Identifying Mental Health and Substance Use Problems of Children and Adolescents:

A Guide for Child-Serving Organizations

Substance Abuse and Mental Health Services Administration
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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Supplements

These supplements build upon the foundational information in Chapters 1–4 and are not meant to stand alone.

Introduction

The Promise of Early Identification

"Childhood is an important time to prevent mental disorders and to promote healthy development, because many adult mental disorders have related antecedent problems in childhood. Thus, it is logical to try to intervene early in children's lives before problems are established and become more refractory. The field of prevention has now developed to the point that reduction of risk, prevention of onset, and early intervention are realistic possibilities. Scientific methodologies in prevention are increasingly sophisticated, and the results from high-quality research trials are as credible as those in other areas of biomedical and psychosocial science. There is a growing recognition that prevention does work…."

—Surgeon General, U.S. Public Health Service[1]

"The earlier we recognize a child's mental health needs, the sooner we can help. Early recognition and intervention can prevent years of disability and help children and families thrive. All parents should learn to recognize the signs and symptoms of mental health problems in early childhood; furthermore, they should seek help for their child's mental health problems with the same urgency as any other health condition."

—Administrator, Substance Abuse and Mental Health Services Administration[2]

"…drugs change brains—and this can lead to addiction and other serious problems. So preventing early use of drugs or alcohol may reduce the risk of progressing to later abuse and addiction…. Research has shown that science-validated programs…can significantly reduce early use of tobacco, alcohol, and illicit drugs…. Discoveries in the science of addiction have led to advances in drug abuse treatment that help people stop abusing drugs and resume their productive lives…."

—National Institute on Drug Abuse, National Institute of Health[3]

About SAMHSA

The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the Department of Health and Human Services (HHS), is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA, together with many partners, has demonstrated that prevention works, treatment is effective, and people recover from mental and substance abuse disorders. SAMHSA's top priority is creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse, including tobacco, and suicide.

Purpose of the Guide

This guide was created to promote the early identification of children and adolescents with mental health and substance use problems as well as to provide guidance, tools, and resources for early identification—including a compendium of the most developmentally, culturally, and environmentally appropriate screening instruments. SAMHSA developed the guide using the input of the members of the Federal/National Partnership* (FNP) Early Identification Workgroup, chaired by representatives from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). Workgroup members include representatives from the Administration for Children and Families, HHS; the Air Force, Department of Defense; CDC, HHS; HRSA, HHS; Indian Health Services, HHS; National Institute on Drug Abuse, National Institutes of Health, HHS; Office on Disability, HHS; Office of Juvenile Justice and Delinquency Prevention, Department of Justice; Office of Safe and Drug-Free Schools, Department of Education (ED); Office of Special Education Programs, ED; and SAMHSA, HHS. Individuals from these agencies reviewed the guide to ensure that it accurately addresses the general concerns and issues as well as the specific needs of children and adolescents targeted by their agency.

The *Federal Action Agenda* Includes a Call to Address Early Identification

SAMHSA's Federal Partner Senior Workgroup produced the publication *Transforming Mental Health Care in America: The Federal Action Agenda*.[4] One of the action steps identified in the *Federal Action Agenda* is to "promote strategies to appropriately serve children at risk for mental health problems in high-risk service systems." The *Federal Action Agenda* calls for a Federal cross-agency group to assess the feasibility of implementing one or a combination of current screening instruments in the systems serving these at-risk youths.

* The Federal/National Partnership (FNP) is the abbreviated title for the Federal/National Partnership for Transforming Child and Family Mental Health and Substance Abuse Prevention and Treatment. The Early Identification Workgroup is one of three task groups of SAMHSA's Federal Partner Senior Workgroup, which consists of agencies from the Departments of Health and Human Services, Education, Housing and Urban Development, Justice, Labor, Veterans Affairs, and Social Security Administration.

It is important to note that SAMHSA and its Federal national partners are not recommending mandatory, universal screening. The U.S. Preventive Services Task Force, which evaluates the evidence on the efficacy of various preventive practices, has recommended screening adolescents for depression in primary care; however, it has not yet reviewed the evidence for general, multicondition screening instruments, such as those discussed in this guide. However, it is likely that many families—especially those whose children fall into groups at elevated risk for mental health or substance use problems—would prefer to know as soon as possible if their child or adolescent shows indications of these problems. Early identification and intervention would allow caregivers* to promptly address any identified problems. Programs and services for youths who are at elevated risk for mental health and substance use problems should, as much as possible, offer caregivers the opportunity to identify any such problems. Because caregivers are the decision makers for their children, the guide emphasizes that informed parental consent must always be obtained before any formal identification or screening process is conducted; it also reinforces that parental involvement from the beginning is appropriate and encouraged.

About the Guide

This guide is written for personnel working in child-serving organizations and the families of the children (birth–12 years) and adolescents (13–22 years)† being served. The purpose of the guide is to address the approaches, methods, and strategies used to identify mental health and substance use problems of high-risk youths (persons whose ages are between birth and 22 years) in settings that serve either a broad spectrum of children and adolescents or a high-risk population. The seven settings addressed in this guide are as follows:

- Child welfare
- Early care and education
- Family, domestic violence, and runaway shelters
- Juvenile justice
- Mental health and substance abuse treatment for co-occurring disorders
- Primary care
- Schools and out-of-school programs

Because each setting has unique considerations, this guide includes supplements targeted to specific child-serving settings. Personnel in these settings must be prepared to actively partner with one another to create comprehensive systems of care that meet the needs of youths with the most serious mental health and substance use problems. Communities undertaking efforts that support positive youth development or address concerns about child and adolescent mental health or substance use also may find these materials helpful.

* 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*.

† 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 mental health problems referenced in the guide encompass social and emotional challenges, psychopathology, and pervasive developmental disabilities. Substance use problems referenced in the guide include the use of alcohol and other illicit drugs. Various conditions—such as autism; fetal alcohol syndrome; and cognitive, language, or fine-motor challenges—that are significant in the high-risk populations are beyond the scope of this guide. Identification methods for mental health and substance use problems referenced in this guide rely on information from self, caregiver, and teacher reports as well as observation. Laboratory tests to detect substance use are beyond the scope of this guide.

A wealth of information is available to address the identification of children's and adolescents' mental health problems along with their healthy social and emotional development. With the availability of so much information for so many audiences, it may be difficult to know where to start and what information is valid and relevant.

This guide is designed so staff, providers, and clinicians of child-serving organizations can quickly locate information and resources that enable them to:

- Understand and interpret the key terminology used to describe screening and identification tools and activities;
- Decide on an appropriate approach for initiating an identification activity; and
- Plan an initiative that follows sound principles of responsible health care.

Personnel in some settings may find the information in the guide sufficient to plan and implement an identification activity with relatively little additional research required. In other settings, program staff may need to actively engage stakeholders in an extensive planning process and gather additional information from the resources identified here or from other sources.

Why Early Identification Is Important

In 2009, children and adolescents made up 27 percent of the population in the United States.[5] Development from birth through adolescence is usually normal and healthy. As children and adolescents grow and develop, they typically become resilient in coping with life challenges such as the loss of a friend, the death of a family member, divorce, or moving.

Some children and adolescents have mental illness and very real substance use problems.

A complex interaction of biological, behavioral, and environmental factors places certain youths at greater risk than others for emotional and behavioral disorders that can range from mild to severe—and may be long lasting. These disorders can overwhelm children's or adolescents' ability to cope and can interfere with their ability to learn and mature.

- Almost 21 percent of children and adolescents in the United States have a diagnosable mental health or addictive disorder that affects their ability to function.[6]

- In any given year, 5 percent to 9 percent of youths ages 9 to 17 have a serious emotional disturbance that causes substantial impairment in how they function at home, at school, or in the community.[7]

Many children and adolescents with mental illness and substance use problems do not receive treatment.

- An estimated 60 percent of children and adolescents with mental health problems do not receive mental health services.[8]
- An estimated 6.1 million youths between the ages of 12 and 17 needed treatment for an illicit drug abuse problem in 2001. Of this group, only 1.1 million youths received treatment, leaving an estimated treatment gap of 5 million.[9]
- In 2000, approximately 3 million youths were at risk for suicide. Of that group, only 36 percent received any treatment for mental health or substance abuse disorders.[10]

Early detection can help.

Early detection can help parents and caregivers identify children's and adolescents' emotional or behavioral challenges and assist in getting these youths the appropriate services and support before their problems worsen and longer term consequences develop.

Organization of the Guide

Information applicable to the seven child-serving settings referenced in this guide is contained in the first four chapters:

- **Chapter 1: Prevention and Early Identification of Children's and Adolescents' Mental Health and Substance Use Problems**
- **Chapter 2: Understanding the Identification Process and Tools**
- **Chapter 3: Key Steps of Early Identification**
- **Chapter 4: Partnering for Resources**

Resource materials relevant to specific settings are located in the guide's Supplements sections following Chapter 4. The seven supplements are not intended to stand alone; each builds upon the foundational information in Chapters 1–4. The supplements are as follows:

- **Supplement 1: Child Welfare**—This supplement is applicable for case workers, social workers, and administrators in state and county child welfare systems and programs. Although this supplement does not specifically address court issues, family courts may find some information to be pertinent.
- **Supplement 2: Early Care and Education**—This supplement is applicable for early care and education teachers, home visitors, public health nurses, and administrators in early care and education (birth to age 5).

- **Supplement 3: Family, Domestic Violence, and Runaway Shelters**—This supplement is applicable for case managers, counselors, social workers, youth workers, and administrators in family, domestic violence, and runaway shelters.
- **Supplement 4: Juvenile Justice**—This supplement is applicable for case workers, probation officers, youth workers, administrators, and judges in family and juvenile courts, correction systems, and correctional programs.
- **Supplement 5: Mental Health and Substance Abuse Treatment for Co-occurring Disorders**—This supplement is applicable for mental health and substance abuse professionals and treatment program administrators of programs for children and adolescents.
- **Supplement 6: Primary Care**—This supplement is applicable for physicians, pediatricians, nurses, health educators, and other health professionals who work in community health centers, office practices, hospitals, school-based centers, and other primary care settings.
- **Supplement 7: School and Out-of-School Programs**—This supplement is applicable for teachers, counselors, social workers, out-of-school program staff, and administrators of schools and out-of-school programs (kindergarten to grade 12).

Appendices—Appendix A provides the full list of acknowledgments. Appendix B provides detailed information about screening tools that meet best practice standards. Appendix C includes a sample parent letter, information sheet, parent consent form, and youth assent form. Appendix D contains a pullout of *Principles Guiding Screening*. Appendix E contains the references.

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.

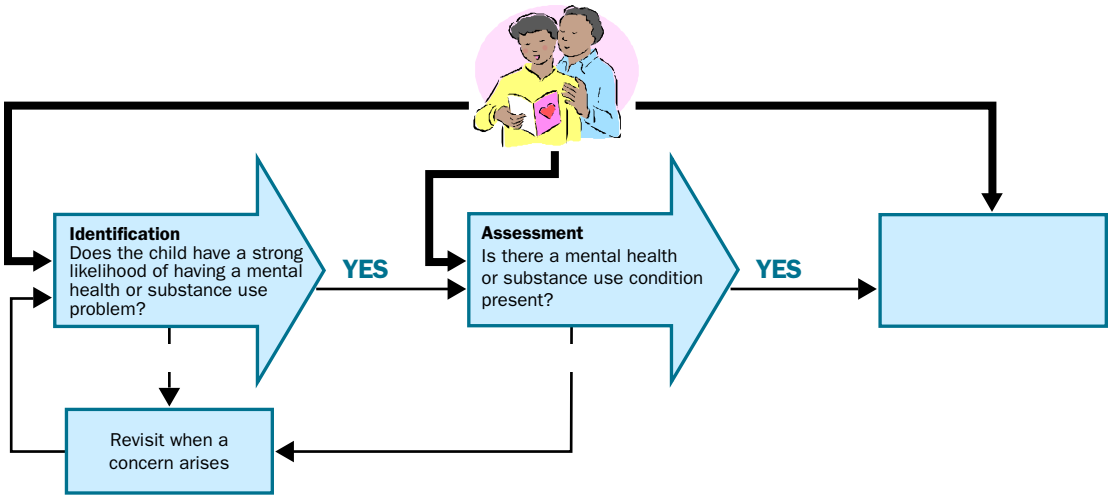
Encouraging the involvement of parents before asking consent to conduct a screening is a valuable approach. The positive involvement of parents may include engaging them in the process of setting goals for an identification initiative and in the selection of methods for identifying mental health and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

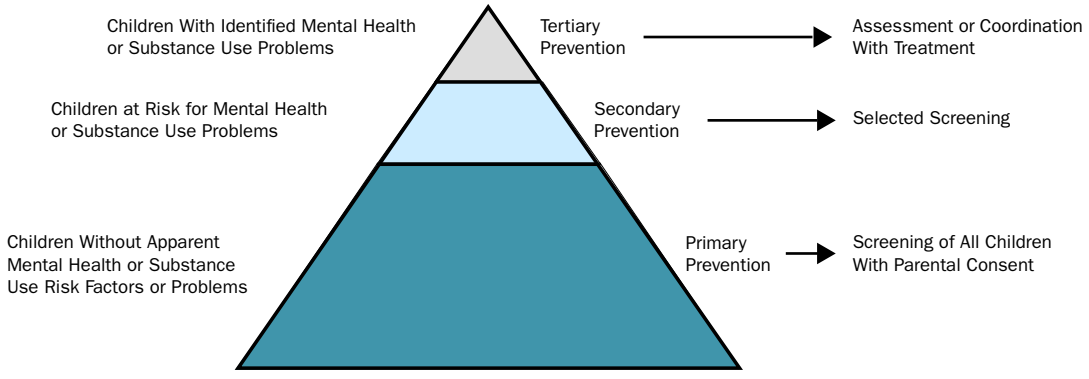
Determining Goals: Populations and Problems of Concern

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]



Identifying Mental Health and Substance Use Problems of Children and Adolescents:

A Guide for Child-Serving Organizations

Supplements




The Substance Abuse and Mental Health Administration (SAMHSA) recognizes the importance of child-serving programs of all kinds working together to develop a strong and effective infrastructure, ensuring that youth with the most serious mental health and substance use problems receive comprehensive and well-coordinated services and supports.

A wealth of resources is available to assist child-serving organizations in their efforts to identify children's and adolescents' mental health and substance use problems as early as possible and initiate creative interventions. The following supplements are designed to be used in conjunction with the information in Chapters 1–4. Each supplement highlights the considerations unique to a specific child-serving setting and identifies the resources that have been developed for that setting.

Supplement 1: Child Welfare

Supplement 2: Early Care and Education

Supplement 3: Family, Domestic Violence, and Runaway Shelters

Supplement 4: Juvenile Justice

Supplement 5: Primary Care

Supplement 6: Mental Health and Substance Abuse Treatment for Co-occurring Disorders

Supplement 7: Schools and Out-of-School Programs

Supplement 1

Child Welfare

This supplement is not intended to stand alone.
It builds upon the foundational information in Chapters 1–4.

Child Welfare

The Need for Mental Health and Substance Use Screening in Child Welfare Settings

An estimated 772,000 children and adolescents, representing on average 1.03 percent of youths in the United States, were found to have experienced abuse or neglect in 2008.[59] An estimated 267,000 children were removed from their homes in 2008 as a result of child maltreatment investigations.[60]

In 2009, an estimated 423,773 children and adolescents were in the foster care system.[61] A small percentage of children and adolescents in the child welfare system have not been abused or neglected; for these children, the families may have relinquished custody so their child can receive the intensive mental health services that otherwise would not be available.

Children and adolescents who have experienced abuse or neglect are at high risk of mental health and substance use problems because of their stressful family and environmental situations. For example, one-third to one-half of youths who have been abused are estimated to have significant emotional and behavioral problems.[62] [63] Depression and eating disorders[64] as well as anxiety disorders (including panic disorder) and dissociative disorders[65] often are found in children and adolescents who have been abused. Also, posttraumatic stress disorder has been found in up to 50 percent of children and adolescents who have been abused.[66] Childhood maltreatment can be associated with the development of personality disorders, which manifest themselves as serious disturbances in relationships and behavior as children reach adolescence and adulthood.[67] Children and adolescents who were prenatally exposed to drugs and alcohol are at greater risk for substance abuse[68] as well as behavioral problems and learning disabilities.[69] Children and adolescents in foster care also have a higher likelihood of making suicide attempts than do other youths.[70]

In addition, children and adolescents who have been abused or neglected have a higher likelihood of abusing substances than do other youths. This tendency is borne out by SAMHSA's National Survey on Drug Use and Health, which found that an average of 33.6 percent of youths in foster care used illicit drugs in 2002 and 2003.[71] Substance use problems can persist into adulthood. Epidemiological studies show that 55 percent to 99 percent of women in substance abuse treatment reported a history of early physical or sexual abuse.[72]

The following resources provide information on trauma.

Resources on Trauma

- National Child Traumatic Stress Network (Web site)
  http://www.nctsn.org
- National Resource Center for Health and Safety in Child Care and Early Education, *Healthy Kids, Healthy Care: Child Abuse and Neglect* (Web page)
  http://nrckids.org/CFOC3/HTMLVersion/Chapter03.html#3.4.4
- *Recognizing and Addressing Trauma in Infants, Young Children, and Their Families* (Online Tutorial)
  http://www.ecmhc.org/tutorials/trauma/index.html
- Resources from the Task Force on Post-Traumatic Stress Disorder and Trauma in Children and Adolescents (Various publications)
  http://www.apa.org/pi/families/resources/task-force/child-trauma.aspx
- Safe Start Center (Web site)
  http://www.safestartcenter.org/
- *Trauma Among Homeless Youth* (Publication)
  http://www.nctsnet.org/sites/default/files/assets/pdfs/culture_and_trauma_brief_v2n1_HomelessYouth.pdf

Numerous studies have found that many youths in the child welfare system have multiple problems.[73]

- Abused and neglected children are 11 times more likely to be arrested for criminal behavior as youth who were not abused or neglected,[74] and as many as 80 percent of abused or neglected youth have been found to meet the diagnostic criteria for at least one psychiatric disorder by age 21.[75]
- In 2002, about one-quarter of children who were identified as victims of abuse or neglect were age 3 or younger.[76]
- Sixteen percent of admissions to foster care in 2009 were children younger than age 1.[77]
- Children younger than age 2 can show symptoms of serious depression,[78] and their behavior and overall social and emotional development usually is greatly affected by what is happening in their environment.[79]
- Many youths who come to the attention of child welfare are from families in which a caretaker has a substance abuse disorder that impairs parenting.[80]

An environment in which child abuse or neglect is an issue can have lasting effects on a child's developmental pathways related to emotions and behavior. The following resources provide information on mental health and substance use problems in child welfare.

Resources on Mental Health and Substance Use Problems in Child Welfare

- Administration for Children and Families, Child Welfare Information Gateway: *Impact of Child Abuse and Neglect* (Web page)
  http://www.childwelfare.gov/can/impact/
- American Academy of Pediatrics, Healthy Foster Care America (Web site)
  http://www.aap.org/fostercare/
- Substance Abuse and Mental Health Services Administration and the Administration for Children and Families, National Center on Substance Abuse and Child Welfare (Web site)
  http://ncsacw.samhsa.gov/
- Technical Assistance Partnership for Child and Family Mental Health: *Child Welfare* (Web page)
  http://www.tapartnership.org/advisors/ChildWelfare/default.asp

Although this guide does not focus on the substance use of caregivers during pregnancy and parenting, the Substance Abuse and Mental Health Administration (SAMHSA) has developed *Screening and Assessment for Family Engagement, Retention, and Recovery*, a resource for the screening and assessment of substance abuse in child welfare settings. Information on this resource follows.

Resource on Caregivers' Substance Abuse

Screening and Assessment for Family Engagement, Retention, and Recovery (Publication)
http://www.ncsacw.samhsa.gov/files/SAFERR.pdf

Effective Implementation of Screening of Abused or Neglected Children and Adolescents

Prompt screening is a best-practice standard.

State and Federal policies recognize the necessity of promptly identifying the needs of children who have been abused or neglected. States are required to refer young children under the age of 3 who are involved in a substantiated case of abuse or neglect to Early Intervention services funded through IDEA Part C[81] under the provision of the Child Abuse Prevention and Treatment Act (CAPTA).[82] Part C programs conduct a comprehensive assessment to determine whether the following conditions are evident: the child is experiencing developmental delays; the child has a diagnosed mental or physical condition with a high probability of resulting in developmental delays; and, in some states, the child is at risk of experiencing a substantial developmental delay if Early Intervention services are not provided.

The Children's Bureau of the Administration for Children and Families (ACF) has issued guidelines[83] recognizing the importance of assessing the needs of children as related to their mental health and substance use problems. Although these guidelines do not include standards for the timing or content of screening or assessment, some states have established requirements of this sort. Minnesota, for example, implemented a legislative requirement for all children and adolescents entering state custody to be screened for mental health and substance use problems with a validated tool. A 2004 review of state Child and Family Service Review (CFSR) final reports found that 16 states had explicitly adopted a requirement for either mental health screening or mental health assessment upon or soon after a youth's entry into foster care.[84]

Several other child-serving organizations have developed recommendations for screening children entering foster care. A joint policy statement from the American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA) recommends that in the case of out-of-home placement, mental health and substance use screening should be conducted within 24 hours of placement.[85] The goal of this screening is to identify children and adolescents in urgent need of emergency mental health services and those who use alcohol and other drugs or exhibit behavior that may pose a danger to themselves or others. The statement recommends that the screen be administered by appropriately trained staff who are on-site or readily accessible for a consultation on mental health and alcohol and other drug use. Similarly, the standards set by the American Academy of Pediatrics (AAP) recommend a health screening evaluation for youths before or shortly after placement to identify any immediate medical or dental needs, urgent mental health needs, or conditions of which the foster family should be aware.[86] More recently, a group of 11 organizations—including the American Psychiatric Association, the Annie E. Casey Foundation, and CWLA—came to a consensus and developed and endorsed *Mental Health Practice Guidelines for Child Welfare*; these guidelines also call for screening for emergent risk within 72 hours of entry into foster care and screening for ongoing mental health service needs within 30 days.[87]

The following resources provide information on professional standards relating to foster care and information on mental health practices.

Resources on Professional Standards Relating to Foster Care

- American Academy of Child and Adolescent Psychiatry and Child Welfare League of America:
  - *Foster Care Mental Health Values* (Policy statement)
    http://www.aacap.org/cs/root/policy_statements/aacap/cwla_foster_care_mental_health_values_subcommittee
  - *Mental Health and Use of Alcohol and Other Drugs, Screening and Assessment of Children in Foster Care* (Policy statement)
    http://www.aacap.org/cs/root/policy_statements/aacap/cwla_policy_statement_on_mental_health_and_use_of_alcohol_and_other_drugs_screening_and_assessment_of_children_in_foster_care
- American Academy of Pediatrics: *Health Care of Children in Foster Care* (Publication)
  http://aappolicy.aappublications.org/cgi/reprint/pediatrics;109/3/536.pdf
- Child Welfare League of America: *Policy Statement on the Mental Health Needs of Infants and Toddlers in Foster Care* (Policy statement)
  http://www.cwla.org/programs/bhd/mhcwstatement.doc

Resource on Mental Health Practices

Mental Health Practices in Child Welfare Guidelines Toolkit (Publication)
http://www.thereachinstitute.org/files/documents/mental-health-practices-childwelfare-toolkit.pdf

Removal from the home can be traumatic, especially for young children.

Recent standards emphasize the potential psychological trauma that can stem from disrupting children's attachments when they are removed from their home; this situation can be effectively addressed by providing a timely intervention when screens indicate a likely problem. The intervention should address the child's feelings regarding the separation and help determine what kind of placement will best meet his or her needs. Because every disruption in caregiving can be traumatic, the joint policy statement of

AACAP and CWLA recommends that screenings should occur when a child or adolescent enters foster care and every time there is a change in placement.[88]

Although child welfare agencies may easily understand the potential trauma for older children and adolescents, awareness of the vulnerability of very young children to disruption in caregiver relationships is relatively new. Identifying infants who are experiencing trauma or social and emotional problems is imperative. A severe disruption of an infant's primary caregivers can lead to a number of attachment issues, and unaddressed social and emotional problems can affect a child's future development.

The following resources provide information on child welfare in early childhood.

Resources on Child Welfare in Early Childhood

- *Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals* (Publication)
  http://www.zerotothree.org/site/DocServer/Infant_Booklet.pdf?docID=1847
- *Mental Health Assessments for Infants and Toddlers* (Publication)
  http://www.zerotothree.org/site/DocServer/Hill_Solchany_Infant_Mental_Health_Assessments_for_court.pdf?docID=1851

Periodic screening should take place.

The joint policy statement of AACAP and CWLA recommends that child welfare agencies ensure that periodic screening occurs as a regular and routine part of well-child care.[89] (See "Joint Statement Recommendations for Screening Children in Foster Care" on page 66.) This policy corresponds with the AAP standards that call for the close monitoring of children and adolescents in foster care because of the changes and difficulties that can arise over time during foster care placement.[90]

The ACF standards for family assessment apply to all children and adolescents who come in contact with child welfare agencies, including those youths who are removed from their homes and the greater number of children and adolescents who receive preventive services while remaining with their families.[91]

Neither the AACAP/CWLA joint statement nor the AAP standards, however, address the identification and treatment of children and adolescents being monitored by the child welfare agency but remaining at home. Given these youths' heightened risk for mental health or substance use problems and the small likelihood that they will receive consistent well-child care, child welfare agencies also should promote access to mental health and substance use screening and assessment in these settings.

Joint Statement Recommendations for Screening Children in Foster Care	
Timing	**Age**
Monthly	First 6 months of age
Every 2 months	Ages 6–12 months
Every 3 months	Ages 1–2 years
Every 6 months	Ages 2 through adolescence
At times of significant changes in placement	Entry into foster care, foster home or placement transfers, or approaching reunification

Challenges in Child Welfare Settings

Child welfare agencies can improve the identification of mental health and substance use problems.

Research indicates that mental health and substance abuse disorders among children and adolescents involved with child welfare agencies are inconsistently identified and treated.[92 93 94 95 96] Although a number of states set requirements for screening or assessing the mental health needs of children entering foster care, the review of CFSR final reports found the following: only one state clearly indicated that all children and adolescents entering foster care actually received a mental health screening or assessment; in 40 states, practices were inconsistent in providing mental health screening and assessment services; and, in 11 states, reviewers could not determine whether children received a mental health screening or assessment.[97]

Child welfare agencies also could make improvements in the use of screening tools and instruments. A 2003 investigation of a probability sample of child welfare agencies in 36 states that were part of a national study found that only about one-quarter of the agencies required child welfare workers to use a specific tool or instrument for identifying children and adolescents with behavioral health needs when they entered out-of-home care.[98] The nature of the requirement varies between states. Sometimes this requirement applies only to a specified age group or other subgroup for which designated personnel have the responsibility for conducting the screen or assessment, and the timeframes for completing the requirement may differ. The review, however, was not able to clearly determine whether most of the remaining 34 states had such a requirement. The agencies that required the use of a specific tool assessed substantially more children than others.[99] Lack of timely information about a child's or adolescent's mental health needs can result in the child not receiving needed mental health services. In addition, case and placement decisions in such situations would be made without full information of the child's needs.

Child welfare staff face challenges in implementing screening.

Many children and adolescents are removed from their homes on an emergency basis. This situation can make it difficult to collect the information needed to complete the screen because:

- A caregiver familiar with the needs of an infant or young child may not be available, may be angry and unwilling to provide information, or may provide biased responses that he or she perceives will most likely get the child back home.
- Children and adolescents who are old enough to answer for themselves may be upset or angry and have difficulty responding to screening questions.
- The logistics of finding a placement, transporting and introducing the child or adolescent to the foster family or other placement, and arranging for school may totally occupy a child case worker, making it difficult to conduct a screen.
- Some caregivers may have substance use and mental health problems themselves, complicating their willingness and ability to provide information.

These situations require a screening tool that is brief and easy to use. If screenings occur in the context of a home visit, the tool must lend itself to unstructured situations. Because of the many challenges, case workers may not be able to meet the ideal standard of screening within 24 hours of placement. If caregivers are unavailable or uncooperative, case workers may need to find other informants who know the child or adolescent well.

If possible, a mental health and substance use screening of the child should be part of the risk and family assessment while the child is still in the home. This approach, however, would not replace the need for a screening or assessment if the child is removed from his or her home to identify possible traumatic effects. In addition, the case worker may not be the one to administer the screen; a physician or clinician may administer it instead.

Working With Caregivers

Caregivers as informants

Caregivers involved in child welfare services experience intensive scrutiny, demands for improving parenting, or even loss of custody if they say the wrong thing. These concerns and stresses may influence the reliability of their answers on a parent-report screening tool. Those caregivers whose children are in foster care have a particularly strong incentive to answer in ways that will lead to reunification. In addition, some caregivers struggle with their own mental health or substance abuse disorders, which may impair the quality of information they are able to provide.

Child welfare agencies interact with families who have a wide variety of languages and cultures. It is critical for the agency to select a tool that is appropriate for the language and literacy level of the caregiver or child responding, but the agency likely will have to use some tools that have not been tested or normed for the cultural groups with which it will be used.

To use such tools appropriately, the person administering the tool must be aware that cultural differences in child rearing may result in very different interpretations of the meaning of a child's behavior; as a result, the screening results should be regarded as less reliable than they would be for cultures on which they have been tested. Ideally, a child welfare agency will work with its cross-cultural staff and representatives from the different cultural groups it serves to identify such issues, select tools that minimize the differences, and help other workers understand the nature of the cultural issues. Training to help staff 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 that will be used by personnel other than those who conducted the screen, the agency needs to develop procedures that document the presence of cross-cultural issues so that these other personnel are able to appropriately weight the results.

