the father’s responses yield 16/24 items with an abnormal score being >3. The pediatrician reviews the form, writes a brief summary, and discusses her observations with the father. A referral is made to a local physical therapist who has a playground activities group and to a local psychologist who has expertise in diagnosing autism spectrum disorders.

CPT 99393-25 Preventive medicine service; established patient, age 5-11 (appended with modifier –25)
ICD-9-CM V20.2 Routine infant or child health check

96110 Developmental testing; limited
ICD-9-CM V20.2 Routine infant or child health check
315.4 Developmental coordination disorder
313.9 Unspecified emotional disturbance of childhood

96111 Vignette #1
An eight-year-old boy with impulsive, overly active behavior and previously assessed “average” intelligence is referred for evaluation of attention deficit disorder. He has by prior history reading and written expression skills at first grade level, and received speech and language therapy during his attendance at Head Start when he was four years old.

Behavior and emotional regulation rating scales completed by the parent and teacher were reviewed at an earlier evaluation and management service appointment. History, physical and neurological examination were also completed at that visit.

On this visit, standardized testing was administered to confirm auditory and visual attention, short term and working memory as well as verbal and visual organization. Testing was administered for standard scores as well as structured observations of behavior. These scores and observations were integrated into a formal report to be used to individualize his education and treatment plan. Testing and the report took approximately 75 minutes. The family schedules a follow up visit to discuss this report and the final diagnosis and treatment plan with the physician.

CPT 96111 Developmental testing; extended
ICD-9-CM 314.0x Attention deficit disorder
x = 0 for no hyperactivity
x = 1 for hyperactivity

96111 Vignette #2
A 5 4/12 year old boy just beginning kindergarten whose mother’s responses on the Pediatric Evaluation of Developmental Status (PEDS) suggested expressive language delays was seen for developmental testing. After greeting the parent and child and explaining to the child that he and the doctor would do some ‘non-school’ activities to see how he ‘used words to tell others about (his) good ideas’, the child and the examiner spent fifty minutes together completing the tasks on the Peabody Picture Vocabulary Test-Third Edition, and the Clinical Evaluation of Language Fundamentals-Fourth Edition. The examiner scored the two tests in five minutes and there was a significant discrepancy detected between the Receptive Language Composite and the Expressive
Composite on the CELF-4. Both test scores were abnormal, indicating a mixed receptive–expressive disorder.

**CPT**

96111  Developmental testing; extended

**ICD-9-CM**

315.32  Mixed receptive expressive language disorder

### III. DOCUMENTATION GUIDELINES

Each administered developmental screening and testing instrument is accompanied by an interpretation and report (eg, a score or designation as normal or abnormal). This is often included in the test itself, but these elements may alternatively be documented in the progress report of the visit itself. Physicians are encouraged to document any interventions based on abnormal findings generated by the tests.

Following are examples of appropriate documentation for some testing tools:

**96110**

PEDS (Parents' Evaluation of Developmental Status)

This questionnaire is designed to identify any parent/primary caretaker’s concerns about a birth through eight-year child’s developmental attainment and behavioral/mental health concerns. There are eight specific domain queries and one asking, “please list any concerns about your child’s learning, development and behavior” and a final “please list any other concerns.” The parent answers are scored into the risk categories of high, moderate, or low. The report form is included with the test.

**ASQ (AGES AND STAGES Questionnaire)**

This parent report instrument, covering ages 1 month through 60 months, includes objective information as the adult notes whether the child performs the skill identified. There are six questions in each of five domains: Communication, Gross Motor, Fine Motor, Problem Solving and Personal-Social. All questions are scored on a point system, with summary scores indicating the need for further evaluation. The ASQ also has a non-specific comprehensive section where general concerns are addressed. No score is provided for these answers, but the instrument developers note any “Yes” responses should also be referred.

**96111**

In general, the documentation of developmental testing includes the scoring, interpretation, and the development of the report. This typically includes all or some of the following: identifying data, time and location of testing, the reason for the type of testing being done, and the titles of all instruments offered to/completed by the child; presence (if any) of additional persons during testing, child’s level of cooperation and observations of child’s behavior during the testing session. Any assistive technology, prosthetics or modifications made to accommodate the child’s particular developmental or physical needs should be described, and specific notations should be made if any items offered resulted in a change in the child’s level of attention, willingness to participate, apparent ease of task accomplishment. The item results should be scored and the test protocol and any/all scoring sheets should be included in the medical chart (computer scanning may be needed for electronic medical records).
interpretation should be recorded and notation should be made for further evaluation or treatment of the patient or family. A legible signature should also appear.

IV. SAMPLE TESTING TOOLS

96110
Ages and Stages Questionnaire-Second Edition (ASQ) and Ages and States Questionnaire: Social-Emotional (ASQ:SE) (Brookes Publishing: Jane Squires, PhD and Diane Bricker, PhD, et. al)

Australian Scale for Asperger’s Syndrome (ASAS) (Michelle Garnett, Master’s Clinical Psychology and Anthony Attwood, PhD)


Behavioral Rating Inventory of Executive Functioning (BRIEF) (Psychological Assessment Resources, Inc.: Gerald Gioia, PhD, Kimberly Espy, PhD, and Peter Isquith, PhD)

Child Development Review (Behavior Science Systems, Inc.: Harold Iretan, PhD, et. al.)

Communication and Symbolic Scales Developmental Profile (CSBS DP) (Brookes Publishing: Amy Wetherby, PhD, CCC-SLP, Barry M. Prizant, PhD, CCC-SLP)

Kaufman Brief Intelligence Test (American Guidance Service: Alan Kaufman and Nadeen Kaufman)

Parents’ Evaluation of Developmental Status (PEDS) (Ellsworth and Vandermeer Press, LLC: Frances Page Glascoe, PhD)

Pediatric Symptom Checklist: A Primary Care Screening Tool to Identify Psychosocial Problems (PSC) (http:psc.partners.org: Michael Jellinek, MD, and J. Michael Murphy, PhD)

Vanderbilt Rating Scales (Mark L. Wolraich, MD)

96111
Beery-Buktenica Developmental Test of Visual-Motor Integration-Fourth Edition, Revised (VMI) (Modern Curriculum Press: Keith E. Beery, PhD)

Clinical Evaluation of Language Fundamentals-Fourth Edition (The Psychological Corporation: Eleanor Semel, PhD, CCC-SLP, Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD, CCC-SLP)

Clinical Evaluation of Language Fundamentals-Preschool Version-Second Edition (Psychological Corporation: Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD, CCC-SLP, and Eleanor Semel, PhD, CCC-SLP)
Comprehensive Test of Nonverbal Intelligence (Pro-Ed: Donald Hammill, Nils Pearson, and J. Lee Wiederholt)

Developmental Test of Visual Perception-Second Edition (Pro-Ed: Donald Hammill, Nils Pearson, Judith Voress)


Test of Auditory-Perceptual Skills-Revised (Psychological and Educational Publications: Morrison Gardner)

Test of Language Competence-Expanded Edition (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

Test of Nonverbal Intelligence-Third Edition (Pro-Ed Publishing: Linda Brown, Rita Sherbenou, Susan Johmsen)

Test of Problem Solving-Revised (LinguiSystems, Inc: Linda Zachman, Rosemary Huisingh, Mark Barrett, Jane Orman, Carolyn LoGiudice)

Test of Word Knowledge (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

Woodcock-Johnson Test of Cognitive Abilities-Third Edition (Riverside Publishing: Richard W. Woodcock, PhD, Kevin S. McGrew, PhD, and Nancy Mather, PhD)
collaborative models survey sample letter

strategies for system change in children’s mental health: a chapter action kit

(place on chapter or practice letterhead)

Date

Dear name of collaborative partner:

The name of the chapter is working to provide primary care clinicians with the tools and skills they need to identify, triage, refer, and/or manage behavioral health conditions. We believe that a critical component of effective behavioral health practice in primary care is collaboration with mental health and substance use/abuse professionals.

To this end, we need your help in defining effective collaboration between primary care clinicians and behavioral health professionals and in describing the role you envision for your own professional discipline in such a collaborative relationship. We thought the best approach would be to ask you what a successful collaborative model would look like and the types of barriers you often face.

We truly value your feedback and hope that you will take the time to complete and return the attached survey by date via e-mail or by mailing it to the following address:

Address

Thank you for your time and commitment. Please feel free to contact name of contact person at phone number or e-mail address if you have any questions.

Sincerely,
collaborative model survey template

strategies for system change in children’s mental health: a chapter action kit

Name (optional):
Street Address (optional):
City: State:
Work Phone (optional):
Alternate Phone (optional):

Credentials:
Zip Code:

Your discipline/primary area of practice (Check all that apply.)
☐ Nurse Practitioner With Behavioral Health Expertise
☐ Psychopharmacologist
☐ School Psychologist
☐ School Social Worker
☐ Child and Adolescent Psychiatrist
☐ Child and Adolescent Clinical Psychologist
☐ Master’s-level Psychologist
☐ Licensed Counselor
☐ Licensed Clinical Social Worker
☐ Marriage and Family Therapist
☐ Substance Abuse Counselor
☐ Other Pediatric Behavioral Health Care Provider (please specify):
☐ Community Nonprofit Organization
☐ Faith-based Organization
☐ Federal or State Agency
☐ Private Practice
☐ Other setting (please specify):

Medical professionals with whom you currently collaborate
☐ General Pediatrician(s)
☐ Developmental-Behavioral Pediatrician(s)
☐ Other Pediatric Subspecialist(s) (please specify):
☐ Family Physician(s)
☐ Neurologist(s)
☐ Nurse Practitioner(s)
☐ Physician Assistant(s)
☐ Nurse(s)
☐ Adult Psychiatrist(s)
☐ Child and Adolescent Psychiatrist(s)
☐ Other Pediatric Health Care Providers (please specify):

Medical professionals with whom you would ideally collaborate
☐ General Pediatrician(s)
☐ Developmental-Behavioral Pediatrician(s)
☐ Other Pediatric Subspecialist(s) (please specify):
☐ Family Physician(s)
☐ Neurologist(s)
☐ Nurse Practitioner(s)
☐ Physician Assistant(s)
☐ Nurse(s)
☐ Adult Psychiatrist(s)
☐ Child & Adolescent Psychiatrist(s)
☐ Other Pediatric Health Care Providers (please specify):
What would you like collaborating medical professionals to know about your professional discipline or area of practice?

List the top 3 barriers to communication and collaboration with medical professionals:

1.
2.
3.

List your suggestions for breaking through each of these barriers to increase communication and collaboration with medical professionals:

1.
2.
3.

What are some common terms that are used in your field or practice that are often misunderstood?

Describe any collaborative models you believe to be successful. (Please provide a link if a description of this model is available via the Internet.)

Other suggestions to promote collaboration between medical professionals and behavioral health professionals:
Please note that the list of projects that follow was compiled from a number of sources, including American Academy of Pediatrics (AAP) chapter presidents, vice presidents, executive directors, Pediatrics for the 21st Century symposium presenters, AAP mental health e-mail list participants, AAP Task Force on Mental Health members, AAP Council on Community Pediatrics Rural Health Special Interest Group members, Bright Futures members, and others. The list is not exhaustive.

As this Chapter Action Kit is also available electronically, it will be updated as information changes and/or is provided to us. If you are aware of any collaborative projects that you would like us to consider including in this list, please e-mail us at mentalhealth@aap.org.

ALABAMA

Mental Health Project
Statewide - AL

Description: The chapter’s Mental Health Project has evolved into a very active, multidisciplinary, statewide effort to increase the number of children screened and referred for mental health services. Within a short period of time, the Mental Health Project Advisory Committee was formed, and developed a questionnaire to survey primary care clinicians on their attitudes regarding the availability of mental health services for children. The committee also planned and implemented a series of educational dinner meetings that were being held at 4 different regions across the state. The sessions consist of 1-hour presentations by child and adolescent psychiatrists and 1 hour of roundtable discussion between pediatricians and mental health professionals. Attendance at these continuing medical education (CME) dinners has been very good, with more than 250 people attending the first 2 meetings. As a result of the project, many resource tools have been developed, including 4 regional mental health directories and standardized referral/follow-up forms to improve communication between pediatricians and child/adolescent psychiatrists.

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**ARIZONA**

**Indian Health Service Telehealth Program**  
*Flagstaff, AZ*

**Description:**
- Active clinical telehealth experience in Indian Health Service (IHS) and Tribal facilities across the country
- Leading clinical applications are radiology, dermatology, psychiatry, retinal screening, and cardiology
- Experience with over 30 different types of clinical telehealth
- Emerging capability in home telehealth, chronic illness care, telepharmacy, rehabilitative services, eICU®, and other services
- Focuses on business modeling, infrastructure development, and collaborations
- Innovative uses of new media for distance learning and training

The tools of telehealth care can improve access to care and chronic illness care management for patients, families, and communities. Innovation in clinical service delivery also offers opportunities for enhancements in quality and cost efficiency.

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**Contact Phone:** 928/214-3920

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**Tuba City Indian Medical Center**  
*Tuba City, AZ*

**Description:** In 2000, a pediatrician member of the Medical Staff and Information Technology Department at the Tuba City Indian Medical Center became interested in telemedicine applications in our remote setting in northeast Arizona. The Arizona Telemedicine program through the University of Arizona (U of A) had been established several years earlier and was interested in expanding its network into rural areas.

Because of staff shortages in mental health that disproportionately affected children and adolescents with emotional and behavioral concerns, we worked toward establishing a Telemedicine link with the U of A Department of Child and Adolescent Psychiatry. Our links were set up at both of our local high schools (a public high school and a former Bureau of Indian Affairs high school that is now a charter school but continues to offer boarding to students who come from even more remote settings). In a unique manner, the schools are tele-connected with the hospital via a wireless radio system. The hospital employs a DS3 connection with the Arizona Telemedicine network.

The local high schools were eager to participate in the proposed telemedicine program. After meetings with Parent Advisory groups, counselors, and school administrators, a
consent form was developed and a standard protocol for student referral was established. Collaborative agreements between the schools and the hospital already existed because of a thriving School-based Health Program sponsored by the Pediatrics, Family Medicine, and Midwifery Departments.

We have been providing in-school telemedicine mental health services on a continual basis for the last 4 school years. The primary provider from University of Arizona is a PhD psychologist, and the Adolescent and Child Psychiatry division director acts as a liaison for more difficult cases or those requiring medication management problems. The Director of Adolescent Health Services oversees all students who do require medication with selective serotonin reuptake inhibitors, but these tend to be the minority of patients seen. We currently provide a total of 6 hours of telepsychiatry per week, a number that is often insufficient to meet need/demand and are exploring other options. The psychologist primarily engages the students in cognitive behavioral therapy. She sees the entire gamut of diagnoses. Our largest area of fallout is student’s who are in need of urgent care. These students get referred to the emergency department at our hospital and are handled by the members of our Mental Health Department at the Tuba City Indian Medical Center.

Web Address:  http://www.ihs.gov/NonMedicalPrograms/DFEE/telemed/index.cfm
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CALIFORNIA

Fresno Healthy Steps Pediatrics: Child Development Training
Fresno, CA

Description: Healthy Steps (http://www.healthysteps.org/) is an innovative, evidence-based approach to primary health care for young children that support mothers and fathers in their role as nurturers of the emotional, behavioral, and intellectual growth of their children. Healthy Steps adds a new member to the primary care faculty team, the Healthy Steps Specialist (HSS), an expert in child development. Healthy Steps services to families include enhanced well child care, home visits, a child development telephone information line, developmental and psychosocial screening, written informational materials, parent groups, linkages to community resources, and literacy promotion through Reach Out and Read. We have shown a 26% reduction in severe and harsh punishment with toddlers, a 24% increase in breastfeeding, a 50% increase in reading to babies, and a 34% decrease in premature water and solid food feeding of babies.

Fresno Healthy Steps not only provides services to children from birth to 5 years of age and their families, but also effective training for primary care residents. The HSS teaches residents normal child development through structured experiential and didactic sessions. At the core of the Healthy Steps training the HSS precepts residents with their patients, including both office well child examinations with the focus on normal child
development, as well as joint home visits with high-risk children. Using the Ages & Stages Questionnaires Child Monitoring System (http://www.agesandstages.com/), residents provide the highest quality developmental screening while improving their child development skills. Residents have shown significant improvement in practice behaviors and knowledge as measured by a beginning- and end-of-year survey and rate Healthy Steps as #1 among all the developmental and behavioral training experiences.

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The Children’s Clinic (TCC), Serving Children and Their Families
Long Beach, CA

Description: The Children’s Clinic (TCC), Serving Children and Their Families, is continuing work to incorporate mental health services into its scope of practice. Community needs assessments and surveys of our patients indicated this is a service that is sorely needed by the population the clinic serves. The Children’s Clinic hired 3 master’s-level social workers to assist in screening for mental illness and referring to community providers; however, there are several barriers that patients face in accessing mental health services, including stigma, lack of insurance, language/cultural barriers, insufficient funding, limited number of mental health professionals with long waiting lists, and lack of communication between health care and mental health professionals. The Children’s Clinic held a meeting with several local mental health professionals to explore these issues and develop collaborative relationships. Memorandums of understanding were developed to facilitate mental health referrals. One agency, Pacific Clinics, volunteered to co-locate therapists on-site at TCC to provide mental health counseling to pediatric patients at a place that is familiar to them and is without stigma. The referral relationships and co-located services allowed patients to access appropriate mental health services. The Children’s Clinic Social Services Manager is participating in various work groups, councils, and coalitions that focus on mental health to ensure that TCC is aware of the local issues in mental health care and to advocate for the needs of TCC’s patient population. This has resulted in a relationship with Los Angeles County Department of Mental Health, which eventually will allow TCC access to county funding streams for the provision of mental health services.
COLORADO

Project CLIMB (Consultation Liaison in Mental Health and Behavior)
Child Health Clinic and The Children’s Hospital
Denver, Colorado

Project CLIMB infuses comprehensive mental health services into a high-volume inner-city primary care residency training clinic and enhances the capacity of primary care clinicians to identify and treat common mental health concerns in children. The intervention involves co-location of mental health clinicians – child psychiatrist (1), child psychologist (1), and trainees including psychiatry fellows, postdoctoral fellows in childhood anxiety and in infant mental health, psychology interns, and psychology graduate students - in the primary care training clinic. CLIMB clinicians are present daily during continuity care clinics and provide on-site services to pediatric providers, children, and their families.

The program includes the following components:

- Healthy Steps for Young Children implementation to enhance developmental services in pediatric primary care settings; delivered during well-child visit.
- Developmental, socio-emotional and postpartum depression screening at well-child checks using validated tools (e.g., Ages and Stages Questionnaire; Edinburgh)
- Resident training using multimedia toolkit, didactics in clinic, noon conference and other venues, and case collaboration.
- Precepting residents and clinical trainees during their continuity care clinics in order to provide consultation and intervention as needed; consultation available from child psychiatry fellows and a psychology intern.
- Direct services for children and their families: psychopharmacology clinics, postpartum depression groups, psycho-educational groups for parents and children, clinic-based individual treatment, liaison to outside mental health services, and outpatient treatment.
- An evaluation component to assess impact of our intervention on family satisfaction and improvement in pediatric resident’s attitude, knowledge, skill, and proficiency in providing basic developmental and mental health services.
• Systems building and integration through consultation, collaboration, and outreach with state and local agencies/partners invested in providing comprehensive care to pediatric populations.

This project is funded by Rose Community Foundation, HealthONE Foundation, and the American Academy of Child and Adolescent Psychiatry.

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FLORIDA

Duval County Community Clinics
Jacksonville, FL

Description: This model consists of a pediatric psychiatrist who works in collaboration with pediatricians and pediatric residents in the Duval County Health Department community clinics. The collaboration began in July 2003 with the hiring of a pediatric psychiatrist by the Duval County Health Department and the University of Florida Department of Pediatrics. The purpose of the collaboration is to train pediatricians and pediatric residents in the diagnosis and treatment of behavioral and mental health problems. The pediatric psychiatrist initially spent half a day, every 2 weeks, in 7 community clinics. The collaboration involves the psychiatrist and the pediatrician or resident seeing patients together and discussing diagnosis and treatment. Previously seen patients also might be discussed, as well as any other questions the pediatrician might have relating to mental health problems. The pediatricians were educated about the diagnostic criteria for mental health disorders in childhood and the appropriate interventions for these disorders, including the use of psychotropic medications. The success of this model has been dependent on the pediatricians’ interests in expanding their practices to include mental health problems. After 2 years, the pediatric psychiatrist continues to work in collaboration in 4 of the 7 community clinics and is available for consultation for all pediatricians within this health system. There has been a documented increase in mental health diagnoses in each of the community clinics since implementation of this model. Future plans include an expansion of the training of pediatric residents in mental health, and elaboration of the collaborative model.

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ILLINOIS

Social/Emotional Screening and Referral
Multiple Cities throughout IL

Description: This project aims to improve the delivery and financing of preventive health and developmental services for children from birth to 3 years of age. The project goals will be reached by offering educational programs, including office-based presentations for primary care clinicians, allied health care professionals, and their office staff. It aims to increase medical professionals' knowledge of social and emotional development, including the use of screening tools to recognize the early signs of delay and facilitate discussion with families and caregivers on social/emotional health and how this can impact the child's long-term development. It is also a desire to increase providers' awareness of community referral resources. By helping to provide health care professionals with a range of strategies they can implement to most effectively provide comprehensive, developmentally oriented health care. The program provides an overview of social/emotional development and teaches how to incorporate screening and referral procedures, for social, emotional and developmental growth into the practice setting. Resource binders are distributed to each practice, along with ideas for how to disseminate the binder's contents appropriately and efficiently. The content is offered at basic to intermediate levels, in an attempt to reach the knowledge of all staff/faculty of the clinic/practice.

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Children’s Hospital of Illinois at OSF Saint Francis Medical Center
Peoria, IL

Description: This project addresses the unmet mental health needs of children in central Illinois through the development of a coordinated system of care, which incorporates:

- Routine screening for behavioral/mental health problems into general pediatric practices
- Increased training on the diagnosis and treatment of depression to pediatric primary care clinicians (pediatricians and nurse practitioners)
• Primary care-linked case coordination and educational services for patients and families
• Increased collaborative associations between mental health professionals and pediatricians

The initial focus is on the identification of depression in children and adolescents and piloting academic detail training of the pediatricians and nurse practitioner in a medical school-based primary care practice. Individual case coordination, parent/family education, and psychiatric backup to the pediatric primary care clinicians will be provided by a centralized resource center called Resource Link™, which is supported by community collaborative efforts. The project is funded by a 3-year grant from the Illinois Children’s Healthcare Foundation. The program will secure other funding for long-term sustainability by the third year. Provided the project is successful, the model will expand with regard to the number of patients served, encompassing a more broad age range. Over time, it is probable that the project will expand to address a more broad range of mental health issues. It is anticipated that a 3-year analysis of program and client outcomes will demonstrate the effectiveness of an interdisciplinary, interagency team working collaboratively to reduce the significant community burden from childhood depression.

_Treating Child and Adolescent Depression in Primary Care_

Through this project, the Illinois AAP Chapter and Children’s Hospital of Illinois at OSF Saint Francis Medical Center developed a 90-minute office-based training that covers the screening, diagnosis, and treatment of depression in children and adolescents. The training content is tailored to meet the specific needs of the primary care physician practice. However, in general the following topics are covered:

• Prevalence of depression among children and adolescents
• _Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)_ diagnostic criteria for depression and differentiating depressive symptoms in adults from those in children and adolescents
• Instructions for incorporating depression screening into the primary care practice by utilizing the Center for Epidemiological Studies Depression Scale for Children.
• A review of evidence-based treatments for depression
• An overview of common medications for treating depression in children and adolescents. This includes a discussion of the Food and Drug Administration’s (FDA’s) black box warning and call for close monitoring
• Question-and-answer session during which practice staff may ask questions about specific medications, disorders, or patients

The training is presented onsite at the primary care practice and it is recommended that as many practice staff as possible attend, including physicians, nurse practitioners, nurses, and office staff. This enables the practice to discuss specific staff roles with regard to the screening and treatment of depression. The format is modular so that it can be completed all at once or broken into 3 half-hour modules. At the conclusion of the training, the practice receives a manual that includes current research articles focusing on child and adolescent depression, case vignettes, informational handouts for parents, a guide for billing for depression screening, a list of Web sites for more information about child and adolescent mental health and tools such as a consent to release health and mental health-related information, the CES-DC screening for depression, and a progress
report form to assist with communication between the counseling provider and the physician.

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**IOWA**

**Healthy Mental Development Health Provider Education Initiative**
*Statewide - IA*

**Description:** There are 4 modules (4 hours) for physicians, nurse practitioners, physician assistants, and nurses that include

- Healthy Mental Development of Young Children in Iowa
- Clinical Implementation of Surveillance for Development; Social, Emotional and Behavioral Health; and Family Risk Factors
- Clinical Implementation of Screening in 4 Domains: Development; Social, Emotional and Behavioral Development; PDD/Autism, and Parental Risk Factors
- Developing Community Partnerships for Referral and Systems Development

For department supervisors, nurse and/or office managers, coders and billing personnel there is one module (1 hour) that includes Office Implementation of the Guidelines.

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**KENTUCKY**

**Prevention and Awareness of Teen Hardships and Suicide**
*Statewide - KY*

**Description:** The Prevention and Awareness of Teen Hardships and Suicide (P.A.T.H.S.) grant has been successfully completed. Kentucky Pediatric Society conducted 5 P.A.T.H.S. events in Northern Kentucky, Barren River, Purchase District, and Lake Cumberland. More than 150 child health providers attended the statewide trainings. Nearly 70% report, as a result of this training, that they will apply the knowledge gained in current work situations and share their handouts and other information with colleagues. In addition, more than 80% of participants rated the workshops and programs or presentations; the organizations include the Kentucky School Counselors Association, the Kentucky School Nurses Association, Jefferson...
County Public Schools, and representatives from the Kentucky Telehealth Network. In an effort to provide ongoing education to child health providers about the prevention of teen suicide in Kentucky, selected materials created for the P.A.T.H.S. program will be posted on the Kentucky Pediatric Society Web site.

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MAINE

Kennebec Pediatrics: From Infancy to Independence  
Augusta, ME

Description: Children with behavioral and/or learning problems have special needs that require additional help and support. Parents, teachers and care providers have to work through many challenges to help children with special needs achieve success. This program model enables families of children with disruptive behavior disorders to access services and care coordination through the primary care clinicians.

Kennebec Pediatrics Cares Program (KP Cares) provides outreach to families to help them consistently follow through on their treatment plans in school and home settings, reduce crises, and improve school performance and social functioning. KP Cares enhances continuity and quality of care for children with behavior disorders by:

- Creating a primary care team to provide supportive services to the child's family and school
- Adding the family perspective directly to team deliberations
- Coordinating more effectively with the child's therapeutic behavioral health support
- Creating a database that contains key information on patients for the team's ongoing work with the child and family and for evaluation of the program

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MARYLAND

D-TECKT
Baltimore, MD

Description: The D-TECKT (Developmental Troubleshooter’s Eclectic Checklist for Kids and Teens) is a template developed by the Maryland Chapter AAP Committee on Emotional Health. The D-TECKT is designed to assist pediatric clinicians in systematically considering what underlying conditions may be contributing to behavior problems in children and adolescents. The D-TECKT is a checklist that is divided into Intrinsic Factors (biomedical, normal development, temperament, and child psychopathology) and Extrinsic Factors (situational, parenting difficulty, communication problems, family dynamics issues, and parental psychopathology). By referring to the checklist, the clinician can develop a differential diagnosis of what issues are contributing to the presenting behavior problem. The clinician can then develop primary care intervention strategies that directly address the underlying problems. The D-TECKT was published in the August 2005 issue of Contemporary Pediatrics. A working copy of the checklist also can be provided for evaluation. The D-TECKT has been presented at pediatric grand rounds at several medical centers in Baltimore, and has been integrated into the behavioral pediatrics rotation at University of Maryland.

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Mental Health Training for Pediatric Residents
Baltimore, MD

Description: An experiential mental health curriculum is being developed for residents in the Johns Hopkins pediatric residency-training program. Residents will work closely with several licensed mental health professionals in 2 settings: the Harriet Lane Clinic (an urban primary care resident continuity clinic) and a community child and adolescent mental health center. The 2-week experience will occur during the 4-week required community and advocacy rotation in the PL-3 year. The content and format of the 2-week experience is guided by a baseline Web-based needs assessment. The objectives for the experience fall within the 6 core competencies of residency training and include the following:

- To recognize and manage common mental health problems and emergencies in patients and families
• To recognize the impact of psychiatric dysfunction and psychosocial distress on youth and families
• To understand the complex system of care for children and families with mental health problems and become familiar with community-based resources
• To communicate effectively with mental health professionals to facilitate effective referral for the diagnosis and treatment of mental health problems in children and adolescents

The curriculum will include didactic, small group, and one-on-one teaching with participating faculty and staff in the Harriet Lane Clinic and the community mental health center.

**MASSACHUSETTS**

**Cambridge Health Alliance - Healthy Tomorrows**

*Cambridge, MA*

**Description:** In 2004, the Cambridge Health Alliance (CHA) began the Healthy Tomorrows project in its pediatric clinics. This collaborative model of practice includes mental health screening using the Pediatric Symptom Checklist (PSC) and co-location of a clinical social worker (LICSW), supervised by a child psychiatrist. To date, more than 2,000 children have been screened and 180 previously unrecognized children have been identified as needing mental health support. Key elements for success include a collaborative management team that represents psychiatry and pediatrics, planning and monitoring the model, adequate reimbursement, and buy-in from practitioners. Funding from the Healthy Tomorrows Partnership for Children helped catalyze the project and provided start-up funding for the LICSW. The multifaceted evaluation examined impediments to progress, changes in the number of identified children, the relationship of PSC score to demographic variables, provider satisfaction, and cost–effectiveness. Key findings include an 80% increase in identification and referral of children with mental health issues and a significant relationship between PSC score and insurance status. The project also has proven to be cost efficient, with the LICSW salary covered by revenue. The numerous benefits of this model include increased access, improved referral processes, and increased provider satisfaction. The model also increased awareness of mental health issues in pediatric practice, decreased stigma for families, and improved communication between pediatrics and psychiatry. We are spreading the model to a second site because it has proven highly sustainable. Additionally, we are incorporating the PSC into the electronic medical record, which will allow spread throughout CHA’s 11 pediatric sites.

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The Massachusetts Child Psychiatry Access Project (MCPAP)
Statewide - MA

The Massachusetts Child Psychiatry Access Project (MCPAP) is aimed at assisting pediatric primary care clinicians to effectively respond to mental health concerns in primary care. Statewide, 6 mental health teams have been developed. Each team includes child psychiatrists, therapists, and a care coordinator, and is led by child psychiatry divisions of academic medical centers, including Baystate Medical Center, Massachusetts General Hospital, McLean Hospital, University of Massachusetts Medical Center, North Shore Medical Center, New England Medical Center, and the Children’s Hospital of Boston. The goal of each team is to have all the pediatric and family physician primary care clinicians in their area who see children or adolescents enrolled in the project. Once enrolled and oriented to the project, primary care clinicians may have access to a number of services for their patients, including telephone consultation, psychiatric/diagnostic evaluation, care coordination to assist in finding available mental health providers, brief psychotherapy, and local educational programming. Funding comes from the Department of Mental Health. The program is open to all children and adolescents regardless of insurance status. Design and administration is under the leadership of Dr. John H. Straus at the Massachusetts Behavioral Health Partnership which is the state Medicaid behavioral health managed care vendor. Child psychiatrists Barry Sarvet and Joe Gold are the program medical directors.

As of the end of August 2007, the MCPAP project has successfully formed teams in all 6 regions of the state, providing mental health support for 92% of the 1.5 million children and adolescents in the population. Satisfaction surveys of PCPs report that, because of MCPAP, they are now able to meet the psychiatric needs of children and adolescents in their practices.

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MINNESOTA

CentraCare Integrative Behavioral HealthCare Initiative
St Cloud, MN

Description:
CentraCare Health System in partnership with BlueCross BlueShield of Minnesota and the Medica Health Foundation has launched an initiative that will integrate behavioral health services and primary care in all of the primary care clinics throughout the health system, including pediatrics, family medicine, obstetrics and gynecology, and internal medicine. The initiative calls for mental health screening at all well visits across the age span, incorporating the use of electronic tablets and Web-based electronic platforms for screening. Each clinic will have a licensed mental health professional to conduct crisis mental health assessments and provide patient education, case management, and consultation on-site. In addition, child and adolescent psychiatrists and adult psychiatrists will provide scheduled consultations to primary care clinicians, and weekly emergency psychiatric appointments will be available for patients who are seen by the primary care clinic-based mental health professional or who are currently being treated by the primary care clinician. Treatment and management protocols are being developed for depression, anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), eating disorders, and substance abuse, which will guide the primary care physician in the ongoing management of the condition, such as how often to follow up, what to do at the follow-up appointments, and how to appropriately monitor for safety and treatment effectiveness.

BlueCross BlueShield has agreed to pay for mental health screening, the clinic-based mental health crisis assessments, and physician–to-physician consultation. CentraCare and BlueCross BlueShield have committed to evaluating outcomes and cost over the next 3 years. Other health plans are being approached to support the integrative model as well. The state of Minnesota has passed legislation that calls for psychiatrists to primary care physician consultation to be reimbursed for Medicaid patients. Efforts are underway in the state to expand this reimbursement for all health plans as well.

The CentraCare Integrative Behavioral HealthCare Initiative is a model that has evolved from 3 specific efforts by St Cloud Hospital and CentraCare Clinics to improve access to children's mental health care and the quality of the mental health care received. These past efforts have included co-location of child and adolescent psychiatry and primary care pediatrics with ongoing open access for informal consultation; a school-based integrative care model and outreach effort that has involved a school-based mental health professional conducting crisis triage mental health assessments and referring high-acuity students to emergency child psychiatric appointments; and, finally, multiple community and professional education efforts to provide opportunities to increase awareness and practical clinical understanding of diagnosis, treatment, and management of common children's mental health problems. These initial efforts have shown that children attending school and receiving care in the areas with access to these services had a reduced utilization of high-cost inpatient adolescent psychiatric hospitalizations and, ultimately, had access to care much faster.

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NEW YORK

Comprehensive Family Care Center
Bronx, NY

Description: In a federally qualified community health center in the Bronx, two programs have been implemented to address the mental health and well being of families and young children: a screening and consultation program and a Healthy Steps for Young Children program.

The first program, implemented in March 2005, consists of the co-location of an infant/toddler psychologist (24 hours weekly) within a pediatric practice to address the social-emotional and developmental needs of children from birth to 3 years of age via screening, consultation, and direct service. The model was implemented with funds provided by the New York City Department of Health and Mental Hygiene, through a city council initiative, and is a collaborative between the Children’s Hospital at Montefiore and the Children’s Evaluation and Rehabilitation Center of the Albert Einstein College of Medicine.

The program has been remarkably successful, as more than 1,600 infants and toddlers have been screened using the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE). Seventeen percent of these children received a score at or above the clinical cutoff. In addition, 9% of children had concerns mentioned on a subclinical ASQ:SE, and an additional 17% were referred by a pediatric provider. Of the total children indicated, 33% were seen for an extended evaluation and/or ongoing therapy, and 26% were referred to another service, such as Early Intervention. Additionally, education regarding infant brain development within a relationship context, postpartum depression, and attachment theory has been delivered to 14 attending physicians, 60 pediatric residents, and 25 fourth-year medical students.

The program is undergoing evaluation, including a process evaluation, a clinical qualitative review, and a quantitative analysis of screener scores across time related to intervention. Chi-square tests revealed that the ASQ:SE may be a particularly sensitive tool for the early identification of language delays/learning problems and regulatory issues in children aged 6 to 36 months, and of behavior problems in general in older toddlers (ages 24-36 months).

Key factors to our success have been the focus on prevention and early detection and the cooperation and support of all providers, including nursing staff. The program will be sustained and expanded pending renewal of funding, and has helped to generate funding for a newly established Healthy Steps program at the practice.

Healthy Steps for Young Children has been implemented at CFCC since September 2006, with two Healthy Steps Specialists (a doctoral level psychologist and a licensed social worker with postgraduate training in infant-parent psychotherapy) caring for more than 100 first-time parents. Healthy Steps families receive home visits and co-managed office visits, children are screened for social emotional, cognitive, language, and motor development (including a specific screening for autism), and parents are screened for mental health problems, domestic violence, parental stress, attachment to their infant,
and harsh disciplinary measures, and families are invited to participate in support groups. 2nd-year residents receive training by the Healthy Steps Specialists during their Developmental Behavioral Pediatrics rotation. There is a control group located at another clinic, and an extensive research component to this program.

New York City Metropolitan Pediatric Clinics – Integrated Mental Health Primary Care Program
New York City, NY

Description: The Integrated Mental Health-Primary Care Program (IMP) is a unique collaboration between the Columbia University Departments of Pediatrics and Pediatric Psychiatry and the Ambulatory Care Network at Morgan Stanley Children's Hospital of New York Presbyterian. Since 2002, psychiatrists and psychologists have practiced in 5 community-based general pediatric clinics in a Hispanic community in Northern Manhattan, working collaboratively with primary care clinicians. This novel treatment system offers psychiatric evaluation and short-term treatment services in the medical home setting. Seventy-two percent of IMP staff are Latino and Spanish speaking, with all staff trained in cultural sensitivity. Patients are seen on site, immediately, reducing parental anxiety, reducing the need for emergency department/crisis service/outside referrals, and simultaneously contributing to pediatrician education, based on patients the pediatrician has referred. Communication between mental health staff and pediatricians is immediate and brief, tailored to busy pediatric clinical schedules. Pediatricians have access to an electronic medical record to track psychiatric treatment. A 2004 survey of IMP-served primary care practices revealed that 86% of primary care physicians reported improved access to psychiatric services, with 88% reporting referring to IMP, and 91% reporting that the referral was helpful. Ninety percent of physicians said patients reported being satisfied or very satisfied with the IMP referral, and 95% of primary care clinicians reported being satisfied or very satisfied with the IMP program. A wide variety of diagnoses have been treated, with 40% of children having ADHD. The program is supported by Medicaid revenues to the hospital clinic and will be sustained.
**Starlight Pediatrics, Monroe County Health Department**  
*(dedicated to the health of children and adolescents in foster care)*  
*Monroe County, NY*

**Description:** Starlight Pediatrics is a primary care pediatric practice located at the health department, and serves as the medical home for children and teens in foster care. In addition to all routine and acute pediatric services, Starlight Pediatrics serves as the health care coordinator for this population. Customers include children and teens, their foster and birth parents, caseworkers, legal professionals, courts, and other health providers. Because the office is under county management, there are minimal communication barriers among health and casework staff. Systems to share information with casework, legal, and mental health professionals have matured over time. Through collaboration with several mental health agencies, Starlight Pediatrics is able to provide contextual evaluations in either the foster home and/or child care setting for children up to age 6 years, as well as intake mental health evaluations through a single mental health site for older children and adolescents.

Starlight Pediatrics, in collaboration with the behavioral health program at the University of Rochester, is embarking on routine mental health screening of all children older than 7 years at admission to foster care. In addition, Starlight Pediatrics will re-screen children who remain in foster care every 6 months. The collaboration with the University of Rochester benefits patients of Starlight Pediatrics through timelier access to mental health services. The feasibility, acceptance, and impact of periodic mental health screening of this high-risk population in the medical home setting will be evaluated.

A developmental pediatrician from the local University performs some on-site developmental evaluations. Starlight also is involved as a clinical site for nurse practitioner and resident education.

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**NORTH CAROLINA**

**Aegis Winston East Pediatrics**  
*Winston-Salem, NC*

**Description:** Our model of co-located care was developed with the “out-stationing” of a mental health provider into an urban pediatric practice with a high volume of Medicaid-enrolled patients. The mental health professional was an employee of the local community mental health center and provided consultations, therapy, and case...
management to the practice. This structural arrangement allowed the pediatricians easy access to psychiatry consultations through the mental health agency. The mental health agency was responsible for all billing and record keeping. The model was implemented with funding from the Duke Endowment. The community mental health center reimbursed the grant with patient fee collections. Monthly reports with expenses and collectibles suggested that the model was self-sustaining. Benefits of the model included increased comfort by medical providers to address their patients’ mental health issues, convenience to the patient and family, immediacy of services, decreased stigma and increased comfort for patients seen for mental health services in their pediatrician’s office, increased follow-through by patients for recommended mental health services, and regular communication between the MH provider and primary care clinicians. Difficulties with the model included significant paperwork required by the mental health system to open a case on a child with Medicaid. Satisfaction with services was rated high by the pediatricians (5/5). Keys to success included “buy-in” by the medical providers and a committed practice manager.

This model has the potential to be replicated and sustained elsewhere by community mental health agencies, if the population served is insured and if reimbursements are sufficient to cover expenses. The model at Aegis Winston East Pediatrics was transitioned to a new configuration after state mental health reforms resulted in failure of the mental health agency; since January 2006, Wake Forest University Health Sciences (WFUHS), the regional academic medical center, has employed the co-located mental health professional. Paper work was simplified. Satisfaction of pediatricians remains high, and, as of February 2007, reimbursements are approaching a level consistent with sustainability. A WFUHS psychiatrist funded by a grant provides on-site consultation during a half-day session every other week and periodic “lunch-and-learn” sessions for the pediatricians.

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Guilford Child Health, Inc.
Greensboro, NC

Description: Guilford Child Health, Inc (GCH), was established in 1997 to provide primary and specialty health care services for underserved children. Motivated by the goal of providing the highest quality, comprehensive, family-centered pediatric care available, all staff members at GCH believe in caring for the “whole” child. By providing health care services for a child’s medical, social, and emotional needs, GCH works to ensure that each child is developmentally prepared at home, at school, and in the community.
Guilford Child Health serves as a pilot for Mental Integration in Primary Care. This pilot involves the use of a mental health collaborative team—4 licensed clinical social workers, 2 developmental and behavioral pediatricians, 1 co-located child psychologist, 1 contracted child and adolescent psychiatrist, and primary care clinicians. GCH provides child and adolescent psychotherapy. The psychiatrist sees referrals but also has case-review sessions with the primary care clinician regarding the care of the primary care clinician’s patients. In addition, psychiatric evaluation and counseling is offered on site. Screening and treatment of maternal depression is also provided. Through a team approach, there is collaboration and treatment coordination for both primary and mental health care. The Developmental and Behavioral, Mental Health Team of providers meets weekly to review referrals and coordinate services.

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Sustaining Psychosocial Screening in Everyday Practice Flow
*Durham, NC*

**Description:** The Healthy Development Collaborative used breakthrough series methodology to engage families and health care providers to improve developmental outcomes of children birth to age 5 through improved office systems in the following areas: (1) eliciting parents’ experiences communicating with their child’s health care provider regarding family issues (e.g., depression) and (2) identifying and referring children at risk of poor developmental outcomes through routine structured psychosocial screening.

