

NATIONAL ACADEMY
for STATE HEALTH POLICY



Building Better Systems for Child and Adolescent Mental Health:

*Highlights from a Meeting Convened by the
Association of Maternal and Child Health Programs (AMCHP)
and the National Academy for State Health Policy (NASHP)*

Catherine Hess

January 2007

Building Better Systems for Child and Adolescent Mental Health:

Highlights from a Meeting Convened by the Association of Maternal and Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP)

Copyright © 2007 National Academy for State Health Policy.
For reprint permission, please contact NASHP at (207) 874-6524.

Publication No.: 2007-201
Available on the Web at: www.nashp.org

About the National Academy for State Health Policy

The National Academy for State Health Policy is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.

NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states. We are a non-profit, non-partisan, non-membership organization dedicated to helping states achieve excellence in health policy and practice. NASHP's funders include both public and private organizations that contract for our services.

To accomplish our mission we:

- Convene state leaders to solve problems and share solutions.
- Conduct policy analyses and research.
- Disseminate information on state policies and programs.
- Provide technical assistance to states.

The responsibility for health care and health care policy does not reside in a single state agency or department. NASHP provides a unique forum for productive interchange across all lines of authority, including executive offices and the legislative branch.

We work across a broad range of health policy topics including:

- Medicaid.
- Long-term and chronic care.
- Public health issues, including obesity.
- Quality and patient safety.
- Insurance coverage and cost containment.
- The State Children's Health Insurance Program.

NASHP's strengths and capabilities include:

- Active participation by a large number of volunteer state officials.
- Developing consensus reports through active involvement in discussions among people with disparate political views.
- Planning and executing large and small conferences and meetings with substantial user input in defining the agenda.
- Distilling the literature in language useable and useful for practitioners.
- Identifying and describing emerging and promising practices.
- Developing leadership capacity within states by enabling communication within and across states.

For more information about NASHP and its work, visit www.nashp.org

Portland, Maine Office:
50 Monument Square, Suite 502
Portland, Maine 04101
Phone: (207) 874-6524
Fax: (207) 874-6527

Washington, D.C. Office:
1233 20th St., N.W., Suite 303
Washington, D.C. 20036
Phone: (202) 903-0101
Fax: (202) 903-2790

About the Association of Maternal and Child Health Programs

The Association of Maternal and Child Health Programs (AMCHP) supports state maternal and child health programs and provides national leadership on issues affecting women and children. For more than 60 years, AMCHP has worked to protect the health and well-being of all families, especially those who are low-income and underserved. AMCHP represents state public health leaders who promote the health of America's families. Its members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, adolescent health coordinators and other public health leaders. Members of this national nonprofit organization also include academic, advocacy and community-based family health professionals, as well as families themselves.

AMCHP members manage public health programs that serve more than 32 million women, children and youth across the country. That's more than 80 percent of infants, 50 percent of pregnant women, and 20 percent of children in the U.S. AMCHP works to build a society where healthy families are the foundation of vital communities. To realize this vision, AMCHP advocates for a national investment in family health, universal health insurance, and care for the most vulnerable Americans.

AMCHP's activities include:

- Leadership training, technical assistance, and educational initiatives to build the capacity of state health agencies to manage vital programs for women, children and families.
- Programs to promote quality health care for women of reproductive age, including comprehensive prenatal and postnatal care.
- Partnerships with state health agencies, schools and youth organizations to prevent behaviors that place youth at risk for HIV, STDs, unintended pregnancy, and other significant health problems. Through a formal partnership with the National Network of State Adolescent Health Coordinators, AMCHP builds strong public support for an investment in youth and families.
- Programs to ensure that children with special health care needs receive high quality, family-centered, and integrated health services. AMCHP works with national and state partners to link children identified with a special need to appropriate health care and support services.
- Policy analysis and advocacy to strengthen national policy and increase resources for maternal and child health programs.
- Data collection and analysis to monitor factors affecting the health of families.

AMCHP receives support from the Maternal and Child Health Bureau and the Centers for Disease Control and Prevention in the U.S. Department of Health and Human Services, and the Annie E. Casey Foundation.

For more information about AMCHP and its work, please visit www.amchp.org

1220 19th Street, N.W., Suite 801
Washington, DC 20036
Phone: (202) 775-0436
Fax: (202) 775-0061

Acknowledgements

This paper was written by Catherine Hess, senior program director, with contributions from Uchenna Ukaegbu, Presidential Management Fellow, and Annette James, research assistant, all with the National Academy for State Health Policy (NASHP). Peter Sybinsky, former chief executive officer, and Kathryn Peppe, former acting chief program officer, of the Association of Maternal and Child Health Programs (AMCHP), and AMCHP member leaders Jeffrey Lobas, Nan Streeter, Bill Hollinshead, and Ralph Shubert provided helpful guidance in planning the meeting that was the basis for this paper. AMCHP and NASHP appreciate the time and expertise provided by meeting presenters and participants who generated the ideas that are summarized in this paper. This paper does not reflect necessarily their individual views. MCHB Cooperative Agreement#U01MC00001 supported this paper and the meeting on which it is based.

Table of Contents

Executive Summary	1
Discussion themes.....	1
Elements of a pathway toward better systems	1
Next steps to move ahead	2
Conclusion	2
Introduction.....	3
Do MCH and CMH Have More in Common Than Acronyms? Setting the Stage and Charge for the Meeting	4
Background on the meeting	4
Background on child and adolescent mental health.....	4
Systemic approaches to child and adolescent mental health	5
The View from the Ground: Issues and Models in Building Systems.....	8
Iowa CSHCN	8
Utah MCH.....	8
Minnesota CMH.....	9
Illinois Children’s Mental Health Partnership (ICMHP).....	10
Reactions and Contributions from Key Partners	12
Discussion	15
While there are commonalities in public health and mental health system approaches, there are also important conceptual, definitional, and language differences and sensitivities.	15
There are bridges that can span systems.....	16
Participants identified a number of significant barriers in developing improved systems ...	16
Participants also identified key elements needed to improve systems	17
Moving Ahead on a Pathway to Better Systems for Child and Adolescent Mental Health	18
Develop a common vision	18
Work on common language and definitions sensitive to family/community perceptions....	18
Develop strategies to build systems infrastructure	18
Build on systems that serve children and youth.....	21
Develop and promote common tools for building infrastructure that can bring multiple systems together.....	21
Develop strategies to address resource needs, including making more effective use of existing resources.....	21
Next Steps	22
Conclusion	24
Participant List.....	25

EXECUTIVE SUMMARY

On August 15, 2006, the Association of Maternal and Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP) convened an invitational meeting to begin a discussion about improving state maternal and child health (MCH) and child mental health (CMH) program coordination in developing systems to meet the mental health needs of children and youth. The meeting was based on the premise that meeting child and adolescent mental health needs requires a continuum of services. This continuum includes promotion of social and emotional health and development, as well as prevention, early intervention, and care for mental health conditions affecting children and adolescents.

Through support from the federal Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA), the meeting was convened by AMCHP and NASHP as a means of engaging state, federal, provider, and consumer experts from the child mental health and maternal and child health fields in conversation about how to develop stronger collaborative approaches to improving systems for child and adolescent mental health. While this first meeting of key MCH and CMH agencies and stakeholders broadly considered the continuum of services for child and adolescent mental health, there was a strong focus on the promotion and prevention end of the continuum. In the context of well-identified, unmet needs along the full continuum of services for children and adolescents, these “upstream” components of mental health systems are particularly underdeveloped. Further, the MCH field has expertise, population-based systems, strong ties to primary care, and other resources that can be brought to bear on developing promotion and prevention strategies for child and adolescent mental health.

