Identifying Mental Health and Substance Abuse Problems of Children and Youth
Part 1

Contents

Chapter 1

Prevention and Early Identification of Children's and Adolescents' Mental Health and Substance Use Problems

The Importance of Social and Emotional Development

The term *mental health* addresses how children (birth–12 years) and adolescents (13–22 years)* think, feel, and act as they face the challenges of life. Mental health is a very important part of children's and adolescents' development. It affects how they handle challenges, learn and progress, form friendships, and make decisions about their lives. It also influences their sense of hope and the ways they look at themselves; their relationships with families, friends, and teachers; and the choices they make about smoking, using alcohol or drugs, and taking other risks. Just as caregivers,† family members, and adults working with youths promote healthy physical development and identify and address any physical or medical challenges, they also are responsible for promoting children's and adolescents' mental health and social and emotional development.

Children and adolescents can have serious mental health and/or substance use problems.

Like adults, children and adolescents can have mental health or substance use problems that interfere with the way they think, feel, and act. Such problems—if not addressed—may interfere with learning and the ability to form and sustain friendships, contribute to disciplinary problems and family conflicts, and increase risky behaviors.

* Legal and other definitions of *adolescence* vary. This guide considers adolescence to extend until age 22, consistent with eligibility for special education services under the Individuals with Disabilities Education Act (IDEA). However, the resources identified in this document may use a different definition and may offer services to youths up to age 26.

† The guide often refers to a child's caregivers. Besides parents, other family members or caregivers—including foster parents—may be fulfilling a parental role for a child. However, when legal aspects of parenthood—such as informed consent—are discussed, only parents or legal guardians meet the legal definition of *parent*.

Serious mental health problems often are a factor in drug abuse and suicide.[11 12 13] Early use of alcohol is a risk factor for developing alcohol problems; in addition, motor vehicle collisions related to teen alcohol use are among the most common causes of teen death.[14 15]

Mental health and substance use problems are common in young people.

Almost 21 percent of U.S. children and adolescents have a diagnosable mental health or addictive disorder that affects their ability to function.[16] In any given year, 5 percent to 9 percent of youths ages 9–17 have a serious emotional disturbance that causes substantial impairment in how they function at home, at school, or in the community.[17] Adolescents face a greater risk than adults of developing drug or alcohol use problems;[18] 7.6 percent of adolescents ages 12–17 have met the criteria for dependence on and/or abuse of illicit drugs or alcohol.[19] Mental health problems in adolescents often increase their use of substances such as alcohol, marijuana, and other drugs. One 2005 study found that adolescents who had experienced a major depressive episode in the past year were more than twice as likely to have used illicit drugs in the past month as their peers who had not experienced a depressive episode (21 percent versus 10 percent).[20]

Some children and adolescents have a higher risk of developing mental health or substance use problems than others.

Children and adolescents whose family members are living with conditions such as depression or other mental health disorders may have a higher risk of developing similar conditions.[21 22] Youths with developmental disabilities and chronic medical conditions also can have a co-occurring mental health condition or can develop a substance use problem.[23] For example, youths with asthma are at higher risk of developing depression than those who do not have asthma.[24] Adolescents who are questioning their sexual identity or becoming aware of the possibility that they may be gay, lesbian, bisexual, or transgender can be at high risk for certain mental health disorders and misuse of substances.[25 26] Children and adolescents in the juvenile justice system—especially girls—have been found to have a very high incidence of mental health and substance abuse disorders.[27]

Experiences and environments can increase or decrease the risk of mental health and substance use problems in children and adolescents.

Protective factors such as family stability, supportive and nurturing relationships, a strong community, and faith organizations can help prevent certain kinds of problems from developing in children and adolescents. These protective factors also can be a source of support that helps children and adolescents cope with mental health and substance use problems if such problems develop.

Stress and psychological trauma are among a number of environmental risk factors that can contribute to the development of mental health or substance use problems in children and adolescents and also can increase the severity of such problems.

Psychological trauma occurs when a youth experiences an intense event that threatens or causes harm to his or her emotional and physical well-being.[28] A range of physiological and psychological behaviors can provide signs that the youth is having difficulty dealing with a traumatic event. However, these reactions are the body's normal response when confronted by danger. Some children and adolescents who have experienced a traumatic event will have longer lasting reactions that can interfere with their physical and emotional health.

- Children and adolescents in families that have experienced significant losses may face greater challenges to healthy development than those without such losses.
- Children and adolescents from poor families have increased rates of developmental problems, stress, and uncertainty, which—along with other factors associated with poverty—can trigger behavioral health problems.[29]
- Psychological trauma can trigger mental health and substance use problems. Children and adolescents who have been abused or neglected are at a higher risk of having mental health or substance use problems.[30]
- Children and adolescents who were exposed to chronic violence at home or in their communities or who experienced a natural disaster or school violence are at heightened risk for mental health or substance use problems.[31]

Prevention and Treatment

In recent years, much has been learned about the healthy development of children and adolescents and the support that caregivers, schools, and communities can provide. A number of interventions have been studied and provide evidence of success in promoting resilience, optimal mental health, and social and emotional development. Such interventions benefit all youths—including those whose problems are not severe enough to warrant treatment—and may help prevent at-risk children and adolescents from developing problems. Interventions of this sort can be an important part of a continuum of prevention, early intervention, and treatment services. Although this guide focuses on early identification and intervention, organizations and communities also may wish to develop preventive interventions in addition to the screening and brief interventions they provide to the children and adolescents they serve.

A wide variety of interventions are used to help children, adolescents, and families cope with mental health and substance use problems.

The following examples (see "Examples of Interventions" on page 10) describe a variety of mental health and substance use problems that children and adolescents may experience. These examples illustrate several methods of identifying such problems—including caregivers' and professionals' awareness of warning signs and the administration of screening tools—and show the process for assessing and developing successful interventions and treatments. Children, adolescents, caregivers, and teachers can learn how to manage symptoms of mental health problems among youths and ways to compensate for these problems by building on youth strengths.

These interventions are examples of the many approaches used to address mental health and substance use problems in children and adolescents who do not require psychotropic medications.*

Examples of Interventions
Joy is a 3-year-old toddler. At Joy's 3-year primary care visit, her mother completes a written screening tool that specifically assesses the social and emotional development of 3-year-olds. The screen indicates that Joy is having significant difficulty settling down to sleep at night and has conflicts with her mother at mealtimes. The primary care provider suggests that Joy might benefit from further assessment. Because Joy attends an early care center that has access to a clinician specially trained in early childhood mental health, her parents are able to request that the clinician observe Joy in the center. The clinician notes subtle behaviors at naptime and during meals, consistent with the difficulties that Joy is experiencing at home. As a result, the clinician develops a coordinated plan with Joy's parents and early care staff that allows them to identify and anticipate these behaviors and develop strategies that help Joy learn how to regulate her eating and sleeping.
Shawn, 7, is beginning to show repetitive behaviors, such as frequent hand washing, knocking three times on every door he passes, and counting on his fingers when he watches television. Worried, his mother consults with the social worker at Shawn's school, who refers him to a therapist. The therapist confirms a diagnosis of obsessive-compulsive disorder. Shawn, now in treatment with the therapist, has learned many new strategies to interrupt his obsessive thoughts.
Matt is a seventh grader whose parents are concerned because his grades have slipped and he is spending a lot of time sleeping. He also has dropped out of soccer and complains of stomachaches each day before reluctantly leaving for school. At Matt's annual pediatric exam, the pediatrician requests and receives parental consent to administer a brief written screening tool. This tool indicates a high likelihood that Matt has a mental health problem. The pediatrician discusses this finding with Matt and his parents, who are relieved to have the opportunity to address their concerns. The pediatrician investigates possible physical causes for Matt's distress but finds none. Based on discussions with Matt and his parents, the pediatrician suspects that Matt has depression and refers him to a mental health clinic for cognitive-behavioral therapy (CBT), an approach that focuses on current issues and symptoms rather than on past history.[33] Matt's CBT treatment helps him to identify and correct inaccurate thoughts associated with depressed feelings, participate in activities he enjoys, and develop problem-solving skills. In addition, the pediatrician refers Matt for evaluation by a child psychiatrist for the possible use of an antidepressant medication. Together, Matt, his parents, the psychiatrist, and the pediatrician will determine if Matt will try medication.
Annette is a precocious 15-year-old, who has earned a B-plus average in her freshman year. She is referred to an outpatient drug program for an evaluation because her mother has found marijuana in her bedroom. During a clinical assessment, the drug counselor learns that Annette began smoking marijuana 2 years ago and generally smokes on weekends. The counselor also learns that Annette is having difficulty adjusting to the loss of her father 18 months previously and, as an only child, to the changes in the relationship with her mother. The counselor refers Annette to a 6-week outpatient program, with group therapy twice a week, to address both her drug involvement and her grief. Through this program, Annette has stopped using marijuana and is improving her relationship with her mother.

* A *psychotropic medication* is "any medication capable of affecting the mind, emotions, and behavior."[32]

Prescribed medication to treat a child's or adolescent's mental health problem usually should be combined with other interventions as part of a comprehensive treatment plan and always should be carefully monitored.

Psychotropic medication can be a very helpful treatment for some children and adolescents. Research on conditions such as depression and attention deficit/hyperactivity disorder (ADHD) has shown that medication is most effective when combined with other interventions, such as counseling or behavior management.[34 35]

However, medication is not the primary form of mental health treatment for most children and adolescents, as indicated by the previous examples illustrating nonmedication approaches for treating such problems. In a 2009 study of a local screening program, parents of teens identified with risk for suicidal behavior were surveyed. The results showed that of the identified teens who were not receiving treatment at the time of the screening but went on to seek services, almost 90 percent of the identified teens received therapy without any psychotropic medications, 11 percent received treatment and medication, and none of these teens received only medication.[36]

Chapter 2

Understanding the Identification Process and Tools

The Value of Early Identification

Early identification allows the possible mental health or substance use problems of many children and adolescents to be determined and treated.

The identification of possible problems allows child-serving organizations to offer a referral for an assessment so that further determination can be made as to whether a problem is present. It also enables these organizations to work with caregivers on planning interventions when the existence of identified problems is confirmed. The guide's Supplements section presents additional information on the basic principles of a responsible identification program and provides information on how these principles may be adapted to specific settings and age groups.

Staff of child-serving organizations have opportunities to identify possible problems.

Caregivers are usually the first to recognize early signs of problems in their children. Medical providers, teachers, or direct care workers in children's programs also are well positioned to improve the identification of mental health and substance use problems among the children and adolescents they serve. Just as schools screen for vision and hearing problems before such problems interfere with learning, service providers can develop early identification programs for mental health and substance use problems.

Settings such as family or runaway shelters and child welfare and juvenile justice agencies have custodial or protective responsibilities for children and adolescents with an elevated risk of developing mental health and substance use problems; these organizations must ensure that such problems are identified and addressed. Further, mental health and substance abuse professionals need to identify problems that fall outside their areas of expertise; in such situations, they need to consult with or refer youths and their families to other treatment providers.

Working in partnership with caregivers and families is essential.

Caregivers and families are key to promoting a youth's healthy development. As with physical health decisions, legal guardians—in consultation with health care providers and other professionals—are the decision makers about their child's or adolescent's care for any identified mental health and substance use problems. Caregivers have valuable information about how their child's or adolescent's normal feelings and behavior have changed and, because of their concerns, often request an assessment. Professionals, including physicians and educators, must respect and listen to caregivers so that problems are identified early and referrals for assessment and care are made quickly.