At the end of the 12-month collaborative, the following key factors were identified as important to successful implementation: (1) a desire in the practice team to make real changes in the way health care is provided to children and families; (2) determining which issues the practice wishes to focus on, which screens best fit the practice’s needs, and identifying a screening schedule; and (3) collecting data that enable practices to measure the impact of changes and adjust efforts accordingly.

Supplemental funding supported measurement and learning session participation. However, practices completed all data collection without additional resources. An evaluation with a control group was completed; analysis is forthcoming. A lack of regular, systematic screening for family psychosocial problems was identified through chart audits and parent feedback at project start-up. Using the breakthrough series collaborative model, participating practices worked toward implementing and sustaining psychosocial screening in everyday practice flow. Preliminary findings show 60% of families received psychosocial screening. Participating practices indicated through exit interview plans to sustain changes past their participation in the collaborative. One practice indicated that “the collaborative provided the motivation to implement psychosocial screening.” A proposal has been submitted to replicate this model.
NC Chapter AAP/NC Pediatric Society
Raleigh, NC

**Description:** The North Carolina Chapter engages in a statewide initiative known as ICARE. This is an acronym for integrated, collaborative, accessible, responsive, evidence-based—a model that we are using to integrate mental health and primary care, which includes training events and resource networking among a variety of organizations. The Web site lists multiple training opportunities of which the North Carolina Chapter is a contributor and supporter. ICARE has grant support from private philanthropy and pharmaceutical companies and is housed in a private nonprofit foundation affiliated with state government.

In addition, the North Carolina Chapter is connected to the southeastern North Carolina’s Southern Regional Area Health Education Center’s Evidence-Based Practices Center, located at [www.ncebpcenter.org](http://www.ncebpcenter.org). This site is dedicated to support evidence-based mental health practices, treatments, and interventions. The site includes information on the following modalities: assertive community treatment, supported employment, family psycho-education, wellness (illness) management and recovery, and integrated dual disorder treatment.

**OHIO**

**Healthy Connections for Families – Family Care Center**
**Toledo, OH**

**Description:** Since 1997, Healthy Connections has been providing mental health services to children through pediatric Services in St Vincent Mercy Family Care Center and the Medical University of Ohio. By using a collaborative approach, primary care clinicians receive training and resources to identify and refer children with behavioral health problems to the mental health professionals located within the same facility. Providing all of the services within the medical home facilitates access and utilization for the families. A case manager is available to support the family, reduce barriers to
service, and facilitate communication among physicians, families, and behavioral health care providers. Families have a strong rapport with their primary care clinician and are open to behavioral health treatment connected to their primary health care, reducing the stigma of mental health. Healthy Connections has used grants to implement this model of integration, such as Mercy Children’s Hospital Foundation, Ohio Hospital Association Foundation for Healthy Communities, Healthy Tomorrows Partnership for Children, and Administration for Children & Families (ACF) Integrated Mental Health Services. Outcomes are measured through length of time from referral to first appointment; show rates, patient satisfaction, and the Ohio Outcomes System. Among the benefits of this model are a collaborative and cohesive approach to mental health care for families, an increase in access and use of mental health services, and higher satisfaction. Healthy Connections will continue to submit grants at the local, state, and federal level and obtain state certification to expand services to other pediatric services.

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**SOUTH CAROLINA**

**Beaufort Pediatrics, PA**
*Beaufort, SC*

**Description:** Beaufort Pediatrics is an 8-provider single-specialty practice located on the coast of South Carolina. The practice handles approximately 60% Medicaid patients, and sees large numbers of Caucasian, African American and Hispanic Patients. Because of a lack of mental health professionals in the community, the practice has hired its own mental health professional to provide on-site counseling. Providing mental health services within the pediatric office is well accepted by patients, many of whom would feel stigmatized going to a mental health center. This arrangement also facilitates consultation between the pediatric staff and the mental health professional, including the use of a joint medical record. Beaufort Pediatrics has rural health clinic status, which enables the practice to receive a more favorable reimbursement rate from Medicaid for those clients. The practice provides free office space and allows the mental health professional to keep 100% of his collections to make his practice financially feasible.

Over the past 15 years, Beaufort Pediatrics has developed a comprehensive screening program to identify those families most at risk for poor mental health and developmental outcomes early in the child's life. The practice now screens for maternal depression, family substance abuse, domestic violence, socioeconomic distress, community connectedness, and developmental status, using a variety of instruments. The practice uses a professional social worker to help refer those families identified as at risk on screening to home-based parenting support and other services within the community. Beaufort Pediatrics believes that, to be successful, satisfactory mental health services must include a preventive and screening component.
SOUTH DAKOTA

Caring for the Whole Child Program
Statewide - SD

Description: Through its Caring for the Whole Child program, the South Dakota Chapter intends to make developing emotionally healthy children a top priority for the state. The Children’s Mental Health Awareness Initiative Advisory Group was established and the group along with input from the South Dakota Voices Coalition for Children, prepared the document, Children’s Mental Health Awareness, Multi-Year Plan for South Dakota. The document outlines the following 2 goals:

- Increase community understanding of strategies and resources to help develop emotionally healthy children
- Increase community recognition of
  - Efficacy of early detection, intervention, and treatment of mental illness
  - Emotional and developmental precursors of mental illness in children
  - Where to go for help

In each goal, health care providers are considered 1 of the 4 target audiences. The chapter president plans to visit every pediatric practice in the state and include those interested family practitioners to inform them about the 2 goals. The intent is to survey them about their understanding of community strategies and resources available related to detection, intervention, and treatment of children’s mental health illnesses. The project includes education by providing 2 valuable AAP resources—Bright Futures in Practice, Mental Health Volume I and II and The Classification of Child and Adolescent Mental Diagnosis in Primary Care (DSM-PC Child and Adolescent version).

TEXAS

Hogg Foundation for Mental Health: Integrated Health Care Initiative Grant Program
Houston/El Paso, TX
Description: In April 2006, the Hogg Foundation for Mental Health, an administrative unit of The University of Texas at Austin, launched its Integrated Health Care Initiative grant program. The 5-grantee organizations will receive more than $2.6 million over 3 years to promote the effective identification and treatment of mental health problems in primary care settings.

The grantees treat mental health problems in different age groups. Three of the 5 organizations provide treatment for children. One focuses exclusively on ADHD, and the other 2 treat a variety of mild to moderate disorders.

The 5 organizations funded through this initiative adopt the collaborative care model and address the implementation barriers they encounter. Adapted from Wagner’s Chronic Care Model, collaborative care is an integrated health care approach in which primary care and mental health professionals’ partner to manage the treatment of persons with mental health problems in the primary care or pediatric setting. Two decades of research have demonstrated that the collaborative care model improves primary care patients’ mental health outcomes with a minimal investment of resources.

For more than 65 years, the Hogg Foundation has accomplished its mandate through grant making to mental health services, research, policy, and public education projects in the state of Texas.

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Texas Adolescent Mental Health in Primary Care Initiative
San Antonio/Longview/El Paso/Gonzales, TX

Description: The purpose of the Texas Adolescent Mental Health in Primary Care Initiative (TAMHPCI) is to improve the health of adolescents in the state of Texas by engaging private and public partnerships and creating sustainable system changes. This collaborative project involves 8 academic health centers, 6 professional organizations/associations, 2 patient advocacy organizations, and 3 state governmental agencies. This initiative is aligned with the goals of the President's New Freedom Commission on Mental Health, the Institute of Medicine, the Substance Abuse and Mental Health Service's Federal Action Agenda, and the fundamental transformation of the Nation's mental health system. The TAMHPCI implementation sites include the Brooke Army Medical Center (a pediatric military clinic), the Community Health Center of South Central Texas, Inc (a Federally Qualified Health Center [FQHC]), the Longview Wellness Center (a FQHC look-a-like), the Texas Tech University Health Sciences Center (TTUHSC) Fabens Clinic (a border school-based clinic), and the TTUHSC Family Practice Center (an academic family practice clinic). Unlike other projects that
have examined either 1 or 2 disorders, the TAMHPCI includes a broad spectrum of psychosocial health, suicide ideation, depression, ADHD, and at-risk drinking, that present among adolescents in primary care settings, using a standardized protocol, while allowing for some variation across local delivery systems to achieve generalizability to real-world clinical settings.

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UNIFORMED SERVICES WEST

Military Youth Coping With Separation: When Family Members Deploy
San Antonio, TX, and multiple military bases nationally and internationally

Description: The teen support video, Youth Coping with Separation: When Family Members Deploy, has been finished and is being distributed. The Department of Defense has considered rapid deployment of the video through its online distribution channels. This would be an initial wave of release that hopefully will peak interest in the subject and provide a tangible resource to youth, families, and youth serving professionals as we continue to work on a more comprehensive distribution plan that will include the ability to make hard-copy packages of the DVD program (video, facilitator guide, interactive military youth stress management plan, and other resources) available through outlets such as Military One Source. The next phase of the teen support project will focus on development of an interactive multimedia form of the currently available military youth stress-management plan and an enhancement to the video that includes parent- and youth-serving professional video perspectives. The other exciting news is that the new Mr. Po and Friends is also nearing its final stages of development. The script has been modified and the story will now be animated rather than a puppet show for the elementary-age demographic. A sneak preview of the new Mr. Po and Friends animated video is available at http://www.rexraygun.com/freelance/decypher/scene1.htm. The new target for completion of the elementary product is May 2007. The possibility of using the teen and elementary video programs as a basis for the Youth component of the Battlemind Program being developed by the Army is being pursued. Battlemind is a psycho-educational program that helps soldiers and their families anticipate, understand, healthfully cope with, and find resources to address the stresses that are associated with the various stages of deployment.

Web address: http://aap.org/sections/unifserv/deployment/index.html
Contact Name: MAJ Keith M. Lemmon MD, FAAP
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Department of Pediatrics
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University Health Care Neurobehavior Healthy Outcomes Medical Excellence Program
Salt Lake City, UT

Description: The Neurobehavior Healthy Outcomes Medical Excellence (HOME) Program is a University of Utah-based, co-located specialty clinic. It began in July 2000 as part of the Medicaid Redesign Project with the Utah State Department of Health, sponsored by the Robert Wood Johnson Foundation Center for Health Care Strategies. The program receives the blended Medicaid medical and mental health funding streams to provide comprehensive health care to individuals with developmental disabilities. The interdisciplinary focus of this program is to provide care in an integrated, collaborative, cost-effective manner to a generally underserved population who often receive fragmented specialty care. Our clinicians have training and experience in working with the complex medical and mental health concerns often presented by patients with traumatic brain injury, epilepsy, genetic syndromes, birth trauma, autism spectrum disorders, and mental retardation.

Services are provided by 2 triple-board physicians (in Pediatrics, Adult Psychiatry, and Child and Adolescent Psychiatry), a Child and Adolescent psychiatrist, a family practice physician, 2 advance practice nurses, 4 clinical social workers, 2 clinic case managers, 4 state-employed case managers, a behavior specialist, a billing/coding specialist, 2 medical assistants, and administrative support staff. Services include the following:

- Primary and preventive medical care
- Psychiatric care
- Coordination of care with university-affiliated specialty care, such as neurology, genetics, physical medicine and rehabilitation, orthopedics, and pulmonology
- Case management and triage of crises
- Individual and family psychotherapy and group psychotherapy
- Functional behavior analysis and supports
- Autism Diagnostic Testing
- Dietitian/Nutritional counseling
- School accommodations advocacy
- Home visits to assess habilitative needs
- Electronic medical records
- Coordination of insurance benefits
- State disability services advocacy
- Community outreach
- Research
- Education and training for residents in psychiatry, family practice, dentistry, social work, and psychology, and nurse practitioner and physician assistant students
- Telemedicine
VERMONT

Hagan and Rinehart Pediatricians, PLLC  
Burlington, VT

Description:  
Our small primary care practice of 2 pediatricians, 2 pediatric nurse practitioners, and an excellent support staff employs 2 innovations to enhance our behavioral health care:

- Case management services for children and youth with special health care needs  
  - Medical home model of care coordination with care plans, family-centered team collaboratives, and an extensive community resource network

- Collaborative practice with clinical psychologists  
  - Clinical psychologist and post-doctoral fellow are on site part-time to see patients on referral, collaborate with pediatric staff on shared cases, and provide behavioral telephone callback for families

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Upper Valley Pediatrics  
Bradford, VT

Description: What began as a Community Access To Child Health grant to a solo pediatrician in 1994 has resulted in a practice with 1 pediatrician, 5 part-time nurse practitioners, and 7 full- and part-time mental health therapists and social workers. The nurse practitioners help with the "nuts and bolts" pediatrics (ie, well child checks and acute episodic illnesses). This allows the pediatrician time to concentrate on children with the behavioral, emotional, and learning problems. The licensed clinical social workers and mental health counselors help to deliver direct psychotherapeutic services to patients at the practice site. These personnel are able to be credentialed by third-party insurers, and the practice has been able to obtain reimbursement such that the practice has actually profited financially. Upper Valley Pediatrics is a practice much better able to respond to patients' "new morbidities," and the extensive use of mental health professionals has allowed us to be financially successful as well. We feel that our collaborative, co-location model is superior because of the following:
• Collaboration between physician and therapist, especially in managing children on psychotropic medication
• Better continuity and quality of psychotherapy than at Community Mental Health Center, where the therapists are generally entry-level employees who leave as soon as they gain credentials and experience
• Less stigma receiving mental health services at pediatric office
• Lower costs to state Medicaid, as we are reimbursed at a lower rate than services delivered at Community Mental Health Center

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WASHINGTON

High Point Medical Center, Puget Sound Neighborhood Health Centers
Seattle, WA

Description: Behavioral health integration was achieved by hiring a behavioral health specialist (BHS) and training primary care physicians, nurses, and other appropriate staff in a community health center to provide integrated care. Training included scope of BHS practice, referral sources, assessment, engagement, negotiation of collaborative care, and triage. This model led to an 80% adherence to the treatment plan. Key factors to success include champions on the clinical team, a children’s integrated preventive model in place, limited wait time for a behavioral health appointment, the convenience and cohesion of on-site care that minimizes obstacles to change and provides a less-fragmented experience for patients, and collaboration between professionals that provides better patient support and facilitates a consistent message from all providers. This allows patients to focus on step-by-step problem solving and achieve small changes on a regular basis, which leads to the maintenance of change over time. Benefits include substantial increases in the goals of assessment of mental health problems and promotion of healthy mental development for children and families at the clinic. A on-site BHS creates an additional resource on the provider team for mental health concerns. Providers are better able to focus on non-mental health medical and dental concerns. The BHS builds immediate relationships with patients so they are not necessarily required to go outside the clinic to address mental health issues. This increases the likelihood that patients will follow through with attending therapy meetings. The clinic is already sustaining the model and the Kids Get Care program has plans to replicate it.

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WISCONSIN

Office Management of Pediatric Mental Health: Promoting Resiliency in Trying Times  
Sheboygan, WI

Description: This comprehensive, 1.5-day CME course, sponsored by the AAP Wisconsin Chapter, an array of experts who gave didactic presentations as well as a case study workshop, all applying directly to pediatric primary care practices. Topics covered:

- Learning Disabilities—Practical Aspects of Screening and Helping Families With LD Children
- Depression: Overview of Trends, Diagnosis, and Treatment Options
- Practical Management of Outpatients With Eating Disorders
- Brief Office-based Interventions for Behavioral Problems and Conflict
- Maximizing Reimbursement for Provision of Mental Health Care
- Assessment and Treatment Planning on Aggressive, Bipolar, Oppositional, and Conduct Disorders
- Use of Screening Tools for Behavioral and Mental Health Disorders
- Case Studies Panel
- Autism: WI Prevalence Data and Current Thoughts on Medication Management
- Balancing a Professional Career: Minimizing Burnout for Ourselves and Our Staff

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MULTIPLE SITES

Federal Program to Promote Models of Integrated Health Care  
New York, Montana, Tennessee, Massachusetts, and Ohio

Description: On the basis of its recognition of the importance of mental health to children’s overall health and well-being, the limited access that young people have to mental health services relative to primary care services, and its documentation of the paucity of models that address these issues, the Maternal and Child Health Bureau has supported the 2-phase initiative, “Integrated Health and Behavioral Health Care for Children, Adolescents, and Their Families,” since 2000. It has competitively awarded 23 two-year planning grants across 3 cohorts and, thus far, 6 three-year implementation grants to health care organizations to develop community-responsive model systems of care that integrate physical and mental health care and substance abuse services.
Models are required to address such dimensions as governance, multidisciplinary staff configuration and interactions, financing, legal and regulatory issues, managed care environment, education and training, information systems, medical records and community involvement, and sustainability. The 6 implementation sites are in New York (2 sites), Montana, Tennessee, Massachusetts, and Ohio, and include an urban ambulatory care center; 11 family medicine practices affiliated with a not-for-profit county-wide health care system; and a health care system that provides services in a family practice, a pediatric practice, and a community health center. Each site serves patients with a mix of private and public health insurance and screens patients using standardized forms that were developed for use in primary care settings. In general, behavioral health clinicians meet identified families in the primary care site and perform further assessment. A national evaluation has been conducted, showing promising results.

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health plan policies fostering co-location and other forms of collaboration in the care of children with mild to moderate mental illness

strategies for system change in children's mental health: a chapter action kit

Authorization/Access

- Patient can access outpatient mental health services without referral authorization.
- Primary care clinician can refer/authorize outpatient mental health services for their patients.
- Authorization of psychiatric care, when required, can be readily obtained via phone/fax/Internet.
- A generous number of outpatient visits is allowed (e.g., up to 26 per year).
- A sufficient number of outpatient visits without a specific diagnosis is allowed (e.g., 6 visits).
- Primary care clinician has access to list and contact information for credentialed (empanelled) mental health professionals.
- Mental health professional lists include notations of their qualifications for the care of children and adolescents.
- Plan surveys prescription claims for multiple providers of psychopharmacology.
- Insurer clarifies coding specifications (see matrix from North Carolina, page).

Payment

- Pediatricians are identified as appropriate primary care clinicians for mental health services in all plans.
- Primary care clinicians are paid for delivering outpatient mental health services.
- A mental health professional employed by a primary care clinician can be reimbursed for services using the primary care physician clinician code; this is termed “incident to.”
- A mental health professional employed by a clinician can bill in his own name.
- Independently credentialed mental health professionals can bill medical insurers directly (e.g., they are not required to be employed by or bill through a mental health management entity).
- Primary care clinicians are paid for mental health case management services (non–face-to-face elements of care/follow-up, such as family or teacher conferences, telephone consultations, etc).
- Independent mental health professionals are paid for mental health case management.
- Mental health professionals employed by a primary care clinician are paid for mental health case management.
- Psychiatrists are reimbursed for specific patient’s consultation with primary care clinician or non-medical mental health professionals (e.g., with patient not present).
• The primary care clinician is reimbursed for consultation with a mental health professional.
• Co-payment rates are the same as those for physical health care.
• Public insurance payment rates at least equal to Medicare.
• Primary care clinicians can bill under mental health diagnostic codes.
• Primary care clinicians with specialty training in mental/behavior health are recognized as specialists.
• Primary care clinicians are reimbursed for mental health screening.
• Primary care clinicians are reimbursed for initial visit(s), prior to determining diagnosis.
• Mental health benefits include a certain number of mental health visits authorized by the primary care clinician (eg, unmanaged by the mental health management entity).

Communication

• Performance standards stipulate that mental health professionals communicate with primary care clinicians.
• Process is in place through which a primary care clinician referral expedites a patient’s intake for outpatient mental health services.
• Mental health professionals are given incentives to collaborate with primary care clinicians.
• Primary care clinicians have access to a directory of the plan’s mental health professionals who have pediatric expertise and experience.
• A “case manager” is designated who will ensure continuation and coordination of care.
• The plan has communication standards for mental health professionals; specifically, routine request for child/parent consent to exchange information with primary care clinician; routine written or verbal update to primary care clinician, especially in relation to medications.
• Primary care clinicians are notified regarding mental health visit to the emergency department, mental health hospitalization, and residential placement, and discharge plans for each.
Co-location of Mental Health Professionals in Primary Care Settings: Three North Carolina Models

Jane Williams, PhD
Steven E. Shore, MSW
Jane Meschan Foy, MD

Summary: The pressing need for identification and treatment of behavioral health disorders in primary care has renewed interest in the concept of co-located models of care. The purpose of this article is to describe three North Carolina practice models in which mental health professionals are co-located with pediatric primary care providers. Each of the models was sustainable, partly due to systemic changes brought about by advocacy efforts. In addition to providing practical guidance for possible replication in primary care, this article reflects on how advocacy efforts can impact the success of co-location models. Clin Pediatr. 2006;45:537-543

Introduction

North Carolina pediatricians have experienced many barriers to serving children with mental health (MH) disorders.1,2 In an effort to address these problems, the North Carolina (NC) Chapter of the American Academy of Pediatrics (AAP) formed a task force consisting of community and academic pediatricians and representatives of MH provider and advocacy organizations to articulate their mutual concerns with the leaders of NC’s Medicaid program.3

Outcomes of that process included a number of changes in NC’s Medicaid policy: direct enrollment of independent MH providers into Medicaid; up to 26 unmanaged MH visits annually per child (6 without a diagnosis), billable by either the primary care provider (PCP) or a MH professional authorized by either the PCP or the area’s public MH authority; and changes in “incident to” rules to permit a PCP to bill for the services of employed MH professionals. An increase in overall Medicaid rates, currently indexed to 95% of Medicare, and 12-month continuous enrollment of children after eligibility determination were also achieved during this period as a result of parallel efforts by other advocates.

These Medicaid changes were intended not only to give greater choice of MH providers for children enrolled in Medicaid, but also to increase collaboration between PCPs and MH providers in the care of mutual patients. Of particular interest to the North Carolina AAP task force was fostering co-location of PCPs with MH professionals. Co-located practices have been found to decrease the use of general health care services by “overserviced and underserved” patients (i.e., chil-
dren with unidentified and untreated MH morbidities and high utilization of medical services for somatic complaints); for these children, a co-location model has resulted in improved outcomes and reduced costs.4,6 When an MH professional is available, the PCP is less reluctant to explore psychosocial issues that might result in a MH referral; families experience less stigma associated with seeking MH care; communication between providers is enhanced; and cross-fertilization of skills and knowledge between disciplines is increased.7

There is a variety of structural and organizational models for co-located care: the PCP may hire staff to provide MH services on site or may provide space in which an independent MH practitioner or an employee of another organization provides MH services on site.4 Co-location models have been viable in large healthcare maintenance organizations and often provide a wide range of medical and MH specialty services. However, in small private primary care practices, co-location has been more fragile due to financial and structural barriers. Grant funds have often been used to support the initial development of co-location arrangements. Unfortunately, the end of the external funding period has often resulted in termination of the model, even though healthcare providers and families have been satisfied with the additional services.8

In reviewing models in North Carolina, the authors found a long-standing pediatric practice in which a co-located group of MH providers has sustained itself through reimbursements from private insurers; however, they have not served the approximately 50% of Medicaid-enrolled children in the practice because, for many years, only public clinics could provide MH services to Medicaid beneficiaries.

The recent changes in North Carolina Medicaid offer the opportunity for co-located practices to serve a mix of Medicaid and privately insured children. This article describes three NC co-location models that serve both privately insured and Medicaid-enrolled children.

Methods

Descriptions of the three models were obtained by a standardized interview with physicians, MH providers, and business managers in each of the practices. Each description focuses on operational arrangements, clinical responsibilities, and professional acceptance and satisfaction.

Model 1: Employee of Community MH Center Out-Stationed in a Private Pediatric Practice

Operational Arrangements

The first model was the “out-stationing” of a MH provider employed by a community MH center into an urban pediatric practice owned by a hospital network (Table 1). The model was initiated with grant support from the Duke Endowment and was a collaboration of the Northwest Area Health Education Center, medical center pediatric faculty, and the community MH center.

Expenses for the co-location model included salary for the MH provider and a laptop computer. Office space was provided “in-kind” by the practice. Office staff time was required for some administrative tasks; however, this cost was offset by decreasing time demands on one nurse who previously made all MH referrals.

Clinical Responsibilities

Responsibilities of the medical providers included time for initial meetings concerning implementation of the project, completion of satisfaction surveys, and any written input concerning needed changes in MH services. Ongoing clinical responsibilities involved informal consultations and/or formal referrals to the MH provider. Medical providers read and signed all notes made by the MH professional in the patient’s medical record. The office manager assisted with interviews for the prospective MH provider and coordinated clinical and office staff activities. Office staff registered patients and assisted with scheduling.

The model employed a licensed clinical social worker, as the pediatric practice required a MH provider with both treatment skills and knowledge of social resources in the community. Services offered included informal...
Co-location of Mental Health Professionals

Consultations between the physician and MH provider, diagnostic interviews, individual and family therapy, and case management. Case management involved referral to other community programs as well as frequent school contacts for children with attention deficit hyperactivity disorder (ADHD) and/or learning disabilities. In addition to making notes in the medical record, the licensed clinical social worker (LCSW) maintained a separate MH record on any child who had paperwork completed for an open case with the community MH center.

Medication consults with psychiatrists were provided directly through the community MH center and facilitated by the co-located MH provider. Patients with medication needs were directly scheduled for the psychiatrist at the MH center without having an additional intake interview.

Outcome Findings

Based on information gained in the interviews, advantages of the model included convenience to the patient and family, immediacy of services, easy access to psychiatry consultations, a perceived increase in follow-through by patients for recommended MH services, a perceived increase in comfort for patients seen for MH services in the pediatric practice rather than being referred to other sources, and regular communication between the MH provider and pediatricians concerning shared patients.

### Table 1

<table>
<thead>
<tr>
<th>Model No.</th>
<th>Practice Size</th>
<th>No. of FTE Physicians, PAs, and NPs</th>
<th>Practice Payer Mix</th>
<th>Type of MH Provider</th>
<th>Weekly Time in Practice</th>
<th>Primary Activities in Practice (% time in each activity)</th>
<th>Most Frequent Diagnoses</th>
<th>Salary Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5,000</td>
<td>4</td>
<td>Medicaid = 72%</td>
<td>LCSW</td>
<td>2 days</td>
<td>Therapy (44%) Consultation/assessment (35%) Case management (21%)</td>
<td>ADHD (49%) Depression/Anxiety (30%) Behavior D/O (10%) Adjustment D/O (6%) Other (5%)</td>
<td>$32,000–$45,000</td>
</tr>
<tr>
<td>2</td>
<td>14,600</td>
<td>7</td>
<td>Medicaid = 50%</td>
<td>LPA</td>
<td>5 days</td>
<td>Testing (67%) Therapy (19%) Consultation/assessment (14%)</td>
<td>ADHD</td>
<td>$45,000</td>
</tr>
<tr>
<td>3</td>
<td>20,000</td>
<td>7.5</td>
<td>Medicaid = 64%</td>
<td>LCSW, PhD, MA, Psychiatrist</td>
<td>2–4 days (Psychiatrist = 1 day/week)</td>
<td>Therapy (40%) Psychological evaluation (30%) Parent consultation (20%) Physician/professional consultation (10%)</td>
<td>ADHD (32%) ODD (28%) Anxiety/depression (24%) LD (8%) OCD (4%) PDD (4%)</td>
<td>$40,000–$80,000</td>
</tr>
</tbody>
</table>

FTE = full-time employee; PA = physician assistant; NP = nurse practitioner; MH = mental health; PPO = preferred provider organization; HMO = health maintenance organization; LCSW = licensed clinical social worker; LPA = licensed psychological associate; ADHD = attention deficit hyperactivity disorder; D/O = disorder; LD = learning disability; ODD = oppositional defiant disorder; PDD = pervasive developmental disorder.
Difficulties with the model included the large amount of paperwork required by the MH center to open a case on a child with Medicaid. This decreased the likelihood of opening a case with the resulting loss of potential reimbursement, as well as the MH provider’s productivity. Initially, patients were offered same-day appointments for both medical and MH services, but this compounded the waiting time and resulted in patient dissatisfaction. The practice decided to split visits unless a crisis was involved, and this problem was resolved. Last, the practice lacked high-speed Internet access, which would have enabled the MH provider to have quick and easy access to the community MH center’s database.

Satisfaction was high for the medical providers, who rated the MH service 5/5 on confidential ratings during the first year. Pediatricians perceived that quality of care improved due to assessment and feedback by the MH provider, as this information assisted them in addressing more of their patients’ psychological issues. When comorbidities were ruled out and a diagnosis was confirmed by the MH provider, comfort increased in prescribing medication.

The MH provider perceived there was more “buy in” by the patient for MH services when a physician referral was made. Collaboration and enhanced dialogue between medical and MH providers were thought to improve patient care.

**Model 2: MH Provider Employed by a Pediatric Practice**

**Operational Arrangements**

The second model involved the employment of a MH provider by a private pediatric practice. The pediatric practice assumed all responsibility for the expenses and reimbursement for this model (Table 1).

Expenses included salary for the MH provider plus benefits, malpractice insurance, office space and a testing room, and administrative costs related to billing and scheduling of patients.

The model was supported by contracts with the school district for testing services and reimbursement for MH services by Medicaid, insurance, preferred provider organizations (PPOs), and health maintenance organizations (HMOs). All billing was completed by the business manager for the pediatric practice. Medicaid charges were billed “incident to” the physician (i.e., billed in the physician’s name in accordance with NC Medicaid rules that allow physicians to bill for MH services provided on site under their direct supervision if the MH provider is employed by the physician or by the same entity that employs the physician). The MH provider did not enroll on the behavioral health panels of some private insurance plans because of poor reimbursement. Parents whose children were covered by these plans were required to pay for MH services, and frequently a payment plan was worked out. MH services were open to both patients and nonpatients of the pediatric practice.

Billed services provided enough revenue to pay the salary, benefits, and administrative costs for the MH professional. Because the model had been so successful, a second MH provider, focused more on therapy services, was employed.

**Clinical Responsibilities**

Responsibilities of the medical providers involved informal consultations and/or formal referrals to the MH provider. Office staff sent out a packet of forms to prospective patients requesting information about background history, present problems, and demographics. The packet was to be completed and returned before the patient was scheduled for an appointment. Scheduling was handled by both the MH provider and staff: the MH provider determined slots available for testing or therapy and reviewed the intake packet, and the office staff called the parent with an appointment. A chart, separate from the medical record, was created for each patient and kept by the MH provider in a secured area.

The clinic employed a licensed psychological associate (master’s level degree in psychology) because of the need for psychological and psychoeducational assessment as well as psychotherapy. Services offered included informal consultations between the physician and MH provider, testing, diagnostic interviews, and individual and family therapy. Utilization was high as intake appointments were typically booked for a month in advance.

Medication consultations with psychiatrists were provided by phone conversation with private providers or referrals to a nearby medical school. These consultations and referrals were initiated by either a medical or MH provider.

**Outcome Findings**

Based on information gained in the interviews, advantages of the model included increased access to MH care in the community; shared educational information between physicians and MH providers; increased specialization of medical practitioners as physicians with an in-
Co-location of Mental Health Professionals

interest in a specific disorder, such as ADHD, could see the majority of these patients, while other providers could focus on other medical or behavioral health problems; perceived improvement in making behavioral health diagnoses; and increased revenue for the practice.

Difficulties with the model included an initial lack of clinical space and the amount of time required for billing. This issue was resolved when the practice moved into a new building, in which the MH provider was allocated an office and testing room in the new clinic. Learning the right questions to ask insurance companies about billing for MH codes was initially time consuming and required persistence by the business manager. Over time, the practice put more responsibility onto families for checking on MH benefits in their insurance policies before making appointments.

Satisfaction by medical providers was focused on increased efficiency and improved diagnostic and treatment processes. For all new cases, the MH provider reviewed the referral packet, obtained information from the school, and conducted a diagnostic interview and/or testing with the child/family. Many of these children/families needed no further evaluation or treatment by the medical providers. If the child needed to see the medical provider, the MH professional’s history was available for the physician to use for diagnostic and treatment purposes. This allowed the medical provider to go into more depth concerning specific symptoms, such as ADHD, and decide on the most appropriate medication. Physicians reported more comfort in writing prescriptions and were more likely to use phone consultations with psychiatrists instead of sending the patient some distance for a referral to a tertiary care setting.

The MH provider perceived that patients were more comfortable, open, and motivated due to trust in the pediatric setting. Compared to traditional MH settings, the MH provider felt that co-location allowed for more flexibility in daily practice and more comfort in setting limits with patients who consistently missed their appointments. The MH provider also was relieved not to have responsibility for billing and other administrative tasks.

Model 3: Co-location of an Independent MH Practice with a Pediatric Practice

Operational Arrangements

The third model was the placement of a self-employed doctoral psychologist in a rural pediatric practice (Table 1). High demand for MH services resulted in the addition of another psychologist, clinical social worker, and psychological associate. A separate corporation for the MH practice was established. The pediatric and MH practices were on the same floor in a building with a common hallway, and the patient reception windows were in close proximity. Each practice had its own practice manager and receptionist, handled its own administrative functions, and had its own private offices. Each practice maintained separate records for patients.

Expenses for the co-location model included salaries and benefits for the MH providers benefits, MH malpractice insurance, office rental and associated expenses, and all administrative costs. All expenses were the responsibility of the MH practice.

The MH professionals were directly enrolled as Medicaid providers and were credentialed by insurance companies, PPOs, and HMOs. In addition, the MH practice had contracts with local schools and other community agencies to provide testing and other services needed by their respective constituencies. All billing for MH services was completed by the MH practice. Both patients and nonpatients of the pediatric practice were seen in the MH practice.

The MH providers spent from 2 to 4 days per week in the practice, and the MH practice was sustainable based on revenues generated and expenses.

Clinical Responsibilities

Ongoing responsibilities of the medical providers involved informal consultations and formal referrals to the MH providers.

The MH receptionist scheduled, called to remind patients of their appointments, and registered patients. Services offered by the MH providers included informal consultations between the medical and MH professionals, diagnostic interviews, psychological and psychoeducational testing, individual and family therapy, parenting, and school consultations.

The MH practice contracted with a psychiatrist to spend 1 day per week in the practice for medication consultations and referrals.

Outcome Findings

Based on information gained in the interviews, advantages of the model included increased communication between medical and MH providers due to immediate access and convenience; shared education between the two sets of providers on a variety of pediatric and mental health
topics as well as developments in patient care; increased comfort for the medical providers in making MH referrals; and perceived improvement in patient care due to the multidisciplinary nature of the MH practice group, working together during a child/family crisis, and the continuity of services for children and families.

Difficulties with the model included adjusting to a diversity of practice styles, philosophies, and approaches for both sets of professionals. Medical providers experienced challenges in learning about the capabilities and roles of the various MH professionals. Partnering with the school systems, which had their own resources in place, was challenging, as it required getting to know the MH professionals in local schools and informing them about how medical and MH providers can work together for the benefit of children and their families.

Both medical and mental health providers expressed satisfaction with the co-location model and spoke of the mutual respect for the professional expertise that each group brought to the care of children. Pediatricians indicated increased confidence in prescribing psychotropic medications due to exposure to the MH group as well as increased skills in caring for children who had been hospitalized for MH disorders.

Although there was no formal evaluation of patient satisfaction, both provider groups related that patients had commented that the familiar surroundings of the co-located offices contributed to a high level of satisfaction and trust. Patients sometimes used the respective waiting rooms for the two practices interchangeably, suggesting patient comfort with co-location.

**Discussion**

Across all three models of co-location, enhanced communication between medical and MH providers was consistently perceived as improving quality of care for patients, increasing comfort in diagnosis and treatment of behavioral health disorders by physicians, and providing educational opportunities between disciplines.

Satisfaction with each of the models was reported by both pediatricians and MH professionals. Pediatricians perceived themselves to be more efficient in their practice, especially when psychosocial issues and comorbidities had been addressed by the MH provider. In one practice, staff efficiency was increased as the MH provider took care of MH referrals that had previously been handled by a practice nurse. In all of the models, convenience for both the patients and the providers was stressed. Several providers perceived decreased stigma and increased follow-through with MH services.

Compared with services provided in traditional community MH centers, the out-stationing of a MH provider by a community MH agency (Model 1), provided more convenience for patients, less stigma, and better communication with primary care physicians. This model offered the advantages of psychiatric supervision from permanent staff of the MH center and the opportunity to share the out-stationed MH provider across multiple pediatric practices. As in other models, sustainability was dependent on the MH provider’s billing for an adequate volume of services; however, its sustainability was potentially enhanced by its capacity to target and shift resources to practices where need is greatest.

In all of the models, a committed practice manager was perceived to be essential to success. In addition, physicians’ beliefs concerning the need for MH services in the medical setting and commitment to working with a co-located MH professional were critical. Flexibility on the part of both MH and medical providers was needed to enhance effectiveness and efficiency. All models required adequate and appropriate space for the MH provider.

All three models demonstrated sustainability at the time of this report. In two of the models, sustainability was enhanced by contracting with schools and other community groups to provide child/family MH services and/or testing and by providing services to both patients and non-patients of the practice. The pediatric practice that employed a MH provider cited coding skills and administrators’ persistence in pursuing reimbursement as critical to sustainability.

**Generalizability**

Although the three models described in this article were all sustainable in NC, the question of generalizability arises because of variability from state to state regarding Medicaid policies and reimbursement. Since all three models serve a high percentage of patients with Medicaid, NC’s Medicaid reimbursement rates, indexed at 95% of Medicare, play a critical role in sustainability. If a state’s rates are less than this, a MH provider would have to provide proportionately more billable service in order to sustain any of the models.

Model 1, the out-stationing of an MH provider employed by a community MH agency, has the potential for replicability in most Medicaid policy environments,
provided the employer’s administrative requirements and paperwork do not create daunting inefficiencies or the inflexibility to respond to the practice’s needs. There must be sufficient patient referrals and billable services to support both the salary and administrative costs of the MH professional.

Model 2, the employment of an MH provider by a pediatric practice, depends on Medicaid policies that either (1) allow physicians to bill MH diagnostic codes on behalf of MH professionals in their employ or (2) allow MH professionals employed by physicians to directly enroll and bill as Medicaid providers and/or participate as providers in MH carve-outs of Medicaid managed care plans. This model is not replicable in areas where Medicaid allows only public MH providers to bill Medicaid.

Model 3, independent MH practitioner(s) co-located with a pediatric practice, depends on policies that allow MH professionals to directly enroll as Medicaid providers or to participate as providers in MH carve-outs of Medicaid managed care plans. Medicaid reimbursement rates that are substantially less for independent MH providers than for public MH providers would threaten the viability and stability of this and any model built around independently enrolled Medicaid providers.

**Limitations of the Study**

Although responses to the questionnaire by professionals in the three models offer insight into the formation and operation of co-located practices, many empirical questions remain concerning outcome findings. It is suggested that access to MH care is increased by co-location but whether the quality of both medical and mental health is improved is unknown. Future studies need to measure both of these variables as well as their interactions. In addition, measurement of patient satisfaction with co-located care is critical, as well as whether patients are more likely to utilize and follow through with physician referrals for co-located MH care.

**Conclusions**

With the increased need for identification, diagnosis, and treatment of MH disorders in primary health-care settings, co-location of MH providers in primary care practices is a concept whose time has come. This article has outlined the experience of implementing three co-location models, described their business structure and level of provider satisfaction, and developed practical guidance drawn from these findings. Although these guidelines are instructive, it is essential to consider the uniqueness of the patient population served, characteristics of providers, and practice parameters when a model is instituted.9

In addition, the article documents the importance of advocacy efforts by pediatricians and MH providers. In this case, systemic changes resulting from advocacy efforts made sustainability of new co-location models achievable.

**Acknowledgments**

The authors would like to acknowledge the assistance given by the three practices: Aegis Winston East Pediatrics (Winston-Salem, NC), Washington Pediatrics (Washington, NC), and Sylva Clinical and Sylva Pediatrics (Sylva, NC). Contacts for further information at each of the practices include: Model 1—Carrie S. King (phone: 336-725-0514), Model 2—Dr. Debbie Ainsworth (phone: 252-946-1134), and Model 3—Dr. Jerry Coffey (phone: 828-586-5555).

**REFERENCES**

Evidence-Based Child and Adolescent Psychosocial Interventions

This tool has been developed to guide teams (inclusive of youth, family, educators and mental health practitioners) in developing appropriate plans using psychosocial interventions. Teams should use this information to prioritize promising options. For specific details about these interventions and their applications (e.g., age setting, gender) see the most recent Evidence Based Services Committee Biennial Report (http://www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html).

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Level 1- BEST SUPPORT</th>
<th>Level 2- GOOD SUPPORT</th>
<th>Level 3- MODERATE SUPPORT</th>
<th>Level 4- MINIMAL SUPPORT</th>
<th>Level 5- KNOWN RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious or Avoidant Behaviors</td>
<td>Cognitive Behavior Therapy (CBT); Exposure</td>
<td>CBT with Parents; CBT with Medication; CBT for Child and Parent; Educational Support; Modeling</td>
<td>None</td>
<td>Eye Movement Desensitization and Reprocessing (EMDR), Play Therapy, Psychodynamic Therapy</td>
<td>None</td>
</tr>
<tr>
<td>Attention and Hyperactivity Behaviors</td>
<td>Behavior Therapy with Medication; Parent Training</td>
<td>Behavior Therapy</td>
<td>None</td>
<td>Biofeedback; Play Therapy, Individual or Group (Supportive) Therapy, Social Skills Training; &quot;Parents are Teacher,&quot; Parent Effectiveness Training, Self-Control Training</td>
<td>None</td>
</tr>
<tr>
<td>Autistic Spectrum Disorders</td>
<td>None</td>
<td>None</td>
<td>Applied Behavior Analysis; Functional Communication Training; Caregiver Psychoeducation Program</td>
<td>Play Therapy, Individual or Group (Supportive) Therapy; Auditory Integration Training***</td>
<td>None</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>None</td>
<td>Interpersonal and social rhythm therapy*</td>
<td>Family psychoeducational interventions*</td>
<td>All other psychosocial therapies</td>
<td>None</td>
</tr>
<tr>
<td>Delinquency and Willful Misconduct Behavior</td>
<td>None</td>
<td>MST; Functional Family Therapy; Multidimensional Treatment Foster Care</td>
<td>None</td>
<td>Individual Therapy, Juvenile Justice System</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>Depressive or Withdrawn Behaviors</td>
<td>CBT (incl. in youth with conduct problems)</td>
<td>CBT with Parents; Interpersonal Therapy; Relaxation</td>
<td>Client-Centered Therapy</td>
<td>Behavioral Problem Solving, Family Therapy, Self-Control Training, Self-Modeling, Play Therapy</td>
<td>None</td>
</tr>
<tr>
<td>Disruptive and Oppositional Behaviors</td>
<td>Parent Training</td>
<td>Anger Control; Assertiveness Training; CBT; Problem Solving Skills Training, Rational Emotive Therapy, AC-SIT, PATHS and FAST Track Programs</td>
<td>Social Relations Training; Project Achieve</td>
<td>Client-Centered Therapy, Communication Skills, Goal Setting, Human Relations Therapy, Relationship Therapy, Relaxation, Stress Inoculation, Supportive Attention</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>CBT* (bulimia only)</td>
<td>Family Therapy (anorexia only)</td>
<td>None</td>
<td>Individual (Supportive) Therapy</td>
<td>Some Group Therapy</td>
</tr>
<tr>
<td>Juvenile Sex Offenders</td>
<td>None</td>
<td>Multisystemic Therapy**</td>
<td>None</td>
<td>Individual or Group (Supportive) Therapy</td>
<td>Group Therapy**</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>None</td>
<td>None</td>
<td>Behavioral Family Management*; Family-Based Intervention*; Personal Therapy*; Social Interventions*</td>
<td>Supportive Family Management*; Applied Family Management*</td>
<td>None</td>
</tr>
<tr>
<td>Substance Use</td>
<td>CBT</td>
<td>Behavior Therapy; Purdue Brief Family Therapy; Functional Family Therapy; Family Systems Therapy</td>
<td>None</td>
<td>Individual or Group (Supportive) Therapy, Interactional Therapy, Family Drug Education, Conjunct Family Therapy</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>Traumatic Stress</td>
<td>CBT</td>
<td>None</td>
<td>None</td>
<td>EMDR</td>
<td>None</td>
</tr>
</tbody>
</table>

* Based on findings with adults only; ** if delinquency and willful misconduct are present. § Also consider medication alone or combined treatment for hyperactivity, or combined treatment for depression or hyperactivity, academics (reading), and family interaction. *** under re-review as possible level 5 intervention; use with caution.
partner with child-serving agencies
Numerous national reports recognize the importance of children’s social and emotional development to their overall health and well-being, school readiness, and academic success. It is widely recognized, however, that mental health systems are ill-equipped to serve the mental health treatment needs of children, let alone implement mental health promotion and early identification efforts for this population. These systems are highly fragmented, under-resourced, and limited in scope. Accordingly, state- and community-based mental health systems can place little emphasis on promoting children’s social and emotional well-being and preventing mental health problems before they become severe even though many of these problems can be prevented or minimized with prevention and early intervention efforts. Many reports have called for sweeping reforms to the mental health system, including services to children and their families.

