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NAMI Beginnings

National Alliance on Mental Illness

A Publication Dedicated to the Young Minds of America from the NAMI Child & Adolescent Action Center

Promoting Evidence-Based Practices

Ask the Doctor: Behavior Therapy for ADHD

NAMI Beginnings
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NAMI is a grassroots, family and consumer, self-help, support, education, and advocacy organization dedicated to improving the lives of children and adults living with severe mental illnesses. Severe mental illnesses are biologically based brain disorders that can profoundly disrupt a person's ability to think, feel, and relate to their environment and others.

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POLICY ALERTS

Capitol Hill and State House Watch

by Darcy Gruttadaro, J.D., Director, NAMI Child & Adolescent Action Center

NAMI Supports Federal Legislation Focused on Children

The 1st Session of the 110th Congress is likely drawing to a close. There were a number of bills introduced and carried over that are designed to improve the lives of children and adolescents living with mental illnesses.

The Keeping Families Together Act (S. 382/H.R. 687) is one of those bills. It is designed to help end the unthinkable practice of forcing families to relinquish custody of their child for the sole purpose of accessing mental health services. This practice of custody relinquishment is also likely to be addressed in a bill to reauthorize the Substance Abuse Mental Health Services Administration (SAMHSA).

NAMI continues to support *The Health Care Crisis Relief Act* (S. 1572/H.R. 2073), legislation targeted at addressing the national workforce shortage of child mental health providers. This shortage is a major barrier to many families accessing mental health services for their child. It is not uncommon for families to be told that they must wait up to six months for an initial appointment or travel hours from their home to see a child mental health professional. This presents a tremendous hardship for children and their families.

This year the House and Senate have focused on mental health in our nation's schools. *The Positive Behavior for Effective Schools Act* (S. 2111/H.R. 3407) was introduced. This bill would make it easier for schools to use federal funding to implement school-wide positive behavioral interventions and supports (PBIS) that promise to create a more positive school environment and help identify students who may be struggling with mental health related concerns. (To learn more about PBIS, visit www.pbis.org).

Also on the school front, NAMI is working with a coalition of national disability rights' groups to call for federal legislation to prohibit the inappropriate use of restraint and seclusion in our nation's schools. We are also closely following draft legislation and discussions on the reauthorization of the *No Child Left Behind* law to help ensure that schools are held accountable for the academic and functional achievement of students with disabilities, including those with mental illnesses.

This year also saw the introduction of the *Mental Health in Schools Act of 2007* (S. 1332/H.R. 3430). This bill expands the availability of comprehensive school-based mental health services for students in communities across America.

You can learn more about these bills by visiting the Library of Congress "Thomas" website at thomas.loc.gov. The bill number, included above for each piece of legislation (Senate bills are designated as "S" and House bills are designated as "H.R."), allows you to easily find the bill, the co-sponsors, action taken on the bill, and its current status.

State House Activity

NAMI continues to work with a small group of national organizations focused on children's mental health. Our group was formed largely in response to anti-psychiatry activity targeting state legislators. NAMI chairs the work group, which consists of the following national organizations: the American Academy of Child & Adolescent Psychiatry (AACAP), American School Counselor Association (ASCA),

Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD), the Child and Adolescent Bipolar Foundation (CABF), the Federation of Families for Children's Mental Health (FFCMH), and Mental Health America (MHA - formerly the National Mental Health Association).

We received reports from advocacy leaders and members of our respective organizations about anti-psychiatry information being shared with state legislators. In response, our work group developed a state advocacy toolkit to share with grassroots leaders affiliated with our organizations that includes jointly endorsed resources and information to distribute to state lawmakers. This information includes a series of fact sheets, sample letters, anti-psychiatry legislation introduced in previous legislative sessions, and more.

The toolkit is near completion and will be posted on the respective web sites of each of our national organizations, making it easy for NAMI leaders, members, families, and friends to download. Please look for the toolkit on the Child & Adolescent Action Center section of the NAMI website at www.nami.org/CAAC.

Anti-psychiatry groups remain active in contacting state and federal lawmakers with false information about children's mental health. We need your help in making sure that materials in the toolkit get into the hands of state legislators and policymakers. Together we will make a positive difference in the lives of children and adolescents living with mental illnesses and their families.

The Implementation of Evidence-Based Practices

by Patrick Kanary, M.Ed., Director, Center for Innovative Practices, Ohio and Kelly Feller, M.S.W, Director, Utah Behavioral Health Center of Excellence

Incorporating evidence-based practices and best practices into systems of care highlights the need to merge quality outcome-based services with effective and efficient systems. Evidence-based practices and effective systems of care are two parts of the whole picture and create a natural and synergistic relationship. Both possess components that produce a more clinically, systemically, and fiscally responsive mental health care system.

Implementation Challenges

For effective implementation of evidence-based practices (EBPs) in systems of care to occur, there are a few key focus areas to consider. These implementation challenges relate to organizational, clinical, and practice level changes that must be made to make EBPs more broadly available. These challenges also include financial, systemic, and policy issues.

Organizational/Clinical/Practice Level. Despite the growing attention to EBPs, the reality is that an extremely small percentage of youth and families have access to evidence-based interventions. These interventions tend to be the exception and are often considered as "pilot" projects, rather than integral parts of the system of care.

There are many reasons why EBPs are not more widely available for children, adolescents, and their families. Here are several of the factors that impact the availability of EBPs:

- Sufficient qualified workforce and system capacity to deliver EBPs;
- Lack of incentives or support to change current practices;
- There is a tremendous amount of resource investment and reinvestment required for significant change in moving to a system that primarily provides EBPs and best practices;
- There are significant organizational changes required in financing and funding EBPs and best practices;
- There may be concerns with the effectiveness of certain EBPs in culturally and racially diverse communities; and
- EBPs may or may not be acceptable to families.

Financial/Funding.
Asking funders to significantly shift and reinvest dollars into EBPs requires that the funders be provided with the tools necessary to understand how to reinvest those dollars. Progress is often inhibited by communities and states struggling with how to design effective financing strategies that match their desired outcomes. For example, if stakeholders decide that their goal is to keep youth and families together and reduce out-of-home placements, then they must work to create financing strategies and procedures that provide funding for the development and availability of more home and community-based services to reach their goals.

Systemic/Policy.
The most significant challenge in more broadly implementing EBPs is the need to "prepare the field" for EBP selection and implementation. Simply dropping evidence-based practices into an existing system will not work or — at the

very least — will not allow for smooth systems' development. A thoughtful planning process is critical in creating a sustainable environment for the acceptance and growth of EBPs. Consideration must be given to the culture of the system and how it functions, its primary consumers, and the context in which services are provided. The reference to "evidence-based practices" can be confusing. Consequently, clearer statements such as "outcome- based interventions" and "data-driven systems of care" may be more useful to help everyone understand what is being considered. Finally, creating an environment conducive to change requires the alignment of federal, state, and local policies that support systems of care and evidence-based practices development.