The following brief executive summary identifies key themes drawn from the lengthier meeting summary that follows. This executive summary also briefly summarizes some of the meeting’s concluding points, including a pathway to move forward and next steps to begin to take action toward stronger collaboration in building better systems for child and adolescent mental health.

Discussion themes

- While there are commonalities in MCH public health and CMH mental health system approaches, there also are important conceptual, definitional, and language differences and sensitivities.
- There are bridges that can span systems, with families playing a key role, along with methods and tools such as training.
- There are a number of significant barriers in developing improved systems, including delivery system structures, lack of services, workforce shortages, and funding.
- Key elements needed to improve systems include: leadership; agency relationships; grassroots engagement and advocacy; public-private partnerships; innovation, spread and sustainability; and measurement and quality improvement.

Elements of a pathway toward better systems

1. Develop a common vision for a universal approach that sees mental health as integral to child and adolescent health and health care;
2. Work on common language and definitions sensitive to family and community perceptions;
3. Develop strategies to build systems infrastructure;

4. Build on the multiple systems that serve children and youth;
5. Develop and promote common tools for building infrastructure that can bring multiple systems together; and
6. Develop strategies to address resource needs, including making more effective use of existing resources.

Next steps to move ahead

1. Drafting the meeting summary paper and sharing it with participants and key stakeholders;
2. Promoting communications among state MCH and CMH programs;
3. Identifying opportunities for federal agencies to engage states in relevant initiatives and to foster connections among systems grantees at state levels;
4. Hosting a meeting on coordinating mental health systems of care and Children and Youth with Special Health Care Needs (CYSHCN) systems; and
5. Seeking partners to support follow-up work on child and adolescent mental health promotion.

As of the publication of this meeting summary, a number of these steps have been accomplished. A draft of this summary was shared with approximately 60 participants at an October 19, 2006 meeting convened by AMCHP, with NASHP participation, for AMCHP members to discuss the issues and ideas identified in August. Discussions at this October meeting reinforced points made in the initial meeting and this summary. Additionally, October meeting discussion groups were able to build on the initial meeting's foundation to identify more specific and additional aspects of issues and ideas to improve systems for child and adolescent mental health. Important federal follow-up action also occurred in the months between the August and October meetings. Federal Maternal and Child Health Bureau (MCHB) and Substance Abuse and Mental Health Services Administration (SAMHSA) representatives reported that they had met together and would continue to meet to address the issues and ideas identified in August. Federal representatives indicated their commitment to support further opportunities for MCH-CMH communication and collaboration, and also encouraged AMCHP and others to engage in existing national mental health partnership vehicles.

Conclusion

Discussions at the August 15 AMCHP-NASHP meeting, similar to conversations that have occurred within some states and among some partners, reinforced that collaboration in developing, coordinating, and integrating systems for meeting the mental health needs of children and adolescents can result in stronger systems and better outcomes for children, youth, and families. This meeting was an opportunity for the state and federal agencies with mandates and missions to address the comprehensive health needs of children and youth to engage in conversation with each other and with other key health maternal and child health and mental health system stakeholders to identify issues and generate ideas for pursuing shared goals. The meeting achieved its objectives of initiating discussions; fostering mutual learning about respective system approaches; identifying and exploring commonalities and differences; generating ideas for moving toward a more coordinated approach; and suggesting next steps that AMCHP, NASHP, and other participants can take to follow-up.

□ □ □

INTRODUCTION

On August 15, 2006, the Association for Maternal and Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP) convened an invitational meeting to begin a discussion about improving state maternal and child health (MCH) and child mental health (CMH) program coordination in developing systems to meet the mental health needs of children and youth. The meeting was based on the premise that meeting child and adolescent mental health needs requires a continuum of services. This continuum includes promotion of social and emotional health and development, as well as prevention, early intervention, and care for mental health conditions affecting children and adolescents.

Through support from the federal Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA), the meeting was convened by AMCHP and NASHP as a means of engaging state, federal, provider, and consumer experts from the child mental health and maternal and child health fields in conversation about how to develop stronger collaborative approaches to improving systems for child and adolescent mental health. A list of participants is attached. While this first meeting of key MCH and CMH agencies and stakeholders broadly considered the continuum of services for child and adolescent mental health, there was a strong focus on the promotion and prevention end of the continuum. In the context of well-identified, unmet needs along the continuum of services for children and adolescents, these “upstream” components of mental health systems are particularly underdeveloped. Further, the MCH field has expertise, population-based systems, strong ties to primary care, and other resources that can be brought to bear on developing promotion and prevention strategies for child and adolescent mental health.

The one day meeting consisted of six main components:

- Brief background to set the stage for discussions;
- Brief presentations from a small number of states to identify both issues and potential models for building systems offering the continuum from promotion through treatment;
- Reactions and additional information from key federal, provider, and family partners;
- Discussion of issues;
- Identification of potential ways to move forward collaboratively to improve systems; and
- Identification of specific next steps to build on the meeting discussions.

This paper summarizes each of these six main components of the meeting.

□ □ □

DO MCH AND CMH HAVE MORE IN COMMON THAN ACRONYMS? SETTING THE STAGE AND CHARGE FOR THE MEETING

Background on the meeting

AMCHP and NASHP, organizations which represent or work closely with states, have identified mental health as a priority issue for states. AMCHP's members, usually located within state health agencies, lead state maternal and child health, children with special health care needs, and other family health related programs, such as maternal and family support, early intervention, and school health programs. AMCHP's members have identified mental health as a major area of unmet needs for families with children. NASHP is a non-profit, non-partisan forum and network for state health policy makers and program administrators. NASHP's relevant work includes Assuring Better Child health and Development (ABCD) initiative, a Commonwealth Fund-supported project working with state Medicaid, MCH, and other agencies to improve health policy and financing for early childhood development services. The second phase of the initiative, ABCD II, has a focus on healthy mental development.

AMCHP and NASHP came together and decided to convene an initial meeting of experts involved with maternal and child health and child mental health to explore perspectives on systemic approaches to child and adolescent mental health. While a number of other agencies – such as education, child welfare, social services, and juvenile justice – have a role to play in systemic approaches to child and adolescent mental health, AMCHP and NASHP aimed to begin a conversation with the two state programs with broad core missions for health and mental health of children and adolescents. The objectives for the meeting were to:

1. Initiate discussion among maternal and child health and child mental health state program leaders and key partners as a step toward increased collaboration in systems development efforts;
2. Learn about respective concepts and attributes of systems as conceptualized by the children's mental health and the maternal and child health sectors ("systems of care" in the mental health sector and MCH/CSHCN systems concepts);
3. Identify and explore commonalities and differences in system approaches;
4. Generate ideas for conceptualizing a coordinated or integrated approach for child and adolescent health and mental health systems that offer a continuum from promotion through treatment, leading toward a "roadmap" for state MCH and CMH agencies; and
5. Suggest next steps that AMCHP, NASHP, and other invitees can take to follow-up on ideas generated at the meeting.