Recognizing that no single agency or system can address this complex issue alone, many states and communities are implementing collaborative multi-agency and multi-system initiatives to institute needed reforms to the mental health system. Key child-serving agencies and systems (eg, health, mental health, public health, education, child care, substance abuse, child welfare, juvenile justice, and developmental disabilities) are addressing a range of issues to improve children’s mental health systems. These issues include mental health promotion, early identification of children who may be experiencing mental health problems, identification of children in need of mental health services, and improved access to comprehensive mental health services. (See the text box for highlights of selected state children’s mental health initiatives.) Additionally, several state mental health agencies have received funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) to lead and implement statewide “transformation efforts” (eg, state reforms to the mental health system) to improve mental health treatment for adults and children.

Unfortunately, many of these statewide system reform efforts do not include primary care clinicians. While some of these efforts are based on sound principles, such as improving family involvement in planning care and community-based (as opposed to centralized) services for those with mental illness, virtually all have been underfunded and most have focused on the adults and children with serious emotional disturbances at the expense of those with mild or moderate levels of impairment. Furthermore, attempts to shift services from state hospitals to communities and from public to private providers commonly result in confusion for consumers and their loss of access to safety net providers. The public mental health community may be unaware of the substantial impact these changes have on primary care clinicians, who increasingly encounter patients without resources to meet their mental health needs.

According to the Collaborative for Academic, Social, and Emotional Learning (CASEL), social and emotional learning is the process of acquiring the skills to recognize and manage emotions, develop caring and concern for others, make responsible decisions, establish positive relationships, and handle challenging situations effectively. Research has shown that social and emotional learning is fundamental to children’s social and emotional development—their health, ethical development, citizenship, academic learning, and motivation to achieve.
Examples of Selected State Initiatives to Improve Children’s Mental Health

- In **Illinois**, the Illinois Children’s Mental Health Partnership (ICMHP), a state entity comprised of 25 members of key child-serving systems and organizations appointed by the governor (including the Illinois Chapter of the American Academy of Pediatric [AAP]), has implemented a range of statewide programs and system reforms, including improved prescreening of children experiencing a mental health crisis who are served by public programs, development of Social and Emotional Learning Standards as part of the Illinois Learning Standards, a consultation initiative to enhance the capacity of mental health agencies to serve young children aged 0 to 7 years, and development of a comprehensive public awareness campaign plan about the importance of children’s social and emotional development and mental well-being. Additional information about the ICMHP and a copy of the ICMHP Strategic Plan is available at http://www.ivpa.org/childrensmhtf/pdf/2006_ICMHP_annual_report.pdf. (See an executive summary of the plan the Tools and Resources section.)

- In **Minnesota**, the Governor’s Mental Health Initiative proposes numerous system reforms, including adoption of a comprehensive mental health benefit set across public programs, integration of mental and physical care, and improved infrastructure for provision of mental health services. Helping to inform this initiative, the Minnesota Department of Human Services convened a task force, composed of legislators, commissioners, deputy commissioners, and experts in the children’s mental health system, to develop a vision for children’s mental health. As a result, the agency has been engaged in a review of the children’s mental health system through the Toward Better Mental Health Initiative and through statewide public hearings. More information about the Governor’s Mental Health Initiative and children’s mental health work is available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION &RevisionSelectionMethod=LatestReleased&dDocName=id_056871.

- In **Washington**, Kids Matter is a collaborative and comprehensive strategic framework for building the early childhood system to improve outcomes for children. The plan identifies key outcomes within 4 goal areas: (1) access to health insurance and medical homes, (2) mental health and social and emotional development, (3) early care and education/child care, and (4) parenting information and support. Developed with the participation of early childhood stakeholders at the state and community level, the plan is intended to guide the actions of public and private stakeholders at all levels of the system. More information about Kids Matter is available at: http://www.earlylearning.org/kids-matter.

What Does This Mean for American Academy of Pediatrics Chapters?

While primary care clinicians are key stakeholders in efforts to reform the children’s mental health system, they may be overlooked as essential partners in the planning, development and implementation of these reforms. Chapters can play a significant role on behalf of their members by ensuring that primary care clinicians are at the planning and implementation “tables” of state- and community-level system reform efforts. In particular, they can ensure that the needs, concerns, and issues of primary care clinicians are considered and sufficiently represented in children’s mental health system reforms. Beginning a dialogue with the state mental health agency and other key agencies and groups can be the basis for building a coalition to enact system-wide policy and programmatic changes.
Chapter Strategies for Partnering With Child-Serving Agencies
Chapters may want to identify and consider a range of strategies for partnering with child-serving agencies to strengthen and implement reforms to the children’s mental health system. Key strategies at the state and local level include the following:

- Conduct a state-level assessment to identify key statewide initiatives, programs, and/or other activities focused on children’s mental health.
- Initiate a dialogue with representatives from key state agencies that are involved in children’s mental health, considering the agencies listed above. Several federal agencies (e.g., the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, Maternal and Child Health Bureau, and Centers for Disease Control and Prevention) have identified children’s mental health as a key priority. As such, state mental health and public health agencies and others already may have begun to engage and involve stakeholders in efforts to improve the children’s mental health system. Please note: Chapter outreach to any federal agency should be coordinated through the AAP DC office. (See the Tools and Resources in this section for further information on key federal initiatives, including the President’s New Freedom Commission on Mental Health, and Selected Healthy People 2010 Mental Health Objectives.)
- Partner with child-serving agencies, child advocates, family groups, and other key organizations to advocate that the state develop a comprehensive children’s mental health system of prevention, early intervention, and treatment. Several states are implementing statewide initiatives to reform the children’s mental health system. These efforts have involved a range of strategies (e.g., pursuing public policy initiatives; development of statewide plans, frameworks and blueprints; improved finance and service-delivery systems) to develop and advance a comprehensive children’s mental health agenda. Many of these state plans and frameworks can provide important information and resources on strategies for reforming the children’s mental health system. (See Resources for Further Information for links to examples of selected state efforts, and the Tools and Resources in this section for a copy of the Overview of the Illinois Children’s Mental Health Partnership, Children’s Mental Health Plan, and Chapter Mental Health Initiatives.)
- Collaborate with state agencies to promote “no wrong door” policies (e.g., a child entering any child-serving system receives a voluntary mental health screening) and/or intake procedures assuring a mental health history.
- Partner with the state education agency and other key state agencies to advocate for efforts to promote the healthy social and emotional development of children in schools. Social and emotional learning can help children learn important skills so that they are better able to resolve interpersonal problems and prevent antisocial behavior, as well as to achieve positive academic outcomes. In

‡ According to the Collaborative for Academic, Social, and Emotional Learning (CASEL), social and emotional learning is the process of acquiring the skills to recognize and manage emotions, develop caring and concern for others, make responsible decisions, establish positive relationships, and handle challenging situations effectively. Research has shown that social and emotional learning is fundamental to children’s social and emotional development—their health, ethical development, citizenship, academic learning, and motivation to achieve.
turn, these efforts can help reduce the caseload burden on health and mental health professionals, and reduce the severity of mental health problems in children.

- Collaborate with the state education agency and other state agencies (eg, mental health or public health agencies) to encourage development of state guidelines on strengthening the integration of school and community-based mental health services through a range of service delivery systems (eg, primary care or mental health systems).

- Collaborate with local school systems (eg, school districts and schools) to encourage development of community-based protocols for exchange of information between primary care clinicians and school staff (eg, psychologists, nurses, counselors, and social workers) who are involved in the mutual care of children with mental health needs.

- Promote initiatives and activities to strengthen the provision of mental health services among primary care and other child-serving settings in communities. (See the Tools and Resources in this section for “A Process for Developing Community Consensus Regarding the Diagnosis and Management of Attention-Deficit/Hyperactivity Disorder.”) The following collaborative projects could be a starting point:
  - Community mental health/substance abuse resource guide
  - Quality standards that require exchange of information between state-funded or state-contracted mental health professionals and primary care physicians
  - Information on case management resources for children who are served in the public mental health system
  - Chronic illness care guidelines for coordinating the care of children with serious emotional disturbance in the medical home
  - Involvement of primary care physicians in the development of comprehensive “system of care” models
  - Identification of strategies to address inappropriate emergency room use for non-emergent mental health problems

References


Resources for Further Information

The AAP Division of State Government Affairs. Available at: http://www.aap.org/advocacy/stgov.htm Accessed April 9, 2007

The AAP Department of Federal Affairs. Available at: http://www.aap.org/advocacy/washing/overview.htm Accessed April 3, 2007

*A system of care for children and adolescents with serious emotional disturbances and their families incorporates a broad array of services and supports that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery and policy levels.
The AAP Division of Community-Based Initiatives. Available at: http://www.aap.org/commpeds/docbi/index.html Accessed April 8, 2007

The Centers for Disease Control and Prevention, Mental Health Work Group provides basic public health information on mental health, including children’s mental health. Available at: http://www.cdc.gov/mentalhealth/ Accessed February 7, 2007


The Collaborative for Academic, Social, and Emotional Learning (CASEL) is a national organization housed at the University of Illinois at Chicago that provides leadership, research, policy, and technical assistance to establish social and emotional learning as an essential part of education. Available at: www.casel.org Accessed February 2, 2007

Foy JM, Earls MF. A process for developing community consensus regarding the diagnosis and management of attention-deficit/hyperactivity disorder. Pediatrics. 115(1):e97-e104


Healthy People 2010. Healthy People 2010 is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. The framework is available at: http://www.healthypeople.gov/ Accessed April 3, 2007


strategies to partner with child-serving agencies
tools and resources

President’s New Freedom Commission on Mental Health: Mission, Goal, and Principles
This resource is the mission statement of the President’s New Freedom Commission on Mental Health.

Selected Healthy People 2010 Mental Health Objectives
This resource lists the selected Healthy People 2010 mental health and substance abuse objectives for children and adolescents. Healthy People 2010 is a comprehensive, nationwide health promotion and disease prevention agenda for improving the health of all people in the United States during the first decade of the 21st century.

Overview of the Illinois Children’s Mental Health Partnership
This document provides a brief overview of the Illinois Children’s Mental Health Partnership (ICMHP) as a pre-introduction to the Executive Summary that follows.

Illinois Children’s Mental Health Partnership: Executive Summary
This resource is the executive summary of the Illinois Children’s Mental Health Partnership’s Children’s Mental Health Plan, a statewide initiative to reform the children’s mental health system by developing a comprehensive system of prevention, early intervention, and treatment.

American Academy of Pediatrics Chapter Mental Health Initiatives
This resource highlights children’s mental health projects conducted by American Academy of Pediatrics chapters, as reported in the 2005 Chapter Annual Report Compendium, the 2006 Chapter Needs Assessment Report, and the Healthy People 2010 Mental Health Chapter grantees.

A Process for Developing Community Consensus Regarding the Diagnosis and Management of Attention-Deficit/Hyperactivity Disorder
Foy JM, Earls MF. A process for developing community consensus regarding the diagnosis and management of attention-deficit/hyperactivity disorder. Pediatrics. 115:e97-e104. Reprinted with permission from Pediatrics. This article describes a process used in Guilford County, NC, to develop a consensus among health care clinicians, educators, and child advocates regarding the assessment and treatment of children with symptoms of attention-deficit/hyperactivity disorder.
Mission
1. Conduct a comprehensive study of the United States mental health service delivery system, including both the private and public sector providers.
2. Advise the President on methods of improving the system.

Goal
Recommend improvements to enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn, and participate fully in their communities.

1. Review the current quality and effectiveness of public and private providers and federal, state, and local government involvement in the delivery of services to individuals with serious mental illnesses and children with serious emotional disturbances, and identify unmet needs and barriers to services.
2. Identify innovative mental health treatments, services, and technologies that are demonstratively effective and can be widely replicated in different settings.
3. Formulate policy options that could be implemented by public and private providers and federal, state, and local governments to integrate the use of effective treatments and services, improve coordination among service providers, and improve community integration for adults with serious mental illnesses and children with serious emotional disturbances.

Principles
The Commission shall

1. Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
2. Focus on community-level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
3. Focus on those policies that maximize the utility of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers.
4. Consider how mental health research findings can be used most effectively to influence the delivery of services.
5. Follow the principles of federalism, and ensure that its recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of states.

References
Healthy People 2010 presents a comprehensive, nationwide health promotion and disease-prevention agenda. It is designed to serve as a road map for improving the health of all people in the United States during the first decade of the 21st century. Healthy People 2010 represents the third time that the US Department of Health and Human Services (HHS) has developed 10-year health objectives for the nation. More information on Healthy People 2010 can be obtained at www.healthypeople.gov.

Listed below is a compilation of selected Healthy People 2010 objectives that relate to mental health and substance abuse (assembled March 1, 2007) for children and adolescents.

6-2. Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.
Target: 17 percent.
Baseline: 31 percent of children and adolescents aged 4 to 11 years with disabilities were reported to be sad, unhappy, or depressed in 1997.
Target setting method: 45 percent improvement (parity with children and adolescents without disabilities in 1997).
Data source: National Health Interview Survey (NHIS), CDC, NCHS.

7-2. Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Target and baseline:

<table>
<thead>
<tr>
<th>Objective: Schools Providing School Health Education in Priority Areas</th>
<th>1994 Baseline (%)</th>
<th>2010 Target (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-2a. All components</td>
<td>28</td>
<td>70</td>
</tr>
<tr>
<td>Individual components to prevent health problems in the following areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-2b. Unintentional injury</td>
<td>66</td>
<td>90</td>
</tr>
<tr>
<td>7-2c. Violence</td>
<td>58</td>
<td>80</td>
</tr>
<tr>
<td>7-2d. Suicide</td>
<td>58</td>
<td>80</td>
</tr>
<tr>
<td>7-2e. Tobacco use and addiction</td>
<td>86</td>
<td>95</td>
</tr>
<tr>
<td>7-2f. Alcohol and other drug use</td>
<td>90</td>
<td>95</td>
</tr>
<tr>
<td>7-2g. Unintended pregnancy, HIV/AIDS, and STD infection</td>
<td>65</td>
<td>90</td>
</tr>
</tbody>
</table>
7-2h. Unhealthy dietary patterns | 1994 Baseline (%) | 2010 Target (%)  
--- | --- | ---  
7-2i. Inadequate physical activity | 78 | 90  
7-2j. Environmental health | 60 | 80

Target setting method: 150 percent improvement for 7-2a; percentage improvement varies for individual components 7-2b through 7-2j.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

7-3. Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas.

Target: 25 percent.

Baseline: 6 percent of undergraduate students received information from their college or university on all six topics in 1995: injuries (intentional and unintentional), tobacco use, alcohol and illicit drug use, sexual behaviors that cause unintended pregnancies and sexually transmitted diseases, dietary patterns that cause disease, and inadequate physical activity.

Target setting method: Better than the best.

Data source: National College Health Risk Behavior Survey, CDC, NCCDPHP.

16-5. Reduce maternal illness and complications due to pregnancy.

Target and baseline:

<table>
<thead>
<tr>
<th>Objective: Reduction in Maternal Illness and Complications</th>
<th>1998 Baseline (Per 100 Deliveries)</th>
<th>2010 Target (Per 100 Deliveries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-5a. Maternal complications during hospitalized labor and delivery</td>
<td>31.2</td>
<td>24</td>
</tr>
<tr>
<td>16-5b. Ectopic pregnancies</td>
<td>Developmental</td>
<td>Developmental</td>
</tr>
<tr>
<td>16-5c. Postpartum complications, including postpartum depression</td>
<td>Developmental</td>
<td>Developmental</td>
</tr>
</tbody>
</table>

Target setting method: Better than the best.

Data source: National Hospital Discharge Survey (NHDS), CDC, NCHS.

Potential data source: National Hospital Discharge Survey (NHDS), CDC, NCHS.

18-1. Reduce the suicide rate.

Target: 5.0 suicides per 100,000 population.

Baseline: 11.3 suicides per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population).

Target setting method: Better than the best.

Data source: National Vital Statistics System (NVSS), CDC, NCHS.
18-2. Reduce the rate of suicide attempts by adolescents.
Target: 12-month average of 1 percent.
Baseline: 12-month average of 2.6 percent of adolescents in grades 9 through 12 attempted suicide in 1999.
Target setting method: Better than the best.
Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

18-5. (Developmental) Reduce the relapse rates for persons with eating disorders including anorexia nervosa and bulimia nervosa.
Potential data source: Prospective studies of patients with anorexia or bulimia nervosa, NIH, NIMH.

18-6. (Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment.
Potential data source: Primary Care Data System/Federally Qualified Health Centers, HRSA.

18-7. (Developmental) Increase the proportion of children with mental health problems who receive treatment.
Potential data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS.

18-8. (Developmental) Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems.
Potential data source: Inventory of Mental Health Services in Juvenile Justice Facilities, SAMHSA.

18-10. (Developmental) Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.
Potential data sources: National Health Interview Survey (NHIS), CDC, NCHS; National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS; Replication of National Comorbidity Survey, NIH, NIMH.

18-12. Increase the number of States and the District of Columbia that track consumers’ satisfaction with the mental health services they receive.
Target: 50 States and the District of Columbia.
Baseline: 36 States tracked consumers’ satisfaction with the mental health services they received in 1999.
Target setting method: Total coverage.
Data source: Mental Health Statistics Improvement Program, SAMHSA.

18-13. (Developmental) Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses cultural competence.
Potential data source: National Technical Assistance Center for State Mental Health Systems, National Association of State Mental Health Program Directors, National Research Institute; SAMHSA, CMHS.

Target and baseline:

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<thead>
<tr>
<th>Objective: Reduction in Steroid Use Among Adolescents in Past Year</th>
<th>1998 Baseline (%)</th>
<th>2010 Target (%)</th>
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<td>26-14b. 10th graders</td>
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<td>26-14c. 12th graders</td>
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Target setting method: Better than the best.
Data source: Monitoring the Future Study, NIH, NIDA.

26-22. (Developmental) Increase the proportion of persons who are referred for followup care for alcohol problems, drug problems, or suicide attempts after diagnosis or treatment for one of these conditions in a hospital emergency department.
Potential data source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

26-23. (Developmental) Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.
Potential data source: Community Partnerships Data, SAMHSA.

**Acronym Key**
CDC = Centers for Disease Control and Prevention
HRSA = Health Resources and Services Administration
NCCDPHP = National Center for Chronic Disease Prevention and Health Promotion
NCHS = National Center for Health Statistics
NIDA = National Institute on Drug Abuse
NIH = National Institutes of Health
NIMH = National Institute of Mental Health
OAS = Office of Applied Studies
SAMHSA = Substance Abuse Mental Health Services Administration

**References**
The Illinois Children’s Mental Health Partnership (ICMHP) is a collaborative, statewide entity that was created by the Illinois Children’s Mental Health (CMH) Act of 2003. The ICMHP is composed of 25 members who were appointed by the Governor and who represent families, child advocates, education, early childhood, primary care clinicians, public health, mental health, child welfare, juvenile justice, substance abuse, violence prevention, and others. State legislators—2 members of each caucus of the House of Representatives and Senate—and representatives from key state agencies and departments (eg, child welfare, public health, mental health, education, and corrections) are also on the ICMHP.

The Illinois CMH Act of 2003 was created to develop a comprehensive system of community and state programs, services and resources that promote the mental health and well-being of children birth to 18 years of age, intervene early to address potential mental health needs, and provide comprehensive mental health services for children who need them. This groundbreaking Act represented the work of more than 100 multidisciplinary agencies and organizations (including the Illinois Chapter of the American Academy of Pediatrics) and families committed to the well-being of Illinois children.

The CMH Act created the Illinois Children’s Mental Health Partnership to develop and monitor implementation of a statewide Children’s Mental Health Plan that outlines a comprehensive, coordinated approach to prevention, early intervention, and treatment for children from birth to 18 years of age. The Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois was submitted to the Governor on June 30, 2005, and is available at: www.ivpa.org. A copy of the Executive Summary of this Strategic Plan follows.

Currently, the ICMHP is implementing key strategic priority areas of the Strategic Plan. A progress report was submitted to the Governor in September 2006 and also is available at www.ivpa.org.
Illinois Children’s Mental Health Partnership

Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois

EXECUTIVE SUMMARY

June 30, 2005

Rod R. Blagojevich
Illinois Governor

Barbara Shaw
Partnership Chair
Research clearly demonstrates that children’s healthy social and emotional development is an essential underpinning to school readiness, academic success, health, and overall well-being. Prevention and early intervention efforts have been shown to improve school readiness, health status, and academic achievement, and to reduce the need for more costly mental health treatment, grade retention, special education services, and welfare supports.
Many mental health problems are largely preventable or can be minimized with prevention and early intervention efforts. Yet, the current children’s mental health system in Illinois places little or no emphasis on prevention or early intervention, and only a small percentage of Illinois children who need mental health treatment receive it.
## Children’s Mental Health Partnership Members

### Partnership Chair
Barbara Shaw  Illinois Violence Prevention Authority

### Executive Committee
- **Ray Connor**  Individual Care Grant Parents Association
- **Ruth Cross**  Naperville School District
- **Claudia L. Fabian**  Latino Coalition for Prevention
- **Karen Freel**  Ounce of Prevention Fund
- **Gaylord Gieseke**  Voices for Illinois Children
- **Gene Griffin**  Illinois Department of Children & Family Services
- **Annette Johnson**  Illinois Chapter, National Black Social Workers Association
- **Christopher Koch**  Illinois State Board of Education
- **Carolyn Cochran-Kopel**  Illinois Department of Human Services
- **Maria McCabe**  Illinois School Counselors Association
- **Anne Marie Murphy**  Illinois Department of Public Aid
- **Peter Nierman**  Division of Mental Health, Illinois Department of Human Services
- **Louanner Peters**  Office of the Governor
- **Amy Ray**  Illinois Department of Corrections
- **Elizabeth Richmond**  Illinois Adoption Advisory Council
- **Toni Rozanski**  Illinois Department of Public Aid
- **Barbara Shaw**  Illinois Violence Prevention Authority
- **Florence Townsend**  Association of Black Psychologists
- **Peter Tracy**  Association of Community Mental Health Authorities of Illinois
- **Paula Wolff**  Chicago Metropolis 2020

### Committee Co-Chairs
**Cultural Competence**
- **Claudia L. Fabian**  Latino Coalition for Prevention
- **Rebecca Smith-Andoh**  Mill Street Elementary School

**Early Childhood**
- **Karen Freel**  Ounce of Prevention Fund
- **Gaylord Gieseke**  Voices for Illinois Children

**Family Involvement**
- **Ray Connor**  Individual Care Grant Parents Association
- **Darnell Cunningham**  System of Care Chicago

**Public Awareness**
- **Florence Townsend**  Association of Black Psychologists
- **Paula Wolff**  Chicago Metropolis 2020

**School Age**
- **Maria McCabe**  Illinois School Counselors Association
- **Peter Tracy**  Association of Community Mental Health Authorities of Illinois
### School Policies and Standards

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<td>Naperville School District</td>
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<td>Illinois Chapter, National Black Social Workers Association</td>
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### Management Team

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<tr>
<td>Barbara Shaw</td>
<td>Illinois Violence Prevention Authority</td>
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<tr>
<td>Gaylord Gieseke</td>
<td>Voices for Illinois Children</td>
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<tr>
<td>Laura Hurwitz</td>
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<td>Karen VanLandeghem</td>
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### Partnership Members

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<tr>
<td>Scott G. Allen</td>
<td>Illinois Chapter, American Academy of Pediatrics</td>
</tr>
<tr>
<td>Superintendent Gene Amberg</td>
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<tr>
<td>Representative Patricia R. Bellock</td>
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<tr>
<td>Debbie Bretag</td>
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<td>Terry Carmichael</td>
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<td>Betsy Clarke</td>
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<td>Illinois Department of Human Services</td>
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<tr>
<td>Susan Krause</td>
<td>Youth Service Bureau for McHenry County</td>
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<tr>
<td>Dian Ledbetter</td>
<td>Illinois Federation of Families</td>
</tr>
<tr>
<td>Lynn Liston</td>
<td>Illinois Association of Infant Mental Health</td>
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<tr>
<td>Senator Iris Y. Martinez</td>
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<td>Maria McCabe</td>
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<td>Division of Mental Health, Illinois Department of Human Services</td>
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<td>Chief Ignacio “Joe” Pena</td>
<td>Fight Crime: Invest in Kids Illinois</td>
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<td>Louanne Peter</td>
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<td>Senator Jeffrey M. Schoenberg</td>
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<td>William Schwartz</td>
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Foreword

The mental health needs of Illinois children and adolescents are very real and evident. You don’t have to look any further than the daily newspaper headlines to find them – teen suicide, toddler expulsions from child care because of behavior problems, school violence and bullying. The mental health needs of our State’s most precious resource – children and adolescents – has reached epidemic proportions and is a public health crisis for our State and the nation. Illinois became a nationwide leader in addressing this crisis when it enacted the Children’s Mental Health Act of 2003, forming the Illinois Children’s Mental Health Partnership and charging it with developing a statewide strategic plan to reform the Illinois children’s mental health system.

It is with great pleasure that the Illinois Children’s Mental Health Partnership (ICMHP) presents its Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois. The Plan represents the work of over 250 individuals and groups and the endorsement of ICMHP members. It is a statewide strategic blueprint or “roadmap” that outlines the recommendations and strategies identified by the ICMHP as critical to reforming the children’s mental health system in Illinois.

In crafting this strategic Plan, the Illinois Children’s Mental Health Partnership set out to identify the key issues facing children, youth and their families and the challenges to and gaps in mental health programs and services for children. The Partnership heard from parents, grandparents, advocates, teachers, school administrators, doctors, child care workers, school nurses, public health professionals, psychologists, psychiatrists, law enforcement, special education teachers, school social workers and counselors, child welfare workers and many others. What we learned was striking and sobering.

- Opportunities are often missed for educating new parents, caregivers such as grandparents, and child-serving professionals about the impact of children’s social and emotional development on overall health, well-being and academic outcomes.
- An alarming number of young children have mental health needs yet many early childhood programs, health care providers and others who come into regular contact with young children and their families are ill-equipped to identify and address these needs.
- Many schools lack sufficient and appropriately trained staff to handle the numbers of students with mental health needs.
- There are not enough mental health providers available to meet the demand for mental health services, particularly in rural and other underserved areas.
- Families who have children with severe mental health disorders must navigate multiple and complex, uncoordinated service delivery systems in order to obtain mental health services.
- A significant proportion of youth in the juvenile justice system have mental health problems and evidence suggests that many were placed in this system because of a lack of community-based mental health services.
- A significant proportion of children and youth entering the child welfare system are suffering from the impact of exposure to trauma, violence and neglect.

Fortunately, we know from the research that by investing in mental health promotion efforts and intervening early when mental health needs first appear, poor outcomes can be dramatically prevented and minimized. Prevention, promotion and early intervention efforts are cost effective and have been shown to build resilience and improve health, mental health and academic outcomes in children and youth.
The Partnership envisions a comprehensive, coordinated children’s mental health system comprised of prevention, early intervention and treatment programs and services for children ages birth – 18 years. This also includes concerns about children transitioning from systems such as child welfare, juvenile justice and mental health. The Children’s Mental Health Plan is a statewide strategic “roadmap” that can help Illinois achieve this vision. It covers a range of recommendations and strategies necessary to reform the children’s mental health system in Illinois that include the following:

- Working with and engaging families in all aspects of the system.
- Promoting children’s optimal social and emotional development.
- Identifying mental health needs and intervening early.
- Ensuring that mental health programs and services meet the needs of diverse communities.

- Promoting multi-agency collaboration at the state, regional, and local level to maximize scarce resources, minimize duplication of services, and facilitate access to services.
- Increasing mental health programs and services, especially in underserved areas of the state.
- Building a culturally-competent, qualified and adequately trained workforce with a sufficient number of professionals to serve children and their families.

In submitting this Plan, the ICMHP recognizes that we have just begun our work. True reform of the children’s mental health system will require engaging families, communities, policymakers, educators, health care and mental health providers and many others in a collaborative effort to achieve these recommendations. And, while many of these recommendations and strategies are readily achievable many others will entail a phased-in approach that is implemented over time. It is a task that we are deeply committed to and collectively ready to undertake.

We urge the Governor to fully support the Plan and to continue to make children’s mental health a priority in Illinois.

Barbara Shaw

*Chair, Illinois Children’s Mental Health Partnership*
The Children’s Mental Health Plan was developed as a result of the diligent work and thoughtful contributions of over 250 individuals and groups committed to and concerned about the health and well-being of Illinois children, adolescents and their families. Under the leadership of Barbara Shaw, ICMHP Chair and Committee Co-Chairs, members of the Partnership and its six standing Committees spent a year-and-a-half examining the latest research, learning about the needs of Illinois children and their families, deliberating about the strategies necessary to achieving true system reform, and obtaining public input to drafts of the Plan. These individuals and groups – families and caregivers, educators, health care and mental health providers, child advocates, legislators, and professionals from early childhood, child welfare, juvenile justice and other systems – are commended for their tireless dedication to this effort.

This Plan could not have been achieved without the important work of the Illinois Children’s Mental Health Task Force. The Task Force developed a ground-breaking report, *Children’s Mental Health: An Urgent Priority for Illinois*, highlighting the significant mental health needs of Illinois children and calling for reform of the Illinois children’s mental health system. This Plan builds on the work of the Task Force report.

Voices for Illinois Children, under the leadership of Gaylord Gieseke, provides critical support to the ICMHP including serving as its fiscal and physical home.

The ICMHP is supported by the Illinois Violence Prevention Authority, the Illinois Department of Children and Family Services, Illinois Children’s Healthcare Foundation, Association of Community Mental Health Authorities of Illinois, The Spencer Foundation, and Michael Reese Health Trust. Blue Cross/Blue Shield of Illinois graciously provides the facilities for many of the ICMHP meetings. Voices for Illinois Children contributed a monetary award to the ICMHP in recognition and support of ICMHP work. In addition, the ICMHP would like to thank the National Governors Association and the National Association of State Mental Health Program Directors for providing technical assistance and support on key issues covered in the Plan.

Finally, Laura Hurwitz and Karen VanLandeghem, ICMHP, Carey McCann, Ounce of Prevention Fund, Kimberly Fitzgerald Moran, Voices for Illinois Children, and John Payton, University of Illinois at Chicago (CASEL) provided critical staff support to the work of the ICMHP Committees. In addition, Vikki Rompala, mental health fellow, provided important staff support to the work of the ICMHP.

This report was written by Karen VanLandeghem, ICMHP associate director, with assistance from Laura Hurwitz, ICMHP project coordinator, and designed by Steve Hartman, president, Creativille, Inc. (www.creativille.net).
The Children’s Mental Health Plan is a comprehensive vision and strategic roadmap for achieving the goals set forth in the Illinois Children’s Mental Health Act of 2003.
Illinois became a nationwide leader in recognizing the importance of mental health to children’s overall health, well-being and academic success when the Illinois General Assembly passed the Children’s Mental Health (CMH) Act of 2003 and Governor Rod Blagojevich signed the bill into law. With the passage of the CMH Act, the Governor and General Assembly made a clear and critical commitment to children’s mental health and to the need for reforming an existing mental health system that is highly fragmented, under-resourced, and inadequately coordinated to meet the needs of Illinois children and their families.

Among other key areas, the CMH Act created the Illinois Children’s Mental Health Partnership (ICMHP) and charged it with developing a Children’s Mental Health Plan containing short-term and long-term recommendations for providing comprehensive, coordinated mental health prevention, early intervention, and treatment services for children from birth to age 18. The ICMHP is pleased to submit this “Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois” to Governor Rod Blagojevich.

This Plan is a comprehensive vision and strategic roadmap for achieving the goals set forth in the Illinois Children’s Mental Health Act of 2003. It embodies the collective vision and tireless work of over 250 individuals representing families, children and youth, policymakers, advocates, and key systems including mental health, education, early childhood, health, child welfare, substance abuse prevention, violence prevention, and juvenile justice.
ICMHP Vision for a Reformed Children’s Mental Health System

Research clearly demonstrates that children’s healthy social and emotional development is an essential underpinning to school readiness, academic success, health, and overall well-being. Prevention and early intervention efforts have been shown to improve school readiness, health status, and academic achievement, and to reduce the need for more costly mental health treatment, grade retention, special education services, and welfare supports. Unfortunately, a significant number of Illinois children experience serious mental health problems and many of them do not receive the services they need.

Nationally, suicide is the leading cause of death for adolescents and young adults; over 90 percent of these youth have experienced a mental disorder. More toddlers are expelled from pre-kindergarten programs due to behavioral concerns than are students in grades K-12. Over 20 percent of children have a diagnosable mental health problem yet only one in five of these children receive services. Mental health programs and services for children in Illinois – like that of most states – are highly fragmented, under-resourced and limited in scope and place little emphasis on promoting children’s social and emotional well-being, and preventing mental health problems.

Many mental health problems are largely preventable or can be minimized with prevention and early intervention efforts. Yet, the current children’s mental health system in Illinois places little or no emphasis on prevention or early intervention, and only a small percentage of Illinois children who need mental health treatment receive it. While many agencies and systems in Illinois including child welfare, public health, education, human service and juvenile justice attempt to address children’s mental health, there is little coordination, and resources are not maximized, leaving children, families, schools and communities struggling to cope with children’s mental health needs. A comprehensive, coordinated children’s mental health system can help maximize resources and minimize duplication of services.

The Illinois Children’s Mental Health Partnership envisions a comprehensive, coordinated children’s mental health system comprised of prevention, early intervention, and treatment programs and services for children ages 0-18 years, and for youth ages 19-21 who are transitioning out of key public programs (e.g., child welfare, school, the mental health system). Programs and services should be available and accessible to all Illinois children and their families – whether they are a new parent adjusting to the demands of parenthood, a toddler struggling to master basic developmental tasks, an adolescent who is experiencing feelings of depression, or a youth with some other mental health need.

A comprehensive and coordinated children’s mental health system in Illinois should include the following key components.

- **Starts early, beginning prenatally and at birth, and continues throughout adolescence**, including efforts to support youth in making the transition to young adulthood, and through key transitions to adulthood and independent living.

- **Engages families/caregivers** in all aspects of promoting their child’s optimal social and emotional development, and overall mental health. Families should have easy access to needed information, resources and supports. Agencies and organizations should partner with families in policymaking, evaluation and resource decisions at the state, regional and local level.
• Educates families/caregivers, children, providers, public officials and the general public about the importance of children’s mental health.

• Provides quality programs and services that are grounded in evidence-based research and are affordable, family-centered, culturally-competent, and developmentally appropriate. Services and systems should be responsive to the cultural perspectives and characteristics of the diverse populations that are served.

• Delivers services in and across natural settings such as early childhood programs, homes, primary health care settings, and schools in order to successfully reach children and their families.

• Adopts a child developmental approach that takes into account the changing needs of children and adolescents, and their families, as youth age.

• Promotes individualized care for each child and their family guided by a comprehensive, single plan of care that is family-driven and addresses strengths as well as problems and needs.

• Supports smooth transitions between systems and services that are effectively implemented and family friendly.

• Assures that all professionals who come in contact with children are adequately prepared and trained to promote, identify, refer and/or address children’s mental health.

• Builds on and integrates existing systems (e.g., early childhood, health care, education, mental health, juvenile justice, substance abuse, child welfare) that serve children and their families.

• Maximizes public and private resources and invests sufficient resources over time.

• Ensures that programs and services are provided in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.

The Importance of Supporting and Advancing the Children’s Mental Health Plan

The Partnership urges the Governor to continue to support and advance the priority recommendations and related strategies contained within this Plan. These recommendations are designed to maximize scarce resources, build on system strengths and model programs, expand resources over time, and ensure that the needs of children and their families are being met. True system reform will involve implementing these recommendations over time using a phased-in approach.

Since the passage of the CMH Act, the Partnership has made significant progress in key areas of the children’s mental health system. Ongoing support for this Strategic Plan will enable the Partnership and its member agencies and representatives to make further progress and improvements to the CMH system. The strategic priorities and recommendations outline the Partnership’s strategic vision for improving the CMH system.
ICMHP Strategic Priorities

The ICMHP has identified the following Strategic Priorities for focus in the coming year or two.

1) Promote ongoing family/consumer and youth involvement in administrative, policymaking and resource decisions regarding the Illinois children’s mental health system at the state, regional and local level.

2) Advocate for increased children’s mental health services and programs.

3) Develop culturally competent mental health consultation initiative(s) that educate, support and assist providers in key child-serving systems (e.g., early childhood, child care, primary care, public health, mental health and education).

4) Create a comprehensive, culturally inclusive, and multi-faceted public awareness campaign plan.

5) Build public and private sector awareness and response to maternal depression with attention to prevention and early intervention efforts, and necessary follow-up assessment and treatment services, where appropriate.

6) Build and enhance school-based activities focused on social and emotional educational and support services, and provide professional development and technical assistance to school administrators and staff.

7) Promote mental health screening and assessment and appropriate follow-up services of children and youth involved in the child welfare and juvenile justice systems.

8) Increase early intervention and mental health treatment services and supports for children:
   - Ages 0-5 years;
   - Transitioning out of public systems (e.g., child welfare, mental health, juvenile justice);
   - Who have been exposed to or experienced childhood trauma (e.g., violence);
   - Who need follow-up services in the SASS system beyond 90 days; and
   - Who have mental health problems that are not severe enough to qualify them for public programs.

9) Convene a multi-agency and multidisciplinary work group to examine how children’s residential mental health treatment services are funded and accessed in order to develop strategies for improving financing, cost-effectiveness, and access to residential services and alternative community services, where appropriate.

10) Initiate development of a policy and research center(s) to support research-based workforce development, best practice models and technical assistance on children’s mental health in such areas as cultural competence, family involvement and consumer-driven care.
Strategic Plan Recommendations

The following recommendations were identified by the Illinois Children’s Mental Health Partnership as key areas to be initiated, developed, or accomplished over the next few years. Detailed strategies for achieving these recommendations are identified in the main section of this strategic Plan.

GOAL I. DEVELOP AND STRENGTHEN PREVENTION, EARLY INTERVENTION, AND TREATMENT POLICIES, PROGRAMS AND SERVICES FOR CHILDREN

PREVENTION

A. Partner with families/caregivers and youth.
   I. **Recommendation:** Promote ongoing family/consumer participation in operations, policymaking and resource decisions regarding the Illinois children’s mental health system at the state, regional and local level.
   II. **Recommendation:** Develop a mental health system accessible to children ages 0-18 years that respects, supports and treats families/caregivers as key partners.
   III. **Recommendation:** Partner with existing youth leadership groups to advise the Partnership and engage youth in planning at the state, regional and local level.

B. Promote children's mental health services and programs that are culturally and linguistically competent.
   **Recommendation:** Promote state and local agency children’s mental health policies and practices that are culturally and linguistically competent.

C. Establish a mental health consultation initiative that serves early childhood, child care, primary care, mental health, education and other key systems that come into regular contact with children and their families.
   **Recommendation:** Develop culturally and linguistically appropriate mental health consultation initiatives that are accessible and available to programs and providers in key child-serving systems including early childhood, child care, primary care, mental health and education.

D. Increase public and private sector response to maternal perinatal depression.
   **Recommendation:** Work in partnership with the Governor’s maternal depression task force to strengthen best practices, quality standards and training associated with efforts to address perinatal depression in women of child-bearing age.

E. Strengthen and develop best practices, quality standards and professional training associated with voluntary mental health screening conducted with parental consent and parental involvement and in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.
   **Recommendation:** Promote and support initiatives that strengthen and develop best practices, quality standards and professional training associated with voluntary mental health screening conducted with parental consent and parental involvement and in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.
Incorporate the social and emotional development of children as an integral component to the mission of schools, critical to the development of the whole child, and necessary to academic readiness and school success, in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.

I. Recommendation: Work with the Illinois State Board of Education (ISBE) to ensure that all Illinois school districts develop a policy for incorporating social and emotional development into the district’s education program. The policy shall address social and emotional learning, and protocols (i.e., guidelines) for responding to children with social, emotional, or mental health needs.

II. Recommendation: Work with ISBE to ensure that the plan, submitted to the Governor on December 31, 2004, is implemented to incorporate social and emotional learning standards as part of the Illinois Learning Standards.

III. Recommendation: Promote increased collaboration and partnerships among schools and school-based mental health, community mental health, health care, juvenile justice, substance abuse, developmental disability agencies, Early Intervention (Part C of IDEA), child care programs and systems, and families/caregivers and others to promote optimal social and emotional development in children and youth, and access to appropriate services.

EARLY INTERVENTION

A. Build coordinated systems for early intervention and response to mental health needs that are responsive to children and their families.