Successful Strategies/Lessons Learned

Implementation of strong systems of care has taught us that the alignment of policies, procedures, fiscal strategies, and clinical interventions is the key to successful outcomes with systems' stakeholders, including children and families, providers, funders, and policy makers. The process and the lessons involved in moving systems of care to include more evidence-based practices is complex. It is important to recognize that a cookie-cutter approach will not work; rather individualized strategic planning for EBPs must take place to achieve effective implementation that works for the state and local communities. Whatever steps are taken toward the broader dissemination of EBPs, they must be framed within the strengths, assets, risks, and opportunities of that state and local community. While each state and local community will face unique issues, the following general strategies and lessons learned are likely applicable:

Organizational, Clinical, and Practice Levels

- Focus on EBPs that address youth and family strengths and include diverse family voices;
- Identify specific practices, whether evidence-based or promising, as preferred treatment interventions for specific behavioral health conditions;
- Increase education, training, and provider expectation to focus more on outcome-based treatments;
- Devote sufficient preparation and technical assistance related to the EBP requirements, such as workforce skills and adequate financing, so that the opportunity for successful implementation will be maximized;
- Attend to the organizational, systemic, and clinical aspects of the EBPs and the factors that must be adopted to effectively implement the EBPs;
- Seek EBPs with structured training, coaching, and fidelity protocols;
- Ensure that providers receive ongoing coaching and consultation to maintain fidelity to the EBP and to stay true to the EBP intervention; and
- Track fidelity to ensure that EBPs are being implemented appropriately.

Financing/Funding

- Thoroughly understand the federal, state, and local financing strategies that may or may not support the specific EBP under consideration;
- Create incentives for more integrated and consolidated resource management and family-based care, which may include federal Medicaid waivers that allow for funding based on needs and outcomes;
- Provide financial technical assistance to create and implement sustainable funding strategies;
- Effectively use federal Medicaid waivers and state funding options, including braided and blended funding from multiple child-serving agencies (mental health, child welfare, juvenile justice), to create funding streams that focus on individualized needs regardless of "systems" identification; and
- Promote collaboration, pooling of resources, and shared risk taking across child-serving systems to include child welfare, mental health, juvenile justice, and education.

Systemic/Policy

- Create shared screening, assessment, and gate keeping practices at all critical entry points for children and adolescents with mental health treatment needs to promote early identification and intervention;
- Drive EBP practice selection through a local planning process that includes key stakeholders (parents/families/youth, providers, funders, representatives from child-serving systems, and other appropriate public-private partners) that determines the needs of the community, based on a comprehensive community assessment of assets, risks, and protective factors;
- Provide both general and specific education on what evidence-based practices are and are not;
- Establish outcomes that are desirable to multiple stakeholders, including parents/families/youth, funders, policy makers, public systems, and other key stakeholders;
- Conduct outreach, engagement, and inclusion of families as "system partners" in all phases of systems reform and EBP implementation;
- Identify state and local leaders who will be EBP champions and advocates;
- Promote EBPs that will meet the greatest need for the community and will produce the best shared outcomes across child-serving systems;
- Build early success, celebrate it, and encourage it to lead to broader systemic reform; and
- Create a community of culture around the need to continue to track and improve service outcomes.

Keys to Success

Many of the "successful strategies" and "lessons learned" presented in this article will help states and communities as they work to make evidence-based practices in children's mental health more widely available. It is important to simultaneously focus on the practice, financing, policy, and systemic levels in order to build a sustainable plan for incorporating evidence-based practices into systems' reform. Ultimately, identifying and harnessing all federal, state, and local resources and expanding on and adapting existing proven strategies to specific community needs and cultures is paramount to achieving EBP implementation success.

Medicaid Coverage of Multisystemic Therapy

By Cathy Surace, Managing Attorney, Maryland Disability Law Center

Introduction

Medicaid funding has emerged as an important factor in the growth of Multisystemic Therapy (MST) programs nationally. MST is a highly touted evidence-based practice for delinquent youth and Medicaid funding is playing a critical role in its financial sustainability in approximately half of the 32 states that currently have licensed MST programs.[i] While advocacy is recommended to ensure MST, as well as other evidence-based practices, are included in a state's Medicaid service array, Medicaid should not be viewed as a "silver bullet" that will cover the full cost of providing MST services for youth. Based on the experience of many states and localities, additional funding streams are necessary to fully support a state's MST program. Given the proven cost effectiveness of MST, state legislators and officials presented with the facts should be willing to appropriate funds and develop programs to support this evidence-based practice that helps children and their families and produces cost-savings to taxpayers on the order of five dollars for every one dollar invested.[ii]

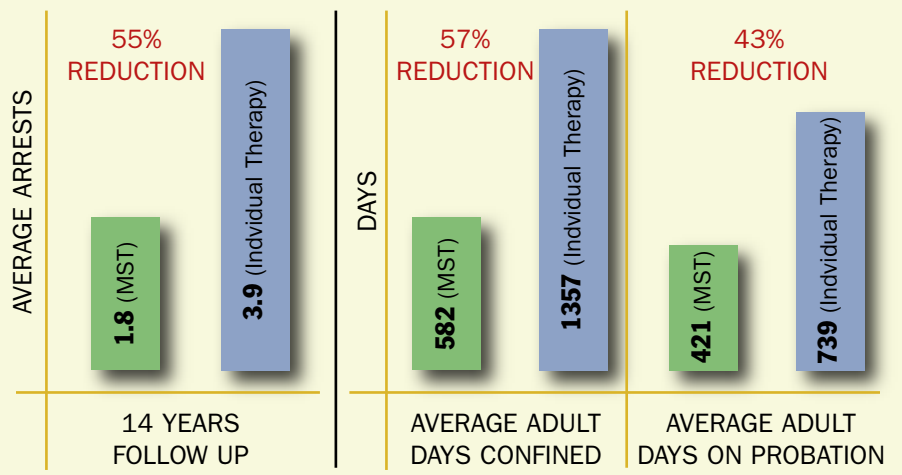
Background on MST and Medicaid

Multisystemic Therapy (MST) is an intensive family and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders across the key settings, or systems, within which youth are embedded (e.g., family, peers, school, neighborhood). MST strives to promote behavior change in the youth's natural environment, using the strengths of each system to facilitate change.[iii]

Scientific evidence shows that juvenile offenders treated with MST or with one of two other evidence-based practices, Functional Family Therapy (FFT) and Multidimensional Treatment Foster Care (MTFC), will be re-arrested less frequently and have improved family functioning and school performance, and decreased substance abuse, psychiatric symptoms, and rates of out-of-home placement.[iv] The benefits of MST last into adulthood. As depicted below in Figure 1, a 14-year follow-up study comparing youth who received MST with youth who received individual therapy has documented a 55% reduction in re-arrest rates and a 57% decrease in the number of days confined.[v]

The United States Department of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Blueprints for Violence Prevention Initiative, and the United States Surgeon General, are among the many entities that have placed MST, FFT and MTFC at the top of their list of model evidence-based programs for youth with delinquent behavior, a high percentage of whom have mental illness.[vi] Approximately 20% to 25% of delinquent youth have serious mental health disorders and up to 70% have a diagnosable mental illness.[vii]

Figure1: MST and Individual Therapy Outcomes at 14-Years Post-treatment



[i] A list of the states with licensed MST programs is available at http://www.mstservices.com/licensed_providers.php.