Child-serving organizations must seek informed parental consent to identify or address possible mental health or substance use problems of the children and adolescents participating in their programs.

Situations when parental consent is not required include the following:

- When a child or adolescent has been removed from parental custody and is in the custody of the state.
- When a child or adolescent is at immediate risk of serious harm or death but a parent or legal guardian cannot be contacted immediately.
- When an adolescent is exercising his or her right to seek services as a mature or emancipated minor. (These rights differ in different states.)
- When an adolescent age 18 or older can consent for himself or herself.

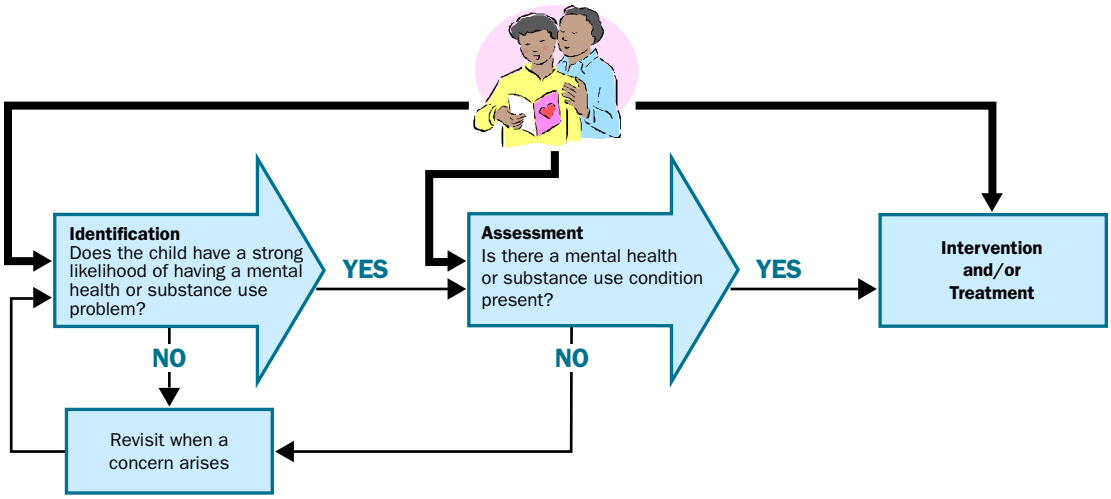
Encouraging the involvement of parents before asking consent to conduct a screening is a valuable approach. The positive involvement of parents may include engaging them in the process of setting goals for an identification initiative and in the selection of methods for identifying mental health and substance use problems.

Developing an Effective Approach to Improve Identification and Access to Care

Three essential elements improve identification and access to care.

Every identification initiative has three elements: identification, assessment, and intervention and/or treatment (see Figure 1). Parents of youths identified with a possible problem should be offered a full assessment by a relevant professional who can collect additional information to determine whether a problem is, in fact, present. Every step of the identification process must include parental consent and youth assent.* If a mental health or substance use problem is confirmed, the professional and family will use the assessment information to plan appropriate interventions and services. Identifying a problem has minimal value, however, if appropriate assistance with accessing follow-up care is not provided.

Figure 1
Improving Identification and Access to Care for Youths at Risk of Mental Health and Substance Use Problems



Identification	Assessment	Intervention and/or Treatment
The method of identifying possible problems must be reliable and valid.	A comprehensive assessment determines the nature of the problem and provides sufficient information for the assessor to recommend an intervention or treatment.	An appropriate intervention or treatment is recommended and selected for those children with the most serious conditions. This approach may involve a formal diagnosis and clinical treatment plan.
Caregivers and youths should be involved in decision making at every step. Parental consent and youth assent may be necessary at every step.		

* For the purposes of this guide, *assent* is an agreement by a child or adolescent not able to give legally valid informed consent of his or her willingness to participate in a health care procedure that has been consented to by his or her legal guardian.

The identification process may be repeated periodically. As children grow older, events in their lives may put them at risk for various problems. For children and adolescents who show clear signs of a mental health or substance use problem, a discrete identification process may not be necessary; instead, these youths can be referred directly for assessment.

IDENTIFICATION

The method used to identify children and adolescents at risk for mental health and substance use problems must be accurate. For people who are not mental health professionals, the most accurate method for identifying children and adolescents likely to have a mental health and/or a substance use problem is to use a screening tool that has been tested and found to be valid and reliable. (See "What Is a Screening Tool?" at right.)

Caregivers and personnel serving children may find it helpful to learn some of the commons signs of mental health and substance use problems and use these signs to help evaluate whether a youth's behavior indicates possible problems that warrant further assessment. (See page 23 for materials that provide information on the signs of a mental health or substance use problem.)

What Is a Screening Tool?

A screening tool is a brief list of questions relating to a youth's behavior, thoughts, and feelings. It usually takes only 5–15 minutes to answer. A specific method is used to score the answers to the questions, and the score indicates whether the youth is at high likelihood of having a problem or is unlikely to have a problem.

As with medical tests, the language used to refer to the results of screening may be confusing. When a score indicates a likely problem, it is called a *positive finding*; when the score indicates that a problem is not likely, it is called a *negative finding*. Like other medical tests, sometimes screening tools might miss problems or are positive when there is not a problem.

For examples of a screening tool, see the Pediatric Symptom Checklist forms (http://www2.massgeneral.org/allpsych/psc/psc_forms.htm).

ASSESSMENT

An assessment is conducted by a qualified, experienced mental health or substance abuse professional who gathers more information about the youth to determine whether an identified possible condition is, in fact, present. In addition to speaking with or observing the youth, the professional also should talk to parents or caregivers and—with the consent of parents or caregivers—to teachers or others who know the youth well. This step may involve determining whether a youth meets specific, defined criteria for a diagnosis according to a formal classification system in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV)[37] or the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3R).[38]

The professional also will collect information that is helpful in working with the child or adolescent and his or her family to develop a plan to address the problem. Because no screening or identification process is perfect, some children and adolescents may be incorrectly found to *not* have a mental health or substance use problem—when, in fact, they actually have one; or they incorrectly may be found to have a mental health or substance use problem when, in fact, they actually do *not* have one.

INTERVENTION AND/OR TREATMENT

The goal of identifying children and adolescents with a high likelihood of having mental health and substance use problems is to provide an appropriate intervention or to connect the youths and their families with assessment and treatment resources. Even when an organization can offer an intervention, it must be prepared for the possibility that a youth's problem may warrant additional, different, or more specialized services; in such situations, the organization must assist the families with accessing those services.

Some organizations may not be able to offer all three elements of an identification initiative. However, the necessary elements can be assembled by partnering with other organizations and linking to other resources in the community. In some cases, an organization may need to offer only coordination, space, and time. (See Chapter 4 for possible partners and resources.)

This guide focuses on the identification process and how it can be linked to assessment and treatment resources.

Applying Basic Principles to the Design of an Early Identification and Access-to-Care Program

As with screening and early identification of any health problem, early detection of emotional and behavioral problems must adhere to the standards and principles of confidentiality and high-quality health care. (See "Principles Guiding Screening for Early Identification of Mental Health and Substance Use Problems in Children and Adolescents" on page 18.)

Principles Guiding Screening for Early Identification of Mental Health and Substance Use Problems in Children and Adolescents

Developed by the Early Identification Workgroup of the Federal/National Partnership (FNP) for Transforming Child and Family Mental Health and Substance Abuse Prevention and Treatment, December 18, 2006.

1. **First, do no harm.**

2. **Obtain informed consent.**
   - Screening should be a voluntary process—except in emergency situations, which preclude obtaining consent prior to screening. In these circumstances, consent should be obtained as soon as possible during or after screening.
   - Informed consent for screening a child and adolescent should be obtained from parents, guardians, or the entity with legal custody of the youth. Informed assent from adolescents also should be obtained. Clear, written procedures for requesting consent and notifying parents or adolescents of the results of early identification activities should be available.

3. **Use a scientifically sound screening process.**
   - All screening instruments should be shown to be valid and reliable in identifying youths in need of further assessment.
   - Screening must be developmentally, age, gender, and racially/ethnically/culturally appropriate for the child or adolescent.
   - Early identification procedures and approaches should respect and take into consideration the norms, language, and cultures of communities and families.
   - Any person conducting screening and involved with the screening process should be qualified and appropriately trained.

4. **Safeguard the screening information, and ensure its appropriate use.**
   - Screening identifies only the possibility of a problem and should never be used to make a diagnosis or to label the child or adolescent.
   - Confidentiality must be ensured.

5. **Link to assessment and treatment services.**

   If problems are detected, screening must be followed by notifying parents, adolescents, guardians, or the entity with legal custody; explaining the results; and offering referral for an appropriate, in-depth assessment conducted by trained personnel with linkages to appropriate services and supports.

See Appendix D for a pullout of the *Principles Guiding Screening*.

First and most important: "Do no harm."

The U.S. Preventive Services Task Force is responsible for reviewing the scientific evidence for the use of specific screening tests by physicians as a regular part of preventive care. In making its recommendations, the task force considers the risks and the potential benefits of both the screening tests and the treatments available for the specified condition.*

Screening can benefit children and adolescents whose conditions are accurately identified; however, it also has certain risks. These risks include falsely identifying a youth as having a problem, which is called a *false positive*, or failing to identify a child or adolescent with a problem, which is called a *false negative*. No identification method or screening tool perfectly identifies children and adolescents at risk. Like lab tests and other medical screening tools, any mental health or substance use/abuse screening tool can falsely suggest a problem in one youth yet miss an actual problem in another.

RISK FROM STIGMA AND LABELING

In every community, the lack of social inclusion that often accompanies an individual's mental health and substance use problems has the real potential to harm the youth and family publicly identified with these problems. In settings such as schools, where safeguarding confidentiality can be challenging, child-serving organizations need to carefully plan their identification activities. Even when information is not shared publicly, an organization's approaches and services may change in inappropriate ways when staff learn about a youth's behavioral health problem. Some caregivers fear that if their child or adolescent is identified as having a behavioral health problem, he or she will automatically be put in special education, labeled, and excluded from both social and educational opportunities. These attitudes and perceptions vary among different caregivers.

A child or adolescent who is falsely identified as having a mental health or substance use problem can become socially isolated, and his or her family may feel shame at this identification. In addition, a false positive can cause hardship by requiring the youth to participate in unnecessary services.

What child-serving organizations can do:

- Prepare the organization and the broader community by providing information about mental health, substance use, screening, and treatment. This approach may include educating residents about the mental health and substance use problems that exist in the community and the resources that are needed to address those problems.
- Involve families and community stakeholders in the planning of an early identification initiative so their concerns are identified and addressed.
- Make special efforts to solicit the input and involvement of youths and their families as well as the input of different cultural groups in the local community to learn about their beliefs and attitudes about mental health and substance use.
- Adhere to strict confidentiality rules in the design and implementation of screening initiatives.

* The U.S. Preventive Services Task Force recommends that primary care doctors screen adolescents for major depression when systems are in place for diagnosis, therapy, and follow-up.