Background on child and adolescent mental health

Mental health is a major area of unmet need for many families, and is of particular interest to state health policy makers, as it is critical for overall health and development. One out of five children and adolescents in the US has a mental health disorder, and at least one in ten – about six million children – suffers from a serious emotional disturbance. Childhood is a vital period for healthy social and emotional development, and early intervention and prevention efforts can affect health outcomes, school readiness, and health costs.

Children’s mental health development can be affected or impaired by factors such as poverty; low birth weight; exposure to environmental toxins, child abuse and neglect; exposure to traumatic events or violence; mental disorder in a parent; and prenatal exposure to alcohol, illegal drugs, and tobacco. The majority of children with a serious emotional disturbance do not receive mental health services. Children who are uninsured are less likely to receive mental health care, and there are racial, ethnic, and geographic disparities in mental health services access and quality as well. There are many barriers to mental health care access for children and adolescents, including high costs of services; fragmentation of services; multiple services settings; provider shortages; lack of parity in insurance coverage; and stigma associated with mental illness.¹

Systemic approaches to child and adolescent mental health

Numerous national reports have recognized the need to address the mental health needs of children and adolescents through a continuum of services starting with promotion and prevention, and including early intervention and treatment. *Promotion* and *prevention* activities promote optimal social and emotional development and emotional wellness, and build resilience in children and youth. Examples include parenting education for new parents and high-risk families, home visiting programs, school-based programs that promote social and emotional skills in students, and public awareness campaigns that reduce stigma. *Early intervention* services routinely screen and assess for potential mental, social, emotional, or learning problems, and include periodic screenings in primary care, school and other settings serving children.

When children and adolescents are diagnosed with mental health disorders, they and their families need access to a *System of Care*, a comprehensive and coordinated array of interventions, treatments, and supports. The System of Care concept has provided the mental health field with an overarching and widely accepted approach to care for children with serious emotional disturbances (SED). System of Care attributes include being child centered and family focused, community based, and culturally competent.²

While less clearly defined as the Systems of Care model, systems approaches are central to the roles and services of maternal and child health (MCH) and children with special health care needs (CSHCN) programs. The Title V Maternal and Child Health Block Grant, which supports the core services of state MCH/CSHCN programs, includes as a key statutory purpose:

- *to provide and to promote family-centered, community-based, coordinated care ... for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families*

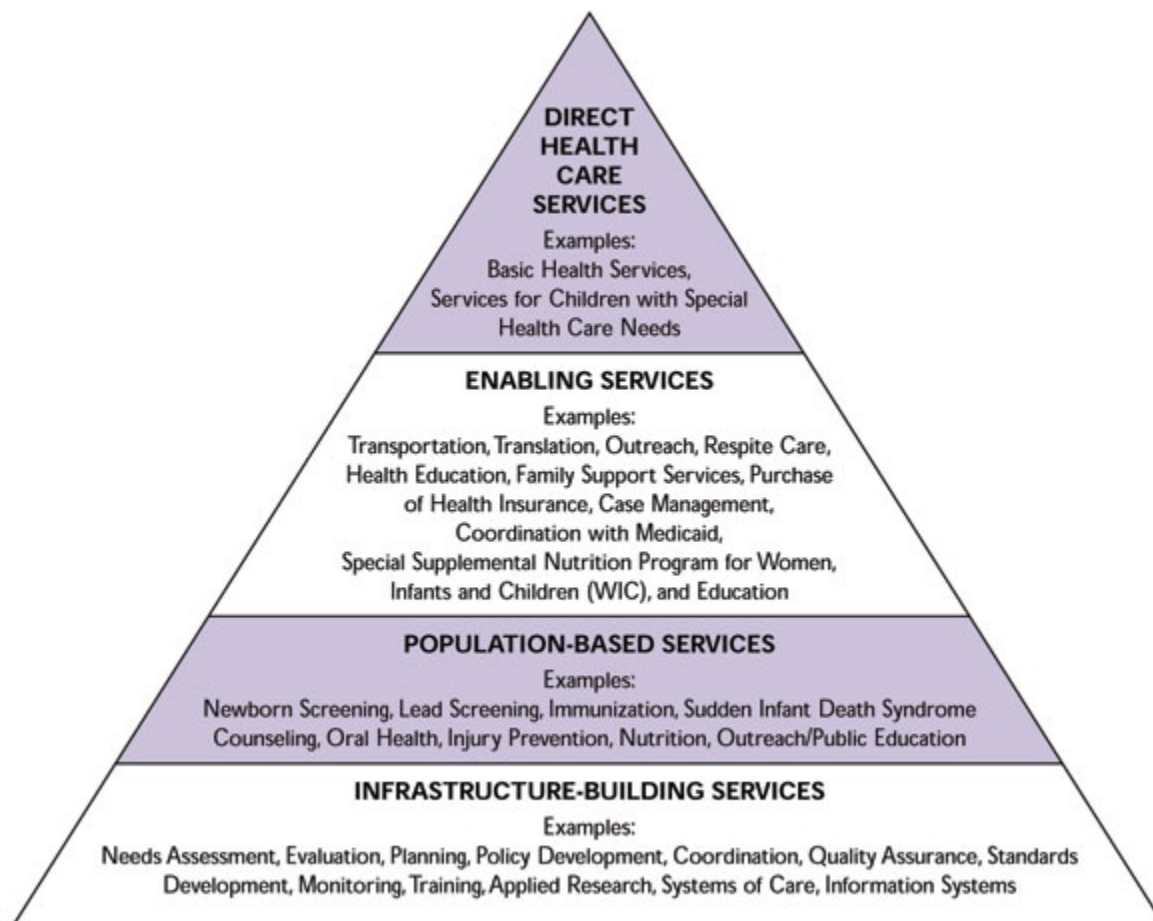
Although the Title V MCH statute is less clear about systemic approaches for health promotion, prevention and early intervention services, the states and the federal MCHB have placed emphasis on systemic approaches in all maternal and child health services. MCHB developed a framework now used in Title V guidance and reporting that rests on a base of “infrastructure

¹ VanLandeghem, Karen and Catherine A. Hess. *Children’s Mental Health: An Overview and Key Considerations for Health System Stakeholders*. (Washington, DC: National Institute for Health Care Management, 2005.)

² Ibid.

building services” that include “systems of care development,” as depicted in the MCH pyramid³:

Figure 1 The MCH Pyramid



Source: The MCH Training Program, MCHB.

Included within these levels of MCH services are many activities that support social and emotional development and the mental health of children and families. A 2002 AMCHP survey identified the following mental health related services being provided by MCH programs:

- Parent education classes,
- Home visits,
- Postpartum depression initiatives,
- Early childhood programs,

³ U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Division of State and Community Health. Maternal and Child Health Services Title V Block Grant Program Guidance and Forms for the Title V Application/Annual Report. OMB No. 0915-0172. Expires May 311, 2009. Accessed at <https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp>.

- Child care provider training,
- Behavioral interventions to promote parent infant attachment,
- Medical provider training,
- Mental health screening and assessment,
- Social and emotional skills building,
- School personnel training,
- Family resource centers, and
- Parent support group interventions.