[ii] Aos, S., Miller, M., & Drake, E., (2006 October), *Cost Effectiveness of Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates,* Washington State Institute on Public Policy (#06-10-1201) at http://www.wsipp.wa.gov/pub.asp?docid=06-10-1201.

[iii] For more information about MST, see website of MST, Inc. at www.mstservices.com and NAMI Beginnings, Fall 2003, Issue 3 at http://www.nami.org/Template.cfm?Section=Child_and_Adolescent_Action_Center&Template=/ContentManagement/ContentDisplay.cfm&ContentID=12717.

[iv] Key Issues, National Center for Mental Health and Juvenile Justice, Key Issue 5 at http://www.ncmhjj.com/faqs/default.asp, relying on Elliott, D. (Ed.) (1998-2002) Blueprints for Violence Prevention Series (Vols. 1-12). Boulder, CO : Center for the Study and Prevention of Violence.

[v] Schaeffer, C. M., & Borduin, C. M. (2005). *Long-Term Follow-Up to a Randomized Clinical Trial of Multisystemic Therapy With Serious and Violent Juvenile Offenders,* Journal of Consulting and Clinical Psychology, 73(3), 445-453. The researchers in this study successfully located 94% of the original participants.

[vi] *Turning Knowledge Into Practice, A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practice,* The Technical Assistance Collaborative, Fall 2003, at 49; Office of Juvenile Justice and Delinquency Prevention, http://ojjdp.ncjrs.org/; http://www.colorado.edu/cspv/blueprints/; Youth Violence: A Report of the Surgeon General, U. S. Department of Health and Human Services, 2001, hereinafter cited as "Youth Violence: A Report of the Surgeon General" at http://www.surgeongeneral.gov/library/youthviolence/.

Under the federal Medicaid program, states are able to recoup from 50% to 83% of billable costs, depending on the state's average per capita income, for providing any health care service that is included in the State Medicaid Plan.[viii] Given this strong fiscal incentive to states, it is not surprising that Medicaid now funds more than half of public mental health system services and is estimated to account for two-thirds of such spending by 2017.[ix] The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid Program, will approve the inclusion of a health care service in a State Medicaid Plan if CMS determines that the service is covered by the federal Medicaid Act. CMS has already determined MST is a covered Medicaid service because the agency has approved at least one State Plan Amendment to add MST as a covered service in North Carolina. In 2003, CMS also created a billing code, H2033 for MST under the Healthcare Common Procedure Coding System (referred to as HCPCS).

Under the Medicaid Act's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate, Medicaid recipients under 21 have a legal right to access any medically necessary healthcare service that *could* be covered by the Medicaid Program. Since CMS has determined MST is a covered service, states not providing MST services under Medicaid are vulnerable to a legal challenge.[x]

It is difficult to pinpoint exactly how many states are billing MST to Medicaid because states are billing MST under other broader Medicaid service and billing categories rather than using the MST HCPCS billing code that would require them to add MST by name as a service in the State Medicaid Plan.[xi] Officials and providers in 18 states plus the District of Columbia have reported billing Medicaid.[xii] Of the 18 states, one state, Alabama, is not using licensed MST providers and it's "MST-lite" or MST-like programs may not yield the same positive outcomes for youth and their families.[xiii] CMS itself, along with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the President's New Freedom Commission on Mental Health, have encouraged states to use Medicaid, where possible, to fund evidence-based practices that they have recognized most individuals with mental illness could not access.[xiv]

Cost and Effectiveness Comparisons

Many state juvenile justice agencies and courts currently rely on costly secure residential placements, such as detention centers, that are not Medicaid reimbursable for juvenile offenders, even though many of these youth could be diverted and returned home safely with MST or FFT, or under other programs, at a fraction of the cost. For example, in Maryland where the cost of MST has ranged from $5,000 to 8,000 per child or approximately $40 to $44 per day for a 4 to 6 month course of treatment, only a few, small MST programs exist.[xv] Instead Maryland, on an average day, placed 253 children in detention centers at a cost of approximately $328 per day and 1494 children in other residential settings that range in cost up to $582 per day for children placed in psychiatric residential treatment centers.[xvi] The proposed spending on detention and deep-end residential placements in Maryland accounted for almost 60% of the Maryland Department of Juvenile Services budget in fiscal year 2005.[xvii]

This huge expense is not justifiable given the fact that these costly placements, unlike MST and other evidence-based practices, do not result in positive outcomes for youth. Recidivism rates in Maryland for youth released from these placements are high and reflect that 67 % will be re-arrested within 2 years and 75 % will be re-arrested within 3 years.[xviii] In contrast, research studies on recidivism rates of MST and FFT graduates reflect that re-arrest rates are typically cut at least in half despite the much lower cost for these evidence-based practices.

The Washington State Institute for Public Policy, a non-partisan research institute created by the state legislature, has done multiple reports on the relative cost effectiveness of juvenile justice treatment programs and ranked MST highly based on documented savings to taxpayers and crime victims

[viii]Shufelt, J. & Cocozza, J., *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study,* National Center for Mental Health and Juvenile Justice, June 2006; Teplin, L., Abram, K., McClelland, G., Duncan, M. Mericle, A., Psychiatric Disorders in Youth in Juvenile Detention, Archives of General Psychiatry, December 2002.

[viii]See http://aspe.hhs.gov/health/fmap07.htm, a notice in the Federal Register announcing the calculated "Federal Medical Assistance Percentages" and "Enhanced Federal Medical Assistance Percentages" that were used in determining the amount of Federal matching for State medical assistance (Medicaid) and State Children's Health Insurance Program expenditures from October 1, 2006 through September 30, 2007.

[ix]Buck, J., *Medicaid, Health Care Financing Trends, and the Future of State-based Public Mental Health Services,* Psychiatric Services, 2003.

[x]*Evidence-Based Practices for Delinquent Youth with Mental Illness in Maryland: Medicaid Must Cover these Cost Effective Services,* A Public Report by Maryland Disability Law Center, January 2007 at 24-25, at http://www.mdlcbalto.org/publications.htm, hereinafter cited as MDLC Public Report on Evidence-Based Practices.

[xi]See discussion below and MDLC Public Report on Evidence-Based Practices at 18, at http://www.mdlcbalto.org/publications.htm

[xii]*MDLC Public Report on Evidence-Based Practices* at 24-25, at http://www.mdlcbalto.org/publications.htm. These states are Alabama, Arizona, California, Colorado, Connecticut, Georgia, Hawaii, Maine, Michigan, Nebraska, New Mexico, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, and Wyoming. MST Services, Inc. lists 12 states as billing Medicaid and does not list Alabama, Colorado, Georgia, Michigan, Tennessee, Texas, and Wyoming at http://www.mstservices.com/funding_and_medicaid_standards.php.

