

Seminars in Adolescent Health : Adolescent Mental Health (May 28, 2003)

>> Welcome to the Maternal and Child Health Bureau Office of Adolescent Health webcast on Adolescent Mental Health.

The topics were selected in consultation with the coordinators.

Technical support for the webcast is provided by the center for the advancement of distance education, CADE, University of Illinois at Chicago.

I am Trina, and will serve as moderator.

Before I introduce our distinguished panel, I would like to review some technical information.

You will see power point slides on your computer screens and hear the voices of the panel but you will not see their faces.

Slides will appear in the central window and should advance automatically.

The slide changes are synchronized with the speakers' presentations.

You do not need to do anything to advance the slides.

You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.

We encourage you to ask the speakers questions at any time during the presentation.

Simply type your question in the white message window on the right of the interface, select question for speaker from the drop down menu and hit send.

Please include your state or organization in your message so that we know from where you are participating.

The questions will be relayed to the moderator periodically throughout this broadcast.

The panel will respond to your questions during the discussion period which follows the three presentations.

If we don't have the opportunity to respond to your question during the broadcast, we will e-mail you an answer afterwards.

Again, we encourage you to submit questions at any time during the broadcast.

On the left of the interface is the audio control.

You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loud speaker icon.

Those of who selected accessibility features will see text captioning underneath the audio control window.

At the end of the broadcast, the interface will close automatically and you will have the opportunity to fill out an on-line evaluation.

Please take a couple minutes to do so.

The responses will help us plan future broadcasts in the series and improve our technical support.

So with that under our belts, we are ready to roll.

Our first speaker is Dr. Gregory Zimet.

He is in the leadership education and adolescent health.

He will provide an overview and access to care.

You can type in questions at any time during his presentation.

Greg, we are ready for you.

>> Thank you.

I am going to attempt to cover a fairly wide range of topics, and give a general overview to prepare you for the subsequent speakers.

Next slide, please.

The things that I'm going to try to cover today include a brief discussion of some key adolescent barriers, and discuss potential solutions to some of the access problems.

Next slide.

Let me start with a discussion of some of the adolescent mental health problems and issues that we commonly see.

Next slide.

One of the more concerning problems that we see in adolescence are eating disorders.

These are fairly prevalent problems, lifetime for female high school students, full syndrome, close to 5%, and partial syndrome which means having many of the diagnostic criteria but not all of them, it's nearly 6%.

Not only are these problems in and of themselves, these kinds of eating disorders, they tend to go along with other mental health problems.

Full syndrome eating disorders, nearly 90% of them have other psychiatric problems embedded and what we see among individuals with full syndrome is depression.

Partial syndrome eating disorders also have frequent co-morbidity, with 80% having that, and depression occurring in over half of the individuals.

Next slide, please.

Very briefly, eating disorders are characterized by a complex interplay of medical, psychological issues.

Also often chronic conditions that require longer term treatment.

The ideal approach to treatment, therefore, would be a team approach, in which the team is composed of multiple disciplines, include at least medical health care provider, a mental health care provider, and a dietician.

Next slide, please.

Let's move on to depression.

Depression is another recognized common problem among adolescence.

The lifetime problem is 15%, minor depression is 10%.

The point prevalence, the amount of adolescence at any time, 10% moderate to severe, 30% report depressive symptoms.

Depression is a problem that when it's more severe tends to reoccur throughout adulthood, so they could have it throughout adulthood.

Obviously another concerning outcome is suicide, both attempts and completed suicides.

Next slide.

The depression really is characterized by both short and long-term severe adverse effects.

It's relatively common among adolescents, and it is multi-modal, and you would have a team involved.

Moving on to the next slide, one of the things I wanted to talk about which I think is very important is how mental health problems present in primary care, primary health care settings.

The prevalence among children of mental health problems in primary care, estimates range from 12 to 17% in the literature.

Among adolescents in primary care, 2% present with psychiatric complaints. However, 38% had a psychiatric disorder, and moderate impair or functioning in over half.

The most common problems were depression and anxiety disorders.

Next slide.

Most children in adolescents with problems are seen at some point by primary care providers.

These are not problems that need to go unrecognized.

However, the psychological problems for a variety of reasons are often under identified.

Next slide.

Most primary care health visits involve problems that have a substantial behavioral or emotional component.

It's also well-recognized that mental health problems can make worse medical conditions.

In turn, also recognized many physical conditions may play a role in the development of depression and other emotional problems.

Mental health and physical health in the majority of cases, if not all cases, are intertwined.

So given this overview and looking at some of the major kinds of mental health issues and problems, let's look then at barriers to access.

Next slide.

First of all, a few adolescents in need of services actually receive services.

This is very well documented.

What are the barriers to care, why is it they are not receiving the mental health services they require?

I'm going to, I made an artificial division of barriers.

Let's move on to the next slide.

In one very interesting study that looked at parents report of barriers, among 7th grade, these are parents of 7th graders, 35% of the parents of 7th graders who, these are 7th graders identified as in need of mental health services, 35% of the parents reported a barrier.

The types of barriers they reported fell into three general categories, structural barriers, perceptions of mechb at all health problems, and perceptions of mental health services.

The structural barriers reported by the parents included some fairly self-evident things, like, that help was perceived as being too expensive, services were too inconvenient, services were too far away, and so inaccessible, parents sometimes didn't know where to go to get mental health services for the 7th graders, they didn't always have a way to get there so there were

transportation problems, or they were made to have a very long wait for an appointment.