The following resources provide information relating to cultural and linguistic competency.

Resources on Cultural and Linguistic Competency

- *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

Including caregivers in the screening process

The principle that families are the decision makers for their children and adolescents becomes complicated for families involved with the child welfare system. Some caregivers may have lost or are at risk of losing their guardianship rights, at least temporarily, while others are able to retain those rights.

To gain access to child welfare residential treatment in some states, caregivers may have to surrender their rights—even if they have not been abusive or neglectful. If caregivers retain custody, they must be fully informed about the screen and how its results will be used; also, their consent must be obtained. If caregivers do not have custody, child welfare agencies should provide this information to establish a productive partnership, which is key to the reunification process.

Foster parents have a right to information.

Foster parents are responsible for a child's or adolescent's care; however, the state retains the legal authority to make significant decisions about the youth, including whether he or she should be screened for mental health or substance use problems. Foster families, however, do have the right to information about the child's or adolescent's health history, health status, and health care needs.[100] The results of a mental health or substance use screening are vital to helping a foster family better understand the needs of the youth placed in their care. When the child or adolescent has been in placement for some time, the foster family is likely to be the most knowledgeable informant about the youth's current status.

The differing perspectives and agendas of foster and biological parents may lead to an unclear picture of how a youth is functioning, making it more complicated to interpret screening results. When screening results are not clear, the child welfare agency should initiate a more comprehensive assessment that gathers information from more than one source. Older children and adolescents can be interviewed and complete self-report tools, and teachers can complete tools for younger children. For children of all ages, behavioral observations by trained clinicians may be necessary. Observation of how infants and toddlers relate to both their biological and foster parents can be especially important.

Maintaining confidentiality is critical.

Because of the many parties involved in a foster child's life (including the courts) and because of the applicable laws on mental health and substance use information, maintaining the confidentiality of the screening results is critical and challenging. Child welfare agencies should remember that screening tools cannot produce a diagnosis; rather, such tools indicate the presence of a potential problem that should receive a more detailed assessment. Premature labeling of children and adolescents is counterproductive and also may be damaging.

The following resources provide information on working with families.

Resources on Working With Families

- *A Family's Guide to the Child Welfare System* (Publication)
  http://www.cwla.org/childwelfare/familyguide.htm
- *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues: Treatment Improvement Protocol (TIP) Series 36* (Publication)
  http://www.ncbi.nlm.nih.gov/books/NBK14695/

Assessing and Treating Foster Children and Adolescents

Child welfare agencies can draw upon the Social Security Act, Title IV, Part E, which focuses on resources for the assessment and treatment of children in foster care. In addition, children and adolescents at risk of being removed from their homes and those in foster care have the right to several important publicly funded health resources:

- **IDEA Part B.** Special education and other services may be provided by the school if a child's or adolescent's mental health condition affects his or her ability to learn. Assistance may be provided to parents and foster parents who need help communicating with the school to get needed services.
- **IDEA Part C.** The CAPTA law now requires that when there is substantiated child abuse or neglect of a child younger than age 3, child welfare agencies must offer caregivers a comprehensive assessment by a local IDEA Part C Early Intervention program. Highly qualified Early Intervention developmental specialists, disabilities therapists, social workers, and psychologists usually can identify and address caregiver and child mental health issues.*
- **Medicaid.** Children and adolescents in foster care are automatically eligible for Medicaid.[101] In some states, the Medicaid agency has a cadre of practitioners who are trained and experienced in diagnosing and treating the special needs of children and adolescents who have been abused or neglected.

States and agencies serving these children and adolescents may wish to review the extent to which child welfare agencies, courts, and treatment agencies use these entitlements and provide youths with the specific services covered by the law. The following resources provide legal information on assessment and treatment of foster children and adolescents.

* A second requirement under CAPTA affects the identification of drug-affected children at birth, for whom a state using CAPTA funds must have a "plan of safe care" and must report the birth to the child protective services agency. This reporting also can trigger services to the child.

Resources on Assessment and Treatment of Foster Children and Adolescents

- Social Security Act, Title IV (Grants to States for Aid and Services to Needy Families with Children and for Child-Welfare Services), Part E (Federal Payments for Foster Care and Adoption Assistance)
  http://www.ssa.gov/OP_Home/ssact/title04/0400.htm
- *Title IV-E: Foster Care and Adoption Assistance* (Publication)
  http://www.dhr.maryland.gov/ssa/foster/pdf/4efact.pdf
- Health Resources and Services Administration: *Find a Health Center* (Search engine for community mental health centers)
  http://findahealthcenter.hrsa.gov/
- IDEA Part B
  Contact the local school system.
- Medicaid
  Enter the term "Medicaid" and your state into an Internet search engine to find the Medicaid agency Web site for your state.
- State Part C Coordinators (List of IDEA Part C Early Intervention for Infants and Toddlers program coordinators by state)
  http://www.nectac.org/contact/ptccoord.asp
- Office of Head Start, Early Childhood Learning & Knowledge Center: *Head Start Locator* (Search engine for Head Start and Early Head Start center locations)
  http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartOffices/

Conclusion

The complex interplay between the demands of protecting children and adolescents and the requirements of identifying and treating youths' mental health and substance use issues poses identification and referral challenges for child welfare agencies, families, and service providers. Overcoming these challenges is especially critical in the context of rising child protection needs and historically inadequate child welfare resources. The growing understanding of the effectiveness and cost-efficiency of early treatment makes screening a valuable investment in the future of at-risk children and adolescents. The advent of scientifically proven, efficient, useful, and relatively inexpensive screening tools makes the task of screening all children and adolescents in the child welfare system achievable.

Supplement 2

Early Care and Education

This supplement is not intended to stand alone.
It builds upon the foundational information in Chapters 1–4.

Early Care and Education

Mental Health in Infants and Young Children

In this supplement, the term *healthy social and emotional development* refers to mental health in infants and children younger than 5 years of age. Even at a young age, infants and young children can experience mental health problems. For example, babies can show signs of depression (sleep problems, inconsolable crying, slow growth).[102] Approximately 13 percent of infants have mothers who suffer from postpartum depression, which may negatively affect the mother-child relationship and the child's development.[103] Many behavioral problems in young children are related to a child's developmental delay.[104] Much of a child's development occurs in the context of relationships with key caregivers.[105] Effective interventions typically involve teaching parents and other caregivers how to help the child develop these skills through positive interactions in the caregiving relationship.

Between 2005 and 2009, the number of U.S. children younger than age 5 averaged almost 21 million—approximately 7 percent of the population.[106] In 2008, more than 21 percent of U.S children younger than age 6 were in families living below the poverty level.[107] Much of the time, people other than parents care for young children. Forty-three percent of 2-year-olds are in full-time child care, as are 32 percent of 1-year-olds.[108] Behavior problems appearing in early care and education settings often can result in a child's expulsion. Young children in prekindergarten programs are expelled at more than three times the rate of students in grades K–12, while preschoolers in child-care centers are expelled at more than 13 times that rate.[109 110]

The promise of promoting healthy social and emotional development

Social and emotional health is a linchpin for a child's learning and other development. It is particularly important in the first years of life, when children are greatly affected by their environment and their interaction with caregivers and the community. The brain grows rapidly during the first years of life. Its evolving circuitry is built over time, affected by relationships and experiences beginning well before birth.[111] For example, preliminary studies suggest that the brains of young children who have experienced trauma differ in certain areas from those of children who have not experienced trauma, with abnormal brain functioning found in adulthood.[112] When trauma or "toxic stress" is experienced, children may function less effectively and behavior changes may persist into adolescence.[113]

However, it is possible to intervene promptly and address these problems effectively. Infants, toddlers, and preschoolers with social and emotional problems who receive Early Intervention services through the Individuals with Disabilities Education Act (IDEA) Parts B and C are more likely to complete high school, live independently, maintain productive employment, and avoid pregnancy and criminal behavior as they mature.[114] Studies of the cost-effectiveness of early childhood interventions indicate that providing appropriate and effective services and supports to young children can result in positive outcomes in areas

such as educational attainment, delinquency and crime reduction, and earnings.[115] These positive outcomes translate into dollar benefits for the larger community as a whole.

Few social and emotional problems are identified before children reach school age.

It is estimated that 70 percent to 80 percent of children with significant developmental and behavioral difficulties enter kindergarten without their problems being identified.[116] The Federal government mandates that children enrolled in Early Head Start (ages 0–3 years) or Head Start (ages 3–5 years) be screened for social, emotional, and developmental problems. However, Head Start reaches only 50 percent of eligible children and Early Head Start reaches only 5 percent.[117] In 2002, findings showed that IDEA Part C programs reached 3 percent or less of infants and toddlers with disabilities or delays[118] while IDEA Part B programs reached 6 percent or less of preschool children with disabilities.[119]

In general, early care and education providers do not have the training and resources to systematically perform screenings. Although they may easily identify children who act out as at risk for mental health problems, these providers may not recognize potential problems in children who are not disruptive. Children from minority cultures or whose families live in poverty are more likely to be at risk but commonly experience more barriers to services. Consequently, these young children are more likely to fall through the cracks.

The following resources provide information on the social and emotional development of young children.

Resources on Social and Emotional Development of Young Children

- Early Head Start National Resource Center (Web site)
  http://www.ehsnrc.org/
- *Fact Sheet: Vulnerable Young Children* (Publication)
  http://www.nectac.org/~pdfs/pubs/factsheet_vulnerable.pdf
- T*he Magic of Everyday Moments: How the Brain, Body and Mind Grow from Birth to Three* (Publications available for various age groups and in English or Spanish)
  http://www.zerotothree.org/child-development/early-development/magic-of-everyday-moments.html
- National Child Care Information Center (Web site)
  http://www.icfi.com/insights/projects/families-and-communities/national-child-care-information-center
- National Scientific Council on the Developing Child (Web site)
  http://developingchild.harvard.edu/initiatives/council/

Identification of Social and Emotional Problems in Very Young Children

What methods are used to identify social and emotional strengths and problems in very young children?

For infants and very young children, early identification is a process of determining whether a child is reaching specific milestones on time. The observations of early care and education providers trained in normal development and signs of potential social and emotional problems can be very useful in identifying signs of potential problems.

Formal screening tools for very young children are based on caregiver or parent observation. These tools provide guidance on what to look for and how to evaluate findings. Because the developmental milestones of young children are measured in weeks and months, screening tools have different versions for different age groups. Effective tools address the child's functioning and his or her interactions with caregivers and other important people. Newer screening tools may be more effective than some traditional tools.

How often should very young children be screened?

Children in early care and education settings should be screened—at minimum—once a year, usually when the child enters the program and/or at the beginning of each program year.* Because very young children develop so rapidly, more frequent screenings may be warranted for those with an elevated risk of social or emotional delays and for children who are not seen regularly in primary care. Whenever a teacher or a caregiver has a concern, it is appropriate to request a screen or assessment. (See "Ages or Events for Social and Emotional Screening" at right.)

Ages or Events for Social and Emotional Screening

- 3 months
- 6 months
- 9 months
- 18 months
- 30 months
- At entry to early care and education settings and annually thereafter when a caregiver is concerned.

* Both Head Start and the National Association for the Education of Young Children (NAEYC) standards require that a child receive a comprehensive developmental screen that includes social and emotional factors within 90 days of enrollment in an early care and education program.

Who should complete a screen?

Caregivers' observations are a critical source of information about the healthy development of their very young child. Caregivers have been shown to be reliable informants when using a reliable screening instrument, regardless of their own well-being, socioeconomic status, or where they live.[120] Others who have opportunities to observe the child, such as other primary caregivers or early care and education providers, also may be valuable informants. Using both a parent version and a teacher version of a tool can be helpful in developing a more detailed and multidimensional picture of the child.

The following resources provide information on screening young children.

Resources on Screening Young Children

- *Compendium of Screening Tools for Early Childhood Social-Emotional Development* (Publication)
  http://www.cimh.org/downloads/IPFMH_Screeningtools.pdf
- *Developmental Screening and Assessment Instruments with an Emphasis on Social and Emotional Development for Young Children Ages Birth through Five* (Publication)
  http://www.nectac.org/~pdfs/pubs/screening.pdf
- *Developmental Screening, Assessment, and Evaluation: Key Elements for Individualizing Curricula in Early Head Start Programs* (Publication)
  http://www.zerotothree.org/site/DocServer/FinalTAP.pdf?docID=221
  (also available in Spanish: http://www.ehsnrc.org/PDFfiles/TA4sp.pdf)
- *Mental Health Assessments for Infants and Toddlers* (Publication)
  http://www.zerotothree.org/site/DocServer/Hill_Solchany_Infant_Mental_Health_Assessments_for_court.pdf?docID=1851
- *Pediatric Developmental Screening: Understanding and Selecting Screening Instruments* (Publication)
  http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Manual/2008/Feb/Pediatric%20Developmental%20Screening%20%20Understanding%20and%20Selecting%20Screening%20Instruments/Pediatric_Developmental_Screening%20pdf.pdf
- *Understanding Young Children's Mental Health: A Framework for Assessment and Support of Social-Emotional-Behavioral Health* (Publication)
  http://www.education.ne.gov/OEC/teaching_pyramid/MH-Assess-Framework.pdf

Recognizing when tools may have limitations for certain cultural groups

The predictive effectiveness of available tools and their accuracy in screening cross-cultural populations has not been fully researched.[121] Tool selection can be a complex challenge; no single tool can be fully appropriate for all cultures because of the significant variance in what is considered normal development and appropriate parenting. Early care and education settings may need to take additional measures (as described on pages 33–35 in Chapter 2 of this guide) to make these tools meaningful for people of different cultures and who speak diverse languages. In cross-cultural situations, a tool may not be as accurate as it is for cultures on which it has been tested. However, a tool can serve as a useful springboard for ongoing discussion, helping parents and caregivers develop a shared understanding of the child's development in the context of specific cultural norms, beliefs, and traditions.

The following resource provides information on cultural competency and early childhood organizations and programs.

Resource on Cultural Competency

ZERO TO THREE: *Cultural Continuity in Child Care* (Web page)
http://www.zerotothree.org/site/PageServer?pagename=ter_key_edu_culture

Resources Relating to Early Childhood Organizations and Programs

- Center on the Social and Emotional Foundations for Early Learning (Web site)
  http://www.vanderbilt.edu/csefel/
- Collaborative for Academic, Social, and Emotional Learning (Web site)
  http://www.casel.org/
- Office of Head Start, Early Childhood Learning & Knowledge Center (Web site)
  http://eclkc.ohs.acf.hhs.gov/hslc/
- Office of Head Start, Early Childhood Learning & Knowledge Center: *Mental Health* (Web page)
  http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/Mental%20Health
- Healthy Child Care America (Web site)
  http://www.healthychildcare.org/index.html
- National Association for the Education of Youth Children (Web site)
  http://www.naeyc.org/
- National Childhood Technical Assistance Center: *Screening, Evaluation and Assessment* (Web page for IDEA Part C)
  http://www.nectac.org/topics/earlyid/screeneval.asp
- Technical Assistance Center on Social Emotional Intervention for Young Children (Web site)
  http://www.challengingbehavior.org/
- ZERO TO THREE: *Early Head Start* (Web page)
  http://www.zerotothree.org/public-policy/infant-toddler-policy-issues/early-headstart-1.html

Working With Caregivers

Confidentiality and parental consent

Early care and education settings that plan to use a screening tool should provide written notification to caregivers informing them of the reason for the screening. This notification should explain what is involved and indicate how the information will be stored and used. It also must indicate the caregivers' right to refuse to have their child screened without fear that any other service will be withheld.

Talking with caregivers when a screen has identified a possible problem

Caregivers of infants and very young children may have difficulty learning that their child may have a possible social or emotional problem. They may not see evidence of the problem and are likely to worry about how their child's growth will be affected. Some caregivers may fear that they are at fault for their child's problem. In these cases, staff at the early care and education settings can show caregivers how they can have a powerful and positive influence on their child's development. Noting a child's strengths may calm some of a caregiver's anxieties, and this approach can set the stage for using the child's strengths as the building blocks for healthy development.

Along with empathy for their worries, caregivers need accurate information about the problem, its seriousness, possible interventions, and what it might mean for the child's development and for family life. Few caregivers are likely to be familiar with the concept of social and emotional health for a very young child and may need a family-friendly explanation of what infant and early childhood mental health is.

The following resources provide information on family-friendly explanations and promotion of positive mental health in early childhood.

Resources on Family-Friendly Explanations

- Free parent brochures and guides (Publications)
  http://www.zerotothree.org/about-us/areas-of-expertise/free-parent-brochures-and-guides/
- *What Is Infant Mental Health?* (Publication)
  http://www.parecovery.org/documents/What_Is_Infant_Mental_Health.pdf
- ZERO TO THREE: *Promoting Social Emotional Development* (Web page)
  http://www.zerotothree.org/child-development/social-emotional-development/

Resources on Promotion of Positive Mental Health in Young Children

- *Management Strategies for Positive Mental Health Outcomes: What Early Childhood Administrators Need to Know* (Publication)
  http://www.rtc.pdx.edu/PDF/pbMgmtStratEarlyChild.pdf
- Triple P (Positive Parenting Program) America (Web site)
  http://www.triplep-america.com/index.html
- *What Works Briefs: Summaries of Effective Practices for Supporting Children's Social-Emotional Development and Preventing Challenging Behaviors* (Publications available in English and Spanish)
  http://www.vanderbilt.edu/csefel/resources/what_works.html

Addressing Social and Emotional Problems in Very Young Children

Effective intervention for a child's identified social and emotional problem may require only educational materials, extra support, or alterations in the child's environment. Early care and education settings can address the range of social and emotional needs of children who need specialized help by using a continuum of services, such as the following:

- Promotion and prevention activities to help families and caregivers foster social skills, emotional health, and positive behaviors in all children. These activities may include preschool skill-building curricula and teacher training.
- Early intervention, such as mental health consultation in early care and education settings and family support services for children with risk factors.
- Intensive treatment strategies, including case management; mental health and other treatment services; and child and family support services for young children with serious social, emotional, or behavioral problems.[122]

The availability of specialized resources for assessment and intervention is a significant challenge. Many communities lack adequate services or professionals specializing in the social and emotional wellness of the very young. However, new initiatives are increasing the number of people trained to help parents, caregivers, and early care and education providers address the social and emotional problems of very young children.

The following resources provide information on behavioral interventions for young children.

Resources on Behavioral Interventions for Young Children

- *Facts about Young Children with Challenging Behaviors* (Publication)
  http://www.challengingbehavior.org/do/resources/documents/facts_about_sheet.pdf
- Parents as Teachers (Web site)
  http://www.parentsasteachers.org/

Mental health consultation

In some programs, trained mental health professionals regularly visit early care and education settings and provide consultation to program staff and caregivers. With parental consent, they also can observe specific children and provide interventions to the child and family or assist them with accessing other behavioral and/or developmental services.

The following resources provide information on early childhood mental health consultation.

Resources on Early Childhood Mental Health Consultation

- Center for Child and Human Development: *Early Childhood Mental Health Consultation* (Web page)
  http://gucchd.georgetown.edu/67637.html
- *Promotion of Mental Health and Prevention of Mental and Behavioral Disorders. Volume I: Early Childhood Mental Health Consultation* (Publication)
  http://www.store.samhsa.gov/shin/content/SVP05-0151/SVP05-0151.pdf
- *What Early Childhood Directors Should Know About Working with Mental Health Professionals* (Publication)
  http://www.rtc.pdx.edu/PDF/fpS0403.pdf
- *What Works? A Study of Effective Early Childhood Mental Health Consultation Programs* (Publication)
  https://gushare.georgetown.edu/ChildHumanDevelopment/CENTER%20PROJECTS/WebSite/ECMHCStudy_Report.pdf

Assessment and treatment resources

The following public resources are available for assessment, treatment, and support of social and emotional problems of very young children:

- **Community mental health centers.** Depending on the state, these centers primarily deliver mental health services for children with the most serious conditions; however, some centers also may offer services for a broad range of mild to moderate problems.
- **Head Start and Early Head Start.** A key component of both Head Start and Early Head Start programs is the promotion of social and emotional development of very young children. Through these programs, parents and early care and education providers have access to a wide range of collaborative and supportive child and family services.
- **IDEA Part B—Early Intervention for Preschool Children.** This program provides comprehensive assessment to determine eligibility and services for those who meet eligibility criteria.
- **IDEA Part C—Early Intervention for Infants and Toddlers.** This program provides comprehensive assessment to determine eligibility and services for those who meet eligibility criteria.
- **Medicaid and the Children's Health Insurance Program.** These programs cover primary care and any needed specialized mental health services to treat identified problems.

Resources on Assessment and Treatment of Young Children

- Health Resources and Services Administration: *Find a Health Center* (Search engine for community mental health centers)
  http://findahealthcenter.hrsa.gov/
- IDEA Part B
  Contact the local school system.
- Medicaid
  To find the Medicaid agency Web site for your state, enter the term "Medicaid" and the state into an Internet search engine.
- State Part C Coordinators (List of IDEA Part C Early Intervention for Infants and Toddlers program coordinators by state)
  http://www.nectac.org/contact/ptccoord.asp
- Office of Head Start, Early Childhood Learning & Knowledge Center: *Head Start Locator* (Search engine for Head Start and Early Head Start center locations)
  http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartOffices/

Conclusion

The identification of social and emotional strengths and needs of infants and very young children is a new field, and further advances are likely. During the last few decades, the trend has been to develop more scientifically rigorous, developmentally appropriate specialized screening tools. One promising area is the development of screening tools that take into account family risks and resources as well as signs of mental health problems in children. Screening need not label young children but can be used to gain a more accurate picture of where they are in their development and, when indicated, point the way to further assessment or services. Early identification is a critical step to prevent problems and ensure that families build on their young children's strengths and enhance their growing capacity to learn.

Supplement 3

Family, Domestic Violence, and Runaway Shelters

This supplement is not intended to stand alone.
It builds upon the foundational information in Chapters 1–4.

Family, Domestic Violence, and Runaway Shelters

Mental Health and Substance Use Problems of Children and Adolescents in Shelters

The National Center on Family Homelessness estimates that 1.5 million American children and adolescents in families are homeless at any one time.[123] The largest percentage of these homeless children, approximately 42 percent, are younger than age 5.[124] The number of homeless youths who are alone, unaccompanied by family members is unknown; most estimates fall between 1.5 and 2 million per year.[125] Such unaccompanied youth may have run away from home or may have been forced out of their home by their caregivers. Homeless children and adolescents may end up in family homeless shelters, domestic violence shelters, or shelters for runaway youth. (For shelters serving children and adolescents entering the custody of the state, see Supplement 1: Child Welfare.)

The stress on children and adolescents who have become homeless and are living in a transitional setting is reflected in their higher risk for illness, difficulty in school, and psychological trauma, as compared to children with stable housing.[126] The effects of this stress also can increase children's risk for mental health and substance use problems. These risks can surface at the youngest ages. Any disruption to infants' and very young children's attachment to their most important caregivers can have lasting effects on their interpersonal growth and development.[127] Complex and repeated psychological trauma can actually alter the architecture and functioning of the very young child's developing brain.[128] [129]

Among children and adolescents ages 6–17 who are homeless:

- Almost 33 percent have at least one major mental health disorder that interferes with daily activities, compared to about 20 percent of other youths;
- Close to 50 percent have problems with anxiety, depression, or withdrawal, compared to about 20 percent of other youths; and
- More than 33 percent manifest delinquent and aggressive behavior, compared to less than 20 percent of other youths.[130]

Youths who run away from home (mostly girls) or who are kicked out of home (mostly boys) by their caregivers often are escaping from an environment of abuse, neglect, or extreme conflict. Any time spent on the street, however, exposes them to other risks. Runaway youths who spend significant time on the street before entering a shelter are more likely to have developed substance use problems, been beaten or raped, or engaged in survival sex.[131] They often are distrustful of adults, making it more difficult for child-serving organizations to help them.

The following resources provide information on the mental health and substance use challenges of homeless children and adolescents.

Resources on Mental Health and Substance Use Challenges of Homeless Children and Adolescents

- *Addressing Mental Health Needs in Families with Children* (PowerPoint presentation)
  http://www.endhomelessness.org/files/1930_file_rimberg.ppt
- Child Welfare League of America: *Mental Health and Homelessness: Impact on Children and Families* (Web page)
  http://www.cwla.org/programs/bhd/mhhomelessness.htm
- *Homelessness and Its Effects on Children* (Publication)
  http://www.fhfund.org/_dnld/reports/SupportiveChildren.pdf
- National Alliance to End Homelessness: *Policy Focus Area: Youth* (Web page)
  http://www.endhomelessness.org/section/policy/policy_focus_areas/youth/
- National Center on Family Homelessness: *Physical and Emotional Awareness for Children Who Are Homeless* (Web page)
  http://www.familyhomelessness.org/peach.php?p=ss
- *Protecting the Mental Health of Homeless Children and Youth* (Publication)
  http://www.nhchc.org/bibliograpy/protecting-the-mental-health-of-homeless-children-and-youth/
- *Runaway and Homeless Youth: Demographics, Programs, and Emerging Issues* (Publication)
  http://www.endhomelessness.org/content/general/detail/1451

Effective Identification of Mental Health and Substance Use Problems

Despite the fact that children and adolescents in family shelters are at increased risk of mental health and substance use problems, the majority of these youths do not manifest such problems. If such problems already have occurred, however, youths or families entering a shelter may find opportunities to get the services and continuing care they need for preexisting problems. In addition, homelessness may have disrupted the regular health care of children or adolescents, so newly arising problems may not have been identified.

Understanding trauma

Psychological trauma is one of the most pressing mental health issue for many children and adolescents in shelters. Homeless youth on their own are likely to be fleeing sexual or physical abuse and are at high risk for further trauma if they live on the street.[132]

Thus, a shelter's first priority is to become trauma informed to better meet the mental health needs of its residents. According to SAMHSA's National Child Traumatic Stress Network, staff must "understand, anticipate, and respond to the special needs of trauma survivors and must ensure that these services do not inadvertently retraumatize families."[133] In addition, a shelter may want to identify children and adolescents with potential problems and implement or make referrals to evidence-based programs that have proven to be effective in treating traumatic stress. Because psychological trauma can affect children and adolescents in a variety of ways, identification of mental health and substance use problems can be best accomplished with the use of a broad-based, well-validated screening tool, such as those tools in Table 1 and Table 2 in Chapter 2.

The following resources provide information on trauma and homelessness.

Resources on Trauma and Homelessness

- *Facts on Trauma and Homeless Children* (Publication)
  http://www.nctsnet.org/sites/default/files/assets/pdfs/Facts_on_Trauma_and_Homeless_Children.pdf
- National Child Traumatic Stress Network (Web site)
  http://www.nctsn.org/
- *Psychological First Aid for Families Experiencing Homelessness* (Publication)
  http://www.nctsnet.org/sites/default/files/assets/pdfs/PFA_Families_homelessness.pdf
- *Psychological First Aid for Youth Experiencing Homelessness* (Publication)
  http://www.nctsnet.org/sites/default/files/assets/pdfs/pfa_homeless_youth.pdf
- Safe Start Center (Web site)
  http://www.safestartcenter.org/
- *Trauma Among Homeless Youth* (Publication)
  http://www.nctsnet.org/sites/default/files/assets/pdfs/culture_and_trauma_brief_v2n1_HomelessYouth.pdf
- *Understanding Traumatic Stress in Children* (Publication)
  http://www.familyhomelessness.org/media/91.pdf

Youth shelter settings

Given the high incidence of prior family abuse and street living among children and adolescents in runaway shelters, researchers "advise service providers to expect a range of high-risk behaviors and family problems and to develop comprehensive counseling and treatment programs for substance abuse, mental and physical health issues,

and family problems."[134] Shelter staff should incorporate methods to promptly identify on admission those children and adolescents who are in crisis. Shelters also should be prepared to identify less severe problems and to support engagement in appropriate treatments for all of their clients. Implementing these efforts can be challenging with youths who have reason to distrust adults. Training staff in the warning signs of mental illness and substance use can be helpful in identifying potential problems that a child or adolescent may be unwilling to disclose.

The following resources provide information on warning signs of mental health and substance use problems.

Resources on Warning Signs of Mental Health and Substance Use Problems

- *The Action Signs Project: A Toolkit to Help Parents, Educators and Health Professionals Identify Children at Behavioral and Emotional Risk* (Publication)
  http://www.thereachinstitute.org/files/documents/action-signs-toolkit-final.pdf
- Adolescent Substance Abuse Knowledge Base: *General Signs of Alcohol or Drug Use* (Web page)
  http://www.adolescent-substance-abuse.com/signs-drug-use.html

Other approaches to identification and intervention

Not all mental health conditions experienced by children and adolescents in shelters are caused by stress or psychological trauma. Some preexisting conditions are either diagnosed or undiagnosed, and others may manifest as a child reaches the age when a condition is most likely to arise. Shelters have a number of opportunities to assist their residents with getting needed health and mental health care:

- Shelters can promptly refer their child and adolescent residents for primary health care check-ups with practitioners who understand the health and mental health risks of homelessness and will screen and assess for those risks. Just as they do for health and dental services, shelters can assist in locating available mental health and substance abuse treatment resources that child and adolescent residents can use if a problem is identified.
- Shelters can educate their staff on warning signs of mental health problems and underage substance use so they can identify the children and adolescents who are most at risk and help their caregivers find needed services.
- Shelters can implement a screening program as part of their intake or service planning process using validated, age-appropriate tools.
- Shelters serving families can promote positive parenting practices and help caregivers better understand and meet each youth's developmental and emotional needs.