[xiii]See discussion below associated with notes 24 and 26.

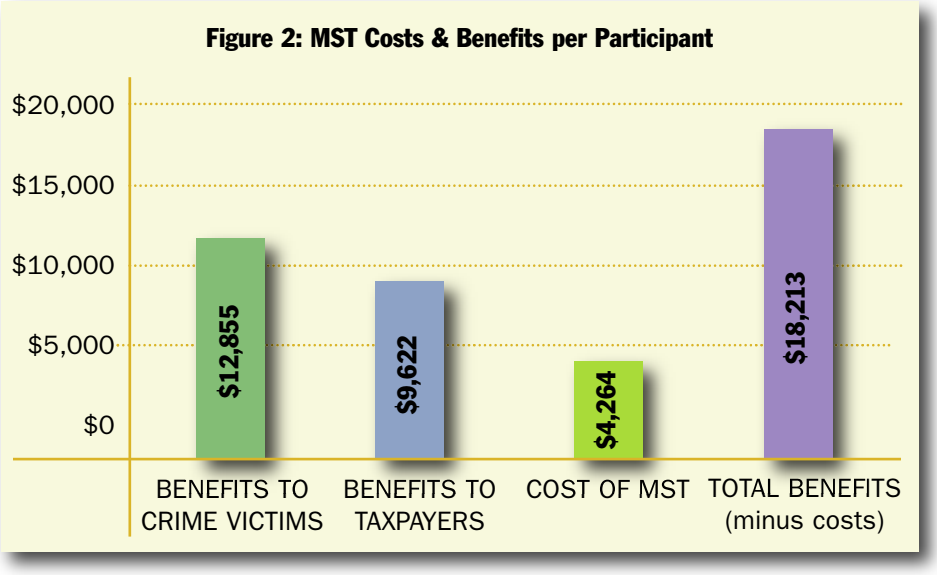
[xiv]*Medicaid Support of Evidence-Based Practices in Mental Health Programs,* a technical assistance paper prepared jointly by SAMSHA and CMS, at http://www.medicine.uiowa.edu/icmh/evidence/documents/Medicaidsupportforebps.pdf; and Subcommittee on Evidence-Based Practices of the President's New Freedom Commission on Mental Health, Background Paper, April 2005, at 23, at http://www.mentalhealthcommission.gov/reports/EBP_Final_040605.pdf.

[xv]*MDLC Public Report on Evidence-Based Practices* at 11, 13-15, at http://www.mdlcbalto.org/publications.htm.

[xvi]*Id.* at 10 and notes 63 – 66. The estimate of $328 per day for the cost of a detention bed has been increased from the $243 cited in this report based on testimony provided during the 2007 budget hearing of the Maryland Department of Juvenile Services.

[xvii]Analysis of the FY 2005 Executive Budget, Maryland Department of Juvenile Services at 32, 2004, at http://mlis.state.md.us/.

[xviii]Analysis of the FY 2007 Executive Budget, Maryland Department of Juvenile Services at 15, ex. 8, 2006, at http://mlis.state.md.us/.



and a computation of benefits minus costs, as depicted in Figure 2.[xix]

Medicaid reimbursement provides another compelling cost consideration. States could be billing a significant portion of the cost of MST services for Medicaid eligible youth to CMS and be reimbursed from 50% to 83% of their bills. In contrast, federal law prohibits states from accessing Medicaid reimbursement for the cost of locked or secure juvenile facilities as well as any health care services youth in such facilities need.[xx] Thus, states now pay for the expensive secure placement *plus* the potentially sizable cost of behavioral and somatic health care services for this population with only state dollars.[xxi]

Even in states that do not use Medicaid funding to provide MST, such as Florida, MST programs with significant cost savings have been ongoing as the result of legislation appropriating funds or other state initiatives. According to a February 2007 report by the Florida legislature, the *Redirection* Program provided MST and FFT to 405 youth and avoided state costs of *$5.8 million* just in its first two years of operation.[xxii] Not surprisingly, Florida's legislature expanded the program to thirteen judicial circuits. The Florida legislation provides a starting point for drafting legislation in other states and the legislative report documenting cost savings from the program should be helpful in securing passage of such laws or promoting state initiatives elsewhere.[xxiii]

Medicaid Billing Is Not a Panacea

In many of the states billing Medicaid for MST, this funding alone has not been sufficient to support a MST program operating with the required fidelity monitoring to ensure strict adherence to the model — known as "model fidelity" — and MST's positive outcomes.[xxiv] According to estimates from some states and the District of Columbia, 40 to 60 percent of a model-adherent MST team's operating budget will be covered by Medicaid funding alone.[xxv] One obvious obstacle to full reimbursement is that not all children in families in need of MST will meet the eligibility criteria for Medicaid. Another obstacle is the inability to bill some of the standardized components of MST, such as training, supervision, and evaluation. This can lead states to implement MST in a manner to maximize Medicaid billing and reduce adherence to model fidelity. Model fidelity is critical because one of the primary reasons MST program replications are effective is that each new program adheres to the same, well-specified treatment implementation and quality assurance model. Even subtle changes in implementation can have a negative impact on a program's outcomes.[xxvi]

For example, some state Medicaid systems only reimburse for face-to-face contacts, and at times, only contacts with family members when the youth is present. This type of funding structure can easily lead to non-model adherent practices that overemphasize youth treatment sessions in clinical implementation. In MST, therapists work frequently and intensively with the youth's caregivers, extended family, and teachers to ensure they can intervene to effectively manage the youth's behavior problems, and the youth may or may not be included in a particular session.

From the provider perspective, the current HCPCS code for MST is based on a 15-minute billing increment that

[xix]The data in figure 2 is from Aos, S., Miller, M., & Drake, E., (2006 October), *Cost Effectiveness of Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates,* Washington State Institute on Public Policy (#06-10-1201), at http://www.wsipp.wa.gov/pub.asp?docid=06-10-1201. Taxpayer savings were estimated by considering how police and court costs are reduced when arrests go down and how jail and prison costs are reduced when sentences decrease. Benefits to crime victims were estimated by placing a monetary value on the costs that crime victims incur that can be avoided if arrests decline. Although the cost of providing MST has increased since the date of this research, it is assumed that the police and court costs as well as costs to crime victims have increased as well.

[xx]The federal Medicaid Act and regulations prohibit federal financial participation "with respect to care or services for any individual who is an inmate of a public institution." See 42 U.S.C. § 1396d(a)(27)(A); 42 C.F.R. §§ 441.33(a)(1), 435.1008 and 435.1009.

[xxi]However, given the high incidence of delinquent children with mental illness and the lack of federal Medicaid reimbursement for these youth when confined, states do not always provide the necessary mental health treatment for delinquent youth in detention and other secure residential settings. *MDLC Public Report on Evidence-Based Practices* at 11, at http://www.mdlcbalto.org/publications.htm.