So these were the kinds of structural barriers that many of the parents reported.

Next slide.

Another category of barriers were perceptions of mental health problems.

And this is an issue sort of residing within the parent.

Many parents saw their child's problems as not serious and so as a result didn't see that it was important to seek mental health services for their 7th graders. Other parents similarly chose to handle problems on their own rather than seek help from others.

Next slide, please.

Next category is parents' perception of mental health services.

These are the different responses that parents gave.

Some parents felt that they didn't, they didn't have confidence in the referral source, other parents talked about experienced, having negative experience with health care professionals in the past.

Some parents who were afraid about what others would say if their child accessed mental health services, and this relates to sort of the long standing stigma associated with mental health problems.

Some parents lacked confidence in the potential success of treatment, and some cases the most trusted people in the parents' world weren't the ones who recommended help and so parents didn't necessarily trust the recommendation.

Some parents said they didn't know whom to trust.

And other parents said that they were, they thought it was a good idea to get mental health treatment but that their child did not want to go.

Next slide, please.

I would like to talk now about provider barriers to access, to mental health care.

These kind of barriers are really all highly interrelated, I'll talk about them separately.

A failure to recognize the problems on the part of the health care provider. Some providers may lack evaluation skills, the ability to determine whether mental health services are needed.

They may lack strategies for referral or treatment when, after problems are identified, and there's another problem which has to do with the brevity of most pediatric visits.

Next slide, please.

Let's talk first about failure to identify.

In one study 50% of children with significant behavior problems were identified by primary care providers which sounds good and is encouraging, it also means 50% of the children with significant behavior problems were not identified by primary care providers.

One of the things that predicted identification by the provider was parental disclosure of concerns.

Another thing that predicted identification recognition of psycho social problems was continuity of care, they saw them every time they went to get medical care saw the same provider, they would recognize the problems.

Fee for service versus managed care made no difference in recognition rates. Many health care providers lack evaluation skills.

They may not know how to ask the right screening questions, and there may be a failure to use potentially useful screening questionnaires.

They are certainly one way, one potentially time-saving way to help in the identification of mental health problems and primary care.

Next slide, please.

There also may be a lack of strategies for treatment once a problem is identified.

Many health care providers have poor access to a mental health provider, and don't have networks for referral.

There may be a lack of availability of timely mental health consultation, so they may identify the problem but don't have anyone to turn to for advice about what to do about it.

There is often limited knowledge of behavioral interventions.

As a result of the desire to provide treatment and help, there may be overreliance on medication.

Next slide, please.

Clearly a major barrier that's related to all the ones that I have mentioned to date has to do with the limited time provided for health care visits.

Typical pediatric visit is ten minutes, adolescent may be longer depending on the provider but rarely 30 minutes, and typically less than that.

The brevity of the visit causes problems, it limits the breadth of the questions that can be asked.

Not all the questions can be covered.

It clearly also limits the depth of questions that can be asked.

Even when cursory questions may be asked about certain areas of functioning, there is not time to go into depth.

It may also limit the ability of health care providers and limit their desire to recognize psychological and behavioral problems.

If there is limited time and a demand to see a large volume of patients, a person may not consciously but unconsciously recognize problems that demand to be dealt with.

Overall the limitations in time clearly limit the ability of health care providers to effectively intervene around psychological and behavioral problems.

Next slide, please.

Final category of barriers I would like to talk about are insurance-based barriers.

And the areas here that I'm going to address include carveouts, excluded diagnoses, procedures, limited time.

Carveouts have turned out to be a fairly major problem in terms of provision of adequate mental health care.

What carveouts are, the development of cost and corporate structure for mental health care separated from the medical care cost corporate insurance structure.

So what happens with carveouts is very often the place where a person may bring their child or adolescent for medical care, even if there are mental health providers there, they may not be covered by the carved out mental health insurance so they may have to go to separate places for mental health care.

They really undermine comprehensive integrated approaches to health care, and also ignore possible cost offset effects for mental health treatment. It's that there is some evidence, although it is mixed at this point, there is some evidence that when people get mental health care, that it reduces their inappropriate, it can be cost saving.

And the trouble is with carveouts, there is no way to take advantage of the cost offset issue.

Next slide, please.

Another insurance-based barrier has to do with excluded diagnoses and procedures.

Many insurance plans exclude oppositional disorder and adjustment disorder from reimbursement, when these are probably the most frequent kinds of diagnoses that are seen with adolescents.

In addition, parent guidance and family therapy are often not reimbursed procedures.

They sometimes are but often not.

By not reimbursing the procedures it's taking the parents out of it which is counter productive and counter intuitive.

Another slide of insurance-based barriers, limited sessions and there is something said they seek treatment, sometimes it is true, most often it is not true.

In my experience the first several sessions with adolescents involves helping them to connect and to commit to treatment.

Limited sessions also ignores the chronicity of some conditions, such as many conditions.

I have identified a lot of problems with access.

Let's talk about potential solutions to access problems, and I know some of the other speakers will address this as well.

Next slide, please.

Starting out at the end of the insurance barriers, let me talk about possible solutions, what you can see on the left side are the problems and on the right side of the slide are potential solutions, some of which are going to be difficult to institute.

The problem with carveouts I think the solution is really very simple.

Carveouts should be eliminated and I don't think there's any question about that.