The following resource provides information on the Child Welfare League of America's positive parenting course, which could be implemented by shelters.

Resource on Positive Parenting During Homelessness

USG Positive Parenting Program for Homeless Families: Implementation Guide (Publication)
http://www.cwla.org/programs/housing/usghousingreport.pdf

Although there is little published guidance that directly addresses mental health and substance use screening in family shelters, information about substance abuse treatment in domestic violence shelters may be relevant. The following resource provides information on substance abuse in domestic violence shelters.

Resource on Substance Abuse in Domestic Violence Centers

Illinois Department of Human Services: *Addressing Substance Abuse In Domestic Violence Agencies* (Web page)
http://www.dhs.state.il.us/page.aspx?item=38459

Working With Children, Adolescents, and Families

Parental consent is necessary to administer a mental health or substance use screen to any child, and older children and adolescents completing their own screen also should provide assent. Parents, older children, and adolescents need to know how the information will be used, that it will be kept private and confidential, and that it will be shared with other parties only with their consent. A shelter must provide privacy when administering screens. Records of screens must be kept confidential. Screening does not provide sufficient information to label or diagnose a mental health or substance use problem, so staff should not use language that suggests anything more than the likelihood that the child or adolescent may have some kind of problem that should be further assessed.

In general, shelters can allow unaccompanied youths to consent to their own screening, even if they are under the age of majority, given the crisis of their homeless state and the legal right that many youths have to request services as mature or emancipated minors. When these conditions do not apply, the consent of a parent or guardian should be sought. However, the shelter should not seek consent from the parent or guardian if seeking such consent might not be safe for the youth or if it might cause the youth to leave the shelter.

Shelters should follow all regulations for safeguarding mental health and substance abuse information collected from their residents. Youths and caregivers may fear that disclosure of information about the use of substances or mental health conditions will result in losing their shelter bed and reducing their choices for services. Shelters should provide information to help residents better evaluate the risk of participating in a screening, but they need to respect residents' right to refuse to participate in the process.

Mental illness and substance abuse often are poorly understood and stigmatized conditions. The process of identifying these problems can be put into a strengths-based, family-friendly context by providing a positive definition of *social and emotional health* for very young children and *mental health* for older children and adolescents. In addition, shelter staff can communicate the fact that many children and adolescents experience such problems and explain that helpful treatments are available. Focusing on a child's or adolescent's difficulties in coping with homelessness rather than on behavioral problems likely will motivate a parent or guardian to consent to and collaborate in the identification process. Information on children's and adolescents' mental health, substance use, and screening results needs to be communicated respectfully, conveyed with understanding of the culture of the youths and their families, and spoken in the caregivers' and youths' language when necessary.

Working with caregivers when a screen is positive

When screening indicates a cause for concern, shelter staff should convey the information in a way that does not overwhelm the caregiver. Findings can be couched in the context of the psychological trauma that a family has been undergoing so the caregiver can hear that the child or adolescent might easily do well under more normal circumstances. In addition, caregivers should understand that, in many cases, what children and adolescents need most is understanding and support. Most interventions for infants and very small children involve working with their primary caregivers. Caregivers also should be actively involved in the treatment of older children and adolescents, which may involve education about their child's mental health condition and treatment; individual, family, and/or group counseling; or behavior plans. Some children and adolescents, with parental consent, also may be helped by medication.

Assessing and Treating Youth in Shelters

Connecting shelter residents with services can be complicated by the likely move to another living situation and—in the case of domestic violence—safety considerations. Therefore, when making a referral, shelter staff should consider where the family or youth will be living next and whether there is access to transportation for appointments. It also is crucial to avoid making referrals that might disclose a youth's or family's location or send them to a site where their abuser is in treatment. Risk of problematic referrals is likely to be highest in rural settings or other areas where treatment facilities are limited. If shelters are able to offer on-site mental health or substance use assessments or services,

they must be careful to provide services in a way that does not identify residents as having mental health or substance use problems.

Children, adolescents, and families in shelters often are eligible for the community resources outlined in Chapter 4. Particular challenges may arise when accessing services from schools or for transition-age youth.

If a child's or adolescent's mental health condition affects his or her ability to learn, caregivers also may need help communicating with the school to get needed services—including, but not limited to, special education.

The following resources provide information on education and mental health of homeless students.

Resources on Education and Mental Health of Homeless Students

- *The Educational Rights of Students in Homeless Situations: What Service Providers Should Know* (Publication)
  http://center.serve.org/nche/downloads/briefs/service_providers.pdf
- *Finding Help and Working with Schools: Tips for Parents of Teens with Mental Health Problems* (Publication)
  http://www.edc.org/sites/edc.org/files/pdfs/great_minds_parents.pdf
- *Homeless Education: An Introduction to the Issues* (Publication)
  http://center.serve.org/nche/downloads/briefs/introduction.pdf
- *The 100 Most Frequently Asked Questions on the Educational Rights of Children and Youth in Homeless Situations* (Publication)
  http://www.nlchp.org/content/pubs/100%20Most%20Frequently%20Asked.pdf
- National Association for the Education of Homeless Children and Youth (Web site)
  http://www.naehcy.org/
- National Center for Homeless Education (Web site)
  http://center.serve.org/nche/
- National Network for Youth (Web site)
  http://www.nn4youth.org/

Unaccompanied youths

Unaccompanied youths have the right to attend public schools. The following resource provides information on the rights of unaccompanied youths.

Resource on the Rights of Unaccompanied Youths

Alone Without a Home: A State-by-State Review of Laws Affecting Unaccompanied Youth (Publication)
http://www.nlchp.org/content/pubs/alone%20Without%20A%20Home1.pdf

Child welfare agencies

Caregivers and shelters may view child welfare agencies as a threat to parents' rights to maintain custody of their children. However, these agencies have resources that can assist families with reestablishing a stable home and arranging needed services.

The following resource provides information for child welfare agencies dealing with unaccompanied youths.

Resource for Child Welfare Agencies Dealing With Unaccompanied Youths

What Child Welfare Advocates Can Do for Unaccompanied Youth (Publication)
http://www.serve.org/nche/downloads/child_wel_uy.pdf

Transition-age youths

Many unaccompanied adolescents have left foster care. They may continue to be eligible for services from the child welfare agency if they are willing to accept such services. Child welfare agencies also are beginning to offer continued services to adolescents between the ages 18 and 21, and a number of other organizations are trying to address the needs of this underserved group. Adolescents older than age 18 generally do not qualify for Medicaid and may have a harder time accessing health and mental health services. However, they may be eligible for services from community mental health centers or may receive health care from programs for the homeless.

The following resources provide information on transition-age youths.

Resources on Transition-Age Youths

- Child Welfare League of America: *Housing and Homelessness: Publications and Reports* (Web page listing publications)
  http://www.cwla.org/programs/housing/housingpubspage.htm
- *Moving On: Analysis of Federal Programs Funding Services to Assist Transition-Age Youth with Serious Mental Health Conditions* (Publication)
  http://bazelon.org.gravitatehosting.com/LinkClick.aspx?fileticket=8Vesx_bWHBA%3d&tabid=104

Conclusion

The mental health and substance use problems of children and adolescents entering shelters should be identified and met within the context of addressing all their health care needs. Shelters' emphasis on countering the stigma of homelessness can be adapted to help residents understand that when a possible mental health or substance use problem is identified, confidential and effective services can help children and adolescents feel better and cope with their current circumstances.

Supplement 4

Juvenile Justice

This supplement is not intended to stand alone.
It builds upon the foundational information in Chapters 1–4.

Juvenile Justice

Mental Health and Substance Use Problems of Youths in the Juvenile Justice System

Law enforcement agencies made 2.2 million arrests of persons under the age of 18 in 2003;[135] in 2002, juvenile courts handled 1.6 million delinquency cases;[136] and, in 2003, about 97,000 juvenile offenders were being held in juvenile residential facilities.[137] Youths from certain racial and ethnic groups are disproportionately represented in the juvenile justice system compared to their representation in the country as a whole.[138] Many of these youths have committed only minor offenses. A small percentage of these youths have not committed any offense, but caregivers may have turned to the juvenile justice system to obtain needed intensive behavioral health services for their children with serious emotional disturbances.[139]

Studies have found that most youths in the juvenile justice system have mental health and/or substance use problems, indicating that the population falls predominantly in the top and middle sections of the prevention pyramid shown in Figure 2 (page 24).

- A 2006 multisite study that included the whole spectrum of settings in the juvenile justice system reported that 80 percent of girls and 67 percent of boys in the system met criteria for at least one mental health disorder.[140]
- Exposure to traumatic experiences is very common among youths in the juvenile justice system. One 2004 study found that more than 90 percent of juvenile detainees reported having experienced at least one traumatic incident.[141] This study also found posttraumatic stress disorder in 11 percent of a sample of youths in a temporary detention center.[142]
- Among youths in the juvenile justice system, the conditions most prevalent in girls differed from those found in boys. Girls were more than twice as likely as boys to experience anxiety and mood disorders.[143] Girls also had a higher incidence of traumatic experiences, many of which included being victimized.[144]
- Many youths in the juvenile justice system have complex and serious disorders in addition to mental health and substance use problems.
- Among youths meeting criteria for a mental health disorder, almost two-thirds also met criteria for a substance abuse disorder and more than one-third met criteria for three or more mental health disorders.[145]
- More than 25 percent of justice system-involved youths experience severe disorders that require significant and immediate treatment, such as conditions that require hospitalization or cause functional impairment.[146]
- A 2006 study of juveniles sampled from intake at the Cook County (Illinois) Juvenile Temporary Detention Center found that virtually half (49 percent) were assessed to have a diagnosis of a substance abuse disorder within the past month and approximately one-third (35 percent) also had a comorbid mental health disorder.[147]

- The risk of suicide for youths in the juvenile justice system exceeds the risk for youths generally.[148] In addition to mental health and substance use problems, these youths often have difficulties in school that are manifested as problems in reading, attention, and language skills.[149]

Juvenile justice systems face challenges in fulfilling their ethical and legal responsibilities to care for the youths in their custody. The mental health and/or substance use problems of some youths may lead to aggression or suicide and affect the safety of not only the justice system-involved youths but also other youths and staff in residential facilities. In addition, these problems may contribute to a youth's reoffending and the danger that he or she may pose to others in adulthood.[150]

The following resources provide information on mental health and substance use problems in the juvenile justice system.

Resources on Mental Health and Substance Use Problems in the Juvenile Justice System

- *Co-occurrence of Substance Use Behaviors in Youth* (Publication)
  http://www.ncjrs.gov/pdffiles1/ojjdp/219239.pdf
- *Psychiatric Disorders of Youth in Detention* (Publication)
  http://www.ncjrs.gov/pdffiles1/ojjdp/210331.pdf

Screening Youths in the Juvenile Justice System

Personnel in the justice system traditionally have used relatively informal and unsystematic practices to make decisions regarding the youths in their charge, which often has led to invalid inferences about the youths and their behavioral health conditions.[151] The juvenile justice system has made considerable progress in moving away from these informal methods and toward the use of scientific tools that identify mental health and substance use problems, resulting in a more accurate and equitable system. By 2002, 53 percent of juvenile offenders were held in facilities that screened for mental health and suicide and 67 percent were held in facilities that screened for substance use.[152] Further, a number of states require the screening of all youths entering a juvenile justice facility using an instrument that addresses both mental health and substance use.[153]

In addition to meeting the criteria for screening all youths, instruments used within the juvenile justice system must meet several criteria specific to the correctional setting. The Office of Juvenile Justice and Delinquency Prevention published *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners,* which provides best practice information on identifying

youth with mental health and substance use problems. This publication also provides detailed information on scientifically sound screening and assessment tools as well as guidance on how to select and administer these tools in a juvenile justice setting. The following resources provide information on screening tools.

Resources on Screening Tools

- *Mental Health Screening within Juvenile Justice: The Next Frontier* (Publication)
  http://www.ncmhjj.com/pdfs/MH_Screening.pdf
- *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners* (Publication)
  http://www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf

Throughout the many levels of the juvenile justice system, attempts are being made to better meet the mental health and substance abuse needs of court-involved youth. The National Center for Mental Health and Juvenile Justice in partnership with the Council of Juvenile Correctional Administrators—both of which are advised by an expert panel and a broadly representative review group—have developed the *Blueprint for Change* to guide and amplify efforts to better address the needs of justice system-involved youths with mental health problems. The *Blueprint for Change* highlights critical intervention points during the judicial process when accurate information about mental health and substance use problems can help inform court decisions. The following resources provide information on *Blueprint for Change*.

Blueprint for Change Resources

- Full Report:
  Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System (Publication)
  http://www.ncmhjj.com/Blueprint/pdfs/Blueprint.pdf
- Summary:
  A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System (Publication)
  http://www.ncmhjj.com/Blueprint/pdfs/ProgramBrief_06_06.pdf

The Center for Promotion of Mental Health in Juvenile Justice at Columbia University hosted a Consensus Conference in 2002 in which a national group of expert researchers and practitioners identified best practices for screening and assessing youths in the juvenile justice system.[154] The group's recommendations have been endorsed by the American Probation and Parole Association, the National Mental Health Association (now Mental Health America), and the National Alliance on Mental Illness. The Voice-Diagnostic Interview Schedule for Children (V-DISC) tool—a version of the DISC Predictive Scales (DPS) listed on pages 165–166—is free for use in juvenile justice settings. The National Center for Mental Health and Juvenile Justice provides the protocols developed for a demonstration project for screening, assessment, and follow-up of juveniles.

Reclaiming Futures is a demonstration program with sites in nine states that are testing approaches for juvenile courts to work collaboratively with community systems of care to better meet the needs of substance-abusing youths in the court system. The sites are documenting lessons learned, and the program's publications address a number of topics—such as collaboration, financing, and working with caregivers—that strengthen court and community responses to youths' substance use problems. Many of these approaches likely will translate effectively to meeting youths' mental health needs.

The following resources provide information on mental health in juvenile justice settings.

Resources on Mental Health in Juvenile Justice Settings

- Center for Promotion of Mental Health in Juvenile Justice: *Best Practices* (Web page)
  http://www.promotementalhealth.org/practices.htm
- National Center for Mental Health and Juvenile Justice (Web site)
  http://www.ncmhjj.com/
- National Youth Screening and Assessment Project (Web site)
  http://www.nysap.us/
- Office of Juvenile Justice and Delinquency Prevention (Web site)
  http://www.ojjdp.gov/
- *Procedural Guidelines for Conducting Need/Risk Screening and Assessment* (Publication)
  http://www.ncmhjj.com/pdfs/ProceduralGuidelinesFinal.pdf
- Reclaiming Futures: Communities Helping Teens Overcome Drugs, Alcohol and Crime (Web site)
  http://www.reclaimingfutures.org/

Screening in judicial settings

The role of the court in juvenile justice settings alters some of the processes for identifying mental health and substance use problems in youths. This situation requires careful planning by juvenile justice programs to ensure that they develop identification processes that address the following considerations:

Confidentiality. If a screening is administered by health care staff, the use of the information must comply with state data-privacy regulations and the Health Insurance Portability and Accountability Act. If the screen is not administered by a health care professional, in some cases and in some states, youths who are in custody have a lesser expectation of confidentiality. For this reason, the standards of the International Association for Correctional and Forensic Psychology (formerly the American Association for Correctional and Forensic Psychology) recommend that juvenile justice system settings develop and document policies and procedures for ensuring confidentiality of all psychological files, records, and test protocols and provide access only to those who have a "need to know."[155] The National Commission on Correctional Health Care underscores the inappropriateness of health care services staff collecting forensic information.[156] Any juvenile justice setting and its associated court need to determine the circumstances under which state law allows screening results to be used in court and then develop procedures and protocols that provide maximum confidentiality available within the law. These settings also need to develop a notice of privacy practices, which must be given to the legal guardian or the emancipated minor prior to screening.

Self-incrimination. Screening instruments may include questions about activities that are illegal. Honest answers to such questions might incriminate a youth who has been involved in illegal activities, some which may be in addition to those that caused the youth to be arrested or detained.[157] Requesting such sensitive information in a court-related setting requires an understanding of how screening information is protected and whether it can be used in judicial proceedings. Each setting should clearly define and communicate the degree to which the information in the screen may be used in a youth's adjudication. Privacy notices should clearly state whether information from a screening will be used to make a legal decision. If a question can cause the revelation of incriminating information that cannot be protected, it is usually best to exclude the question. Even when information is protected from use in adjudication decisions, people collecting information should take into account the fact that adolescents and families may perceive such information to be potentially prejudicial and may change their answers accordingly. The higher the stakes for the outcome of a screening, the higher the standard should be in assuring the quality of the screening tool.[159]

Avoid Causing Youths to Self-Incriminate

"Justice facilities must have protections in place so that either information provided in an intake screen cannot be used in support of current or future charges, or facilities do not ask questions by which youths may self-incriminate."

—Wasserman et al. (2003)[158]

The following resources provide information on self-incrimination and confidentiality.

Resources on Self-Incrimination and Confidentiality

- *A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System* (Publication)
  http://www.ncmhjj.com/Blueprint/pdfs/ProgramBrief_06_06.pdf
- Center for the Promotion of Mental Health in Juvenile Justice: *Self-Incrimination* (Web page)
  http://www.promotementalhealth.org/confidentiality.htm
- *Protecting Youth from Self-Incrimination when Undergoing Screening, Assessment and Treatment within the Juvenile Justice System* (Publication)
  http://www.jlc.org/resources/publications/protecting-youth-self-incrimination-when-undergoing-screening-assessment-and-

Laboratory testing for drug or alcohol use

Because laboratory testing is regarded as a physical process, the laws pertaining to consent and self-incrimination in regard to screens of urine, blood, or saliva are different from those that apply to screening and assessment tools for mental health and substance use problem identification. Although the appropriate use of laboratory testing is beyond the scope of this guide, other resources are available for reference.

The following resource provides information on drug testing.

Resource on Drug Testing

Drug Identification and Testing in the Juvenile Justice System (Publication)
http://www.ncjrs.gov/pdffiles/167889.pdf

Positive youth development

The principles of positive youth development (such as facilitating healthy behavior and discouraging harmful behavior) can help juvenile justice staff put screening into a strengths-based context—an approach that is being widely adopted by many child-serving settings and can be integrated into the rehabilitative goals of the juvenile justice system. Although working within juvenile justice security and supervision requirements can be challenging, child-serving organizations can use many diverse and creative approaches to meet the needs of youths involved in the juvenile justice system.

The following resource provides information on positive youth development.

Resource on Positive Youth Development

Focusing Juvenile Justice on Positive Youth Development (Publication)
http://www.chapinhall.org/sites/default/files/publications/249.pdf

Working With Caregivers

The principle behind partnering with caregivers in the provision of mental health and substance use screening and services is equally applicable to juvenile justice programs. However, juvenile justice systems in many jurisdictions are not accustomed to actively partnering with caregivers. In fact, building effective partnerships with caregivers may be particularly difficult if problematic family situations may have contributed to a youth's delinquency or if the family of a delinquent youth has become extremely frustrated with his or her behavior. In addition, staff may need to bridge linguistic and cultural barriers to communicate with caregivers.

The importance of partnering with caregivers

Caregivers provide valuable information. Juvenile justice programs may need more complete and accurate information about a youth's behavior, mental health condition, and treatment than the youth can provide. When a youth is detained, the caregiver's provision of information about medications and anticipated behaviors can be essential in ensuring the safety of the youth and others. In addition, caregivers who have actively sought services for a youth with a severe emotional disturbance have important information about what has and has not helped, which is valuable in developing service plans.

Caregivers have profound concern for their child. Parents or guardians generally retain their rights to consent to medical screening and procedures for youths involved in community programs or at the beginning of the judicial process. When a youth is placed in a juvenile facility, the continued concern of parents and guardians must be recognized and respected, even if they eventually relinquish or lose some of their parental rights. As services are provided, caregivers need to receive regular information about the youth's progress and should be included in planning activities.

Caregivers continue to have influence over their child. Youths with mental health and substance use problems, court involvement, and possible learning problems need the support of caring adults. The ongoing importance of caregivers in a youth's life needs to be recognized and incorporated into any treatment. In particular, problematic family relationships can be significant in their negative influence on a youth and can have implications on a youth's ability to positively complete his or her legal obligations, such as the conditions of probation or parole.

Caregivers help youths in out-of-home settings prepare for their return to home and community. Both caregivers and youths need safe and realistic plans to prepare for a youth's successful return to home and the community.

Strategies for partnering with caregivers

Caregivers need clear information, reference materials, and support to understand the legal process and the rights of their child. Before focusing on a youth's mental health or substance use problems, however, a family may need assistance with understanding and coping with court procedures.

- Caregivers who do not speak English well and those with limited understanding of the U.S. police and court systems may need information in their own language about police and court procedures and their rights and those of their child.
- Many families feel ashamed and defensive when a youth becomes involved with the court, making it more difficult for court staff to establish a positive relationship. Staff should offer respect and understanding to families and avoid blame.
- A youth's arrest may result from or precipitate a family crisis, making it difficult for the family to be an active partner in the juvenile justice process. Staff should be aware that although crises can increase motivation for a family to make needed changes, the process is still difficult.

Staff should be patient and offer referrals for supportive services that can help families stabilize the situation as well as address the needs of the youth.

- Families have competing responsibilities. Most caregivers need to continue to hold down a job and care for other children—some of whom may have special needs. Staff should be realistic about what families can take on and be flexible in scheduling meeting times so caregivers can meet their employment needs and care for other children.
- Juvenile justice staff should establish protocols for communicating regularly with caregivers about the status and progress of their child throughout the youth's involvement with the court.
- Juvenile justice staff should include caregivers in the development of a realistic plan for a youth's successful transition to home and school. Caregivers need to be aware of any probation or parole requirements and continued care needs so they can support their child in fulfilling all obligations.

Some juvenile justice staff may hold negative views of families that can interfere with their ability to effectively work with families. Staff also may need training in communication to encourage engagement, create awareness of mental health and substance use conditions and treatments, and promote the use of community treatment and support resources. Local family-support organizations may be willing to collaborate on improving juvenile justice capacity in this regard. Local leaders of various cultural communities can help build a better understanding of their culture and preferred communication style; at times, they may act as a bridge to facilitate communication between the family and juvenile justice staff.

Parents or guardians of juveniles being brought before the court usually retain their right to consent to the youth's health care.

Facilities must formulate procedures consistent with the laws in their jurisdiction. For example, Minnesota has a procedure to notify parents or guardians that the juvenile justice system plans to screen the youth and also informs them that they have a right to refuse consent for the screening. If an adolescent is exercising rights as a mature minor, he or she must receive the same notification. In emergency situations, when a professional has determined that there is a risk to a youth's life or health, screening can proceed without consent, but parents and guardians should be notified as soon as possible thereafter.

The following resources provide information on working with families.

Resources on Working With Families

- *Engaging and Empowering Families in Finding Solutions: An Annotated Bibliography of Recent Works and Resources Available on the World Wide Web* (Publication)
  http://spfdsapolicyinstitute.pbworks.com/f/RFBiblio-Families.pdf
- *Involving Families of Youth Who Are in Contact with the Juvenile Justice System* (Publication).
  http://www.ncmhjj.com/pdfs/publications/family.pdf
- *What Families Think of the Juvenile Justice System: Findings from a Multi-State Prevalence Study* (Publication)
  http://www.rtc.pdx.edu/PDF/fpS0607Corrected.pdf

Minnesota has developed a mental health screening notice that is consistent with its state laws and regulations and may provide a useful model for other states. Information on this resource follows. Each state, however, must ensure that its procedures comply with its own laws and regulations.

Model Mental Health Screening Notice

Mental Health Screening Notice from the Minnesota Department of Human Services (Sample notice)
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4828-ENG

Assessing and Treating Youths in the Juvenile Justice System

Finding assessment, treatment, and support resources for youths involved in the juvenile justice system is challenging in a number of ways. Juvenile justice staff often are not acquainted with the range of proven, efficacious treatments for the conditions common among the youths they serve. Columbia University has developed a guide to help clinicians match a youth to appropriate treatment. Information about this resource follows.

Resource on Referrals to Treatment

Columbia University Guidelines for Child and Adolescent Mental Health Referral (Publication)
http://www.promotementalhealth.org/downloads/Guidelines.pdf

Given the high prevalence of trauma in the histories of both boys and girls, juvenile justice programs need to become trauma informed. They must develop practices that do not inadvertently retraumatize the youths and exacerbate their mental health problems. In addition, juvenile justice programs need to provide or make referrals for treatment services that are able to address the challenges of trauma. Several resources offer information and technical assistance on serving youths who have been traumatized.

Resources on Trauma

- Center for Early Childhood Mental Health Consultation: Tutorial 6: *Recognizing and Addressing Trauma in Infants, Young Children, and Their Families* (Online tutorial)
  http://www.ecmhc.org/tutorials/trauma/index.html
- *Culture and Trauma Brief* (Publication)
  http://www.nctsnet.org/nctsn_assets/pdfs/culture_and_trauma_brief_v2n1_HomelessYouth.pdf
- National Resource Center for Health and Safety in Child Care and Early Education: *Healthy Kids, Healthy Care: Child Abuse and Neglect* (Web page)
  http://nrckids.org/CFOC3/HTMLVersion/Chapter03.html#3.4.4
- National Center for Trauma-Informed Care (Web site)
  http://mentalhealth.samhsa.gov/nctic/
- National Child Traumatic Stress Network (Web site)
  http://www.nctsn.org/
- Safe Start Center (Web site)
  http://www.safestartcenter.org/
- *Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions* (Publication)
  http://www.ncmhjj.com/pdfs/Trauma_and_Youth.pdf

Many juvenile offenders with mental health or substance use problems will need appropriate services during their participation in juvenile justice programs and also will need ongoing community services afterward. Those who have completed a period of incarceration or residential treatment will need services and supports that can support their reentry into the family and community. With the increasing availability of evidence-based, comprehensive aftercare models that combine criminological approaches with needed treatment services, juvenile justice systems are working actively to establish strong linkages with community providers to ensure that juvenile offenders receive needed services upon reentry into the community. The following resource provides information on aftercare.

Resource on Aftercare

Aftercare Services (Publication)
http://www.ncjrs.gov/pdffiles1/ojjdp/201800.pdf

Finding community treatment services for justice system-involved youths is challenging because resources often are limited. Youths incarcerated in juvenile facilities are not eligible for Medicaid, putting the burden of financing treatment services solely on state government. In addition, sometimes these youths do not regain Medicaid after release or there are long delays in reestablishing it.[160] States can coordinate the suspension rather than termination of Medicaid benefits between the juvenile justice agency and Medicaid while youths are incarcerated. In addition, state and county juvenile justice authorities may wish to review information about how Federal funding sources can be used for minors in contact with the juvenile justice system.

The following resources provide information on funding mental health services for youths in the juvenile justice system.

Resources on Funding

- *Blueprint for Change: Funding Mental Health Services for Youth in Contact with the Juvenile Justice System* (Publication)
  http://www.ncmhjj.com/pdfs/BlueprintFunding.pdf
- *Funding Mental Health Services for Youth in the Juvenile Justice System: Challenges and Opportunities* (Publication)
  http://www.ncmhjj.com/pdfs/publications/Funding_Mental_Health_Services.pdf

Finally, older teens involved in the justice system face extra challenges as they transition into adulthood. They may benefit from assistance with accessing vocational, housing, educational, and other services to help them reach their life goals and move away from criminal behavior.

Conclusion

Given the high risk of behavioral health disorders among youth involved in the juvenile justice system, screening these youths is clearly justified. Indeed, more than one-half of juvenile offenders are being held in facilities that currently screen for mental health problems, suicide risk, and/or substance use. States and counties need to establish clear, thorough protocols for screening, assessment, and follow-up. Juvenile justice, mental health, substance abuse, and medical systems should work together to effectively meet the needs of the youths in their care.

Supplement 5

Mental Health and Substance Abuse Treatment for Co-occurring Disorders

This supplement is not intended to stand alone.
It builds upon the foundational information in Chapters 1–4.

Mental Health and Substance Abuse Treatment for Co-occurring Disorders

Incidence of Co-occurring Mental Health and Substance Abuse Disorders

Mental health and substance abuse practitioners face the challenges of identifying co-occurring mental health and substance abuse disorders and treating children and adolescents who are struggling with both problems. A high proportion of youths in mental health or substance abuse treatment have co-occurring substance use and mental health problems,[161] and each condition can contribute to developing the other.[162]

- In 2005, a survey of children and adolescents ages 12–17 from 26 states found that youths reporting a major depressive episode in the last 12 months were about twice as likely as youths who had not experienced major depression to start using alcohol or an illicit drug.[163] This pattern was similar for specific types of illicit drug use, including marijuana, cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription-type psychotherapeutic drugs.
- In 2003, 26 reporting states indicated that of the approximately 78,000 children and adolescents ages 12–17 admitted to hospitals for treatment of mental health or substance use problems, more than 20 percent (about 16,000) had co-occurring psychiatric and alcohol and/or drug problems.[164]
- Children and adolescents may suffer from more than one mental health condition and may have problems with multiple substances. Effective treatment requires identifying all of a youth's challenges.
- Research among clinical samples indicates that adolescents with behavioral and substance abuse disorders tend to have other psychiatric disorders as well.[165] [166] [167] Overall comorbidity rates vary as a function of age for children and adolescents receiving services.
- One 2004 evaluation of children and adolescents with serious emotional challenges who were served through a large Federal grant program found that more than 50 percent had a secondary behavioral diagnosis. Attention deficit/hyperactivity disorder most frequently co-occurred with nonsubstance-related disorders, and substance abuse most frequently co-occurred with conduct disorder.[168] Children and adolescents with co-occurring mental health and substance abuse disorders are at higher risk than those with either condition alone.
- Co-occurring disorders in children and adolescents are associated with problems with the law. Of hospital admissions in 2004 for co-occurring disorders in youth, nearly half (48 percent) of referrals for treatment were from the juvenile justice system.[169]

- In 2004, a psychiatric condition was diagnosed in 41 percent of suicidal persons making drug-related emergency room visits.[170] More than 21,500 emergency department visits in 2004 were by children and adolescents ages 12–17 whose suicide attempts involved drugs.[171]

Co-occurring mental health and substance use problems can operate synergistically to influence a youth's thinking, behavior, and neurological functioning. For children and adolescents with mental health issues, abuse of alcohol or drugs often can exacerbate symptoms. For those children and adolescents whose mental health condition compromises their judgment and behavior, substance use may contribute to problems with making appropriate decisions. In addition, use of certain substances can trigger some mental illnesses. For example, children and adolescents who are vulnerable to psychosis or who are prepsychotic are likely to become fully psychotic if they use amphetamines (stimulants).