[xxii]http://www.oppaga.state.fl.us/reports/crime/r07-10s.html.

[xxiii]*Id.* and additional information about the Florida legislation and program is available upon request to Dan Edwards or Bob Rhen at Evidence Based Associates at www.evidencebasedassociates.com.

[xxiv]Schoenwald, S.K., Sheidow, A.S., Letourneau, E.J. (2004). *Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes.* Journal of Child and Adolescent Clinical Psychology, 33, 94-104.

[xxv]http://www.mstservices.com/licensed_teams_by_location.php.

[xxvi]*Youth Violence: A Report of the Surgeon General,* Chapter 6 at http://www.surgeongeneral.gov/library/youthviolence/toc.html; Schoenwald, S.K., Sheidow, A.S., Letourneau, E.J., *Toward Effective Quality Assurance in Evidence-based* Practice: Links between Expert Consultation, Therapist Fidelity, and Child Outcomes, Journal of Child and Adolescent Clinical Psychology, 33, 94-104, 2004.

is burdensome on providers who prefer a daily, weekly, or monthly billing rate that CMS will not currently approve.

Despite these obstacles, at least one state, California, is currently funding its MST and FFT programs for Medicaid eligible children *entirely under Medicaid* using the Rehabilitation Option.[xxvii] Providers bill through county mental health plans based on the actual minutes spent providing direct services but at a rate that is computed based on each provider's *actual costs* for providing model-adherent MST subject to a maximum hourly rate imposed by the State Department of Mental Health. Los Angeles County is starting a new initiative to provide MST to children in the child welfare system referred to the juvenile justice system that will also be funded entirely with Medicaid funds.

Other positive reports on billing MST under Medicaid come surprisingly from providers in states that have managed behavioral health care where service access is usually considered more difficult compared to fee-for-service Medicaid systems. MST providers in New Mexico and Pennsylvania report that it has been *easier* to provide MST under managed care. Managed care organizations (MCOs) prefer MST because of the cost savings in avoiding Medicaid covered residential placements, the clear eligibility criteria, and the short-term treatment approach that stops dependence on service providers and gives caregivers the ability to manage youth behavior. Medicaid waivers also give MCOs the flexibility to structure the funding for MST in the form of a per diem, weekly, or monthly billing rate that is easier for providers.

A more typical description of MST Medicaid billing comes from the District of Columbia where the private MST provider receives a portion of the established per diem MST rate from the Department of Mental Health and is expected to bill Medicaid under a service called Community Based Intervention for the remaining portion. Though technically there is no cap on how much the provider can bill Medicaid, the per diem rate functions as a ceiling on the provider's reimbursement. Although this financing method fully supports model-adherent MST, the provider noted the uncertainty each year about whether the Department of Mental Health budget will contain the matching funds for the program.[xxviii]

Conclusion

Mental health advocates and professionals should educate state officials and legislators both about the cost effectiveness of MST and the coverage of MST as a behavioral health care service under Medicaid in many states. Although Medicaid dollars alone will not likely provide a sufficient source of funding for model-adherent MST, states have used Medicaid as one financing strategy, combined with state and local dollars, to sustain and expand the availability of MST for delinquent youth, who have a high incidence of mental health disorders. Advocates should recommend that their state implement or expand MST programs based on a multi-faceted funding stream that blends or "braids" multiple sources of funding at a budgetary level and incorporates the available Medicaid reimbursement with other sources of funding in such a way that model adherence and client outcomes are always the primary focus for every MST clinician and program administrator.

When presented with clear facts on the benefits for children and families plus the cost-savings generated from providing MST services, state officials and legislators should be willing to budget or appropriate state dollars that can be combined with Medicaid reimbursement to finance and expand MST programs.

Melanie Duncan, Ph.D., Program Development Coordinator, MST Services, and Keller Strother, President, MST Services, contributed to this article.

NAMI'S Child & Adolescent Action Center Releases Family Guide on Evidence-Based Practices

NAMI's Child & Adolescent Action Center is pleased to announce the release of a new publication titled: *A Family Guide ~ Choosing the Right Treatment: What Families Need to Know About Evidence-based Practices.* The guide is designed to educate and inform families about evidence-based practices (EBPs) in children's mental health and to share information on an array of treatment and support options.

NAMI received input on the guide from families and mental health advocacy organizations to ensure the development of a family-friendly guide.

We hope that NAMI leaders and family advocates find this guide helpful in their efforts to bring more effective services and supports to children with mental illnesses and their families. Educated and informed families are in the best position to advocate for the most effective treatment and supports for their child.

The guide is available as a PDF document to download on the NAMI Child & Adolescent Action Center website (www.nami.org/caac). Sections of the guide are also available in Spanish online. If you would like a hard copy of the Family Guide, please contact Bianca Ruffin, Program Assistant for the CAAC, at biancar@nami.org.

[xxvii]Information provided by Todd Sosna with the California Institute of Mental Health, created by the California county directors of mental health to provide technical assistance, research, policy development, and training in California's mental health system, at www.cimh.org.
[xxviii]Information provided by a representative of Youth Villages, a provider of MST Services in D.C. and several states with further information at http://www.youthvillages.org/.

The ABC's of Bipolar

by Clara LaBrier, High School Junior Living in Colorado

All my life I wondered what
Bipolar means to me
Causing you to cut?
Does it make you see differently?
Ever since I was diagnosed with bipolar
Freeing my individuality was rough
Greatly I now appreciate my disorder
Highly holding my head when I've had enough
I still don't understand and
Just in case you don't know
Keep your "Foot prints in the sand"
Losing yourself will not help you grow
My mom is here for me just like yours will be too
Not a second will you deal with this alone
Overwhelmed sometimes you may want to let go
Please believe me when I say your best help is at home
Quietly or with words left unsaid
Relax, but don't give in
Sitting, crying on your bed
Thinking your disorder is a sin
Uneasiness will come around
Vaguely making you think wrong
Wildly not making a sound
X-amining where you belong
You belong here with us as one big disorder
Zenith are the people with bipolar

Clara LaBrier

Bipolar Disorder

by Clara LaBrier, High School Junior Living in Colorado

Betrayed and feeling alone in your life
I know it's difficult to forget the past
Perhaps if you felt like you had a friend
Overcoming life's obstacles wouldn't be so hard and
Losing the you in yourself not so easy to do
After you find yourself lost in this pain
Really then will you realize you aren't insane

Dying on the inside and crying on the out
I also know it's a tough habit to live without
So when you are feeling alone remember who I am
Or if you need a friend remember these words, "I can"
Rather than the words, "I can't"
Death is the easy way out
Even if you think you have it the roughest
Remember you're not alone because everyone has
something to deal with

Mental Health Curriculum for Middle Schools

The National Institute of Mental Health (NIMH) has introduced a mental health curriculum supplement, *The Science of Mental Illness,* to assist educators in teaching middle school students about mental illnesses.