There appear to be a number of commonalities in CMH and MCH/CSHCN approaches to meeting the needs of children and families. Each embraces important principles of services being family focused, community based, and culturally competent. CMH and MCH/CSHCN each are working on systemic approaches that recognize the importance of organizing services and coordinating the roles of public and private agencies, providers, and families. These commonalities suggest fertile ground for developing collaborative efforts among these state programs and for determining ways to improve coordination or integration of services across systems to better meet the needs of children and families. Highlights of discussion at the meeting about some differences in approaches, as well as ideas on how to move forward to improve coordination, follow later in this summary.

□ □ □

THE VIEW FROM THE GROUND: ISSUES AND MODELS IN BUILDING SYSTEMS

To further inform meeting discussions, a number of state participants shared their perspectives on both successes and challenges in addressing the mental health needs of children and youth, particularly in efforts to work across agencies. The President and President-elect of AMCHP shared views from their states' CSHCN and MCH program perspectives in Iowa and Utah respectively. Minnesota's CMH program, which is frequently cited by peers and experts as a model for systems development with a focus on promotion and prevention, presented to the group. Finally, a unique multi-agency, multi-stakeholder state level partnership effort in Illinois was described. Through these discussions, a few common themes emerged: the importance of interagency and public-private partnerships; the need to develop and strengthen mechanisms for collaboration and communication; and the benefits of coordinating and integrating services for agencies and families.

Iowa CSHCN

Dr. Jeffrey Lobas, director of Iowa's Child Health Specialty Clinics, noted that when he first came to Iowa a number of years ago, it was clear that mental health was the single biggest unmet need. Now, the most recent household survey showed that 50 percent of families with mental health needs could not obtain services. There are 23 child psychiatrists in the whole state, mostly at the university. Waiting lists are up to 6-12 months, and readmission rates are at 25 percent. Iowa does not have mental health parity in insurance coverage; a person needs to have severe mental illness to get coverage. Without higher political priority, it will be difficult for more improvement in mental health services and coverage to take place.

The Department of Public Health (DPH) has a division for substance abuse and mental health; its focus is very adult-oriented. It has been difficult for the university-based CSHCN program to determine who to work with to address identified child mental health needs. The lack of structure in the state leads to fragmentation of efforts. Because there are so few psychiatric resources, a focus on primary care in this state is important. Partnerships between primary care, schools, and other services are crucial. Mental health services are carved out of Medicaid managed care. The mental health provider's telehealth service has worked well and seems to be a good model for the future. Iowa CSHCN has done a number of satisfaction surveys; families seem to be satisfied so far. Dr. Lobas concluded that there is a lot of good news, but a lot of room for improvement in Iowa.

Utah MCH

Utah's MCH Director, Nan Streeter, noted that Utah has one of the highest youth suicide rates in the nation. High levels of postpartum depression also contribute to the Utah MCH program's identification of mental health as a significant concern for maternal and child health. There is activity in the private sector in Utah to integrate mental health services in primary care settings. In the public sector, the Division of Substance Abuse and Mental Health in the Department of Human Services has received a 5-year grant to transform children's mental health services and is

in the process of developing a state suicide prevention plan for individuals of all ages. In the Department of Health, Medicaid and MCH have been collaborating to improve developmental screening, through NASHP's ABCD program. MCH also has added a Children's Mental Health Promotion Specialist to the staff, whose job is to promote child and maternal mental health, especially by contributing to state planning to ensure that funded health services include mental health and working particularly with the state's substance abuse and mental health program. Ms. Streeter laid out elements for her vision for mental health: new terms would be used and stigma reduced; promotion services would be readily available; every child and parent would have access to needed services; and insurance coverage for mental health would be equal to that provided for health.

Minnesota CMH

Glenace Edwall, director of the Children's Mental Health Division in the Minnesota Department of Human Services, gave a brief overview of that state's children's mental health system, and touched on the progressive history of state action to address children's mental health. This history includes establishment of a Children's Mental Health Task Force in 2002, and passage of legislation in 2003 that expanded Medicaid and SCHIP benefits and mandated screening for children in child welfare and juvenile justice systems. CMH, Head Start, MCH, and Part C, together with action groups and associations in the state, have taken a number of steps to increase the focus on promotion and prevention, particularly through screening services. Recent state agency restructuring elevated CMH within the Department of Human Services, a move which resulted in increased communication among staff working on related programs. Programs in the state have worked together on more efficient use of resources, including the mapping out of programs and resources within particular regions to reduce overlap. Future plans include increasing partnerships with the private sector, child care, TANF, and school readiness initiatives.

Relationships among the public programs and with external stakeholders have been critical to the state's accomplishments. These include: common plans for mothers with mental health needs and their children; common tools to enhance child screening; provider training on screening, early childhood mental health and maternal depression; and work to integrate children's mental health into the array of primary care services available to children, including through co-location of services. This latter work was initiated and inspired by the ABCD project, and is being connected to the state's Medical Home project. In Minnesota's ABCD pilot projects there has been a bolstering and pooling of community resources in selected areas to design a relatively seamless system from the perspectives of families. Inclusion of CMH from the beginning of the Medical Home project not only enabled that project to benefit from what was developing through ABCD, but also aided CMH in evaluation and improvement strategies for its wrap-around and case management services.

Dr. Edwall noted that CMH systems are in varying stages of development from state to state. She shared some "lessons learned" from Minnesota's experience:

- Collaboration should be based on strengths and roles of each partner.

- Don't re-invent the wheel; see how collaboration can help with problems along the whole spectrum.
- Transformation comes from vision, not funding streams; focus first on what is needed, then on how to finance the solutions to the needs.
- Critical partners cannot be limited to public systems; help is needed from such sources as economists, health plans, and grant writers.
- A common table facilitates policy development and resource identification; in Minnesota, ABCD II helped set that table.
- Technology can expand access and cut costs, facilitating screening, co-location, and consultation.
- Outcome and evaluation data are critical in guiding system development, including financial and work flow analyses in health care systems.

Illinois Children's Mental Health Partnership (ICMHP)

ICMHP Chair Barbara Shaw explained that this partnership grew out of the recognition that mental health issues were real and prevalent among Illinois youth even in early childhood. Illinois responded by developing a task force comprised of organizations concerned with the mental health of children. A broad coalition of public and private partners, including family organizations, public health groups, mental health providers, pediatricians and family practice physicians, law enforcement, child advocates, professional associations, and others worked within the Task Force to address the mental health needs of children birth to age 18 from a promotion, prevention, early intervention, and treatment perspective.

The Task Force developed a comprehensive report on the state of child mental health, and suggested approaches for building a comprehensive children's mental health system in Illinois. The Task Force then moved on to developing legislation to reform the CMH infrastructure in the state. With the broad base of support cultivated by the Task Force, the legislation passed in 2003, formalizing the public-private ICMHP and mandating that the ICMHP develop and monitor the implementation of a comprehensive strategic state plan, which was submitted to Governor Blagojevich in June 2005. The legislation also included the creation of Social and Emotional Learning (SEL) Standards as part of the state's learning standards, and expanded pre-psychiatric hospitalization screening (SASS Program) for all Medicaid eligible children, in order to identify those who might benefit from community services in lieu of more costly hospitalizations. The state has achieved more than \$44 million in costs savings resulting from the expanded screening program.

ICMHP was successful in gaining \$5 million in the FY 07 budget during the last state legislative session. Funds will be used to support grants for schools to implement the SEL Standards and provide mental health supports for students, an anti-stigma campaign, an evidence-based practice initiative, pilot grants for development of transition programs for youth aging out of the child and adolescent mental health system and juveniles returning to the community from corrections facilities, and grants to pilot development of early intervention programs. ICMHP will advocate for additional funds in FY 08 and beyond to support the implementation of the strategic plan.