I. Recommendation: Expand on and build the capacity of child-serving systems and agencies (e.g., early childhood, health care, education, community mental health) to provide early intervention services that are accessible to children.

II. Recommendation: Promote and support initiatives that strengthen best practices, quality standards, and professional training associated with mental health screening and related follow-up assessment and treatment services, as appropriate, for children in the child welfare and juvenile justice systems, in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.

III. Recommendation: Promote the development of a coordinated community response to children exposed to trauma.

IV. Recommendation: Identify best practices for educating expecting families and the general public about the impact of substance abuse on children’s development and for addressing and treating substance exposed infants.

TREATMENT

A. Promote that children have access to quality, coordinated, and culturally competent systems of care that provide comprehensive treatment and family supports.

I. Recommendation: Build and strengthen a quality system of care in Illinois based on the mental health “System of Care” Principles to ensure that children once identified as needing services, have access to a comprehensive array of clinically appropriate assessment, treatment services and supports.

II. Recommendation: Develop mechanisms, as part of the System of Care design, to provide assistance and direct families/caregivers to culturally competent, gender and clinically appropriate services. The system will include clear referral pathways for children involved in the child welfare, juvenile justice, education, substance abuse, family violence, sexual assault, homeless shelters, and developmental disabilities systems.
GOAL II. INCREASE PUBLIC EDUCATION AND AWARENESS

Recommendation: Develop a comprehensive, culturally inclusive, and multi-faceted public awareness campaign to reduce the stigma of mental illness; educate families, the general public and other key audiences (e.g., educators, health and mental health providers, juvenile justice system officials, faith-based organizations, local health department officials) about the importance of children’s social and emotional development; inform families/caregivers, providers, and others about how to access services; and educate policymakers and others about the need for expanding mental health resources.

GOAL III. MAXIMIZE CURRENT INVESTMENTS AND INVEST SUFFICIENT FISCAL RESOURCES OVER TIME

I. Recommendation: Maximize the use of key federal and state program funds for children’s mental health, integrate multiple federal and state funding streams, and promote the use of local matching funds, where appropriate.

II. Recommendation: Make effective use of Medicaid and KidCare to ensure that children receive appropriate mental health services.

III. Recommendation: Initiate development of state funding sources and mechanisms, including incentive-based funding structures and community-based pilot projects and models, to promote best practices in prevention, early intervention, and treatment.

IV. Recommendation: Make policy and planning recommendations to the Governor regarding a state budget for prevention, early intervention, and treatment across all state agencies.

V. Recommendation: Initiate development of state and local mechanisms for integrating federal, state, and local funding sources for children’s mental health.

VI. Recommendation: Explore mechanisms and strategies for increasing private insurance coverage of children’s mental health services.

GOAL IV. BUILD A QUALIFIED AND ADEQUATELY TRAINED WORKFORCE WITH A SUFFICIENT NUMBER OF PROFESSIONALS TO SERVE CHILDREN AND THEIR FAMILIES THROUGHOUT ILLINOIS

A. Expand and develop the mental health workforce.

I. Recommendation: Initiate efforts to expand the mental health workforce to ensure a diverse, adequately trained and qualified workforce that meets the needs of children and their families throughout Illinois.

II. Recommendation: Increase the capacity of programs and providers who work with children (e.g., early childhood, health care, education, mental health, education, child welfare, juvenile justice) to promote and support the social and emotional development and mental health needs of children and their families.
GOAL V. CREATE A QUALITY-DRIVEN CHILDREN'S MENTAL HEALTH SYSTEM WITH SHARED ACCOUNTABILITY AMONG KEY STATE AGENCIES AND PROGRAMS

Recommendation: Initiate development of outcome indicators and benchmarks including links to and integration of early childhood and school learning standards, for ensuring children’s optimal social and emotional development, and improving overall mental health.

GOAL VI. INVEST IN RESEARCH

I. Recommendation: Initiate a Children’s Mental Health Resource Center(s) to collect and facilitate research on best practices and model programs; share information with Illinois policymakers, practitioners and the general public; develop culturally and linguistically competent training and educational materials; provide technical assistance; and implement other key activities.

II. Recommendation: Develop and conduct process and outcome evaluations that measure changes to the children’s mental health system and in child outcomes as a result of implementation of the Illinois Children’s Mental Health Plan.
Framework for a Coordinated Mental Health System* in Illinois for Children Ages 0-18

Prevention

*Coordinated Systems for Promoting Healthy Social and Emotional Development in Children*
- Public education and awareness
- Mental health consultation with providers
- Voluntary home visits
- Parent education and support services
- Social and emotional development programs and curricula for community services and schools

Early Intervention

*Coordinated Systems for Early Detection, Identification, and Response to Mental Health Needs*
- Mental health consultation with providers
- Student support services
- Early identification, assessment, referral, and follow-up
- Short-term counseling and support groups
- Skills-building classes (e.g., problem-solving, anger management)
- Ongoing and crisis support

Treatment

*Coordinated Systems of Care for Providing Comprehensive Treatment and Family Supports*
- Therapy and support groups
- Comprehensive assessment, diagnostic and referral services
- Hospitalization and inpatient mental health treatment services
- Respite and other support services for families
- Drug treatment

*These systems include early childhood, education, mental health, juvenile justice, health, human services, substance abuse, violence prevention, corrections, and other relevant systems.

Adapted from: Minnesota Children’s Mental Health Task Force, Minnesota Framework for a Coordinated System to Promote Mental Health in Minnesota; Center for Mental Health in Schools, Interconnected Systems for Meeting the Needs of All Youngsters.
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Each year, the American Academy of Pediatrics (AAP) compiles annual reports from each chapter. This Chapter Annual Report Compendium highlights projects that chapters have reported working on over the last year, as well as a summary of chapter goals, finances, activities, membership, and administration. Additionally, every 3 years, chapters complete a needs assessment to determine what services the national AAP can provide for chapters. The information provided below can be accessed by members on the AAP member center. The list is not exhaustive.

Most chapters reported working on activities related to the top 5 AAP child health priority areas—Immunizations (98%), Obesity (95%), Mental Health (91%), Children with Special Health Care Needs (89%), and Smoking/Tobacco (84%).

As this Chapter Action Kit also is available electronically, it will be updated as information changes and/or is provided to us. If you are aware of any initiatives that you would like us to consider including in this list, please e-mail us at mentalhealth@aap.org.

### Mental Health Related Chapter Activities 2005-2006

<table>
<thead>
<tr>
<th>State</th>
<th>Activities</th>
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<tbody>
<tr>
<td>Alabama (HP 2010)</td>
<td>Multidisciplinary statewide effort to increase the number of children screened and referred for mental health services; provides ongoing mental health education for members; collaborative efforts between psychiatry and primary care; established a Committee on Mental Health.</td>
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<tr>
<td>Arizona</td>
<td>Training program for pediatricians on developmental screening; workshops on how to use the AAP attention-deficit/hyperactivity disorder toolkit; provides ongoing mental health education for members.</td>
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<tr>
<td>California 3</td>
<td>Behavior and developmental screenings and interventions for children from birth to 5 years of age; works jointly with the local chapter of the American Academy of Child and Adolescent Psychiatry.</td>
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<tr>
<td>Georgia</td>
<td>Coalition with mental health professionals for advocacy, education, and collaboration; provide ongoing mental health education for members; established a Mental Health Task Force.</td>
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<tr>
<td>Kentucky (HP 2010)</td>
<td>Provides ongoing mental health education for members; Implemented Prevention and Awareness of Teen Hardships and Suicide program in an effort to reduce teen suicide and suicide attempts through a rural statewide education/awareness and training program. (For more information see Education Chapter Members Tools and Resources section.)</td>
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<tr>
<td>State</td>
<td>Activities</td>
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<tr>
<td>Louisiana</td>
<td>Formed a collaborative as part of a grant to better provide mental health needs to at-risk children.</td>
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<tr>
<td>Maine</td>
<td>Working on a number of collaborative efforts between psychiatry and primary care.</td>
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<tr>
<td>Massachusetts</td>
<td>Established a Mental Health Task Force.</td>
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<tr>
<td>Minnesota</td>
<td>Projects on maternal and early childhood screening; improving interaction with child psychiatry.</td>
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<tr>
<td>Mississippi</td>
<td>Provides ongoing mental health education for members.</td>
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<tr>
<td>New Jersey</td>
<td>Established a Mental Health Task Force.</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Provides ongoing mental health education for members.</td>
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<tr>
<td>New York 1</td>
<td>Educating primary care clinicians on adolescent depression.</td>
</tr>
<tr>
<td>New York 3 (HP 2010)</td>
<td>Collaborating in Reaching Children Initiatives; implemented Web-based Child Psychiatry Access Project program to make child and adolescent psychiatric services more accessible to primary care professionals via a Web-based consultation program.</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Multiple projects on developmental and behavioral screening, early childhood mental health recognition, assessment, and treatment; multiple projects on training, liaison, and referrals; multiple projects on co-location and collaborative practice; working on a number of collaborative efforts related to psychiatry and primary care.</td>
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<tr>
<td>Ohio</td>
<td>Plans to expand mental health support for children; provides ongoing mental health education for members.</td>
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<tr>
<td>Oregon</td>
<td>Learning collaborative on early childhood mental health and community services; working on collaborative efforts between psychiatry and primary care.</td>
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<tr>
<td>Pennsylvania</td>
<td>Establishing a more coordinated behavioral health system.</td>
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<tr>
<td>Rhode Island</td>
<td>Provides ongoing mental health education for members; working on collaborative efforts between psychiatry and primary care.</td>
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<tr>
<td>South Dakota (HP 2010)</td>
<td>Plans for chapter members and university child and adolescent psychiatry residents to host collaborative office rounds; provides ongoing mental health education for members.</td>
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<td>Tennessee</td>
<td>Piloting co-location models with behavioral health organizations.</td>
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<tr>
<td>Texas</td>
<td>Writing issue briefs on the unaddressed mental health needs of children; established a Mental Health Task Force.</td>
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<td>Uniformed Services East</td>
<td>Programs geared for the special mental health needs of children with deployed parents and parents that have been injured or killed while deployed.</td>
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<tr>
<td>Uniformed Services West (HP 2010)</td>
<td>Implemented the program Deployment Effects on Child and Adolescent Mental Health to increase awareness of, and provide innovative solutions to, complex mental health challenges experienced by children and adolescents of deployed members.</td>
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<tr>
<td>State</td>
<td>Activities</td>
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<tr>
<td>Vermont</td>
<td>Regional meetings with psychiatrists and pediatricians around topics of mental health.</td>
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<tr>
<td>Virginia</td>
<td>Developing strategies to expand access to mental health services or to expand pediatric competencies in care for minor mental conditions; coordinating a collaborative office rounds program; developing collaborative teams of pediatricians and child psychiatrists to link primary care and mental health; provides ongoing mental health education for members; and in April 2006 held a statewide “Linking Primary Care and Mental Health” conference attended by pediatricians, child psychiatrists, state government, and maternal child organizations.</td>
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A Process for Developing Community Consensus Regarding the Diagnosis and Management of Attention-Deficit/Hyperactivity Disorder

Jane Meschan Foy, MD*; and Marian F. Earls, MD‡§

ABSTRACT. There remain large discrepancies between pediatricians’ practice patterns and the American Academy of Pediatrics (AAP) guidelines for the assessment and treatment of children with attention-deficit/hyperactivity disorder (ADHD). Several studies raise additional concerns about access to ADHD treatment for girls, blacks, and poorer individuals. Barriers may occur at multiple levels, including identification and referral by school personnel, parents’ help-seeking behavior, diagnosis by the medical provider, treatment decisions, and acceptance of treatment. Such findings confirm the importance of establishing appropriate mechanisms to ensure that children of both genders and all socioeconomic, racial, and ethnic groups receive appropriate assessment and treatment. Publication of the AAP ADHD toolkit provides resources to assist with implementing the ADHD guidelines in clinical practice. These resources address a number of the barriers to office implementation, including unfamiliarity with Diagnostic and Statistical Manual of Mental Disorders criteria, difficulty identifying comorbidities, and inadequate knowledge of effective coding practices. Also crucial to the success of improved processes within clinical practice is community collaboration in care, particularly collaboration with the educational system. Such collaboration addresses other barriers to good care, such as pressures from parents and schools to prescribe stimulants, cultural biases that may prevent schools from assessing children for ADHD or may prevent families from seeking health care, and inconsistencies in recognition and referral among schools in the same system. Collaboration may also create efficiencies in collection of data and school-physician communications, thereby decreasing physicians’ nonface-to-face (and thus nonreimbursable) elements of care. This article describes a process used in Guilford County, North Carolina, to develop a consensus among health care providers, educators, and child advocates regarding the assessment and treatment of children with symptoms of ADHD. The outcome, ie, a community protocol followed by school personnel and community physicians for >10 years, ensures communication and collaboration between educators and physicians in the assessment and treatment of children with symptoms of ADHD. This protocol has the potential to increase practice efficiency, improve practice standards for children with ADHD, and enhance identification of children in schools. Perhaps most importantly, the community process through which the protocol was developed and implemented has an educational component that increases the knowledge of school personnel about ADHD and its treatment, increasing the likelihood that referrals will be appropriate and increasing the likelihood that children will benefit from coordination of interventions among school personnel, physicians, and parents. The protocol reflects a consensus of school personnel and community health care providers regarding the following: (1) ideal ADHD assessment and management principles; (2) a common entry point (a team) at schools for children needing assessment because of inattention and classroom behavior problems, whether the problems present first to a medical provider, the behavioral health system, or the school; (3) a protocol followed by the school system, recognizing the schools’ resource limitations but meeting the needs of community health care providers for classroom observations, psychoeducational testing, parent and teacher behavior rating scales, and functional assessment; (4) a packet of information about each child who is determined to need medical assessment; (5) a contact person or team at each physician’s office to receive the packet from the school and direct it to the appropriate clinician; (6) an assessment process that investigates comorbidities and applies appropriate diagnostic criteria; (7) evidence-based interventions; (8) processes for follow-up monitoring of children after establishment of a treatment plan; (9) roles for central participants (school personnel, physicians, school nurses, and mental health professionals) in assessment, management, and follow-up monitoring of children with attention problems; (10) forms for collecting and exchanging information at every step; (11) processes and key contacts for flow of communication at every step; and (12) a plan for educating school and health care professionals about the new processes. A replication of the community process, initiated in Forsyth County, North Carolina, in 2001, offers insights into the role of the AAP ADHD guidelines in facilitating development of a community consensus protocol. This replication also draws attention to identification and referral barriers at the school level. The following recommendations, drawn from the 2 community processes, describe a role for physicians in the collaborative community care of children with symptoms of ADHD. (1) Achieve consensus with the school system regarding the role of school personnel in collecting data for children with learning and behavior problems; components to consider include (a) vision and hearing screening, (b) school/academic histories, (c) classroom observation by a counselor, (d) parent and teacher behavior rating scales (eg, Vanderbilt, Conner, or Achenbach scales), (e) consideration of speech/language evaluation, (f) screening intelligence testing, (g) screening achievement testing, (h) full intelligence and achievement testing if discrepancies are apparent in abbreviated...
Community Consensus on ADHD

Publication of the American Academy of Pediatrics (AAP) guidelines for assessment1 and management2 of attention-deficit/hyperactivity disorder (ADHD) was a welcome contribution to pediatricians’ efforts to improve the care and outcomes of 6- to 12-year-old children with attention and behavior problems. As a chronic disorder that affects 4% to 12% of 6- to 12-year-old children1 and results in very challenging personal, clinical, educational, and societal problems, ADHD is an appropriate focus for the efforts of the AAP and practicing pediatricians.

There remain large discrepancies between pediatricians’ practice patterns and the AAP guidelines. As many as 50% of children with ADHD are unidentified and untreated.3 A study by Zito et al4 of methylphenidate use patterns among Medicaid-insured youths raised the additional concern of racial disparities in the treatment of ADHD. That study found that black youths were 2.5 times less likely to receive methylphenidate than were white youths. Bussing5 reported that there are significantly greater barriers to ADHD treatment for girls, blacks, and poorer individuals; these barriers occur at multiple levels, including obtaining evaluations by parents, obtaining the diagnosis by the provider, and obtaining treatment. These studies confirm the importance of establishing appropriate mechanisms to ensure that children of both genders and all socioeconomic, racial, and ethnic groups receive appropriate assessment and treatment.

The AAP ADHD toolkit (available to members at www.aap.org/MOC and to others by telephone order at 800-433-9016, extension 5898) provides resources to assist with implementation of the ADHD guidelines in clinical practice. These resources address a number of the barriers to office implementation, including unfamiliarity with Diagnostic and Statistical Manual of Mental Disorders criteria; difficulty identifying comorbidities; and inadequate knowledge of effective coding practices. Also crucial to the success of improved processes within clinical practice is the establishment of community collaboration in care, particularly collaboration with the educational system. Such collaboration is essential for addressing other barriers to good care, such as pressures from parents and schools to prescribe stimulants, cultural biases that may prevent schools from assessing children for ADHD or prevent families from seeking health care, and inconsistencies in recognition and referral among schools in the same system. Collaboration may also create efficiencies in collection of data and school-physician communications, thereby decreasing physicians’ non-face-to-face (and thus nonreimbursable) elements of care.

This article describes a community process that has the potential to increase practice efficiency and improve practice standards for children with ADHD. This approach also has the potential to enhance identification of children in schools. Perhaps most importantly, this community process has an educational component that increases knowledge of school personnel regarding ADHD and its treatment, increasing the likelihood that referrals will be appropriate and will not presume diagnosis and treatment and increasing the likelihood that children will benefit from coordination of interventions among school personnel, physicians, and parents.

The process depends, at its core, on the mutual interest of school personnel and community health care providers in improving the care of children with ADHD. Like physicians, school personnel find ADHD both challenging and time-consuming. Teachers and school counselors spend enormous amounts of time addressing concerns regarding children who may have ADHD; however, educators may have little accurate knowledge about ADHD and may, in some cases, share misperceptions common among parents, ie, that ADHD is not a real disorder, that ADHD is real but is a minor problem, or that ADHD is caused by too much sugar, food additives, poor parenting, or a stressful family environment. They may think that ADHD is overdiagnosed and overtreated, they may not know which treatments are effective or ineffective, or they may jump to conclusions that children have ADHD and
prompt parents to demand medication. School psychologists are typically more knowledgeable about ADHD but are often overwhelmed by their caseloads and may experience systematic disincentives to identify children with special needs. They may be adversarial toward physicians who demand testing and services for their patients or who do not provide timely medical evaluations and clear communication of results. Nevertheless, it is our experience that a school system’s lead psychologist and/or director of student services will be very interested in an opportunity to collaborate with the community’s health care providers regarding ADHD assessment and management, interested enough to commit both time and resources to the process.

The process described in this article has been used in 2 communities, 1 involving 3 school systems and the other involving 1 school system. The process may be more difficult to apply in communities where many different school systems feed physicians’ practices. In those locations, a regional or state collaboration could follow a similar path.

The outcome of the community collaborative process described in this article is a consensus of school personnel and community health care providers regarding the following: (1) ideal ADHD assessment and management principles (facilitated by the AAP guidelines for children 6-12 years of age); (2) an inventory of relevant services currently available in the community; (3) a common entry point (a team) at schools for children needing assessment because of inattention and classroom behavior problems, whether the problems present first to a medical provider, the behavioral health system, or the school; (4) a protocol followed by the school system, recognizing the schools’ resource limitations but meeting the needs of community health care providers for classroom observations, psychologic testing, parent and teacher behavior rating scales, and functional assessments; (5) a packet of information about each child who is determined to need medical assessment; (6) a contact person or team at each physician’s office to receive the packet from the school and direct it to the appropriate clinician; (7) an assessment process that investigates comorbidities and applies appropriate diagnostic criteria; (8) evidence-based interventions; (9) processes for follow-up monitoring of children after establishment of a treatment plan; (10) roles for central participants (school personnel, physicians, school nurses, and mental health professionals) in assessment, management, and follow-up monitoring of children with attention problems; (11) forms for collecting and exchanging information at every step; (12) processes and key contacts for flow of communication at every step; and (13) a plan for educating school and health care professionals about the new processes.

CASE STUDY 1: GUILFORD COUNTY, NORTH CAROLINA

Guilford County, North Carolina, had 3 school systems in 1992, when this community process began. The school population was ~60,000. Local pediatricians were frustrated with the lack of data on which to base diagnoses for children with classroom behavior problems and to determine treatment. Pediatricians commonly received requests for stimulant medication from parents who had been advised by teachers to make such requests. The requests sometimes came with some documentation from the school or with nothing except the teacher’s verbal report to the parent. This put the pediatrician in the position of trying to make a very complex decision during the very limited time of a routine office visit, in which the child or adolescent might demonstrate none of the classic characteristics of ADHD. When medication was prescribed, the physician was most often “out of the loop” for feedback about classroom effectiveness and needed to decide on medication adjustments without data from the school.

Developmental/behavioral pediatricians in private community practice received numerous referrals from pediatricians and parents. Because the children referred to them were privately insured and were able to pay for components of care not reimbursed by third parties, these developmental/behavioral pediatricians were able to provide thorough evaluations; however, they also experienced barriers to communication with teachers and school officials. Other specialists who treated patients for ADHD, ie, private psychiatrists, psychologists, and neurologists, also did not have consistent processes for communication with schools. The area’s public mental health program (PMHP) was inundated with referrals for therapy and medication management, primarily for children who had Medicaid insurance and whose families did not have access to private specialists. Because the PMHP also monitored many children with other psychiatric diagnoses and with severe persistent illnesses, the PMHP found ADHD referrals unmanageable. In addition, the stigma of receiving services at the PMHP center and the difficulty of keeping all of the required visits for therapy resulted in poor follow-through by families.

Most of the Guilford County children with Medicaid insurance received their primary care from pediatricians in comprehensive pediatric clinics of the Guilford County Department of Public Health, now collectively as Child Health (CH). The CH pediatricians were the catalysts for the development of the community collaboration process for ADHD. The schools were also frustrated with the haphazard referral process and the variation in treatment patterns. Teachers, psychologists, and administrators all desired better communication. School nurses were often in the untenable position of responding to questions from school personnel about ADHD medications with no information from the physician. Parents were often poorly informed and uncomfortable with medication decisions. Communication problems frequently resulted in an adversarial relationship between the parents and the school, the physician, or both. It was in this setting that conversation among the participants became imperative.
**Motivation for Change**

The process through which Guilford County achieved consensus regarding assessment and treatment of children with attention problems required 9 months and 6 meetings of a multiagency community group. The CH pediatricians led the community planning effort. These physicians were inundated by requests for methylphenidate prescriptions from parents and teachers, typically without supporting information from the school and without a commitment for parallel behavioral interventions or evaluations for comorbidities.

The CH physicians developed a consensus report on the care of children with ADHD. The report highlighted the prevalence of ADHD and its comorbidities, their combined societal impact, the importance of school information in diagnosis and follow-up monitoring, the necessity of identifying comorbid mental health conditions, the challenges posed by the chronicity of ADHD and by disconnected sites of service in the community, and the importance of educational and behavioral interventions in association with medication. The report ended with the following statement: “Child Health physicians planned to implement new practices in the care of children with ADHD. These practices would require more information from schools before prescribing stimulant therapy and, in most instances, a mental health assessment to assess for comorbidities. The school and mental health assessments were considered necessary to rule out comorbidities such as learning or language disabilities, depression, anxiety, or oppositional disorder” (J.M.F., unpublished data, 1991). The report acknowledged that these new requirements would have an impact on community school and mental health systems.

**Identification of Stakeholders**

After making telephone contact with all stakeholders and establishing a meeting time, the CH pediatricians sent their report to all community agencies involved in the education and health care of children and to local parent support and advocacy groups, along with invitations to participate in a planning process for the improved care of children with attention and behavior problems. Invitees included representatives of the 3 local school systems, local health department administration and the school health nursing leadership, and the local PMHP, developmental and behavioral pediatricians, psychologists, and family advocacy representatives.

The impending CH changes created a strong motivation for invitees to participate. Most also reported particular difficulties in providing services and coordinating care for low-income children with ADHD and were responsive to the planning effort.

**Clear Objectives for the Process**

Objectives for the process were clearly stated in the invitation to participate, ie, (1) to communicate the changing emphasis of CH in the care of children with ADHD, (2) to anticipate the effects of that new emphasis and related procedures on schools and on clients’ utilization of local mental health agencies, (3) to clarify the roles of schools and local agencies in the care of children with ADHD, and (4) to identify coordinating mechanisms in the care of children with ADHD.

**Resources to Facilitate the Process**

The medical director of CH (this report’s lead author) had the resources to lead the process, including protected administrative time, secretarial support, access to professionals with content expertise in ADHD, and training in group processes. The structure provided for the process included meeting locations, detailed minutes, compilation and distribution of materials, an agenda and facilitator for each meeting, and consultation with an expert, Steven Band, PhD, a clinical psychologist with a special interest in ADHD.

**Contents of Meetings**

**Introductory Meeting**

The following questions were addressed: Who are current providers of services to children with attention and classroom behavior problems? What are their biases, experiences, limitations, strengths, and capacities? What are they currently doing to serve these children? What tools are they using? What can they contribute to a community model of care? What processes do they recommend for pursuing the group’s objectives and planning a community model of care?

This session began with the self-introduction of participants, many of whom had not met previously. Each participant had the opportunity to express frustration, describe resource concerns, provide that organization’s perspective on gaps and issues, and summarize organizational mandates, emphases, and trends. Careful notes documented these introductory remarks and enabled participants to move from “turf” concerns to broader issues. The exchange enabled school representatives to air their concerns about the adversarial quality of some demands parents and physicians made of the school, often including a complete battery of psychologic tests for students with relatively minor problems; physicians aired their concerns about demands for medication, conveyed by parents and/or school staff members. Participants agreed on topics and a schedule for subsequent meetings, with each organization identifying its potential service contribution and role in coordination.

**Building Consensus Regarding Assessment**

The following questions were addressed: What are the components of an ideal assessment? What is a realistic standard for the community? What specific methods and tools can we use to meet that standard? Which of these methods and tools are available to physicians and which must be provided by others? How can we ensure that necessary information is available to those who need it? How can we identify and refer children who require additional mental health assessment and related procedures on schools and on clients’ utilization of local mental health agencies, (3) to clarify the roles of schools and local agencies in the care of children with ADHD, and (4) to identify coordinating mechanisms in the care of children with ADHD.
health evaluation, and how can we ensure that their other problems are addressed?

This was the most challenging and complex undertaking of the process. Participants discussed ADHD symptoms, comorbidities, diagnostic methods, and tools. They generated a list of decisions critical to a community protocol. Key items included a common definition of the minimal components of assessment and common forms to prompt complete data collection and to facilitate the exchange of information. The group decided to form subcommittees to draft a coordinated interagency assessment model and to develop tools to facilitate transmission of information.

The subcommittees met before the third meeting of the entire group. Work products included a packet for the use of physicians, including 2-way release forms for all agencies; descriptive materials for parents about each agency; educational materials about ADHD for parents; a report form for medical providers to communicate their diagnoses and medication decisions to schools and other agencies; a coordinating mechanism to balance the load of referrals among community providers; and a preassessment protocol to be followed by schools before referral of a child for medical and/or mental health assessment. The latter included vision and hearing screening, health history, school history, classroom observation by a counselor, completion of behavior rating scales by the parents and teacher; consideration of speech/language evaluation, classroom interventions (trial of at least 6 weeks), evaluation of interventions, and consultation with a school psychologist.

Key compromises were made. Physicians, who had initially expected the schools to provide complete individual intelligence and academic test results for each child, acknowledged the schools' resource limitations and agreed to accept screening intelligence and achievement tests (ie, the Kaufman Brief Intelligence Test and the Kaufman Test of Educational Achievement) as a part of the preassessment protocol, provided that students with discrepancies would be tested more fully. School personnel agreed not to prompt parents to demand medication for their children. All participants agreed that children who presented to them directly with their concerns would not be offered a bypass around this process; they would be directed to take their concerns to a common entry point, namely, the school-based committee responsible for collecting the preassessment data.

The subcommittee offered a draft summary form to record all preassessment data and a draft diagram of a community assessment pathway. In addition to the features described above, the model designated a team, composed of a school psychologist and representatives of the PMHP and CH, that would meet regularly to review preassessment materials collected by the schools, to determine individual children's assessment plans (ie, whether medical and/or mental health evaluations were indicated and which agencies should be involved and in what sequence), and to prioritize children awaiting evaluation. At the third full group meeting, participants responded to the assessment subcommittee reports with suggestions for additional refinements.

Building Consensus Regarding Interventions

The following questions were addressed: What are effective and ineffective interventions for ADHD? Which organizations have services to offer? How can the community share responsibility for serving diagnosed children and how can their various services be coordinated?

After responses to the work of the assessment subcommittees, discussion at the fourth full group meeting moved on to intervention strategies. After review of the literature on effective and ineffective interventions for ADHD, the group generated a list of community gaps and needs. An intervention subcommittee was charged with developing a community intervention model based on existing resources and best practices.

The intervention subcommittee proposed that a multidisciplinary intervention team at CH receive the assessment recommendations from medical and mental health providers. The team would develop an intervention and follow-up plan and assign a school-based intervention coordinator to implement plans, to track progress, and to ensure ongoing communication with parents and reassessment if indicated.

The subcommittee proposed the intervention model to the full group at the fifth meeting. Because of the differing resources and geographic features of the 3 school systems, there were some differences in details adopted by the 3 systems, although there was an overall consensus regarding roles and concepts. The meeting closed with a clarification of the "other health impaired" designation process and the respective roles of participants in pursuing such a designation for a child.

Wrapping Up

The following questions were addressed: Do we have agreement? How will we disseminate the plan and enact it?

The agenda of the final full group meeting included a progress report from each school system, distribution of finalized model diagrams and forms, and plans for educating various school and health care professional groups and parents about the new model. The group adjourned.

Outcome

School system representatives facilitated implementation at the school level, through a series of in-service training sessions for school counselors and other key personnel. As a result of the community collaborative process, CH pediatricians began to receive a packet of information for each child who had been referred with a possibility of ADHD. At CH, a multidisciplinary procedure, which involved review of school preassessment packets for 2 or 3 children in an afternoon, was implemented. The group reviewed information, requested additional assessments if deemed necessary, and made plans for the child's medical assessment and for a mental health assessment, if necessary. The school nurse coordinated ap-
pointments, ensured communication between health care providers and the school, facilitated a medication trial (if medication was prescribed), and obtained follow-up forms needed to monitor the child’s progress in school and at home.

The viability of the community process has depended on periodic review, updates, and improvements. For example, with time the multidisciplinary meetings became logistically unwieldy. It also became clear that the PMHP did not have the staff or resources to focus on children with the diagnosis of ADHD. Four years after the initial community meetings, a child psychiatrist from the PMHP developed a task force to revisit the original consensus. The task force again convened all stakeholders and reached a new consensus regarding the school as the point of entry for referral, an interagency review team to assign referral sites, and common forms and procedures for information-sharing. This process has continued since then, eventually involving patients of private pediatricians as well as CH. A flowchart representing the current Guilford County process and generic versions of the forms used to convey information from schools to physicians and from physicians to schools are available at the Web site of the North Carolina Chapter of the AAP (www.ncpeds.org).

Every year, school system leaders reinforce the process at a pediatric grand rounds with community physicians. The intention is to involve new physicians and to update and maintain the process.

CASE STUDY 2: REPLICATION OF THE COMMUNITY PROCESS IN FORSYTH COUNTY, NORTH CAROLINA, 2001 TO PRESENT

In 2001, a similar process was initiated in Forsyth County, North Carolina, in an effort to build community consensus regarding the assessment and treatment of elementary school-aged children with ADHD symptoms. The Forsyth County process benefited from the publication of the AAP guidelines for assessment and management of ADHD; however, the Forsyth County process brought to light an unexpected impediment to the identification and referral of children with symptoms of ADHD. For these reasons, this process is briefly described, as it contrasts with the Guilford County process.

Forsyth County has a single school system serving ~45,000 students. Although the initiative in Forsyth County occurred 10 years later than that in Guilford County, community pediatricians and school personnel experienced similar frustrations with the identification and care of children with attention and behavior problems. Unlike in Guilford County, low-income children receive their care in both private and public settings, approximately one half in county-funded, university-administered clinics and one half in private practices.

The Forsyth County consensus-building process was simpler than that for Guilford County, involving the lead psychologist and lead social worker from the school system and a university-based pediatrician (the same individual who initiated the Guilford County process) and targeting elementary school-aged children. A private pediatrician and representatives of the area’s PMHP participated on an ad hoc basis, to address issues specific to their respective groups.

The AAP guidelines greatly facilitated the consensus-building phase of the effort. Furthermore, because the school system representatives were acquainted with and motivated by the success in Guilford County, the Forsyth County process moved rapidly to the decision that elementary school personnel would provide community physicians with the information they needed to meet the AAP standards. School administrative personnel committed to collect the following information: (1) 2-way, information-release forms signed by parents, (2) demographic information, (3) school diagnostic information (including aptitude and achievement screening results), (4) child and family histories (later eliminated; see discussion below), (5) Vanderbilt Parent and Teacher Behavior Rating Scales, (6) teacher comment sheets, and (7) classroom modifications/interventions (later eliminated as a component of the initial physician packet; see discussion below).

The Forsyth County decision to use the Vanderbilt scale as the screening instrument offered several advantages for physicians, ie, an ADHD-specific, Diagnostic and Statistical Manual of Mental Disorders-based format, screening for comorbidities, assessment of functional impairment, and follow-up monitoring for medication side effects. It also offered advantages for school psychologists, because it is free and easy to use and because other instruments (eg, the Behavior Assessment System for Children or the Achenbach scale) can be reserved for second-tier testing. School personnel committed to screen each child’s cognitive ability and academic performance and to pursue complete psychologic testing if discrepancies appeared significant. The process called for school personnel to compile the specified information on forms developed during the consensus process and to forward the forms in a packet to the child’s physician. Physicians were charged with communicating back to the child’s school their assessment and treatment decisions and follow-up needs. School system representatives assigned primary responsibility for implementation of the process at the school level to the chair of each elementary school’s Student Assistance Team (SAT) (typically, the school guidance counselor).

In the early months, physicians did not consistently receive the promised packets. SAT chairs complained that the process was too cumbersome. In retrospect, process leaders concluded that inclusion of SAT representatives in the planning process might have anticipated or averted the implementation problems. The planning group reconvened in September 2003, this time with SAT representatives. The group agreed to eliminate from the initial physician packet the child and family histories (relying on physicians to collect this information in their offices) and to eliminate the report of classroom modifications (implementing and reporting on them at a later point in the process).

The participation of SAT chairs contributed signif-
antly to the group’s understanding of factors affecting educational evaluation and medical referral of children with symptoms of ADHD. It came to light that there is considerable variation in the function of SATs at individual elementary schools. (This variation is a result of the school system’s commitment to decentralized, site-based management.) Whereas some SATs assume broad responsibility for assessing children with behavior and academic problems, others have the narrowly defined role of evaluating only students who appear to qualify for exceptional children’s services. In schools served by the narrowly focused SATs, students who experience behavior problems in the classroom are typically referred to the assistant principal for disciplinary action, rather than behavioral or educational assessment. Students perceived by teachers as inattentive or hyperactive (and academically average or above) are not typically referred to the SAT; instead, teachers advise the parents to seek medical evaluation for what school personnel consider to be the child’s purely medical problem, to be managed with medication. Parents resistant to stimulant medication and those with limited access to primary health care for their children, including many minority parents, typically do not follow through with the recommended medical evaluation.

Therefore, it has become evident that in Forsyth County many students who experience behavior problems or inattentiveness never come to the attention of their physicians or the SAT. Ongoing efforts will be necessary to persuade principals and SAT members that students with discipline problems may benefit from collaborative educational and medical assessments and that students with ADHD are best served with multimodal approaches, not simply medication.

A flowchart describing the Forsyth County process is available at the Web site of the North Carolina Chapter of the AAP (www.ncpeds.org). Implementation of this process is progressing slowly. A system is in place to monitor the timeliness and quality of schools’ responses to physician requests. The absence of school nurses in the Forsyth County process reflects the very low ratio of school nurses to students (1 nurse per >4000 students). In contrast to the Guilford County process, which relies heavily on school nurses to coordinate assessments and to transmit information, the Forsyth County process will rely on established contact persons at each elementary school and in each practice, transmission of packets by mail to pediatric offices in advance of scheduled visits, and troubleshooting by an administrative assistant in the schools’ psychology office. A registry of physicians interested in the process will provide a framework for ongoing dialogue about the process, for problem-solving, and for communication regarding changes.

CONCLUSIONS

The following principles contributed to the success of both processes. (1) The structure provided for the process included meeting locations, detailed notes, compilation and distribution of materials, and an agenda and facilitator for each meeting. Consultation with an expert was an important mechanism for reaching consensus in the Guilford County process; reference to the AAP guidelines substituted for this in the Forsyth County iteration. (2) Development of specific forms and diagrams focused participants on necessary decisions and operationalized agreements. (3) Much of the labor took place outside meetings; the larger group reacted to the recommendations of individuals or subcommittees. (4) Tasks were assigned to persons most motivated to achieve the result. (5) Work products were distributed regularly to the group, to retain members’ interest and to incorporate their feedback. (6) Education of all participants was a critical step in implementation. All partners were responsible for organizing educational programs regarding ADHD and the new process for their respective agencies; other partners collaborated in presenting the programs. (7) An unexpected barrier to implementation of the process required gathering of more information and additional group problem-solving efforts. Such barriers might be avoided by including key stakeholders in the planning process from the outset. These stakeholders might include school-based personnel, as well as school administrators. (8) The process must include periodic revisiting of agreements and a willingness to make needed changes. Even good processes require continual review, updating, and improvement.

The following recommendations, drawn from both community processes, describe a role for physicians in the collaborative community care of children with symptoms of ADHD. (1) Achieve consensus with the school system regarding the role of school personnel in collecting data for children with learning and behavior problems; components to consider include (a) vision and hearing screening, (b) school/academic histories, (c) classroom observation by a counselor, (d) parent and teacher behavior rating scales (eg, Vanderbilt, Conner, or Achenbach scales), (e) consideration of speech/language evaluation, (f) screening intelligence testing, (g) screening achievement testing, (h) full intelligence and achievement testing if discrepancies are apparent in abbreviated tests, and (i) trials of classroom interventions. (2) Use pediatric office visits to identify children with academic or behavior problems and symptoms of inattention (history or questionnaire). (3) Refer identified children to the contact person at each child’s school, requesting information in accordance with community consensus. (4) Designate a contact person to receive school materials for the practice. (5) Review the packet from the school and incorporate school data into the clinical assessment. (6) Reinforce with the parents and the school the need for multimodal intervention, including academic and study strategies for the classroom and home, in-depth psychological testing of children whose discrepancies between cognitive level and achievement suggest learning or language disabilities and the need for an individualized educational plan (special education), consideration of the “other health impaired” designation as an alternate route to an individualized educational plan or 504 plan (classroom accommo-
(dations), behavior-modification techniques for targeted behavior problems, and medication trials, as indicated. (7) Refer the patient to a mental health professional if the assessment suggests coexisting conditions. Obtain parental consent for exchange of information with mental health professionals. Request that the school packet be sent to the mental health professionals/agency. Clarify the role of the mental health professionals/agency, compared with one’s own role in follow-up monitoring. (8) Use communication forms to share diagnostic and medication information, recommended interventions, and follow-up plans with the school and the family. (9) Receive requested teacher and parent follow-up reports and make adjustments in therapy as indicated by the child’s functioning in targeted areas (rather than symptoms). (10) Maintain communication with the school and the parents, especially at times of transition (eg, beginning and end of the school year, change of schools, times of family stress, times of change in management, and adolescence). ADHD is a chronic condition that commonly persists past childhood.

REFERENCES
improve mental health financing
Effective financing systems for children’s mental health are essential to building an overall comprehensive system of care. Yet, there are numerous challenges and barriers, many of which impact not only financing and service delivery systems but children’s access to mental health services. These issues include:

- Limitations on coverage for mental health services in public and private health insurance systems
- Inadequate payment for mental health services, including preventive services, to primary care clinicians, mental health professionals, and other key professionals
- Billing and coding rules and regulations that impede the provision of mental health services by primary care clinicians and other types of clinicians
- Behavioral health care carve-outs in managed care plans that limit the ability of primary care clinicians to make direct referrals for mental health services, thereby creating access barriers to services for children and their families
- Lack of compensation for case management and care coordination efforts
- Time restrictions that limit the ability of primary care clinicians to adequately address mental health needs in children

Because the financing of children’s mental health services is complex, efforts to improve financing systems should involve strategies aimed at both the public and private sectors. While public and private health care systems typically operate separately, there are many areas of intersection that have implications for financing systems. Many children with mental health needs are served by both public (eg, Early Intervention and special education) and private (eg, health insurance) systems. Moreover, many primary care clinicians serve both publicly and privately insured children.

**What Does This Mean for American Academy of Pediatrics Chapters?**

Since public programs fund a substantial proportion of children’s mental health services, chapters may want to consider how they can improve the financing of children’s mental health services through the public system. A significant step to identifying realistic chapter strategies in this area is to first identify and consider the opportunities and barriers that state and community agencies experience in addressing this issue, which will be different for every state.

Every state is unique in its organization and delivery of children’s mental health services. Chapters may want to conduct an initial “environmental scan” to identify issues, including:

- The key state agencies with responsibilities for children’s mental health
- Where those agencies are located within the state government organizational structure
• The core children’s mental health goals and priorities for these agencies
• Any existing state initiatives (eg, state task forces, parity laws, and legislation) to address children’s mental health overall and, in particular, financing of mental health services

Gathering information on existing, planned, and even failed state initiatives can help inform chapter efforts and identification of strategies to improve financing of children’s mental health programs and services. Chapters may want to consider holding meetings with representatives from key state agencies and programs (eg, mental health, public health, and Medicaid) and with key child and family advocacy organizations in their state. These meetings can help further inform the environmental scan and identification of the areas that are most relevant, optimal, and timely for chapter involvement and work. Chapters also may want to convene a variety of stakeholders to address children’s mental health overall, including financing of programs and services. Strategies and considerations for convening key stakeholders in children’s mental health are included in other sections of this Chapter Action Kit.

What’s in a Name?
State and community children’s mental health initiatives are as varied as the systems that support them. In some states, early childhood development is a core priority and, while not officially called “children’s mental health,” has all the semblances of efforts to improve the overall children’s mental health system. “Social and emotional development” is another policy area being advanced by states, particularly state public health and education agencies.

Chapters may want to think broadly and consider the range of initiatives and programs that are related to children’s mental health—initiatives that, at first glance, might not seem focused on financing, but may have significant implications for the financing and delivery of children’s mental health services. A good example is the efforts in Illinois to address maternal depression (and its impact on young children) by providing Medicaid payment for maternal depression screening that is conducted by pediatricians as part of a well child visit.