The problem with excluded diagnoses, again, I think that there needs to be greater thought to why certain diagnoses are excluded and I think they should probably not be excluded in most cases.

The same thing with excluded procedures.

I think mental health treatment really the approach should be to include family members.

And there clearly needs to be greater flexibility in terms of the number of sessions provided.

One of the important issues as well that I have on the bottom of the slide has to do with something called integrated primary care, which is a new model for delivery of mental health services within the context of primary health care.

This is an approach that really emphasizes all together.

Integrated primary care sees traditional mental health treatment as a subspecialty, the equivalent of subspecialty treatment and really comes up with an approach to delivering mental health services that really fits with the kind of pace and time limitations that are characteristic of primary care of care.

Next slide, please.

In terms of provider barriers, some of the possible solutions.

The problems, failure to identify psychological problems, this integrated primary care approach is really an ideal way to help health care settings and health care providers identify mental health and psychological problems, lack of evaluation skills, additional training in the use of screening tools can help in terms of increasing evaluation skills and the ability to identify, lack of strategy for referral and treatment, integrated primary care would take care of this problem, brevity of the visit again bringing up integrated primary care is again a way of dealing with the brevity of the visit because it really develops, it has to do with the development of mental health services that fit with the pace of medical care.

Next slide, please.

In terms of parent-based barriers, the kinds of structural barriers that parents talked about, clearly school-based, school-linked and community clinics can really help with many of the structural barriers, that is difficulty getting to clinics, and those kinds of issues.

In terms of perception of mental health problems, the advantage again of integrated primary care is it helps to convey a norm of mental health care being integrated with health care and it's a way of potentially over time overcoming some of the stigma associated with mental health services.

Perception of mental health services, school-based clinics, integrated primary care are ideal ways to deal with some of the perception problems.

And that's the end of my talk.

The final two slides list some of the key references that I used in developing the talk.

Thank you.

>> Greg, thank you so very much for an excellent overview of adolescent mental health problems.

And for our audience, please remember that you can type in questions for him to answer.

Actually right now or at any point during the other presentations, you might want to do it right now while his remarks are fresh in your mind.

Next I would like to introduce our second panelist, Dr. Mark greenBerg, his chair of prevention research and professor of family studies at Penn State University.

Mark will discuss prevention of mental disorders in adolescence.

He has prerecorded his presentation and will join us live during the discussion period to answer questions you may have.

And remember you can type in questions at any time during this presentation.

>> I am happy to present to you today on the prevention of mental disorder in school-aged children making the connections.

As you see on my second slide, I have a quote here from president Kennedy in which he says first we must seek out the cause us of mental illness and eradicate them.

Here more than any other area an ounce of prevention is worth more than a pound of cure.

It is far more economical and will be successful.

Prevention will provide both selecttive causes as well as a general strengthening of the social welfare and social problems can do much to eliminate the harshness of environmental conditions most often associated during mental illness.

It tells a lot about prevention, first that we hope and believe it will be far more economiccal, and specific programs at different levels in the communities.

This is a wide prestaged discussion of the problems that we now face in prevention.

If you go to the third slide, you'll see I asked the question, why is school-based prevention critical to the community mental health of children.

As president Kennedy obviously alluded to, treatment, even when effective, will not have a substantial impact on new cases.

Treatment will not stem the development of new cases and of course we know the development of mental health problems has increased in American society, the rate of depression has almost doubled with adolescence in the past decade. More likely we are to be able to identify children early, the more likely we are that treatment and advance prevention techniques will lead a better prognosis. School problems can be prevented.

And by building factors that promote good mental health, we play an important essential role in the mental health system.

It was not to treat problems on but to help in partnership with skooltion.

moving on to the next slide, a number of challenges that it faces in the development in the last 20 or 30 years and still faces and all about systems integration.

The first is across levels of care, I'll discuss more in a minute.

The second is cross stages there will be many different programs, and can we create systems integration across the community structures of family centers, substance abuse facilities, and schools.

As you see on the next slide, adopted from Howard Adelman, right now we spend a great deal of time and money on the blue portion of our mental health system, the treatment of severe and chronic problem, high end and high cost. We believe as we develop more of both the pink and the yellow systems we'll reduce the size of that blue system and the pink being the early intervention, moderate and moderate cost per child and then universal and selective, low end, low need, develop skills and promote positive youth development. Unfortunately the systems now tend to work almost everywhere in America separately rather than connected, and you see at the bottom he states systematic intervention is essential.

This is one of the major barriers, if you will, to effective integration is the issue of systems integration.

Well, as you see on the next slide my cartoon, hey, it's no problem, this is not simple to do as you would guess, and many communities across America are working and struggling with this issue of integration across systems.

Now prevention is based on the public health model which is focussed on risk and protective factor theory as alluded to in the next slide.

That is slide seven, similar to the public health and medical model, we believe there are certain risk factors that lead to disorders just like we can consider the risk factor for card I -- cardiovascular disorder.

We know risk factors increase the chance of mental disorders, protective can help buffer those.

I'll review a number of those risk and protective factors.

At the individual level, we know the constitutional and genetic risk are important factors in the variety of mental disorders, we know early pre and post natal can have an effect, and early problems, difficult temperament and other things are all factors of behavior problems.

And factors not only on the individual level, but slide number nine, family risk factors.

We know that families that have a combination of harsh parenting, major marital conflict, and families that have a fair degree of chaos and instability in family members.