PERCEIVED RISK OF MENTIONING SUICIDE

Many people fear that raising a topic such as suicide increases the probability that a youth will attempt suicide. However, a 2005 randomized controlled trial involving more than 2,000 students found that asking about suicide is safe.[39] During the trial, one screening tool that asked about suicidal ideation (thoughts about suicide) and suicidal behavior was administered, and the results were compared with results from the same tool without questions regarding suicide. The tool that addressed suicide did not create any greater distress or depressed feelings among healthy students, students with symptoms of depression or substance abuse, or students who had made a prior suicide attempt than the screening tool that did not address suicide. In fact, the study found that high-risk students who were asked about suicide were less likely to express suicidal thoughts than high-risk students who were not asked about suicide.

What child-serving organizations can do:

- To dispel misconceptions, educate caregivers and staff about the topic of suicide.
- Assure caregivers that appropriate personnel will be promptly available to respond to youths who react negatively to the screen and to youths whose screening results indicate a high risk of suicide.

RISK OF FAILING TO FIND A PROBLEM

If the identification process does not identify a mental health or substance use problem in a child or adolescent who truly has one, the youth may not receive needed help and the problem may escalate. In addition, receiving information that a child or adolescent does *not* have a problem may lead caregivers and child-serving personnel to discount their observations if they see indications that a problem is present or, conversely, prevent them from giving adequate attention to a youth's complaints about such problems.

What child-serving organizations can do:

- Inform staff and caregivers that screening tests are not perfect.
- Encourage staff and caregivers to follow up whenever they are concerned about a child or adolescent.

PERCEIVED AND REAL RISKS OF TREATMENT

Caregivers may have fears about mental health treatment and may resist any efforts to identify mental health problems in their children. They also may express concerns about medication, perhaps because of studies indicating that psychotropic medications for ADHD may be overused and that some antidepressants may increase the risk of suicide in children. Caregivers may have little accurate information about mental health and substance abuse treatment.

What child-serving organizations can do:

- Provide accurate and factual information about mental health and substance abuse treatments for children and adolescents, evidence of the effectiveness of such treatments, and/or references to sources of such information.
- Discuss the procedures for safeguarding parents' rights to consent to screening and follow-up.
- Connect parents, caregivers, and families to other families who can act as peer mentors.

Sometimes the identification of mental health or substance use problems causes youths to be excluded from their social group and cultural communities. Partnerships with representatives from these communities can help identify any potentially negative consequences that could arise from early identification. Such partnerships are invaluable when devising preventive strategies.

Participation in screening should be voluntary.

Informed consent for children and adolescents to participate in a program to identify possible mental health or substance use problems should be obtained from parents, guardians, or the entity with legal custody. In addition, a child or adolescent who is capable of understanding should receive an explanation of what the early identification process is and why it is being done; he or she also should be given the right to refuse to participate. (For samples of how to request parental consent and youth assent, see the forms in Appendix C.)

Parents or guardians are the key decision makers for their child's or adolescent's health.

Parents who have given consent for their child or adolescent to be screened must be informed when the screen indicates a possible problem. Typically, it is the parents' decision as to how they will follow up on referrals for assessment and treatment. In some settings, however, the child welfare department, a juvenile justice department, or the court has custody of the youth. In other cases, a state's laws about mature minors may apply.

Confidentiality requirements for mental health and substance use information must be maintained.

Information about a child's or adolescent's mental health or substance use problems are subject to laws regarding confidentiality of this sensitive information, even if it was not collected by a mental health or substance abuse professional. Early identification results should not be considered part of an organization's regular record, and access to information should be restricted to only those appropriately qualified staff who are assisting parents with following up on results. However, organizations should consider requesting that parents provide written consent to share results with other service providers, such as the child's or adolescent's primary care provider, teachers, or early care and education providers whose contributions can help with assessing the problem.

Employing Sound Methods to Identify Children and Adolescents Who May Have a Mental Health or Substance Use Problem

People who are not mental health or substance abuse professionals can employ two basic methods to identify children and adolescents who may have a mental health or substance use problem:

- Become familiar with signs of mental health and substance use problems.
- Administer a scientifically validated screening tool.

Identification Is *Not* Diagnosis

The goal in identifying children and adolescents with possible mental health or substance use problems is to provide the option for further assessment. Such identification does *not* involve reaching a diagnosis of a particular condition. Only mental health, substance abuse, or medical professionals (as determined by each state's licensing laws) are qualified to make a diagnosis. Neither action signs nor screening tools provide sufficient information to reach a diagnosis.

Become familiar with signs of mental health and substance use problems.

Often, a child's or adolescent's behavior or appearance can provide signs of a mental health or substance use problem. These signs warrant action by caregivers and adults who work with the youth and can reliably identify the indicators so that the problem is assessed further and the child or adolescent has the opportunity to receive appropriate treatment. Materials are available to help educate adults about these signs. (See "Materials That Provide Information on the Signs of a Mental Health or Substance Use Problem" on page 23.)

Signs of some problems—such as depression, bulimia, or early stages of substance use—either may be actively concealed from adults or may not be readily apparent. Research has shown that these types of problems are difficult for caregivers and other adults to identify.[40 41 42] The National Institute of Mental Health and SAMHSA sponsored a research group of scientists and physicians to identify signs that indicate the need to take action and address mental health conditions in children and adolescents. The research group focused on conditions that can cause serious problems but frequently are not identified. It also sought broad input on and tested both the validity of the signs for conditions that warrant taking action and the effectiveness of the educational materials describing these signs. The information about action signs for these often overlooked conditions can be reviewed at *The Action Signs Project: A Toolkit to Help Parents, Educators and Health Professionals Identify Children at Behavioral and Emotional Risk* (http://www.thereachinstitute.org/files/documents/action-signs-toolkit-final.pdf).

Materials That Provide Information on the Signs of a Mental Health or Substance Use Problem

For Infants:

- *What Is Infant Mental Health and Why Is It Important?* (Publication)
  http://www.projectabc-la.org/dl/ABC_InfantMentalHlth_English.pdf

For Children:

- *Mental Illness and the Family: Recognizing Warning Signs and How to Cope* (Web page)
  http://www.nmha.org/go/information/get-info/mi-and-the-family/recognizing-warning-signs-and-how-to-cope

For Teens—Mental Health:

- *Mental, Emotional, and Behavioral Disorders in Teens* (Web page)
  http://www.cumminsbhs.com/teens.htm

For Teens—Substance Use:

- *Warning Signs of Teenage Drug Abuse* (Web page)
  http://parentingteens.about.com/cs/drugsofabuse/a/driug_abuse20.htm
- *General Signs of Alcohol or Drug Use* (Web page)
  http://www.adolescent-substance-abuse.com/signs-drug-use.html

For Suicide Prevention:

- *Risk Factors for Child and Teen Suicide* (Web page)
  http://www.healthyplace.com/depression/children/risk-factors-for-child-and-teen-suicide/menu-id-68/
- *Suicide Warning Signs* (Web page)
  http://store.samhsa.gov/shin/content//SVP11-0126/SVP11-0126.pdf (English)
  http://store.samhsa.gov/shin/content//SVP11-0126SP/SVP11-0126SP.pdf (Spanish)

Administer a scientifically validated screening tool.

The specific questions (items) included in a validated screening tool were tested on a large number of youths and were found to most accurately identify children and adolescents with a high likelihood of having mental health or substance use problems. Because different conditions are prone to arise at different stages of development or manifest differently at different ages, screening tools are designed for specific age ranges. Different tools or versions of a tool have been designed and tested to identify different

conditions and to be answered by different informants. Informants can be physicians, parents or other caregivers, teachers, or other child service providers who are able to observe the youth; the informant also can be the child or adolescent if he or she is able to understand and answer the questions.

A number of studies have shown that such screening tools are better than the interviewing process used by primary care physicians[43 44 45] or a clinical assessment conducted by mental health clinicians[46] at identifying children and adolescents with mental health and substance use problems. The research results for the tested tools indicate the rate and type of problems found in different populations. Screening tools are the best brief method available for personnel who are not mental health or substance abuse professionals to identify children and adolescents at risk of mental health and substance use problems; but, like any medical test, no screening tool is correct all of the time.

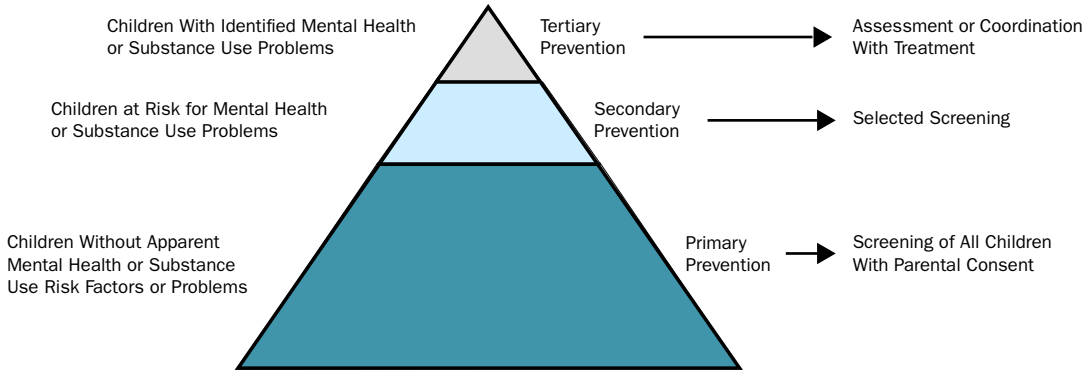
Determining Goals: Populations and Problems of Concern

Before selecting a method of identification, organizations should clearly define the goals they want to achieve through an identification process. This approach includes deciding which children are of most concern and what conditions they are most at risk for. Depending on the goals of identification, different strategies may be needed to best meet the goals for specific populations and settings. This guide is predicated on the assumption that people closest to youths—specifically caregivers, organizations that serve children and adolescents, and the community itself—are best suited to determine what mental health and substance use problems are of most concern and to design the prevention, identification, and intervention approaches best suited to their community.

Think about the needs of the children and adolescents being served.

Figure 2 highlights the concepts used to develop public health programs that may be helpful in selecting an approach appropriate for the goals of a specific identification program.

Figure 2
The Prevention Pyramid: Levels of Risk for Mental Health or Substance Use Problems



Adapted from Walker et al. (1996)[47]

Figure 2 shows the population of all children and adolescents (ages birth to 22 years) divided into three categories by the level of risk for mental health or substance use problems. It also indicates the differing amount of information about children's and adolescents' possible mental health or substance use problems within each level. The top band of the pyramid illustrates the small percentage of children and adolescents known to have mental health or substance use problems and those with indications of a mental health or substance use problem; the middle band illustrates a somewhat larger group of children and adolescents known to have an elevated likelihood of such problems because they are part of a group with known risk factors; and the large bottom band represents the remaining children and adolescents not known to be part of a high-risk group.

Settings such as family or runaway shelters and child welfare programs that serve high-risk children tend to draw disproportionately from the top two bands of the pyramid; consequently, their service population will differ from the proportions illustrated on the pyramid. Schools, early care and education programs, and other programs that serve the general public probably see children from each band in proportions similar to those represented on the pyramid. However, such programs serving a high-risk community will see a greater proportion of higher risk youth.

Three levels of preventive public health approaches

For the three categories of risk, three levels of preventive public health approaches have been developed: tertiary prevention, secondary prevention, and primary prevention. A community may wish to develop or work toward a comprehensive identification program that employs prevention strategies at all three levels. Preventive approaches for each of these risk categories are defined in the following sections. This guide, however, focuses primarily on children and adolescents at high risk for mental health and substance use problems: the two bands at the top of the pyramid.