Co-occurring conditions also affect the course of treatment. A youth who frequently abuses substances may not be able to make use of treatment or to apply gains made in treatment in behavioral decisions. A youth with mental health problems may not be able to make use of the many cognitive behavioral strategies used in substance abuse treatment and may be more vulnerable to treatment failure or relapse. When medical professionals prescribe medication for children and adolescents, they should consider potential drug interactions and misuse of the medication.

Few children and adolescents are likely to receive treatment for both a mental health problem and a substance use problem. Figures for adults show very low rates, and there is no reason to think that treatment for children and adolescents is substantially better. In 2006, among the 5.6 million people ages 18 and older with serious psychological distress and substance abuse disorders, approximately one half (51 percent) received mental health and/or substance abuse treatment at a specialty facility; of this 51 percent, 40 percent received treatment for mental health challenges only, 3 percent received substance abuse treatment only, and only 8 percent received both treatments. (The remaining 49 percent received no treatment.)[172]

The following resources provide information on co-occurring disorders.

Resources on Co-occurring Disorders

- Co-occurrence of Substance Abuse and Mental Illness (pp. 200–218) in *Collection of Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs,* 3rd Edition (Publication)
  http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD212008/$file/HD21_2008.pdf
- *Co-occurrence of Substance Use Behaviors in Youth* (Publication)
  http://www.ncjrs.gov/pdffiles1/ojjdp/219239.pdf
- *Prevalence and Comorbidity of Major Internalizing and Externalizing Problems among Adolescents and Adults Presenting to Substance Abuse Treatment* (Publication)
  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2238174/

Screening Tools: A Valuable Component of a Comprehensive Mental Health or Substance Use Assessment

The high prevalence of co-occurring mental health and substance use problems in children and adolescents calls for active collaboration between mental health treatment services and substance abuse treatment services in identifying and treating both conditions. The prevalence of co-occurring mental health conditions in youths calls for careful attention to identify all conditions, not just those related to a youth's presenting challenge.

The standards for mental health and substance abuse professionals set by associations and Federal agencies—including the National Association of Social Workers, the American Psychological Association, and the Substance Abuse and Mental Health Services Administration—recognize this need and call for assessments to comprehensively identify all potential medical, developmental, psychiatric, or substance abuse disorders through history taking, interviews, observation, and information seeking from multiple sources.[173] [174] [175] These standards also recognize the importance of assessing the family and community to address the mental health and substance use issues appropriately and effectively.

Few mental health and substance abuse professionals are cross-trained.

A 2007 national study of the substance abuse prevention workforce by the Annapolis Coalition on the Behavioral Health Workforce found that substance abuse clinicians need

to have more training in the active identification of comorbid mental health challenges and in the integration of mental health treatment into substance abuse services.[176] In mental health, many social work and psychology programs continue to fail to require the study of and training in substance abuse assessment and treatment.[177]

Screening tools can help clinicians identify co-occurring disorders efficiently.

Co-occurrence of substance use and mental illness often complicates diagnostic profiles, making it difficult for practitioners to identify the problem. Some symptoms—such as anxiety, psychomotor agitation, problems in thinking and judgment, behavioral disinhibition, withdrawal or acting out, and self-destructiveness—can be present in youths with either mental illness or substance use. An assessment must identify whether the source of the symptoms is due to one or the other condition or to both conditions. Given the high incidence of co-occurring mental health and substance use problems among children and adolescents in treatment for one or the other condition and the current gaps in workforce expertise, clinicians should use valid and reliable tools to identify problems outside their area of expertise.

Mental health screening tools also can strengthen assessments of mental health conditions. A broad-based mental health screening tool as part of a mental health assessment helps a mental health clinician assess a broad array of symptoms and quickly rule out those that are not present. Incorporating such a screening tool can guard against the natural temptation to follow up solely on presenting issues, which can result in overlooking co-occurring conditions and failing to fully address a child's or adolescent's problems. In some cases, treatment for one condition may be contraindicated for another, making it imperative to identify both before initiating treatment. For example, Ritalin prescribed to a hyperactive child or adolescent who also may be vulnerable to psychotic thinking can result in psychosis.[178]

Clinicians also can make good use of longer mental health assessment tools that take more time and may require a professional to interpret. For the screening to be reliable, a systematic and structured format is essential. Even highly trained and experienced behavioral health clinicians have difficulty obtaining reliable information relevant to identifying behavioral health conditions if they use an unstructured format. The reliability of the assessments increases when a more systematic and structured interview format is used.[179]

The following resources provide information on screening and assessing co-occurring disorders in children and adolescents.

Resources on Screening and Assessing Co-occurring Disorders

- *Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions* (Publication)
  http://archives.drugabuse.gov/pdf/monographs/156.pdf
- *Brief Overview of Screening and Assessment for Co-occurring Disorders* (Publication abstract)
  http://springerlink.com/content/n1753r32k80365p5/
- *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders:* Chapter 4. "Evidence-Based Practices for Co-Occurring Disorders—Interventions for Children and Adolescents with Co-Occurring Disorders" (Publication)
  http://www.samhsa.gov/reports/congress2002/chap4icacd.htm
- *Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders* (Publication)
  http://www.addictioncounselorce.com/articles/101545/OP2-ScreeningandAssessment-8-13-07.pdf
- *Screening for and Assessment of Co-occurring Substance Use and Mental Health Disorders by Alcohol & Other Drug and Mental Health Services* (Publication)
  http://www.dualdiagnosis.org.au/home/index.php?option=com_docman&task=doc_download&gid=23&Itemid=27
- *Screening: Technical Assistance (TA) Report for the Co-Occurring State Incentive Grants (COSIGs)* (PowerPoint presentation)
  http://www.samhsa.gov/co-occurring/topics/screening-and-assessment/screening/slide_02.html
- *Substance Abuse Treatment for Persons With Co-Occurring Disorders: Treatment Improvement Protocol (TIP) Series 42* (Publication)
  http://www.ncbi.nlm.nih.gov/books/NBK14528/
- *Substance Abuse and Mental Health Services Administration: Co-Occurring Disorders: Screening and Assessment* (Web page)
  http://www.samhsa.gov/co-occurring/topics/screening-and-assessment/index.aspx

Screening tools can help in gathering information from other informants.

Children and adolescents are accurate informants for many of their *internalized* mental health conditions—such as depression or anxiety. Caregivers, teachers, or other adults who know a youth well, however, may be better informants about a youth's *externalized* conditions or problems—such as substance abuse or eating disorders, which some children and adolescents may deny. In addition, adults may be able to provide information about where and when the symptoms and effects of the youth's conditions arise; such information can be helpful to the clinician in understanding how the condition affects the youth's functioning and in developing treatment plans. Brief screening tools designed for caregivers and teachers can be an efficient way for clinicians to gather information from these parties.

Screening tools can help identify conditions that arise during treatment.

In mental health services, substance use screening not only should be required during diagnostic evaluation but also should be done periodically thereafter, especially if a youth's treatment progress is slow or inconsistent. Likewise, periodic mental health screening is important in substance abuse services, especially when assessing relapses. For example, the element of hope and the ability to look to the future are critical in relapse and recovery models, but a child or adolescent who has become clinically depressed may be unable to be hopeful. Screening tools can help measure progress and track outcomes in both mental health and substance abuse treatment. Such tools also can promote treatment by engaging children and adolescents in evaluating their status, setting goals, and evaluating progress.

Some screening tools have limitations.

The predictive effectiveness of available tools and their accuracy in screening cross-cultural populations has not been fully researched.[180] Because of the lack of research on the cultural appropriateness of the tools, special attention must be paid to making these tools meaningful for people who are from different cultures and who speak diverse languages. This approach is especially important because of the significant variation across cultural beliefs and practices in what is considered normal development and developmentally appropriate parenting.[181] A practitioner should be aware that the findings of the tool may not be as reliable as when it is used among children and adolescents from populations on which it has been validated. Despite these limitations, however, using a screening tool can provide an opportunity for a practitioner to discuss a child's or adolescent's problems and to learn how such problems are interpreted by the youth and his or her family in the context of their culture.

The following resource provides information on screening immigrant children and adolescents.

Resource on Screening Immigrant Children and Adolescents

The Center for Health and Health Care in Schools: *Immigrant and Refugee Children* (Web page)
http://healthinschools.org/en/Immigrant-and-Refugee-Children.aspx

Informed consent and confidentiality

Clinicians are required by their disciplines as well as by law to inform clients of any limitations to confidentiality. Even in situations where the parent or guardian has the legal right to consent to treatment, the child or adolescent has a right to be fully informed about where the information from any screening will go and how it can be used. This information is particularly important if it can affect court decisions about custody or adjudication of criminal charges. Equally important is letting a child or adolescent know when information will not be shared with caregivers, teachers, or other authorities. In addition to discussing where information from screening will go and how it will be used, clinicians should seek informed assent from the youth and engage the youth in deciding together what information will and will not be shared and with whom. When assured of the limits of confidentiality and their level of control in a situation, children and adolescents may be more willing to share sensitive information.

Clinicians must be scrupulous when seeking information from individuals outside of the family. Screening tools should be used by adults other than parents only with informed parental consent and youth assent. (See Appendix C for sample parent consent and youth assent forms.) When such tools are used by parents or guardians of a mature or emancipated minor, the youth must provide informed consent. Together, the professional identity of the clinician and the contents of the tool may indicate that a child or adolescent is being considered as having a possible mental health or substance use problem. Clinicians must consider the possibility that engaging in this process may result in a youth being labeled or stigmatized. Therefore, the value of the information must be carefully balanced with the potential harm to the child or adolescent.

Treating Youths With Co-occurring Disorders

If screening indicates that a child or adolescent may have co-occurring mental health and substance use problems, the optimal action is to refer him or her to an agency that integrates both mental health and substance abuse services. In many areas, however, such integrated services are scarce. When integrated services are not available, the mental health and substance abuse clinicians should develop coordinated treatment plans that address both mental health and substance use problems in the order and at a level of intensity that the youth and family are willing to undertake.

One approach is to initiate substance abuse treatment before beginning mental health therapy because of the compromising effect that substance abuse has on most aspects of therapy. Alternatively, substance abuse services may be less likely to be effective for persons with serious untreated mental illness, such as psychosis or thought disorders. Even if it is ideal to address the two conditions simultaneously, a youth and family may find it difficult logistically, financially, and emotionally to undertake both at the same time. In addition, the youth and family may have more trust or feel less stigmatized from one type of service than the other. In such cases, treatment may need to begin with the service that the youth and family are most likely to engage in and sustain.

Conclusion

Substance abuse and mental illness often occur together, and their co-occurrence can interfere greatly with screening, diagnosis, and treatment. Routine screening for substance use problems by mental health service clinicians and routine screening for mental illness by substance abuse clinicians should occur more often. Services in which screening, treatment, and referrals for both problems are well coordinated have the greatest likelihood of successful intervention and ongoing wellness for children and adolescents.

Supplement 6

Primary Care

This supplement is not intended to stand alone.
It builds upon the foundational information in Chapters 1–4.

Primary Care

The Role of Pediatric Primary Care in Promoting Healthy Mental Development

The American Academy of Pediatrics (AAP), the American Medical Association (AMA), the American Academy of Family Physicians (AAFP), and the National Association of Pediatric Nurse Practitioners (NAPNP) all recognize the importance of identifying and addressing mental health and substance use problems as part of regular preventive health care for children and adolescents. In addition, the U.S. Preventive Services Task Force recently recommended screening adolescents for depression when systems for accurate diagnosis, psychotherapy, and follow-up are in place.[182]

> "[T]he mental health of children, adolescents, and families is a vital and compelling concern for health professionals. …[P]rimary care health professionals…are in a unique position to develop the relationships with children, adolescents, and their families necessary for promoting mental health and recognizing early signs of psychosocial problems."
>
> *—Bright Futures in Practice: Mental Health. Volume I. Practice Guide*[183]

Primary care providers participating in state Medicaid child health programs through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program are legally required to provide comprehensive health screening services, including the identification of potential mental health conditions (which encompass substance abuse disorders), to participating children and adolescents during primary care visits. The EPSDT Program also entitles children and adolescents with positive screens to an assessment and, if necessary, treatment for the identified condition.

Furthermore, there is a movement among medical practitioners as well as public and private payers to develop "medical homes" for children with special health care needs. The medical home is a model for delivering primary, subspecialty, emergency, and hospital care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. The hub of this model is the primary care provider (supported by additional resources for health education and care coordination), who is responsible for actively coordinating with the family and other service providers. Healthy social and emotional development and treatment of mental health and substance use problems are integral parts of this comprehensive health care model, and practitioners are finding ways to address the historical separation between medical and behavioral health care.

Physicians and other primary care providers typically are not trained as extensively in mental health and substance abuse as in other aspects of pediatric care, although they often encounter these conditions during pediatric office visits. Psychosocial

challenges are a frequent reason for pediatric office visits, increasing from 7 percent in 1979 to 19 percent in 1996.[184] Consequently, primary care providers have become important providers of mental health and substance abuse services. Their roles include identifying problems and responding to complaints; assessing, treating, and referring children and adolescents for specialty services; and coordinating care. Primary care providers also serve an important role for children and adolescents who may benefit from psychotropic* medications as a part of their treatment but do not have access to child psychiatrists or psychiatric nurse practitioners.

As specialty health resources for children continue to be limited, the role of primary care providers in pediatric mental health will become even more important. A 2006 study estimated a national need for 30,000 child psychiatrists but found only 6,300 in practice.[186] The number of child psychiatrists in practice is expected to increase to approximately 8,300, a 32 percent increase, by the year 2020,[187] while the number of pediatricians is expected to increase by more than 60 percent in the same time period.[188]

Effective Methods of Identification

Typically, physicians screen for mental health and substance abuse disorders by talking informally to or interviewing patients and caregivers—rather than using validated checklists or questionnaires.[189] Although professional practice guidelines and payer requirements encourage the use of standardized tools in primary care, many practitioners have not yet adopted such tools. A 2005 survey found that about three-quarters of physicians treating adolescents regarded questioning teens about mental health problems and the use of alcohol and other drugs as their responsibility; however, only about half of these physicians screened for mental health problems and, of those who did, only about 40 percent used a standardized tool.[190]

An interview approach alone has some significant weaknesses and frequently fails to detect behavioral and emotional problems.[191] [192] [193] [194] One 1998 study[195] documented that physicians' interviews accurately identified only 2 of 10 clinically depressed adolescents (20 percent), a disturbingly poor rate. Although an unstructured interview can build rapport, offer opportunities for observing behavior, and provide a chance for education,[196] [197] it also has some subtle disadvantages,[198] including the following:

- **Limited time.** Collecting the necessary information through an unstructured interview is difficult in a time-limited office visit.
- **Nondisclosure by caregivers and adolescents.** Many caregivers are not aware that sharing concerns about their child's or adolescent's behavioral and emotional matters is appropriate during a doctor appointment; as a result, few caregivers share their concerns with their child's doctor.[199] [200] [201] [202] [203] [204] This situation makes it unlikely that behavioral or emotional concerns are discussed with the physician during the very brief interview that typically is part of an office visit. The failure to share information may be reinforced if the physician does not meet individually with older children and teens for part of the visit.

* A *psychotropic medication* is "any medication capable of affecting the mind, emotions, and behavior."[185]

- **Incomplete information.** When using an unstructured format, even highly trained and experienced behavioral health providers have difficulty reliably obtaining information relevant to identifying behavioral health conditions.[205] In contrast, a directive interviewing style that includes specific probes and requests for detailed descriptions is associated with the collection of more complete and better quality factual information than a more free-style approach.[206]
- **Avoidance of difficult subjects.** Studies indicate that providers tend to forgo probing for information that is unlikely to be volunteered or may be socially embarrassing to the youth or family.[207] [208] [209] [210] [211] This omission can be particularly harmful because a youth's suicidal behavior, substance use, and other high-risk activities may not be considered at all or may be inadequately addressed. Other studies have shown that provider and patient characteristics such as race, gender, and age can affect the topics that are addressed or avoided during an office visit.[212] [213] [214] [215]

The following resources provide information on professional standards and policies relating to health and preventive services for children and youth.

Resources on Professional Standards and Policies Relating to Health and Preventive Services

American Academy of Family Physicians

- *Mental Health, Physician Responsibility* (Policy Statement)
  http://www.aafp.org/online/en/home/policy/policies/m/physresp.html

American Academy of Pediatrics

- *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition (Publication)
  http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html
- *Bright Futures*—Theme 3: "Promoting Mental Health" (Publication)
  http://brightfutures.aap.org/pdfs/Guidelines_PDF/4-Promoting_Mental_Health.pdf
- *Bright Futures*—Theme 10: "Promoting Community Relationships and Resources" (Publication)
  http://brightfutures.aap.org/pdfs/Guidelines_PDF/11-Promoting_Community_Relationships.pdf
- *Children's Mental Health in Primary Care* (Web page)
  http://www.aap.org/mentalhealth/
- *The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC): Child and Adolescent Version* (Publication)
  Available for order from several sources

Resources on Professional Standards and Policies Relating to Health and Preventive Services (continued)

- *The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care* (Policy Statement)
  http://aappolicy.aappublications.org/cgi/reprint/pediatrics;124/1/410.pdf
- *Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration* (Joint statement by American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry)
  http://www2.aap.org/commpeds/dochs/mentalhealth/docs/Special%20Article-%20April%202009.pdf
- *Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration* (Background paper)
  http://www2.aap.org/commpeds/dochs/mentalhealth/docs/White%20Paper%20Background.pdf
- *Recommendations for Preventive Pediatric Health Care* (Publication)
  http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf

American Medical Association

- *Guidelines for Adolescent Preventive Services* (Publication)
  http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf
- *Guidelines for Adolescent Preventive Services Questionnaires* (Free-of-cost questionnaires for younger adolescents, middle/older adolescents, and parents/guardians, in English and Spanish)
  http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/adolescent-health/guidelines-adolescent-preventive-services.shtml

National Association of Pediatric Nurse Practitioners

- *KySS Guide to Child and Adolescent Mental Health Screening, Early Intervention and Health Promotion* (Publication)
  http://www.napnap.org/ProgramsAndInitiatives/MentalHealth/KySSMentalHealthGuide.aspx

Validated screening tools can improve identification rates.

When primary care physicians supplement interviews with a screening tool, studies suggest that the identification of mental health problems increase.[216] [217] Using such a tool can provide a starting point for discussion with the youth and/or parents to get more information, provide education, or develop plans for follow-up and assessment.

Primary care providers face a number of barriers to incorporating such tools into their practices, including the limited time of the office visit, lack of reimbursement for the service, discomfort in addressing these issues, and reluctance to identify problems for which services may not be available. Alternatives to administering a written or oral screen during the visit include sending out tools for parents or youths to complete at home—which can reduce the time needed in the office visit—or using a computer-based screen, sometimes with audio headsets, which produces the highest rates of self-disclosure by children and adolescents. Providers also may perform laboratory testing to detect the use of substances; however, the appropriate use of this kind of testing is beyond the scope of this guide.

Recent initiatives to increase the identification and treatment of developmental problems—including mental health and substance use conditions—have produced practical guidelines on how primary care providers can incorporate mental health and substance use screening into office operations. These guidelines cover both scientific and organizational issues, including billing and coding.

The following resources provide information on implementing screening in primary care settings.

Resources on Implementing Screening in Primary Care Settings

American Academy of Pediatrics

- *Developmental Screening/Testing: Coding Fact Sheet for Primary Care Pediatricians* (Fact sheet)
  http://practice.aap.org/content.aspx?aid=2714
- *Section on Developmental and Behavioral Pediatrics* (Web page)
  http://www.aap.org/sections/dbpeds/

Assuring Better Child Health and Development (ABCD) Resource Center

- *ABCD Forum* (Online discussion forum)
  http://www.nashp.org/ABCD-forum/

The Commonwealth Fund

- *A Practical Guide for Healthy Development* (Publication)
  http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=462115

National Center for Medical Home Implementation

- *Developmental/Behavioral Screening* (Web page)
  http://www.medicalhomeinfo.org/how/clinical_care/developmental_screening/

MassHealth Children's Behavioral Health Initiative

- *Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative* (Publication)
  http://www.mass.gov/eohhs/docs/masshealth/cbhi/sccreening-tool-pccs.pdf

Limitations for some cultural groups

The predictive effectiveness of available tools and their accuracy in screening cross-cultural populations has not been fully researched.[218] Consequently, special attention should be given as to how these tools can be made more meaningful for people of different cultures and who speak diverse languages. This approach is especially important because there is significant variation across cultural beliefs and practices as to what is considered normal child development and developmentally appropriate parenting.[219] Variation may be most significant among preschool and younger children. In these situations, a primary care provider should be aware that the findings of the tool for diverse populations may not be as reliable as when it is used for children from populations on which it has been validated. Despite these limitations, using a screening tool can provide an opportunity for the provider to open a dialogue with the child's or adolescent's parents to understand how they interpret

to open a dialogue with the child's or adolescent's parents to understand how they interpret the child's behavior and development in the context of their culture.

Prioritizing children and adolescents who are at higher risk

Primary care providers who are unable to implement a comprehensive behavioral health screening program for their entire practice may wish to focus on screening higher risk patients. High-risk groups vary depending on the primary care provider's practice but may include children and adolescents in foster care, those with special health care needs or conditions (such as diabetes or asthma) who have elevated rates of co-occurring depression, or those with home or environmental risk factors.

Responding to patient concerns

One of the most important actions that a primary care provider can take to improve behavioral health care for children and adolescents is to respond to parents or youths who raise concerns about possible mental health or substance use problems. Whether conducting an initial screen or making a referral, the provider should take the expressed concerns seriously and offer appropriate assistance to further assess the issues.

Working With Children, Adolescents, and Families

The AAP has recognized that primary care providers have a unique opportunity to develop relationships with children, adolescents, and their families. Such providers are able to address mental health and substance abuse in the context of overall health and in a health-identified setting. These factors reduce the barriers to addressing topics that many families find to be threatening and uncomfortable. Furthermore, primary care providers can easily manage the confidentiality of screening information in their medical records system.

Providing privacy and confidentiality for adolescent patients

One challenge faced by primary care providers is the transition to providing confidential services to children and adolescents as they mature. Laws guiding confidentiality for minors vary by state, but providers should offer adolescents confidentiality to the fullest extent possible. Studies have shown that teens are more likely to discuss concerns relating to mental health and substance use with their doctor when they have a confidential opportunity to do so.[220 221] A 2009 study, however, showed that only 40 percent of teens meet privately with their physicians.[222]

For this reason, teens should be offered an opportunity to discuss health issues with their primary care provider privately—without a parent in the room, for at least part of the visit. Most parents will support this practice. In a 2000 study to test a teen health-risk-behavior questionnaire designed for primary care offices, most parents wanted their teen to complete the questionnaire and discuss it with the physician or nurse practitioner. The majority of parents also felt that their teens deserved privacy for those discussions.[223]

Teens may not be aware that a private discussion with their doctor is confidential. Therefore, offices should explain the right to confidentiality to teens, provide signage (such as the sample confidentiality notice presented at right), or add the confidentiality information to existing forms. Any limitations to confidentiality also should be explained.

Sample of Confidentiality Notice

Our Policy on Confidentiality

Our discussions with you are private. We hope that you feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger.

Follow-up and Referrals for Positive Screens

Primary care providers increasingly play important roles in caring for children with emerging and less serious mental health conditions. Their involvement can include diagnosing, managing, and treating mental health disorders such as attention deficit/hyperactivity disorder, depression, and anxiety; providing guidance on behavior management; prescribing and monitoring medications; facilitating referral for assessment or therapy by mental health specialists; and coordinating specialty care and primary care services for children who receive treatment from mental health specialists.

Resources are being developed to help primary care providers increase their knowledge of mental health and substance use problems. These resources may include a range of proven interventions and treatments, guidelines for when and how to prescribe and monitor psychotropic medications for children, and strategies for strengthening collaborative relationships with mental health specialists. Practice models—in which mental health professionals are integrated into the primary care setting to provide psychiatric consultation—also are being developed to support primary care providers in carrying out these roles.

Access to specialized mental health services is difficult in many communities. Primary care providers may be reluctant to identify social and emotional problems in children if they believe that services are not available to treat such problems. In many communities, parents and families of children with mental health and substance use problems have developed peer support organizations that can assist in linking families to services.

Despite continued limitations in children's mental health services, primary care providers who explore the resources in their communities—such as peer support and other resources described in Chapter 4—may find service providers who are more responsive to children and their families, more established in the community, and more aware of the need to collaborate with other medical and service providers than they were in the past. Primary care providers should seek out community mental health and substance abuse resources and develop collaborative relationships so they are prepared to provide appropriate referrals for children in need and have access to consultation on these topics.

The following resources provide information on primary care treatment of mental and substance use conditions.

Resources on Primary Care Treatment of Mental and Substance Use Conditions

Children's Health Innovation Project (CHIP)

- Second Annual CHIP Conference: "Mental Health Services for Children and Adolescents: Improving Clinical Skills and Implementing High Fidelity Wraparound" (Conference Materials)
  http://www.sjhsyr.org/sjhhc/stj_phy_6.asp?id=395

Massachusetts Child Psychiatric Access Project (MCPAP)

- Web site
  http://www.mcpap.com/

Massachusetts Department of Public Health, Bureau of Substance Abuse Services

- *Adolescent Screening, Brief Intervention, and Referral to Treatment for Alcohol and Other Drug Use: Using the CRAFFT Screening Tool* (Provider Guide)
  http://www.masspartnership.com/pcc/pdf/CRAFFTScreeningTool.pdf

Safe Start Center

- *Tools and Resources* (Web page)
  http://www.safestartcenter.org/resources/
- *Safe Start Center Series on Children Exposed to Violence,* Issue Brief 2: "Pediatric Care Settings" (Publication)
  http://www.safestartcenter.org/pdf/IssueBrief2_PEDIATRIC.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Web site
  http://www.samhsa.gov/

To find information for your state, access the SAMHSA Web site. In the "Search SAMHSA" search engine at the top right of the Web page, enter the phrase "Screening, Brief Intervention, Referral and Treatment (SBIRT)" and the state name.

Don't wait and see! Refer infants and toddlers to IDEA Part C services.

The Individuals with Disabilities Education Act (IDEA) Part C (Early Intervention for Infants and Toddlers) is underutilized. It serves less than 10 percent of infants, toddlers, and preschoolers with delays or disabilities.[224] (Further, IDEA Part B, which is provided by school systems for preschoolers, also is significantly underutilized.) Taking advantage of these services is vital while children are young. Primary care providers need to conduct an objective screen using a validated tool that identifies children with likely problems so these children can receive a comprehensive Early Intervention assessment to determine their eligibility for services.

The following resources relate to services available through IDEA.

Resources on Individuals with Disabilities Education Act (IDEA) Services

IDEA Part B (Special Education)

- For information on services, contact the child's local school system.

IDEA Part C (Early Intervention for Infants and Toddlers)

- State Part C Coordinators (Web page)
  http://www.nectac.org/contact/ptccoord.asp
- List of Part C Lead Agencies (Web page)
  http://www.nectac.org/partc/ptclead.asp

Tracking and follow-up

After making recommendations regarding further mental health or substance abuse treatment, primary care providers need to follow up with families on subsequent visits. Providers can offer support and encouragement for addressing problems that carry an uncomfortable stigma, help families recognize that such problems need to be addressed and are not just a passing phase, and provide assistance for families who are having difficulties navigating the system to access services. For families experiencing long waits for service, the primary care provider can help develop interim interventions.

Conclusion

Primary care is often the first place that parents seek assistance when they suspect that their child has a behavioral health problem. Most parents also are willing to authorize and participate in a behavioral health screening when asked. Primary care providers are in a particularly favorable position for bringing up sensitive issues such as behavioral problems or substance abuse for the following reasons: they often have a positive and supportive preexisting relationship with the family; the setting is private, and the information is confidential; and nothing about the visit is specifically identified with the stigma of mental health or substance use problems.

An increased number of resources can become available to families when primary care practices implement the person-centered healthcare home model (described on page 56). The important role that primary care providers play in supporting positive social and emotional development in the children and adolescents they serve will only expand in the future, and providers should use the best clinical tools that science has to offer.

Supplement 7

Schools and Out-of-School Programs

This supplement is not intended to stand alone.
It builds upon the foundational information in Chapters 1–4.

Schools and Out-of-School Programs

How Children's and Adolescents' Mental Health Affects Their Ability to Learn

Schools touch the lives of virtually all children and adolescents in the United States.

Schools are well positioned to work with families and communities to identify children's and adolescents' mental health and substance use problems and help them get needed services. Before- and after-school programs and recreation programs also touch the lives of many children and adolescents; these programs present frequent opportunities to communicate with the families of participating youths. If a school system does not catch the signs of a youth's mental health problem, an out-of-school program offers a second chance.