These family factors are also likely to increase the risk for a variety of mental disorders from depression to externalizing problems.

We also think about school risk factors that are important.

Children's early and persistent anti-social behavior in the first years of school, academic failure for a child, especially reading in elementary school, and school bonding are predictive of later failure in school as well as delinquency and crime.

And larger community factors.

Persistent poverty places all members at higher risk, transition of mobility, for example new is your about your ban communities are at high risk for alcohol and substance abuse and teen depression, and we know the communities that

in general don't coordinate services well between schools, family and community agencies place children at risks for higher rates of disorders. Moving on to the 12th slide, just like we can consider risk factors for mental health problems, when we consider prevention techniques, most importantly we need to consider protective factors.

These are the factors we try to build in reducing the risk of mental disorders through prevention programs.

And there are individual characteristics, of course, primarily social and emotional competence which I'll talk about more later, but also earlier development and continued development of healthy relationships.

Early infant/parent attachment relationship, family relationships, the child's relationship to teachers at school, and peer relation, all these can be built more effectively and when children have healthy relationships.

And lastly we believe the context of community support is an important protective factor.

Now going back to the social competence, you see on slide 13 that I have a list of key social and emotional competencies.

I can't spend time on them today, but children have better ability to recognize and talk about their emotions, ability to calm down when they are upset and set goals, the ability to communicate effectively, those kinds of competencies are teachable, we know reduce the children's risk for mental disorders from, again, the spectrum of aggression to depression.

When we think about prevention, we think about it as part of the continuum. Slide 14, you see in prevention universal prevention that is prevention for all people, for example, school-based prevention programs or might think about the use of fluoride as a universal prevention for tooth decay, selective, programs selected for populations of children at risk but not diagnosing any children at risk, and head start might be a prevention program for poor children, or children of divorce or that are having bereavement.

Even though no particular child who is divorced is identified as having a specific problem.

And then there are indicated prevention programs, those are for children showing early signs of a disorder in which an individual child is identified.

For example, children having aggression or peer problems in the school.

You can see that's the end of prevention and then we move to treatment and maintenance, the three different forms of prevention are important and three programs developed.

As you see on the next slide, I and my colleagues have developed a review of effective prevention programs for the prevention of mental disorders.

You can see that the ULR can take you to that review as well as ten other outside reviews of our review.

And I'll briefly tell you a little about what we know about effective prevention programs focussed on the building the protective factors and reducing risk factors I have already discussed.

There are a variety of universal prevention programs shown to be effective.

I can't spend the time in this short presentation to go through each of them, you can see there are programs in violence prevention, development of social and emotional competence, helping children through ecological programs, a healthy school, through transition, deal with the issues of bullying or other kinds of school-wide programs, and then multi-domain programs, not one domain but school and family together.

Each of these programs is reviewed in detail and the review paper that I, which is presented in a previous slide.

Then there are also a series of programs that have been shown to be effective for externalizing problems.

Indicated programs where children were identified as having specific problems or needs, there are child focus programs basically building on social and emotional coping skills, the skills I discussed earlier, multi-component programs that focus on family and focus just on family or on mentors, for example, the well-known big brothers' program.

Similarly to externalizing programs, there are programs effective for children internalizing.

There are programs as you can see on mood disorders and depression.

A well-known program from Australia on anxiety in adolescence, a program that focuses on the prevention of suicide, and a vent trigger program, programs focussed on children that have specific experience, these are selective programs, divorce and bereave meant.

all the programs are reviewed in detail with specific information on the research and how they can be contacted and the review paper I discussed previous will you that you can go to the URL on the Internet.

What this tells us is that prevention has moved toward a great deal in the last 20 years.

20 years ago very few programs that have been proven effective and randomized trial data, and now 35 programs we have reviewed that we believe fit the data.

The question is how do we effectively use the programs in communities and sustain them across time.

The 19th slide I talk about systems integration across institutional structures. It does not have a permanent home in communities the way treatment does. Primarily not paid for by patient fees, and therefore a need for community development in order to develop sustainable prevention.

I designate four areas I believe that are necessary to develop in order to substantiate long-term institutionalization of programs.

The first is develop community leadership, and what we often find in community is school and agencies have different ideas, don't communicate and share leadership in the way they plan the futures of the agencies and districts. Second thing is we need to educate leadership regarding the impact of prevention, that many problems can be prevented through validated programs, and the need to develop better cross institutional long-term planning and cooperation.

We need to provide training to agency staff and teacher support staff and the training needs to be ongoing and lastly, we need to develop and showcase model communities.

This is part of the goal for the center for mental health services capacity building programs and prevention, I'm involved in one exciting project that's going on now in Harrisburg, Pennsylvania, is an attempt to build the systems integration across levels.

As you see on the last slide, we need to think about this broadly when we think about the prevention programming, and here I just designate quickly there are three levels in which we want to do community planning to promote prevention, the first is universal programs, mass media, school and workplace intervention programs and legislation of policies, at the selective level, interventions for risk groups I have discussed, and at the indicated level, similarly individual and group interventions for children already showing problems.

By using this universal selective and indicated model, and developing community planning as identified in the previous slide that create agency and school cooperation for long-term planning, and these ways we can be most effective in developing and sustaining effective prevention in our communities. Thank you.

>> And thanks very much to mark for a very, very rich and broad overview of the prevention of mental disorders in teenagers.

He will be with us live for part of our discussion period.