Public and Private Payment of Mental Health Services
Chapters also may want to consider policy issues that are related to public and private payment of mental health services. To identify key payment issues, chapters may want to survey members or use a Hassle Factor Form to gain insight into payment barriers and challenges. (See Tools and Resources in this section for the Hassle Factor Form.)

Questions to consider in identifying payment issues include:

• What diagnoses (and related diagnostic codes) do private health insurance plans and public insurance programs (eg, Medicaid and SCHIP) pay for?
• What diagnostic codes are accepted by various public and private health insurance plans?
• Do private health insurance plans and Medicaid pay for primary care clinicians to treat mental health disorders (eg, depression, attention-deficit/hyperactivity disorder, and anxiety disorders) in children?
• Can specialists and mental health professionals get paid by public insurance programs and private health insurance plans?
Examples of policy changes that chapters could negotiate with payers include:

- Expand the number of mental health visits without a diagnosis that can be reimbursed by Medicaid.
- Empanel pediatricians with advanced mental health credentials on behavioral health carve-outs. (Chapters may want to consider advancing recommendations that begin with empanelling developmental/behavioral-boarded pediatricians.)
- Ensure that key primary care clinicians and mental health professionals (eg, licensed clinical psychologists and social workers, and nurses with specialized psychiatric training) are eligible to receive payment for assessment and treatment services under Medicaid.
- Expand the “Incident To” Rule\(^1\) to pay mental health professionals under Medicaid.
- Establish a standard of mental health practice that requires exchange of information between mental health professionals and primary care clinicians.

**Strategies for Improving Financing of Children’s Mental Health Services**

Chapters may want to identify and consider a range of strategies for improving the public and private financing of children’s mental health services. These strategies include the following:

- Recommend maximizing the use of key federal and state program funds for children’s mental health and integrate multiple federal and state funding streams. (See Tools and Resources in this section for the American Academy of Pediatrics State Government Affairs Issue Brief: Mental Health.)
- Recommend that all parts of the children’s mental health system are adequately financed. (See Tools and Resources in this section for the National Conference of State Legislators Brief: Children and Mental Health Parity, and Collecting Information for Chapter Advocacy: Mental Health Public and Private Payer Matrix.)
- Recommend improved coordination of financing among the key state agencies and child-serving programs (eg, mental health, substance abuse prevention, public health, Medicaid/SCHIP, child welfare, juvenile justice, education, and Early Intervention) with responsibilities for children’s mental health.
- Recommend blending or braiding of state programmatic funds to provide more services and eliminate duplication of services. Blended funding involves combining funding from multiple funding sources into a single “pot” of dollars that can be used to fund services. Braided funding entails using multiple sources of funds to pay for services, while maintaining tracking and accountability of these funds for administrative purposes. Given federal rules and regulations for use of funds, braided funding is often seen as a more attractive and simpler strategy for state agencies. **Vermont** has used a braided funding system composed of federal child welfare, juvenile justice, mental health, and special education funds.

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\(^1\)The Incident To Rule refers to services provided by physician extenders (eg, clinical psychologists, clinical social workers, nurse practitioners, and nurses) under the direct supervision of a physician that are an integral, although incidental part of a physician’s professional service in the course of diagnoses or treatment of an injury or illness. Such services may be billed as though personally rendered by the physician, provided all criteria for billing incident to are met.
to support programs for children and adolescents with serious emotional disturbances.  

- Recommend full implementation of Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program to ensure that eligible children receive the mental health screens and services to which they are entitled.  
- Advocate for full mental health parity or equal coverage laws.  
- Recommend increasing investments in prevention and early intervention programs and services to prevent mental health issues from developing into more serious problems. These investments may come from existing programmatic funding sources, such as the Title V Maternal and Child Health (MCH) Services Block Grant, which have flexibility in how funds are used. Idaho, Illinois, Michigan, Minnesota, North Carolina, Rhode Island, and Washington are some of the states that have implemented initiatives to improve access to children’s mental health services and/or the overall children’s mental health system.  
- Develop and/or utilize an existing Pediatric Council, which meets regularly with managed care organization representatives, to discuss issues of quality care, including inadequate communications between clinicians, system issues, and barriers to mental health care (eg, behavioral health care carve-outs). Twenty-four chapters have established these councils. The Massachusetts Chapter Pediatric Council has been in existence the longest of these councils, and has been successful in changing the policies and practices of managed care companies as they relate to children’s health care. Although fees cannot be discussed during these meetings, it is acceptable to discuss the lack of communication and resulting problems due to behavioral health care carve-outs. (See the Tools and Resources section for the Chapter Pediatric Councils Overview.)  
- Initiate discussions with private insurance companies through Pediatric Councils to advocate for enhanced coverage of children’s mental health services. (See the Tools and Resources section for Pediatric Mental Health Payment Strategies Targeting Payers, Pediatric Mental Health Coverage Template Letter and Survey, and Hassle Factor Form.)  
- Initiate discussions with benefits managers in large businesses and companies to educate them about the benefits of comprehensive coverage of mental health services for the children of their employees.  

References  
Resources for Further Information
The AAP Division of State Government Affairs. Available at: http://www.aap.org/advocacy/stgov.htm Accessed December 1, 2006

The AAP Division of Health Care Finance and Quality Improvement. Available at: http://www.aap.org/visit/divfinprac2.htm Accessed December 4, 2007


strategies to improve children’s mental health financing tools and resources

Chapter Pediatric Councils Overview
This resource provides an overview of the purpose of chapter pediatric councils and examples of changes in mental health coverage and policies that result from the work of these councils. It includes a matrix of Current Procedural Terminology (CPT) codes that are recognized by health insurance carriers, developed by the North Carolina chapter.

Hassle Factor Form
This tool may be completed online with the American Academy of Pediatrics (AAP) to report insurance, administrative, and claims processing concerns, including settlement disputes that have been filed by pediatric practices. It is available on the AAP Member Center site and is intended to be submitted electronically.

Pediatric Mental Health Coverage Template Letter and Survey
This tool is a sample survey and cover letter for obtaining information from health insurance carriers on the scope of coverage for pediatric mental health.

Collecting Information for Chapter Advocacy: Mental Health Public and Private Payer Matrix
This tool is a template for chapters and their pediatric councils to gather information about public and private health plans in the state regarding coverage policies (e.g., coverage services, and payment authorization policies) for mental health services.

Pediatric Mental Health Payment Strategies Targeting Payers
This resource provides strategies for pediatric practices to use in promoting coverage of mental health care, and in managing carrier denials and contractual issues related to pediatric mental health.

American Academy of Pediatrics State Government Affairs Issue Brief: Child and Adolescent Mental Health
This issue brief provides an overview of child and adolescent mental health issues for use by chapters when communicating with legislators or other public officials.
National Conference of State Legislatures Brief: Children and Mental Health Parity (May 2005)
Reprinted with permission from the National Conference of State Legislatures. This Policy Matters resource from the National Conference of State Legislatures (NCSL) is included for its broad discussion of mental health parity and public policy in the states. Because it was published in 2005, it includes information on state laws that is out of date. For more up to date information about mental health parity laws and other current state policy trends, please consult the Child and Adolescent Mental Health Issue Brief from the AAP Division of State Government Affairs located in this section.
Children’s mental health services are financed through an extensive patchwork of public and private funding sources at the federal, state, and community levels. These sources include public health care coverage (e.g., Medicaid and the State Children’s Health Insurance Program), and other federal programs (e.g., the Comprehensive Community Mental Health Services for Children and Their Families Program* † and Early Intervention), private health insurance, state and county funds, and private foundations. Of all mental health services that are provided to adults and children, more than half (53%) are paid for by public sources.¹ In fact, public funding sources pay for a disproportionate share of mental health services for children as compared to private health insurance.

Financing of children’s mental health services is largely aligned with the presence of a diagnosable mental health disorder. Consequently, children who have a mental health problem but lack a full mental health diagnosis often experience limited or no access to mental health services. In addition, efforts to provide care for mild and moderate mental health problems can be impeded. A national study of children and adolescents aged 9 to 17 years revealed that nearly 21% had a mental health problem. Almost half of the child/adolescent population had some treatment, while the remainder received no mental health treatment in any sector of the health care system. Of the children with mental health problems, many did not meet the full criteria for a mental disorder diagnosis.¹

Historically, mental health services for children have been highly fragmented, underfunded, and often duplicated. Where resources do exist, funds are largely targeted to children with serious emotional disorders with few resources available for prevention and early intervention efforts, and care for children with mild to moderate mental health issues. As a result, families must often navigate a complex system of private and public services and programs to obtain services for their child—services that may not be paid for by private health insurance or reimbursable by public program funds.

**Mental Health Care Expenditures for Children²**

- Children account for approximately 7% of all mental health expenditures.
- The cost of treating children and adolescents is nearly $12 billion with most funds spent on outpatient care.

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¹Federal Comprehensive Community Mental Health Services for Children and Their Families Program funds are administered by the Substance Abuse and Mental Health Services Administration and available to States, communities, Territories, and Indian tribes/tribal organizations to build community capacity, provide treatment services, and involve families in serving children and adolescents (under 22 years of age) with diagnosable serious emotional, behavioral, or mental disorders and who require services from multiple agencies.
Among children aged 1 to 17 years, adolescents (aged 12 to 17 years) account for 60% of the total costs for mental health services yet make up only 35% of the child population.

Children aged 6 to 11 years account for 35% of the mental health costs and preschoolers (aged 1 to 5 years) account for 5% of these costs.

Numerous Federal Programs Support Children’s Mental Health
The highly fragmented nature of children’s mental health services is largely due to the myriad public and private systems that serve children and their families. These public systems include primary care, public health, mental health, child care, child welfare, education, substance abuse prevention, and juvenile justice. Each of these systems receives federal funding that stipulates its own set of rules and regulations, target populations, and eligibility categories for services. In turn, these federal dollars usually are administered by numerous state agencies (eg, Medicaid, education, and public health). As a result, states and communities often struggle to integrate programs and services, and blend complex federal, state, and community funding streams into a seamless system of care for children. Building a comprehensive system of children’s mental health services requires an understanding of these numerous systems and the programs that fund them, collaboration among key state agencies, and a willingness on the part of state agencies to blend complex funding streams.

Every State Has a Designated State Mental Health Authority
Historically, the financing and delivery of public mental health services has been a state responsibility. Most state spending comes from general revenue funds, state Medicaid contributions, and other state funds (eg, private foundations). Every state has a designated state mental health authority—a state mental health agency or a mental health division that is located within a larger state health agency—as required by the federal Community Mental Health Services (CMHS) Block Grant Program.

The CMHS Block Grant Program, administered by the Substance Abuse and Mental Health Services Administration, is the largest federal funding contribution dedicated to improving mental health service systems for adults and children nationwide. It provides funds to states to establish or expand a comprehensive community-based system for providing mental health services to adults with serious mental illness and children with serious emotional disturbances (SED), as outlined in a State Mental Health Plan. Among numerous requirements, states must establish a State Mental Health Planning Council, composed of consumers, family members, clinicians, and others, to review their State Mental Health Plan. In addition, states are required to set aside a portion of CMHS Block Grant funds for children and adolescents with SED.

Medicaid Pays for the Bulk of Mental Health Services in States
While the CMHS Block Grant is the largest source of federal funds for mental health services, Medicaid pays for the bulk of mental health services in states—half of state and local mental health spending. Eligible children are entitled to any authorized service under Medicaid. Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requires that states cover any service that is medically necessary to

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"correct or ameliorate defects and physical and mental illnesses and conditions, regardless of whether the service or item is covered under the state Medicaid program." Mental health screens can be the result of a formal health checkup or screen for a potential mental health problem.

Because of the Medicaid entitlement and breadth of the Medicaid EPSDT requirement, coverage of mental health services under Medicaid is more comprehensive than private health insurance. In spite of the protections afforded eligible children under Medicaid, there is wide variability in states’ implementation of the EPSDT benefit, leaving many children without the mental health screens and treatment that they are entitled to under federal law. States define medically necessary services in different ways or not at all, and do not always specify required mental health services with Medicaid contracting agencies, leaving decisions about which mental health services to cover up to health plans.

The State Children’s Health Insurance Program (SCHIP) covers low-income children whose family incomes are too high to qualify them for Medicaid but who lack private health insurance. States can choose to expand Medicaid, create a separate SCHIP program, or develop a combination program. While SCHIP is an important source of health care coverage for low-income children, children with mental health needs can experience challenges in accessing mental health and substance abuse services, particularly in states with separate SCHIP programs. For these states, coverage of mental health services may be less generous than Medicaid coverage since the SCHIP statute only requires that they provide a mental health benefit that is 75% of the value of the benefit in the benchmark plan.

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<tr>
<th>Children’s Mental Health Services Covered by Medicaid</th>
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<tr>
<td>• Mental health screening and assessment</td>
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<tr>
<td>• Inpatient hospital care, residential treatment centers, or group homes</td>
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<tr>
<td>• Clinic services by a physician or under a physician’s direction</td>
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<tr>
<td>• Outpatient hospital services</td>
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<td>• Physician services and services by other licensed professionals</td>
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<td>• Prescription drugs</td>
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<td>• Rehabilitation services</td>
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<td>• Targeted case management (eg, activities to connect children with mental health needs to services)</td>
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<tr>
<td>• Home and community-based services (versus care in an institution), in states with federal Medicaid waivers</td>
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</table>

Children’s mental health programs and services are supported by numerous other federal programs in addition to those outlined above. These programs include:

‡See the resources, Funding Early Childhood Mental Health Services and Supports, and Mix and Match: Using Federal Programs to Support Interagency Systems of Care for Children with Mental Health Needs for listings of federal programs that support children’s mental health services.
• Early Intervention (Part C of the Individuals with Disabilities Education Act)
• Developmental Disabilities
• The Title V Maternal and Child Health Services Block Grant
• The Social Services Block Grant, the Child Care Block Grant
• The Juvenile Justice and Delinquency Prevention Act
• Federal funds for foster care, special education, and child welfare

How and whether states use these funds to support a comprehensive children's mental health system of prevention, early intervention, and treatment varies significantly by state.

Private Insurance Pays for Nearly Half of Children's Mental Health Services Yet Access and Services Are Limited

Even though 70% of children are privately insured, private health insurance pays for less than half of the costs for children's mental health services. As previously mentioned, private health insurance coverage of mental health services is far less generous than public insurance coverage. Parity of mental health benefits—requirements that insurers provide the same level of mental health service coverage as that of physical health—is seen as a key strategy for increasing access to mental health services for children and adults. (See the Tools and Resources in this section, Pediatric Mental Health Payment Strategies Targeting Payers, for strategies that pediatric practices can use in promoting coverage of mental health care and in managing carrier denials and contractual issues that are related to pediatric mental health.)

Currently, 46 states have some type of enacted mental health parity law, yet these laws vary considerably. Many are not considered full parity because they allow discrepancies in the level of benefits provided between mental illnesses and physical illnesses. Efforts to enact full parity legislation at the federal level have been met with resistance from private insurance companies and other groups that are concerned about increases in insurance costs. The federal Mental Health Parity Act of 1996, which was extended through 2002 after expiring in 2001, did not require that insurers offer mental health benefits, but stated that, if mental health benefits were offered, they must be equal to the annual or lifetime limits offered for physical care. Evidence indicates that the impact of parity laws on increases in health care costs is minimal. (See the State Government Affairs Issue Brief “Child and Adolescent Mental Health” included in this Chapter Action Kit for more information on state parity laws.)

Conclusion

Thanks to key national reports, such as Neurons to Neighborhoods and the Surgeon General’s Report on Children’s Mental Health, states and communities are increasingly recognizing the need to improve how children’s mental health services are financed and delivered. Consequently, many states and communities have implemented new initiatives, programs, and policy changes to address the widespread recognition that children’s mental health is as important to their overall health and well-being as their physical health. Many of these initiatives include attention to improvements in how children’s mental health services are financed. Chapters may want to identify and consider a range of strategies for advancing and improving both the public and private financing of children’s mental health services. (See the Strategies to Improve Mental Health Financing in this section for a list of chapter strategies.)
References
6. 42 USC §1396d(a)
Resources for Further Information


Pediatric councils are groups that are formed to foster dialogue between pediatricians and insurance plan administrators. The American Academy of Pediatrics supports chapter development of pediatric councils as forums to discuss concerns about policies and administrative procedures that affect coverage, access, and quality. Chapters have reported that pediatric councils facilitate communication and lay the groundwork for successful problem solving with payers.

Following are some examples of changes in mental health coverage and policies that resulted from the work of chapters and pediatric councils:

- **Massachusetts**: Carriers will cover annual developmental screening.
- **Pennsylvania**: Most insurers recognize mental health codes.
- **Texas**: BlueCross BlueShield of Texas will now pay separately for developmental screening (Current Procedural Terminology [CPT] code 96110), whereas previously it bundled this with the evaluation and management (E/M) service.
- **New Jersey**: Many of the fee-for-service plans pay for mental health services by pediatricians; capitated plans don't "carve out" mental health.
- **New York**: A group practice in Rochester, NY, met with the regional BlueCross medical director and presented its case on the work-up for depression, which included a comprehensive review of family and social history, as well as many evaluation tools. Negotiations resulted in payment of the initial depression consult as a 99215, with subsequent follow-up at the 99214-level.
- **Ohio**: The Chapter joined an interdisciplinary Coalition for Healthy Communities to support passage of Mental Health Parity in the state.
- **Rhode Island**: Mental health was discussed at the June 2006 Rhode Island pediatric council meeting. Recently, BlueCross BlueShield of Rhode Island agreed to reimburse 99610 for developmental screening at well child visits.
- **Wisconsin**: The Wisconsin Council advocated with Humana’s regional medical director on pediatric mental health as an access issue. Humana agreed to pay pediatricians for managing common mental health conditions, such as attention-deficit/hyperactivity disorder, rather than paying only the less available child psychiatrists, often in carve-out contracts, for similar services.
- **North Carolina**: The North Carolina Council developed a matrix of CPT codes recognized by carriers. (See the ADD/ADHD and Coding: Recognition of CPT codes by Payer that follows.)

**Pediatric Council Start-up Kit**

A Pediatric Council Start-up Kit was developed based on experiences of chapters with pediatric councils and is intended to share information on starting and maintaining pediatric councils. The Pediatric Council Start-up Kit can be accessed on the AAP Member Center at: [http://www.aap.org/moc/reimburse/privatesector.htm#pediatriccouncils](http://www.aap.org/moc/reimburse/privatesector.htm#pediatriccouncils).

For more information, please contact Lou Terranova at terranova@aap.org.
Pediatricians and Managed Care Directors in North Carolina understand that there has been much confusion around coding for ADD/ADHD. We have pulled together some information to help you understand when to use certain CPT codes when caring for children with behavioral health issues, specifically ADD/ADHD. Additionally, we have asked some of the larger health plans in North Carolina to see if they reimburse for these codes. The following information is the result of our work over the past 6 months.

**COMMONLY USED CODES IN BEHAVIORAL HEALTH**

99212-5. Evaluation and Management (E&M) office visit, established patient, levels 2-5. (face-to-face time required)

99202-5. Evaluation and Management (E&M) office visit, new patient, level 2-5. (face-to-face time required)

99241-5. Consultation office visit, new or established. (face-to-face time required; requires referral from a teacher/psychologist and a return follow-up letter/phone call to the referral source)

90887. Interpretation or explanation of results of psychiatric, other medical exam to family or advising them how to assist patient (face-to-face not required)

99354. Prolonged physician service in the office requiring face to face time beyond usual service, 1st hour (face-to-face required)

99358. Prolonged E&M service before and/or after direct patient care (for example, review of extensive records and tests), 1st hour (face-to-face not required)

99361. Medical conference by a physician with interdisciplinary team of health professionals, approximately 30 minutes (team interaction)

99371. Telephone calls by a physician to a patient or for consultation or medical management or coordinating medical management with other health care professionals (face-to-face not required)

Please note the codes that require face-to-face contact and the codes that do not require face-to-face contact. Please note the difference between codes 99354, requiring face-to-face contact for at least 1 hour beyond the usual 20-30 minute appointment, and 99358,
review of extensive records and tests without face-to-face contact for the first hour.

Also, please remember that E/M level of service codes reflect complexity rather than time unless greater than 50% is spent in counseling. When this is the case, the following time limits apply:

<table>
<thead>
<tr>
<th>CODE</th>
<th>TIME(min)</th>
<th>CODE</th>
<th>TIME(min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>99211</td>
<td>5</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>99212</td>
<td>10</td>
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<td>99203</td>
<td>30</td>
<td>99213</td>
<td>15</td>
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<tr>
<td>99204</td>
<td>45</td>
<td>99214</td>
<td>25</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>99215</td>
<td>40</td>
</tr>
</tbody>
</table>

Below is a matrix of these codes and 5 NC health plans, providing a synopsis of payer recognition of these codes. (This should be used as a general guideline and may change from time to time. This information is correct as of October 2001):

<table>
<thead>
<tr>
<th>CPT code</th>
<th>BCBSNC†</th>
<th>CIGNA</th>
<th>United</th>
<th>Partners</th>
<th>Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212-5</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>99202-5</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>99241-5</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>90887</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>99354</td>
<td>Y</td>
<td>?</td>
<td>?</td>
<td>Y</td>
<td>?</td>
</tr>
<tr>
<td>99358</td>
<td>Y</td>
<td>?</td>
<td>?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>99361</td>
<td>Y</td>
<td>Y</td>
<td>?</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>99371</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

All 5 insurers will pay for the standard E/M codes. When the encounter involves review of medical records/tests, interpretation/explanation of psychiatric or other medical exams with advice, and telephone calls before or after the visit (all codes not requiring face to face contact), please consult the matrix for recognition by payer. Seldom will the encounter involve enough direct patient time to satisfy CPT code 99354. If a patient requires a medical conference with an interdisciplinary team, consult the matrix for recognition by payer.

* Codes must be supported by written documentation in order to justify payment. Please use the current CPT book as a guide to know how to code for all services. A pediatric-specific version of most commonly used codes can by obtained by calling the AAP or through their website at www.aap.org.

† Benefits are determined when the claim is processed and the claim is subject to member and provider contractual limitations and exclusions and subscriber eligibility. In addition, medical records may be requested and reviewed for documentation. Consultation codes should not be billed for established patients. Using the proper level of Evaluation and Management code, supplemented, if necessary by codes for prolonged physician services and/or medical conferences should permit appropriate payment.
HASSLE FACTOR FORM

The online Hassle Factor Form may be completed online to report insurance administrative and claims processing concerns including settlement disputes that you may have filed (see Settlement Disputes below for additional information). The information provided will be used to assist the AAP and chapters in identifying trends and facilitating public and private sector advocacy related to health plans.

Please note that completion of the following form is for data collection purposes only; information on hassles will be available to the national AAP and your chapter. You will not receive a reply when completing the Hassle Factor Form.

By collecting data on issues pediatricians have with third party payers, the AAP at the national and chapter levels will be better able to identify common areas of concern and facilitate dialogue with payers. Please complete one form per carrier.

Proceed to the online Hassle Factor Form

Should you require additional assistance on a particular coding or health plan coverage issue, contact your chapter or the AAP Coding Hotline at AAPCodingHotline@aap.org or 800/433-9016 ext 4022.

Settlement Disputes:
As a result of lawsuits brought against the major health plan carriers, some carriers have agreed to settlements that should benefit physicians. Settlements with Aetna and CIGNA have recently been finalized and one of the agreed upon terms is a process for physicians to file disputes with an external entity. Pediatricians are encouraged to file a dispute with the carrier(s) should there be a violation of the billing, medical necessity or settlement terms by accessing the forms on www.hmosettlements.com and then report any disputes that they file against Aetna, CIGNA and any other carriers by completing the Hassle Factor Form. Please note that the pediatric practice must file the dispute themselves - the AAP will not file a dispute. Completing the Hassle Factor Form is a way to notify the AAP that your practice has filed a dispute.

For information about the settlements see www.hmosettlements.com or the AAP MOC, private sector advocacy page link to managed care litigation.

See Form Below
HASSLE FACTOR FORM

Please complete each section of this form.

SECTION A: General Information

<table>
<thead>
<tr>
<th>Physician Name:</th>
<th>First Name:</th>
<th>Middle Name:</th>
<th>Last Name:</th>
</tr>
</thead>
</table>

Subspecialty: 

AAP Member ID: 

Practice City: 

State: 

Practice Chapter: 

Practice Type: 

Person completing this form: 

(If other than the physician identified above)

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Name:</th>
<th>Last Name:</th>
<th>Title:</th>
</tr>
</thead>
</table>

SECTION B:

Please check all that apply and briefly describe problems on the next section (Section C). If provided examples do not describe your hassle, please check "Other Problem Not Listed," and detail on the next section (Section C).

**Administration**

- [ ] Calls not returned
- [ ] Claim/appeal lost by organization
- [ ] Credentialing delay/problems
- [ ] Excessive wait on telephone
- [ ] Failure to notify enrollees of denied services or failure to do so in a timely manner
- [ ] Grievance procedure problems
- [ ] Inaccurate data entry following clean claim
- [ ] Insufficient pediatric subspecialists in the network
- [ ] Medical records request problem
- [ ] Numerous calls for single claim
- [ ] Organization missing supporting documents
- [ ] Uncustomary request for patient information

**Payment Processing**

- [ ] Related to a specific CPT, ICD-9-CM, HCPCS Level II code
Specify the code [ ] CPT  [ ] ICD-9-CM  [ ] HCPCS

- Denial of payment
- Reduction of payment
- Recording of billed services (bundling, downcoding, etc.)
- Payment incorrect as per contract
- Late payment problem(s)
- Failure to follow CPT guidelines
- Non-recognition of modifiers
- Changing units of service

**Claims Adjudication**

- Denial of preauthorization (specify whether hospital or other)
  - [ ] Hospital  [ ] Other (If ‘Other’ please specify)
- Excessive delay in processing claims
- Excessive denials of referral
- Excessive emergency room service denial
- Excessive mental health service denial
- Excessive operative report requests
- Excessive prepayment or postpayment review
- Excessive requests for medical necessity review
- Lack of clear communication on EOB, written communications
- Length of stay dispute

**Contractual Issues**
(based on reviewing your managed care contract)

- Lab tests cannot be performed at preferred location
- Reimbursement denied due to carve out provisions
- Fee schedule not provided or excessive delay in obtaining it
- Managed care formulary
- Uncompensated for language interpretation

- Other problem not listed (Briefly Describe in Section C)

**SECTION C:**

Name of carrier with whom the hassle is related: (REQUIRED)
Type of Plan:  

How Frequently does this occur:  

Briefly describe the problem(s) including any actions you have taken (phone call, letter, etc) and any responses  

HASSELE FACTOR FORM

Please complete this remaining section of the form.

SECTION D:
DISPUTES FILED AS PART OF LITIGATION SETTLEMENTS

Since you identified a carrier that is involved in the managed care litigation and has agreed as part of the settlement to the dispute process, please respond to the following: (for information on the settlements, see www.hmosettlements.com)

Have you filed a Dispute about this issue?  

If yes, is the dispute related to (check all that apply)  

Billing dispute  
Compliance with terms of settlement dispute  
Medical necessity dispute  

Please note that completion of the Hassle Factor Form does not constitute filing a dispute as part of the settlement. Pediatric practices must file the settlement dispute as the AAP does not submit the settlement dispute.
Dear Medical Director:

The American Academy of Pediatrics __________ Chapter is addressing the issue of pediatric mental health care. One area of interest is the level of benefits coverage available to children covered under private health plans.

Attached is a brief survey on the extent of coverage for pediatric mental health services. Please note that data are not being collected on fees paid or charged. The intent is to obtain a perspective on the scope of benefits for pediatric mental health care. It is understood that health plan coverage may vary based on the scope of benefits purchased by the employer or family. However, we hope to obtain a better understanding of mental health services that are covered under the standard health plan or as part of carrier policy.

Please let me know if you have any questions or need additional information. Your response by ____________ would be greatly appreciated.

Sincerely,
Pediatric Mental Health Coverage Survey

1. Does the plan’s mental health professional network include:
   • Primary care clinician?    Yes ☐   No ☐
   • Developmental pediatricians? Yes ☐   No ☐

2. Do you have standards concerning exchange of information between the plans’
   credentialed mental health professional and their patients’ primary care clinician?
   Yes ☐   No ☐

   If yes, do these standards include (please check all that apply)
   ☐ Verbal or written communication of a presumptive diagnosis and plan of
   treatment within 3 days of completion of assessment of the patient?
   ☐ Ongoing progress reports at least monthly?
   ☐ Description of the discharge plan when the mental health professional
   terminates the treatment?
   ☐ Other?  (Please list)

3. Under the standard carrier contract with pediatricians, will your claims systems
   process and pay claims submitted by pediatricians using the following Current
   Procedural Terminology (CPT) codes for evaluation and treatment of behavioral
   and mental health conditions?

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ 99201/99202/99203/99204/99205</td>
<td>Office or other outpatient services, new patient. Problem-focused history and examination</td>
</tr>
<tr>
<td>Yes ☐ 99212/99213/99214/99215</td>
<td>Office or other outpatient services, established patient</td>
</tr>
<tr>
<td>Yes ☐ 99241/99242/99243/99244</td>
<td>Office or other outpatient consultations.</td>
</tr>
<tr>
<td>Yes ☐ 99354/99355</td>
<td>Prolonged physician service with face-to-face patient contact; outpatient</td>
</tr>
<tr>
<td>Yes ☐ 99371/99372/99373</td>
<td>Use to report telephone calls made by the physician to patient/parent, or for consultation or medical management, or for coordinating medical management with other health care professionals.</td>
</tr>
<tr>
<td>Yes ☐ 96110</td>
<td>Developmental testing, limited with interpretation and report</td>
</tr>
<tr>
<td>Yes ☐ 96111</td>
<td>Developmental testing, extended with interpretation and report, per hour</td>
</tr>
</tbody>
</table>

4. Under the standard carrier contract with pediatricians, will your claims systems
   process and pay on claims submitted by pediatricians treating behavioral and
   mental health conditions using the International Classification of Diseases, 9th
   Revision, Diagnostic Manual (ICD-9-DM) codes listed on the following page.
   Yes ☐   No ☐

   (NOTE: The chapter would determine which diagnoses they are interested in learning
   about coverage.)  Thank you for providing this information.
This matrix serves as a template for chapters and their pediatric councils to gather information about public and private health plans in the state, regarding coverage policies for mental health services. It asks about what services are covered, which health care clinicians can provide them, and payment and authorization policies. Chapters and their pediatric councils are encouraged to gather this information on all major plans in the state and use the matrix as a way to compare the plans. The matrix can help identify gaps in services that chapters can address in their discussions with health plans.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>State Medicaid</th>
<th>Managed Care (HMO)</th>
<th>Self-insured Plan (PPO)</th>
<th>Other Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are patients authorized to receive outpatient mental health services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care clinician referral sufficient</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Primary care clinician obtains authorization</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Phone</td>
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<td>Fax</td>
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<tr>
<td>Electronic</td>
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<tr>
<td>Patient/family obtains authorization</td>
<td>☐</td>
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<td>Phone</td>
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<td>Electronic</td>
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<tr>
<td>Other, please specify:</td>
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<tr>
<td>Plan Name</td>
<td>State Medicaid</td>
<td>Managed Care (HMO)</td>
<td>Self-insured Plan (PPO)</td>
<td>Other Plan</td>
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<tr>
<td>Does the plan pay primary care clinicians for outpatient mental health/substance abuse services?</td>
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<tr>
<td>Yes</td>
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<tr>
<td>No</td>
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<tr>
<td>Is the plan limited to certain diagnostic codes?</td>
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<tr>
<td>Yes</td>
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<tr>
<td>No</td>
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<tr>
<td>If yes, does it permit ICD-9 deferred diagnoses codes?</td>
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<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>No</td>
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<tr>
<td>How many visits can a patient receive after initial authorization?</td>
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<tr>
<td>Which mental health/substance abuse professionals does the plan reimburse for outpatient mental health/substance abuse services?</td>
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<tr>
<td>Are they restricted to certain employment arrangements?</td>
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<tr>
<td>Yes</td>
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<tr>
<td>No</td>
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<tr>
<td>If yes, specify arrangements.</td>
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</tr>
<tr>
<td>Plan Name</td>
<td>State Medicaid</td>
<td>Managed Care (HMO)</td>
<td>Self-insured Plan (PPO)</td>
<td>Other Plan</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td><strong>Does the plan allow primary care clinicians to bill “incident to” for mental health/substance use/abuse services delivered by a mental health professional in the primary care clinicians employ?</strong></td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Yes</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
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<tr>
<td>No</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td><strong>If yes, which disciplines (eg, child and adolescent psychiatrist or licensed clinical social worker)?</strong></td>
<td></td>
<td></td>
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<tr>
<td>✗</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Are there mental health/substance use/abuse providers with pediatric expertise available in all geographic regions of the state served by the plan(s)?</strong></td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Yes</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>No</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td><strong>Are children and adolescents matched with mental health/substance use/abuse providers who have pediatric expertise?</strong></td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
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<tr>
<td>Yes</td>
<td>✗</td>
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<td>No</td>
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<tr>
<td>Plan Name</td>
<td>State Medicaid</td>
<td>Managed Care (HMO)</td>
<td>Self-insured Plan (PPO)</td>
<td>Other Plan</td>
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<tr>
<td><strong>Does the plan have standards requiring mental health professional to communicate with primary care clinicians?</strong></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>With reference to the following Evidence-based Child and Adolescent Psychosocial Interventions, which does the plan pay for? (please check all that apply):</strong></td>
<td>Cognitive behavioral therapy</td>
<td>Behavior therapy</td>
<td>Parent training</td>
<td>Educational support</td>
</tr>
<tr>
<td><strong>Does the plan have mental health professionals qualified to perform the evidence-based therapies itemized above?</strong></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>How many child psychologists per covered lives?</strong></td>
<td>7-28</td>
<td>7-28</td>
<td>7-28</td>
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</tr>
<tr>
<td>Plan Name</td>
<td>State Medicaid</td>
<td>Managed Care (HMO)</td>
<td>Self-insured Plan (PPO)</td>
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<tr>
<td>How many child and adolescent psychiatrists per covered lives?</td>
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<tr>
<td>How many licensed clinical social workers per covered lives?</td>
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<td></td>
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<tr>
<td>How many other child and adolescent mental health professionals per covered lives?</td>
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<td></td>
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<tr>
<td>How many developmental and behavioral subspecialists per covered lives?</td>
<td></td>
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<td></td>
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<tr>
<td>Does your plan credential developmental and behavioral subspecialists as mental health professionals?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Please explain:</td>
<td></td>
<td></td>
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<tr>
<td>In each state, what percentage of the plan’s major products covers mental health benefits?</td>
<td></td>
<td></td>
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<tr>
<td>Does the plan use an ambulatory managed behavioral health care company (eg, carve-out)?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Plan Name</td>
<td>State Medicaid</td>
<td>Managed Care (HMO)</td>
<td>Self-insured Plan (PPO)</td>
<td>Other Plan</td>
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<tr>
<td>If yes, which one(s)?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Which of the plans has the best mental health benefits?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>What percentage of children in the state participate in this plan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the plan have mental health co-pays and deductibles that differ from physical health co-pays and deductibles?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please specify:</td>
<td></td>
<td></td>
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</tbody>
</table>
Carriers may have health plans that do not cover mental health services or that “carve out” mental health benefits completely or partially (eg, create a separate set of rules, providers, and authorization procedures for mental health). They may offer employers plans that diminish or exclude mental health benefits. Following are strategies for pediatric practices to use in promoting coverage of mental health care and in managing carrier denials and contractual issues related to pediatric mental health. Should a practice have several health plan contracts, these strategies may be concentrated on the top (3-5) major plans with which the practice works.

The key is to determine the level of coverage by the health plan for pediatric mental health services. Health insurance carriers have multiple health plans and coverage may vary from plan to plan.

Dealing With Mental Health Carve-outs
Some carriers may carve out mental health services from the medical provider network, assigning them to a smaller mental health specialty network or a disease management program. Employers or families may select a health plan that has limited mental health benefits.

- The pediatric practice should contact the carrier to determine the nature of the carve-out and the degree to which coverage and payment are available for mental health services.
- Pediatricians and their staff should be aware of health plan enrollment periods and be available to advise their patients’ families on coverage issues. Often, families make decisions on health plan selection on the basis of premium expense, without consideration of other out-of-pocket expenses, such as deductibles, co-payments, and level of coverage.
- Advocate for coverage and payment of pediatric mental health services, particularly during the contract renewal period.
- Frame your position on how lack of coverage impacts quality of care, cost effectiveness, and patient satisfaction. Carriers are very conscious of quality issues, expenses and efficiency, and their market share.
- Provide reassurance that increasing access to outpatient mental health services creates cost savings in areas such as emergency room utilization and hospitalization. Studies have shown that per member/per month mental health costs do not increase significantly when mental health benefits are at parity with medical benefits.
- Highlight cases in which your practice has provided high-quality, cost-effective mental health services.
Joining the Network
While most behavioral health plans are limited to mental health specialists, there is a movement by health plans to merge mental health and medical benefits and to expand their network. Developmental-behavioral pediatricians, in particular, may want to participate as mental health professionals.

- Check with the carrier to determine whether the provider panel is open to pediatricians and what credentialing criteria may be in place.
- See whether the carrier provides training or online programs that enable prospective providers to join the network.
- Determine whether access to mental health specialty care is an issue for the carrier, and use this to negotiate with the carrier to serve as a mental health professional. Carriers may realize that pediatricians may play a role in mental health care screening, evaluation, treatment, and/or follow-up.

Payment for Non-covered Services
If mental health benefits are not part of the health plan, or if the pediatrician is not part of the network, the family would be financially responsible for mental health services. The clinician should obtain a waiver or advance beneficiary notice prior to providing non-covered services. A waiver is a statement that a patient/parent/guardian signs acknowledging that the requested service is, or may not be, covered by health insurance and accepting responsibility for payment for the service. The waiver may be accompanied by a request for payment for the service at the time of the service. Clinicians should seek the advice of legal counsel before incorporating the use of waivers into their practice, as the use of waivers may not be permitted by the terms of contract(s) with the third-party payer or state law.

Managing Denials and Appeals
When facing denials by carriers, strategies include filing appeals and negotiating contractual provisions. A sample letter to send to carriers on bundling and carve-outs is included.

Filing Appeals
Pediatric practices can follow these general guidelines when appealing claim denials or partially paid claims (excerpted from Appealing Claim Denials Can Improve the Bottom Line, AAP News, June 2004):

1. Review all carrier explanation of benefits (EOB). Compare the billed amount and Current Procedural Terminology (CPT) codes with the EOB to determine the level of discounts, denials, inappropriate carrier re-coding, or partial payments.
2. Make sure that the claim was prepared properly, that all information is correct, and that documentation supports the CPT codes. Once assured that the denial was not due to an error on the practice’s part, proceed with the appeal.
3. Send appeal in writing and to the right person—look up the contact person in the contract or call the carrier, explain the situation and what is coming so they can be on the lookout. If you are not satisfied with the response, contact the plan’s medical director.
4. Send the appeal by certified mail to verify receipt by the health plan.
5. List the member’s name, carrier identification number, and claim number on all documentation.

6. State your case in objective and factual terms. Identify the result you want and provide medical justification and CPT coding guidelines to support your case (keep in mind most claim processors do not have a medical or coding background, so be clear and specific). Sample appeal letters that can be used as templates are available on the Member Center of the American Academy of Pediatrics (AAP) Web site (www.aap.org/moc) under the Private Payer Advocacy page.

7. Suggest how denials can be avoided in the future, particularly if it is a recurring problem.

8. Monitor for a response. If the carrier does not respond within the time frame specified in your initial appeal, follow up with a second letter.

9. Create a spreadsheet to track appeals to each carrier so that, at contract renewal time, you can determine whether to continue to work with that carrier and identify items to modify in the contract.

10. Each health plan should have a written statement explaining the procedures required for both first and second level appeals. If it is not excluded in the contract, and the practice has correctly coded and properly documented the services, continue to appeal. Should further action be required, contact the state department of insurance or depending on the state in which you practice, the state department of banking and insurance or state department of health. Most states have prompt pay laws. If a managed care organization violates the prompt pay law, the physician may be eligible for interest payments on the amount owed, depending on state law.

11. If a claim is denied and the health plan informs the practice that the service is not covered or is the plan member’s responsibility, bill the plan member and include a copy of the EOB and denial with the bill.

12. Contact your AAP chapter to keep it aware of your issues. Some chapters have pediatric councils that meet regularly with health plan medical directors and Medicaid representatives to address coverage issues. Utilize the AAP Hassle Factor Form to report problems with carriers. (Some chapters have made the Hassle Factor Form available on their Web site, or it can be accessed on the Member Center, under the “More Resources” link.)

**Negotiating Contractual Provisions**

In contacts with the health plans to discuss contractual issues, the key components are to:

1. Address the issue of benefit coverage with the person who has authority to make decisions regarding payment. The carrier provider representative may not have the decision-making authority in this type of matter.

2. Focus the argument on how this is cost-effective to the family and health plan, as well as how it relates to quality care. (Provide documentation supporting your position.)

3. Frame your position around the impact on quality of care, cost-effectiveness, and patient satisfaction. Carriers are very conscious of quality issues, how a proposed change will affect overall expenses and efficiency, and their market
share. The carrier’s current policy may not cover mental health-related services, and the carrier needs to be made aware of the impact to the patient, family, pediatrician, and carrier.

4. Consider notifying the family and employer, since they may bring pressure onto the carrier and employer to expand health plan coverage.

5. If a carrier refuses to cover medical providers for services related to mental health, the practice then needs to decide whether to provide the service or refer the family to the plan’s network mental health professional for those services and inform the family that it is the family’s insurance carrier requirement. The family and/or employer, as the purchaser, then may bring pressure onto the health plan to expand coverage.
TO: Claims Processing Department or Health Plan Medical Director

RE: Bundling services related to mental health evaluation and treatment
Claim # ______________________

I would like to clarify that *Current Procedural Terminology (CPT)* guidelines indicate that services identified with specific codes should be reported separately from any other code and, therefore, they should not be “bundled” into any other code(s). Unfortunately, many carriers are unaware that they are violating *CPT* guidelines in inappropriately bundling together 2 services when each has a separate *CPT* code. This concept is found throughout *CPT* guidelines. Some examples include

- “If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing a preventive medicine service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M (Evaluation and Management) service, then the appropriate Office/Outpatient code 99201-99215 also should be reported. Modifier–25 should be appended to the Office/Outpatient code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service” (*CPT 2006 [professional edition]*, page 30).

- “If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough ‘Immunizations and ancillary studies involving laboratory, radiology, other procedures, or screening tests identified with a specific CPT code are reported separately’ (*CPT 2006 [professional edition]*, page 30).