TERTIARY PREVENTION: ASSESSMENT AND TREATMENT COORDINATION FOR CHILDREN AND ADOLESCENTS WITH IDENTIFIED PROBLEMS

Tertiary prevention is focused on the small percentage of children and adolescents who have known problems or whose behavior indicates they are likely to have mental health or substance use problems. For those youths, screening is not a necessary step. Instead, organizations can focus directly on assessment and treatment services.

For children and adolescents already in treatment, organizations need to be able to coordinate with the specific service providers. Children and adolescents who show signs of a mental health or substance use problem can be referred directly for an assessment. If parents, caregivers, or staff have sufficient indication that a youth has a mental health or substance use problem, they may arrange for an assessment; screening is not required to justify an assessment. When serving a high-risk population, an organization should be proactive by training staff about the types of problems that are most likely to be present and the warning signs of those problems. An organization serving high-risk youths also needs to be aware of signs of a crisis so it can put in place appropriate services to prevent or safely manage a mental health or substance use crisis.

If the majority of children and adolescents in an organization's population are known to have a particular problem—such as substance use among older adolescents involved in the juvenile justice system—the organization may choose to "screen out" versus "screen in" for services. In this case, all teens coming into the program would be referred for a substance use assessment unless they tested negative on a substance use screen.

SECONDARY PREVENTION: SELECTED SCREENING OF AT-RISK CHILDREN AND ADOLESCENTS

Secondary prevention is focused on children and adolescents who are in groups known to have an elevated risk for mental health or substance use problems. Higher risk populations can be identified in a number of ways, and common examples of their attributes are as follows:

- **Behavior or functioning.** Children and adolescents may demonstrate disciplinary problems; declining academic performance; or a marked change in behavior, mood, or functioning. However, some behavior signs are subtle and easily missed.
- **Illnesses or disabilities.** Children and adolescents with certain health problems are at higher risk for depression and other mental health problems. Children and adolescents serving as caretakers for ill or disabled parents or caregivers also are at high risk.
- **Environmental stress.** Children and adolescents living in a community with a high rate of poverty or violence are at increased risk of being identified with problems such as substance use or suicide, as compared to children and adolescents in other communities.
- **High-risk life situations.** Children and adolescents—particularly those who were prenatally exposed to drugs and alcohol—who come to the attention of child welfare systems or who are in homeless or domestic violence shelters are at high risk for mental health and substance use problems. Children or adolescents involved with the juvenile justice system also are associated with a much higher risk of mental health and substance use problems than children and adolescents in the general population.
- **Stressful events.** Stressful events or transitions that are the result of becoming homeless or entering into the child welfare system or juvenile detention involve significant losses and create considerable uncertainty for children and adolescents. Already vulnerable, these youths become even more so. State agencies and programs caring for these children and adolescents not only must safeguard the individual from harming himself or herself but also must ensure that the youth does not harm others. Screening for high-risk conditions as part of the intake process can help these agencies make initial placements and arrangements that are safe for the youth and others. Such screenings also assist in prioritizing assessments by a professional to address ongoing service and placement needs.
- **Traumatic events.** Children and adolescents not otherwise at risk may be exposed to an incident of violence or a natural disaster that warrants an effort to identify those who need assistance.

- **Age groups.** Certain ages or developmental stages might be prioritized for identification because of the high value of identifying problems or the low likelihood that problems will be identified elsewhere. For example, screening preschool children presents an early opportunity for intervention and has great value in preventing a problem or minimizing its impact on the child's future school performance and overall functioning. Screening teens in high school—a time when they no longer may see a primary care physician on a regular basis—has the potential to identify problems less likely to be identified elsewhere. Natural but stressful events associated with specific ages, such as the transition from elementary to middle school, also present potentially useful points of intervention.
- **Sexual orientation.** Children and adolescents questioning their sexual orientation or gender identity and those who identify as gay, lesbian, bisexual, transgender, queer, intersex, or two-spirit may have an elevated risk of mental health and substance use problems.

The best method for a worker who is not a mental health or substance abuse professional to quickly identify children and adolescents with likely mental health and substance use problems is to use an appropriate and well-tested screening tool that includes items identifying high-risk conditions.

Before administering a screen, an organization needs to be prepared to respond appropriately to children and adolescents in crisis and to those who have serious and complex conditions. Organizations serving high-risk groups also must be prepared to identify a higher percentage of children and adolescents needing assessment and treatment than would be identified in the general population.

PRIMARY PREVENTION: GROUPS WITHOUT KNOWN RISK FACTORS

Primary prevention seeks to identify children and adolescents with no known risk factors for a particular health condition. In public health, this approach is described as universal screening. Screening all children for vision and hearing problems when they first enter school is an example of universal screening. Because this guide is focused on the identification of children and adolescents at high risk, it places less emphasis on the primary prevention approach. In addition, because this guide recommends screening only children and adolescents whose parents have given consent, it avoids using the public-health term universal screening.

Nonetheless, organizations serving a population without significant environmental risk factors may find the principles of primary prevention relevant to developing identification goals and processes. For example, primary prevention is applicable to pediatric primary care. It also applies to any identification initiative where the group to be screened has not been selected because of risk factors or because it shows indications of problems.

Conduct periodic surveillance.

Ideally, both selected screening and primary prevention approaches are repeated periodically. There are two reasons for conducting periodic screenings. First, a screen is a point-in-time snapshot of a child's or adolescent's emotional condition. A few months later, the screen can no longer be relied upon as an accurate indication of the youth's current condition. Second, there is value in screening periodically throughout childhood because children and adolescents are at risk for different mental health and substance use problems at different ages and certain stresses or traumas can trigger previously nonexistent conditions. For example, the American Academy of Pediatrics (AAP) and other primary care organizations recommend that screening for age-appropriate mental health and substance use problems should be included as an integral part of well-child care. AAP has developed a periodicity schedule based on the stages of development.[48] Similarly, an organization might consider screening children and adolescents at different ages for conditions applicable to their age group. Figure 3 indicates commonly arising conditions for various age groups of children and adolescents.

Figure 3
Commonly Arising Conditions at Various Ages

For These Ages	Most Commonly Arising Conditions
Young Children Birth to Age 5 	• Autism • Developmental delays • Hyperactivity • Oppositionality • Parental attachment problem • Pervasive developmental disabilities • Separation anxiety • Trauma from neglect • Trauma from physical or sexual abuse
School-Age Children Ages 6 to 12 	• ADHD • Depression and other mood disorders • Oppositionality • Separation anxiety • Suicide • Trauma from neglect • Trauma from physical or sexual abuse • Use of substances
Adolescents Ages 13 to 22 	• Anxiety • Conduct problems • Depression and other mood disorders • Eating disorders • Psychosis • Substance abuse disorders • Suicide • Trauma from neglect • Trauma from physical or sexual abuse

Selecting an Identification Method

After defining the goals for early identification, an organization must select an appropriate and valid screening tool for identifying the problems of concern. In creating this guide, researchers from the Columbia University Center for the Advancement of Children's Mental Health and the University of Minnesota reviewed the available screening tools and identified those that exhibited the strongest scientific evidence of usefulness. At the end of this chapter, the guide provides a short list of the tools most likely to be of use in several settings (see the two matrices on pages 39–40). All these tools can be administered by people who are not trained as mental health or substance abuse professionals. However, staff need to be trained to administer these tools, and mental health or substance abuse professionals need to be available to follow up on results.

The following questions can help organizations determine which screening tools have the features that meet their needs.

What are the ages of the children and adolescents being served?

As Figure 3 indicates, different conditions are most likely to appear at different ages and manifest themselves in different ways, depending on the age of the youth. For younger children, parents or caregivers may need to answer questions on the screening tool. Older children and adolescents also can answer the questions if they assent to do so. The selected tool should be appropriate for the age of the child or adolescent who completes it.

What kinds of problems are being identified, and how will the information be used?

Is there a concern about a high-risk condition that needs immediate intervention? Is information needed to help make a decision about where to place a youth who cannot remain at home? Is a court making a legal decision about custody or juvenile justice status? Is a custodial agency making a decision about placement? Is the screening part of a periodic surveillance of health status? Is there a concern about identifying particular kinds of problems (internalized problems that are not readily apparent or a substance use problem)? Are co-occurring problems a potential issue?

The selected tool should have proven ability to accurately identify the conditions of greatest concern.

What level of validity and reliability is needed?

Although tools on the short list (pages 39–40) have favorable psychometric properties, they may differ in the dimensions of validity, reliability, sensitivity, and specificity. (See "Psychometric Properties of a Screening Tool" at right.)

Because all the tools identified in this guide have acceptable levels of validity and reliability, perhaps the most useful dimensions to consider when selecting among them are their sensitivity and specificity.

- Selecting a tool with high *sensitivity* is warranted if the highest priority is to identify all children and adolescents who have a mental health or substance use problem.
- Selecting a tool with high *specificity* is warranted if the highest priority is to avoid falsely identifying children and adolescents who do not have the conditions for which they are being screened.

Psychometric Properties of a Screening Tool

- **Validity** describes *what* the tool measures and *how well* it does so. This term refers to the screening tool's accuracy in identifying children and adolescents with and without the condition of interest.
- **Reliability** is a measure of the consistency in scores for the same youth by different raters using the same tool.
- **Sensitivity** is a measure of the percentage of children and adolescents who actually have the condition of concern and are correctly identified by the screening tool as having the condition.
- **Specificity** is a measure of the percentage of children and adolescents who do *not* have the condition of concern and are correctly identified by the screening tool as *not* having the condition.

Who will complete the screen?

Parents and caregivers have been found to be more accurate informants for adolescents' *externalizing problems* (such as substance use and oppositional behavior), while adolescents themselves more accurately identify *internalizing problems* (such as depression and anxiety).

The caregivers of children and adolescents coming into foster care or the juvenile justice system may not be available to answer questions, while a new foster parent typically has limited information about the youth. The selected tool should make the best use of the available informants. If the available informant does not know the youth well, less reliance should be placed on the results of the screen. Alternatively, if the situation is high risk, the youth can be sent directly for an assessment with a qualified professional. If the situation is not high risk, the screen can be postponed until a better informant is available.

How much time is available to administer and score a screen?

By definition, screening tools are fairly brief, requiring about 5–15 minutes for administration. The selected tool should fit well with the operations of the organization. For example, some schools screen all their students at one time while others screen small groups throughout the year.

In addition to the time required to administer the screening tool, time is needed for the answers to be reviewed and the screen scored. Afterward, children and adolescents whose screens are positive for mental health and/or substance use problems must be followed up. Some tools identify high-risk conditions (such as risk for suicide or serious depression), and organizations that identify such conditions need to be able to follow up immediately.

How much does the tool cost?

Some of the tools included in the short list are in the public domain and are free; others have a nominal cost.

What staff, equipment, and materials are available to administer the tool?

Some tools are computer based while others may be administered verbally or with paper and pencil. Organizations must provide an appropriate degree of privacy so that screening results do not become public. For example, a computer-based screening must be conducted where no one can see the information on the monitor; also, the entered information must be protected to ensure that only authorized personnel have access to it. The privacy of parents or caregivers also must be ensured when they are asked and answer questions that are not age-appropriate for the child or adolescent accompanying them. Similarly, when completing screening tools, adolescents should have privacy from their parents.