Ms. Shaw also shared some lessons learned, including:

- It is important to find funds (public and private) to support partnership efforts; coordinated, collaborative efforts need staffing and technical assistance to be successful.
- Part of Illinois' success was buy-in from different sectors; in Illinois' case, this partnership was the work of more than 200 people representing more than 100 different organizations and agencies.
- Some of the strongest leaders are from the early childhood community; they have been very important players, helping to spread understanding of the importance of focusing on early ages, an approach that is different from a traditional medical approach in that it is based on social and emotional development, mental health promotion, prevention, and early intervention.
- Consultation is an excellent approach to fill provider knowledge and capacity gaps in serving young children; health and mental health providers often are not trained or equipped to work with younger children and their families.
- Be prepared for challenges arising from concerns from some about public health approaches to mental health. Screening children can raise fears about over-identification, labeling, and over-medicating children. Care also has to be taken in discussing prevention, which some family groups have interpreted as placing blame.
- Having a Governor, such as Governor Blagojevich, who is early childhood and children's health oriented, provides important support.

□ □ □

REACTIONS AND CONTRIBUTIONS FROM KEY PARTNERS

Dr. Larke Huang, who is the Senior Advisor on Children in the Office of the Administrator, Substance Abuse and Mental Health Services Administration, discussed the President's New Freedom Commission on Mental Health, and its emphasis on early identification and screening for emotional and behavioral disorders in health settings, and on the need for a public health approach to mental health care.

Dr. Huang noted that primary care has been described as the “de facto mental health care delivery system,” and that barriers to improved physical-mental health services integration include communications, confidentiality, financial, and workforce issues. She touched on SAMHSA's strong commitment to interagency efforts, including the Federal National Partnership for Children's Mental Health involving multiple federal agencies and national organizations and the Federal Interagency Partnership for Mental Health Transformation.

Dr. Huang suggested that it is unlikely that substantial new funding will be infused into the systems that can address children's mental health needs. Therefore, agencies need to reconfigure partnerships and use funds in different ways. She recognized that there are states that have the resources and the political will to build comprehensive state mental health systems and emphasized the need for an integrated health and mental health focus for children – extending from promotion of health and mental health to prevention, early identification, and treatment.

Dr. Trina Anglin, director of the Office of Adolescent Health in the Maternal and Child Health Bureau, shared information on a range of mental health related activities underway at MCHB and through the programs it funds. She observed that state Title V MCH/CSHCN programs are clearly focusing on mental health, as demonstrated by a search of the Title V information system. As part of 2005 comprehensive needs assessments, 48 states and territories identified a total of 103 priority needs relevant to mental health. They covered a wide range of issues, including healthy development and the healthy functioning of families, mental health promotion, capacity and infrastructure building, depression, adolescent suicide, child abuse and neglect, substance abuse, interpersonal violence, early identification, and access to mental health services.

Additionally, between 2000 and 2005, there was a substantial increase in the number of state Title V programs with performance measures relevant to mental health. In 2000, 24 states had at least one mental health related performance measure; the number increased by 50% to a total of 36 states in 2005. The total number of mental health related performance measures increased by 90% across this time period, from 30 in 2000 to 57 in 2005. In addition, there were changes in the content. Performance measures in 2005 were more likely to address general mental health status and depression than possible causes of mental disorders, such as exposure to violence. In addition, in 2005, more states focused on healthy development, including transition to adulthood for youth with special health care needs, and more states addressed capacity building in mental health.

Dr. Anglin also reviewed a number of specific MCHB mental health related initiatives at the federal level. These include a technical assistance effort on EPSDT which has a web-based module on mental health under development; Healthy Start supported consumer materials and

special grants to address maternal and infant mental health; the Early Childhood Comprehensive Systems (ECCS) grant program to support states' interagency collaboration for young children around five components, one of which is mental health and social-emotional development; the State Agency Partnerships for Promoting Child and Adolescent Mental Health Program; the Integrated Health and Behavioral Health Care for Children, Adolescents and their Families Program; and a number of initiatives underway in collaboration with SAMHSA to improve integration of children's mental health with primary care provided through the medical home.

Dr. Penny Knapp, a member of the American Academy of Pediatrics' Task Force on Mental Health, spoke of the need to update tools for the primary care system to promote appropriate provision of mental health related services. Pediatric primary care providers are ideally positioned to recognize risks for developmental and social-emotional problems, and to identify emerging mental health disorders. Currently, most pediatricians are limited in their ability to address children's mental health needs by (1) inadequate mechanisms for reimbursement for mental health services, (2) unfamiliarity with the evidence base for pediatric psychopharmacological, non-pharmacological, and alternative treatments, (3) lack of information about or access to referral services, and (4) wide variance in training, comfort, and experience with behavioral health issues.

Without sufficient information or preparation, it is also difficult for pediatric primary care providers to work with parents who may have mental health issues themselves, or to equip parents with helpful information on parenting skills or techniques for helping their children. Families are facing increasing stressors – from poverty and also potentially from disaster. System tools and supports must address realities of pediatric practice, particularly time constraints. Effective systems need to provide early recognition, timely referrals, and also address special population group needs, such as children in foster care and adolescents in the juvenile justice system.

Sandra Spencer, executive director of the Federation of Families for Children's Mental Health, commented from a family viewpoint. For parents and families, there often is a large disconnect between primary care and mental health services, with parents caught in the middle. Stigma is a major concern for families; there is a need to normalize mental health services. Ms. Spencer suggested that pediatricians should be discussing mental health, and obstetricians need to address postpartum depression and its effects on families. She noted that good case management is often a key missing piece in the system; it is critical for the pediatrician to talk to the psychiatrist. Other observations offered by Ms. Spencer included:

- Parents often know first that their child has a mental health problem, but it can take years before the service system correctly diagnoses it. During that time, attention often is shifted to the families. Once the child presents in school, the teacher refers back to the mental health system and then the *child's* needs finally gets addressed.
- Parenting education often is not helpful in addressing children's specific mental health issues.
- Language and terminology used in mental health and public health are very important to families. When talking about children, resilience is a more appropriate concept than

recovery. Prevention can have negative associations for families as it is associated with blame.

- Screening in schools produces an over-representation of children of color. There is a need to examine whether screening tools are culturally appropriate for diverse family structures.
- Systems to address children’s mental health needs should include advocacy, training, and social support for families.
- Attention to the whole family is important: for example, siblings are often affected by the initial symptomatic child – the current structure is not holistic.
- Community-based approaches that include important community resources, such as faith-based institutions, are essential in building stronger systems to meet child and family needs.

□ □ □

DISCUSSION

The meeting presentations were interspersed and followed with rich discussions, comments, and questions. These both reinforced and surfaced a number of themes that then guided development of a potential pathway toward addressing needed improvements in systems to better meet the mental health needs of children, adolescents, and families. Brief summaries of key discussion themes follow.

While there are commonalities in public health and mental health system approaches, there are also important conceptual, definitional, and language differences and sensitivities.

The discussion elaborated on some differences identified by presenters in how families, providers and agencies understand and use ideas and terms related to the mental health of children and youth. Terms used in MCH, primary care, and mental health can have different connotations, and sometimes different meanings altogether, for those outside each of these fields, as well as for families.