The *CPT* guidelines are applicable to any other screening tests or procedures that are identified with a specific *CPT* code, such as developmental testing and psychological or behavioral assessment. Therefore, physicians are correct in reporting such services separately from any accompanying E/M service. While there is no legal mandate requiring private carriers to adhere to *CPT* guidelines, it is considered a “good faith” gesture for them to do so, given that the guidelines are the current standard within organized medicine. Those separately reportable services that are not recognized by a carrier should be designated non-covered benefits and billable to the patient.

Enclosed is a copy of the original claim that was submitted with a request that you process payment as indicated on the claim. I look forward to receiving your response. If you have any questions, please feel free to contact me at ______________________.

Sincerely,
TO: Claims Processing Department or Health Plan Medical Director

RE: Developmental testing

Claim # ________________________

I am writing to you regarding the above claim and your practice of bundling the developmental testing (Current Procedural Terminology [CPT] 96110) with the preventive medicine code (99381-99397). I ask that you reconsider this in light of the following.

Current Procedural Terminology code 96110 (developmental testing; limited [eg, Developmental Screening Test II, Early Language Milestone Screen], with interpretation and report) should be reported separately from a preventive medicine service code (99381-99397) when a developmental test is interpreted and a report is developed from that interpretation during the course of a well child exam. It is important to note that the interpretation and report must constitute a significant, separately identifiable service from the preventive medicine visit. Examples of when it would be appropriate to report CPT code 96110 in addition to a preventive medicine service code include:

- Two-year-old well child care visit; physician administers Brigance screening tool (physician administers via face-to-face interview, 10 minutes)
- 30-month-old well child care visit, review of Parents’ Evaluation of Developmental Status (PEDS) questionnaire (parent completes for 10 minutes, physician reviews results with the parent for 3 minutes)
- Three-year-old well child visit, physician administers Child Development Inventory checklist (physician administers via face-to-face interview, 2 minutes)

If a less formal developmental assessment is conducted, it would be included in the preventive medicine service code or, alternatively, if a mini-mental status examination is conducted by the physician, it could be reported with an office or other outpatient services code (99201-99215).

Enclosed is a copy of the original claim that was submitted, with a request that you process payment as indicated on the claim. I look forward to your response to this matter. If you have any questions, please feel free to contact me at ____________________.

Sincerely,
Child and Adolescent Mental Health

Overview
Within the last 20 years, the role of mental health care has become recognized as a critical component of America’s health care system. A 2004 survey conducted by the Center for Health and Health Care in Schools http://www.healthinschools.org/sh/psychotropic.pdf found that 19% of all pediatric visits involved a psychosocial problem requiring attention or intervention. In fact, psychosocial problems rank first, surpassing asthma and heart disease, as the chronic conditions that most often account for pediatric visits.

Childhood mental health issues can produce a negative effect on quality of life through adulthood, and the importance of early identification and treatment of mental health concerns cannot be overstressed. The economic impact alone of untreated mental health concerns is staggering. Untreated mental health disorders lead to higher rates of juvenile incarcerations, school dropout, family dysfunction, drug abuse, and unemployment. Societal costs can be alleviated by early detection and treatment of mental health conditions.

This issue brief focuses on 4 distinct topics:

- The establishment of parity between insurance coverage for mental health care and physical health care.
- The prevention of suicide in children and adolescents.
- The use of school-based mental health programs in identifying and treating mental health conditions.
- The administration of psychotropic medications to children and referral for psychotropic medications by school personnel.

Mental Health Insurance Parity
The National Institute of Mental Health (NIMH) http://www.surgeongeneral.gov/topics/cmhb/ reports that it is estimated that less than 1 in 5 of the children and adolescents, who suffer from mental illness severe enough to cause some level of impairment, receive treatment for their condition.

According to the AAP Policy Statement “Insurance Coverage of Mental Health and Substance Abuse Services for Children and Adolescents: A Consensus Statement” http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/860 it is currently estimated that at least 13 million children are in need of mental health or substance abuse services, yet attempts to restrain health care costs have resulted in decreased availability of mental health and substance abuse services for children and adolescents.

The Mental Health Parity Act (MHPA) of 1996 prohibited employer-sponsored group plans larger than 50 employees, from imposing annual or lifetime maximums on mental health benefits that are lower than those imposed on other benefits. Despite the name, the law does not require parity between mental health benefits and other illness coverage benefits in the terms of deductibles, outpatient visit limits, inpatient day limits, and medical necessity requirements or prior authorization requirements. To fill in the gaps left open from the MHPA, every state except for Wyoming has enacted some form of mental health parity legislation. In February 2007, legislation was introduced in the U.S. House of Representatives that would require mental health substance and abuse treatment parity for employer-sponsored insurance plans with 50 or more employees. As of this writing, this legislation is still pending.
AAP Recommendations
Many children do not receive preventive or follow-up care for mental health conditions. The Academy makes the following recommendations in the consensus statement:

- Parity should be established between medical health services and mental behavioral and substance abuse services.
- The State Children’s Health Insurance Program (SCHIP), which has provided additional resources for children’s health care and has allowed for some flexibility in the distribution of resources, should be supported and expanded to include coverage for mental and behavioral health and substance abuse services.
- The number of qualified child mental health and substance abuse clinicians should be increased through support for training programs, better recruitment into these programs and job incentives.
- Managed care and behavioral health organizations should be required to provide adequate panels of culturally competent clinicians who are qualified to address child and adolescent mental and behavioral health and substance abuse needs.
- Competent, licensed providers with training and expertise in providing services to children should be equally included on panels, without limitations to specific disciplines.
- Professionals need to be accessible and available to families within a reasonable distance and time frame.
- Services provided by clinicians in alternative sites such as schools, homes, and centers must be reimbursed.
- Families and purchasers of health care plans need to be clearly informed about the adequacy of the health care coverage they are considering. The health plan should specifically identify mental health services provided to children, including child and adolescent psychopharmacology, child and adolescent psychological and neuropsychological assessments, child and adolescent psychotherapy, behavioral medicine (eg, pain management, chronic illness management, eating disorders), and substance abuse programs.

Limited Mental Health Parity Laws
Three (3) states (Indiana, Kentucky, and Maine) require mental health and substance abuse treatment parity only in group insurance plans with 50 or more employees. Rhode Island requires that both mental health and substance abuse conditions be covered at the same rate as other physical illnesses, with some limitations on outpatient visits. Two (2) states (New Mexico and Washington) require mental health parity for group health plans with more than 50 employees, but do not include coverage for treatment of substance abuse in the mandate. Six (6) states (Arizona, Arkansas, North Carolina, Oklahoma, Tennessee, and West Virginia) require mental health parity within group health insurance coverage, provided that parity does not raise the cost of coverage by more than 1 to 2%. Idaho mandates mental health parity in coverage only for state employees and their families.

Eight (8) states (California, Colorado, Delaware, Louisiana, Montana, New Hampshire, New Jersey, and South Dakota) limit mental health parity to people determined to have “Severe Mental Illness” (SMI). The definition of SMI varies from state to state, but is generally accepted to mean a biological-based mental illness. Eight (8) other states (Hawaii, Illinois, Iowa, Massachusetts, Nebraska, South Carolina, Texas, and Virginia) limit mental parity to treatment of SMI in group insurance plans.

Mental Health Mandates
Twelve (12) states (Alabama, Alaska, Florida, Georgia, Kansas, Michigan, Mississippi, New York, North Dakota, Ohio, Pennsylvania, and Wisconsin) mandate mental health care coverage within private health insurance, but do not stipulate in these mandates that mental health care coverage and physical illness coverage be equal. Two (2) states (Nevada and Utah) have laws that limit out-of-pocket expenses for treatment of SMI within group health insurance plans and Missouri limits out-of-pocket expenses on coverage of all mental health conditions.

Recent Legislative Activity
During the 2007 legislative session, 10 states introduced bills that would require or strengthen mental health parity with medical benefits. Colorado passed legislation that will require insurers to cover coverage for mental disorders in addition to SMI. New Mexico passed a bill that will allow residents with an individual insurance policy, which does not include mental health benefits, the eligibility to buy into a pool policy to provide mental health services. Washington passed a bill that will require existing mental health benefits to be extended to small employer and individual plans. West Virginia removed the sunset clause for mental health parity laws for group plans.

State Activity
Mental Health Parity Laws
Currently 5 states (Connecticut, Maryland, Minnesota, Oregon, and Vermont) mandate mental health parity, requiring that all mental health conditions and substance abuse disorders be covered at the same level as a physical illness.
School-Based Mental Health Programs
Access to mental health coverage is not the only barrier to children’s mental health care. The AAP Policy Statement “School-Based Mental Health Services” http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;113/6/1839 reports that barriers also include lack of transportation, financial constraints, child mental health professional shortages, and stigmas related to mental health problems. These barriers might explain why 40% to 60% of families who begin therapy sessions end prematurely, and why most people only attend 1 to 2 sessions before terminating. School-based mental health services are evolving as a strategy to address these concerns by removing barriers to accessing mental health services and improving coordination of these services.

AAP Recommendations
The Academy recognizes that school-based mental health clinics can play an important role in addressing barriers to mental health services and makes the following recommendations:

- The mental health program (preventive strategies and mental health services) should be coordinated with educational programs and other school-based health services. School social workers, guidance counselors, school psychologists, school nurses, and all mental health therapists should plan preventive and intervention strategies together with school administrators and teachers, as well as families and community members.
- Preventive mental health programs should be developed that include a healthy social environment, clear rules, and expectations that are well publicized. Staff members should be trained to recognize stresses that may lead to mental health problems as well as early signs of mental illness and refer students to trained professionals within this setting.
- Mental health referrals (within the school system as well as to community-based professionals and agencies) should be coordinated by using written protocols, should be monitored for adherence and should be evaluated for effectiveness.
- School-based specific diagnosis screenings, such as for depression, should be implemented at school only if they have been supported by peer-reviewed evidence of their effectiveness in the setting.
- Roles of all the various mental health professionals who work on campus with students should be defined so that students, families, all school staff members, and the mental health professionals themselves understand them.
- Group, individual, and family therapies should be included as schools arrange for direct services to be provided at school sites. Alternatively, referral services should be available for each of these modes of therapy so that students and families receive the mode most appropriate to their needs.
- It should be documented that mental health professionals providing services on site in school (whether hired, contracted, or invited to school sites to provide services) have training specifically in child and adolescent mental health (appropriate for student ages) and are competent to provide mental health services in school settings.
- Private, confidential, and comfortable physical space should be provided at the school site. Often, this is not difficult for schools if mental health services are provided after school hours. Having school-based services should not preclude the opportunity for mental health services to be provided at nonschool sites for situations in which therapy for a student may be ill advised (eg, student who feels uncomfortable discussing a history of sexual abuse in a school setting). During extended school breaks, schools must provide continued access to mental health services.
- Staff members should be provided with opportunities to consult with child psychiatrists or clinical psychologists (on or off school site) so that they may explore specific difficult situations or student behaviors and review policies, programs, and protocols related to mental health.
- Quality-assurance strategies should be developed for mental health services provided at school, and all aspects of the school health programs should be evaluated, including satisfaction of parent, student, and third-party payers and mental health professionals.
- Confidentiality of health information should be maintained as required by law.

State Activity
School-based mental health centers are typically developed and run by individual school districts utilizing funding from federal, state, and local resources. According to a study by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), while school districts operating school-based mental health clinics are found in nearly every state, only 17% of school districts currently operate them. However, the number of school districts with mental health clinics is continuing to grow, fueled
in part by state initiatives. States are exploring options for achieving permanence and expanding to other school districts by passing legislation that authorize school-based mental health clinics, facilitating agency collaboration through an interagency memorandum of understanding, or through an executive order from the governor establishing mental health authority within the state education departments. States are also exploring establishing additional state funding, requesting additional federal funds, or establishing legislative task forces to determine the best methods to fund a statewide program.

In 2007, Connecticut introduced a bill that would provide 2 million dollars to create and fund school-based mental health clinics in the state. In 2006, California and Colorado allocated state funding specifically for school-based mental health centers for the first time. Illinois passed a bill that allowed school health centers to be considered as primary care providers to allow for Medicaid and private insurance payment of providers.

Federal Activity
In February of 2007, the U.S. Senate introduced a bill that would provide direct federal funding in the form of grants to school-based health centers. Currently, many school districts in local communities throughout the United States are utilizing federal funding from already established sources to pay for mental health services in school settings. Using braided or blended federal funds such as Medicaid (Early and Periodic Screening, Detection and Treatment (EPSDT), State Children’s Health Insurance Program (SCHIP), or Individuals with Disabilities Education Act (IDEA) to finance these services within schools, allows school districts to incorporate existing school funds with potentially untapped resources to create or expand mental health programs within their schools. See more about the potential use of braided or blended federal funds to subsidize children’s mental health services in “How Children’s Mental Health Services are Financed” in the AAP Mental Health Chapter Action Kit.

Suicide Prevention
Suicide is the third leading cause of death of children between the ages of 15-19. In recent years suicide rates have been declining, but according to statistics from the Centers for Disease Control and Prevention (CDC) published in the February 2007 issue of Pediatrics, adolescent suicide rates increased by 18% from 2003 to 2004, making it the only cause of death for children that increased in this period.

These alarming rates are even higher among one segment of the adolescent population. The AAP Clinical Report, “Sexual Orientation and Adolescents” notes that school-based studies have found that adolescents who self-identify as gay, lesbian, or bisexual are 2 to 7 times more likely to attempt suicide compared with heterosexual peers. The report also notes that these psychosocial problems and suicide attempts in nonheterosexual youth are neither universal nor attributable to homosexuality per se, but they are significantly associated with stigmatization of gender nonconformity, stress, violence, lack of support, dropping out of school, family problems, acquaintances’ suicide attempts, homelessness, and substance abuse.

AAP Recommendations
The AAP Policy Statement “Suicide and Suicide Attempts in Adolescents” urges that the following provisions be included in state suicide prevention plans:

• Promoting school-based initiatives.
• Gatekeeper training for those who are able to observe high-risk behavior among youth.
• School-based suicide prevention programs that incorporate screening and suicide prevention information into health and human services.
• Crisis intervention services for schools and communities that provide a rapid response to tragic events.
• Establishing statewide crisis hotline and information for consultation and education services.
• Increasing access to and the coordination of mental health and substance abuse services.
• Reducing child and adolescent access to lethal means of self-harm, such as firearms.
• Forming public and private partnerships to raise community awareness.

Because of the higher rate of suicide attempts among gay, lesbian, and bisexual youth, the AAP Clinical Report, “Sexual Orientation and Adolescents” notes, “It is critical that schools find a way to create safe and supportive environments for students who are or wonder about being nonheterosexual or who have a parent or other family member who is nonheterosexual.” In addition, the report encourages community advocacy by pediatricians to:

• Help raise awareness among school and community leaders of issues relevant to nonheterosexual youth.
• Help with the discussion of when and how factual materials about sexual orientation should be included.
in school curricula and in school and community libraries.

- Support the development and maintenance of school- and community-based support groups for nonheterosexual students and their friends and parents.
- Support HIV and AIDS prevention and education efforts.
- Develop and/or request continuing education opportunities for health care professionals related to issues of sexual orientation, nonheterosexual youth, and their families.

**State Activity**

Forty-three (43) states (including the District of Columbia) have suicide prevention plans, and 7 states have plans in development. North Carolina is the only state without a suicide prevention plan or without one in development. In addition to suicide prevention plans, Tennessee has introduced legislation requiring teachers to undergo suicide prevention training.

**Federal Activity**

The federal Garrett Lee Smith Memorial Act enacted in 2004, authorized $82 million in federal spending for suicide prevention in fiscal years 2005, 2006, and 2007. Through the Substance Abuse and Mental Health Services Administration (SAMHSA), the law appropriates funding to assist states and educational institutions in establishing early intervention and detection programs for suicide prevention.

**Psychotropic Medications**

An estimated 4 million U.S. children have been identified as having attention deficit/hyperactivity disorder (ADHD), while 1% of children and 5% of adolescents have been diagnosed with depression. Within the past 20 years, advances in medication have allowed these conditions formerly treated with behavior modification therapy to be treated with drugs designed to regulate the brain’s chemistry. Recent studies showing the increased threat of suicidal thoughts from the administration of antidepressants to children and adolescents, have cautioned physicians in the use of specific psychotropic medications in treatment of mental health disorders. A backlash from the perceived “over-prescription” of psychotropic medications for children with ADHD among some groups added to a public policy debate about the merits of psychotropic medication to treat ADHD and other mental health disorders in children. These controversies have the potential to stigmatize the use of psychotropic drugs, which have been proven to be safe and effective in the treatment of mental health disorders, and may cause parents to become hesitant to administer these medications to their children.

**AAP Recommendations**

While the Academy supports the use of caution when prescribing antidepressant medications to children and adolescents, the Academy’s main concern is to ensure access to the best therapies for children who suffer from mental disorders. The Academy has expressed concerns through communications with the Federal Drug Administration (FDA) that “black box” warnings may discourage pediatricians from prescribing needed medications to children and adolescents. The decision to prescribe medication to address depression or other mental health conditions in a child should be left up to the child’s physician in consultation with the parents and the child.

Academy policy concerning treatment of ADHD outlined in “Clinical Practice Guideline: Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder,” (http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/4/1033) recommends that the treating clinicians work in conjunction with parents and teachers to target appropriate outcomes to guide the management of ADHD. It is important that school personnel not be subjected to a real or perceived “gag order” when discussing the presence and appropriate response to ADHD. While teachers should not be diagnosing ADHD in children, the teacher and other school personnel should work in conjunction with a child, their parents, and the child’s medical home when a biological cause is suspected of hindering the child’s academic performance or creating behavioral disturbances. Teachers and parents should both actively monitor target outcomes and adverse effects.

**State Activity**

State legislatures are using mandates directed at schools, state child custody systems, and child welfare services as a mechanism to limit access to psychotropic drugs. Two (2) states (Connecticut and Utah) have enacted laws that stipulate that failure or refusal to administer psychotropic medications to children does not warrant neglect or abuse. Seven (7) states (Colorado, Delaware, Florida, Illinois, Minnesota, Texas, and Virginia) have passed laws limiting nonmedical school personnel from recommending that a student be prescribed medications or place sanctions on a child whose parents refuse to administer psychotropic medications. Meanwhile, 2 states (California and Illinois) allow school personnel with medical training to recommend that a student be examined for ADHD and/or prescribed psychotropic medications to treat the disorder. Nine (9) state legislatures (California, Connecticut,
Florida, Hawaii, Louisiana, North Carolina, New Mexico, Texas, and Washington) have authorized studies monitoring the use of psychotropic medications to children in state custody. Five (5) states (Delaware, Georgia, New Hampshire, North Carolina, and Virginia) have established legislative committees/tasks forces to study the number of children within their states diagnosed with ADHD and/or administered medication. Two (2) state boards of education (Colorado and Texas) passed resolutions promoting the use of academic management to address behavioral problems rather than a psychiatric approach. Finally, Indiana requires all medical practitioners prescribing psychotropic medications to children to follow the AAP Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity while evaluating children for ADHD.

In 2007, Utah enacted legislation that would prohibit school personnel from recommending that a child be prescribed psychotropic drugs or prohibiting a child from a classroom based on a parent’s refusal to administer psychotropic drugs. California enacted legislation that allows only a judicial court officer to make orders regarding the administration of psychotropic drugs. Hawaii passed legislation that prohibits the Department of Human Services from restricting coverage or access to psychotropic drugs.

Federal Activity
In 2004, the Federal Drug Administration (FDA) required all antidepressant medications to include a “black box” warning prominently displayed on the label providing information regarding potential medical complications associated with the drugs, including increase in suicidal thoughts and behaviors.

In early 2005, the FDA’s Drug Safety and Risk Management Advisory Committee met and recommended that the FDA label certain stimulant prescription drugs for ADHD with a black box warning. However, a separate pediatric advisory committee rejected the call for a black box warning on ADHD medications and instead recommended adding more information to the labels for the benefit to the doctors, parents, and patients, providing parents with a medication guide that would tell parents to discuss with their doctors if their child experienced hallucinations, and alerting parents that ADHD medications can increase the risk for a heart attack and a stroke among people with undiagnosed heart problems.

Advocacy Considerations
• Emphasize the Impact of Early Detection on a Child’s Life. Mental health disorders can have a negative impact of the quality of a child’s life for years to come. If addressed early in childhood, the child will be less likely to exhibit poor school performance, less likely to commit crimes later in life, and will exhibit increased self-esteem and confidence that will allow them to become healthy, productive adults. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/860

• Seek Pediatrician Appointment to State Mental Health Advisory Committee. When considering mental health policy, state policy makers may overlook the role of the primary care provider. Pediatricians are often the first stop in diagnosing and developing a plan to treat mental health conditions, and therefore should become actively involved in formation of state health mental policy by working with their chapters to seek appointments to state advisory boards and committees.

• Use Patient Stories to Illustrate Need for Change. Individual stories, when utilized with appropriate confidentiality measures, can be the best tool for advocating changes to the current system. Policy makers are often swayed more by an individual case than statistics that point to the same conclusions. Identify a family with a poignant story who would agree to share their story with state officials through testimony. If the family would prefer not to testify, have them share their story through letters to or meetings with their legislator. Letters from children and adolescents affected by a mental health condition accompanied by a parent’s letter are often the most effective advocacy tools.

• Highlight Improved State Budgets as Opportunity to Improve Access to Health Care for Children. Legislators are no longer facing the barren coffers within their state budgets that plagued them the early part of the decade. For the first time since 2000, almost all states are expecting a budget surplus. This presents an excellent opportunity to expand current and fund new children and adolescent mental health programs.
Resources

AAP Consensus Statement: Insurance Coverage of Mental Health and Substance Abuse Services for Children and Adolescents: A Consensus Statement
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/860

AAP Policy Statement: Suicide and Suicide Attempts in Adolescents
http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;105/4/871

AAP Policy Statement: Sexual Orientation in Adolescents
http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;113/6/1827

AAP Policy Statement: School-Based Mental Health Services
http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;113/6/1839

AAP Mental Health Task Force Chapter Action Kit: “How Children’s Mental Health Services are Financed”

Bazelon Center for Mental Health “Way to Go: School Success for Children with Mental Health Care Needs”
http://www.bazelon.org/newsroom/2006/6-7-6-WayToGo.html

National Conference of State Legislatures, “Table: Full Parity, Mandated Benefit and Mandated Offering State Laws”
http://www.ncsl.org/programs/health/Mentalben.htm

National Mental Health Association “What Have States Done to Ensure Parity”
http://www.nmha.org/state/parity/state_parity.cfm

NAMI Policy Institute Task Force Report, “Children and Psychotropic Medications”
http://www.nami.org/Content/ContentGroups/CAAC/NAMIs_Report_on_Children_and_Psychotropic_Medications.htm

The Robert Wood Johnson Foundation (RWJF) “Making the Grade: State and Local Partnerships to Establish School-Based Health Centers”
http://www.rwjf.org/reports/npreports/MakingGrade.htm

For more information on federal activities and advocacy, please contact: AAP Department of Federal Affairs at kids1st@aap.org or 202/347-8600. http://aap.grassroots.com/

NOTE: Issue briefs provide AAP chapters with an introduction to state government issues and additional background information that can be used when communicating with legislators or other public officials. While they are not intended as a presentation for, or to be distributed to, legislators, the media, or the general public, excerpts of nonstrategic information may be utilized in your advocacy work.

July 16, 2007
During the past decade, a growing awareness of the social and economic costs of mental illness has prompted state legislators to mandate increases in the coverage of mental illnesses by private health insurance companies. These laws, commonly known as parity mandates, parity laws or simply “parity,” require equal coverage for the treatment of both mental and physical illness. This paper evaluates how institutional barriers—such as exemptions for small businesses, managed care organizations that act as gatekeepers for benefits, and federal restrictions on states’ powers to impose insurance mandates—may reduce the effectiveness of parity as a tool for ensuring coverage of mental health services for vulnerable populations. Parity is described by mental health advocacy groups—such as the National Alliance for the Mentally Ill (NAMI) and the National Mental Health Association (NMHA)—as a tool for improving coverage and reducing the stigma associated with mental illnesses. However, a number of factors may greatly reduce the effectiveness of parity mandates. These include managed care organizations that can act as gatekeepers to services; federal legislation that prohibits states from placing insurance mandates on self-funded health plans; and exemptions in both state and federal parity legislation for small employers that further limit the pool of people to whom parity is a relevant issue. Unfortunately, insufficient data and restrictive definitions of mental illness in parity legislation continue to limit the ability of researchers to determine the extent to which parity increases coverage of mental health services for vulnerable populations.

**Parity Defined**

Parity encompasses a variety of legislative approaches to ensuring adequate insurance coverage for mental health illnesses. Its definition often depends upon who is using the word. NCSL defines a law as **parity** if it “… requires an insurer to provide benefits for mental illnesses and/or substance abuse that are equal to those provided for other physical disorders and diseases.” The language of Vt. Stat. 8 V.S.A. §4089b (1997), the Vermont parity legislation implemented in 1997 that is widely hailed as the most comprehensive in the nation, states:

(b) A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.

d) A health insurance plan shall be construed to be in compliance with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions. The commissioner may disapprove any plan that the commissioner determines to be inconsistent with the purposes of this section.

Other types of legislation that are sometimes referred to as parity include **minimum mandated benefit laws** and **mandated offering laws**. Minimum mandated benefit laws typically specify base levels for mental health insurance coverage; benefits given under these provisions are not necessarily equal to those set for physical illnesses. A typical minimum mandated benefit law states, “… will require that benefits for “X” ("X" being mental illness and/or substance abuse), be provided at level "Y" ("Y" then specifies the degree top which “X” is covered). The following language from Pa. Stat. tit. 40 §764g (2004), Pennsylvania’s minimum mandated benefit law, provides an example of minimum mandated benefit law:

(c) Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards: 1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually; 2) a person covered
under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis; 3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses; 4) cost-sharing arrangements, including, but not limited to, deductibles and copayments for coverage of serious mental illnesses shall not prohibit access to care. The department shall set up a method to determine whether any cost-sharing arrangements violate this subsection.5

Mandated offering laws require insurers to either offer the option of mental health coverage to the insured, often with a higher premium, or mandate that, if an insurer decides to offer mental health benefits, they must be provided at a level specified by the law.6 Utah Code §31A-22-625 (2002), a Utah law, is an example of the first type of mandated offering legislation, specifying that:

At the time of purchase and renewal, an insurer shall offer to each small employer that it insures or seeks to insure a choice between catastrophic mental health coverage and 50/50 mental health coverage.7

Fla. Stat §627.6685 (2004), a Florida insurance mandate, is an example of the second type of mandated offering legislation, amending:

(a)1. In the case of a group health plan, or health insurance coverage offered in connection with such a plan, which provides both medical and surgical benefits and mental health benefits: a. If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits. b. If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage must: (I) Apply that applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or (II) Not include any aggregate lifetime limit on mental health benefits which is less than that applicable lifetime limit.8

In this paper, the term insurance mandate describes any legislation that increases benefit levels or access to insurance benefits. As figure 1 shows, many states have passed laws that closely adhere to one of these definitions, while others have blended aspects of two or more of the insurance mandate types by passing more than one law pertaining to mental health insurance coverage.

| Mandated Benefit | AR, MD, MI, MS, ND, NV, OR, PA, RI, TN, TX, VA |
| -- | |
| Mandated Offering | AL, AZ, FL, GA, IN, KS, KY, LA, MO, NE, NY, OH, UT, WI |
| Parity | CA, CO, CT, DE, HI, IL, MA, ME, MN, MT, NC, NH, NJ, NM, OK, SC, SD, VT, WA, WV |
| No Requirement | AK, IA, ID, WY |

Notes
1. Massachusetts and New Hampshire mandate parity coverage for biologically based mental illness; there is a mandated benefit for all DSM diagnosis not covered under the parity provision.
2. Minnesota has a parity mandate for HMOs and a minimum mandated offering for group and individual plans.
3. Mississippi has a mandated offering for small providers with 100 employees or less, and a mandated benefit for all other businesses.
4. Montana mandates parity for severe mental illness and has a mandated benefit clause for other forms of mental illness.
5. New Jersey mandates parity for biologically based illnesses and has an alternative mandated offering for individual coverage.
6. North Carolina and South Carolina mandate minimum benefits for state employees.
7. South Dakota mandates parity for biologically based mental illness.

TALKING ETHICS: PARITY AND VALUES

Insurers and advocacy groups strongly disagree about the merits of parity. At the heart of the debate is a dispute over what government should mandate. Opponents believe that insurance mandates limit freedom of choice by imposing increased costs on businesses and individuals for services they may not want or be able to afford. Proponents hold that parity in insurance coverage of mental illness helps fulfill an obligation to ensure social equity by increasing access to, and use of, health services.

Mental health advocates explain that parity reduces the stigma and discrimination associated with mental illness that led to inequitable differences in coverage. NAMI, a prominent advocacy group representing consumers and families, states that “… there is simply no scientific or medical justification for insurance coverage of mental illness treatment to be on different terms and conditions than other diseases.”9 The organization holds that mental health is a fundamental right and services that maintain it should be available to everyone. Proponents also state that mental health is a crucial component of overall well-being because mental ailments often are associated with higher levels of physical illness. Such groups cite data that shows that mental illness leads to higher expenditures by public and private health insurance providers through lost productivity due to absenteeism (missed work days) and elevated expenditures on visits to the doctor for treatment of physical illnesses related to mental ailments.10,11

Opponents of parity, including employer and insurer groups, focus on the importance of freedom and choice, describing insurance mandates as additional costs for businesses and consumers. The nation’s largest business lobbying group, the U.S. Chamber of Commerce, states that insurance mandates, “… artificially raise the cost of health plans, limit employers’ ability to tailor benefits according to workforce need and demand, and stifle health plans’ efforts to provide consumers with a variety of choices.”12 That is, the additional costs associated with mandates are passed along to consumers in the form of a decrease in insurance products on the market. As a result, they say, consumer choice declines. Opponents also assert that increased costs for employers and workers lead to decreased coverage: “When workers have to bear more of the cost of their group health coverage, they opt out of insurance programs – jeopardizing their overall health status.”13

Although both sides in this debate make cost-efficiency arguments to support their positions, the debate often is framed in terms of values. At the heart of the issue is a disagreement about the relative importance of equity versus freedom of choice in health services.

Managed Care and Parity

Economic theory suggests that, in the absence of direct personal costs, people tend to overuse health services, which drives up system costs. Parity increases access to services, which indicates that usage also will increase.14 Many insurers use managed care systems that attempt to rein in health spending by controlling access to and use of health services. There is, however, some concern about the effectiveness of parity in a managed care environment: parity increases offerings, while managed care limits usage. Parity legislation of all types seeks to increase coverage of mental health services in private insurance plans. In contrast, managed care systems such as health maintenance organizations (HMOs) or managed care organizations (MCOs) use a variety of techniques to monitor and direct the use of health care services by members to contain costs, improve the quality of services, or both.15 Given the influence of managed care organizations in the field of mental health care, advocates have been concerned about the effect of managed care on access to mental health benefits.

Optimally, managed care services can improve the quality and appropriateness of the services that people receive: managed care plans that focus on preventive care can actually increase access to primary care, reducing the likelihood that a person will need more costly urgent care later in life. A trend in managed care that may alleviate some advocates’ concerns is the use of carve-outs, which are health care payer systems wherein insurers form agreements with specialized contractors to administer and fund mental health services separately from physical health services. Commonly stated reasons for using carve-outs include controlling system costs and improving service quality for targeted populations. Some reviews of carve-out systems suggest that, at least in the private market, “… costs have been contained, while access to any behavioral specialty care has tended to remain constant or even increase.”16 This suggests that carefully designed systems that couple parity and managed care may be able to control costs while targeting additional benefits to those in need. The issue of system design remains a major concern because constructing a network of providers to supply services in a carve-out can be difficult. This may lead to limits on access to services despite official insurance coverage.

PARITY IMPLEMENTATION

Studies examining the effects of parity on cost and access to services in managed care have found that spending generally does not increase. Notably, the U.S. Department of Health and Human Services conducted an evaluation of Vermont’s 1997 parity law, which is among the most comprehensive parity law in the nation. The resulting report, which gathered data from the first two to three years after parity was implemented in Vermont, concludes that “… increased use of managed care helped make parity affordable but may have reduced access and utilization for some services and beneficiaries.”17 The authors of the Vermont report explained that access to outpatient mental health services improved,
while access to substance abuse services declined. They also found that consumers’ share of total spending decreased and health plan spending, i.e., payments made by the insurance company, did not rise as much as critics of the plan feared: “Spending by Blue Cross Blue Shield of Vermont increased by four percent following implementation of parity. In other words, the amount spent increased by 19 cents per member per month.”

Similar research by Mathematica Policy Research Inc., which examined the process of parity implementation in California in 1999, found that insurance premium costs did not appear to increase and employer health insurance offerings did not decline. The main problems that they discovered were related more to difficulty in overcoming administrative hurdles during the transition than to the process itself. The report states, “Early education and communication efforts about benefit and delivery system changes were not viewed as adequate by several stakeholders.”

**Child Custody Relinquishment**

Paying for health care services for mentally ill children is a significant hardship for many families around the country. The 1999 Mental Health: Report from the Surgeon General suggests that 4 million American children between the ages of 9 and 17 suffer from a “significant functional impairment” from mental illness and “have a high need for services.” As figure 2 shows, approximately 1 child in 10 will need some form of therapy, and roughly 1 in 20 will face extreme need.

![Figure 2. Diagnosable Mental or Addictive Disorders Among Children Ages 9 to 17](image)

<table>
<thead>
<tr>
<th>Impairment Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Impairment</td>
<td>9.4%</td>
</tr>
<tr>
<td>Mild</td>
<td>5.4%</td>
</tr>
<tr>
<td>Moderate</td>
<td>6.1%</td>
</tr>
<tr>
<td>Severe</td>
<td>79.1%</td>
</tr>
</tbody>
</table>

Many of these children do not receive adequate mental health services. A recent Kaiser Family Foundation report states that, “… although nearly all covered workers (98%) have mental health benefits, limits on the number of visits for outpatient care and the number of days for inpatient care remain a common feature for all plan types.” These restrictions generally apply to dependents who receive benefits through their working parent or spouse. Consequently, the parents of children with mental illness often pay for the cost of treatment out-of-pocket.

When high-cost or long-term care is necessary, those payments can exceed parents’ financial resources, forcing them to make difficult decisions, such as spending down their resources until they qualify for Medicaid services. This occurs when parents are too well-off to qualify for Medicaid but too poor to pay for all the necessary services on their own. As an alternative, many families relinquish custody of their children to state authority each year solely to gain access to publicly funded mental health services. A recent report by the General Accountability Office (GAO) estimates that, in the United States, more than 12,700 children were voluntarily relinquished to state custody in 2001 solely to give them access to mental health services.

Children become wards of the state when relinquished, cycling through the foster care system despite the fact that their parents may want to take care of them. Solutions to this problem have been slow in coming. Although it is increasingly clear that community-based services can help keep families together and reduce trauma, it is also apparent that supplying additional services costs money, of which states have limited supply.

Mental health advocates suggest that mental health parity may increase coverage of health care services for children, thereby reducing the rate of custody relinquishment. However, the strength of the effect of parity on custody relinquishment has not been sufficiently examined. The degree to which increases in coverage can affect the rate of custody relinquishment and increase access to health care for mentally ill children is a function of how effectively insurance mandates can target specific populations. Several factors seem to create barriers to the targeted use of parity as a solution to custody relinquishment, among them the advent of managed care systems to control health care use, as well as exclusions from parity that may be granted to small and self-insured businesses by states and the federal government. Little research has been conducted to examine how these dynamics affect parity and child custody relinquishment.

This information gap highlights the value of research to policymaking: using parity legislation as a solution to the problem of custody relinquishment of children assumes an ability to target resources to members of this vulnerable population. It is not clear that parity can help provide a solution. Future steps that could help clarify this issue might include identifying the families of children with mental illness at the state level. Additional research could examine how the degrees and types of need vary by family income level, location, and so forth. Determining who needs assistance, how much, and in what mix could help reduce the number of children who are relinquished by their parents in order to receive services. As a result, state foster systems would bear less of the burden of providing for children with severe mental illnesses.
Parity: A Patchwork of Federal and State Legislation

Many states have used the primary federal parity legislation, the Mental Health Parity Act (MHPA), which was passed by Congress in 1996 with a yearly sunset, as a template for their insurance mandate laws, adding additional exemptions and inclusions in each new iteration.\textsuperscript{30} As a result, parity is a patchwork of federal and state legislation, with all the complications that such a structure implies.

The Centers for Medicare and Medicaid Services suggests that the federal parity act “… may prevent your group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower—less favorable—than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.”\textsuperscript{31} However, as they also take care to point out, “… MHPA does NOT require group health plans and their health insurance issuers to include mental health coverage in their benefits package.”\textsuperscript{32} In this respect, the MHPA conforms to the National Conference of State Legislature’s definition of a mandated offering because it compels insurers to offer equal coverage for mental illnesses in their insurance benefit packages if they offer mental health insurance coverage. Insurers can, however, choose to not offer mental health insurance coverage or to offer an optional mental health benefit package with a higher premium. Other specific provisions of the law include an exemption for small businesses with fewer than 50 employees, and an exemption for group insurers that can demonstrate a percent or greater cost increase in the cost of insurance due to the law. Group insurers can be thought of as the bulk purchasers of health insurance policies; they are employers’ groups and associations such as unions that cannot efficiently self-insure but that can pool their purchasing power to buy discounted coverage from insurance companies. As table 1 shows, many states include similar exemptions in their legislation, thus shielding small business and insurers from the risk of cost increases but also restricting the pool of people affected by state parity legislation.

A significant difference between federal and state insurance mandates is that the MHPA applies to the self-funded insurance plans that many large businesses maintain for their employees. Whereas the Employee Retirement Income Security Act (ERISA) generally precludes states from passing laws regulating the self-funded health insurance plans that many large employers provide for their workers, the Mental Health Parity Act does apply to those plans.\textsuperscript{33,34} Of the estimated 63 percent of firms that currently offer health insurance to their employees, approximately 54 percent have self-funded health insurance plans, “… in which the

<table>
<thead>
<tr>
<th>State</th>
<th>Small Business Exemption</th>
<th>Cost Increase Exemption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Alaska</td>
<td>5 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Arizona</td>
<td>50 employees or less</td>
<td>1% or more</td>
</tr>
<tr>
<td>Arkansas</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Colorado</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Hawai'i</td>
<td>25 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Illinois</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Indiana</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Kentucky</td>
<td>51 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Louisiana</td>
<td>50 employees or less</td>
<td>1% or more</td>
</tr>
<tr>
<td>Maine</td>
<td>20 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Michigan</td>
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<td>3% or more</td>
</tr>
<tr>
<td>Mississippi</td>
<td>None</td>
<td>1% or more</td>
</tr>
<tr>
<td>Nebraska</td>
<td>15 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Nevada</td>
<td>25 employees or less</td>
<td>2% or more</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>50 employees or less</td>
<td>2% or more</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Tennessee</td>
<td>50 employees or less</td>
<td>1% or more</td>
</tr>
<tr>
<td>Texas</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Virginia</td>
<td>25 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Washington</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>West Virginia</td>
<td>None</td>
<td>State employees: 2%; 25 employees or less: 1%; 25 employees or more/HMOs: 2%</td>
</tr>
</tbody>
</table>

employer assumes direct financial responsibility for the costs of enrollees’ medical claims.”35,36 In other words, more than half of all private companies are not required to comply with state insurance mandates. It is also important for state policymakers to consider the rate of self-funded plans by firm size. As figure 3 shows, larger firms are more likely to self-insure than are smaller firms. Together, the federal ERISA law and exemptions provided to employers by both state and federal governments such as exemptions for businesses with less than 50 employees limit the ability of parity legislation to ensure coverage of mental illnesses.37

**CONCLUSION**

The degree to which parity laws that are designed to increase insurance coverage of mental illness are actually helping people is unclear for three reasons: 1) managed care organizations can act as gatekeepers, controlling access to benefits; 2) federal legislation prohibits states from placing insurance mandates on self-funded health plans, greatly reducing the number of people affected by any state insurance mandate; and 3) exemptions for small employers in state parity legislation further limit the pool of employees affected by this type of legislation. Nevertheless, anecdotal evidence suggests that parity is helping some people by increasing coverage of selected mental illnesses under managed care arrangements such as carve-outs or those that place a strong focus on preventive care. Insurance costs have increased little when parity is implemented, perhaps because managed care organizations act as gatekeepers for mental health services.

For lawmakers who seek to understand this set of issues, better information about target populations would facilitate more effective policy. State-level reviews of how current private, state and federal institutional structures interact to determine who has benefits, and at what levels, could further clarify best practices for the design of future policy. Legislation drafted using this additional information could improve the ability of parity mandates to address the unmet needs of people with mental illness.

**Acknowledgments**

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selected aap
mental health policies
Access to Optimal Emergency Care for Children
Committee on Pediatric Emergency Medicine
*Pediatrics.* 2007;119:161-164
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;119/1/161

 Millions of pediatric patients require some level of emergency care annually, and significant barriers limit access to appropriate services for large numbers of children. The American Academy of Pediatrics has a strong commitment to identifying barriers to access to emergency care, working to surmount these obstacles, and encouraging, through education and system changes, improved levels of emergency care available to all children.

Child Life Services
Child Life Council and Committee on Hospital Care
*Pediatrics.* 2006:118:1757-1763
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/4/1757

 Child life programs have become standard in most large pediatric centers and even on some smaller pediatric inpatient units to address the psychosocial concerns that accompany hospitalization and other health care experiences. The child life specialist focuses on the strengths and sense of well-being of children while promoting their optimal development and minimizing the adverse effects of children’s experiences in health care or other potentially stressful settings. Using play and psychological preparation as primary tools, child life interventions facilitate coping and adjustment at times and under circumstances that might prove overwhelming otherwise. Play and age-appropriate communication may be used to (1) promote optimal development, (2) present information, (3) plan and rehearse useful coping strategies for medical events or procedures, (4) work through feelings about past or impending experiences, and (5) establish therapeutic relationships with children and parents to support family involvement in each child’s care, with continuity across the care continuum. The benefits of this collaborative work with the family and health care team are not limited to the health care setting; it may also optimize reintegration into schools and the community.