What kind of personnel will administer the tool?

If staff who are not mental health or substance abuse professionals administer the tool, they should be trained to instruct informants accurately, clarify the questions included in the tool, answer any questions about how the tool will be used, and observe appropriate boundaries with respect to safeguarding confidentiality and privacy.

Can tools be combined?

It is possible to administer more than one tool to provide a more comprehensive screening program. For example, both a substance use/abuse screening tool and a mental health screening tool can be administered. This combined approach is a valid means of obtaining information. However, it is not valid to combine parts of different tools into one screen or omit items from a tool. Each tool is developed as a unit consisting of a number of items that—when used together—have demonstrated properties of validity and reliability. When individual items are used, however, the ability of the new tool to identify potential problems is unknown.

Are children and adolescents who may have experienced trauma being screened?

A number of screening tools focus on psychological trauma. Most elicit information on the nature of a traumatic event and symptoms related to posttraumatic stress. Some are specific to a particular kind of trauma, such as a natural disaster or a specific kind of abuse. Many of these tools have not been well tested for validity and reliability.

Children and adolescents may react to traumatic stress in a variety of ways, experiencing not only symptoms of posttraumatic stress but also conditions such as depression and behavioral problems. Although a relevant trauma-screening tool may be a useful part of an effort to identify mental health problems stemming from trauma, the use of a tool such as one of the broad-based mental health screening tools included in this guide is needed to ensure that all the possible effects of psychological trauma are identified. This type of tool also provides the advantage of identifying problems that may not necessarily be related to psychological trauma.

How can a screening tool that focuses on problems be used in a strengths-based framework?

Screening tools generally focus on indications of problems. However, it is imperative that organizations use such tools thoughtfully in a strengths-based and social-inclusion context. Partnering with a family advocacy or youth advocacy organization can help in planning and implementing a family-friendly or youth-friendly approach. Introducing the screening initiative can present an opportunity to provide information about mental health and substance use problems and the value and nature of intervention and treatment, which helps frame the discussion in a strengths-based context. Ideally, organizations will use a staff member who is a trained mental health or substance abuse professional (or will partner with an organization that has such a person on staff) to communicate positive test results to older children, adolescents, and caregivers. That person can review records or speak to the teachers or caregivers to identify the youth's strengths and potential. A positive screen does not constitute a diagnosis, so language that suggests a diagnosis or a label should never be used.

Another part of a strengths-based framework is to respect the chosen response of the caregiver, child, or adolescent to the screening tool's results. Some identified youths will be in treatment already, but the family has no obligation to share that information. Families may wish to pursue remedies that are traditional in their culture rather than follow up on a referral. Staff in child-serving organizations also should remember that a small number of the children and adolescents with a positive screen do not, in fact, have a mental health or substance use problem.

Considering the Cultures and Languages of the Groups Being Screened

Are culturally and linguistically diverse populations being served?

Use of tools developed and tested primarily on an English-speaking population from the mainstream culture introduces a number of important considerations related to the linguistic and cultural appropriateness of the tool and interpretation of results. Organizations should be aware that the predictive effectiveness of available tools and their accuracy in screening cross-cultural populations has not been fully researched.[49] Lack of research on the cultural appropriateness of the tools requires special attention regarding how to make these tools meaningful for people of different cultures and for those who speak diverse languages. Such attention is especially important because of the significant variation across cultural beliefs and practices in what is considered normal development and developmentally appropriate parenting.[50] Variation may be most significant for preschool and younger children.

What degree of literacy and fluency in English do the respondents have?

Some tools have translations, and some have been tested for a range of literacy levels. However, even when translations are available, organizations may need to determine if a tool effectively communicates concepts to the specific population being served. For example, Mexican and Puerto Rican Spanish differ in the meaning of certain expressions. Translations have not always been tested across the broad range of U.S. immigrants to determine linguistic equivalence with the language spoken in the countries of origin. Therefore, it is necessary to determine whether the available translation is easily understood by the participating children, adolescents, caregivers, families, and other informants.

In addition, data showing the linguistic validity of the translated tool can be used to establish norms for comparable populations served by an organization. This approach provides a baseline for what is expected, on average, from clients from specific populations. Testing with non-English-speaking populations is quite limited so far. Because the developers of the selected tool may have information that has not yet been published about the use of the tool in translation or about results from a similar population, those individuals or organizations should be contacted to help find an appropriate translation.

What are the cultural beliefs and values of the service population regarding normal development, mental health, and substance use?

Cultural differences in child-raising customs and in what is considered normal development may show up as problems if the screening tool has not been normed for or informed by such variations. The tool may be consistently misunderstood by the population being served, or it may fail to distinguish the children and adolescents with problems from those who are developing normally. Different cultural groups should be

consulted and asked to identify areas where misunderstandings may occur. If necessary, another tool may be selected, or the existing tool may be modified by rewording a question or weighting certain responses differently than prescribed.

Because changes to the screening tool or the interpretation of the results may affect the tool's validity, it is advisable to consult with the tool's developers before making final changes. Tool developers may have worked with other organizations on tool modifications, or they may have recent research results that have not been published. At the very least, the developers can provide insight into how the proposed changes may affect the screening results.

What are the limitations of using a screening tool that has not been fully tested with a particular cultural group?

If a tool's predictive effectiveness has not been fully researched for an organization's target population, the organization should keep in mind that the findings may not be as reliable as the findings for children and adolescents from populations on which it has been validated. Even when language is not a concern, the organization should select a tool that is seen to be acceptable, useful, and in accordance with a specific community's values and expectations in regard to child raising, mental health, or the use of substances.

Few screening tools, however, are designed for and tested on a variety of groups that differ culturally and linguistically from the majority of the population. As a result, feedback from members of such groups is needed to help assess whether proposed screening tools will be clearly understood and to identify any screening items that will not be able to predict targeted problems in that particular culture.

The knowledge and understanding of cultural values acquired during this process must inform the interpretation of screening results. The person administering the screens must be aware that cultural differences in child rearing may result in very different interpretations of a child's behavior. Items that may be misinterpreted or that can carry a different meaning in a specific culture should be given less weight, and the overall score should be considered less accurate. Ideally, an organization will work with its cross-cultural staff and representatives from the different cultural groups it serves to identify such issues, select tools that minimize those issues, and help other workers understand the nature of the cultural differences. Training to help staff members who administer the screens to discuss potential cultural issues with the family also would be of value. If the screen becomes part of a permanent record used by agencies other than the one conducting the screen, the agency needs to develop procedures for documenting the presence of cross-cultural issues so that other personnel are able to appropriately consider the results.

Nonetheless, using a screening tool with a group for which it is not fully tested can provide an opportunity to open a dialogue with caregivers to develop an understanding of how they interpret the youth's behavior and development in the context of their culture. The following resources are available for a more detailed discussion of culturally and linguistically appropriate screening tools that have been studied.

Resources on Cultural and Linguistic Competency

- *Care for Diverse Populations* (Web page)
  http://www.molinamedicare.com/providers/ (see bottom of Web page)
- Center for Health and Health Care in Schools: *Caring Across Communities: Addressing the Mental Health Needs of Refugees and Immigrants* (Web page)
  http://www.healthinschools.org/Immigrant-and-Refugee-Children/Caring-Across-Communities.aspx
- Culturally and Linguistically Appropriate Services: *Review Guidelines* (Web page)
  http://clas.uiuc.edu/review/index.html
- Indian Health Service (Web site)
  http://www.ihs.gov
- National Center for Cultural Competence: *Child and Adolescent Mental Health Project* (Web page)
  http://www11.georgetown.edu/research/gucchd/nccc/projects/camh.html
- National Network to Eliminate Disparities: *Resources* (Web page)
  http://nned.net/index-nned.php/resources/
- *Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs* (Publication)
  http://www.rwjf.org/files/research/3320.32211.0508issuebriefno.1.pdf
- Technical Assistance Partnership for Child and Family Mental Health: *Cultural and Linguistic Competence Community of Practice* (Web page)
  http://www.tapartnership.org/COP/CLC/default.php

A Short List of Mental Health and Substance Use/Abuse Screening Tools for Children and Adolescents

Tables 1 and 2 summarize the key characteristics of several screening tools identified by experts as meeting best practice criteria for identifying children and adolescents with a high likelihood of having a significant mental health or substance use problem. (See "Best Practice Criteria Used in Determining Which Screening Tools to Include in the Matrices" on page 38.) In addition, the information in these tables details whether the tool has been studied in one or more of the child-serving settings mentioned in this guide.

Description of the selected tools

TABLE 1: MATRIX OF MENTAL HEALTH AND COMBINED SCREENING TOOLS

This table (page 39) provides tools identifying conditions that include symptoms of psychopathology, social and emotional problems, and pervasive developmental disabilities. Some tools also address substance use problems.

TABLE 2: MATRIX OF SUBSTANCE USE/ABUSE SCREENING TOOLS

This table (page 40) provides tools that identify alcohol use and drug involvement, but the identified conditions are not specific to any diagnostic label or related consequences. Although nicotine was not included as a substance of focus, many substance use/abuse tools include items that elicit information about nicotine use. This information may be useful because the risk of disclosing nicotine use is not as great as disclosing other drug use. Further, early nicotine use is a risk factor for other drug use.[51]

Information on how the tools were selected

Tool selection was based on a comprehensive review of research that showed each tool's effectiveness in the early identification of mental health and substance use problems in children and adolescents. All tools have acceptable levels of validity and reliability and are suitable for administration by a wide range of child-serving staff. Although these tools can be valuable in mental health or substance abuse treatment settings, the list is not intended to include all tools that behavioral health professionals might appropriately employ. In addition, this listing of non-Federal resources does not constitute an endorsement by SAMHSA or HHS.

PRACTICAL CONSIDERATIONS

Researchers selected tools that met the following criteria concerning the feasibility and appropriateness for use in the settings addressed by this guide:

- The tools are brief enough to be used for screening purposes (as opposed to assessment);
- The tools can be administered, scored, and interpreted by child-serving staff with a broad range of experience and training (i.e., not necessarily a trained professional in mental health or substance abuse); and
- The tools do not result in a presumptive diagnosis.

EXCLUSIONS

The following types of tools were specifically excluded: intelligence tests; personality inventories; and tools addressing cognition, learning, and language or motor development.

Using the matrices to choose an appropriate tool

Tables 1 and 2 enable child-serving organizations to easily compare the key characteristics of each screening tool. Such comparisons are helpful when an organization needs to select one or more tools to use for a specific purpose, in a specific setting, or with a specific population. Staff should take the following steps:

1. Review the matrices to determine which tools have the characteristics needed to reach the goals set for the screening initiative. These attributes include:
   - Target conditions
   - High-risk items included
   - Informant or applicable age groups
   - Tool format
   - Usual administration time
   - Reading level required
   - Translations available
   - Settings where tool has been studied
   - Cost
2. Use the information on the specific settings where a tool has been researched to help identify relevant tools. Many tools have been used successfully in a variety of settings. All the tools from the short list are valid and reliable and may be well suited to a particular identification goal, even if specific research documenting their use in particular settings is not available. A review of each specific tool and its method of administration should provide a good sense of its feasibility and appropriateness for use in different settings.
3. After the tools with the necessary characteristics have been identified, find additional information by referring to the page references in the bottom row of each table. Those page numbers indicate where information is located in Appendix B of the guide. Appendix B includes more detailed descriptions of the tools and provides references and information on each tool's measures of validity, reliability, sensitivity, and specificity.