Students are taught that mental illnesses are biologically-based and no different than other physical illnesses and diseases. The curriculum includes lessons about the brain, mental illnesses, factors that can affect the development of a mental illness, lived experiences, and effective treatments.

An overarching aim of the program is to help students understand the importance of scientific inquiry by stressing the value of scientific evidence in making important choices about their personal health. Students develop skills such as observation, problem solving, and critical thinking as part of this goal.

The web version of the curriculum and downloadable materials can be accessed online at www.nimh.nih.gov (click on "Health & Outreach," then "Publications").

The Road to Recovery

by Laurie Bliss, Parent

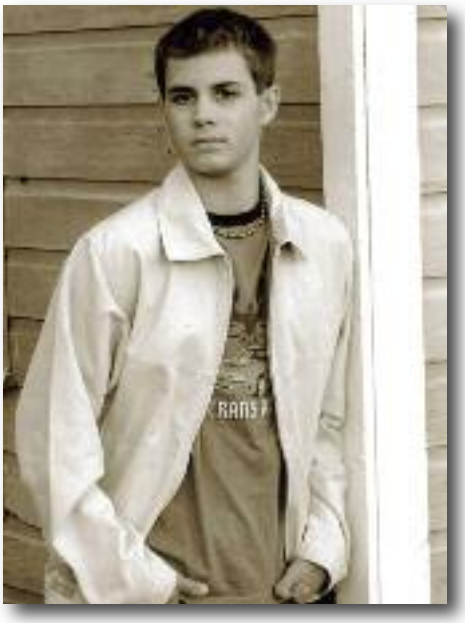
My family consists of myself, my husband Scott, our daughters Kandyce and Keniesha, and our son Kendall. We live in Canby, a small town in southwest Minnesota.

Our son started to struggle in school in first grade. He had trouble adjusting to two teachers. He became frustrated and started acting out. We, as parents, did everything possible to help him, but nothing seemed to work. The school told us to have him evaluated by a mental health agency. We called one but they would not evaluate him without a referral from a social worker. This would involve Family Services and this scared me to death for fear they would try and remove him from our home. I opted not to call them at that time.

By the summer after first grade, Kendall's behavior got much worse. He was only eight years old and wanted to kill himself! Then, at work one night, a customer overheard me telling a co-worker about my concerns with my son. He happened to be the school social worker for Canby Schools and he offered to help. We made an appointment for an evaluation and Kendall was diagnosed with attention-deficit/hyperactivity disorder (ADHD). We put him on medication (actually several) but none of them worked. The school social worker helped me contact Family Services to see if there might be community programs available. We were assigned an extremely caring and understanding social worker.

We worked with this social worker for about seven years and during that time we accessed several evidence-based interventions, including in-home behavior therapy, family education and support therapy, respite care, and a mentoring program. They all helped Kendall, especially the mentoring program.

Kendall's diagnosis was re-evaluated and changed from ADHD to depression and oppositional defiant disorder (ODD).



Kendall Bliss

In-Home Behavior Therapy

Kendall received in-home behavior therapy designed to help him develop anger coping skills. He struggled for the first few years with the anger coping therapy, but ultimately responded quite well to this intervention.

The behavioral therapists focused on helping Kendall develop coping skills for challenging behaviors. He learned how to cope when he was angry by taking action like counting to ten before responding to someone who was teasing him. When counting to ten did not help, he had a series of questions to ask himself before acting out, such as how would your parents feel if you got into trouble or would you like the consequences of your actions? He learned how to better control his frustration in the classroom by leaving the classroom to get a drink and to calm down. The behavior therapy also taught him how best to handle teasing from other students.

One of the biggest obstacles with the in-home behavior therapy was staff turnover. Kendall struggled every time they switched to a new in-home therapist, which seemed to happen all too often.

Kendall continues to use the skills he learned in the behavior therapy and he wishes that more people could learn the everyday coping skills that he did.

Family Education and Support Therapy

The family education and support therapy benefited everyone in our family. We all learned consistent strategies and supports to help Kendall. We also learned to spot the early signs of Kendall's frustration so we could help him before he reached a complete meltdown and became uncontrollable. Some parents fear that this type of therapy will focus on mistakes they are making or their "bad parenting." However, in our experience, we learned skills that we continue to use today and that helped us to better support Kendall.

Respite Care

The respite care program proved to be extremely important for our family. It allowed my husband and me to take time away from our family to care for ourselves and our relationship, while a responsible adult caretaker took responsibility for our children, especially our son Kendall.

It allowed us to recharge our batteries and return ready to address the challenging needs of Kendall and the needs of our other children.

The Mentoring Program

God Bless the mentoring program! I would have to say that the biggest influence for Kendall was the mentor that Family Services and PACT 4 found for him. PACT 4 is a Family Services and Children's Mental Health Collaborative. The mentor assigned to my son was awesome. He went above and beyond his assigned role. Kendall liked him immediately.

The mentor worked with the in-home behavior therapists and the family support therapists to help ensure that they were all focusing on the same lessons for Kendall at the same time. What amazed us was that even when the mentoring program was cut

because of lack of funding, the mentor continued to work with Kendall on his own time. He would pick Kendall up at least one or two times a week and they would spend time together, often on wood-working projects. They would also conduct science experiments and go fishing. The mentor taught Kendall CPR, first aid, and got him interested in politics. They still keep in touch today. I truly believe this person was the reason my son thought life was worth living. It's hard to find a special person like that these days and we were blessed to have had him working with Kendall.

The Importance of Evaluations

We completed evaluations showing improved outcomes and positive progress for each of the evidence-based interventions we accessed for Kendall. The service evaluations our family completed were sent to an evaluation committee to determine the services that worked best for Kendall.

The evaluations gave us the chance to communicate with the evaluation committee about what was working and making a positive difference in Kendall's life.

Policy makers and officials making funding decisions about services and supports must hear from families and consumers about the services that are most effective and valued. The focus should remain on those services that produce the best outcomes and help people to develop the skills and support they need to ultimately lead independent and productive lives.

Recovery and Looking Back

By the time my son was in tenth grade he was no longer taking medication. His behavior had improved dramatically. When he got extremely frustrated, he used the skills he was taught in behavior therapy and in the family support and education program. He also used the skills he learned from his mentor to handle extreme frustration.

In his junior year of high school, he was invited to be a page during the Minnesota legislative session. His involvement in this program greatly increased his self esteem. He also joined the Army National Guard in the summer of his junior year. He is now 21 years old and attending college in Moorhead for pre-law and political science.

He has grown into a fine young man who we are all very proud of. I thank the school social worker, my Family Services worker, PACT 4, and his mentor for not giving up on him and for working so well with our family. We are convinced that the availability of effective services and caring professionals helped Kendall put his life on the road to recovery.

Behavioral Treatment for Children and Teenagers with AD/HD

Editor's Note: This article was reprinted with permission from CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder) and is from the CHADD National Resource Center on AD/HD.