So please at this time make sure that you type in questions that you would like him to address.

Okay.

Now going to move to the third speaker in our panel of three.

I would like to introduce the director of the center for school mental health assistance.

As a psychologist, mark is an associate professor.

He will discuss advancing school mental health in the United States.

And again, remember that you can type in questions at any time during his presentation.

Okay.

>> Thank you.

There's really been considerable progress in the school mental health over the past decade and I want to capture some of the key fields.

I'll try to move fast for the safety of discussion.

The first slide, a major part that is to do with increasing recognition.

As Dr. Zimet said, most in need of care don't receive it.

We need to reach youth where they are and we find in the next slide schools are the most universal setting, combining students and staff we can reach one-fifth of the population by moving the efforts to schools.

The next slide, a lot going on in the school mental health, articulated by the counter parts at UCLA, an effort for the way coordinating school mental health, and other initiatives playing out.

School-based health centers now around 1500 of them and they are really playing a major role in promoting advocacy for mental health in schools. Seeing the community mental health centers are realizing they are not reaching the youth, the same for private practitioners, the broad initiatives in full service schools or communities in schools where mental health is a critical component.

And a large research base that is growing of studies that are fully supported by research grants documenting positive outcomes for school-based mental health.

Our way to try to come up with an approach that is manageable in terms of mental health in schools is to develop the framework we call expanded school mental health reflecting core elements of what we believe and others believe to be effective mental health in schools, the school joining forces with other community programs and systems to develop a full array of mental health promotion and intervention for youth in both general and special education. Go to the next one.

Evaluation data and some early research data are documenting that the programs are showing effectiveness reaching youth who are unlikely to be reached, having staff who is highly productive, preliminary data, cost effectiveness, and qualitative data, such as improved satisfaction, and in some cases improved student outcome, grades, attendance, lateness, discipline problems, and some of the own research has documented system level outcome such as reduced inappropriate referrals to special education.

If you could go to the next one, however, we are still in the early phases. Don't really know how many expanded school mental health programs are out there, we estimate less than 10% of the nation's schools, and we are seeing a trend where they move high end in the schools but not much in the way of early intervention prevention, and major issues in the funding area as Greg alluded to earlier.

Lots of work to do, the field is still really very young.

Many communities there is limited services and programs available for youth and schools and also limited mental health services available for youth in other settings.

If that's the scenario you are faced with, it points to a very large advocacy which should begin with raising awareness of youth mental health issues, involving the -- influencing policy and enhanced the resources strategically. Going to the next one, there's a big discussion playing out around how to best identify youth who have problems early in the developments of the problems, we are learning when we implement screening oftentimes we identify problems that exceed capacity.

How do we screen for problems, respond to them and at the same time use findings from screening to build up advocacy and a sense of urgency about the work ahead.

There's a lot to do in the training area, moving toward interdisciplinary approaches in training, training folks who have not been equipped to work in schools to be able to do that, developing approaches that capitalize on

strengths, masters degrees, other educational background to maximize our impact.

The quality assessment and improvement area, very, very limited, I'm going to talk more about that later.

Next page.

Coordinating services in schools is not a small task if you have a number of folks from the community coming in to join the school employed, folks like the school psychologists and counselors and social workers, how do you do that in a way that is coordinated and doesn't duplicate efforts, and how do you coordinate the work in the schools to what is going on in other community centers, residential treatment, psychiatric hospitals, those kinds of things. Within the movement toward expanded health, areas we are not doing a lot, one area is substance abuse where in most communities there is not much you can access in the community related to substance abuse, and similarly not a lot to access in the schools.

The whole part on shift around moving toward prevention and mental health promotion is beginning to play out in this country, and the discussion around supporting using and building the evidence base has become dominant in both the research and practice literatures.

In terms of the discussion of effectiveness which is really key to all the work, of the many different types of school mental health as alluded to earlier, really there are relatively few approaches that have full research report and full scale experimental research to document impacts.

That means the field is safe with a very large agenda to move to scale in terms of effectiveness of evaluation, not just for research-supported programs.

Looking at some of the research-supported programs, we have documented effectiveness in multiple domains.

Some of the key reviews including the review that Mark mentioned.

His work characterizing some of the qualities of effective programs, moving to the next slide, the full discussion around implementing the evidence base for those of us who work in the school we realize there are many, many needs to implement the evidence base that for the most part are not available in schools.

Really positive interventions that match with the school, we need significant training and technical support, the right environmental conditions, etcetera, and in many of those realms schools do not have adequate support to effectively have the programs.

We also need to address the reality that there is significant variability in what is going on in school mental health, the variables are all over the map which makes it difficult to evaluate that independent variable.

Research and practice, there's been progress, it still remains largely disconnected, and as I mentioned, in school for those who work in the trenches, seems to be little support for evidence-based practice, although that is changing.

Next slide, we point out that really there's a larger context to effectively implement evidence-based programs.

The top is to achieve those things, we need to be implementing effective programs and interventions.

To do that, we need a number of things such as training, technical assistance, ongoing support, to achieve these things we need positive staff and program qualities, stakeholder involvement, which those things we need adequate capacity to, have adequate capacity you get into many of the advocacy dimensions I was mentioning earlier.

The next one.

In terms of the quality agenda, we have done a comprehensive literature review.

Little literature on quality and mental health, and little literature on quality and school mental health.

What is out there is not very exciting.

We hope to be funded soon in a study, we are going to be implementing principles for best practice and associated quality indicators.