As noted by a number of presenters, for many families, prevention is associated with approaches that blame families for their children's mental health problems. Promotion, prevention, and early intervention also are defined differently by different fields and disciplines; what is prevention to one may be early intervention to another. Promotion might be viewed as "pre-primary" in the health model of primary, secondary, and tertiary prevention. Susan Keys with SAMHSA discussed promotion as a universal approach to promoting positive mental health and development, and prevention as recognizing who may be at risk and building resilience.

Resilience and recovery are terms and concepts used extensively in the mental health field, and a focus on resilience has been growing in the MCH field. Families and child mental health agencies have recognized that the concept of recovery is less relevant to children than that of resilience. Glenace Edwall noted that state CMH directors have found resilience to be a term that bridges promotion and prevention concepts.

Medical model and medical home both also received attention in the discussion. The mental health field is working to move away from a medical model in its approach. The early childhood field also was noted to be employing a non-medical approach. Medical home as a term suggested to some grounding in a medical model approach, and some asked why the concept was not that of a "health home." Parents may perceive the medical home to be an out-of-home placement, and associate it with punitive child welfare actions. MCH and pediatric representatives explained that the medical home is intended to be the focal point for continuous health care, where, in the case of the pediatric medical home, the pediatrician or family doctor, specialists, case manager, parents, and others, coordinate their efforts to provide safe and effective care for the child.

Screening came up repeatedly. It was identified both as an important service and tool, and as a method with which some families and communities have significant reservations. As noted earlier, school screenings can result in overrepresentation of children of color. It was suggested

that assessment might be a less laden term and approach, especially if the assessment includes areas of resilience and strength, as well as risks or problems.

Other areas were identified where terms are different, but where it is not clear if those differences actually reflect different approaches. Examples here include “child-centered,” “family-centered,” “family-focused,” and “family- driven.”

There are bridges that can span systems

While using different language, all participants in the meeting emphasized areas for building common ground. Given the importance accorded to families in MCH and CMH systems, families can be a pivotal force for driving agency actions to make better system connections. Participants also agreed that intervening with children and youth alone would not achieve our mental health goals for children. Family and community are critically important, and agencies can come together in attending to supports for them.

Other bridging mechanisms identified were methods to improve services and systems that inherently require cross-agency action. These include training, consultation, and common tools, such as for screening.

Participants identified a number of significant barriers in developing improved systems

In the meeting discussion, a number of barriers and problems in developing better systems were identified. These included:

- State agency and local delivery system structures. The ways in which public health, medical, mental health, and other services are organized and delivered at the community level, and supported and overseen at the state level, can affect the ease or difficulty of coordinating or integrating services. Participants cited challenges in integrating services in states with behavioral carve-outs from managed care plans. In other states, reliance on community mental health centers made connections with public health and primary care challenging.
- Lack of services. The lack of services across the continuum – from health promotion through treatment – is a major concern and underscores needs for interagency collaboration to better coordinate and develop resources.
- Workforce. Insufficient numbers of skilled mental health professionals and competencies in mental health for other providers remain a major problem in building better systems for child mental health.
- Funding. While inadequate funding was raised in the discussion, there also was emphasis on the need to better use existing resources that flow from multiple funding streams.

Participants also identified key elements needed to improve systems

Meeting discussions yielded the following key ingredients to success in improving systems:

- Leadership and champions. Visible and active leaders and champions are needed at national, state, and community levels to advance the agenda of improving systems for promotion, prevention, early intervention, and care.
- Agency relationships. Communication and working relationships between agencies are critical to systems improvements. Agency structures can be barriers or facilitators to such relationships; personal relationships can have impact regardless of structures.
- Grassroots engagement and advocacy. While state and federal policy and program development and coordination are important, change requires bottom-up action as well.
- Public-private partnerships. States that are leading the way in developing comprehensive systems have engaged the private sector.
- Innovation, spread, and sustainability. There is a clear need for innovation in developing additional models for meeting child and adolescent mental health needs. Equally important is the need to spread and sustain successful models.
- Measurement and quality improvement. While the state of the art and practice of child health quality measurement is not well developed, participants agreed it is very important to build into systems the capability to measure and take steps to improve quality and performance in child and adolescent mental health.

□ □ □

MOVING AHEAD ON A PATHWAY TO BETTER SYSTEMS FOR CHILD AND ADOLESCENT MENTAL HEALTH

Participants considered a number of frameworks that have been developed to outline key components and interactions of comprehensive systems for child mental health. Two of these – Framework for a Coordinated Mental Health System in Illinois for Children Ages 0-18, and Interconnected Systems for Meeting the Needs of All Children – are shown as Figures 2 and 3, respectively. While participants agreed that the one day meeting did not afford sufficient time to begin working together on common models for systems development across MCH and CMH, they did agree on the key elements that should be addressed in developing better integrated systems. Together, these elements form a logical pathway or a theory of change for continued work together and with other partners to build the continuum from promotion to prevention. This pathway could form the basis for operationalizing a more specific “road map” for state MCH and CMH programs as was envisioned by the meeting sponsors. The key elements of this pathway are:

Develop a common vision

Participants saw this as a logical basis for further work together, particularly for the promotion and prevention end of the continuum of services which has received less attention. This vision might address:

- a universal approach for achieving good mental health for all children and adolescents,
- mental health as an integral part of children’s health and health care,
- social and emotional health and development, possibly as preferred terms over mental health, and
- values and principles, particularly in regard to families’ roles.

Work on common language and definitions sensitive to family/community perceptions

Key concepts and terms that can be reviewed and discussed to arrive at a more common vocabulary that unites rather than divides stakeholders include:

- promotion,
- prevention,
- family-centered and family-driven, and
- resilience.