Behavior treatment involves both social and psychological therapies. It is a very important part of treatment for attention-deficit/hyperactivity disorder (AD/HD) in children and teens.

Behavior modification or behavior therapy is also called psychosocial treatment. It works by changing the behavior of a child or adolescent. Research shows that behavioral treatments work well for the symptoms of AD/HD, especially when they are used with stimulant medication.

Treating AD/HD in children often involves medical, educational, and behavioral treatments used together. Treatment should be planned and carried out only after learning what individual needs each child and family have.

Why use behavioral treatments?

Behavioral treatment for AD/HD is important because it helps with issues such as:

- problems doing well in school
- behavior problems at school
- problems with friendships with others their age
- problems getting along with parents and with brothers and sisters

Behavioral treatments work by teaching new skills to parents, teachers and the children for handling problems.

What is behavior modification?

With behavior modification (or behavior therapy), parents, teachers and the child with AD/HD learn new skills for interacting with others. Adults teach the child or adolescent new ways of behaving by changing the ways they

themselves respond to the child's or teen's behaviors.

Parents and teachers should both use the new skills at the same time to get the best results. They should all do the following:

- Start with goals that the child can succeed at, in small steps.
- Be consistent -- even at different times of the day, in different places and with different people around.
- Use the new skills over the long haul -- not just for a few months.
- Remember that teaching and learning new skills take time, and the child's improvement will be little by little.

How does a behavior modification program begin?

The health professional begins by taking a complete history of the child's problems at home and school and during social activities. Most of this information comes from parents and teachers. The therapist also meets with the child to get a sense of what the child is like.

This evaluation should end with a list of target behaviors for treatment. Target behaviors are ones that need to be changed so the child gets better. They can be either behaviors that need to stop or new skills that need to be learned.

The areas targeted for treatment may not be the symptoms of AD/HD (such as being much too active, not paying attention, and doing rash or sudden things without thinking). Instead, they may address the problems that those symptoms cause in daily life, such as playing well with brothers and sisters, or obeying parent's requests.

Similar behavioral treatments are used both at home and at school. Parents and teachers carefully watch the child's response to the treatment. The treatment changes as the child changes.

Parent Training

Parents need careful teaching and support to learn the new parenting skills and how to use them all the time. The topics covered in parent-training sessions may include the following:

- Setting house rules and a routine
- Learning to praise wanted behaviors and to ignore mild unwanted behaviors (choosing your battles)
- Using appropriate ways to let the child know what you want from him or her
- Using "when-then" directions (when there is unwanted behavior, then adults take away rewards or privileges)
- Planning ahead and working with children in public places
- Using "time outs" during or after unwanted behavior
- Using daily charts and point systems for both rewards and consequences
- Using a school-home note system to reward school behavior and to track homework

Parent training can be done in groups with or without the child. Parent training can also happen during individual family sessions that include the child. When the child is a teenager, parent training is a bit different. Parents learn skills that are right for teens. The parents and teenager may meet with the therapist to come up with solutions they can agree on for behavioral problems. Parents try to gain improvements in the teenager's target behaviors (such as better grades in school) in exchange for rewards that they can control (such as allowing the teenager to go out with friends).

Therapy at School

Many children with AD/HD have teachers who may not know much about AD/HD or behavior modification. Parents of children with AD/HD should work closely with teachers to help them learn needed skills to manage behavior in classrooms.

Managing teenagers with AD/HD in school is different from managing children with AD/HD. Parents will often work with guidance counselors or other school staff rather than the individual teachers who will carry out the classroom behavior modification programs.

Therapy with the Child

Very often children with AD/HD have serious problems getting along with other children. Children who overcome these problems do better in the long run than those who don't.

Here are five good ways to help children who don't get along well with other children:

1. Teach social skills (how to get along with other people)
2. Help to solve social problems
3. Teach other skills that children find important, such as sports skills and board-game rules
4. Decrease unwanted behaviors such as bossiness or not sharing
5. Help to form a close friendship between the child with AD/HD and another child

To best help the child, the skills for changing unwanted behavior should be the same for the parent, school, and healthcare professional. The same behaviors should be watched, discouraged or encouraged, and rewarded in all three settings.

Social skills training groups are a common type of treatment. Social skills groups with children with AD/HD only work well when they are matched with what the parents and school are doing to reduce disruptive and negative behaviors.

What about combining behavior approaches with medication?

Both medication and behavioral treatment work well to improve AD/HD symptoms. Medication alone is more effective in treating AD/HD symptoms than behavioral treatment alone. In some cases, combining the two approaches works best. No one treatment plan is right for everyone.

This *What We Know* fact sheet was supported by Cooperative Agreement R04/CCR321831 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

To access additional information from the CHADD National Resource Center on AD/HD, please visit www.help4adhd.org.

Promoting Evidence-Based Practices in Illinois

by Lora Thomas, Executive Director, NAMI Illinois

NAMI Illinois was extremely pleased when the NAMI Child & Adolescent Action Center notified us that Illinois was one of three target states in a project designed to build a family network to promote the broader dissemination and availability of evidence-based practices (EBPs) in children's mental health. The project is funded by the MacArthur Foundation. We recognized the importance of EBPs and the need to bring more effective services to children and adolescents living with mental illnesses and their families. We appreciated the opportunity to play a key role in helping to educate and inform families about effective treatment choices and to provide advocacy tools to help create greater demand for EBPs in our state and local communities.

Launching the EBP Project at the 2006 NAMI IL Meeting

The education process began at the NAMI IL Education Conference in October 2006 with a presentation by Ron Honberg, NAMI National Policy Director. The presentation outlined the evidence-based practices project and how families in Illinois could become more involved in advocating for the broader availability of EBPs. It also covered the growing national focus on effective interventions and the importance of EBPs to children and their families.

The presentation raised the interest of NAMI Illinois members and affiliate leaders in the project and in learning how to effectively promote the broader dissemination of EBPs.

Planning for Onsite TA Visits with NAMI National

In early 2007, we worked with NAMI national to plan a series of onsite meetings on EBPs in children's mental health with key stakeholders in Illinois. We recognized the critical need to include just the right mix of stakeholders for the late spring onsite meetings. Our job was made easier by the existence of the Illinois Children's Mental Health Partnership (ICMHP), which consists of representatives from the key state child-serving agencies and family advocacy groups. The ICMHP has been an extremely influential state-wide group working to reform children's mental health in Illinois.

In planning for meetings related to the EBP project, we also collaborated with the Division of Mental Health and learned that they had formed a committee on evidence-informed practices, essentially looking at bringing more effective interventions into Illinois. We wanted to be sure that our NAMI onsite meetings would include key members of the state committee focused on EBPs. We were also extremely fortunate to have Barbara Burns, Ph.D., a leading national expert on evidence-based practices in children's mental health, involved with NAMI national on this project.