Here you see one of the principles, number three, programs are implemented to address needs and stress assets, and some of the quality indicators would be have you conducted assessments on quality risk factors, and right now we have ten principles and 45 quality indicators that we are going to use to hopefully guide the development of quality assessment and improvement in school mental health.

We are very much involved in this discussion around evidence-based practice. One of the things we would like to say, not only one component, but as Mark said earlier, train youth and validate skills.

In terms of stress factors, he presented these.

A number we know if we seek to reduce these things, likely to be a positive impact in the lives of children and families.

Same for protective factors, the individual family and community level, the literature is strong, these help youth and families do well.

In terms of skills, if you disentangle, there are poor skills in many of them.

Rather than train folks to use a bunch of different manuals, train them in skills across manuals, promoting positive psychosocial functioning and academic achievement in children, self-control training, etcetera.

We also believe it's important to use manualized interventions, but it's a different thing to do.

We have done, going into the next slide, comprehensive literature review as he and his colleagues have done on programs that can be done, implemented by mental health programs at the universal level, at the selected level, programs at the indicated level.

Going to the next slide, school mental health continuum, in our work in Baltimore in 22 years, in some of our writers, we promote this continuum where ideally the school mental health staff will be broadly involved and promotion on the early intervention and treatment, and conspire we are acting

like change agents, helping to promote a positive environment, resources into the school, helping to get mentoring programs, 56 to 60% of the time working as the prevention specialists doing early intervention, working with educators to improve behavior, and 1, 2, 3, mental health for diagnoses, and 30% of the time more intensive treatment.

The fee for service part of the work involving working with youth with diagnoses tends to take up much more time than the amount allocated here related to all the bureaucracy that you have to contend with.

To advance the work, it's important to do needs assessments.

One way to do it is look at the major child serving systems, we have public health, mental health, juvenile justice, child welfare, using the older prevention model, tertiary, primary, secondary, most communities would look something like this.

That is there is nothing really happening in the prevention realm.

Some tertiary treatment available for use in special ed in the schools, and some tertiary treatment being provided for youth who act out in the community mental health centers, and the most part public mental health is not involved because we have dismantled the public health system in many communities in the U.S.

If that's the reality, we move toward a vision of doing a lot of the work in natural settings such as schools, having education being the lead agency since we are working in schools, using a framework to guide our work in education but still not enough, we need mental health and other groups to join on and having mental health, public health, juvenile justice and others joining to fill in gaps in the continuum.

And then next slide, importantly, decisions need to be made in schools on how that is going to play out.

An example, no stereo typing intended, a school psychologist, social worker, and a community staff who comes in from a mental health center, going to do what?

It's not a small decision.

Anchoring those decisions around the prevention continuum so in the figure you see regular at zero and special ed X's, in the figure the school psychologist would take the lead for primary prevention for regular and youth and special education.

Primarily the one in the lead for early intervention with youth and special ed, and for treatment for youth and special ed.

School social worker doing the lion's share of the treatment but also prevention, school counselors involved with prevention, and the community staff involved at all three levels, but the tertiary and primary education.

The important point is we need to have a purposeful decision-making process about who is going to do what.

At some point the advocacy agenda has to address the issue of our reliance on fee for service funding in the United States, an illness care, not a health care system, which means that for one you have to diagnose before you can do anything, and there are kinds of issues with diagnoses.

I don't have time to get into them.

But also the very significant issues with paperwork, serves to limit productivity of staff and a real contingency if you spend a lot of time developing a chart and enrolling a child in fee for service care, then you are going to be likely to hold onto them if they continue to show things, which makes more issues in community mental health because slots are not being opened up.

What we want to do on the next slide, move to a full continuum of funding, maximizing all potential sources of revenue, since revenue for mental health in schools is tenuous from the beginning.

So we want to begin really with allocations from schools and departments of education, beginning focusing on what schools are doing in the business of mental health and schools, and again, I would defer to my colleagues at UCLA who are providing important leadership in this area, bring in the mental health folks, how do we fund them, through local grants and contracts, through federal and foundation grants and contracts, innovative prevention funding, fee for service as some of the examples.

I'm going to conclude by just briefly talking about our centers for mental health in schools supported by the office of MCHB as Trina mentioned.

I would strongly encourage folks to check out our companion center at UCLA, just a wealth of resources and knowledge and experience that they offer.

Turning to our center, we have four major goals in terms of providing technical assistance and consultation, national training, two conferences, one in Maryland and one that moves around the country.

Portland, Oregon October 23-25 and would encourage folks to visit the website to learn more about our conference.

That concludes my presentation.

I just have some references that follow.

Thank you.

>> Thanks very much, Dr. Mark Wiest.

Now going to move to our discussion period and actually have a good 15 or 20 minutes for our panelists to respond to your questions.

So we invite you even now to submit questions for our speakers, and the two slides that will now appear on your screen provide reference information for two federal publications of mental health, as well as the websites of our speakers' programs.

So please feel free to type in questions to the speakers right now.

Our first question is addressed to Dr. Greg Zimet.

The question comes from Massachusetts, concerns how we might reconcile the mental health issues of eating disorders with the new concern on obesity and overweight among youth.

>> How we might reconcile.

Well, we clearly need to address both sets of issues.

I know there may be concern that addressing one issue may make the other worse, but I don't really think that should be of grave concern.