Almost 21 percent of children and adolescents in the United States have a diagnosable mental health or addictive disorder that has some effect on their ability to function.[225] In any given year, 5 percent to 9 percent of youths between the ages of 9 and 17 have a serious emotional disturbance that substantially impairs how they function and, for many, affects their ability to succeed in school.[226] However, many children and adolescents do not receive treatment for these problems.

Mental health and substance use challenges are related to poor school outcomes.

Unidentified and untreated mental health disorders can affect children's critical developmental years and lead to subsequent school failure. In addition, approximately 50 percent of students ages 14 and older with a mental health disorder drop out of high school—the highest dropout rate of any disability group.[227] Identifying and addressing these problems improves students' ability to learn and also can reduce the disruptive behaviors often associated with these problems, which can impair the learning environment. Beyond having poor educational outcomes, students with untreated mental health and substance use problems can develop more serious problems, such as substance abuse, involvement with the juvenile justice system, or suicide. In contrast, however, some youths with mental health or substance use problems may excel in school, and their mental health or substance problems are less likely to be identified or taken seriously.

School is the setting where a child or adolescent is most likely to receive mental health services.

All schools must provide special education services for youths whose mental health problems cause significant learning challenges. Although many schools offer mental health or substance abuse services directly,[228] some schools provide additional services by partnering with or referring children and adolescents to other organizations.

Identification of Students' Mental Health and Substance Use Problems

Schools need public support to address sensitive issues.

Because schools are integrally connected to families and the broader community, they need to work with parents and community stakeholders to gain broad public support for an identification program's goals and methods. Many school districts have well-established mental health services, and some conduct mental health or suicide screening programs that have widespread community support. School districts in other communities, however, have encountered public opposition to conducting mental health screening or providing mental health services. Without building broad support beforehand, schools may find that the activities intended to identify mental health problems can be misunderstood by the community.

Schools and community stakeholders can identify priority concerns through a community needs assessment.

Schools will have greater success if they obtain consensus and community support for the goals of an identification initiative. The Centers for Disease Control and Prevention (CDC) developed the *CHANGE Action Guide* for assessing community needs and created the Community Health Resources database for locating resources.

In addition, CDC sponsors the Youth Risk Behavior Surveillance System (YRBSS), a survey conducted every 2 years among a representative sample of high school students. The purpose of this survey is to monitor priority health-risk behaviors that contribute markedly to the leading causes of death, disability, depression, and the use of alcohol and illegal substances among youths and adults in the United States. Results on subsamples that are representative of most states and some large school districts are available on the CDC Web site. Some communities also administer this survey in their local schools.

The following CDC resources provide information on community involvement in youth health issues.

Resources From the Centers for Disease Control and Prevention

- *Community Health Assessment and Group Evaluation (CHANGE): Building a Foundation of Knowledge to Prioritize Community Health Needs—An Action Guide* (Publication)
  http://www.cdc.gov/healthycommunitiesprogram/tools/change/pdf/changeactionguide.pdf
- Community Health Resources (Database)
  http://apps.nccd.cdc.gov/dach_chaps/Default/index.aspx
- *Improving the Health of Adolescents and Young Adults: A Guide for States and Communities* (Publication)
  http://nahic.ucsf.edu/wp-content/uploads/2011/11/Complete2010Guide.pdf
- Youth Risk Behavior Surveillance System (YRBSS) (Web site)
  http://www.cdc.gov/HealthyYouth/yrbs/

State health departments collaborate with local entities on public health planning and are responsible for maintaining data relevant to these efforts. During the past few years, the Substance Abuse and Mental Health Services Administration (SAMHSA) has funded epidemiologic work groups to assess substance use problems in all states, in Pacific and Atlantic jurisdictions, and in a handful of Native American Indian tribes. The Office of National Drug Control Policy (ONDCP) has funded approximately 800 communities with a similar purpose. Information compiled from these assessment processes can help build an understanding of community needs and help inform planning efforts. For example, data on visits to local emergency rooms related to youth drinking or drug use, suspected child abuse, or suicide attempts can help identify priority concerns. Data on the number of adolescent hospital discharges related to suicide, self-harm, or substance abuse also can provide relevant information. States maintain vital statistics that include deaths by suicide and other causes related to possible mental health or substance use problems. Local hospitals may be willing to share their data and collaborate with local stakeholders to address local health priorities.

In the absence of such data, community surveys or discussions can help identify the mental health or substance use problems that most worry parents, teachers, and health practitioners. Such identification efforts can focus on the schools or classes with children and adolescents who are perceived to be at the highest risk.

Selecting a prevention approach

Schools and school systems can refer to the prevention pyramid (Figure 2, page 24) to help clarify their goals and develop an identification approach that fits their goals and resources. The planning process should take into account the resources needed to carry out activities for the high-risk groups.

The following resources provide information on screening and addressing mental health problems in schools.

Resources on Screening and Addressing Mental Health Problems in Schools

- American School Health Association (ASHA): *School-Based Mental Health Services* (Resolution)
  http://www.ashaweb.org/files/public/Resolutions/School_Based_Mental_Health_Services.pdf
- *Finding Help and Working with Schools: Tips for Parents of Teens with Mental Health Problems* (Publication)
  http://www.edc.org/sites/edc.org/files/pdfs/great_minds_parents.pdf
- *Journal of School Health:* "Mental Health Screening in Schools" (Publication)
  http://www.nami.org/Template.cfm?Section=schools_and_education&template=/ContentManagement/ContentDisplay.cfm&ContentID=43074
- Massachusetts General Hospital, School Psychiatry Program and Madi Resource Center: *For Educators* (Web page)
  http://www2.massgeneral.org/schoolpsychiatry/for_educators.asp
- *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
- *Screening Mental Health Problems in Schools* (Publication)
  http://smhp.psych.ucla.edu/pdfdocs/policyissues/mhscreeningissues.pdf

Indicated assessment: Focus on those with identified needs.

All schools must be prepared to intervene if a student's behavior indicates an acute mental health or substance use problem. For example, schools should have arrangements for referring a child or adolescent for an immediate psychological assessment if he or she arrives at school intoxicated or under the influence of drugs or attempts to harm himself or herself or others.[229] Schools also must work with children who have identified mental health or substance use problems by providing an individualized education program (IEP) through the Individuals with Disabilities Education Act (IDEA) Part B if those problems are determined to create special education needs. Whether a child or adolescent has an IEP or not, schools need to coordinate with parents and provide appropriate supports for youths with identified mental health or substance use problems. This coordination may involve such activities as administering medications during school hours, preventing bullying, modifying academic methods, and using consistent and positive behavior management practices.

Selected screening: Focus on groups at high risk for mental health and substance use problems.

Schools are well aware of children and adolescents who cause disciplinary problems in class, school, and/or the community. These youths may be at higher risk for mental health and substance use problems than other students. In addition, laboratory tests* conducted on youths participating in school sports and the use of breathalyzers at some school events have identified an increasing number of students as substance users.

Catching children's or adolescents' mental health and substance use problems in the early stages can offer the best opportunity to help these youths and prevent future problematic and possibly high-risk behaviors. Schools can seek parental consent to screen children and adolescents who present disciplinary challenges or show other warning signs for possible mental health or substance use problems.

Many youths conceal substance use and mental health problems (such as eating disorders), however, and signs of youth depression and anxiety can be overlooked easily. To remedy the situation, teachers and other school staff can be trained to better identify such problems and are more likely to do so if a school has established methods for referring such students for formal screening, assessment, intervention, and treatment. The Action Signs Project from the REACH (REsource for Advancing Children's Health) Institute at Columbia University has scientifically identified and validated signs of significant mental health problems that often are overlooked among children and adolescents. Training teachers, school counselors, caregivers, and adults in the community to recognize these signs and respond appropriately can help more youths get the treatment they need.

The following resources provide information on action signs for identifying mental health and substance use problems.

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* Use of these techniques is beyond the scope of this guide.

Resources on Action Signs for Identifying Mental Health and Substance Use Problems

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 and Adolescents—Mental Health

- *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
- *Mental, Emotional, and Behavioral Disorders in Teens* (Web page)
  http://www.cumminsbhs.com/teens.htm
- TeenScreen National Center for Medical Health Checkups (Web site)
  http://www.teenscreen.org/
- *The Action Signs Project: A Toolkit to Help Parents, Educators and Health Professionals Identify Children at Behavioral and Emotional Risk* (Publication)
  http://www.thereachinstitute.org/files/documents/action-signs-toolkit-final.pdf

For Adolescents—Substance Use

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

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/
- SOS (Signs of Suicide) Prevention Program (Web site)
  http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/
- *Suicide Warning Signs* (Publication)
  http://store.samhsa.gov/shin/content/SVP05-0126/SVP05-0126.pdf (English)
  http://store.samhsa.gov/shin/content//SVP11-0126SP/SVP11-0126SP.pdf (Spanish)

Another valuable resource is Parents and Teachers as Allies, a 2-hour inservice training program developed by the National Alliance on Mental Illness to educate teachers and school staff about the early warning signs of mental illnesses and the best intervention approaches. The training covers the experience of children and adolescents living with mental illness and indicates the best ways for schools to communicate with families about mental health-related concerns.

The following resources provide information on resources for parents and teachers.

Resources for Parents and Teachers

- Child and Adolescent Action Center (Web site)
  http://www.nami.org/template.cfm?section=child_and_teen_support
- Parents and Teachers as Allies (Web Site)
  http://www.nami.org/Template.cfm?Section=Schools_and_Education&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=74&ContentID=39133

School systems also may identify schools or age groups at higher risk and focus formal identification processes on those groups. Evaluating a group of students—after seeking parental permission—can facilitate the identification of those who are suffering distress without showing external signs and also identify problems in the early stages.

Using a validated screening tool is the most efficient way to evaluate a large number of students. Information on the rate of positives from tests conducted on similar groups can help schools more accurately estimate and prepare for the number of children and adolescents with positive screens. This approach allows schools to determine whether to conduct a single screen or phase the process throughout the year so that the program can be scaled to the available resources.

Preparing for and implementing a screening process

Schools need to be well organized to responsibly carry out a number of key steps in the identification process. Preparing for screening requires:

- Informing parents and caregivers fully of the screening content and process and how results will be used;
- Informing students fully of the screening content and process and gaining their informed assent;
- Tracking documentation of parental consent and ensuring that only students with consent participate in screening;

- Providing alternative activities for students who are not being screened; and
- Training any school staff who will be involved in the process.

Implementing a screening process requires schools to arrange for a qualified individual to:

- Review screening results;
- Answer students' and caregivers' questions or concerns generated by the screening;
- Interview students who have positive results;
- Develop recommendations for follow-up; and
- Communicate results and provide referrals for caregivers.

Protocols for prioritizing responses from students whose results indicate a possible acute problem must be in place so that parents are offered a prompt assessment by a qualified clinician. In some cases, school staff with appropriate qualifications and who are perceived by students as trustworthy and able to maintain confidentiality may review the results. In other cases, arranging for outside clinicians to carry out this function reassures students and parents that the screening information will not be shared with school staff or become part of a student's record.

Established national programs with well-developed planning and implementation processes are available to assist schools with implementing mental health screening programs.

Screening tool selection

Selection of a screening tool is another opportunity for schools to involve the community in planning for an identification initiative. This step is particularly important when a school serves recent immigrant communities and communities of different cultures.

Primary prevention: Groups without indications of elevated risk

As presented in the prevention pyramid (Figure 2, page 24), primary prevention approaches focus on children without apparent mental health or substance use problems, secondary prevention approaches focus on children who are at risk for such problems, and tertiary prevention approaches focus on children with identified mental health or substance use problems. This guide is not focused on primary prevention approaches, and relatively few school systems have the resources to conduct formal identification initiatives on student groups not identified as high risk. However, much of the information related to secondary prevention is relevant to primary prevention initiatives.

Schools also may want to develop programs fostering positive school environments that support the healthy social and emotional development of all students, including those at high risk. These programs would be considered a form of primary prevention.

Partnering With Caregivers and Ensuring Confidentiality

Until children reach age 18, legal guardians have the authority to make decisions on virtually all aspects of their children's health care. Schools typically conduct some forms of screening for health disorders, such as hearing deficits and scoliosis, without prior parental consent. However, the sensitive nature of mental health and substance use problems—along with the associated stigma—warrant seeking prior parental consent and ensuring the confidentiality of results. A letter seeking informed parental consent and informational forums, where caregivers have the opportunity to ask questions, also may be helpful in gaining consent and building support. (See the sample parent letter, information sheet, and consent form in Appendix C.)

In addition, the children and adolescents to be screened need to understand the reason for screening; the means by which it will be conducted; who will have access to the results; and the limits to confidentiality if indications of child abuse, neglect, or danger to self or others are identified. This process also is an opportunity to provide nonstigmatizing information about mental health and substance abuse.

Screening results must be carefully handled.

Only school personnel with a "need to know" should have access to the screening results. Given the stigma and misunderstanding associated with mental health and substance use problems, some teachers or school staff might draw unwarranted conclusions if they learn about a student's mental health or substance use problem. To avoid this situation, schools need to carefully design an identification program that safeguards student privacy and follows Family Educational Rights and Privacy Act regulations. If a health care professional is involved in collecting student data, these records also may be subject to Health Insurance Portability and Accountability Act regulations.

Safeguarding privacy requires careful consideration of all the ways that information can be communicated. For example, if students identified as having possible problems are interviewed by a mental health clinician, the interview should be conducted so that neither the timing of the student's absence from class nor the location of the interview is associated with mental health or substance use issues.

The following resources provide information on confidentiality of student health records.

Resources on Confidentiality of Student Health Records

- *Confidential Health Records* (Web site)
  http://www.nationalguidelines.org/guideline.cfm?guideNum=4-25
- *Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to Student Health Records* (Joint guidance from the U.S. Department of Health and Human Services and the U.S. Department of Education)
  http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hipaaferpajointguide.pdf

Schools need to communicate respect for caregivers' rights to make health decisions for their child.

Schools can develop trusting and collaborative relationships with students and their families by clearly communicating the boundaries they will respect in regard to students' possible mental health and substance use problems. This approach requires developing policies and procedures for communicating with children, adolescents, and families about potential mental health and substance use problems and training school personnel in their use. Such policies need to reflect state laws and practices regarding the right of mature minors to consent to their own treatment. Schools also can educate caregivers about their rights. Caregivers not only have the right to consent to health treatment for their children but also should be reassured that Federal law prohibits schools from requiring a youth to be placed on medication as a condition for attending school.[230]

The following resources may help caregivers whose child is diagnosed with a mental health problem work productively with the school to meet their child's needs.

Resources for Caregivers

- *Finding Help and Working with Schools: Tips for Parents of Teens with Mental Health Problems* (Publication)
  http://www.edc.org/sites/edc.org/files/pdfs/great_minds_parents.pdf
- Massachusetts General Hospital, School Psychiatry Program and Madi Resource Center: *For Parents* (Web page)
  http://www2.massgeneral.org/schoolpsychiatry/for_parents.asp
- *Parent Technical Assistance Center Network* (Web site)
  http://www.parentcenternetwork.org/

Interventions for Identified Challenges

Simple interventions can help many students.

Schools can offer nonclinical interventions that may be sufficient to meet the needs of many students with incipient mental health problems. In one 2006 situation, about half of the students identified by a voluntary middle school screening program as having mental health problems did not require a mental health assessment; their problems could be appropriately addressed by referrals for tutoring or assisting the student with getting involved in a school social or recreational activity.[231]

Mental health and substance abuse services for children and adolescents can be difficult to access. Consequently, if schools cannot provide sufficient school-based services, they may be reluctant to identify more students with mental health and substance use problems. Despite this limitation, many schools sponsoring identification initiatives have successfully arranged for service providers who can assess and treat identified students. Information on a screening tool's rate of problem identification in similar populations allows a school to predict the approximate number of positive screens that it will generate. This approach allows schools to pace or time their screening program to match the local service system's capacity to accept referrals for assessment and treatment.

Schools also have developed a number of strategies for helping students access mental health and substance abuse services and for providing support at school. These strategies include the following:

- Making referrals to community mental health centers, substance abuse clinics, or mental health practitioners;
- Partnering with community mental health centers or other providers to deliver services on the school campus, either during school hours or before or after school;

- Partnering with community mental health centers to offer expanded school-based mental health services. The term *expanded mental health* indicates that schools and mental health practitioners are working actively together to foster positive classroom environments that meet the needs of all students, collaborate on brief interventions for students with identified problems, and provide clinical services for students with more serious problems.
- Establishing school-based health centers that offer mental health and/or substance abuse services and provide a place where students can seek help without being identified as having a mental health or substance use problem.
- Establishing "sober high schools" or "rehab high schools" that provide a high school curriculum along with support services for students in recovery from a substance use problem.

The following resources provide information on expanded school mental health and school-based health centers.

Resources on Expanded School Mental Health and School-Based Health Centers

- Center for School Mental Health, University of Maryland School of Medicine: *What Is (Expanded) School Mental Health?* (Web page)
  http://www.schoolmentalhealth.org/Resources/ESMH/DefESMH.html
- National Assembly on School-Based Health Care: *Mental Health* (Web page)
  http://www.nasbhc.org/site/c.ckLQKbOVLkK6E/b.7697107/apps/s/content.asp?ct=11053187

Any referral system needs to incorporate strategies that assist caregivers with following up on referrals when help is needed and desired. Assistance may involve facilitating the scheduling of an appointment with a provider, arranging for transportation to the appointment, and helping the family address any barriers to accessing continued treatment.

Positive Behavioral Interventions and Support (PBIS) is a whole-school prevention approach supported by the Office of Special Education Programs (OSEP), U.S. Department of Education. PBIS is a primary prevention program that is helpful and appropriate for students with identified or not-yet-identified mental health problems. Because PBIS positively supports desired behaviors across the entire school environment, it meshes well with more intensive interventions. OSEP's Technical Assistance Center on PBIS provides capacity-building information and technical support to assist states and districts with the design of effective behavioral systems for schools.

The following resource provides information on PBIS.

Resource on Positive Behavioral Interventions and Supports

Positive Behavioral Interventions and Supports (PBIS), National Technical Assistance Center, Office of Special Education Programs (Web site)
http://www.pbis.org/

Technical assistance and other resources

The Health Resources and Services Administration, Department of Health and Human Services, has sponsored two technical assistance centers that provide mental health resources to schools at the University of Maryland and University of California–Los Angeles. Also, George Washington University and Miami University of Ohio have centers specializing in school mental health. OSEP has partnered with more than 55 national organizations, technical assistance providers, organizations, and agencies at the state and local levels to develop learning communities of practice dedicated to improving outcomes for students and youths with disabilities. The Department of Education's Office of Safe and Drug-Free Schools offers training materials for school leaders.

The following resources provide information on technical assistance for school-based mental health programs.

Resources on Technical Assistance for School-Based Mental Health Programs

- Center for Health and Health Care in Schools, George Washington University (Web site)
  http://www.healthinschools.org/
- Center for Mental Health in Schools, University of California–Los Angeles (Web site)
  http://smhp.psych.ucla.edu/
- Center for School-Based Mental Health Programs, Miami University of Ohio (Web site)
  http://www.units.muohio.edu/csbmhp/
- Center for School Mental Health, University of Maryland (Web site)
  http://csmh.umaryland.edu/
- *Communities of Practice: A New Approach to Solving Complex Educational Problems* (Publication)
  http://www.nasdse.org/Portals/0/Documents/Download%20Publications/PNA-0778.pdf
- Office of Safe and Drug-Free Schools, U.S. Department of Education: *Editor's Picks* (Web page)
  http://www2.ed.gov/admins/lead/safety/edpicks.jhtml
- Office of Safe and Drug-Free Schools, U.S. Department of Education: *Reports and Resources* (Web page)
  http://www.ed.gov/about/offices/list/osdfs/resources.html

A number of mental health programs that are designed for schools and use promising and evidence-based practices have been evaluated and proven successful. The following resources provide information on two registries that can be searched to identify promising and evidence-based practices.

Resources on Promising and Evidence-Based Practices in Schools

- Ohio Mental Health Network for School Success: Quality and Effective Practice Registry (Registry of successful Ohio strategies and programs for meeting the academic needs and social and emotional needs of students)
  http://www.units.muohio.edu/csbmhp/network/registry.html
- Promising Practices Network on Children, Families and Communities (Searchable database with summaries that describe intervention programs for mental health problems set in schools and their evidence of effectiveness)
  http://www.promisingpractices.net/

Conclusion

Schools have a dual challenge: meeting students' educational needs and fostering their growth and development. In addition to a long history of serving as sites for public health initiatives to identify preventable and treatable problems, schools have a growing role in the identification, assessment, and treatment of mental health and substance use problems. This role is indicated by the fact that schools already are important sites where many children and adolescents receive mental health services. Whatever their level of addressing students' mental health and substance use problems, schools can improve their ability to identify potential problems and assist families with finding treatment resources. Careful planning and partnering with parents, community stakeholders, and treatment providers can ensure that schools' screening efforts make wise use of limited resources, incorporate cultural competency, and achieve broad support.

Identifying Mental Health and Substance Use Problems of Children and Adolescents:

A Guide for Child-Serving Organizations

Appendices

Appendix A

Acknowledgments

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At DMA Health Strategies, Wendy Holt was assisted by D. Russell Lyman, Ph.D., and Sylvia Perlman, Ph.D., who contributed to drafting the supplements. DMA partnered with the Center for the Advancement of Children's Mental Health at Columbia University, where Peter S. Jensen, M.D., currently heading the REACH (REsource for Advancing Children's Health) Institute, and Jessica Mass Levitt, Ph.D., identified the short list of mental health screening tools (see Table 1 on page 39) and contributed much of the content in Supplement 6: Primary Care. The REACH Institute updated the information on the mental health screening tools. DMA also partnered with Ken Winters, Ph.D., from the University of Minnesota, who identified the short list of substance use/abuse screening tools (see Table 2 on page 40).

The writing team worked closely with Project Officer Lisa Rubenstein and a small team consisting of Sybil Goldman and Joyce Sebian, from the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development, and Mojdeh Motamedi, from American Institutes for Research.

The Early Identification Workgroup of the Federal/National Partnership (FNP) for Transforming Child and Family Mental Health and Substance Abuse Prevention and Treatment developed a set of commonly accepted principles to guide the effort (see Appendix D: Principles Guiding Screening for Early Identification of Mental Health and Substance Use Problems in Children and Adolescents) and reviewed this document with respect to the needs of the children and adolescents who are the focus of their own agency. Members of this workgroup are listed below. Those names marked with an asterisk note members who served as reviewers.

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Finally, several other individuals and organizations reviewed the draft document and provided feedback. They are listed below.

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Deborah Stone	Substance Abuse and Mental Health Services Administration, Department of Health and Human Services
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Appendix B

Tool Descriptions

Appendix B contains detailed overviews of each screening tool included in the mental health and substance use/abuse matrices (see Table 1 and Table 2 on pages 39–40). The type of research conducted for each tool is categorized by the following areas:

- **Feasibility testing.** Administration of the instrument by existing staff in a specific setting for case findings or to enhance assessment practices.
- **Sensitivity and/or specificity testing as a screening tool.** A study examining an instrument's accuracy or predictive validity in a setting based on sensitivity (how well the tool identifies children with problems) or specificity (how well the tool avoids false positives) across different types of settings. A receiver operating characteristic (ROC) curve or other methods can establish cutoff scores.
- **Psychometric testing in setting.** An examination of an instrument's reliability or validity when used with a setting-specific population.
- **Instrument used in setting for research.** Use of the instrument as part of a research study focused on a setting-specific population (e.g., to establish prevalence of mental health problems in a population).

Adolescent Alcohol and Drug Involvement Scale (AADIS)

Target Conditions: Alcohol and drug use problem severity

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Juvenile justice		X	X	X
Substance abuse treatment		X	X	X

High-Risk Items Included: Yes

Informants/Youth Age Range: 14–20 years

Format: Structured interview or self-administered survey

Length of Instrument: 27 items

Usual Administration Time: 5 minutes

Reading Level Required: Not specified

Method of Scoring: Summing of items

Validity and Reliability: Favorable alpha coefficients were obtained across all demographic subgroups (range 0.92–0.95) in a juvenile justice sample when administered by trained interviewers (Moberg, 2003). Also available are limited but promising data on validity, based on samples of Midwestern white adolescents already referred to intervention and treatment programs (Moberg, 2003).

Sensitivity and Specificity: Using a cutoff score of 37 to identify a substance abuse disorder, 85 percent of a sample of juvenile offenders were correctly classified as having or not having a substance abuse disorder. The false negative rate was 0.05 and the false positive rate was 0.38 (Moberg, 2003).

Cost: Free

Contact Information: Paul Moberg, Ph.D., University of Wisconsin–Madison
dpmoberg@wisc.edu or 608-263-1304
http://uwphi.pophealth.wisc.edu/programs/evaluation-research/index.htm

Citations and Related References:

Moberg, D. P. (2003). *Screening for alcohol and other drug problems using the Adolescent Alcohol and Drug Involvement Scale (AADIS).* Madison: University of Wisconsin, Center for Health Policy and Program Evaluation.

Adolescent Drinking Index (ADI)

Target Conditions: Alcohol use problem severity

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Schools			X	X
Mental health treatment		X		
Substance abuse treatment		X	X	X

High-Risk Items Included: Yes

Informants/Youth Age Range: 12–17 years

Format: Self-administered survey, individually or in a group

Length of Instrument: 24 items

Usual Administration Time: 5 minutes

Reading Level Required: Fifth grade

Method of Scoring: Add item scores to produce total score and two subscales.

Validity and Reliability: Internal consistency coefficients across samples are uniformly high, exceeding 0.90. The cutoff score has an 82 percent accuracy rate, and the ADI correlates 0.60 to 0.63 with the Michigan Alcoholism Screening Test (Harrell & Wirtz, 1989b; Psychological Assessment Resources, 2011).

Sensitivity and Specificity: A cutoff score shows satisfactory sensitivity of 88 percent and specificity of 82 percent (Harrell & Wirtz, 1989b). It has an accuracy rate (correctly identified as having severe drinking problems vs. moderate, minor, or no drinking problems) of 82 percent (Psychological Assessment Resources, 2011).

Norms Available: Normed for youths ages 12–17 years: (1) youths in school, (2) youths under evaluation for psychological challenges, and (3) youths in substance abuse programs (Harrell & Wirtz, 1989b; Psychological Assessment Resources, 2011).

Cost: $100 for ADI introductory kit (includes ADI manual and 25 test booklets)

Contact Information: Materials available through Psychological Assessment Resources, 16204 N. Florida Ave., Lutz, FL 33549 http://www4.parinc.com/products/product.aspx?Productid=ADI

Citations and Related References:

Harrell, A. V., & Wirtz, P. W. (1989a). *Adolescent Drinking Index (ADI) professional manual* (HV 5808 H28a). Odessa, FL: Psychological Assessment Resources.

Harrell, A. V., & Wirtz, P. W. (1989b). Screening for adolescent problem drinking: Validation of a multidimensional instrument for case identification. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1*(1), 61–63.

Psychological Assessment Resources. (2011). *Adolescent Drinking Index (ADI)* [Web site]. Retrieved January 25, 2011, from http://www4.parinc.com/Products/Product.aspx?ProductID=ADI

Adolescent Obsessive-Compulsive Drinking Scale (A-OCDS)

Target Conditions: Craving and problem drinking; used to differentiate adolescent problem drinkers from experimenters or abusers

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Substance abuse treatment			X	X

High-Risk Items Included: Yes

Informants/Youth Age Range: 14–20 years

Format: Self-rated questionnaire

Length of Instrument: 14 items

Usual Administration Time: 5–10 minutes

Reading Level Required: Fifth grade

Method of Scoring: Scored by simple addition in 1 minute; computerized scoring or interpretation is available

Sensitivity and Specificity: Sensitive and specific to identify two factors (irresistibility and interference) related to problematic drinking and craving in adolescents and young adults (Thomas & Deas, 2005).

Norms Available: Yes; normed on unspecified subgroups.

Cost: Free

Contact Information: Deborah Deas, M.D., M.P.H., Medical University of South Carolina, Center for Drug and Alcohol Programs, 67 President St., Charleston, SC 29425

Citations and Related References:

Deas, D. V., Riggs, P., Langenbucher, M., Goldman, M., & Brown, S. (2000). Adolescents are not adults: Developmental considerations in alcohol users. *Alcoholism: Clinical and Experimental Research, 24*(2), 232–237.

Deas, D. V., Roberts, J. S., Randall, C. L., & Anton, R. F. (2001). Adolescent Obsessive-Compulsive Drinking Scale (A-OCDS): An assessment tool for problem drinking. *Journal of the National Medical Association, 93*(3), 92–103.

Thomas, S. E., & Deas, D. (2005). A-OCDS predicts both craving and alcohol cue reactivity in adolescent alcoholics. *Addictive Behaviors, 30,* 1638–1648.

Ages & Stages Questionnaires: Social-Emotional (ASQ-SE)

Target Conditions: Personal-social (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people)

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Primary care			X	
Early care			X	

High-Risk Items Included: No

Informants/Youth Age Range: Parents of children ages 1 month to 5½ years

Format: Self-administered

Length of Instrument: 22–36 questions

Usual Administration Time: 10–15 minutes

Translations: Spanish

Reading Level Required: Fourth to sixth grade

Method of Scoring: Scoring sheet takes a professional 1–3 minutes to score. Includes scores on child progress in seven crucial developmental areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. Includes considerations for making referrals.

Validity and Reliability: Reliability: 94 percent. Validity: ASQ-SE has between 88 percent and 94 percent agreement with the Child Behavior Checklist and/or the Vineland Social-Emotional Early Childhood Scales (Squires, Bricker, & Twomby, 2001).