Pediatric Mental Health Emergencies in the Emergency Medical Services System
American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians and Pediatric Emergency Medicine Committee
*Pediatrics.* 2006;118:1764-1767
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/4/1764

 Emergency departments are vital in the management of pediatric patients with mental health emergencies. Pediatric mental health emergencies are an increasing part of emergency medical practice because emergency departments have become the safety net for a fragmented mental health infrastructure that is experiencing critical shortages in
services in all sectors. Emergency departments must safely, humanely, and in a culturally and developmentally appropriate manner manage pediatric patients with undiagnosed and known mental illnesses, including those with mental retardation, autistic spectrum disorders, and attention-deficit/hyperactivity disorder and those experiencing a behavioral crisis. Emergency departments also manage patients with suicidal ideation, depression, escalating aggression, substance abuse, posttraumatic stress disorder, and maltreatment and those exposed to violence and unexpected deaths. Emergency departments must address not only the physical but also the mental health needs of patients during and after mass-casualty incidents and disasters. The American Academy of Pediatrics and the American College of Emergency Physicians support advocacy for increased mental health resources, including improved pediatric mental health tools for the emergency department, increased mental health insurance coverage, and adequate reimbursement at all levels; acknowledgment of the importance of the child’s medical home; and promotion of education and research for mental health emergencies.

**Chemical-Biological Terrorism and Its Impact on Children**
Committee on Environmental Health and Committee on Infectious Diseases
*Pediatrics*. 2006;118:1267-1278
[http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/3/1267](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/3/1267)

Children remain potential victims of chemical or biological terrorism. In recent years, children have even been specific targets of terrorist acts. Consequently, it is necessary to address the needs that children would face after a terrorist incident. A broad range of public health initiatives have occurred since September 11, 2001. Although the needs of children have been addressed in many of them, in many cases, these initiatives have been inadequate in ensuring the protection of children. In addition, public health and health care system preparedness for terrorism has been broadened to the so-called all-hazards approach, in which response plans for terrorism are blended with plans for a public health or health care system response to unintentional disasters (eg, natural events such as earthquakes or pandemic flu or manmade catastrophes such as a hazardous-materials spill). In response to new principles and programs that have appeared over the last 5 years, this policy statement provides an update of the 2000 policy statement. The roles of both the pediatrician and public health agencies continue to be emphasized; only a coordinated effort by pediatricians and public health can ensure that the needs of children, including emergency protocols in schools or child care centers, decontamination protocols, and mental health interventions, will be successful.

**Identifying Infants and Young Children With Developmental Disorders in the Medical Home:**
An Algorithm for Developmental Surveillance and Screening
Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children With Special Needs Project Advisory Committee
*Pediatrics*. 2006;118:405-420
[http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405)

Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals. This statement
provides an algorithm as a strategy to support health care professionals in developing a pattern and practice for addressing developmental concerns in children from birth through 3 years of age. The authors recommend that developmental surveillance be incorporated at every well-child preventive care visit. Any concerns raised during surveillance should be promptly addressed with standardized developmental screening tests. In addition, screening tests should be administered regularly at the 9-, 18-, and 30-month visits. (Because the 30-month visit is not yet a part of the preventive care system and is often not reimbursable by third-party payers at this time, developmental screening can be performed at 24 months of age. In addition, because the frequency of regular pediatric visits decreases after 24 months of age, a pediatrician who expects that his or her patients will have difficulty attending a 30-month visit should conduct screening during the 24-month visit.) The early identification of developmental problems should lead to further developmental and medical evaluation, diagnosis, and treatment, including early developmental intervention. Children diagnosed with developmental disorders should be identified as children with special health care needs, and chronic-condition management should be initiated. Identification of a developmental disorder and its underlying etiology may also drive a range of treatment planning, from medical treatment of the child to family planning for his or her parents.

Scope of Health Care Benefits for Children From Birth Through Age 21
Committee on Child Health Financing
Pediatrics. 2006;117:979-982
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;117/3/979

The optimal health of children can best be achieved by providing access to comprehensive health care benefits. This policy statement outlines and defines the recommended set of health insurance benefits for children through age 21. These services encompass medical care, critical care, pediatric surgical care, behavioral health services, specialized services for children with special health care needs, and oral health. It replaces the 1997 statement, "Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years."

The Pediatrician and Disaster Preparedness
Committee on Pediatric Emergency Medicine, Committee on Medical Liability, and the Task Force on Terrorism
Pediatrics. 2006;117:560-565
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;117/2/560

Recent natural disasters and events of terrorism and war have heightened society's recognition of the need for emergency preparedness. In addition to the unique pediatric issues involved in general emergency preparedness, several additional issues related to terrorism preparedness must be considered, including the unique vulnerabilities of children to various agents as well as the limited availability of age- and weight-appropriate antidotes and treatments. Although children may respond more rapidly to therapeutic intervention, they are at the same time more susceptible to various agents and conditions and more likely to deteriorate if not monitored carefully.

The challenge of dealing with the threat of terrorism, natural disasters, and public health emergencies in the United States is daunting not only for disaster planners but also for our medical system and health professionals of all types, including pediatricians. As part
of the network of health responders, pediatricians need to be able to answer concerns of
patients and families, recognize signs of possible exposure to a weapon of terror,
understand first-line response to such attacks, and sufficiently participate in disaster
planning to ensure that the unique needs of children are addressed satisfactorily in the
overall process. Pediatricians play a central role in disaster and terrorism preparedness
with families, children, and their communities. This applies not only to the general
pediatrician but also to the pediatric medical subspecialist and pediatric surgical
specialist. Families view pediatricians as their expert resource, and most of them expect
the pediatrician to be knowledgeable in areas of concern. Providing expert guidance
entails educating families in anticipation of events and responding to questions during
and after actual events. It is essential that pediatricians educate themselves regarding
these issues of emergency preparedness.

For pediatricians, some information is currently available on virtually all of these issues
in recently produced printed materials, at special conferences, in broadcasts of various
types, and on the Internet. However, selecting appropriate, accurate sources of
information and determining how much information is sufficient remain difficult
challenges. Similarly, guidance is needed with respect to developing relevant curricula
for medical students and postdoctoral clinical trainees.

**Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children With Special Health Care Needs**
Council on Children With Disabilities
*Pediatrics.* 2005;116:1238-1244
[http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/5/1238](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/5/1238)

Care coordination is a process that facilitates the linkage of children and their families
with appropriate services and resources in a coordinated effort to achieve good health.
Care coordination for children with special health care needs often is complicated
because there is no single point of entry into the multiple systems of care, and complex
criteria frequently determine the availability of funding and services among public and
private payers. Economic and sociocultural barriers to coordination of care exist and
affect families and health care professionals. In their important role of providing a
medical home for all children, primary care physicians have a vital role in the process of
care coordination, in concert with the family.

**Providing Care for Immigrant, Homeless, and Migrant Children**
Committee on Community Health Services
*Pediatrics.* 2005;115:1095-1100
[http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/4/1095](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/4/1095)

This policy statement, which replaces the retired statements "Health Care for Children of
Immigrant Families" (1997) and "Health Needs of Homeless Children and Families"
(1996), is a broader discussion and addresses not only immigrant but also homeless and
migrant child populations. It provides pediatricians with the necessary framework for
addressing underserved children: those who face substantial barriers that limit access to
appropriate health care services. This statement supports a community-based approach
to health care delivery to ensure that underserved children have a medical home.
The Pediatrician’s Role in Community Pediatrics
Committee on Community Health Services
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/4/1092
This policy statement reaffirms the pediatrician’s role in community pediatrics. It offers pediatricians a definition of community pediatrics and provides a set of specific recommendations that underscore the critical nature of this important dimension of the profession.

Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy
Committee on Pediatric Workforce
Pediatrics. 2004;114:1677-1685
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;114/6/1677

This policy statement defines culturally effective health care and describes its importance for pediatrics and the health of children. The statement also defines cultural effectiveness, cultural sensitivity, and cultural competence and describes the importance of these concepts for training in medical school, residency, and continuing medical education. The statement is based on the conviction that culturally effective health care is vital and a critical social value and that the knowledge and skills necessary for providing culturally effective health care can be taught and acquired through focused curricula throughout the spectrum of lifelong learning, from premedical education and medical school through residency and continuing medical education. The American Academy of Pediatrics also believes that these educational efforts must be supported through health policy and advocacy activities that promote the delivery of culturally effective pediatric care.

School-Based Mental Health Services
Committee on School Health
Pediatrics. Vol. 113 No. 6 June 2004, pp. 1839-1845
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/1839

More than 20% of children and adolescents have mental health problems. Health care professionals for children and adolescents must educate key stakeholders about the extent of these problems and work together with them to increase access to mental health resources. School-based programs offer the promise of improving access to diagnosis of and treatment for the mental health problems of children and adolescents. Pediatric health care professionals, educators, and mental health specialists should work in collaboration to develop and implement effective school-based mental health services.

Families and Adoption: The Pediatrician’s Role in Supporting Communication
Deborah Borchers, MD, and Committee on Early Childhood, Adoption, and Dependent Care
Pediatrics. 2003;112:1437-1441
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/6/1437

Each year, more children join families through adoption. Pediatricians have an important role in assisting adoptive families in the various challenges they may face with respect to
adoption. The acceptance of the differences between families formed through birth and those formed through adoption is essential in promoting positive emotional growth within the family. It is important for pediatricians to be informed about adoption and to share this knowledge with adoptive families. Parents need ongoing advice with respect to adoption issues and need to be supported in their communication with their adopted children.

**Out-of-School Suspension and Expulsion**

Committee on School Health

*Pediatrics.* 2003;112:1206-1209

http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/5/1206

Suspension and expulsion from school are used to punish students, alert parents, and protect other students and school staff. Unintended consequences of these practices require more attention from health care professionals. Suspension and expulsion may exacerbate academic deterioration, and when students are provided with no immediate educational alternative, student alienation, delinquency, crime, and substance abuse may ensue. Social, emotional, and mental health support for students at all times in all schools can decrease the need for expulsion and suspension and should be strongly advocated by the health care community. This policy statement, however, highlights aspects of expulsion and suspension that jeopardize children’s health and safety. Recommendations are targeted at pediatricians, who can help schools address the root causes of behaviors that lead to suspension and expulsion and can advocate for alternative disciplinary policies. Pediatricians can also share responsibility with schools to provide students with health and social resources.

**Family-Centered Care and the Pediatrician's Role**

Committee on Hospital Care

*Pediatrics.* 2003;112:691-696

http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/3/691

Drawing on several decades of work with families, pediatricians, other health care professionals, and policy makers, the American Academy of Pediatrics provides a definition of family-centered care. In pediatrics, family-centered care is based on the understanding that the family is the child’s primary source of strength and support. Further, this approach to care recognizes that the perspectives and information provided by families, children, and young adults are important in clinical decision making. This policy statement outlines the core principles of family-centered care, summarizes the recent literature linking family-centered care to improved health outcomes, and lists various other benefits to be expected when engaging in family-centered pediatric practice. The statement concludes with specific recommendations for how pediatricians can integrate family-centered care in hospitals, clinics, and community settings as well as in more broad systems of care.
Radiation Disasters and Children
Committee on Environmental Health
Pediatrics. 2003;111:1455-1466
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/6/1455

The special medical needs of children make it essential that pediatricians be prepared for radiation disasters, including 1) the detonation of a nuclear weapon; 2) a nuclear power plant event that unleashes a radioactive cloud; and 3) the dispersal of radionuclides by conventional explosive or the crash of a transport vehicle. Any of these events could occur unintentionally or as an act of terrorism. Nuclear facilities (eg, power plants, fuel processing centers, and food irradiation facilities) are often located in highly populated areas, and as they age, the risk of mechanical failure increases. The short- and long-term consequences of a radiation disaster are significantly greater in children for several reasons. First, children have a disproportionately higher minute ventilation, leading to greater internal exposure to radioactive gases. Children have a significantly greater risk of developing cancer even when they are exposed to radiation in utero. Finally, children and the parents of young children are more likely than are adults to develop enduring psychologic injury after a radiation disaster. The pediatrician has a critical role in planning for radiation disasters. For example, potassium iodide is of proven value for thyroid protection but must be given before or soon after exposure to radioiodines, requiring its placement in homes, schools, and child care centers. Pediatricians should work with public health authorities to ensure that children receive full consideration in local planning for a radiation disaster.

Identifying and Treating Eating Disorders
Committee on Adolescence
Pediatrics. 2003;111:204-211
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/1/204

Pediatricians are called on to become involved in the identification and management of eating disorders in several settings and at several critical points in the illness. In the primary care pediatrician’s practice, early detection, initial evaluation, and ongoing management can play a significant role in preventing the illness from progressing to a more severe or chronic state. In the subspecialty setting, management of medical complications, provision of nutritional rehabilitation, and coordination with the psychosocial and psychiatric aspects of care are often handled by pediatricians, especially those who have experience or expertise in the care of adolescents with eating disorders. In hospital and day program settings, pediatricians are involved in program development, determining appropriate admission and discharge criteria, and provision and coordination of care. Lastly, primary care pediatricians need to be involved at local, state, and national levels in preventive efforts and in providing advocacy for patients and families. The roles of pediatricians in the management of eating disorders in the pediatric practice, subspecialty, hospital, day program, and community settings are reviewed in this statement.
A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs
American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians-American Society of Internal Medicine
Pediatrics. 2002;110:1304-1306
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/6/S1/1304

This policy statement represents a consensus on the critical first steps that the medical profession needs to take to realize the vision of a family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent health care system that is as developmentally appropriate as it is technically sophisticated. The goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood. This consensus document has now been approved as policy by the boards of the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians-American Society of Internal Medicine.
Psychosocial Implications of Disaster or Terrorism on Children: A Guide for the Pediatrician
Joseph F. Hagan, Jr, MD, Committee on Psychosocial Aspects of Child and Family Health, and Task Force on Terrorism
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/3/787

During and after disasters, pediatricians can assist parents and community leaders not only by accommodating the unique needs of children but also by being cognizant of the psychological responses of children to reduce the possibility of long-term psychological morbidity. The effects of disaster on children are mediated by many factors including personal experience, parental reaction, developmental competency, gender, and the stage of disaster response. Pediatricians can be effective advocates for the child and family and at the community level and can affect national policy in support of families. In this report, specific children’s responses are delineated, risk factors for adverse reactions are discussed, and advice is given for pediatricians to ameliorate the effects of disaster on children.

The Evaluation of Sexual Abuse in Children
Nancy Kellogg, MD, and Committee on Child Abuse and Neglect
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/2/506

This clinical report serves to update the statement titled "Guidelines for the Evaluation of Sexual Abuse of Children," which was first published in 1991 and revised in 1999. The medical assessment of suspected sexual abuse is outlined with respect to obtaining a history, physical examination, and appropriate laboratory data. The role of the physician may include determining the need to report sexual abuse; assessment of the physical, emotional, and behavioral consequences of sexual abuse; and coordination with other professionals to provide comprehensive treatment and follow-up of victims.

Chronic Abdominal Pain in Children
Subcommittee on Chronic Abdominal Pain
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/3/812

Children and adolescents with chronic abdominal pain pose unique challenges to their caregivers. Affected children and their families experience distress and anxiety that can interfere with their ability to perform regular daily activities. Although chronic abdominal pain in children is usually attributable to a functional disorder rather than organic disease, numerous misconceptions, insufficient knowledge among health care professionals, and inadequate application of knowledge may contribute to a lack of effective management. This clinical report accompanies a technical report (see page e370 in this report) on childhood chronic abdominal pain and provides guidance for the clinician in the evaluation and treatment of children with chronic abdominal pain. The
recommendations are based on the evidence reviewed in the technical report and on consensus achieved among subcommittee members.

**Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Substance Abuse**
John W. Kulig, MD, MPH, and Committee on Substance Abuse
*Pediatrics*. 2005;115:816-821
[http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/3/816](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/3/816)

Substance abuse remains a major public health concern, and pediatricians are uniquely positioned to assist their patients and families with its prevention, detection, and treatment. The American Academy of Pediatrics has highlighted the importance of such issues in a variety of ways, including its guidelines for preventive services. The harmful consequences of tobacco, alcohol, and other drug use are a concern of medical professionals who care for infants, children, adolescents, and young adults. Thus, pediatricians should include discussion of substance abuse as a part of routine health care, starting with the prenatal visit, and as part of ongoing anticipatory guidance. Knowledge of the nature and extent of the consequences of tobacco, alcohol, and other drug use as well as the physical, psychological, and social consequences is essential for pediatricians. Pediatricians should incorporate substance-abuse prevention into daily practice, acquire the skills necessary to identify young people at risk of substance abuse, and provide or facilitate assessment, intervention, and treatment as necessary.

**Managed Care and Children With Special Health Care Needs**
Theodore A. Kastner, MD, and Committee on Children with Disabilities
*Pediatrics*. 2004;114:1693-1698
[http://aappolicy.aappublications.org/cgi/content/full/pediatrics;114/6/1693](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;114/6/1693)

The implementation of managed care for children with special health care needs is often associated with apprehension regarding new barriers to health care services. At times, these barriers may overshadow opportunities for improvement. This statement discusses such opportunities, identifies challenges, and proposes active roles for pediatricians and families to improve managed care for children with special health care needs.

**Sexual Orientation and Adolescents**
Barbara L. Frankowski, MD, MPH, and Committee on Adolescence
*Pediatrics*. 2004;113:1827-1832
[http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/1827](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/1827)

The American Academy of Pediatrics issued its first statement on homosexuality and adolescents in 1983, with a revision in 1993. This report reflects the growing understanding of youth of differing sexual orientations. Young people are recognizing their sexual orientation earlier than in the past, making this a topic of importance to pediatricians. Pediatricians should be aware that some youths in their care may have concerns about their sexual orientation or that of siblings, friends, parents, relatives, or others. Health care professionals should provide factual, current, nonjudgmental information in a confidential manner. All youths, including those who know or wonder whether they are not heterosexual, may seek information from physicians about sexual orientation, sexually transmitted diseases, substance abuse, or various psychosocial difficulties. The pediatrician should be attentive to various potential psychosocial...
difficulties, offer counseling or refer for counseling when necessary and ensure that every sexually active youth receives a thorough medical history, physical examination, immunizations, appropriate laboratory tests, and counseling about sexually transmitted diseases (including human immunodeficiency virus infection) and appropriate treatment if necessary.

Not all pediatricians may feel able to provide the type of care described in this report. Any pediatrician who is unable to care for and counsel nonheterosexual youth should refer these patients to an appropriate colleague.

**Helping Children and Families Deal With Divorce and Separation**
[http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/5/1019](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/5/1019)

More than 1 million children each year experience their parents’ divorce. For these children and their parents, this process can be emotionally traumatic from the beginning of parental disagreement and rancor, through the divorce, and often for many years thereafter. Pediatricians are encouraged to be aware of behavioral changes in their patients that might be signals of family dysfunction so they can help parents and children understand and deal more positively with the issue. Age-appropriate explanation and counseling is important so children realize that they are not the cause of, and cannot be the cure for, the divorce. Pediatricians can offer families guidance in dealing with their children through the troubled time as well as appropriate lists of reading material and, if indicated, can refer them to professionals with expertise in the emotional, social, and legal aspects of divorce and its aftermath.
For decades, emergency planning for natural disasters, public health emergencies, workplace accidents, and other calamities has been the responsibility of government agencies on all levels and certain nongovernment organizations such as the American Red Cross. In the case of terrorism, however, entirely new approaches to emergency planning are under development for a variety of reasons. Terrorism preparedness is a highly specific component of general emergency preparedness. In addition to the unique pediatric issues involved in general emergency preparedness, terrorism preparedness must consider several additional issues, including the unique vulnerabilities of children to various agents as well as the limited availability of age- and weight-appropriate antidotes and treatments. Although children may respond more rapidly to therapeutic intervention, they are at the same time more susceptible to various agents and conditions and more likely to deteriorate if they are not monitored carefully.

This article is designed to provide an overview of key issues for the pediatrician with respect to disaster, terrorism, and public health emergency preparedness. It is not intended to be a complete compendium of didactic content but rather offers an approach to what pediatricians need to know and how pediatricians must lend their expertise to enhance preparedness in every community. To become fully and optimally prepared, pediatricians need to become familiar with these key areas of emergency preparedness: unique aspects of children related to terrorism and other disasters; terrorism preparedness; mental health vulnerabilities and development of resiliency; managing family concerns about terrorism and disaster preparedness; office-based preparedness; hospital preparedness; community, government, and public health preparedness; and advocating for children and families in preparedness planning.

Chronic Abdominal Pain in Children
Subcommittee on Chronic Abdominal Pain
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/3/e370

Chronic abdominal pain, defined as long-lasting intermittent or constant abdominal pain, is a common pediatric problem encountered by primary care physicians, medical subspecialists, and surgical specialists. Chronic abdominal pain in children is usually functional, that is, without objective evidence of an underlying organic disorder. The Subcommittee on Chronic Abdominal Pain of the American Academy of Pediatrics and the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition has prepared this report based on a comprehensive, systematic review and rating of the medical literature. This report accompanies a clinical report based on the literature review and expert opinion.
The subcommittee examined the diagnostic and therapeutic value of a medical and psychological history, diagnostic tests, and pharmacologic and behavioral therapy. The presence of alarm symptoms or signs (such as weight loss, gastrointestinal bleeding, persistent fever, chronic severe diarrhea, and significant vomiting) is associated with a higher prevalence of organic disease. There was insufficient evidence to state that the nature of the abdominal pain or the presence of associated symptoms (such as anorexia, nausea, headache, and joint pain) can discriminate between functional and organic disorders. Although children with chronic abdominal pain and their parents are more often anxious or depressed, the presence of anxiety, depression, behavior problems, or recent negative life events does not distinguish between functional and organic abdominal pain. Most children who are brought to the primary care physician's office for chronic abdominal pain are unlikely to require diagnostic testing. Pediatric studies of therapeutic interventions were examined and found to be limited or inconclusive.

Telemedicine: Pediatric Applications
S. Andrew Spooner, MD, MS, Edward M. Gotlieb, MD, Steering Committee on Clinical Information Technology, and Committee on Medical Liability
Pediatrics. Vol. 113 No. 6 June 2004, pp. e639-e643
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/e639

The newly developing field of telemedicine has the potential to benefit pediatric care by increasing access to pediatric specialists and services. This report explores the current uses and limitations of telemedicine in pediatrics.

The Psychological Maltreatment of Children—Technical Report
Steven W. Kairys, MD, MPH, Charles F. Johnson, MD, and Committee on Child Abuse and Neglect
Pediatrics. Vol. 109 No. 4 April 2002, pp. e68
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/4/e68

Psychological maltreatment is a common consequence of physical and sexual abuse but also may occur as a distinct entity. Until recently, there has been controversy regarding the definition and consequences of psychological maltreatment. Sufficient research and consensus now exist about the incidence, definition, risk factors, and consequences of psychological maltreatment to bring this form of child maltreatment to the attention of pediatricians. This technical report provides practicing pediatricians with definitions and risk factors for psychological maltreatment and details how pediatricians can prevent, recognize, and report psychological maltreatment. Contemporary references and resources are provided for pediatricians and parents.
Consensus Statement on Management of Intersex Disorders
Peter A. Lee, MD, PhD, Christopher P. Houk, MD, S. Faisal Ahmed, Ieuan A. Hughes, in collaboration with the participants in the International Consensus Conference on Intersex organized by the Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology
*Pediatrics.* Vol. 118 No. 2 August 2006, pp. e488-e500
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/2/e488

The birth of an intersex child prompts a long-term management strategy that involves myriad professionals working with the family. There has been progress in diagnosis, surgical techniques, understanding psychosocial issues, and recognizing and accepting the place of patient advocacy. The Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology considered it timely to review the management of intersex disorders from a broad perspective, review data on longer-term outcome, and formulate proposals for future studies. The methodology comprised establishing a number of working groups, the membership of which was drawn from 50 international experts in the field. The groups prepared previous written responses to a defined set of questions resulting from evidence-based review of the literature. At a subsequent gathering of participants, a framework for a consensus document was agreed. This article constitutes its final form.
additional tools and resources
National and State Data Sources on Children’s Mental Health
This resource lists national and state-by-state data sources for statistics on child and adolescent mental health.

Internet Resource List for Child and Adolescent Mental Health
This resource provides an overview and the links to the Web sites of federal agencies, national professional and advocacy organizations, national initiatives, and other groups that address children’s mental health.

From Neurons to Neighborhoods: The Science of Early Childhood Development
Reprinted with permission from (From Neurons to Neighborhoods) © (2000) by the National Academy of Sciences, Courtesy of the National Academies Press, Washington, D.C. This executive summary looks at child development and issues a series of challenges to decision makers about the balance of work and family life, issues of racial and ethnic diversity, and the integration of children’s cognitive and emotional development.

The Federation of Families for Children’s Mental Health
This tip sheet offers guidance for involving family members in the work of mental health policy groups. It contains strategies for recruiting family members to join policy groups, training and supporting family members to do the work, and sustaining their participation over time.

2-1-1 Fact Sheet
Reprinted with permission from the United Way of America. This fact sheet provides information on the 2-1-1 system. 2-1-1 is an easy-to-remember telephone number that, where available, connects people with important community services and volunteer opportunities.

Guiding Principles for Collaboration Between Mental Health and Public Health (May 2005)
Reprinted with permission from the National Association of County & City Health Officials. This resource provides guiding principles for collaboration between public health and mental health.
national and state data sources on children’s mental health

strategies for system change in children’s mental health: a chapter action kit

The following is a non-exhaustive list of national and state-by-state data sources for children’s mental health:

**Mental Health Work Group, Centers for Disease Control and Prevention (CDC),** provides national summary mental health statistics, based on the National Health Interview Survey. Available at: [http://www.cdc.gov/mentalhealth/data.htm](http://www.cdc.gov/mentalhealth/data.htm).

**Mental Health Statistics, Center for Mental Health Services, National Mental Health Information Center, Substance Abuse and Mental Health Services Administration (SAMHSA)** provides links to 3 of SAMHSA’s agency Web sites that maintain national and state-by-state statistics on substance abuse prevention, addiction treatment, and mental health services. Available at: [http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/](http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/).

The **National Technical Assistance Center for Children’s Mental Health, Georgetown University**, provides resources and links on children’s mental health data. Available at: [http://gucchd.georgetown.edu/programs/ta_center/index.html](http://gucchd.georgetown.edu/programs/ta_center/index.html).

**National Center for Health Statistics, Centers for Disease Control and Prevention,** is the federal government’s principal vital and health statistics agency. The agency provides a wide variety of data on the Nation’s health, including data on vital statistics. Available at: [http://www.cdc.gov/nchs/](http://www.cdc.gov/nchs/).

The **National Institute of Mental Health** provides a compilation of statistical mental health resources. Available at: [http://www.nimh.nih.gov/healthinformation/statisticsmenu.cfm](http://www.nimh.nih.gov/healthinformation/statisticsmenu.cfm).

The **Office of Applied Studies, SAMHSA**, provides the latest National data on: (1) alcohol, tobacco, marijuana, and other drug abuse; (2) drug-related emergency department episodes and medical examiner cases; and (3) the nation’s substance abuse treatment system. Available at: [http://www.oas.samhsa.gov](http://www.oas.samhsa.gov).

The **Title V Information System, Maternal and Child Health Bureau, Health Resources and Services Administration** includes data from annual Title V Maternal and Child Health Services Block Grant applications and reports submitted by the 59 US States, territories, and jurisdictions. Information on key measures of maternal and child health in the US is included. Available at: [http://mchb.hrsa.gov/data/](http://mchb.hrsa.gov/data/).

**Youth Risk Behavior Surveillance System (YRBSS), Centers for Disease Control and Prevention**, includes national data trends on priority health risk behaviors in youth, including suicide ideation and attempts. Available at: [http://www.cdc.gov/HealthyYouth/yrbs/index.htm](http://www.cdc.gov/HealthyYouth/yrbs/index.htm).
FEDERAL AGENCIES

Center for Mental Health Services (CMHS)
The CMHS has a number of child, adolescent, and family resources.
Web site: http://www.mentalhealth.samhsa.gov/cmhs/

CMHS/ Systems of Care
The CMHS/ Systems of Care is dedicated to providing information about the mental health of children, youth, and families.
Web site: http://www.systemsofcare.samhsa.gov/

Centers for Disease Control and Prevention (CDC)
The CDC increasingly has helpful information on mental health related issues, including statistical information on suicide.
Web site: http://www.cdc.gov/

Centers for Medicare & Medicaid Services (CMS)
The CMS administers the Medicare, Medicaid, and State Children’s Health Insurance Program programs.
Web site: http://www.cms.hhs.gov/

US Department of Education (DOE), Office of Special Education and Rehabilitative Services (OSERS)
The OSERS has a wide array of information for families, school districts, and states in 3 main areas: special education, vocational rehabilitation, and research.
Web site: http://www.ed.gov/about/offices/list/osers/index.html

Insure Kids Now!
The US Department of Health and Human Services has created this national campaign to link the nation’s 10 million uninsured children, from birth to 18 years, to free and low-cost health insurance.
Web site: http://www.insurekidsnow.gov/

Maternal and Child Health Bureau (MCHB)
The MCHB strives to ensure equal access for all to quality health care in a supportive, culturally competent, family, and community setting.
Web site: http://www.mchb.hrsa.gov

National Institute of Mental Health (NIMH)
The mission of NIMH is to diminish the burden of mental illness through research.
Office of Juvenile Justice and Delinquency Prevention (OJJDP)
The OJJDP’s mission is to provide national leadership, coordination, and resources to prevent and respond to the needs of individuals in the juvenile justice system. The OJJDP supports states and local communities in their efforts to develop and implement effective and coordinated prevention and intervention programs.
Web site: http://www.ojjdp.ncjrs.org/

Office of the Surgeon General
The Surgeon General’s office issues reports on children’s mental health.

President’s New Freedom Commission on Mental Health
The commission was created to examine the current gaps in mental illness treatment services and to make recommendations to the President on ways in which the federal government can help states increase access to care and improve quality in their public programs.
Web site: http://www.mentalhealthcommission.gov/

Substance Abuse and Mental Health Services Administration (SAMHSA)
The Substance Abuse and Mental Health Services Administration is a public health agency within the Department of Health and Human Services. SAMHSA is responsible for improving accountability, capacity, and effectiveness of the nation’s substance abuse prevention, addictions treatment, and mental health delivery system.
Web site: http://www.samhsa.gov

CHILDREN’S MENTAL HEALTH AND ADVOCACY ORGANIZATIONS

Autism Society of America (ASA)
The ASA provides information and resources on autism.
Web site: http://www.autism-society.org/

Bazelon Center for Mental Health Law
The center works on a broad array of children's mental health issues and has an array of publications related to children’s mental health and related policy issues.
Web site: http://www.bazelon.org/

Child & Adolescent Bipolar Foundation (CABF)
The CABF is a parent-led, web-based membership organization of families raising children diagnosed with, or at risk for, early-onset bipolar disorder. The Web site includes information and resources on early-onset bipolar disorder.
Web site: http://www.bpkids.org/

Children and Adults with Attention-Deficit/Hyperactivity-Disorder (CHADD)
The CHADD is a national organization representing individuals with ADHD in providing education, advocacy, and support to individuals and families. The organization is composed of dedicated volunteers from around the country who play an integral part in providing resources and encouragement to families, educators, and professionals.
Web site: http://www.chadd.org/
**Children's Defense Fund (CDF)**
The CDF’s mission is to provide a strong, effective voice for all US children who cannot vote, lobby, or speak for themselves, and to educate the nation about the needs of children and encourages preventive investment before they get sick or into trouble, drop out of school, or experience a family breakdown. The CDF addresses the needs of poor and minority children and those with disabilities.

**Child Welfare League of America (CWLA)**
The CWLA is the nation’s oldest membership-based child welfare organization committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.
*Web site: [http://www.cwla.org/default.htm](http://www.cwla.org/default.htm)*

**Council for Children with Behavioral Disorders (CCBD)**
The CCBD is the official division of the Council for Exceptional Children (CEC), committed to promoting and facilitating the education and general welfare of children and youth with emotional or behavioral disorders.
*Web site: [http://www.ccbd.net/index.cfm](http://www.ccbd.net/index.cfm)*

**Federation of Families for Children’s Mental Health (FFCMH)**
The FFCMH is dedicated to providing education, resources, and information to children with mental health needs and their families.

**Health Resources and Services Administration (HRSA) Bullying Campaign**
The HRSA bullying campaign provides resources for professionals, parents, children, and youth on bullying behavior and how to help when someone you know is being bullied.

**Mental Health America (MHA)**
Formerly known as the National Mental Health Association (NMHA), the MHA is an advocacy, education, and support organization working to address the needs of people with mental health related needs and mental illnesses.

**National Alliance on Mental Illness (NAMI)**
The National Alliance on Mental Illness is the nation’s largest grassroots mental health organization dedicated to improving the lives of children and adults living with mental illness and their families. Founded in 1979, NAMI has become the nation’s voice on mental illness, a national organization including NAMI organizations in every state and in over 1100 local communities across the country who join together to meet the NAMI mission through advocacy, research, support, and education.
National Center for Mental Health and Juvenile Justice (NCMHJJ)
The NCMHJJ promotes awareness of the mental health needs of youth in the juvenile justice system and assists the field in developing improved policies and programs based on the best available research and practice.
Web site: http://www.ncmhjj.com/

National Disability Rights Network (NDRN)
The NDRN is a national organization of protection and advocacy and client assistance programs for children and adults with disabilities. These programs provide legally based advocacy services for people with disabilities, including mental illnesses, in the United States.
Web site: http://www.napas.org/

National Health Law Program (NHelp)
The NHelp program has a number of excellent publications, resources, and information on Medicaid and other important health-related topics.
Web site: http://www.healthlaw.org/

National Youth Violence Prevention Resource Center
The center is a resource for parents, professionals, and youth who are working to prevent violence committed by and against youth.
Web site: http://www.safeyouth.org/

New Freedom Initiative: State Coalitions to Promote Community-Based Care (Olmstead)
This new initiative provides support for states and territories in their efforts to respond to the goals outlined in the President's New Freedom Commission on Mental Health Report. The initiative provides financial assistance, technical assistance, and training to promote community-based care.

Obsessive Compulsive Disorder (OCD) Resource Center
The center provides information and resources available on OCD.
Web site: http://www.ocdresource.com/

Youth Law Center
The center employs staff attorneys that investigate reports of abuse of children in adult jails, juvenile detention facilities, state institutions, and child welfare systems, and uses training, technical assistance, and negotiation to bring about needed change. If abusive conditions or practices continue, the center uses litigation as a last resort to protect children and ensure humane treatment.
Web site: http://www.youthlawcenter.org/

Zero to Three
Zero to Three works to promote the healthy development of our nation’s infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf. The organization is dedicated to advancing current knowledge; promoting beneficial policies and practices; communicating research and best practices to a wide variety of audiences; and providing training, technical assistance and leadership development.
Web site: http://zerotothree.org
ORGANIZATIONS FOCUSED ON SPECIAL EDUCATION AND SCHOOL-BASED MENTAL HEALTH

Centers for School Mental Health, Technical Assistance Centers
In 1995, 2 national training and technical assistance centers focused on mental health in schools were established with partial support from the US Department of Health and Human Services and the Center for Mental Health Services. One center is at the University of California at Los Angeles (UCLA) and the other is at the University of Maryland (U of MD) at Baltimore. The Web sites include information and resources on school-based mental health programs.
Web site: http://www.smhp.psych.ucla.edu/ (UCLA)
Web site: http://medschool.umaryland.edu/psychiatry/services_research/centers_cmhsr.asp (U of MD at Baltimore)

Individuals with Disabilities Education Act (IDEA) Partnership
The IDEA Partnership is dedicated to improving outcomes for students and youth with disabilities by joining state agencies and stakeholders through shared work and learning. The Web site includes many helpful resources for schools, families, and advocates.
Web site: http://www.ideapartnership.org/

National Dissemination Center for Children with Disabilities (NICHCY)
The NICHCY is an information and referral center that provides information on disabilities and disability-related issues for families, educators, and other professionals, with a special focus on children and youth from birth to age 22 years.
Web site: http://www.nichcy.org/

School Psychiatry Program and Mood & Anxiety Disorders Institute (MADI) Resource Center
The School Psychiatry Program and MADI Resource Center, both part of the Department of Psychiatry at Massachusetts General Hospital (MGH), jointly created this Web site, which is committed to enhancing the education and mental health of every student in every school. The Web site has resources for parents, educators, and clinicians to ensure that each group is working together to support children and teens with mental health conditions.
Web site: http://medschool.umaryland.edu/psychiatry/services_research/centers_cmhsr.asp

Technical Assistance (TA) Alliance for Parent Centers
The alliance is an innovative project that supports a unified technical assistance system for the purpose of developing, assisting, and coordinating Parent Training and Information Projects and Community Parent Resource Centers under the Individuals with Disabilities Education Act.
Web site: http://www.taalliance.org/

Wrightslaw: Special Education Law
The Wrightslaw Web site is designed for families, advocates, educators, and attorneys looking for accurate, up-to-date information about special education law and advocacy for children with disabilities, including those with mental illnesses.
PROFESSIONAL ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
Web site: http://www.aacap.org/

American Academy of Pediatrics (AAP)
Web site: http://www.aap.org/

American Psychiatric Association (APA)
Web site: http://www.psych.org/

American Psychological Association (APA)
Web site: http://www.apa.org/

American School Counselor Association (ASCA)
Web site: http://www.schoolcounselor.org/

American School Health Association (ASHA)
Web site: http://www.ashaweb.org/

National Association of School Psychologists (NASP)
Web site: http://www.nasponline.org/

National Association of Social Workers (NASW)
Web site: http://www.naswdc.org/

National Association of State Mental Health Program Directors (NASMHPD)
Web site: http://www.nasmhpd.org/

ACADEMIC CENTERS FOCUSED ON CHILDREN’S MENTAL HEALTH

Center for the Advancement of Children’s Mental Health
The center is located at Columbia University and is dedicated to a variety of issues related to children and adolescents with mental illness.
Web site: http://www.kidsmentalhealth.org/

Center for the Promotion of Mental Health in Juvenile Justice
The center is located at Columbia University and is dedicated to providing expert guidance to juvenile justice settings regarding best practices for mental health assessment and referral.
Web site: http://www.promotementalhealth.org/

Florida Mental Health Institute at the University of South Florida, Research & Training Center for Children’s Mental Health (RTC)
The goal of the RTC is to improve services for children and adolescents with serious emotional disabilities (SED) and their families by strengthening the knowledge base for effective services and systems of care.
Web site: http://rtckids.fmhi.usf.edu/
Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health
Since 1984, the Technical Assistance Center has been dedicated to working in partnership with families and many other leaders across this country to reform services for children and adolescents with mental health treatment needs and their families.
Web site: http://gucchd.georgetown.edu/programs/ta_center/index.html

New York University Child Study Center
The goals of the center are to increase awareness of child and adolescent mental health disorders and to advance research to improve the prevention, early identification, and treatment of these disorders.
Web site: http://www.aboutourkids.org/

Portland Research & Training Center, Portland State University
The center promotes effective community-based, culturally competent, family-centered services for families and their children who are, or may be, affected by mental, emotional, or behavioral disorders.
Web site: http://www.rtc.pdx.edu/

Yale Child Study Center
The mission of the center is to understand child development; social, behavioral, and emotional adjustment; and psychiatric disorders; and to help children and families in need of care.
Web site: info.med.yale.edu/chldstdy/

ORGANIZATIONS FOCUSED ON SUICIDE PREVENTION

American Foundation for Suicide Prevention (AFSP)
Web site: http://www.afsp.org/

Columbia University TeenScreen Program
Web site: http://www.teenscreen.org/

The JED Foundation
The work of the JED Foundation is focused on college students.
Web site: http://www.jedfoundation.org/

National Strategy for Suicide Prevention
Web site: http://mentalhealth.samhsa.gov/suicideprevention/

SOS Signs of Suicide Program
Web site: http://www.mentalhealthscreening.org/highschool/

Suicide Prevention Action Network (SPAN) USA
Web site: http://www.spanusa.org/

Suicide Prevention Resource Center (SPRC)
Web site: http://www.sprc.org/
Yellow Ribbon Suicide Prevention Program
Web site: http://www.yellowribbon.org/

Youth Suicide Prevention School-Based Guide
Web site: http://theguide.fmhi.usf.edu/

WEB SITES FOR ADOLESCENTS

KidsHealth
KidsHealth has separate sections for children, adolescents, and parents that includes its own design, age-appropriate content, and tone. There are many in-depth features, articles, animations, games, and resources developed by experts in the health of children and teens. For information on teen mental health, click on “teens” and then click on “Your Mind” to access a broad array of resources for teens.
Web site: http://www.kidshealth.org/

Mind Zone—Cope.Care.Deal.
Mindzone is a mental health Web site for adolescents funded by the Annenberg Foundation Trust at Sunnylands with support from the Annenberg Public Policy Center of the University of Pennsylvania.
Web site: http://www.copecaredeal.org/_MindZone.aspx

CHILD AND ADOLESCENT HEALTH INITIATIVES

Bright Futures
Bright Futures, initiated by the Maternal and Child Health Bureau of the Health Resources and Services Administration, Department of Health and Human Services and administered by the American Academy of Pediatrics, is a philosophy and approach that is dedicated to the principle that every child deserves to be healthy, and that optimal health involves a trusting relationship between the health professional, the child, family, and community. As part of this initiative, Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents was developed to provide comprehensive health supervision guidelines, including recommendations on immunizations, routine health screenings, and anticipatory guidance.
Web site: http://www.brightfutures.aap.org/web/

Maternal and Child Health (MCH) Library Knowledge Paths
The MCH Library at Georgetown University has compiled a variety of knowledge paths on maternal and child health-related topics. Components of a knowledge path include links to Web sites, electronic publications, databases, and discussion groups, and citations for journal articles and other print resources. Existing knowledge paths include Locating Community-Based Services to Support Children and Families (June 2005) and Mental Health in Children and Adolescents (May 2004).
FAMILY-CENTERED, CULTURAL COMPETENCY RESOURCES

American Academy of Pediatrics (AAP)
The AAP provides a number of resources related to the provision of culturally effective, family-centered care.

- Culturally Effective Pediatric Care
  Web site: http://www.aap.org/commpeds/cepc/
- Culturally Effective Pediatric Care Facts & Figures
  Web site: http://www.aap.org/commpeds/cepc/fact_fig.html
- Family-Centered Care
  Web site: http://www.medicalhomeinfo.org/health/family.html

Center for Healthy Families and Cultural Diversity
Web site: http://www2.umdnj.edu/fmedweb/chfcd/index.htm

Disparities and Cultural Issues in Access to Care
Web site: http://culturalaccesstocare.fmhi.net/blog/index.php

Georgetown University Center for Child and Human Development, National Center for Cultural Competence
Web site: http://www11.georgetown.edu/research/gucchd/nccc/

Health Resources and Services Administration (HRSA) Cultural Competence Web Site
Web site: http://www.hrsa.gov/culturalcompetence/

National Health Plan Collaborative
Web site: http://www.chcs.org/NationalHealthPlanCollaborative/index.html

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Office of Minority Health Resource Center (OMHRC)
Web site: http://www.omhrc.gov/

Research & Training Center for Children's Mental Health
Web site: http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/default.cfm

Substance Abuse and Mental Health Services Administration (SAMHSA)—Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups
Web site: http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3457/default.asp

Center for Medical Home Improvement
The center provides the following resources which may be useful for primary care clinicians: (1) Medical Home Index; (2) The Medical Home Index Short Version; (3) The Medical Home Family Index; and (4) the Center for Medical Home Improvement Family/Caregiver Survey.
Web site: http://www.medicalhomeimprovement.org/outcomes.htm
The Commonwealth Fund—Cultural Competency Resources
Web site: http://www.commonwealthfund.org/topics/topics.htm?attrib_id=12025

The Institute for Family-Centered Care

The Provider's Guide to Quality & Culture
Web site:
http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English
Executive Summary

Scientists have had a long-standing fascination with the complexities of the process of human development. Parents have always been captivated by the rapid growth and development that characterize the earliest years of their children's lives. Professional service providers continue to search for new knowledge to inform their work. Consequently, one of the distinctive features of the science of early childhood development is the extent to which it evolves under the anxious and eager eyes of millions of families, policy makers, and service providers who seek authoritative guidance as they address the challenges of promoting the health and well-being of young children.