I'm not sure that that answers the question, but I think clearly both issues are problems for youth today, and I don't have a whole lot more to say about that.

I'm not, unless maybe the questioner can be more specific or maybe some of the other speakers have thoughts about it.

But I think clearly both issues have to be addressed, and I think we can't be terribly concerned about that, you know, that helping individuals with one will make it worse.

>> Do you think there is any possibility, this is now my question more specifically, given the fact that many youngsters who develop full blown eating disorders, kind of the straw that broke the camel's back, is when they were teased for being plump, and the national concern now on preventing overweight and addressing obesity amongst all population groups, that that in some way might actually increase the number of youngsters who are concerned about their being slightly overweight and might tilt them toward developing an eating disorder.

>> Theoretically I suppose that might happen.

I think thought implemented programs where the approach to prevention would be the adoption of healthy lifestyle in general, and not simply a focus on weight, I think clearly would be helpful.

You know, I really don't think that dealing with one set of problems in any way necessarily means an exacerbation of the other problems, and I think again a thoughtful implementation of prevention, you know, policies to prevent obesity really can, I think need to have as their goal a comprehensive lifestyle approach.

>> Okay.

Thank you.

The next question comes from New York state, and is actually addressed to all three of our panelists.

Wondering whether Dr. Mark Greenberg has been able to join us.

>> Yes, I have.

>> Thank you so much for coming.

>> This question, I will read it almost verbatim is actually somewhat of a commentary but also a very thoughtful question.

What thoughts are underway or being considered to support training of primary care providers and school personnel at an early point in time before problems become entrenched.

It's unlikely that in the near future we will be able to create an adequate supply of psychologists and psychiatrists to meet the emerging needs of youth.

Are we aware of any efforts and programs around training basically of professionals that have contact with kids?

>> I would defer to Dr. Zimet of training of primary care training.

There are others doing work in that area.

I think the other part is the need to train educators.

As the primary mental health clinicians out there now, and who pretty much have no training to do that work, if you look at the undergraduate curriculum from those educators they might have one psychology class that doesn't team them much in pragmatic skills for identifying issues and managing classrooms and life skills training programs and things like that, there's an effort to train

educators at all levels, undergraduate, pre-service, in-service graduates in mental health beginning to gain momentum and we are part of a group that has a placeholder name, the mental health integration consortium, but a critical agenda for primary care providers.

>> Greg and Mark, do you have any thoughts on this question?

And to throw into the mix, the majority of our audience are public health professionals, and are not mental health professionals in general, but really come from, you know, from general public health background, and from a general public health perspective is that mental health issues of all segments of the population are starting to come to the fore.

And so I'm sure many of our audience would like to know how they themselves can receive better awareness and education in this area.

>> I can talk a little bit about my experience in departments of pediatrics, in terms of training of pediatricians, which I think is pretty inadequate in general, although I think there are some notable exceptions to that.

But I think there's a lot of discussion of the need to increase awareness and to increase screening skills, but I think in practice not a whole lot occurs in most pediatric training programs.

You certainly can speak to that as well.

>> I certainly can, and that's actually one of, I know for folks that don't know, I actually come from a pediatric adolescent medicine background, that was one of the areas that I, and it was very important to me to address.

>> I'll just add one component to this.

I don't think there's been very good training and screening by anyone that deals with children.

It hasn't been a primary concern of any of the professions.

I think that the work that's been done on a screening of depression and primary health care settings is adults, it's very important to this, and particularly the developments that have occurred mostly in health maintenance organizations around getting quick screening of adults with depression.

Probably the most under-diagnosed of mental disorders, as we know, maternal depression in the infant period is probably the best single predictor of poor outcomes for children.

>> Those are very, very, like excellent pieces of information.

>> I might add another plug for this, which I think it fits very well with what he was just saying, another plug for this model of integrated primary care, which, much of which was developed in the context of some managed care organizations, but it really, it -- when you read about it you realize how sensible it is and you realize it's not just medical health professionals that don't have adequate training in these kinds of issues.

It's also mental health professionals and I certainly never received, my training was in traditional psychotherapy models.

>> In a related area really is the interface of sort of physical or general health care with mental health care.

Is that even, you know, if primary care practitioners are able to identify youngsters, if they do not themselves possess something, they shouldn't in

providing treatment for kids and their families, how can we then develop the capacity of our mental health system and how can we then get one community to talk with the other?

Clearly Greg has talked briefly about, you know, integrated systems of care, and the ma Maternal -- Maternal and Child Health Bureau is developing models for kids and teenagers, and both these two have talked about the importance of mental health in school, another type of model.

My sense is that there are many, many kids out there whose communities do not support a good interface between mental health care, and that perhaps is an important public health question.

>> I think the national move toward school-based health centers presents an opportunity, we are working with groups around developing a training program for mental health folks in schools, also for primary care providers, focusing on brief interventions to capitalize on the evidence-based building on what we have been talking about today in terms of teaching both the mental health professionals and the primary care providers to be reducing stress and risk, training and validating skills, and as they can, to be using manualized-based intervention.

That would be one area that would hold promise where there is also a level of intervention.

>> Okay.

Another general question, is that how we might be able to approach mental health issues for adolescent special populations, clearly there are many groups or sub populations of adolescent and youth, and off the top of my head I can think of gay, lesbian, kids in the juvenile justice system, foster care system, kids who are not in any system who live out there in the streets, teen parents, kids who have been abused and therefore perhaps are already part of the foster care system or the juvenile justice system, that many of our audience are officials within state departments of health and have a general overview of all youth, also have a special interest in special populations.