Sensitivity and Specificity: Sensitivity: 71 percent to 85 percent. Specificity: 90 percent to 98 percent (Squires, Bricker, & Twomby, 2001).

Norms Available: Normative sample of more than 3,000 was stratified to be representative of children and families of the U.S. population in terms of ethnicity, geographic region, parent education, income, and gender of children.

Cost: $249.95 for Third Edition Starter Kit (includes questionnaires and scoring sheets, *Quick Start Guide,* online management, and online questionnaire completion)

Contact Information: Paul H. Brookes Publishing Company
http://www.brookespublishing.com/store/books/squires-asq/index.htm

Related Educational Materials:

Associated parent education materials in English and Spanish provide information about development and developmental challenges (see Twombly & Fink, 2004, 2009).

Citations and Related References:

Czaja, C. F. (2001). Identifying social-emotional problems in young children: A special educator's view. *Early Childhood Research Quarterly, 16*(4), 421–426.

Lyman, D. R., Njoroge, W. F. M., & Willis, D. W. (2007). Early childhood psychosocial screening in culturally diverse populations: A survey of clinical experience with the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE). *ZERO TO THREE, 27*(5), 46–54.

Squires, J., & Bricker, D., (2007). *An activity-based approach to developing young children's social emotional competence.* Baltimore: Brookes.

Squires, J., Bricker, D., Heo, K., & Twombly, E. (2001). Identification of social-emotional problems in young children using a parent-completed screening measure. *Early Childhood Research Quarterly, 16,* 405–419.

Squires, J., Bricker, D., & Twombly, E. (with Yockelson, S., Davis, M. S., & Kim Y). (2001). Technical report on ASQ:SE (Appendix A). In J. Squires, D. Bricker, D., & E. Twombly (with S. Yockelson, M. S. Davis, & Y. Kim), *Ages & Stages Questionnaires: Social-Emotional (ASQ:SE): A parent-completed, child-monitoring system for social-emotional behaviors.* Baltimore: Brookes. Retrieved January 25, 2011, from http://www.brookespublishing.com/store/books/squires-asqse/ASQ-SE_TechnicalReport.pdf

Squires, J., Bricker, D., & Twombly, L. (2002). *The Ages & Stages Questionnaires: Social-Emotional. A parent-completed, child-monitoring system for social-emotional behaviors.* Baltimore: Brookes.

Squires, J., Bricker, D., & Twombly, L. (2002). *The ASQ:SE user's guide for the Ages & Stages Questionnaires: Social-Emotional.* Baltimore: Brookes.

Squires, J., Bricker, D., & Twombly, E. (2004). Parent-completed screening for social emotional problems in young children: The effects of risk/disability status and gender on performance. *Infant Mental Health Journal, 25*(1), 62–73.

Stout, M. D., & Jodoin, N. (2006). *MCH Screening Tool project: Final report* (Prepared for The Maternal & Child Health Program First Nations and Inuit Health Branch). Ottawa, Ontario, Canada: Assembly of First Nations. Retrieved January 25, 2011, from http://64.26.129.156/cmslib/general/MCH-ST.pdf

Twombly, E., & Fink, G. (2004). *Ages & Stages learning activities.* Baltimore, Brookes.

Twombly, E., & Fink, G. (2009). *Edades & etapas actividades de aprendizaje de 0 a 5 años.* Baltimore: Brookes.

Yovanoff, P., & Squires, J. (2006). Determining cutoff scores on a developmental screening measure: Use of receiver operating characteristics and item response theory. *Journal of Early Intervention, 29*(1), 48–62.

Assessment of Substance Misuse in Adolescence (ASMA)

Target Conditions: Drug use problem severity

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Primary care			X	X
Schools			X	X
Substance abuse treatment		X		X

High-Risk Items Included: Yes

Informants/Youth Age Range: Adolescents

Format: Self-report questionnaire

Length of Instrument: 8 items

Usual Administration Time: 5 minutes

Reading Level Required: Not specified

Method of Scoring: Rapid scoring takes just 2 minutes.

Validity and Reliability: Good reliability, both within the overall sample of respondents and in a drug-using subsample. Very favorable internal consistency (0.90). Total score was significantly related to several indices of drug and alcohol use (Willner, 2000).

Sensitivity and Specificity: Using a cutoff score >8 showed extremely high sensitivity (85 percent) and specificity (95 percent) to detect frequent (weekly/daily) drug use. A higher cutoff score >12 showed high specificity (>99 percent) to detect daily drug use but lower sensitivity (36 percent) (Willner, 2000).

Norms Available: Yes, for a general population.

Cost: Free

Contact Information: Centre for Substance Abuse Research, Department of Psychology, University of Wales–Swansea, Swansea, UK
p.willner@swansea.ac.uk

Citations and Related References:

Abou-Saleh, M. T., Bugelli, T., Dominoni, A., & Fitzpatrick, G. (2008). The prevalence of substance misuse and emotional and behavioral problems in adolescents admitted to pediatric wards and those attending the antenatal clinic. *Addictive Disorders and Their Treatment, 7*(1), 25–30.

Willner, P. (2000). Further validation and development of a screening instrument for the assessment of substance misuse in adolescents. *Addiction, 95*(11), 1691–1698.

Brief Infant-Toddler Social and Emotional Assessment (BITSEA)

Target Conditions: Social and emotional development, strengths, and areas of concern or risks.

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Early care			X	

High-Risk Items Included: No

Informants/Youth Age Range: Parents of children ages 12–35 months; early care and education provider of children ages 12–35 months

Format: Self-administered by informant

Length of Instrument: 42 items

Usual Administration Time: 7–10 minutes

Translations: Chinese, Dutch, French, German, Gujarati, Hebrew, Italian, Russian, Spanish, and Thai

Reading Level Required: Sixth grade

Method of Scoring: Hand scored

Validity and Reliability: Test-retest reliability was excellent, and there was good agreement between two parents and between parent and a child-care provider. Problems identified by the BITSEA correlated with those of a concurrent evaluator and with the Child Behavior Checklist (CBCL).

Sensitivity and Specificity: The combined problem/competence cutpoints identified 85 of subclinical/clinical CBCL/1.5-5 scores while maintaining acceptable specificity (75 percent) (Briggs-Gowan, Carter, Irwin, Wachtel, & Cicchetti, 2004).

Norms: National sample of 600 children

Cost: $108.60 for BITSEA manual, 25 parent forms, and 25 early care and education provider

Contact Information: Available from Pearson Education: http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8007-352&Mode=summary

Citations and Related References:

Briggs-Gowan, M. J., Carter, A. S., Irwin, J. R., Wachtel, K., & Cicchetti, D. V. (2004). The Brief Infant-Toddler Social and Emotional Assessment: Screening for social-emotional problems and delays in competence. *Journal of Pediatric Psychology, 29*(2), 143–155.

Karabekiroglu, K., Rodopman-Arman, A., Ay, P., Ozkesen, M., Akbas, S., Tasdemir, G. N., et al. (2009). The reliability and validity of the Turkish version of the Brief Infant-Toddler Social Emotional Assessment (BITSEA). *Infant Behavioral Development, 32*(3), 291–297.

CRAFFT

Target Conditions: Alcohol and drug use problem severity

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Primary care		X	X	X
Juvenile justice (DUI juvenile offender)				X
Substance abuse treatment			X	

High-Risk Items Included: Yes

Informants/Youth Age Range: Adolescents

Format: Verbal questionnaire administered by physician or examining professional during a primary care exam. The name is a mnemonic device to remind physicians of the 6 questions (see "Screening Test" under Contact Information).

Length of Instrument: 6 items

Usual Administration Time: 5 minutes

Translations: English version could be easily adapted by a bilingual provider.

Reading Level Required: Appropriate for youths with poor reading skills.

Method of Scoring: Sum items and use cutoff score. Very brief; easy to score and interpret.

Validity and Reliability: Administration in a medical clinic setting and 1 week later found test-retest reliability to be satisfactory (Levy et al., 2004).

Sensitivity and Specificity: Sensitivity 0.92 (0.88–0.96) and specificity 0.64 (0.59–0.69) (Knight, Sherritt, Harris, Gates, & Chang, 2003).

Cost: Free

Contact Information Center for Adolescent Substance Abuse Research, 300 Longwood Ave., Boston, MA 02115; 617-355-5433
Screening Test: http://www.slp3d2.com/rwj_1027/webcast/docs/screentest.html

Citations and Related References:

Kelly, T. M., Donovan, J. E., Chung, T., Bukstein, O. G., & Cornelius, J. R. (2009). Brief screens for detecting alcohol use disorder among 18–20 year old young adults in emergency departments: Comparing AUDIT-C, CRAFFT, RAPS40QF, FAST, RUFT-Cut, and DSM-IV 2-item scale. *Addictive Behaviors, 34,* 668–674.

Knight, J. R., Harris, S. K., Sherritt, L., Van Hook, S., Lawrence, N., Brooks, T., et al. (2007). Adolescents' preference for substance abuse screening in primary care practice. *Substance Abuse, 28,* 107–117.

Knight, J. R., Sherritt L., Harris, S. K., Gates, E. C., & Chang, G. (2003). Validity of brief alcohol screening tests among adolescents: A comparison of the AUDIT, POSIT, CAGE, and CRAFFT. *Alcoholism: Clinical and Experimental Research, 27*(1), 67–73. Abstract retrieved January 25, 2011, from http://www.ncbi.nlm.nih.gov/pubmed/12544008

Levy, S., Sherritt, L., Harris, S. K., Gates, E. C., Holder, D. W., Kulig, J. W., et al. (2004). Test-retest reliability of adolescents' self-report of substance use. *Alcoholism: Clinical and Experimental Research, 28*(8), 1236–1241. Abstract retrieved January 25, 2011, from http://www.ncbi.nlm.nih.gov/pubmed/15318123

Thomas, K. M., Donovan, J. E, Chung, T., Cook, R. L., & Delbridge, T. R. (2004). Alcohol use disorders among emergency department-treated older adolescents: A new brief screen (RUFT-Cut) using the AUDIT, CAGE, CRAFFT, and RAPS-QF. *Alcoholism: Clinical and Experimental Research, 28,* 746–753.

DISC Predictive Scales (DPS)

Target Conditions: Most *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV) mental health diagnoses, substance abuse diagnoses, degree of impairment

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Primary care		X		X
Schools	X			
Juvenile justice			X	

In addition, the TeenScreen program using the DISC Predictive Scales has been implemented in foster care, primary care, pediatric practices, shelters, drop-in centers, and residential treatment facilities.

High-Risk Items Included: Yes

Informants/Youth Age Range: 9–17 years

Format: Standardized interview administered verbally via computer and headphones

Length of Instrument: 52 items

Usual Administration Time: 10 minutes

Translations: Spanish

Reading Level Required: Not specified

Method of Scoring: Rapid computer scoring produces a report indicating high-risk symptoms and probable diagnoses.

Validity and Reliability: Adequate reliability. Test-retest (across scales) = 0.52–0.82 (Lucas et al., 2001).

Sensitivity and Specificity: In a large epidemiologic sample of U.S. youths in community and residential care settings ages 9–17, sensitivity was 0.67–1.00 and specificity was 0.49–0.96 (Lucas et al., 2001).

Cost: Cost varies; can be provided free of charge

Contact Information

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New York University Child Study Center,
215 Lexington Ave., 13th Floor, New York, NY 10016
chris.lucas@nyumc.org

Citations and Related References:

Grupp-Phelan, J., Delgado, S. V., & Kelleher, K. J. (2007). Failure of psychiatric referrals from the pediatric emergency department. *BMC Emergency Medicine,*7, 12. Retrieved January 25, 2011, from http://www.biomedcentral.com/1471-227X/7/12

Leung, P. W. L., Lucas, C. P., Hung, S., Kwong, S., Tang, C., Lee, C., et al. (2005). The test-retest reliability and screening efficiency of DISC Predictive Scales–Version 4.32 (DPS-4.32) with Chinese children/youths. *European Child & Adolescent Psychiatry, 14*(8), 461–465.

Lucas, C. P., Zhang, H., Fisher, P. W., Shaffer, D., Regier, D. A., Narrow, W. E., et al. (2001). The DISC Predictive Scales (DPS): Efficiently screening for diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(4), 443–439.

McGuire, L. C., & Flynn, L. (2003). The Columbia TeenScreen program: Screening youth for mental illness and suicide. *TEN, 5*(2), 56–62.

McReynolds, L. S., Wasserman, G. A., Fisher, P., & Lucas, C. P. (2007). Diagnostic screening with incarcerated youths: Comparing the DPS and voice DISC. *Criminal Justice and Behavior, 34*(6), 830–845.

Roberts, N., Stuart, H., & Lam, M. (2008). High school mental health survey: Assessment of a mental health screen. *Canadian Journal of Psychiatry, 53*(5), 314–322.

Scott, M. A., Wilcox, H. C., Schonfeld, S., Davies, M., Hicks, R. C., Turner, J. B., et al. (2008). School-based screening to identify at-risk students not already known to school professionals: The Columbia Suicide Screen. *American Journal of Public Health, 99*(2), 1–6.

Shaffer, D., Fisher, P., Lucas, C. P., Dulcan, M. K., & Schwab-Stone, M. E. (2000). NIMH Diagnostic Interview Schedule for Children, Version IV (NIMH DISC-IV): Description, differences from previous versions and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(1), 28–38.

Shaffer, D., Scott, M., Wilcox, H., Maslow, C., Hicks, R., Lucas, C. P., et al. (2004). The Columbia TeenScreen: Validity and reliability of a screen for youth suicide and depression. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(1), 1–9.

Shaffer, D., Wilcox, H., Lucas, C., Hicks, R., Busner, C., & Parides, M. S. (1996). The development of a screening instrument for teens at risk for suicide. Poster presented at the 1996 meeting of the American Academy of Child and Adolescent Psychiatry, New York, NY.

(For additional references on TeenScreen and suicide prevention, see the TeenScreen Resources Web page at http://www.teenscreen.org/resources/.)

Drug Abuse Screening Test–Adolescents (DAST-A)

Target Conditions: Drug use problem severity

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Shelters (homeless girls)		X	X	X
Substance abuse treatment			X	

High-Risk Items Included: Drug-related risks including blackouts, withdrawals, and illegal activities

Informants/Youth Age Range: Adolescents

Format: Self-report

Length of Instrument: 20 items

Usual Administration Time: 5 minutes

Translations: Adult version has been translated and tested in Spanish. A bilingual provider could likely translate the few differences on the adolescent version.

Reading Level Required: Sixth grade

Method of Scoring: Sum items and use cutoff score; easy to score and interpret.

Validity and Reliability: Satisfactory measures of reliability and validity for clinical uses

Sensitivity and Specificity: A score of greater than 6 yielded sensitivity of 78.6 percent, specificity of 84.5 percent, and positive predictive powers of 82.3 percent (Martino, Grilo, & Fehon, 2000).

Cost: Free or nominal cost

Contact Information: The Addiction Research Foundation, Marketing Department, 33 Russell St., Toronto, Ontario, Canada M5S-2S1; 416-595-6000

Citations and Related References:

Cole, J. C., Goudie, A. J., Field, M., Loverseed, A. C., Charlton, S., & Sumnall, H. R. (2008). The effects of perceived quality on the behavioral economics of alcohol, amphetamine, cannabis, cocaine, and ecstasy purchases. *Drug and Alcohol Dependence, 94,* 183–190.

Martino, S., Grilo, C. M., & Fehon, D. C. (2000). Development of the Drug Abuse Screening Test for Adolescents (DAST-A). *Addictive Behaviors, 25,* 57–70.

Global Appraisal of Individual Needs–Short Screener (GAIN-SS)

Target Conditions: Internalized or externalized psychiatric disorders, substance abuse disorders, and crime or violence problems

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Child welfare	X	X	X	
Juvenile justice	X	X	X	
Mental health treatment	X	X	X	
Substance abuse treatment	X	X	X	

High-Risk Items Included: Suicide, substance use, psychiatric disorders, crime/violence problems, and others

Informants/Youth Age Range: Adolescents

Format: Self-administered

An application can be installed on the Web site of any licensed GAIN user (application service provider, Microsoft IIS, and SQL Server Express required).

Length of Instrument: 20 items, 2 versions: Recent version is answered on a 4-point scale; former version is answered on a yes/no scale.

Usual Administration Time: 5 minutes

Translations: Spanish

Reading Level Required: Eighth grade

Method of Scoring: Count number of 2 and 3 scores or number of yes answers in 4 categories to yield score on internalizing, externalizing, substance abuse, and crime/violence.

Validity and Reliability: Good internal consistency (alpha of 0.96 on total screener) is highly correlated (r ¼ 0.84 to 0.94) with the longer 123-item scales in the full GAIN. The GAIN–SS also does well in terms of its receiver operator characteristics (90 percent or more under the curve in all analyses) (Dennis, Chan, & Funk, 2006).

Sensitivity and Specificity: Clinical decision-making cutpoints have excellent sensitivity (90 percent or more) for identifying people with a disorder and excellent specificity (92 percent or more) for correctly ruling out people who do not have a disorder (Dennis et al., 2006).

Cost:	$100 license fee covers multiple administrations over a 5-year period. Forms and manual available for free download by licensed users.
Contact Information:	Chestnut Health Systems, Lighthouse Institute http://www.chestnut.org/LI/gain/GAIN_SS/index.html
Citations and Related References:	Dennis, M. L., Chan, Y. F., & Funk, R. R. (2006). Development and validation of the GAIN Short Screener (GAIN-SS) for psychopathology and crime/violence among adolescents and adults. *The American Journal on Addictions, 15* (supplement 1), 80–91. Lucenko, B., Mancuso, D., & Estee, S. (with the DSHS Integrated Screening and Assessment Workgroup). (2008). *Co-occurring disorders among DSHS clients* (Report to the Legislature). Olympia, WA: Department of Health and Social Services; Planning, Performance and Accountability Administration; Research and Data Analysis Division. McDonell, M. G., Comtois, K. A., Voss, W. D., Morgan, A. H., & Ries, R. K. (2009). Global appraisal of Individual Needs Short Screener (GSS): Psychometric properties and performance as a screening measure in adolescents. *The American Journal of Drug and Alcohol Abuse, 35*(3), 157–160.

Massachusetts Youth Screening Inventory, 2nd Edition (MAYSI-2)

Target Conditions: Urgent mental health problems in need of immediate attention; screening performed upon admission to juvenile justice facility

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Juvenile justice	X	X	X	

High-Risk Items Included: Alcohol or drug use, anger or irritability, depression, anxiety, suicide ideation, somatic complaints, and thought disturbance (boys only); traumatic experiences

Informants/Youth Age Range: 12–17 years

Format: Self-administered, yes-or-no questionnaire

Length of Instrument: 52 questions

Usual Administration Time: 10–15 minutes

Translations: Spanish

Reading Level Required: Fifth grade

Method of Scoring: Easily scored in about 3 minutes

Validity and Reliability: Adequate reliability and validity (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001). Internal consistency = 0.51–0.86; test-retest (8.3 days) = 0.53–0.89.

Sensitivity and Specificity: In a juvenile justice sample, sensitivity was 0.65–0.75 and specificity was 0.60–0.80 (Grisso et al., 2001).

Cost: $85 for manual, which includes instrument and scoring forms, unlimited usage (user photocopies for number of youths). $194.95 for CD with manual for electronic administration. Separate 2nd screening to follow up high scores available, $20 for 7 copies of form.

Contact Information: National Youth Screening and Assessment Project, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655
http://www.nysap.us/ or nysap@umassmed.edu

Related Educational Materials: Secondary screening form for high-scoring youth

Citations and Related References:

Bailey, S., & Tarbuck, P. (2006). Recent advances in the development of screening tools for mental health in young offenders. *Current Opinion in Psychiatry, 19*(4), 373–377.

Grisso, T., Barnum, M. D., Fletcher, K. E., Cauffman, E., & Peuschold, D. (2001). Massachusetts Youth Screening Instrument for mental health needs of juvenile justice youths. *Child and Adolescent Psychiatry, 40*(5), 541–548.

Vincent, G. M., Grisso, T., Terry, A., & Banks, S. (2008). Sex and race differences in mental health symptoms in juvenile justice: The MAYSI-2 national meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(3), 282–290.

Pediatric Symptom Checklist (PSC-35)

Target Conditions: Psychosocial risk

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Primary care	X	X	X	X
Schools	X	X	X	X

High-Risk Items Included: No

Informants/Youth Age Range: Parent of youth ages 3–16 years; youth ages 11–16 years

Format: Self-administered by informant

Length of Instrument: 35 items

Usual Administration Time: 5–10 minutes

Translations: **Parent version:** Brazilian-American Portuguese, Chinese, Dutch, European Portuguese, Filipino, French, German, Haitian-Creole, Hindi, Hmong, Japanese, Somalie, Spanish, and Spanish (Chilean version)

Youth version: Brazilian-American Portuguese, French, and Spanish

Reading Level Required: Fifth to sixth grade

Method of Scoring: Item scores are summed. Cutoff scores indicate the need for further evaluation. Office staff sum ratings. Easy to score.

Validity and Reliability: Adequate reliability and validity (Murphy, Jellinek, & Milinsky, 1989; Navon, Nelson, Pagano, & Murphy, 2001). Shown to be feasible in school settings (Gall, Pagano, Desmond, Perrin, & Murphy, 2000; Pagano, Cassidy, Little, Murphy, & Jellinek, 2000). Test-retest reliability (4–6 weeks) = 0.80 (Navon et al., 2001).

Sensitivity and Specificity: In a primary care sample, the parent report version had sensitivity of 0.95 and specificity of 0.68 (Jellinek et al., 1988). In a school sample, the youth report has a sensitivity of 0.94 and a specificity of 0.88 (Pagano et al., 2000).

Cost: Free

Contact Information: Massachusetts General Hospital, Pediatric System Checklist: http://www2.massgeneral.org/allpsych/psc/psc_home.htm

Citations and Related References:

Chisolm, D. J., Gardner, W., Julian, T., & Kelleher, K. J. (2008). Adolescent satisfaction with computer-assisted behavioral risk screening in primary care. *Child and Adolescent Mental Health, 13,* 163–168.

Frankenfield, D. L., Keyl, P. M., Gielen, A., Wissow, L. S., Werthamer, L., & Baker, S. P. (2000). Adolescent patients: Healthy or hurting? Missed opportunities to screen for suicide risk in the primary care setting. *Archives of Pediatrics and Adolescent Medicine, 154,* 162–168.

Gall, G., Pagano, M. E., Desmond, M. S., Perrin, J. M., & Murphy, J. M. (2000). Utility of psychosocial screening at a school-based health center. *Journal of School Health, 70,* 292–298.

Husky, M. M., Miller, K., McGuire, L., Flynn, L., & Olfson, M. (2008). *Screening adolescents for mental health problems in primary care.* Paper presented at the 55th annual meeting of the American Academy of Child and Adolescent Psychiatry, Chicago, IL.

Jellinek, M. S., Murphy, J. M., Robinson, J., Feins, A., Lamb, S., & Fenton, T. (1988). The Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *The Journal of Pediatrics, 112,* 201–209.

Mojtabai, R., & Olfson, M. (2008). Parental detection of youth's self-harm behavior. *Suicide and Life-Threatening Behavior, 38,* 60–73.

Murphy, J. M., Arnett, H. L., Bishop, S. J., Jellinek, M. S., & Reede, J. Y. (1992). Screening for psychosocial dysfunction in pediatric practice. A naturalistic study of the Pediatric Symptom Checklist. *Clinical Pediatrics, 31,* 660–667.

Murphy, J. M., Jellinek, M. S., & Milinsky, S. (1989). The pediatric symptom checklist: Validation in the real world of middle school. *Journal of Pediatric Psychology, 14,* 629–639.

Navon, M., Nelson, D., Pagano, M., & Murphy, M. (2001). Use of the pediatric symptom checklist in strategies to improve preventive behavioral health care. *Psychiatric Services, 52*(6), 800–804.

Pagano, M. E., Cassidy, L. J., Little, M., Murphy, J. M., & Jellinek, M. S. (2000). Identifying psychosocial dysfunction in school-age children: The Pediatric Symptom Checklist as a self-report measure. *Psychology in the Schools, 37*(2), 91–106.

Simonian S. (2006). Screening and identification in pediatric primary care. *Behavior Modification, 30,* 114–131.

Wren, F., Scholle, S., Heo, J., & Comer, D. (2003). Pediatric mood and anxiety syndromes in primary care: Who gets identified? *International Journal of Psychiatry in Medicine, 33,* 1–16.

(For additional references, see the bibliography on the PSC Web site at http://www2.massgeneral.org/allpsych/psc/psc_bibliography.htm.)

Personal Experience Screening Questionnaire (PESQ)

Target Conditions: Chemical dependency, select psychosocial problems, and faking good and faking bad tendencies.

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Schools		X	X	X
Juvenile justice		X	X	X
Substance abuse treatment		X	X	X

High-Risk Items Included: Drug use and certain psychosocial problems

Informants/Youth Age Range: 12–18 years

Format: Self-report questionnaire

Length of Instrument: 40 items; subscales for problem severity, psychosocial items, drug use history

Usual Administration Time: 10 minutes

Translations: French, Portuguese, and Spanish

The PESQ has been adapted for the Indian Health Service (IHS-PESQ) to recognize the use of substances used in Native religious ceremonies and to define 3, rather than 2, scoring categories.

Reading Level Required: Fourth grade

Method of Scoring: Automatically scored as administered; no training needed.

Computer scoring available. Provides a "red" or "green" flag problem-severity score and a brief overview of psychosocial challenges, drug use frequency, and faking tendencies.

Validity and Reliability: Internal consistency reliability very high (0.90–0.91) (Winters, 1991). Problem severity scale correlates with Personal Experience Inventory (0.88) and with group status, treatment history, and diagnostic ratings; sensitivity = 0.88, specificity = 0.85 (Winters, 1991).

Sensitivity and Specificity: The test is estimated to have an accuracy rate of 87 percent in predicting the need for further substance abuse assessment (Winters, 1991).

Norms Available: Manual includes norms for a school sample, a school clinic sample, a drug clinic sample, and a juvenile correctional institution sample.

Cost:	$60 for manual, $43 for 25 forms, $99 for a kit that includes the manual and 25 forms. Available from Western Psychological Services, 12031 Wilshire Blvd., Los Angeles, CA 90025-1251; 800-648-8857; http://portal.wpspublish.com/portal/page?_pageid=53,69732&_dad=portal&_schema=PORTAL
Contact Information:	Ken Winters, Ph.D., University of Minnesota, Department of Psychiatry, 420 Delaware St. SE, P.O. Box 393, Minneapolis, MN 55455; 612-626-2879; winte001@umn.edu
Citations and Related References:	George, M. S., & Skinner, H. A. (1991). In H. M. Annis & C. S. Davis (Eds.), *Drug use by adolescents: Identification, assessment and intervention* (pp. 85–108). Toronto, Ontario, Canada: Alcoholism and Drug Addiction Foundation. Winters, K. (1991). *Manual for the Personal Experience Screening Questionnaire (PESQ).* Los Angeles: Western Psychological Services. Winters, K. C. (1992). Development of an adolescent alcohol and other drug abuse screening scale: Personal Experiences Screening Questionnaire. *Addictive Behaviors, 17,* 479–490. Winters, K. C., Remafedi, G., & Chan, B. (1996). Assessing drug abuse problem severity and HIV risk among young gay/bisexual men. *Psychology of Addictive Behaviors, 10,* 228–236.

Rutgers Alcohol Problem Index (RAPI)

Target Conditions: Alcohol use problem severity

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Schools (colleges)		X	X	X
Shelters (homeless youth)		X	X	X
Substance abuse treatment		X	X	X

High-Risk Items Included: Yes

Informants/Youth Age Range: Adolescents

Format: Interview or self-administered survey

Length of Instrument: 18 items

Usual Administration Time: 10 minutes

Reading Level Required: Sixth to seventh grade

Method of Scoring: Easily scored by adding the numbers from each response

Validity and Reliability: RAPI's face validity is based on selection of items from lists developed by substance abuse experts. It has good reliability (0.8 or higher) in clinical and nonclinical samples (White & Labouvie, 1989). RAPI has been found to discriminate between drinking and problem drinking in adolescents. It has good convergent validity with the AAIS, ADS, DSM-III, DSM-III-R ($r>0.7$ in a clinical sample) (Miller et al., 2002).

Norms Available: Normed on adolescent community sample and on adolescent clinical (drug and alcohol problems) sample; one study of homeless youth.

Cost: Free, but authors request users to send them the age/sex forms as well as a description of their sample. Online sample: http://alcoholstudies.rutgers.edu/research/prevention_etiology/health_human_development/RAPI23.pdf

Contact Information: Helene White, Center of Alcohol Studies, Rutgers University, 607 Allison Road, Piscataway, NJ 08855-0969

Citations and Related References:

Center of Alcohol Studies Cognitive Neuroscience Laboratory, Rutgers University. (2010). *Rutgers Alcohol Problem Index* [Web site]. Retrieved January 25, 2011, from http://alcoholstudies.rutgers.edu/research/prevention_etiology/health_human_development/RAPI.html

Collins, S., Carey, K., & Sliwinski, M. (2002). Mailed personalized normative feedback as a brief intervention for at-risk college drinkers. *Journal of Studies on Alcohol, 63,* 559–567.

Earleywine, M., LaBrie, J. W., & Pedersen, E. R. (2008). A brief Rutgers Alcohol Problem Index with less potential for bias. *Addictive Behaviors, 33,* 1249–1253.

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1995). The prevalence and risk factors associated with abusive or hazardous alcohol consumption in 16 year olds. *Addiction, 90,* 935–946.