PUTTING THE STUDY IN CONTEXT

Two profound changes over the past several decades have coincided to produce a dramatically altered landscape for early childhood policy, service delivery, and childrearing in the United States. First, an explosion of research in the neurobiological, behavioral, and social sciences has led to major advances in understanding the conditions that influence whether children get off to a promising or a worrisome start in life. These scientific gains have generated a much deeper appreciation of: (1) the importance of early life experiences, as well as the inseparable and highly interactive influences of genetics and environment, on the development of the brain and the unfolding of human behavior; (2) the central role of early relationships
• **Recommendation 7** — The President should establish a joint federal-state-local task force charged with reviewing the entire portfolio of public investments in child care and early education. Its goal should be to develop a blueprint for locally responsive systems of early care and education for the coming decade that will ensure the following priorities: (1) that young children’s needs are met through sustained relationships with qualified caregivers, (2) that the special needs of children with developmental disabilities or chronic health conditions are addressed, and (3) that the settings in which children spend their time are safe, stimulating, and compatible with the values and priorities of their families.

• **Recommendation 8** — The President’s Council of Economic Advisers and the Congress should assess the nation’s tax, wage, and income support policies with regard to their adequacy in ensuring that no child who is supported by the equivalent of a full-time working adult lives in poverty and that no family suffers from deep and persistent poverty, regardless of employment status. The product of this effort should be a set of policy alternatives that would move the nation toward achieving these fundamental goals.

**Interactions Among Early Childhood Science, Policy, and Practice Are Problematic and Demand Dramatic Rethinking**

Policies and programs aimed at improving the life chances of young children come in many varieties. Some are home based and others are delivered in centers. Some focus on children alone or in groups, and others work primarily with parents. A variety of services have been designed to address the needs of young children whose future prospects are threatened by socioeconomic disadvantages, family disruptions, and diagnosed disabilities. They all share a belief that early childhood development is susceptible to environmental influences and that wise public investments in young children can increase the odds of favorable developmental outcomes. The scientific evidence resoundingly supports these premises.

**Conclusions**

• The overarching question of whether we can intervene successfully in young children’s lives has been answered in the affirmative and should be put to rest. However, interventions that work are rarely simple, inexpensive, or easy to implement. The critical agenda for early childhood intervention is to advance understanding of what it takes to improve the odds of positive outcomes for the nation’s most vulnerable young children and to determine the most cost-effective strategies for achieving well-defined goals.
EXECUTIVE SUMMARY

- The scientific knowledge base guiding early childhood policies and programs is seriously constrained by the relatively limited availability of systematic and rigorous evaluations of program implementation; gaps in the documentation of causal relations between specific interventions and specific outcomes and of the underlying mechanisms of change; and infrequent assessments of program costs and benefits.

- Model early childhood programs that deliver carefully designed interventions with well-defined objectives and that include well-designed evaluations have been shown to influence the developmental trajectories of children whose life course is threatened by socioeconomic disadvantage, family disruption, and diagnosed disabilities. Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impacts. In contrast, services that are based on generic family support, often without a clear delineation of intervention strategies matched directly to measurable objectives, and that are funded by more modest budgets, appear to be less effective.

- The elements of early intervention programs that enhance social and emotional development are just as important as the components that enhance linguistic and cognitive competence. Some of the strongest long-term impacts of successful interventions have been documented in the domains of social adjustment, such as reductions in criminal behavior.

- The reconciliation of traditional program formats and strategies—many of which emphasize the importance of active parent involvement and the delivery of services in the home setting—with the economic and social realities of contemporary family life is a pressing concern. Particularly urgent is the need to ensure access to these intervention programs for parents who are employed full-time, those who work nonstandard hours, and those who are making the transition from public assistance to work.

- Early childhood policies and practices are highly fragmented, with complex and confusing points of entry that are particularly problematic for underserved segments of the population and those with special needs. This lack of an integrative early childhood infrastructure makes it difficult to advance prevention-oriented initiatives for all children and to coordinate services for those with complex problems.

- The growing racial, ethnic, linguistic, and cultural diversity of the early childhood population requires that all early childhood programs and
medical services periodically reassess their appropriateness and effectiveness for the wide variety of families they are mandated to serve. Poor “take-up” and high rates of program attrition that are common to many early intervention programs, while not at all restricted to specific racial, ethnic, or linguistic groups, nonetheless raise serious questions about whether those who design, implement, and staff early childhood programs fully understand the meaning of “cultural competence” in the delivery of health and human services.

- The general political environment in which research questions are formulated and investigations are conducted has resulted in a highly problematic context for early childhood policy and practice. In many circumstances, the evaluation of intervention impacts is largely a high-stakes activity to determine whether policies and programs should receive continued funding, rather than a more constructive process of continuous knowledge generation and quality improvement.

- As the rapidly evolving science of early child development continues to grow, its complexity will increase and the distance between the working knowledge of service providers and the cutting edge of the science will be staggering. The professional challenges that this raises for the early childhood field are formidable.

Recommendations

- **Recommendation 9** — Agencies and foundations that support evaluation research in early childhood should follow the example set by the nation’s successful approach to clinical investigation in the biomedical sciences. In this spirit, the goals of program-based research and the evaluation of services should be to document and ensure full implementation of effective interventions, and to use evidence of ineffectiveness to stimulate further experimentation and study.

- **Recommendation 10** — The time is long overdue for state and local decision makers to take bold actions to design and implement coordinated, functionally effective infrastructures to reduce the long-standing fragmentation of early childhood policies and programs. To this end, the committee urges two compelling first steps. First, require that all children who are referred to a protective services agency for evaluation of suspected abuse or neglect be automatically referred for a developmental-behavioral screening under Part C of the Individuals With Disabilities Education Act. Second, establish explicit and effective linkages among agencies that currently are
EXECUTIVE SUMMARY

charged with implementing the work requirements of welfare reform and those that oversee the provision of both early intervention programs and child and adult mental health services.

- **Recommendation 11** — A comprehensive analysis of the professional development challenges facing the early childhood field should be conducted as a collaborative effort involving professional organizations and representatives from the wide array of training institutions that prepare people to work with young children and their families. The responsibility for convening such a broad-based working group or commission should be shared among the fields of education, health, and human services.

RESEARCH AND EVALUATION

Research has historically played a significant role in enhancing human development and preventing, ameliorating, and treating a range of conditions that can begin prenatally, at birth, or during the early years of life. To identify priorities among the many possible recommendations that could be made for promising further research, the committee was guided by three goals.

First, it is clear that the capacity to increase the odds of favorable birth outcomes and positive adaptation in the early childhood years would be strengthened considerably by supporting creative collaborations among child development researchers, neuroscientists, and molecular geneticists. Second, there is a pressing need to integrate basic research aimed at understanding developmental processes with intervention research that assesses efforts to influence developmental outcomes. Such collaborative initiatives hold the promise of advancing both understanding of environmental effects on development and improving the effectiveness of the nation’s early intervention strategies. Third, the entire early childhood evaluation enterprise warrants a thorough reassessment in order to maximize opportunities for valid causal inference and generalization, to assess what has been learned cumulatively across the full array of evaluation studies, and to establish a constructive environment for discussion of ongoing research and its application to policy. The themes and issues presented below are elaborated in the committee’s full complement of research priorities in the final report.

**Integrating Child Development Research, Neuroscience, and Molecular Genetics**

Enormous potential exists at the intersection of child development research, neuroscience, and molecular and behavioral genetics to unlock some of the enduring mysteries about how biogenetic and environmental factors interact to influence developmental pathways. These include: (a)
understanding how experience is incorporated into the developing nervous system and how the boundaries are determined that differentiate deprivation from sufficiency and sufficiency from enrichment; (b) understanding how biological processes, including neurochemical and neuroendocrine factors, interact with environmental influences to affect the development of complex behaviors, including self-regulatory capacities, prosocial or antisocial tendencies, planning and sustained attention, and adaptive responses to stress; (c) describing the dynamics of gene-environment interactions that underlie the development of behavior and contribute to differential susceptibility to risk and capacity for resilience; and (d) elucidating the mechanisms that underlie nonoptimal birth outcomes and developmental disabilities.

Integrating the Basic Science of Human Development and the Applied Science of Early Childhood Intervention

There are currently few avenues for integrating knowledge gained from basic developmental science and from evaluations of early interventions. Yet both enterprises ultimately seek to improve children’s early outcomes and life opportunities. A great deal stands to be gained from deliberate efforts to forge ongoing interactions among scientists engaged in these complementary yet largely disconnected research traditions. Among the important objectives to be addressed are: (a) enhanced understanding, detection, and treatment of early precursors of psychopathology; (b) improved preventive and ameliorative interventions for women and children who are exposed to biological insults and adverse environmental conditions, as well as for children with identified disabilities; (c) the identification of modifiable mechanisms that link impoverished family resources to both adverse outcomes for individual children and persistent disparities across groups of children in learning skills and other developmental capacities; and (d) refined understanding of how interventions and the staff that implement them can work effectively with families that differ along dimensions defined by race and ethnicity, immigration status, religion, or other cultural characteristics. The capacity of research to address these objectives will hinge in part on investments in improving the available tools for measuring important, but generally neglected early developmental outcomes, such as the multiple components of self-regulatory and executive capacities, and the ability to make friends and engage with others as a contributing member of a group, as well as on increased efforts to evaluate the biological systems that are affected by early interventions.
EXECUTIVE SUMMARY

Improving Evaluations of Early Childhood Interventions

To improve the nation's capacity to learn from evaluations of early childhood interventions, the committee recommends substantially increased attention to program implementation as an integral component of all early childhood evaluation research, the adoption of higher standards for the use of rigorous and appropriate evaluation study designs, the inclusion of early childhood outcomes in evaluations of broad-based community and economic interventions, and the convening of regular forums at the National Institutes of Health to synthesize evaluation research evidence across programs and strategies that share similar developmental aims.

CONCLUDING THOUGHTS

As this report moved to completion, it became increasingly clear to the members of the committee that the science of early childhood development has often been viewed through highly personalized and sharply politicized lenses. In many respects, this is an area in which personal experience allows everyone to claim some level of expertise. Moreover, as a public issue, questions about the care and protection of children confront many of the basic values that have defined our country from its founding—personal responsibility, individual self-reliance, and restrained government involvement in people's lives. In a highly pluralistic society that is experiencing dramatic economic and social change, however, the development of children must be viewed as a matter of intense concern for both their parents and for the nation as a whole.

In this context, and based on the evidence gleaned from a rich and rapidly growing knowledge base, we feel an urgent need to call for a new national dialogue focused on rethinking the meaning of both shared responsibility for children and strategic investment in their future. The time has come to stop blaming parents, communities, business, and government, and to shape a shared agenda to ensure both a rewarding childhood and a promising future for all children.

The charge to this committee was to blend the knowledge and insights of a broad range of disciplines to generate an integrated science of early childhood development. The charge to society is to blend the skepticism of a scientist, the passion of an advocate, the pragmatism of a policy maker, the creativity of a practitioner, and the devotion of a parent—and to use existing knowledge to ensure both a decent quality of life for all of our children and a productive future for the nation.
as a source of either support and adaptation or risk and dysfunction; (3) the powerful capabilities, complex emotions, and essential social skills that develop during the earliest years of life, and (4) the capacity to increase the odds of favorable developmental outcomes through planned interventions.

Second, the capacity to use this knowledge constructively has been constrained by a number of dramatic transformations in the social and economic circumstances under which families with young children are living in the United States: (1) marked changes in the nature, schedule, and amount of work engaged in by parents of young children and greater difficulty balancing workplace and family responsibilities for parents at all income levels; (2) continuing high levels of economic hardship among families, despite overall increases in maternal education, increased rates of parent employment, and a strong economy; (3) increasing cultural diversity and the persistence of significant racial and ethnic disparities in health and developmental outcomes; 4) growing numbers of young children spending considerable time in child care settings of highly variable quality, starting in infancy; and (5) greater awareness of the negative effects of stress on young children, particularly as a result of serious family problems and adverse community conditions that are detrimental to child well-being. While any given child may be affected by only one or two of these changes, their cumulative effects on the 24 million infants, toddlers, and preschoolers who are now growing up in the United States warrant dedicated attention and thoughtful response.

This convergence of advancing knowledge and changing circumstances calls for a fundamental reexamination of the nation's responses to the needs of young children and their families, many of which were formulated several decades ago and revised only incrementally since then. It demands that scientists, policy makers, business and community leaders, practitioners, and parents work together to identify and sustain policies and practices that are effective, generate new strategies to replace those that are not achieving their objectives, and consider new approaches to address new goals as needed. It is the strong conviction of this committee that the nation has not capitalized sufficiently on the knowledge that has been gained from nearly half a century of considerable public investment in research on children from birth to age 5. In many respects, we have barely begun to use our growing research capabilities to help children and families negotiate the changing demands and possibilities of life in the 21st century.

THE COMMITTEE'S CHARGE

The Committee on Integrating the Science of Early Childhood Development was established by the Board on Children, Youth, and Families of the National Research Council and the Institute of Medicine to update scien-
EXECUTIVE SUMMARY

tific knowledge about the nature of early development and the role of early experiences, to disentangle such knowledge from erroneous popular beliefs or misunderstandings, and to discuss the implications of this knowledge base for early childhood policy, practice, professional development, and research.

The body of research that the committee reviewed is extensive, multidisciplinary, and more complex than current discourse would lead one to believe. It covers the period from before birth until the first day of kindergarten. It includes efforts to understand how early experience affects all aspects of development—from the neural circuitry of the maturing brain, to the expanding network of a child's social relationships, to both the enduring and the changing cultural values of the society in which parents raise children. It includes efforts to understand the typical trajectories of early childhood, as well as the atypical developmental pathways that characterize the adaptations of children with disabilities.

The committee's review of this evidence addresses two complementary agendas. The first is focused on the future and asks: How can society use knowledge about early childhood development to maximize the nation's human capital and ensure the ongoing vitality of its democratic institutions? The second is focused on the present and asks: How can the nation use knowledge to nurture, protect, and ensure the health and well-being of all young children as an important objective in its own right, regardless of whether measurable returns can be documented in the future? The first agenda speaks to society's economic, political, and social interests. The second speaks to its ethical and moral values. The committee is clear in our responsibility to speak to both.

CORE CONCEPTS OF DEVELOPMENT

As the knowledge generated by interdisciplinary developmental science has evolved and been integrated with lessons from program evaluation and professional experience, a number of core concepts, which are elaborated in the report, have come to frame understanding of the nature of early human development.

1. Human development is shaped by a dynamic and continuous interaction between biology and experience.

2. Culture influences every aspect of human development and is reflected in childrearing beliefs and practices designed to promote healthy adaptation.

3. The growth of self-regulation is a cornerstone of early childhood development that cuts across all domains of behavior.
4. Children are active participants in their own development, reflecting the intrinsic human drive to explore and master one's environment.

5. Human relationships, and the effects of relationships on relationships, are the building blocks of healthy development.

6. The broad range of individual differences among young children often makes it difficult to distinguish normal variations and maturational delays from transient disorders and persistent impairments.

7. The development of children unfolds along individual pathways whose trajectories are characterized by continuities and discontinuities, as well as by a series of significant transitions.

8. Human development is shaped by the ongoing interplay among sources of vulnerability and sources of resilience.

9. The timing of early experiences can matter, but, more often than not, the developing child remains vulnerable to risks and open to protective influences throughout the early years of life and into adulthood.

10. The course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes.

POLICY AND PRACTICE

The committee's conclusions and recommendations are derived from a rich and extensive knowledge base and are firmly grounded in the following four overarching themes:

- All children are born wired for feelings and ready to learn.
- Early environments matter and nurturing relationships are essential.
- Society is changing and the needs of young children are not being addressed.
- Interactions among early childhood science, policy, and practice are problematic and demand dramatic rethinking.

All Children Are Born Wired for Feelings and Ready to Learn

From the time of conception to the first day of kindergarten, development proceeds at a pace exceeding that of any subsequent stage of life. Efforts to understand this process have revealed the myriad and remarkable accomplishments of the early childhood period, as well as the serious problems that confront some young children and their families long before school entry. A fundamental paradox exists and is unavoidable: development in the early years is both highly robust and highly vulnerable. Although there have been long-standing debates about how much the early years really matter in the larger scheme of lifelong development, our con-
EXECUTIVE SUMMARY

Conclusion is unequivocal: What happens during the first months and years of life matters a lot, not because this period of development provides an indelible blueprint for adult well-being, but because it sets either a sturdy or fragile stage for what follows.

Conclusions

- From birth to age 5, children rapidly develop foundational capabilities on which subsequent development builds. In addition to their remarkable linguistic and cognitive gains, they exhibit dramatic progress in their emotional, social, regulatory, and moral capacities. All of these critical dimensions of early development are intertwined, and each requires focused attention.

- Striking disparities in what children know and can do are evident well before they enter kindergarten. These differences are strongly associated with social and economic circumstances, and they are predictive of subsequent academic performance. Redressing these disparities is critical, both for the children whose life opportunities are at stake and for a society whose goals demand that children be prepared to begin school, achieve academic success, and ultimately sustain economic independence and engage constructively with others as adult citizens.

- Early child development can be seriously compromised by social, regulatory, and emotional impairments. Indeed, young children are capable of deep and lasting sadness, grief, and disorganization in response to trauma, loss, and early personal rejection. Given the substantial short- and long-term risks that accompany early mental health impairments, the incapacity of many early childhood programs to address these concerns and the severe shortage of early childhood professionals with mental health expertise are urgent problems.

Recommendations

- Recommendation 1 — Resources on a par with those focused on literacy and numerical skills should be devoted to translating the knowledge base on young children’s emotional, regulatory, and social development into effective strategies for fostering: (1) the development of curiosity, self-direction, and persistence in learning situations; (2) the ability to cooperate, demonstrate caring, and resolve conflict with peers; and (3) the capacity to experience the enhanced motivation associated with feeling competent and loved. Such strategies and their widespread diffusion into the early childhood field must encompass young children both with and with-
out special needs. Successful action on this recommendation will require
the long-term, collaborative investment of government, professional orga-
nizations, private philanthropy, and voluntary associations.

- **Recommendation 2** — School readiness initiatives should be judged
  not only on the basis of their effectiveness in improving the performance of
  the children they reach, but also on the extent to which they make progress
  in reducing the significant disparities that are observed at school entry in
  the skills of young children with differing backgrounds.

- **Recommendation 3** — Substantial new investments should be made
  to address the nation's seriously inadequate capacity for addressing young
  children's mental health needs. Expanded opportunities for professional
  training, as recently called for by the Surgeon General, and incentives for
  individuals with pertinent expertise to work in settings with young children
  are essential first steps toward more effective screening, early detection,
  treatment, and ultimate prevention of serious childhood mental health prob-
  lems.

**Early Environments Matter and Nurturing Relationships Are Essential**

The scientific evidence on the significant developmental impacts of
early experiences, caregiving relationships, and environmental threats is
incontrovertible. Virtually every aspect of early human development, from
the brain's evolving circuitry to the child's capacity for empathy, is affected
by the environments and experiences that are encountered in a cumulative
fashion, beginning early in the prenatal period and extending throughout
the early childhood years. The science of early development is also clear
about the specific importance of parenting and of regular caregiving relationsh
ships more generally. The question today is not whether early experience matters, but rather how early experiences shape individual development and contribute to children's continued movement along positive pathways.

**Conclusions**

- The long-standing debate about the importance of nature *versus*
nurture, considered as independent influences, is overly simplistic and scientifi
cally obsolete. Scientists have shifted their focus to take account of the
fact that genetic and environmental influences work together in dynamic
ways over the course of development. At any time, both are sources of
human potential and growth as well as risk and dysfunction. Both genetically
determined characteristics and those that are highly affected by expe
rience are open to intervention. The most important questions now con-
cern how environments influence the expression of genes and how genetic
EXECUTIVE SUMMARY

makeup, combined with children’s previous experiences, affects their ongoing interactions with their environments during the early years and beyond.

• Parents and other regular caregivers in children’s lives are “active ingredients” of environmental influence during the early childhood period. Children grow and thrive in the context of close and dependable relationships that provide love and nurturance, security, responsive interaction, and encouragement for exploration. Without at least one such relationship, development is disrupted and the consequences can be severe and long-lasting. If provided or restored, however, a sensitive caregiving relationship can foster remarkable recovery.

• Children’s early development depends on the health and well-being of their parents. Yet the daily experiences of a significant number of young children are burdened by untreated mental health problems in their families, recurrent exposure to family violence, and the psychological fallout from living in a demoralized and violent neighborhood. Circumstances characterized by multiple, interrelated, and cumulative risk factors impose particularly heavy developmental burdens during early childhood and are the most likely to incur substantial costs to both the individual and society in the future.

• The time is long overdue for society to recognize the significance of out-of-home relationships for young children, to esteem those who care for them when their parents are not available, and to compensate them adequately as a means of supporting stability and quality in these relationships for all children, regardless of their family’s income and irrespective of their developmental needs.

• Early experiences clearly affect the development of the brain. Yet the recent focus on “zero to three” as a critical or particularly sensitive period is highly problematic, not because this isn’t an important period for the developing brain, but simply because the disproportionate attention to the period from birth to 3 years begins too late and ends too soon.

• Abundant evidence from the behavioral and the neurobiological sciences has documented a wide range of environmental threats to the developing central nervous system. These include poor nutrition, specific infections, environmental toxins, and drug exposures, beginning early in the prenatal period, as well as chronic stress stemming from abuse or neglect throughout the early childhood years and beyond.
Recommendations

- **Recommendation 4** — Decision makers at all levels of government, as well as leaders from the business community, should ensure that better public and private policies provide parents with viable choices about how to allocate responsibility for child care during the early years of their children’s lives. During infancy, there is a pressing need to strike a better balance between options that support parents to care for their infants at home and those that provide affordable, quality child care that enables them to work or go to school. This calls for expanding coverage of the Family and Medical Leave Act to all working parents, pursuing the complex issue of income protection, lengthening the exemption period before states require parents of infants to work as part of welfare reform, and enhancing parents’ opportunities to choose from among a range of child care settings that offer the stable, sensitive, and linguistically rich caregiving that fosters positive early childhood development.

- **Recommendation 5** — Environmental protection, reproductive health services, and early intervention efforts should be substantially expanded to reduce documented risks that arise from harmful prenatal and early postnatal neurotoxic exposures, as well as from seriously disrupted early relationships due to chronic mental health problems, substance abuse, and violence in families. The magnitude of these initiatives should be comparable to the attention and resources that have been dedicated to crime prevention, smoking cessation, and the reduction of teen pregnancy. They will require the participation of multiple societal sectors (e.g., private, public, and philanthropic) and the development of multiple strategies.

- **Recommendation 6** — The major funding sources for child care and early childhood education should set aside a dedicated portion of funds to support initiatives that jointly improve the qualifications and increase the compensation and benefits routinely provided to children’s nonparental caregivers. These initiatives can be built on the successful experience of the U.S. Department of Defense.

**Society Is Changing and the Needs of Young Children Are Not Being Addressed**

Profound social and economic transformations are posing serious challenges to the efforts of parents and others to strike a healthy balance between spending time with their children, securing their economic needs, and protecting them from the many risks beyond the home that may have an adverse impact on their health and development.
EXECUTIVE SUMMARY

Conclusions

- Changing parental work patterns are transforming family life. Growing numbers of young children are being raised by working parents whose earnings are inadequate to lift their families out of poverty, whose work entails long and nonstandard hours, and whose economic needs require an early return to work after the birth of a baby. The consequences of the changing context of parental employment for young children are likely to hinge on how it affects the parenting they receive and the quality of the caregiving they experience when they are not with their parents.

- The developmental effects of child care depend on its safety, the opportunities it provides for nurturing and stable relationships, and its provision of linguistically and cognitively rich environments. Yet the child care that is available in the United States today is highly fragmented and characterized by marked variation in quality, ranging from rich, growth-promoting experiences to unstimulating, highly unstable, and sometimes dangerous settings. The burden of poor quality and limited choice rests most heavily on low-income, working families whose financial resources are too high to qualify for subsidies yet too low to afford quality care.

- Young children are the poorest members of society and are more likely to be poor today than they were 25 years ago. Growing up in poverty greatly increases the probability that a child will be exposed to environments and experiences that impose significant burdens on his or her well-being, thereby shifting the odds toward more adverse developmental outcomes. Poverty during the early childhood period may be more damaging than poverty experienced at later ages, particularly with respect to eventual academic attainment. The dual risk of poverty experienced simultaneously in the family and in the surrounding neighborhood, which affects minority children to a much greater extent than other children, increases young children’s vulnerability to adverse consequences.

Recommendations

The challenges that arise at the juxtaposition of work, income, and the care of children reflect some of the most complex problems of contemporary society. Rather than offer recommendations for specific actions, many of which have been made before and gone unheeded, the committee wishes to underscore the compelling need for a focused, integrative, and comprehensive reassessment of our nation’s child care and income support policies.
This Tip Sheet offers guidance for involving family members in the work of mental health policy groups. It provides a definition of "family member" and briefly describes the context for family involvement in policy group work. It contains strategies for recruiting family members to join policy groups, training and supporting family members to do the work, and sustaining their participation over time.

Involving Families in Policy Group Work

Definition of Family Member

A child’s family is the group of individuals who support that child – emotionally, physically, and financially. It can include individuals of various ages who are biologically related, related by marriage, or not related at all.

A family unconditionally provides love, guidance, care, support, and otherwise nurtures all members, especially its children. Each family has a culture of its own – in addition to the external cultures it affiliates with. This influences how the family approaches the tasks of daily living (food, dress, work, school) and can direct how a family faces the challenges of raising a child with mental health needs. Families work in different ways and have different resources at their disposal.

Context

Mental health policy groups are made up of individuals who are expected to speak with authority and make recommendations based on their experience and knowledge. Many mental health policy groups, such as State Mental Health Planning & Advisory Councils, are required to include family members of children who are served by the agency or program.

Policy Groups leaders work hard to maintain continuity, cohesion, and focus in the face of changing membership (family and others) and shifts in the political climate or economic environment. Bringing new members on board and up to speed is an ongoing activity.

Family members contribute integrity to policy group work by providing reality-based, culturally relevant information from a perspective that no one else has. Yet, policy group leaders struggle to find family members who are willing and able to make such a commitment and sustain their involvement over time.

Recruiting Family Members for Policy Groups

States and their Mental Health Policy Groups can reach out to families in a variety of ways. Indirect methods for reaching families include contacting existing state and local agencies, groups or associations that support the mission of the policy group. Examples of this approach include family organizations like chapters of the Federation of Families for Children’s Mental Health, parent support groups, mental health providers, children’s mental health advocacy organizations, and schools. More direct methods for establishing connections with families include sponsoring and/or attending conferences, forums or public discussions.
concerning children’s mental health. Hosting public gatherings that create awareness of the policy group’s purpose and achievements can also attract families.

Once a link has been established with families, a representative of the policy group should meet with them to:

- Explore common hopes and concern
- Explain the purpose of the policy group
- Share the group’s accomplishments
- Discuss the family’s interest in being involved
- Ask what they will need in order to participate
- Accept the level of involvement that families can offer
- Understanding how the group operates is essential. Families must know what the structure is and how decisions are made. Answers to the following questions will help families decide if they want to participate:
  - Does the policy group focus solely on children’s issues, or is there a sub-committee of the group responsible for children and youth?
  - What is the authority of the group and its committees?
  - Does the group have by-laws and are they enforced?
  - What are the requirements for membership?
  - What is the composition of the group?
  - How much influence does the group have?
  - When and where does the group meet?
  - How much time commitment, beyond attending meetings, is expected to prepare for meetings or attend to committee assignments?

Families & family organizations do not need to wait to be approached by policy groups. Just as policy groups are seeking family involvement, families and family organizations are looking for the opportunity to effectively participate in policy work. Family-run organizations that successfully seek out and reach out to policy groups advise the following.

- Get to know the mental health authority & make an appointment; ask questions; explore how you can be involved in existing opportunities; send a note of appreciation after your visit.
- Ask for and read your state’s plans for agencies that serve children with mental health needs & ask questions about sections you don’t understand.
- Know the responsibilities of the policy group.
- Learn who the members of the policy group are and what their background is & meet with any of them individually or attend a meeting and learn about their priorities.
- Find out when and where policy groups meet and attend as an observer.
- Ask about the current focus of their work.
- Learn how the group operates.
- Follow through with commitments.

In addition to establishing relationships with policy groups, it is vital for family organizations to know the realities of the environment in which the work is done. Internal and external factors (such as personal agendas, turf issues, systems crisis or litigation) can have impact upon how the policy group selects priority issues and makes decisions. Family organizations can become more aware of the environment by:

- Staying connected with the network of a family organization.
- Developing common agendas with others.
- Creating strategic alliances.
- Maintaining integrity to their mission.

### Training and Supporting Family Members on Policy Groups

Policy groups that have access to flexible, tangible and practical resources are better prepared to meet the individual needs of their family members. Training for family representatives is essential for them to effectively participate in policy activities. Training group members in working collaboratively with families is equally essential.

While the personal experiences of family members are critically informative at policy tables, it is challenging for family representatives to present their stories and keep any distressing accompanying emotions (fear, anxiety, humiliation, anger, frustration, distrust and disappointment with the service system) in check. Family members and other policy group members can significantly benefit from training in how to reframe
personal experiences to reveal the underlying systems issues. Family members and family-run organizations that have system experience can best provide such training. There are other important ways of making sure family members consistently and effectively participate on policy groups.

Select meeting times and locations that support attendance

Families of children and youth with mental health issues have demanding schedules. Check with family members' schedules before finalizing policy group meeting times and locations. Providing a light meal or childcare can also make it easier for family members to attend daytime meetings.

Policy groups should be flexible and creative in finding meeting times that accommodate family scheduling needs. Some options are to meet in the evening or on weekends or patch families in by conference call. Consider using distance-learning technologies such as computers or video and satellite conferencing facilities that may be available at colleges and universities to allow families in remote parts of the state to participate.

Recruit more than one family representative

It is a heavy burden for one family member to represent all the families in a community or state. Having a diverse group of peers to work with on a policy group is very appealing to family members because it insures them that the diversity of family experiences, cultures, backgrounds, and perspectives will have a voice at the table and that there is "back-up" if an emergency keeps them from attending a meeting. This will also help prevent feelings of "tokenism" and provide a friendly environment for new families who join. Give families opportunities and supports to meet one another prior to the meeting if they wish. Policy groups will benefit substantially from the informal orientation and mentoring that result from families connecting with one another.

Supply flexible financial support

Many families cannot afford the ancillary expenses of joining a policy group. Stipends and reimbursements for dependent care, transportation (airline, buses, or

other public means, tolls, mileage, etc.), lodging (if necessary) and meals can make a critical difference for family members. Policy groups that arrange travel, provide cash per diems in advance and master bill hotel rooms for national meetings reduce the financial burden and stress on family members attending events requiring that they be away from home. Agencies that administer funds for policy groups need methods for timely (immediate) reimbursement of out-of-pocket expenses born by family members. Arranging for cash reimbursement at the meeting makes it possible for family members to attend and participate when they don't have credit cards or checking accounts.

Provide access to communication

Just as other policy group members use cell phones and pagers to communicate with staff, co-workers or their families, family members have to respond to the immediate needs of their children, schools, daycare or work. Practices that can help family members keep in touch with home include:

- Letting group members know the incoming phone numbers ahead of time so they can leave this information with their families.
- Providing phone cards for long distance calls and making sure there are pay phones available for families
- Having a cell or regular phone at the meeting registration desk to receive emergency calls
- Scheduling phone breaks during the meeting
- Family members can help their policy groups by clearly explaining their communication needs in advance and being responsible about using the resources they are given.

Share Information

Family members at the policy table have a responsibility to represent their constituency's needs and not just their own personal agenda. When taking a position or presenting a perspective they should be prepared to explain where the information came from and what process was used to get it. Legitimate data sources include (but are not limited to) formal reports, focus groups, surveys, support group discussions. Policy groups should feel free to seek additional information from family organizations that reach out to numerous families; and also to seek substantiating data.
Policy groups should make it easy for family members who have new and relevant information to get it copied and distributed to others. Policy groups should build funds for these expenses into their budgets. The actual copying can be done by a local copying and printing business, be assigned to the support staff for the group; or be handled by the (or other) agency sponsoring the policy group.

Policy groups, in turn, should make sure that family members are well informed of the issues the group is discussing. However, family members do not want to be overwhelmed by too much information. Some may be reluctant to ask for help interpreting background materials or proposals for discussion. Offering a clear explanation of what is being worked on (including budgets) and how it relates to the bigger picture will help family members feel comfortable, confident, and competent to make informed decisions. Pairing family members, especially newer members, with more experienced members of the group is an effective strategy for reviewing materials before meetings take place.

Provide validation & appreciation

Family members on policy groups want to know that their input is valued. Other families in the community need to see how their representative’s contributions are being used. Publishing meeting minutes creates a formal record of group activities, the results of any follow up on their actions and documents the role that members played in making recommendations and decisions.

Sustaining Family Involvement on Policy Groups

Maintaining a full and diverse complement of members is essential for the ability of mental health policy groups to make fully informed, publicly responsible decisions. Having valid information and consistent communication reduces the confusion and frustration that may result in loss of members. Mental health authorities can assist by providing sufficient and consistent staff support and resources for policy group activities. State and local agencies can contribute to group stability by having incoming staff representatives attend a meeting with their exiting predecessor.

Families who have the supports necessary for coping with turmoil or confusion in their daily lives are better equipped to follow through with commitments to policy groups. Agencies sponsoring policy groups should make every effort to help family representatives stay connected to appropriate providers so their children can continue to receive all essential mental and physical health services and supports, educational services, child care and family supports.

Group members all need a sense of purpose, acceptance and accomplishment. Policy groups that are successful at sustaining family involvement have clearly defined mission, purposes, policies, operational procedures (by-laws in some cases), responsibilities, lines of authority and accountability, and reliable clerical and administrative support for communication and logistics. They hold meetings consistently and efficiently conduct them in a manner that is respectful, safe and supportive for all members. Successful policy groups have effective leadership that all members recognize as legitimate and they express their appreciation for the work of their members.

Data and the ability to understand its implications are key to making appropriate policy recommendations, preserving precious resources, achieving intended outcomes, and promoting necessary change. Policy groups that are successful in sustaining family involvement make sure that all members have access to the same information in a format and language that is universally understandable and free of jargon, complicated technical terms, or acronyms. Technology can assist in keeping members up to date with accurate and timely information. Strategic planning accompanied by training and technical assistance for all policy group members helps to foster collaborative working relationships.

Where to Get More Information

For more information and training on strategies for engaging families in policy work contact the

- Federation of Families for Children’s Mental Health, 1101 King Street, Suite 420, Alexandria, VA 22314, (703) 684-7710 www.ffcmh.org
- National Council on Family Relations, 3989 Central Ave. NE, #550, Minneapolis, MN 55421, (763) 781-9331 www.ncfr.org
This document was developed by the Federation of Families for Children's Mental Health as part of the Targeted Technical Assistance project of the National Association of State Mental Health Program Directors (NASMHPD) and the Division of State and Community Systems Development (Mental Health Block Grant) of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
2-1-1 Fact Sheet

2-1-1 is an easy to remember phone number that connects individuals with resources in their community.

With approximately 1.5 million nonprofit organizations in the United States plus scores of government agencies, finding help can be confusing and intimidating. 2-1-1 centers are staffed by trained specialists who quickly assess the callers’ needs and refer them to the help they seek. It’s simple to remember, accessible to everyone at no cost, and available 24/7 with multilingual capabilities.

2-1-1 enables people to get help or give help.

2-1-1 offers information on a broad range of services, including rent assistance, food banks, affordable housing, health resources, child care, after-school programs, elderly care, financial literacy, and job training programs. Specialists at 2-1-1 centers facilitate thousands of volunteer hours and direct donors to locations where their gifts may be most needed and appropriate. One call center’s referrals facilitated nearly 65,000 volunteer staff hours worth over $1 million.

2-1-1 benefits the nation.

The human services system in many of our cities and states is not only inefficient and costly, but is confusing and time consuming for consumers seeking to give or get help. It need not be this way. A 2004 University of Texas at Austin cost-benefit analysis of 2-1-1 estimates a net value to society approaching $130 million in the first year alone, and a conservative estimate of $1.1 billion over ten years. A national 2-1-1 system produces cost savings for tax payers, employers and government; and 2-1-1 in any community saves time and enhances the human services experience for those needing assistance.

Supporting 2-1-1 benefits your community.

2-1-1 is locally designed by community stakeholders who are aware of their local and state needs and resources. 2-1-1 is part of the community fabric, employs local citizens, and serves the local community. Businesses, nonprofit organizations, and government officials support 2-1-1 as a way to improve the lives of the residents in their communities. As of January 1, 2007, 2-1-1 was available to over 190 million Americans – approximately 65% of the U.S. population – with 209 active 2-1-1 systems operating in 41 states, the District of Columbia and Puerto Rico.

2-1-1 enhances public safety and crisis recovery efforts.

From hurricanes and floods to bio-terrorism, 2-1-1 call centers that already exist in communities, operating 24/7, are the logical platform for building emergency response communication capacity. In the wake of Hurricanes Katrina and Rita, hundreds of thousands of Louisiana, Texas and Alabama residents called 2-1-1 with a multitude of needs, including shelter, transportation, medical, food and water, construction materials, mental health, and questions about the availability of and application process for federal, state, and nonprofit assistance. 9-1-1 referred non-emergency calls to 2-1-1, freeing up 9-1-1 operators for life-and-death situations.

“2-1-1 offers information on a broad range of services, including rent assistance, food banks, affordable housing, health resources, child care, after-school programs, elderly care, financial literacy, and job training programs.”

2-1-1 is a private-public partnership.

2-1-1 is funded through local and state sources including local United Ways and other nonprofits, foundations, businesses, and state and local government. The Calling for 2-1-1 Act seeks to authorize federal funding of $150 million for years one and two, and $100 million for years three through five through the U.S. Department of Health and Human Services (HHS) to help implement and sustain 2-1-1 nationwide. States would be required to provide a 50% match in order to draw down the federal dollars.
National Association of County & City Health Officials

MENTAL

health

Statement of Purpose:
The evolving understanding of the inter-relationship between public health and mental health is fundamental to promoting overall health and well-being. In 1999, the landmark Surgeon General’s Report on Mental Health highlighted mental health as essential to achieving prosperity and reducing disability. In the efforts to promote the public’s health, mental health promotion and the prevention of mental illness must be included as part of the overall health of the community. Subsequent reports, by the President’s New Freedom Commission on Mental Health and the Institute of Medicine (Crossing the Quality Chasm), have highlighted the need for accessible high-quality health services. As noted by the New Freedom Commission on Mental Health, “as future opportunities emerge to transform health care in America, mental health care must be considered part of the reform necessary to achieve optimal health benefits for the American public.” All of these factors speak to the need for stronger collaboration between public health and mental health authorities, providers and interest groups.

Encouraging understanding of and collaboration between mental health and public health issues and communities, resulted in the coming together of the National Association of County and City Health Officials (NACCHO) and the National Mental Health Association (NMHA) for a consensus meeting in April 2004. The mental health and public health professionals at the meeting discussed the current connection between the practice and systems of public health and mental health. Participants identified key challenges to incorporating public health practices into mental health services and exchanging resources and expertise to achieve the goal of improving the public’s health. These Guiding Principles are based on the results of the consensus meeting and recommendations for increasing collaboration.

Guiding Principles for Collaboration between Mental Health and Public Health

Principles:

I. Education and Collaboration
Health promotion, through mental health and public health system collaboration, must be acknowledged and integrated into program planning and practice in the areas of chronic disease, environmental health, and maternal and child health. Mental health and public health policy makers and practitioners must promote increased awareness and collaboration at all levels, among federal, national, state and local public health and mental health partners.

II. Comprehensive Planning
There is a need for collaborative and comprehensive plans at the local, state and national levels that address the health and mental health needs of individuals, families and communities. Strategic activities must respond to issues identified in community needs assessments, and work towards Healthy People 2010 and New Freedom Commission priorities.

III. Partnership
Mental health and public health communities must create and foster partnerships to promote health and prevent adverse conditions. Partnerships must occur in all activities and situations, such as education, screening, and emergency/disaster response, and for all target populations, including prison and jail populations.

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IV. Communication
Communication between the mental health and public health professions and among community groups, policy makers, and the public is fundamental. Communication is essential for effective collaboration, planning and partnership. Forums can encourage dialogue and improve communication among mental health and public health service providers. Sharing information about funding streams, service providers and best practices can facilitate increased collaboration and support.

V. Workforce Development
As the nation’s population becomes increasingly diverse, the composition of the health professional workforce must follow suit, drawing mental health and public health professionals from all races and ethnicities and all types of backgrounds. Mental health and public health have a mutual need for a highly trained and diverse workforce, and professionals must have opportunities for training and workforce development in each other’s fields. Joint conferences, cross-trainings and dialogue opportunities will enhance knowledge and practice of both mental health and public health professionals.

VI. Data Collection
In the attempt to improve epidemiological data for mental health at the local, state and national level, investments must be made in infrastructure development. Public health’s knowledge of and capacity for epidemiology must be used to assist the assessment and enhancement of the surveillance and epidemiological capacity of mental health systems. Epidemiology can be used to profile mental health systems, similar to the way epidemiology is used to explain infectious disease.

VII. Access
Early efforts at planning, partnership, workforce development, and communication will help make increased access and integrated services a reality. Integration of mental health and public health services will improve access to mental health services, and both the public health and mental health communities must advocate for more comprehensive insurance coverage for mental health services. Individuals must no longer settle for simply a medical home, but the mental health and public health communities should strive to provide access to a comprehensive “health home”.


NACCHO is the national organization representing local public health agencies (including city, county, metro, district, and tribal agencies). NACCHO works to support efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, and supporting effective local public health practice and systems.

NMHA is the country’s oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans, especially the 54 million people with mental disorders, through advocacy, education, research and service.

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