Additional resources for information on screening tools

A full compendium of screening and assessment tools for substance abuse disorders is maintained by the Alcohol and Drug Abuse Institute at the University of Washington (http://lib.adai.washington.edu/instruments). Users can select desired attributes, and the institute's search engine will identify available evidence-based screening tools with those attributes and psychometric properties that have been vetted by one or more professional organizations.

Best Practice Criteria Used in Determining Which Screening Tools to Include in the Matrices

Essential Criteria

1. The tool is developed for a specific age group, addresses a broad range of age-appropriate behavioral health conditions, and uses informants (children, caregivers, teachers, or child workers) proven to be accurate for the age and targeted condition.
2. The tool was psychometrically evaluated on the target age group for which the tool was intended.
3. The tool is psychometrically sound (has acceptable validity, reliability, sensitivity, and specificity), as indicated by a manual or detailed journal article providing relevant data.
4. The language and cultural groups on which psychometric results have been tested are specified.
5. The tool is feasible in one or more of the specified child-serving settings, as indicated by its being employed by personnel working within the specified setting for screening purposes (rather than being used by research personnel hired through a research grant).
6. The tool is accompanied by detailed administration guidelines to ensure that it is used appropriately.
7. The tool is accompanied by scoring and interpretation guidelines that describe the scoring procedures. Ideally, guidelines for the clinical decision (e.g., immediate referral for assessment, routine referral for assessment, monitoring, no action needed) are included.
8. If the tool identifies high-risk conditions, it provides an indication of whether a follow-up assessment is needed on an urgent basis.

Cultural and Linguistic Appropriateness

The following criterion was judged to be desirable; but, had it been applied, most tools would have been excluded.

The tool is appropriately adapted to different cultures by testing concepts of mental illness, mental health, and substance use that are congruent with the culture and by expressing the concepts using culturally and linguistically appropriate phrasing.

Table 1. Matrix of Mental Health and Combined Screening Tools

Tool Characteristics	Ages & Stages Questionnaires: Social-Emotional (ASQ-SE)	Brief Infant-Toddler Social and Emotional Assessment (BITSEA)	DISC Predictive Scales (DPS)	Global Appraisal of Individual Needs–Short Screener (GAIN-SS)	Massachusetts Youth Screening Inventory, 2nd Edition (MAYSI-2)	Pediatric Symptom Checklist (PSC-35)	Strengths and Difficulties Questionnaire (SDQ)
Target Conditions	Personal-social (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people)	Social and emotional development, strengths, and areas of concern or risks	Most *DSM-IV* mental health diagnoses and substance abuse diagnoses, degree of impairment	Internalized or externalized psychiatric disorders, substance abuse disorders, and crime or violence problems	Urgent mental health problems in need of immediate attention; screening performed upon admission to juvenile justice facility	Psychosocial risk	Psychosocial risk (adjustment, psychopathology, chronicity, distress, social impairment)
High-Risk Items* Included	No	No	Yes	Yes—Suicide, substance use, psychiatric disorders, crime or violence problems, and others	Yes—Alcohol or drug use, anger or irritability, depression, anxiety, suicide ideation, and others	No	No
Informants or Youth Age Range	Parent of child ages 1 month to 5½ years	Parent of child ages 12–35 months; early care or education provider of child ages 12–35 months	Youth ages 9–17 years	Adolescent ages 12 years or older	Youth ages 12–17 years	Parent of youth ages 3–16 years; youth ages 11–16 years	Parent or preschool teacher of child ages 3–4 years; parent or teacher of youth ages 5–10 years; parent or teacher of youth ages 11–17 years; youth ages: 11–17 years
Format (Self-administered unless stated otherwise)	Paper & pencil, computer	Paper & pencil	Computer & headphones	Paper & pencil, computer, web	Paper & pencil, computer	Paper & pencil	Paper & pencil
Usual Administration Time	10–15 minutes	7–10 minutes	10 minutes	5 minutes	10–15 minutes	5–10 minutes	5–10 minutes
Reading Level Required	4th–6th grade	6th grade	Not specified	8th grade	5th grade	5th–6th grade	Not specified
Translations	Spanish	Chinese, Dutch, French, German, Gujarati, Hebrew, Italian, Russian, Spanish, and Thai	Spanish	Spanish	Spanish	Parent version in 13 other languages; youth version; in 3 other languages	67 other languages
Settings Where Tool Has Been Studied (*Note:* Tools may have been used successfully in settings where they have not yet been researched.)							
Primary Care	X		X			X	X
Schools			X			X	X
Early Care	X	X					
Child Welfare				X			X
Juvenile Justice			X	X	X		X
Shelters							X
Mental Health Treatment				X			X
Substance Abuse Treatment				X			
Cost	$249.95 for Third Edition Starter Kit (includes questionnaires and scoring sheets, *Quick Start Guide,* online management, and online questionnaire completion)	$108.60 for manual and 25 parent and 25 early care and education provider forms	Cost varies; can be provided free of charge	$100 for license fee allowing unlimited administrations	$85 for manual, instrument, and unlimited scoring forms; $194.95 for computer CD and manual	Free	Free
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* High-risk items are those that identify acute mental health or substance use conditions warranting a prompt response. Examples of such conditions are suicidal thoughts, plans for self-harm, or abuse of substances. Specific high-risk items are listed for some tools.

Table 2. Matrix of Substance Use/Abuse Screening Tools

	Alcohol Use/Abuse Screening Tools			Drug Use/ Abuse Screening Tools	Substance Use/Abuse Screening Tools for Adolescents			
Tool Characteristics	**Adolescent Drinking Index (ADI)**	**Adolescent Obsessive-Compulsive Drinking Scale (A-OCDS)**	**Rutgers Alcohol Problem Index (RAPI)**	**Drug Abuse Screening Test–Adolescents (DAST-A)**	**Adolescent Alcohol and Drug Involvement Scale (AADIS)**	**Assessment of Substance Misuse in Adolescence (ASMA)**	**CRAFFT**	**Personal Experience Screening Questionnaire (PESQ)**
Target Conditions	Alcohol use problem severity	Craving and problem drinking; differentiates drinkers from experimenters or abusers	Alcohol use problem severity	Drug use problem severity	Alcohol and drug use problem severity	Drug use problem severity	Alcohol and drug use problem severity	Chemical dependency, psychosocial problems, and faking
High-Risk Items* Included	Yes	Yes	Yes	Yes—Includes drug-related risks, such as blackouts, withdrawal, and illegal activities	Yes	Yes	Yes—Also includes driving with a driver who has been drinking or is high	Yes—Drug use and certain psychosocial challenges
Informants or Youth Age Range	Youth ages 12–17 years	Youth ages 14–20 years	Adolescents	Adolescents	Youth ages 14–20 years	Adolescents	Adolescents	Youth ages 12–18 years
Format (Self-administered unless stated otherwise)	Paper & pencil, (group or individual)	Paper & pencil	Paper & pencil or interview	Paper & pencil	Paper & pencil or structured interview	Paper & pencil	Interview	Paper & pencil
Usual Administration Time	5 minutes	5–10 minutes	10 minutes	5 minutes	5 minutes	5 minutes	5 minutes	10 minutes
Reading Level Required	5th grade	5th grade†	6th–7th grade	6th grade	Not specified	Not specified	Appropriate for youth with poor reading skills	4th grade
Translations				Adult Spanish version could be easily adapted by a bilingual provider			English version could be easily adapted by a bilingual provider	French, Spanish, and Portugese; English version adapted for Alaskans and Native Americans
Settings Where Tool Has Been Studied (*Note:* Tools may have been used successfully in settings where they have not yet been researched.)								
Primary Care						X	X	
Schools	X		X (College)			X		X
Early Care								
Child Welfare								
Juvenile Justice					X		X	X
Shelters			X	X				
Mental Health Treatment	X							
Substance Abuse Treatment	X	X	X	X	X	X	X	X
Cost	$100 for manual and 25 test booklets	Free	Free	Free or nominal cost	Free	Free	Free	$60 for manual; $43 for 25 forms; $99 for a kit that includes the manual and 25 forms
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* High-risk items are those that identify acute mental health or substance use conditions warranting a prompt response. Examples of such conditions are suicidal thoughts, plans for self-harm, or abuse of substances. Specific high-risk items are listed for some tools.

† As indicated in Deas, Roberts, Randall, and Anton (2001).[52]

Chapter 3

Key Steps of Early Identification

Obtaining Informed Parental Consent

A child-serving organization must have in place clearly written procedures that comply with a state's legal requirements for requesting consent and notifying legal guardians or adolescents of the results of early identification activities. These procedures should identify specific circumstances in which the information will be shared with other service providers. In health care settings, these procedures can be combined with existing confidentiality procedures and agreements. In other settings, these procedures can be integrated into existing intake processes but they should have their own dedicated confidentiality agreements.

After obtaining a clear understanding of the identification process, determining goals, and selecting tools (as described in Chapter 2), a child-serving organization should consider the following factors when implementing key steps of the early identification process:

If the legal guardian is to be the informant, getting parental consent is straightforward. The person administering the screen needs to:

- Explain that the tool can help identify if the child or adolescent has a social or emotional challenge;
- Inform the legal guardians that if such a challenge is identified, they will be assisted in following up on the information;
- Explain confidentiality;
- Let caregivers know that they are not required to complete the tool or answer any question they find objectionable; and

- Encourage legal guardians to ask questions and express concerns about their child's social and emotional development.

If the legal guardian will not be present when the screening tool is administered, the organization needs to obtain written, informed consent from the legal guardian. (See the sample parent letter and consent form in Appendix C.) The following steps have been found to be helpful in answering legal guardians' questions and addressing their concerns:

- Provide information about the tool, the process, and follow-up assistance;
- Provide a contact name for someone who can answer questions; and
- Make a copy of the screening tool available to the legal guardians. This approach often puts parental concerns about the process to rest.

SAMHSA recommends that organizations require *active consent,* which means that a child or adolescent is not screened unless the legal guardian has signed a consent form and returned it to the organization. SAMHSA advises against using *passive consent,* in which parents are informed of the early identification program and unless they indicate that they want to opt their child out of the program, the child will be screened. Blanket consents given for school activities or health programs should not be used as a substitute for a signed parental consent form to administer a mental health or substance use/abuse screening tool.

Emergency situations

In emergency situations involving mental health or substance use problems, a youth's identification, assessment, and treatment may take place without obtaining parental consent. However, consent should be obtained as soon as possible during or after a screening.

Communicating with families from other cultural and linguistic groups

Although communicating clearly about children's and adolescents' mental health and substance use is challenging within a community that has shared cultural values, it is even more challenging to discuss these topics with populations who are linguistically and culturally diverse. Not only should programs find staff or volunteers with the necessary language skills, but the designated communicators need to understand the diverse cultural values and vocabulary regarding mental health and substance use. Program staff and volunteers must be able to convey respect—such as knowing who in the family is able to speak for the family—and avoid unintentional disrespect. Clearly, the more often an organization has initiated conversations with the communities it serves, provided information about children's and adolescents' mental health and substance use problems, and learned the preferred terminology and values of each culture, the better prepared it will be to request consent for an identification effort.