Larimer, M. E., Turner, A. P., Anderson, B. K., Fader, J. S., Kilmer, J. R., Palmer, R. S., et al. (2001). Evaluating a brief intervention with fraternities. *Journal of Studies on Alcohol, 62,* 370–380.

Marlatt, G. A., Baer, J. S., Kivlahan, D. R., Dimeff, L. A., Larimer, M. E., Quigley, L. A., et al. (1998). Screening and brief intervention for high-risk college student drinkers: Results from a 2-year follow-up assessment. *Journal of Consulting and Clinical Psychology, 66,* 604–615.

Martens, M. P., Neighbors, C., Dams-O'Connor, K., Lee, C. M., & Larimer, M. E. (2007). The factor structure of a dichotomously scored Rutgers Alcohol Problem Index. *Journal of Studies on Alcohol and Drugs, 68,* 597–606.

Miller, E. T., Neal, D. J., Roberts, L. J., Baer, J. S., Cressler, S. O., Metrik, J., et al. (2002). Test-retest reliability of alcohol measures: Is there a difference between Internet-based assessment and traditional methods? *Psychology of Addictive Behaviors, 16,* 56–63.

Thompson, M. P., Spitler, H., McCoy, T. P., Marra, L., Sutfin, E. L., Rhodes, S. D., et al. (2009). The moderating role of gender in the prospective associations between expectancies and alcohol-related negative consequences among college students. *Substance Use and Misuse, 44,* 934–942.

White, H. R. (2000, June). *Longitudinal trends in problem drinking as measured by the Rutgers Alcohol Problem Index.* Paper presented at the Research Society on Alcoholism meeting, Denver, CO.

White, H. R., & Labouvie, E. W. (1989). Towards the assessment of adolescent problem drinking. *Journal of Studies on Alcohol, 50,* 30–37.

Strengths and Difficulties Questionnaire (SDQ)

Target Conditions: Psychosocial risk (adjustment, psychopathology, chronicity, distress, social impairment); addresses strengths as well as problems.

Type of Research Support by Setting:

	Feasibility Testing	Sensitivity/ Specificity Testing	Psychometric Testing	Research
Primary care			X	X
Schools	X		X	X
Child welfare		X		
Juvenile justice			X	
Mental health treatment			X	X
Substance abuse treatment			X	

High-Risk Items Included: No

Informants/Youth Age Range: 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

Length of Instrument: 25 items, 5 supplemental questions to assess chronicity, distress, and social impairment; 2 questions to assess response to intervention

Usual Administration Time: 5–10 minutes

Translations: Afrikaans, Amharic, Arabic, Basque, Bengali, Bulgarian, Catalan, Chinese, Croatian, Czech, Danish, Dari, Dutch, English (Aus), English (USA), English (UK), Estonian, Farsi, Finnish, French, Gaelic (D), Gallego, German, Greek, Greenlandish, Gujarati, Hebrew, Hindi, Hmong, Hungarian, Icelandic, Indonesian, Irish (D), Italian, Japanese, Kannada (D), Khmer, Korean, Lithuanian, Macedonian, Malay (D), Malayalam, Maltese, Norwegian (B), Norwegian (N), Pashto, Polish (D), Portuguese (B), Portuguese (P), Punjabi, Romanian, Russian, Sami, Serbian, Sinhalese, Slovak, Slovene, Somali, Spanish, Spanish (RP), Swedish, Tamil (D), Thai, Turkish, Ukranian, Urdu, Welsh, Xhosa, and Yoruba

Key:
D = translation is still in draft form.
Otherwise the letter indicates a specific regional dialect:
Norwegian = Nynorsk (N), Bokmal (B)
Portuguese = Portugal (P), Brazil (B)
Spanish = Rio de la Plata (RP)

Reading Level Required:	Not specified
Method of Scoring:	Relatively easy to score; hand scoring using transparent scoring keys or computer scoring. Computer algorithms for predicting psychiatric diagnoses; online scoring and reports; computer scoring syntax for SPSS, SAS, and Microsoft Access.
Validity and Reliability:	Adequate reliability and validity (Goodman, 2001; Goodman, Meltzer, & Bailey, 1998). Mean internal consistency (across informants) = 0.73; Overall test-retest reliability (4–6 months, across informants) = 0.62
Sensitivity and Specificity:	In a representative sample of 5- to 15-year-olds, parent, teacher, and youth report versions had sensitivities of 0.23–0.47 and specificities of 0.94–0.95 (Goodman, 2001).
Cost:	Free
Contact Information:	Information and downloadable versions available at http://www.sdqinfo.org/
Citations and Related References:	Bailey, S., & Tarbuck, P. (2006). Recent advances in the development of screening tools for mental health in young offenders. *Current Opinions in Psychiatry, 19*(4), 373–377. Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire (SDQ). *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 1337–1345. (Abstract) Goodman, R., Meltzer, H., & Bailey, V. (1998). The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry, 7,* 125–130. Hill, C., & Hughes, J. N. (2007). An examination of the convergent and discriminant validity of the Strengths and Difficulties Questionnaire. *School Psychology Quarterly, 22*(3), 380–406. Palmierei, P. A., & Smith, G. C. (2007). Examining the structural validity of the Strengths and Difficulties Questionnaire (SDQ) in a U.S. sample of custodial grandmothers. *Psychological Assessment, 19*(2), 189–198. Ruchkin,V., Jones, S., Vermeiren, R., & Schwab-Stone, M. (2008). The Strengths and Difficulties Questionnaire: The self-report version in American urban and suburban youth. *Psychological Assessment, 20*(2), 175–182. (For additional references, see the articles on the *SDQ: Relevant Publications* Web page at http://www.sdqinfo.org/f0.html.)

Appendix C

Sample Parent Letter, Information Sheet, and Forms for Consent and Assent

The following parent letter, information sheet, and forms for consent and assent were adapted with permission from models developed by the TeenScreen National Center for Mental Health Checkups at Columbia University. These documents are provided as samples. Organizations may modify these documents as needed.

Sample Parent Letter

Date

Dear Parent or Legal Guardian:

[Insert a brief description of why your organization has developed a screening program, such as:

- Incidence of problems you are screening for;
- Lack of identification of many children or adolescents with these challenges; and/or
- Availability of effective ways to help children or adolescents with challenges.]

We are now making free and voluntary social and emotional health screening available to the children and adolescents whom we serve. You can take advantage of this confidential service for your child.

Please read the attached information sheet carefully and then sign the attached parent consent form to indicate whether or not you want your child to participate. Your child cannot participate unless you return the signed consent form.

[If using a youth assent form, insert an explanation such as the following: Your child also will be asked to complete the attached youth assent form. Your child has the option to refuse to participate or refuse to answer any of the questions during the screening.]

If you have any questions, please do not hesitate to call [name] at [number]. Additional information is available at [provide Web site addresses or references for any other relevant information about your screening tool or screening program].

Sincerely,

[Designated Program Staff]

Sample Information Sheet

Common Questions and Answers About Screening

What is [insert name of the screening tool or screening program]?

[Name of screening tool] is a health screening tool developed by [name of developer] to identify [age group being targeted] who may suffer from [conditions you are screening for, e.g., depression or other emotional challenges] and to help their caregivers connect those who are in need with professional health resources in the community.

How does the program work?

[Designated program staff] will be in charge of the program. It will take place [when] in a private setting at [location]. Your child will not be screened without your permission. There are three steps to the screening procedure:

- **Step 1: Screening**
  [Children/youths in the targeted age group] complete a [describe tool, e.g., 10-minute questionnaire about general health, depression, anxiety, and use of drugs and alcohol].
- **Step 2: Evaluation of the results, answering questions**
  [Describe what will happen if the screen indicates a potential problem. For example, if your child's answers reveal a potential problem or if your child asks for help, he or she will then meet with a trained health professional in private to determine if further evaluation is recommended. Youths whose answers show that they probably do not need help will meet briefly with other program staff to answer any questions they may have about the program.]
- **Step 3: Notification of caregivers**
  You will be notified by program staff only if your child meets with a health professional and the professional recommends further evaluation for your child. If this situation is the case, program staff will share the overall results with you and discuss ways to get help.

What is the process for getting help?

[Name of your organization] provides this screening at no cost but does not provide further evaluation or treatment services. It is up to you to decide if you want to obtain any additional services for your child. Our staff can suggest ways that you may be able to get further services.

Are screening results confidential?

To protect your child's privacy, his or her screening results and related files will not be stored with his or her [file for our program—e.g., academic records]. Our [teaching/early care/etc.] staff will not be involved in the screening procedure. If program staff believe that your child is in some danger or is a danger to others, they will take action and notify appropriate personnel and/or necessary authorities.

What if I provide consent, but my child does not want to participate?

Because we believe screening should be totally voluntary, your child may refuse to participate or may refuse to answer any questions during the screening. We will notify you by letter if your child chooses not to participate or is absent on the day of the screening.

Will treatment be recommended?

The people who administer the screening will not make any recommendations for treatment but can help families find a health professional who is qualified to make such recommendations. All treatment decisions are made by families in close consultation with a health professional of their choice. Families may elect to share the screening information with their health care provider, who will perform any further evaluation that is needed to fully understand the child's or adolescents' problem.

How accurate is the screening questionnaire?

The screening questionnaire was developed by [specify developer], and research has concluded that it is effective in identifying youths with possible [specify nature of the problems that you are targeting. Possible descriptions include depression, anxiety, mental health challenges or problems, substance use problems, etc.]. However, the questionnaire results are not a medical diagnosis. Medical diagnoses are beyond the scope of the screening program.

Can caregivers see the questionnaire?

Yes. If you wish to review the [name of screening questionnaire], the assent form that your child will be asked to sign prior to his or her participation in the program, or any instructional materials related to the screening, please submit a request to [name of program staff] at [contact information]. You will be notified of the time and place where you may review these materials.

Who is supporting this screening program?

The program is supported by [indicate where you are getting support and if it is nonprofit—e.g., foundations and local communities]. [If true and it would be helpful to the caregiver, you may wish to state: "The program receives no funding from pharmaceutical companies."]

If I have additional questions, whom do I contact?

If you have any questions, please do not hesitate to call [name] at [number]. Additional information is available at [provide Web site addresses or references for any other relevant information about your screening tool or screening program].

Sample Parent Consent Form

Parent Consent Form

I have read and understand the description of the early identification program offered at [organization name] on or about [insert date of administration].

___ I would like my child to participate in the early identification program.

___ I do not want my child to participate in the early identification program.

Child's Name (Print): _____

Other Identifier (if needed): _____

Parent/Legal Guardian's Name (Print): _____

Parent/Legal Guardian's Signature: _____

Date: _____

If your child will be participating, please provide the following information so we can contact you if necessary:

Address: _____

Home Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Best times to reach you:

1) _____ Tel.#: _____

2) _____ Tel.#: _____

Please return this form by mail or have your child deliver it by [date] to:

[Name]

[Location]

Sample Youth Assent Form

Youth Assent Form

Name (please print): _____

Grade: _____ Age: _____

I have read and understand the following statements about the early identification program offered at [organization name] on or about [insert date of administration]:

a. [Brief description of organization and screening program.]

b. The program asks questions about my health, experiences I have gone through and feelings I've had, because they think this is the best way to understand what teens are thinking and going through. The program provides help for those who need it.

c. If I agree to participate, I will be asked to [describe your screening process].

d. If my answers show that I could use some help with problems I am having, the program staff will talk to me and my caregivers.

e. Participation in this program is voluntary.

f. The entire program will take [time that screen will take, including time to talk with a professional about results if applicable].

g. The questionnaire will not have my name on it and will not be included in my permanent records. My answers will not be seen by [organization name] staff without my approval and the approval of my legal guardian.

h. This sheet of paper is the only one that has my name on it, and it will be stored in a locked file cabinet that only the program staff can enter. All records will be kept confidential to the extent permitted by law.

i. If my answers indicate that I am a danger to myself or others, the program staff are required to inform my caregivers and the proper authorities. This action will be taken only after discussing the situation with me.

j. If my answers indicate that I am being abused, the program staff are required to inform the proper authorities. This action will be taken only after discussing the situation with me.

k. The program staff will contact my caregivers to discuss any problems or behaviors that cause concern. This action will be taken only after discussing the situation with me.

l. If I have any further questions about this program, I may speak with [name] at [number].

(Choose one:)

___ I would like to participate in the early identification program.

___ I do not want to participate in the early identification program. I also understand that my caregivers will be notified of my decision by letter.

Sign your name _____ Date _____

Appendix D

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

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.

Appendix E

References

Introduction

1. Office of the Surgeon General. (1999). Children and mental health. In *Mental health: A report of the Surgeon General* (Chap. 3, pp. 123–220). Rockville, MD: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health. Retrieved January 25, 2011, from http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf, page 132.

2. Substance Abuse and Mental Health Services Administration. (2010, May 6). *New study indicates that early intervention for young children with mental health challenges supports healthy development and improves family life* (SAMHSA News Release). Rockville, MD: U.S. Department of Health and Human Services. Retrieved January 25, 2011, from http://www.samhsa.gov/newsroom/advisories/1005065224.aspx

3. National Institute on Drug Abuse. (2010). *Drug, brains and behavior: The science of addiction* (NIH Pub. No. 10-5605). Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health. Retrieved January 25, 2011, from http://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf, pages 11–12, 25.

4. Substance Abuse and Mental Health Services Administration. (2005). *Transforming mental health care in America. The federal action agenda: First steps* (HHS Publication No. SMA 05-4060). Rockville, MD: U.S. Department of Health and Human Services. Retrieved January 25, 2011, from http://www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx

5. U.S. Census Bureau. (2009). *American Community Survey demographic and housing estimates: 2005–2009* [Web site]. Retrieved January 25, 2011, from http://factfinder2.census.gov/

6. Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1996). Prevalence of serious emotional disturbances in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health, United States: 1996* (Chap. 6, pp. 71–89). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

7. Friedman, Katz-Leavy, Manderscheid, & Sondheimer (1996).

8. Howell, E. (2004). *Access to children's behavioral health services under Medicaid and SCHIP* (New Federalism: National Survey of America's Families Series B, No. B-60). Washington, DC: The Urban Institute. Retrieved January 25, 2011, from http://www.urban.org/uploadedPDF/311053_B-60.pdf

9. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2002). Highlights. In *Results from the 2001 National Household Survey on Drug Abuse. Volume I: Summary of national findings* (NHSDA Series H-17, HHS Publication No. SMA 02-3758). Rockville, MD: U.S. Department of Health and Human Services. Retrieved January 25, 2011, from http://www.oas.samhsa.gov/nhsda/2k1nhsda/vol1/highlights.htm

10. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2002). *Substance use and the risk of suicide among youths* (The NHSDA Report). Rockville, MD: U.S. Department of Health and Human Services. Retrieved January 25, 2011, from http://www.oas.samhsa.gov/2k2/suicide/suicide.pdf

Chapter 1: Prevention and Early Identification of Children's and Adolescents' Mental Health and Substance Use Problems

11. Harris, E., & Barraclough, B. (1997). Suicide as an outcome for mental disorders: A meta-analysis. *British Journal of Psychiatry, 170*(3), 205–228.

12. Cavanagh, J. T., Carson, A. J., Sharpe, M., & Lawrie, S. M. (2003). Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine, 33*(3), 395–405.

13. Substance Abuse and Mental Health Services Administration. (1999). *The relationship between mental health and substance abuse among adolescents*. Rockville, MD: U.S. Department of Health and Human Services.

14. DeWit, D. J., Adlaf, E. M., Offord, D. R., & Ogborne, A. C. (2000). Age at first alcohol use: A risk factor for the development of alcohol disorders. *American Journal of Psychiatry, 157*, 745–750.

15. National Highway Traffic Safety Administration. (2009). *Fatal crashes involving young drivers* (Traffic Safety Facts Research Note). Washington, DC: Author. Retrieved January 25, 2011, from http://www-nrd.nhtsa.dot.gov/Pubs/811218.pdf

16. Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1996). Prevalence of serious emotional disturbances in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health, United States: 1996* (Chap. 6, pp. 71–89). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

17. Friedman, Katz-Leavy, Manderscheid, & Sondheimer (1996).

18. Chambers, R. A., Taylor, J. R., & Potenza, M. N. (2003). Developmental neurocircuitry of motivation in adolescence: A critical period of addiction vulnerability. *American Journal of Psychiatry, 160,* 1041–1052.

19. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National findings* (NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD: U.S. Department of Health and Human Services. Retrieved January 25, 2011, from http://oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm

20. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2005). *Depression among adolescents* (The NSDUH Report). Rockville, MD: U.S. Department of Health and Human Services. Retrieved January 25, 2011, from http://www.oas.samhsa.gov/2k5/youthDepression/youthDepression.pdf

21. Nicholson, J., Biebel, K., Hinden, B., Henry, A., & Stier, L. (2001). *Critical issues for parents with mental illness and their families*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

22. Frey, R. J. (2003). Genetic factors and mental disorders. *Gale Encyclopedia of Mental Disorders*. Farmington Hills, MI: The Gale Group Inc. Retrieved January 25, 2011, from http://www.encyclopedia.com/doc/1G2-3405700172.html

23. Kerker, B. D., Owens, P. L., Zigler, E., & Horwitz, S. M. (2004). Mental health disorders among individuals with mental retardation: Challenges to accurate prevalence estimates. *Public Health Reports, 119*(4), 409–417.

24. Zielenski, T. A., Brown, E. S., Nejtek, V. A., Khan, D. A., Moore, J. J., & Rush, J. A. (2000). Depression in asthma: Prevalence and clinical implications. *Primary Care Companion to the Journal of Clinical Psychiatry, 2*(5), 153–158.

25. Gibson, P. (1989). Gay male and lesbian youth suicide. In *Report of the Secretary's Task Force on Youth Suicide* (HHS Publication No. ADM 89-1623, Vol. 3, pp. 110–142). Washington, DC: U.S. Government Printing Office.

26. Gonsiorek, J. C. (1988). Mental health issues of gay and lesbian adolescents. *Journal of Adolescent Health Care, 9*, 114–122.

27. Shufelt, J. L., & Cocozza, J. J. (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study* (Research and Program Brief). Delmar, NY: National Center for Mental Health and Juvenile Justice. Retrieved January 25, 2011, from http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf

28. National Child Traumatic Stress Network. (2003). *What is child traumatic stress?* [Web site]. Retrieved January 25, 2011, from http://www.athealth.com/consumer/disorders/childtrauma.html

29. Bradley, R. H., & Corwyn, R. F. (2002). Socioeconomic status and child development. *Annual Review of Psychology, 53*, 371–399.

30. Burn, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., et al. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(8), 960–970.

31. National Institute of Mental Health. (2001). *Helping children and adolescents cope with violence and disasters* (Fact Sheet). Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health. Retrieved January 25, 2011, from http://www.eric.ed.gov/PDFS/ED475703.pdf

32. MedicineNet.com. (2011). *Definition of psychotropic medication* [Web site]. Retrieved January 25, 2011, from http://www.medterms.com/script/main/art.asp?articlekey=30808

33. University of Michigan Depression Center. (2010). *Cognitive-behavioral therapy (CBT)* [Web site]. Retrieved January 25, 2011, from http://www.depressiontoolkit.org/treatmentoptions/Psychotherapy/CBT.asp

34. MTA Cooperative Group. (2004). National Institute of Mental Health multimodal treatment study of ADHD follow-up: 24-month outcomes of treatment strategies for attention-deficit/hyperactivity disorder. *Pediatrics, 113*(4), 754–761.

35. Treatment for Adolescents with Depression Study (TADS) Team. (2004). Fluoxetine, cognitive behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association, 292*(7), 807–820. Retrieved January 25, 2011, from http://jama.ama-assn.org/content/292/7/807.full

36. Gould, M. S., Marrocco, F. A., Hoagwood, K., Kleinman, M., Amakawa, L., & Altschuler, E. (2009). Service use by at-risk youths after school-based suicide screening. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(12). Abstract retrieved January 25, 2011, from http://www.jaacap.com/article/S0890-8567(09)66075-5/abstract/

Chapter 2: Understanding the Identification Process and Tools

37. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

38. ZERO TO THREE. (2005). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood* (Revised ed., DC:0-3R). Washington, DC: Author.

39. Gould, M. S., Marrocco, F. A., Kleinman, M., Thomas, J. G., Mostkoff, K., Cote, J., et al. (2005). Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. *Journal of the American Medical Association*, *293,* 1635–1643.

40. Logan, D. E., & King, C. A. (2002). Parental identification of depression and mental health service use among depressed adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry,* 41, 296–304.

41. Reynolds, W. M. (1987). *Reynolds adolescent depression scale: Professional manual.* Odessa, FL: Psychological Assessment Resources.

42. Levitt, J. M., Saka, N., Romanelli, L. H., & Hoagwood, K. (2007). Early identification of mental health problems in schools: The status of instrumentation. *Journal of School Psychology, 45*(2), 163–191.

43. Schubiner, H., Tzelepis, A., Wright, K., & Podany, E. (1994). The clinical utility of the Safe Times Questionnaire. *Journal of Adolescent Health, 15,* 373–382.

44. Smith, M. S., Mitchell, J., McCauley, E. A., & Calderon, R. (1990). Screening for anxiety and depression in an adolescent clinic. *Pediatrics, 85,* 262–266.

45. Cox, A., Hopkinson, K., & Rutter, M. (1981). Psychiatric interviewing techniques II. Naturalistic study: Eliciting factual information. *British Journal of Psychiatry, 138,* 283–291.

46. Piacentini, J., Shaffer, D., Fisher, P., Schwab-Stone, M., Davies, M., & Gioia, P. (1993). The Diagnostic Interview Schedule for Children–Revised Version (DISC-R): III. Concurrent criterion validity. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 658–665.

47. Walker, H. M., Horner, R. H., Sugai, G., Bullis, M., Sprague, J.R., Bricker, D., et al. (1996). Integrated approaches to preventing antisocial behavior patterns among school-age children and youth. *Journal of Emotional and Behavioral Disorders, 4,* 194–209.

48. American Academy of Pediatrics & Bright Futures. (2008). *Recommendations for preventative pediatric health care* [Chart]. Elk Grove Village, IL: American Academy of Pediatrics. Retrieved January 25, 2011, from http://practice.aap.org/content.aspx?aid=1599

49. Lyman, D. R., Njoroge, W., & Willis, D. (2007). Early childhood psychosocial screening in culturally diverse populations: A survey of clinical experience with the Ages and Stages Questionnaire: Social Emotional (ASQ:SE). *ZERO TO THREE Bulletin, 27*(5), 46–54.

50. Lyman, Njoroge, & Willis (2007).

51. Office of Safe and Drug-Free Schools, U.S. Department of Education. (2006, Spring). Interview: NIDA director discusses drug abuse among teens. *The Challenge, 14*(3). Retrieved January 25, 2011, from http://www.eric.ed.gov/PDFS/ED497140.pdf

52. Deas, D., Roberts, J., Randall, C., & Anton, R. (2001). Adolescent Obsessive-Compulsive Drinking Scale: An assessment tool for problem drinking. *Journal of the National Medical Association, 93*(3), 92–103. Retrieved January 25, 2011, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2593946/pdf/jnma00332-0036.pdf

Chapter 3: Key Steps of Early Identification

53. Ford, C. A., Bearman, P. S., & Moody, J. (1999). Foregone health care among adolescents. *Journal of the American Medical Association, 282,* 2227–2234.

54. Encyclopedia of Everyday Law. (2011). *The mature minor doctrine* [Web site]. Retrieved January 25, 2011, from http://www.enotes.com/healthcare-reference/treatment-minors#mature-minor-doctrine

55. West's Encyclopedia of American Law. (2011). *Age of majority* [Web site]. Retrieved January 25, 2011, from http://www.enotes.com/wests-law-encyclopedia/majority

Chapter 4: Partnering for Resources

56. Nemeroff, R., Levitt, J. M, Faul, L., Wonpat-Borja, A., Bufferd, S., Setterberg, S., et al. (2008). Establishing ongoing, early identification programs for mental health problems in our schools: A feasibility study. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 328–338.

57. Mauer, B. J. (2009). *Behavioral health/primary care integration and the person-centered healthcare home*. Washington, DC: National Council for Community Behavioral Healthcare. Retrieved January 25, 2011, from http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf

58. Substance Abuse and Mental Health Services Administration. (2011). *Understanding health reform: Integrated care and why you should care*. Washington, DC: U.S. Department of Health and Human Services. Retrieved January 25, 2011, from http://www.samhsa.gov/healthReform/docs/ConsumerTipSheet_IntegrationImportance.pdf

Supplement 1: Child Welfare

59. Children's Bureau; Administration on Children, Youth, and Families. (2010). *Child maltreatment: 2008*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved January 25, 2011, from http://www.acf.hhs.gov/programs/cb/pubs/cm08/cm08.pdf

60. Children's Bureau; Administration on Children, Youth, and Families (2010).

61. Children's Bureau; Administration on Children, Youth, and Families; Administration for Children and Families; U.S. Department of Health and Human Services. (2010). *The AFCARS [Adoption and Foster Care Analysis and Reporting System] Report: Preliminary FY 2009 estimates as of July 2010 (17)* [Web site]. Retrieved January 25, 2011, from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.htm

62. Goldman, H. H., & Morrissey, J. P. (1997). *A conceptual framework for evaluating the intersystem impacts of managed behavioral health care: Report on a roundtable discussion*. Cambridge, MA: Human Services Research Institute.

63. Landsverk, J. A., Garland, A. F., & Leslie, L. K. (2002). Mental health services for children reported to child protective services. In E. B. John, C. Myers, T. Hendrix, L. Berliner, C. Jenny, J. Briere, et al. (Eds.), *APSAC handbook on child maltreatment* (2nd ed., pp. 487–507). Thousand Oaks, CA: Sage.

64. Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse and Neglect*, *20(8),* 709–723.

65. Teicher, M. D. (2000). Wounds that time won't heal: The neurobiology of child abuse. *Cerebrum: The Dana Forum on Brain Science, 2*(4), 50–67.

66. Hagele, D. M. (2005). The impact of maltreatment on the developing child. *North Carolina Medical Journal, 66*(5), 356–359. Retrieved January 25, 2011, from http://www.ncmedicaljournal.com/wp-content/uploads/2010/11/Hagele.pdf

67. Hagele (2005).

68. Alati, R., Al Mamun, A., Williams, G. M., O'Callaghan, M., Najman, J. M., & Bor, W. (2006). In-utero alcohol exposure and prediction of alcohol disorders in early adulthood: A birth cohort study. *Archives of General Psychiatry*, *63(9),* 1009–1016.

69. Centers for Disease Control and Prevention. (2010). *Facts about fetal alcohol spectrum disorders* [Web site]. Retrieved January 25, 2011, from http://www.cdc.gov/ncbddd/fasd/facts.html

70. Pilowsky, D. J., & Wu, L. T. (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. *Journal of Adolescent Health*, *38(4),* 351–358.

71. Office of Applied Studies & RTI International. (2005). *Substance use and need for treatment among youths who have been in foster care* (The NSDUH Report). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2011, from http://www.oas.samhsa.gov/2k5/FosterCare/FosterCare.pdf

72. Moses, D. J., Glover, R. B., Mazelis, R., & D'Ambrosio, B. (2003). *Creating trauma services for women with co-occurring disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders Who Have Histories of Violence Study*. Delmar, NY: Policy Research Associates. Retrieved January 25, 2011, from http://www.nationaltraumaconsortium.org/documents/CreatingTraumaServices.pdf

73. Child Welfare Information Gateway. (2008). *Long-term consequences of child abuse and neglect* (Fact Sheet). Washington, DC: Author. Retrieved January 25, 2011, from http://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf

74. English, D. J., Widom, C. S., & Brandford, C. (2004). Another look at the effects of child abuse. *NIJ Journal*, *251,* 23–24.

75. Silverman, Reinherz, & Giaconia (1996).

76. Child Welfare League of America. (2004). *Child protection*: *Facts and figures* [Web site]. Retrieved January 25, 2011, from http://www.cwla.org/programs/childprotection/childprotectionfaq.htm

77. U.S. Department of Health and Human Services; Administration for Children and Families; Administration on Children, Youth, and Families; Children's Bureau (2010).

78. ZERO TO THREE Policy Center. (2004). *Infants, toddlers and child welfare* (Fact Sheet). Washington, DC: Author. Retrieved January 25, 2011, from http://www.zerotothree.org/site/DocServer/childwelfarestate.pdf?docID=682

79. Shonkoff, J., & Philips, D.A. (Eds.). (2000). *From neurons to neighborhoods: The science of early child development*. Washington, DC: National Academy Press.

80. Young, N. K., Boles, S. M., & Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps and opportunities. *Child Maltreatment*, *12*(2), 137–149.

81. Individuals with Disabilities Education Improvement Act of 2004, Pub. L. No. 108-446, Part C—Infants and toddlers with disabilities (2004). Retrieved January 25, 2011, from http://idea.ed.gov/explore/view/p/%2Croot%2Cstatute%2Cl%2CC%2C

82. Child Abuse Prevention and Treatment Act (CAPTA) Amendments of 1996, P.L. 104-235 (1996). Retrieved January 25, 2011, from http://www.acf.hhs.gov/programs/cb/laws_policies/cblaws/capta/

83. Schene, P. (2005). *Comprehensive family assessment guidelines for child welfare*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Retrieved January 25, 2011, from http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/family_assessment.pdf

84. McCarthy, J., Van Buren, & E., Irvine, M. (2007). *Child and family services reviews: 2001–2004: A mental health analysis*. Washington, DC: National Technical Assistance Center for Children's Mental Health & Technical Assistance Partnership for Child and Family Mental Health. Retrieved January 25, 2011, from http://www.air.org/files/CFSR_ServicesReview.pdf

85. American Academy of Child and Adolescent Psychiatry & Child Welfare League of America. (2002). *Values and principles for mental health and substance abuse services and supports for children in foster care* [Web site]. Retrieved January 25, 2011, from http://www.cwla.org/programs/bhd/mhvaluesandprinciples.htm

86. Committee on Early Childhood, Adoption, and Dependent Care; American Academy of Pediatrics. (2002). Health care of young children in foster care. *Pediatrics, 109*(3), 536–541. Retrieved January 25, 2011, from http://aappolicy.aappublications.org/cgi/reprint/pediatrics;109/3/536.pdf

87. Jensen, P. J., Romanelli, L. H., Pecora, P. J., & Ortiz, A. (2009). Mental health practice guidelines for child welfare: Context for reform [Special issue]. *Child Welfare*, *88*(1).