Any thoughts on any words of wisdom here?

>> Mark again.

I think part of the problem is it's a tricky issue and that resources are in school mental health often so inadequate in general across the board needs are not being met so how do you build awareness of the unique needs of a sub population when across the board needs are not being met.

I think that can be done and should be done in a way that really helps to build advocacy agendas.

I think the challenge would be to orchestrate the activities across the various sub groups.

So that lessons learned for one would be beneficial to another sub group.

>> For like Mark, I am wondering how preventing mental disorders among youth and the work you have done, how that might basically decrease the risk of some of these kids entering the big problem areas, like for example, kids do not grow up in homes that are appropriately supportive, nurturing and have

authoritative parenting, would be they less likely to end up in the juvenile justice system?

>> There is data that that is the case, children in high risk situations will require more than just universal interventions, more indicated preventive prevention programs, once we identify children who have serious problems in the early years, we work aggressively with the schools and the parents to provide the quality parenting skills and also the academic level with their ability to manage themselves in school, both behaviorally but also academically.

An example is the fast track project, sort of creative systems of care, in addition we identify the children at high risk for school failure and delinquency, and rather than wait until they can be identified we work with the families and the schools at the entrance to kindergarten and 1st grade to protect them from later poor outcomes.

There is data from fast track as well as other studies I reviewed in the paper that shows this kind of work can reduce the risk of later poor outcomes. I think partly what it requires, and that's what I mentioned in my overhead, and we alluded to the same issue, integrative systems, oftentimes it's taken me a year or two, in a school before I will find out there is another program, almost working at odds with the current program we are implementing in a school, or the mental health providers working with the same children we are working on prevention with are not all working with the kind of concepts we are trying to teach the school to use.

So this ability to link effective services between prevention and universal prevention, indicated prevention and treatment, is critically important to build a whole system for children and families.

>> And a final general question I know our audience also grapples with, given the fact that our country and many, many of our communities are very diverse ethnically, and we also know that people of different ethnic background might have different attitudes toward mental health and even seeking care for mental disorders, how can you, what are your words of wisdom in terms of developing cultural competence and working with families in groups that perhaps are of different ethnicity than we are from?

Anybody care to tackle that one?

>> I'll be glad to say something, and I think another might have ideas on this, I think you are right that we need to be very careful.

I think language is very important here, and the word mental health itself is frightening to some persons, and to other people it signals more than just fright, signals entering a system that may damage rather than help.

And this is due to often the past history of many of the families we are working with.

When we do preventive interventions with families, we don't ever discuss the issue of mental health in the early period.

We talk about how to help their children succeed in school, how to help them make their families more healthy places.

As soon as the word mental health arises, families associate it with diagnoses and psychiatry, and not at all to put down the important effects of psychiatry, but to the general population this often will be so frightening to lead them not to follow up with referrals.

We find families, there is a very low percentage that fom up and go to treatment.

To not have the mental health label, the more likely you are to treat families that are, especially culturally different from our own.

>> Yeah, our center had a recent critical issue meeting on the topic of cultural competence in school mental health.

We could talk about the use of that term in length, pluses and minuses.

A key theme during the meeting there are a lot of content dimensions, making sure we know how to work people with different ethnicity, hiring people of color, and there are process dimensions that can guide the work, does the program have a general approach of wanting to reach out to the various communities it serves, the different ethnic groups it serves and involve them in a meaningful way in planning for the way mental health promotion and intervention plays out, that may be more important than some of the content dimensions the notion of real idea of collaborating with the community, the youth, families, the school folks, and valuing their perspectives and have them drive the way programs are developed.

>> I was wondering if you have any comments about training professionals who might have been born in countries other than the United States, and helping them to be able to address some of the needs of our youth.

>> Well, I have a sort of general approach that I think might be useful.

Or maybe first to say what I think is not useful, you know, I think there's a lot of efforts, both in helping individuals from this country as well as from other countries become culturally sensitive by using cook book approaches which I think can often be more damaging than helpful, saying with a group of this ethnic origin this is typically how they do things and view things.

And I think those can be, those kinds of issues can be somewhat helpful but I think it leads to over generalizations that can be damaging in practice.

I think, you know, I think so much has to do with learning good interviewing skills in general, and you know, there are some specific skills that I think probably some very concrete kinds of things that can be taught to people from other countries who come here to practice as well as people here who deal with different ethnic and racial groups, but I think the bottom line is really teaching sensitivity and observation skills and good interviewing skills.

>> Okay.

Thank you very much.

Okay.

For our audience, it is now time to conclude our webcast.

I hope that you've enjoyed it and found it to be a good learning experience.

Next webcast is scheduled for Wednesday, June 25th, it will address the prevention of adolescent suicide.

This webcast will be archived at the following website, MCHCOM.com, and you can also download the slides from the website, we have had several questions that have been answered individually, but if you are interested in downloading the slides, they will be available as part of that website.

So thanks again to our panel.

We appreciate the technical support of CADE at the University of Illinois in Chicago, and thank the audience for their participation and generation of important questions in discussion points.

We now invite you to spend a couple minutes evaluating the webcast.

A link will appear automatically after the broadcast ends.

Your responses will help us plan future broadcasts and improve our technical support.

This concludes our webcast on adolescent mental health, and thanks again.