Mature minors and young adults

Some adolescents will choose not to participate in mental health or substance abuse treatment if their caregivers are informed.[53] For this reason, many states have developed doctrines allowing mature minors* to obtain treatment without parental consent in certain circumstances. Most states allow mature minors to consent to substance abuse treatment, and many states allow them to consent to mental health treatment. However, because prescription drugs generally are not covered by the mature minor laws, their use would require parental consent. Youths who either are recognized as emancipated minors† or are considered to be young adults (because they have reached the age of majority‡) must provide consent for themselves. In these cases, parents should not be contacted without the written permission of the youth. However, child-serving organizations should make every effort to gain permission to share early identification results with caregivers if a referral for further evaluation is recommended. Because the laws and practices vary by state, programs must be familiar with their own state's laws and practices. The following information may be of value in locating each state's laws.

Resources on State Laws

Center for Adolescent Health and the Law

- Web site
  http://www.cahl.org
- *Policy Compendium on Confidential Health Services for Adolescents* (Publication)
  http://www.cahl.org/web/policy-compendium-2005/
- *State Minor Consent Laws: A Summary* (3rd Edition) (Publication)
  http://www.cahl.org/web/index.php/state-minor-consent-laws-a-summary-third-edition

Legal Information Institute

- *Emancipation of Minors* (Web page)
  http://www.law.cornell.edu/wex/emancipation_of_minors
- *Emancipation of Minors: Laws* (Web page)
  http://www.law.cornell.edu/wex/table_emancipation

* *Mature minor* is defined differently in different states, but the mature minor doctrine is most consistently applied to situations where a teen is at least 16, understands the medical service or procedure for which consent is needed, and the procedure is not serious.[54]

† An *emancipated minor* is a child (under age 18) who has been granted the status of adulthood by a court order or other formal arrangement. Emancipated minors usually must be able to support themselves financially.

‡ *Age of majority* is defined as the age in which a child is legally considered to reach adulthood (age of majority) and to be responsible for his or her actions; in many states, the age of majority is age 18.[55]

Obtaining the Assent of Children and Adolescents

Although most minors cannot provide legal consent, a child-serving organization should seek informed assent from a child or adolescent who is asked to complete a screen. *Assent* is the willing agreement to participate in an activity for which the purpose and process has been explained and any alternatives have been discussed. In addition to being the right thing to do, assent is a practical necessity when the informant's willingness to participate openly is critical to obtaining useful results. In many cases, it may be advisable to document a child's and adolescent's informed assent with a signed assent form. (See the sample youth assent form in Appendix C.) A child or an adolescent who has communicated unwillingness to participate is allowed to refuse to participate even when his or her legal guardians have given formal consent.

Sizing an Early Identification Program: Estimating the Number of Children and Adolescents Who Will Be Identified With Likely Problems

Using a validated screening tool for early identification enables a child-serving organization to estimate the number of children and adolescents likely to be identified, based on the norms of a similar population served by the organization. These estimates are used to plan an early identification process where the type and number of resources needed to follow up on positive screens is anticipated. For example, if a screening tool is known to identify between 5 percent and 8 percent of children from a general population, a school with ample resources might choose to screen a class of 500 at one time, generating between 25 and 40 positive results. In contrast, a school in an area with limited treatment resources could have the school nurse screen two homerooms per month during the 9-month school year, generating three to four referrals per month. Organizations serving higher need populations must be prepared for much higher identification rates.

Ensuring Confidentiality

Regardless of how or where a screen is administered and the results stored, confidentiality must be ensured:

- A screen that is conducted orally should take place in a private setting where questions and responses cannot be overheard.
- A screen that is completed on paper must be handled, shared, and filed as a confidential health record and should not become part of an organization's regular files.
- Screening results in some settings may be accessed only by authorized individuals who are assigned an identification code.
- Procedures should not implicitly indicate the results of a screen. For example, when in a public setting, children and adolescents who have positive screens should not be sent to a different location than those with negative screens.

Administering the Screen

Screening questions are personal in nature and may address sensitive issues. Staff who explain, seek consent, and conduct the screen should be courteous, respectful, and warm. They also should administer the screens exactly as written.

STANDARD PROTOCOL FOR SCREEN ADMINISTRATION:

- A screen should not be altered or combined with another instrument. Only expert evaluators should change a measurement instrument.
- A screen should be used in its entirety or not at all.
- A screen's wording and the order of items should be retained as written. Changing the items in any way can destroy the measure's integrity.

EXCEPTIONS:

- If an informant is uncomfortable answering a question, he or she should be allowed to skip it.
- If, after conducting an investigation, an organization fails to find a tool that is linguistically and culturally appropriate, staff should consider consulting with a tool developer to modify a tool or develop alternative strategies for identification. Any such changes, however, will make the tool's results less accurate; consequently, information should be sought as to how to account for the effect of the changes.

Responding to Screening Results

This guide provides information on screening tools with instructions for scoring the screens and interpreting the results by individuals who are not professionals in the mental health, substance use, or medical fields. Whenever possible, nevertheless, a mental health, substance abuse, or medical professional should be present to help interpret screening results and prioritize any necessary referrals. If such a professional is not on-site, arrangements should be made to have one available to provide guidance on how to appropriately respond when a screen indicates a possible critical problem that requires prompt attention.

In addition, a professional can meet briefly with a child or adolescent in a private and confidential setting to help interpret scores that fall on the boundary between positive and negative. The professional can provide support and guidance for next steps. Such meetings also can help to assess the urgency of following up on any responses that identify a high likelihood of a mental health or substance use problem. In addition, some children and adolescents may have questions or concerns about participating in a screen; they should have an opportunity to air these concerns in a private setting—even if their screening result is negative.

For larger scale identification processes, partnerships with volunteer clinicians and schools of professional studies can provide the necessary clinical coverage, which may require considerable prior planning and collaboration.

Communicating Results to Caregivers

Communicating concerns about warning signs or positive screening results to caregivers is imperative unless adolescents are exercising their rights as mature minors or young adults. Because caregivers must consent to assessment and treatment of their child or adolescent and decide how to follow up, they should be contacted promptly by telephone or in person by the individuals trained to discuss children's and adolescents' mental health and substance use problems. Only the warning signs and an explanation of what the screen can determine should be discussed. Neither a diagnosis nor a specific condition should be identified. In addition to informing the caregivers at this time, an organization should offer resources for assessment as well as assistance in making needed arrangements.

Communicating with caregivers who speak languages other than English or who are part of a different cultural group requires special skills. These skills may include speaking the family's language, identifying who in the family is the appropriate spokesperson, and conveying information accurately using language and terminology that is understood. Good resources for helping staff communicate with families are available under "Care for Diverse Populations" at Molina Medicare Providers (http://www.molinamedicare.com/providers/).

High-risk situations

An organization should put a method in place for prioritizing the notification of caregivers whose child's warning signs or screens indicate the existence of a high-risk or urgent situation. Unless the caregivers have rejected further communication, they should be called promptly to find out whether they were able to schedule a timely appointment, whether they have any concerns about getting care, and whether they need another referral.

Peer support, family and youth support, and education

An important part of mental health and substance abuse treatment is the ongoing support of other youths and caregivers of children and adolescents with mental health and substance use problems. As part of the notification process, a child-serving organization should offer youths and caregivers information about and referrals to an organized peer support network. However, the organization should be careful to balance peer support with the requirements for confidentiality. Others should not be informed of a youth's screening status or perform the notification. Peer support organizations may want to offer some special educational or support events soon after the identification process to answer youths' and caregivers' questions.

Following up on referrals

Families often encounter difficulties in accessing mental health services. Child-serving organizations should check back with families—when they are willing—and help them address any challenges they may have encountered.

Communicating Results to Mature Minors and Young Adults

Some youths may accept screening and follow-up services only if their caregivers are not involved. When a youth meets standards for service as a mature minor or is a young adult, caregivers must not be informed of screening results without the express consent of the mature minor or young adult.

Chapter 4

Partnering for Resources

Benefits of Partnering to Access Community Resources

Assessments should be conducted by a qualified mental health, substance abuse, or medical professional. (See "Examples of Professionals Who Are Qualified to Diagnose Mental Health or Substance Use Problems" at right.) Child-serving organizations frequently partner with mental health and substance abuse providers to ensure that identified children and adolescents have access to assessment and treatment.

Examples of Professionals Who Are Qualified to Diagnose Mental Health or Substance Use Problems

- Social worker or counselor (master's level)
- Psychologist (master's level or doctoral level)
- Physician or psychiatrist
- Licensed substance abuse counselor

In many communities, mental health and substance abuse treatment resources for children and adolescents are very limited. If a community does not have adolescent substance abuse counselors, an adolescent with substance use problems is likely to be referred into the mental health system or the adult substance-abuse system. Organizations that serve children and adolescents may be reluctant to identify those youths with mental health or substance use problems if they believe that appropriate assessment and treatment are not available.

A 2008 study of an early identification screening provides encouraging evidence that mental health service systems can respond to referrals generated by such screenings.[56] In this initiative, a program involving school screening made arrangements with local mental health providers to expand capacity to act on referrals for assessments within 2 weeks. Most families were able to get timely services through their regular private and Medicaid insurance networks. Consequently, very few children identified by screening needed to rely on added capacity.

> The relationships established with local mental health and substance abuse treatment resources for identification efforts are important. These relationships provide a foundation for the continued coordination that will be necessary for ongoing support and treatment of children and adolescents with more serious problems.

When organizations anticipate an access-to-care problem, they should explore the willingness of the local mental health and substance abuse treatment community to support a planned identification initiative. Treatment providers are likely to experience busy times of the year; as a result, providers may be more willing and able to accommodate referrals from a screening program if the program is scheduled for a less busy time of year.

Mental health and substance use assessments often are covered by health insurance.

Medicaid benefits cover the assessment and treatment of mental health and substance use problems of children and adolescents with low family income, those in foster care, and some who have disabilities. This benefit often is referred to as the Early and Periodic Screening, Diagnosis, and Treatment Program, but some states may use different terminology. Most states also participate in the Children's Health Insurance Program (CHIP)*, which provides low-cost health insurance for some families that do not qualify for Medicaid.

In states with mental health parity,† most private insurance coverage also should cover an assessment and some degree of treatment if a problem is identified. However, parity does not always apply to substance abuse and may exclude certain mental health conditions. The specific boundaries of the Mental Health Parity and Addiction Equity Act‡ also apply. Other resources will have to be sought to meet the needs of children and adolescents with private insurance but limited behavioral health benefits and for those who are uninsured.

Under the Affordable Care Act,§ children with preexisting conditions—such as a mental health or substance use disorder—can no longer can be denied health coverage. In addition, some preventive services offered through health insurance may be available at no additional costs: preventive services such as depression screening for adolescents at higher risk, alcohol and drug use assessments for adolescents, and behavioral assessments for children of all ages.

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* The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 renewed CHIP through the end of 2013.

† Mental health parity laws require insurers—if they offer mental health and substance abuse benefits—to offer them on the same basis as medical services. For example, insurers cannot impose treatment limitations and financial requirements on mental health and substance abuse benefits that are stricter than the limitations and requirements for medical and surgical benefits.

‡ The Mental Health Parity and Addiction Equity Act was passed in 2008 and took effect on January 1, 2010.

§ The Affordable Care Act was passed by Congress and signed into law by President Obama in March 2010.

The relationships established with local mental health and substance abuse treatment resources for identification efforts are important. These relationships provide a foundation for the continued coordination that will be necessary for ongoing support and treatment of children and adolescents with more serious problems.