88. American Academy of Child and Adolescent Psychiatry & Child Welfare League of America (2002).

89. American Academy of Child and Adolescent Psychiatry & Child Welfare League of America (2002).

90. Jensen, Romanelli, Pecora, & Ortiz (2009).

91. Schene (2005).

92. Simms, M. D., & Halfon, N. (1994). The health care needs of children in foster care: A research agenda. *Child Welfare, 73,* 505–24.

93. Leslie, L., Gordon, J., Ganger, W., & Gist, K. (2002). Developmental delay in young children in child welfare by initial placement type. *Infant Mental Health Journal, 23,* 496–516.

94. Dubowitz, H., Feigelman, S., Zuravin, S., Tepper, V., Davidson, N., & Lichenstein, R. (1992). The physical health of children in kinship care. *American Journal of Diseases of Children, 146,* 603–610.

95. Leslie, L. K., Landsverk, J., Ezzet-Lofstrom, R., Tschann, J. M., Slymen, D. J., & Garland, A. F. (2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse & Neglect, 24,* 465–476.

96. Takayama, J. I., Wolfe, E., & Coulter, K. P. (1998). Relationship between reason for placement and medical findings among children in foster care. *Pediatrics, 101,* 201–207.

97. McCarthy, Van Buren, & Irvine (2007).

98. Leslie, L. K., Hurlburt, M. S., Landsverk, J., Rolls, J. A., Wood, P. A, & Kelleher, K. J. (2003). Comprehensive assessments for children entering foster care: A national perspective. *Pediatrics, 112,* 134–142.

99. Leslie et al. (2003).

100. Neff, M. A. (2006). *NY foster parent legal status and legal rights* [Web site]. Retrieved January 25, 2011, from http://nysccc.org/fostercare/legal-issues/nys-foster-parent-rights/foster-parent-legal-status-and-rights/

101. Allen, M. L., & Bissell, M. (2004). Safety and stability for foster children: The policy context. *The Future of Children, 14*(1), 49–73. Retrieved January 25, 2011, from http://futureofchildren.org/futureofchildren/publications/docs/14_01_03.pdf

Supplement 2: Early Care and Education

102. Luby, J. L. (2009). Depression. In C. H. Zeanah Jr. (Ed.). *Handbook of infant mental health* (3rd ed., pp. 409–420). New York: Guilford Press.

103. National Women's Health Information Center. (2009). *Depression during and after pregnancy* [Web site]. Retrieved January 25, 2011, from http://www.womenshealth.gov/faq/depression-pregnancy.cfm

104. Webster, R. I., Majnemer, A., Platt, R., & Shevell, M. I. (2008). Child health and parental stress in school-age children with a preschool diagnosis of developmental delay. *Journal of Child Neurology, 23*(1), 32–38.

105. Zeanah, C. H., Jr., & Zeanah, P. D. (2001, August/September). Towards a definition of infant mental health. *ZERO TO THREE Bulletin, 22,* 13–20. Retrieved January 25, 2011, from http://main.zerotothree.org/site/DocServer/ZTT22-1_aug_sep_01.pdf?docID=7293

106. U.S. Census Bureau. (2005–2009). Table S0101. Age and sex. In *American Community Survey 5-year estimates* [Web site]. Retrieved January 25, 2011, from http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2009_5YR_G00_S0101&-ds_name=ACS_2009_5YR_G00_

107. DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2009). *Income, poverty, and health insurance coverage in the United States: 2008* (Current Population Reports P60-236). Washington, DC: U.S. Government Printing Office. Retrieved January 25, 2011, from http://www.census.gov/prod/2009pubs/p60-236.pdf

108. ZERO TO THREE Policy Center. (2005). *Laying the foundation for successful prekindergarteners by building bridges to infants and toddlers* (Fact Sheet). Washington, DC: Author.

109. Gilliam, W. S., & Shahar, G. (2006). Prekindergarten expulsion and suspension: Rates and predictors in one state. *Infants and Young Children, 19,* 228–245.

110. Gilliam, W. S. (2005). *Prekindergarteners left behind: Expulsion rates in state prekindergarten systems* (Policy Brief 3). New York: Foundation for Child Development. Retrieved January 25, 2011, from http://www.fcd-us.org/sites/default/files/ExpulsionPolicyBrief.pdf

111. Shonkoff, J., & Philips, D.A. (Eds.). (2000). *From neurons to neighborhoods: The science of early child development*. Washington, DC: National Academy Press.

112. Ito, Y., Teicher, M. D., Glod, C.A., & Ackerman, E. (1998). Preliminary evidence for aberrant cortical development in abused children: A quantitative EEG study. *Journal of Neuropsychiatry and Clinical Neurosciences, 10*(3), 298–307.

113. Shonkoff & Philips (2000).

114. Glascoe, F. (2000). Early detection of developmental and behavioral problems. *Pediatrics in Review, 21*(8), 272–280.

115. Karoly, L. A., Kilburn, M. R., & Cannon, J. S. (2005). *Early childhood interventions: Proven results, future promise*. Arlington, VA: RAND Corporation.

116. Glouden K. J. (2004). *Teaching developmental-behavioral screening/surveillance to healthcare professionals*. Elk Grove Village, IL: American Academy of Pediatrics. Retrieved January 25, 2011, from http://www.aap.org/sections/dbpeds/pdf/TeachingDevelopmental.pdf

117. Fight Crime: Invest in Kids. (2009). *2009 legislative recommendations* [Web site]. Retrieved January 25, 2011, from http://www.fightcrime.org/page/2009-legislative-recommendations/

118. Dunst, C. J., Hamby, D. W., & Fromewick, J. (2004, July). Status and trends in the number of infants and toddlers served in the IDEA Part C Early Intervention Program (1994–2002). *Snapshots, 1*(1). Retrieved January 25, 2011, from http://www.tracecenter.info/snapshots/snapshots_vol1_no1.pdf

119. Dunst, C. J., Hamby, D. W., & Fromewick, J. (2004, August). Status and trends in the number of preschoolers served in the IDEA Part B Preschool Special Education Program (1994–2002). *Snapshots, 1*(2). Retrieved January 25, 2011, from http://www.tracecenter.info/snapshots/snapshots_vol1_no2.pdf

120. Glascoe, F. (1997). Parents' concerns about children's development: Prescreening technique or screening test? *Pediatrics, 99*(4), 522–528.

121. Lyman, D. R., Njoroge, W., & Willis, D. (2007). Early childhood psychosocial screening in culturally diverse populations: A survey of clinical experience with the Ages and Stages Questionnaires: Social Emotional (ASQ:SE). *ZERO TO THREE Bulletin*, *27*(5), 46–54.

122. Johnson, K., & Knitzer, J. (2006). *Early childhood comprehensive systems that spend smarter: Maximizing resources to serve vulnerable children*. New York: National Center for Children in Poverty. Retrieved January 25, 2011, from http://www.nccp.org/publications/pdf/text_655.pdf

Supplement 3: Family, Domestic Violence, and Runaway Shelters

123. National Center on Family Homelessness. (2009). *America's youngest outcasts: State report card on child homelessness*. Newton, MA: Author. Retrieved January 25, 2011, from http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf

124. National Law Center on Homelessness and Poverty. (2004). *Key data concerning homeless persons in America*. Washington, DC: Author.

125. Moore, J. (2006). *Unaccompanied and homeless youth: Review of the literature* (1995–2005). Greensboro, NC: National Center for Homeless Education. Retrieved January 25, 2011, from http://www.serve.org/nche/downloads/uy_lit_review.pdf

126. National Center on Family Homelessness (2009).

127. Onunaku, N. (2005). *Improving maternal and infant mental health: Focus on maternal depression*. Los Angeles: National Center for Infant and Early Childhood Health Policy. Retrieved January 25, 2011, from http://main.zerotothree.org/site/DocServer/maternaldep.pdf?docID=622

128. Perry, B. D. (2000). Traumatized children: How childhood trauma influences brain development. *The Journal of the California Alliance for the Mentally Ill*, *11*(1), 48–51.

129. Teicher, M. H., Andersen, S. L., Polcari, A., Anderson, C. M., Navalta, C. P., & Kim, D. M. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience and Biobehavioral Reviews, 27*(1–2), 33–44.

130. Better Homes Fund. (1999). *Homeless children: America's new outcasts*. Newton, MA: Author. (*Note:* The Better Homes Fund is now known as the National Center on Family Homelessness.)

131. Moore (2006).

132. Moore (2006).

133. Homeless and Extreme Poverty Working Group, National Child Traumatic Stress Network. (2005). *Facts on trauma and homeless children*. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress. Retrieved January 25, 2011, from http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/Facts_on_Trauma_and_Homeless_Children.pdf, page 2.

134. Moore (2006), page 16.

Supplement 4: Juvenile Justice

135. Snyder, H. N., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 national report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Retrieved January 25, 2011, from http://www.ojjdp.gov/ojstatbb/nr2006/downloads/NR2006.pdf

136. Snyder & Sickmund (2006), page 157.

137. Snyder & Sickmund (2006), pages 197–198.

138. Huizinga, D., Thornberry, T., Knight, K., & Lovegrace, P. (2004). *Disproportionate minority contact in the juvenile justice system: A study of differential minority arrest/ referral to court in three cities* (Document 219743). Unpublished paper available on the Web site of U.S. Department of Justice. Retrieved January 25, 2011, from http://www.ncjrs.gov/pdffiles1/ojjdp/grants/219743.pdf

139. Minority Staff Special Investigation Division, Committee on Government Reform. (2004). *Incarceration of youth who are waiting for community mental health services in the United States*. Washington DC: U.S. House of Representatives. Retrieved January 25, 2011, from http://hsgac.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=bdb90292-b3d5-47d4-9ffc-52dcd6e480da-

140. Shufelt, J. L., & Cocozza, J. J. (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study* (Research and Program Brief). Delmar, NY: National Center for Mental Health and Juvenile Justice. Retrieved January 25, 2011, from http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf

141. Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S., McClelland, G., & Dulcan, M. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of General Psychiatry, 61,* 403–410. Retrieved January 25, 2011, from http://archpsyc.ama-assn.org/cgi/reprint/61/4/403.pdf

142. Abram et al. (2004).

143. Shufelt & Cocozza (2006).

144. Juvenile Justice Working Group, National Child Traumatic Stress Network. (2004). *Trauma among girls in the juvenile justice system.* Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress. Retrieved January 25, 2011, from http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/trauma_among_girls_in_jjsys.pdf

145. Shufelt & Cocozza (2006).

146. Shufelt & Cocozza (2006).

147. Teplin, L. A., Abram, K. M., McClelland, G. M., Mericle, A. A., Dulcan, M. K., & Washburn, J. J. (2006, April). Psychiatric disorders of youth in detention. *OJJDP Bulletin*. Retrieved January 25, 2011, from http://www.ncjrs.gov/pdffiles1/ojjdp/210331.pdf

148. Hayes, L. M. (2000, April). Suicide prevention in juvenile facilities. *Juvenile Justice Journal*, *VII*(1). Retrieved January 25, 2011, from http://www.ncjrs.gov/html/ojjdp/jjjnl_2000_4/sui.html

149. Grisso, T., & Underwood, L. A. (2004). *Screening and assessing mental health and substance use disorders among youth in the juvenile justice system: A resource guide for practitioners* (NCJ 204-956). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Retrieved January 25, 2011, from http://www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf

150. Grisso & Underwood (2004), page 1.

151. Center for the Promotion of Mental Health in Juvenile Justice. (2003). *Why screen and assess?* [Web site]. Retrieved January 25, 2011, from http://www.promotementalhealth.org/rationale.htm

152. Snyder & Sickmund (2006), pages 225–228.

153. Grisso, T., & Barnum, R. (2000). *Massachusetts Youth Screening Instrument—Version 2: User's manual and technical report*. Worcester, MA: University of Massachusetts Medical School.

154. Center for the Promotion of Mental Health in Juvenile Justice. (2003). *Best practices* [Web site]. Retrieved January 25, 2011, from http://www.promotementalhealth.org/practices.htm

155. International Association for Correctional and Forensic Psychology. (2010). Standards for psychology services in jails, prisons, correctional facilities, and agencies (3rd ed.). *Criminal Justice and Behavior, 37*(7), 739–808.

156. National Commission on Correctional Health Care. (1999). *Standards for health services in juvenile detention and confinement facilities*. Chicago: Author.

157. Center for the Promotion of Mental Health in Juvenile Justice. (2003). *Self-incrimination* [Web site]. Retrieved January 25, 2011, from http://www.promotementalhealth.org/confidentiality.htm

158. Wasserman, G. A., Jensen, P. S., Ko, S. J., Cocozza, J., Trupin, E., Angold, A., et al. (2003). Mental health assessments in juvenile justice: Report on the Consensus Conference. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(7), 752–761. Retrieved January 25, 2011, from http://devepi.duhs.duke.edu/library/pdf/16927.pdf, page 755.

159. Grisso & Underwood (2004), page 10.

160. Cooper, J. L. (2007). *The big picture: Financing mental health for children, youth and their families* [APA professional briefing on children's mental health]. New York: Columbia University, National Center for Children in Poverty. Retrieved January 25, 2011, from http://www.nccp.org/publications/pdf/text_773.pdf

Supplement 5: Mental Health and Substance Abuse Treatment for Co-occurring Disorders

161. Greenbaum, P., Foster-Johnson, L., & Petrila, A. (1996). Co-occurring addictive and mental disorders among adolescents: Prevalence research and future directions. *American Journal of Orthopsychiatry, 66*(1).

162. Measelle, J. R., Stice, E., & Hogansen, J. M. (2006). Developmental trajectories of co-occurring depressive, eating, antisocial, and substance abuse problems in female adolescents. *Journal of Abnormal Psychology, 115(3),* 524–538

163. Office of Applied Studies & RTI International. (2007). *Depression and the initiation of alcohol and other drug use among youths aged 12 to 17* (The NSDUH Report). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2011, from http://www.oas.samhsa.gov/2k7/newUserDepression/newUserDepression.pdf

164. Office of Applied Studies, Synectics for Management Decisions, & RTI International. (2005). *Adolescents with co-occurring psychiatric disorders: 2003* (The DASIS Report). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2011, from http://www.oas.samhsa.gov/2k5/youthMH/youthMH.pdf

165. Grilo, C. M., Becker, D. F., Fehon, D. C., Edell, W. S., & McGlashan, T. H. (1996). Conduct disorder, substance use disorders, and coexisting conduct and substance use disorders in adolescent inpatients. *American Journal of Psychiatry, 153*(7) 914–920.

166. Grilo, C. M., Becker, D. F., Fehon, D. C., Edell, W. S., & McGlashan, T. H. (1997). Personality disorders in adolescents with major depression, substance use disorders, and coexisting major depression and substance use disorders. *Journal of Consulting and Clinical Psychology, 65*(2), 328–332.

167. Wilens, T. E., Biederman, J., Abrantes, A. M., & Spencer, T. J. (1997). Clinical characteristics of psychiatrically referred adolescent outpatients with substance use disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(7), 941–947.

168. Macro International Inc. (2007). *The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation findings—Annual report to Congress: 2004* (SMA-CB-E2004CD). Rockville, MD. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Retrieved January 25, 2011, from http://store.samhsa.gov/shin/content/SMA-CB-E2004CD/SMA-CB-E2004CD.pdf

169. Office of Applied Studies, Synectics for Management Decisions, & RTI International (2005).

170. Office of Applied Studies & RTI International. (2006). *Suicidal thoughts, suicide attempts, major depressive episode, and substance use among adults* (The OAS Report, Issue 34). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2011, from http://www.oas.samhsa.gov/2k6/suicide/suicide.pdf

171. Crane, E., (with Herman-Stahl, M.). (2006). *Disposition of emergency department visits for drug-related suicide attempts by adolescents: 2004* (The New DAWN Report, Issue 6). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2011, from http://dawninfo.samhsa.gov/files/TNDR/2006-03R/TNDR03AdolescentSuicideAttemptsHTML.pdf

172. Office of Applied Studies. (2007). *Results from the 2006 National Survey on Drug Use and Health: National findings* (NSDUH Series H-32, HHS Publication No. SMA 07-4293). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2011, from http://www.oas.samhsa.gov/nsduh/2k6nsduh/2k6results.pdf

173. National Association of Social Workers. (2005). *NASW standards for social work practice with clients with substance use disorders.* Washington, DC: Author. Retrieved January 25, 2011, from http://www.socialworkers.org/practice/standards/NASWATODStatndards.pdf

174. American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999). *Standards for educational and psychological testing.* Washington, DC: American Psychological Association.

175. New Hampshire–Dartmouth Psychiatric Research Center & Westat. (2009). *Integrated treatment for co-occurring disorders: Building your program* (HHS Pub. No. SMA 08-4366). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2011, from http://store.samhsa.gov/shin/content/SMA08-4367/BuildingYourProgram-ITC.pdf

176. Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2007). *An action plan for behavioral health workforce development: A framework for discussion.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2011, from http://www.samhsa.gov/workforce/annapolis/workforceactionplan.pdf

177. Chiert, T., Gold, S. N., & Taylor, J. (1994). Substance abuse training in APA-accredited doctoral programs in clinical psychology: A survey. *Professional Psychology: Research and Practice, 25*(1), 80–84.

178. U.S. Food and Drug Administration. *(2009). Ritalin–SR* [Medication guide]. Washington, DC: Author. Retrieved January 25, 2011, from http://www.fda.gov/downloads/Drugs/DrugSafety/ucm089095.pdf

179. Piacentini, J., Shaffer, D., Fisher, P., Schwab-Stone, M., Davies, M., & Gioia, P. (1993). The Diagnostic Interview Schedule for Children–Revised Version (DISC-R): III. Concurrent criterion validity. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 658–665.

180. Lyman, D. R., Njoroge, W., & Willis, D. (2007). Early childhood psychosocial screening in culturally diverse populations: A survey of clinical experience with the Ages and Stages Questionnaires: Social Emotional (ASQ:SE). *ZERO TO THREE Bulletin, 27*(5), 46–54.

181. Lyman, Njoroge, & Willis (2007).

Supplement 6: Primary Care

182. U.S. Preventive Services Task Force. (2009). *Major depressive disorder in children and adolescents* [Web site]. Retrieved January 25, 2011, from http://www.uspreventiveservicestaskforce.org/uspstf/uspschdepr.htm

183. Jellinek, M., Patel, B. P., & Froehle, M. C. (Eds.). (2002). *Bright futures in practice: Mental health. Volume I. Practice guide.* Arlington, VA: National Center for Education in Maternal and Child Health. Retrieved January 25, 2011, from http://www.brightfutures.org/mentalhealth/pdf/01BFMHFrontMatter.pdf, page xix.

184. Kelleher, K. J., McInerny, T. K., Gardner, W. P., Childs, G. E., & Wasserman, R. C. (2000). Increasing identification of psychosocial problems: 1979–1996. *Pediatrics, 105*, 1313–1321.

185. MedicineNet.com. (2011). *Definition of psychotropic medication* [Web site]. Retrieved January 25, 2011, from http://www.medterms.com/script/main/art.asp?articlekey=30808

186. Thomas, C. R., & Holzer, C. E. (2006). The continuing shortage of child and adolescent psychiatrists. *Journal of the American Academy of Child and Adolescent Psychiatry, 45,* 1023–1031.

187. Kim, W. J. (2003). Child and adolescent psychiatry workforce: A critical shortage and national challenge. *Academic Psychiatry, 27,* 277–282.

188. Shipman, S. A., Lurie, J. D., & Goodman, D. C. (2004). The general pediatrician: Projecting future workforce supply and requirements. *Pediatrics, 113,* 435–442.

189. Gardner, W., Kelleher, K. J., Pajer, K. A., & Campo, J. V. (2003). Primary care clinicians' use of standardized tools to assess child psychosocial problems. *Ambulatory Pediatrics, 3,* 191–195.

190. Romer, D., & McIntosh, M. (2005). The role of primary care physicians in detection and treatment of adolescent mental health problems. In D. L. Evans, E. B. Foa, R. E. Gur, H. Hendin, C. P. O'Brien, M. E. P. Seligman, et al. (Eds.), *Treating and preventing adolescent mental health disorders: What we know and what we don't know* (pp. 579–596). New York: Oxford University Press. Retrieved January 25, 2011, from http://amhi-treatingpreventing.oup.com/anbrg/public/index.html

191. Lavigne, J. V., Binns, H. J., Christoffel, K. K, Rosenbaum, D., Arend, R., Smith, K., et al. (1993). Behavioral and emotional problems among preschool children in pediatric primary care: Prevalence and pediatricians' recognition. *Pediatrics, 91,* 649–655.

192. Glazebrook, C., Hollis, C., Heussler, H., Goodman, R., & Coates, L. (2003). Detecting emotional and behavioral problems in pediatric clinics. *Child: Care, Health & Development, 29,* 141–149.

193. Goodman, R., & Scott, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful? *Journal of Abnormal Child Psychology, 27,* 17–24.

194. Kramer, T., & Garralda, M. E. (1998). Psychiatric disorders in adolescents in primary care. *British Journal of Psychiatry, 173,* 508–513.

195. Kramer & Garralda (1998).

196. Graham, P., & Rutter, M. (1968). The reliability and validity of the psychiatric assessment of the child: II. Interview with the parent. *British Journal of Psychiatry, 114,* 581–592.

197. Rutter, M., & Graham, P. (1968). The reliability and validity of the psychiatric assessment of the child: I. Interview with the child. *British Journal of Psychiatry, 114,* 563–579.

198. Kendell, R. E. (1975). The role of diagnosis in psychiatry: Diagnosis as a practical decision making process. Oxford, England: Blackwell.

199. Dulcan, M. K., Costello, E. J., Costello, A. J., Edelbrock, C., Brent, D., & Janiszewski, S. (1990). The pediatrician as gatekeeper to mental health care for children: Do parents' concerns open the gate? *Journal of the American Academy of Child and Adolescent Psychiatry, 29,* 453–458.

200. Garrison, W. T., Bailey, E. N., Garb, J., Ecker, B., Spencer, P., & Sigelman, D. (1992). Interactions between parents and pediatric primary care physicians about children's mental health. *Hospital Community Psychiatry, 43,* 489–493.

201. Glascoe, F. P., MacLean, W. E., & Stone, W. L. (1991). The importance of parents' concerns about their child's behavior. *Clinical Pediatrics, 30,* 8–11.

202. Wildman, B. G., Kizilbash, A. H., & Smucker, W. D. (1999). Physicians' attention to parents' concerns about the psychosocial functioning of their children. *Archives of Family Medicine, 8,* 440–444.

203. Wissow, L. S., Roter, D. L., & Wilson, M. E. (1994). Pediatrician interview style and mothers' disclosure of psychosocial issues. *Pediatrics, 93,* 289–295.

204. Briggs-Gowan, M. J., Horwitz, S. M., Schwab-Stone, M. E., Leventhal, J. M., & Leaf, P. J. (2000). Mental health in pediatric settings: Distribution of disorders and factors related to service use. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 841–849.

205. Piacentini, J., Shaffer, D., Fisher, P., Schwab-Stone, M., Davies, M., & Gioia, P. (1993). The Diagnostic Interview Schedule for Children–Revised Version (DISC-R): III. Concurrent criterion validity. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 658–665.

206. Cox, A., Hopkinson, K., & Rutter, M. (1981). Psychiatric interviewing techniques II. Naturalistic study: Eliciting factual information. *British Journal of Psychiatry, 138,* 283–291.

207. Bagley, C., & Genius, M. (1991). Psychology of computer use: Sexual abuse recalled: Evaluation of a computerized questionnaire in a population of young adult males. *Perceptual and Motor Skills, 72,* 287–288.

208. Beck, A. T., Steer, R. A., & Ranieri, W. F. (1988). Scale for suicidal ideation: Psychometric properties of a self-report version. *Journal of Clinical Psychology, 44,* 499–505.

209. Greist, J. H., Gustafson, D. H., Stauss, F. F., Rowse, G. L., Laughren, T. P., & Chiles, J. A. (1973). A computer interview for suicide risk prediction. *American Journal of Psychiatry, 130,* 1327–1332.

210. Levine, S., Ancill, R. J., & Roberts, A. P. (1989). Assessment of suicide risk by computer-delivered self-rating questionnaire: Preliminary findings. *Acta Psychiatrica Scandinavica, 80,* 216–220.

211. Lucas, R. W., Mullin, P. J., Luna, C. B., & McInroy, D. C. (1977). Psychiatrists and a computer as interrogators of patients with alcohol-related illnesses: A comparison. *British Journal of Psychiatry, 131,* 160–167.

212. Burgoyne, R. W. (1977). The structured interview: An aid to compiling a clear and concise database. *International Journal of Mental Health, 6,* 37–48.

213. Gauron, E. F. & Dickinson, J. K. (1966). Diagnostic decision making in psychiatry. I: Information usage. *Archives of General Psychiatry, 14,* 225–232.

214. Jackson, H., & Nuttall, R. (1993). Clinician responses to sexual abuse allegations. *Child Abuse and Neglect, 17,* 127–143.

215. Jackson, H., & Nuttall, R. (1994). Effects of gender, age, and a history of abuse on social workers' judgments of sexual abuse allegations. *Social Work Research, 18,* 65–128.

216. Schubiner, H., Tzelepis, A., Wright, K., & Podany, E. (1994). The clinical utility of the Safe Times Questionnaire. *Journal of Adolescent Health, 15,* 373–382.

217. Smith, M. S., Mitchell, J., McCauley, E. A., & Calderon, R. (1990). Screening for anxiety and depression in an adolescent clinic. *Pediatrics, 85,* 262–266.

218. Lyman, D. R., Njoroge, W., & Willis, D. (2007). Early childhood psychosocial screening in culturally diverse populations: A survey of clinical experience with the Ages and Stages Questionnaires: Social Emotional (ASQ:SE). *ZERO TO THREE Bulletin, 27*(5), 46–54.

219. Lyman, Njoroge, & Willis (2007).

220. Breslin, M. (1998). When physicians assure confidentiality, teenagers are willing to talk openly. *Family Planning Perspectives, 30*(1), 52–52.

221. Carlisle, J. J., Shickle, D. D., Cork, M. M., & McDonagh, A. A. (2006). Concerns over confidentiality may deter adolescents from consulting their doctors. A qualitative exploration. *Journal of Medical Ethics, 32*(3), 133–137.

222. Irwin, C. E., Adams, S. H., Park, M. J., & Newacheck, P. W. (2009). Preventive care for adolescents: Few get visits and fewer get services. *Pediatrics, 123,* e565–e572.

223. Klein, J. D., & Graff, C. A. (2000). *New York State Department of Health cognitive interview report.* Rochester, NY: University of Rochester Medical Center, Division of Adolescent Medicine.

224. Dunst, C. J., Hamby, D. W., & Fromewick, J. (2004). Status and trends in the number of infants and toddlers served in the IDEA Part C Early Intervention Program (1994–2002). *Snapshots, 1*(1). Retrieved January 25, 2011, from http://www.tracecenter.info/snapshots/snapshots_vol1_no1.pdf

Supplement 7: Schools and Out-of-School Programs

225. Office of the Surgeon General. (1999). Organizing and financing mental health services. In *Mental healt*h: *A report of the Surgeon General* (Chap. 6, pp. 403–433). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health. Retrieved January 25, 2011, from http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c6.pdf

226. Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1996). Prevalence of serious emotional disturbances in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health, United States:* 1996 (Chap. 6, pp. 71–89). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

227. Office of Special Education and Rehabilitative Programs. (2001). *Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act. Section I: Results.* Washington, DC: U.S. Department of Education. Retrieved January 25, 2011, from http://www2.ed.gov/about/reports/annual/osep/2001/section-i.pdf

228. Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich J. (2005). *School mental health services in the United States, 2002–2003* (HHS Publication No. SMA 05-4068). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Retrieved January 25, 2011, from http://store.samhsa.gov/shin/content/SMA05-4068/SMA05-4068.pdf

229. Rubin, M. (2006). *Considerations for schools on the early identification of students with social, emotional, behavioral, and other learning difficulties.* Unpublished manuscript, American School Health Association.

230. National Alliance on Mental Illness, Mental Health America, Federation of Families for Children's Mental Health, Children and Adults with Attention Deficit/Hyperactivity Disorder, Children and Adolescent Bipolar Foundation, American School Counselor Association, & American Academy of Child and Adolescent Psychiatry. (2007). *Improving the mental health and well-being of America's children.* Arlington, VA: National Alliance on Mental Illness. Retrieved January 25, 2011, from http://www.nami.org/Template.cfm?Section=Schools_and_Education&template=/ContentManagement/ContentDisplay.cfm&ContentID=43239

231. Vander Stoep, A., McCauley, E., Thompson, K., Kuo, E., Brulotte, J., & Gunovick, C. (2006, February). *Universal school-based emotional health check-up: Participation, early identification, and linkage.* Presentation at the 19th Annual Conference, "A System of Care for Children's Mental Health: Expanding the Research Base," Tampa, FL.

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