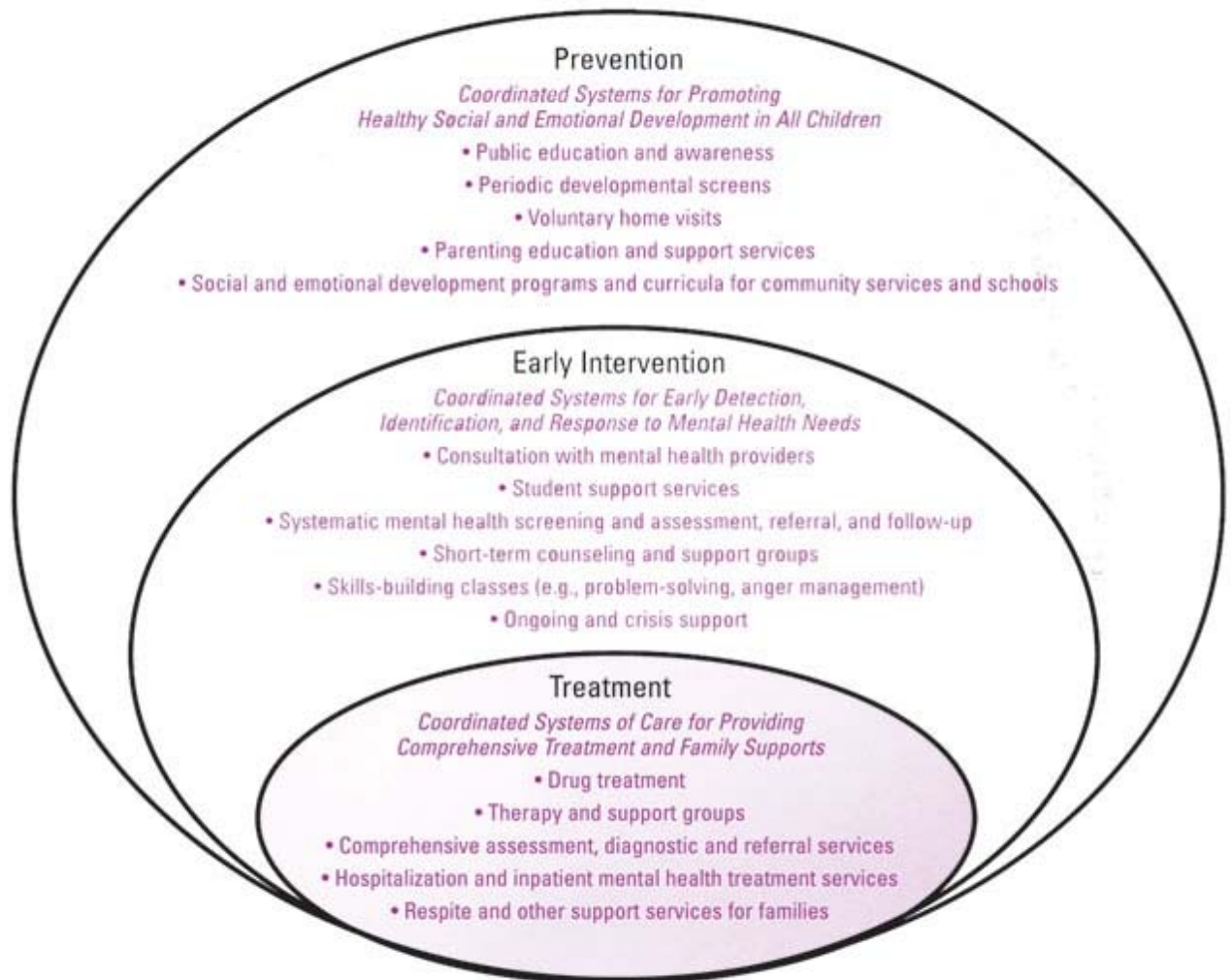
Develop strategies to build systems infrastructure

Federal-state strategies should build on federal initiatives underway and on models under development in states to address system barriers. Strategies should address:

- leadership development and support,
- workforce,

Figure 2 Frame Work for a Coordinated Mental Health System for Children

**FRAME WORK FOR A COORDINATED MENTAL HEALTH SYSTEM*
IN ILLINOIS FOR CHILDREN AGES 0-18**

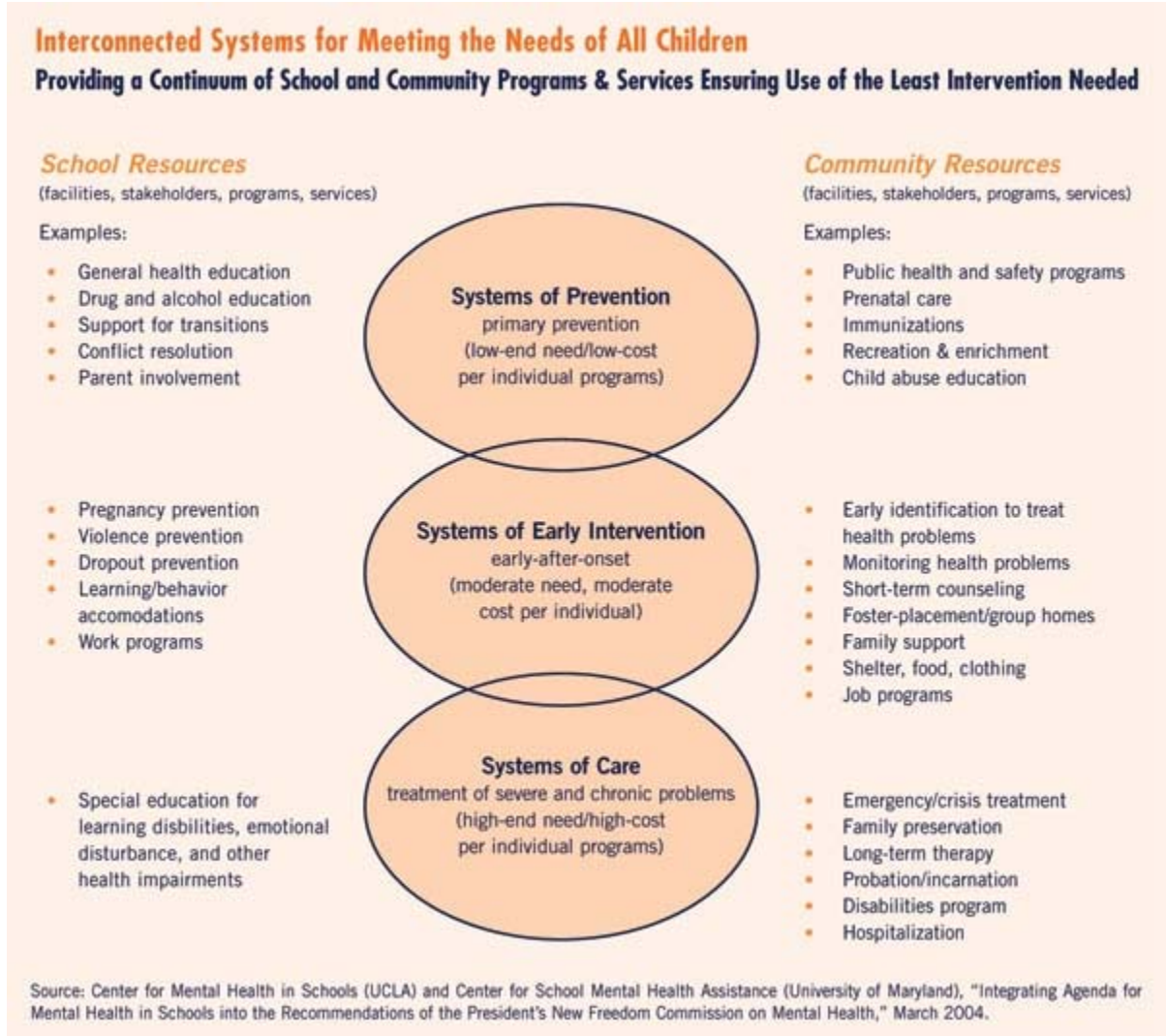


*These systems include early childhood, education, mental health, juvenile justice, health, human services, substance abuse, violence prevention, corrections, and other relevant systems.

Adapted from: Minnesota Children's Mental Health Task Force, *Minnesota Framework for a Coordinated System to Promote Mental Health in Minnesota*; Center for Mental Health in Schools, *Interconnected Systems for Meeting the Needs of All Youngsters*.

Source: *Children's Mental Health: An Urgent Priority for Illinois*. Final report of the Illinois Children's Mental Health Task Force, April 2003.

Figure 3 Interconnected Systems for Meeting the Needs of All Children



- data and measurement,
- quality improvement,
- innovation and spread of innovation,
- sustainability of model programs and systems, and
- organizational relationships.