Potential Partners

Peer support

Families and youth often feel that peers are the only source of support that comes without blame or shame. Consequently, family and youth support groups play a valuable role in helping families negotiate service systems, educate themselves about their child's or adolescent's condition, or cope with the demands of a child or adolescent with special needs. Child-serving organizations should seek to partner with or offer referrals to family and youth support organizations operating within their state. The following family and youth support organizations have local chapters that provide peer support.

Family and Youth Support Organizations

- National Alliance on Mental Illness, Child and Adolescent Action Center (Web site)
  http://www.nami.org/template.cfm?section=Child_and_Teen_Support
- National Federation of Families for Children's Mental Health: *Chapters and State Organizations* (Web page)
  http://ffcmh.org/who-we-are/chapters-state-organizations/
- Youth M.O.V.E. National (Web site)
  http://youthmovenational.org

Self-help

Self-help and peer support are recognized components of substance abuse treatment. Some communities have Alcoholics Anonymous groups for teens (Alateen).

Faith communities

Communities of faith can be important partners by providing prevention activities and support to their members and the broader community. One example is church-sponsored substance-free youth activities.

Local mental health associations

Many mental health associations are local affiliates of Mental Health America, whose members include mental health professionals and local individuals concerned about mental health. Members may contribute expertise and assist in locating and coordinating the efforts of mental health professionals who are willing to support the early identification process and accept referrals to assess children and adolescents with positive screens.

Local community mental health centers

In many states, community mental health centers receive state, county, and Medicaid funds to serve children, adolescents, and adults with mental health problems. Some centers also may participate as providers for private health care plans. These centers may be able to accept referrals and generally have some funding to serve children and adolescents without insurance coverage. They also may be able to refer organizations to the major providers serving private health plans. These providers are usually listed on a state's mental health authority Web site.

Public substance abuse clinics

Publicly supported substance abuse clinics often serve Medicaid-eligible and uninsured people. Although services for teens may be limited, they do exist. A list of clinics in a particular state may be found by contacting the state's substance abuse and Medicaid agencies.

Local community health centers

Community health centers provide primary health care for individuals on Medicaid or for those who are uninsured. Increasingly, such centers also provide mental health services or have partnerships with providers who serve their primary care clientele. Community health centers are relevant to all child-serving organizations because they are a resource for providing assessment or treatment services. The Health Resource and Services Administration provides a "Find a Health Center" Web site (http://findahealthcenter.hrsa.gov/) to locate community health centers in specific areas.

Early Intervention for infants and toddlers with disabilities

The Individuals with Disabilities Education Act (IDEA) Part C (Early Intervention for Infants and Toddlers) is a Federal grant program that assists states with operating a comprehensive statewide program of Early Intervention services for infants and toddlers with disabilities, birth through 2 years of age, and their families. States must provide a developmental assessment of any referred child and services for those assessed as having developmental delays. Often, services are provided in the home. The standards that states set for the determination of developmental delays are within Federal guidelines. A few states have exercised the option of serving children who are determined to be "at risk" for developmental delays. Young children for whom there is a substantiated report of abuse or neglect must be referred for an Early Intervention assessment. More information can be found by contacting individual state agencies.

State IDEA Agencies

- State Agencies Designated as IDEA Part C Leads (Web page)
  http://www.nectac.org/partc/ptclead.asp
- IDEA Part C Program Coordinators (Web page)
  http://www.nectac.org/contact/ptccoord.asp

Early Intervention programs for children ages 3–5

When a child receiving Part C services turns 3 years old, states may choose to offer parents an option of continuing Part C services with a Part C Early Intervention provider until the child enters kindergarten or begins receiving Part B Special Education services from the local education authority (school system). Either way, IDEA services must include an educational component that promotes school readiness and incorporates preliteracy, language, and numeracy skills when the child reaches the age of 3. IDEA services for children ages 3–5 are accessed by contacting either the Part C program coordinator or the local school system for Part B services.

Special Education: Individuals with Disabilities Education Act, Part B

IDEA Part B requires states and local education agencies to provide services that meet the educational and related needs of children with disabilities, beginning at age 3 and extending through age 22. Emotional disturbances that interfere with learning are one of the 13 required categories of disability that must be addressed. Schools must provide the necessary services to assist the child or adolescent with becoming involved and making progress in the general education curriculum. These services also must meet all other educational needs that arise from the child's disability. Organizations should contact a child's or adolescent's local school system or the state education agency for assistance in establishing eligibility and arranging services for a youth with a mental health-related disability.

Medicaid and Children's Health Insurance Program plans and providers

States have a statutory responsibility to ensure that children and adolescents enrolled in Medicaid receive any Medicaid services needed to treat mental health and substance use problems identified through screening. The state Medicaid agency, its contracted managed care plans, or its major mental health and substance abuse* providers are required to assess and treat identified problems. Consequently, states must develop a comprehensive developmental and behavioral health screening program as part of their Medicaid program's primary care services. The state's Medicaid managed care and/or behavioral health providers may be willing to actively collaborate with other early identification programs and accept referrals for

* Some states may not provide substance abuse services through Medicaid.

Medicaid-eligible children and adolescents identified with possible problems. Providers can be located through each state's Medicaid agency Web site. Information on state Medicaid agencies can be found by entering Medicaid and the state's name into an Internet search engine.

As mentioned previously in this chapter, CHIP is another health insurance option for uninsured children. Many states have used CHIP funds to expand Medicaid eligibility, while others have established separate plans under it. Most if not all programs cover treatment for mental health conditions, and some cover treatment for substance abuse. Information about CHIP usually is located on the same Web site as a state's Medicaid program. States often use a common application form for both programs, so only one form needs to be submitted. Consequently, children will be enrolled in either Medicaid or CHIP, depending on which eligibility criteria they meet.

Note: Medicaid programs and CHIP programs frequently are known by other state-specific names—such as BadgerCare (in Wisconsin) or MassHealth (in Massachusetts).

Hospitals

Hospitals are often willing to collaborate on plans to improve health in their local communities. If hospitals offer psychiatric outpatient services or have affiliated mental health programs, they are likely to participate in the provider networks of many health plans and can be a source of care for children who are members of those health plans. Some hospitals also may accept Medicaid or have funds to provide free care for uninsured children and adolescents.

Private insurers

Private insurers in some states are willing to participate in local initiatives to improve health. The private plans with the largest enrollment in an organization's service area can be identified and asked to facilitate referrals from an early identification program. This approach also may help meet the needs of children and adolescents with private health insurance. A state's insurance commission—sometimes called the Office of the Commissioner of Insurance or the Department of Insurance—or a local hospital may have information about the plans with the largest enrollment in designated areas.

Partnership Models

Child-serving organizations can work with mental health and substance abuse providers in a number of ways to link an early identification program to assessment and treatment.

Referrals

The most common referral method is to develop a network of child-serving mental health and substance abuse professionals and clinics that are willing and able to accept referrals for youth with the most prevalent insurance options in a particular community.

Facilitated referrals or case management

Parents unfamiliar with their health insurance plan or who do not have a health insurance plan may need assistance to access benefits. With a facilitated referral, someone trained in Medicaid and other health plan benefits helps the family get the necessary authorizations or documentation to use services. This individual can help arrange transportation or locate other sources of support that parents need to get the child to the provider for assessment and treatment. A facilitated referral also can help staff coordinate care between the treatment provider and the schools, medical care providers, faith-based organizations, peer groups, and programs that are important in the child's life.

Consultation

Many community mental health centers and some substance abuse providers offer consultation to schools, early care and education, and other child-serving programs. When consultation is for a specific child with a diagnosed problem and the child has Medicaid or other insurance coverage, these services may be billable. Federated fundraising organizations—such as the United Way or local foundations—may offer grants to cover consultation, enabling child-serving organizations and programs to better serve children with behavioral health problems.

Collaborations

Child-serving organizations that have good working relationships with providers offering mental health and substance abuse treatment in their area often collaborate—with parental consent and participation—to better meet the needs of a child in treatment. In addition, mental health and addiction professionals can be consulted on program design, or they can provide valuable assistance that enables the staff to best handle specific types of mental health or substance use problems. When providers and other organizations work together, they develop a better understanding of one another's challenges and strengths and can make better referrals. *A Public Health Approach to Children's Mental Health: A Conceptual Framework* (available at http://gucchdtacenter.georgetown.edu/publications/PublicHealthApproach.pdf) provides information on how to facilitate collaboration through a public health approach to children's mental health.

Colocation

Often, a child-serving organization can provide space for behavioral health professionals. Such allocated space facilitates the provision of on-site services. Primary care physicians' offices and school health centers are two types of settings in which behavioral health professionals are colocated.* Colocation eliminates the barrier of having to go to another location. It also reduces stigma, because the setting is not associated with the stigmatized conditions of mental health or substance abuse. Colocation also facilitates cross-training and collaboration between child-serving professionals and mental health or substance abuse professionals. Although most colocation programs are permanent, behavioral health professionals may be brought in to conduct an early identification screening and evaluate the screening results.

Multidisciplinary teams

Multidisciplinary teams may include mental health or substance abuse professionals along with professionals in other disciplines to serve a group of children or adolescents. The team develops integrated and comprehensive approaches that address behavioral health and other concerns, such as medical problems; academic needs; disabilities; or recreation, protective, or juvenile justice issues.

Systems of care

Many communities and states have developed a system of care (SOC) to serve children or adolescents with serious emotional problems who need services from more than one child-serving organization. An SOC is a coordinated network of community-based services and supports organized to meet the needs of children and adolescents with serious mental health problems as well as the needs of their families. Services are guided by a clear set of values and principles that ensure effective interventions, are family driven and youth guided, build upon the strengths of individuals, and address each person's cultural and linguistic needs. The goal of these services is to help children, adolescents, and families function better at home, in school, in the community, and throughout life. Generally, SOCs combine multiple funding sources and use them flexibly to finance a better integrated and coordinated network of community-based services and supports.

SOCs are behind the development of the wraparound approach that individualizes care. In this approach, children and adolescents—along with their families—identify the services and supports they need; these services and supports then "wrap around" both the youth and family so that the child or adolescent can remain at home and continue to participate in regular community activities. SOC projects also have dedicated resources to create and support caregivers and youth organizations that provide education, support, and advocacy services. Person-centered healthcare homes† may coordinate services for children and adolescents with mental illness (as they do for those with other special health care needs) and are considered to be important partners in an SOC. Information on SOCs can be found through SAMHSA's National Children's Mental Health Awareness Day Web site (http://www.samhsa.gov/children/).

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* The school mental health field is working to move beyond simple colocation in order to develop integrated mental health and education approaches. Some of these approaches to school-based mental health are described in Supplement 7: Schools and Out-of-School Programs. Primary care also is moving beyond colocation to integration.

† Person-centered healthcare homes offer an added behavioral health capacity and focus on supporting a person's capacity to set goals for improved self-management; such homes are an expanded version of patient-centered medical homes,[57] in which a provider or a team of health care professionals is accountable for a person's care and manages and coordinates all of the services that a person receives. This individualized model is a way for each patient to receive coordinated services and for health professionals to work together more efficiently for the benefit of each person.[58]

Substance Abuse and Mental Health Services Administration. (2011).
Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations.
(HHS Publication No. SMA 12-4670). Rockville, MD: Author.

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