Build on systems that serve children and youth

Developing the continuum of services to meet child and adolescent mental health needs, including the promotion and prevention end, requires integrating this focus within the multiple systems that see children. These include:

- primary care/health/medical homes,
- child care/early childhood programs,
- schools,
- child/youth serving public systems, including foster care, child welfare, juvenile justice, and
- private and community based programs and resources.

Develop and promote common tools for building infrastructure that can bring multiple systems together

These bridging strategies include:

- training,
- developing competencies,
- consultation models, including:
 - consultation for primary care providers on child/adolescent mental health,
 - consultation for child/adolescent serving agencies on mental health,
 - consultation to mental health agencies on serving children and adolescents, and
- screening and assessment tools

Develop strategies to address resource needs, including making more effective use of existing resources

Participants acknowledged that substantial infusions of new funding at the federal level and in many states will be difficult to achieve. While additional resources are needed, participants felt that improved collaboration could yield strategies to make wiser use of current resources.

□ □ □

NEXT STEPS

As meeting participants considered how to begin to move forward on the pathway, a number of ideas were generated. There were suggestions to: compile information about and describe models and best practices; develop a shared MCH-CMH action agenda on promotion and prevention; and conduct a survey of state programs to learn more about current activities and collaboration.

Participants suggested that moving forward could be pursued through multiple follow-up conversations. A focus on promotion and prevention could take a developmental approach and engage the education community. There also could be a focus on coordination and integration of mental health systems of care for emotionally disturbed children and systems for children with special health care needs.

Meeting participants also agreed that other key stakeholders need to be engaged. In addition to education, public and private health care purchasers and insurers, especially Medicaid and the State Children's Health Insurance Program (SCHIP) were seen to be critical. A focus on young children requires involvement of the early childhood community; a focus on adolescents requires another set of stakeholders.

The meeting concluded with commitments to a set of specific action steps to build on the meeting discussions and begin to move forward on the pathway to improved systems for child and adolescent mental health. These steps included:

1. NASHP will draft the summary brief of the meeting;
2. AMCHP will share the draft paper, discuss the meeting results, and obtain feedback at a follow-up meeting open to all AMCHP members on October 19, 2006.
3. NASHP and AMCHP will share the draft paper with meeting participants and request feedback from them and from key constituencies, including the Board of Directors and the Children, Youth and Families division (DCYF) of the National Association of State Mental Health Program Directors (NASMHPD).
4. AMCHP will disseminate the final summary meeting brief to key stakeholders in child and adolescent mental health and maternal and child health.
5. AMCHP will work with NASMHPD/DCYF to promote communications among state MCH and CMH programs, such as including representatives from the other programs in relevant organizational task forces and committees (such as DCYF's early childhood task force calls) and inviting presentations from the other programs at relevant conferences.
6. Federal partners at SAMHSA and HRSA/MCHB will identify opportunities to engage state MCH, CMH, and NASHP representatives in relevant federal initiatives.
7. Federal partners at SAMHSA and HRSA/MCHB will review their respective system development and coordination grants to identify ways to promote and support connections between state SAMHSA and HRSA systems grantees.
8. MCHB will co-host with SAMHSA a meeting on coordinating child mental health systems of care and CSHCN systems.

9. AMCHP, NASHP and other interested participant organizations will seek partners, such as foundations, to support follow-up work focusing on systems for promotion.

As of the publication of this meeting summary, a number of these steps have been accomplished. A draft of this summary was shared with approximately 60 participants at the October 19 meeting convened by AMCHP for its members to discuss the issues and ideas identified in August. Discussions at this October AMCHP meeting reinforced points made in the initial meeting and this summary. Additionally, October meeting discussion groups were able to build on the initial meeting's foundation to identify more specific and additional aspects of issues and ideas to improve systems for child and adolescent mental health.

Important follow-up action also occurred in the months between the August and October meetings. Federal MCHB and SAMHSA representatives reported that they had met together and would continue to meet to address the issues and ideas identified in August. Federal representatives indicated their commitment to support further opportunities for MCH-CMH communication and collaboration, and also encouraged AMCHP to engage in existing national mental health partnership vehicles.

□ □ □

CONCLUSION

Discussions at the August 15 AMCHP-NASHP meeting, similar to conversations that have occurred within some states and among some partners, reinforced that collaboration in developing, coordinating, and integrating systems for meeting the mental health needs of children and adolescents can result in stronger systems and better outcomes for children, youth, and families.

The meeting was an opportunity for the state and federal agencies with mandates and missions to address the comprehensive health needs of children and youth to engage in conversation with each other and with other key health maternal and child health and mental health system stakeholders to identify issues and generate ideas for pursuing shared goals. The meeting achieved its objectives of initiating discussions; fostering mutual learning about respective system approaches; identifying and exploring commonalities and differences; generating ideas for moving toward a more coordinated approach; and suggesting next steps that AMCHP, NASHP, and other participants can take to follow-up.

□ □ □

Participant List

Association of Maternal and Child Health Programs (AMCHP)/
National Academy for State Health Policy (NASHP)
Meeting on Systems for Child and Adolescent Mental Health

Trina Anglin
Chief, Office of Adolescent Health
Maternal and Child Health Bureau, HRSA

Mark Beck-Heyman
SAMHSA Intern

Glenace Edwall (via phone)
Director
Children's Mental Health Division
Minnesota Department of Human Services

Bill Emmet
Project Director
National Association of State Mental Health
Program Directors

Catherine Hess
Senior Program Director
NASHP

William Hollinshead
AMCHP Board of Directors,
Medical Director, Division of Family Health,
Rhode Island Department of Health

Larke Huang
Senior Advisor on Children,
Office of the Administrator, SAMHSA

Annette James
Research Assistant,
NASHP

Kathy Katz
American Psychological Association
Director of Perinatal Behavioral Research
Georgetown University Medical Center

Neva Kaye
Senior Program Director, NASHP

Susan Keys
Chief,
Prevention Initiatives and Priority Programs
Development Branch,
Center for Mental Health Services, SAMHSA

Penny Knapp
AAP Task Force on Mental Health,
Medical Director,
California Department of Mental Health

Christopher Kus
NASHP Steering Committee on Health System
Performance and Public Health,
Pediatric Director
New York State Department of Health

Jeffrey Lobas
AMCHP President,
University of Iowa Child Health Specialty
Clinics

Lee Partridge
Health Policy Advisor
National Partnership for Women and Families

Kathy Peppe
Acting Chief Program and Policy Officer,
AMCHP

Roy Praschil
Director of Operations
National Association of State Mental Health
Program Directors

Lauren Ramos
Principal Director, Public Health Prevention and
Promotion Programs
Association of State and Territorial Health
Officials

Barbara Shaw
Chair
Illinois Children's Mental Health Partnership

Patty Snodgrass
Director
West Virginia Adolescent Health

Sandra Spencer
Executive Director
Federation of Families for Children's Mental
Health


Nan Streeter
AMCHP President-elect,
Bureau Director
Utah Department of Health

Bonnie Strickland
Acting Director, DSCSHN
Maternal and Child Health Bureau, HRSA


Peter Sybinsky
Chief Executive Officer
AMCHP

Uchenna Ukaegbu
Presidential Management Fellow
NASHP

□ □ □



National Academy for State Health Policy
Portland, Maine and Washington, D.C.
www.nashp.org



Association of Maternal and Child Health Programs
Washington, D.C.
www.amchp.org