In working with NAMI national, we ultimately decided to hold three separate meetings as part of the onsite technical assistance on EBPs. The first meeting was held with representatives from the FACE (Family Advocacy, Communication and Education) committee of the ICMHP and with representatives from the Evidence-Informed Practice Committee of the Division of Mental Health. The second meeting was held with representatives from the ICMHP and the Division of Mental Health and the third meeting was held with families and advocacy groups from around the state.

The three onsite meetings were held over two days in April. Dr. Burns and NAMI national participated in all three meetings. Dr. Burns provided excellent presentations and shared her expertise on EBPs in children's mental health. Participants got to engage in a dialogue with Dr. Burns and other key stakeholders during all the meetings.

At the first meeting, Amy Starin, the Administrator for Child & Adolescent Services in the Illinois Division of Mental Health, provided an overview of the work being done by the state to focus on evidence-based interventions. The state completed a survey of providers on EBPs. The responses showed that 92% of providers were interested or very interested in learning more about EBPs. The state is engaging in a five-pronged approach to addressing evidence-based practices in the children's mental health service system, which includes the following activities:

1. Providing ten mental health agencies around the state with grants to train and supervise providers in the skills involved in two evidence-based interventions — cognitive behavioral therapy (CBT) and behavior parent training;
2. Educating child and adolescent mental health providers on evidence-based interventions. The state found that many child mental health providers do not understand EBPs and that myths surrounding EBPs that could prevent families from accessing effective treatment options needed to be dispelled;
3. Supporting the development of an EBP certification process in three graduate schools to ensure that mental health providers are adequately trained in EBPs and can provide these services coming out of school. The graduate schools are interested in expanding the project to provide ongoing training for providers practicing in the field;
4. Looking at state level policies to see how they might support or hinder the use of evidence-based interventions. The state's committee on EBPs will develop resources on the steps that must be taken to ensure a culture that promotes the implementation of

evidence-based practices; and

5. Educating families and consumers on EBPs to create demand by encouraging community providers to become better trained and informed on EBPs.

NAMI national's initiative to bring in a leading national expert on EBPs and educate families and consumers about EBPs complimented the work already underway in Illinois. The FACE committee and the Division of Mental Health proved to be extremely valuable partners, both in planning for the onsite meetings and during the meetings.

The second meeting of the onsite visit included the state Division of Mental Health and representatives from the Illinois Children's Mental Health Partnership. We were extremely pleased to have Barbara Shaw, the chair of the Illinois Children's Mental Health partnership, participating in this meeting. Barbara Shaw has proven to be a tremendous leader in working to transform children's mental health in Illinois.

The third meeting focused on families and included family advocacy leaders from across the state. There were NAMI members and leaders, and representatives from the Illinois Federation of Families for Children's Mental Health, Voices for Illinois Children, and other key groups. Dr. Burns provided an overview of EBPs and discussed the critical need for families to become more involved in advocating for the broader dissemination of EBPs. NAMI shared information about the development of family resources designed to help educate and inform families about EBPs.

We were extremely pleased to have Dr. Burns leading the three onsite meetings. Her national prominence and expertise on EBPs in children's mental health helped to secure a strong turnout for these meetings. The format of holding three meetings allowed us to meet with key stakeholders to strategize on collaborating to ensure the broader availability of EBPs for children with mental illnesses and families.

We continue to work in Illinois to educate and inform families about EBPs. Our ultimate goal is to improve the treatment and service outcomes for children and adolescents living with mental illnesses.

To learn more about NAMI Illinois' work on this EBP project, please contact Lora Thomas, NAMI Illinois Executive Director, at 217.522.1403 or Thomas.lora@sbcglobal.net.

AFFILIATE NEWS

Reaching and Teaching Students about Mental Illnesses

by Donna Pollard, Program Director & Parents and Teachers as Allies Trainer, NAMI Orange County, California

In 1995, NAMI Orange County recognized the need to teach students in schools about serious mental illnesses. Many of our affiliate members were current or former teachers so this seemed a logical target for our work.

We started the process by looking at what other NAMI groups were doing around the country. We recognized that teachers are being asked to do more and more these days, so rather than try to convince teachers to share information about serious mental illness with students; we offered to do it for them. We volunteered to come to the classroom and teach a lesson about mental illnesses.

Our beginnings were humble. A group of interested volunteers met, made some decisions about what the lesson would look like, and began offering our services to schools. Our goals were:

- To help teachers and students identify and understand the symptoms of and treatments for mental illness;
- To reduce the myths and stigma of mental illness, to open minds, and to reduce discrimination;
- To encourage those experiencing symptoms of a mental illness to seek treatment when needed;
- To raise awareness among youth about NAMI Orange County so they could take advantage of our available resources; and
- To ensure that students would become adults that better understood mental illnesses and the impact they have on society.

We wanted to make sure that students understood that mental illnesses are physical illnesses of the brain and that most individuals living with them are not dangerous. Our effort has grown into a team of about 40 volunteers, who meet quarterly and reach from 3,000 to 6,000 students a year.

Some changes have occurred in our outreach efforts over the years. We developed additional materials and hired a part-time program coordinator after securing a few grants. We added posters, overheads, and visuals to the lessons, thanks to volunteer graphic artists. A skilled NAMI member created a video titled, *The Many Faces of Mental Illness,* using a local psychiatrist and some talented volunteer actors. One of our volunteers taped a presentation for students so we could show it to new volunteers. Our program also uses an

evaluation tool to help us track the effectiveness of our program and to report to organizations that have provided funding for it.

We receive many positive comments about our program — here are two of the comments:

- "Your presentation was informative and educational. I believe it is essential to educate people (especially teenagers) about mental disorders and you do an excellent job. Your presentation was very touching"— from a Student.
- "I want to thank you and NAMI Orange County for speaking to my health classes — students bond with real life stories because the information comes alive. My sincerest thanks and appreciation to you for sharing your time and knowledge" — from a Teacher.

A school outreach volunteer may be a family member, a professional, a person who has had an illness, or any combination of the above. While we have many education professionals involved in our program, we also have lawyers, business professionals, doctors, and others. Volunteers interested in delivering the program must first attend an orientation meeting, observe another volunteer delivering the program, and do a presentation with a mentor. Volunteers create their own lesson plans using suggestions included in our volunteer notebooks and by meeting our program goals. Each volunteer brings something unique and special to the classroom.

At a recent quarterly volunteer meeting, volunteers were asked to share how they had benefited from volunteering for the program. Here are just a few of the comments:

- It's life affirming.
- I benefit more than others.
- I am able to make a difference.
- I am becoming more empowered.
- We're here to serve, a big honor.
- I've stretched!
- Sharing has lessened my denial. I'm healthier.

These comments and others show an unexpected benefit from our program — that not just students gain, but volunteers do as well.

It is impossible to know the true impact of our program and whether it improves help-seeking behaviors, but there are a number of instances when students have self-disclosed mental health concerns to our volunteers. Our volunteers assist students in finding help if it seems appropriate. Students also always receive a brochure with referral information at the end of our presentations. We know of a few students living with mental illnesses who have received treatment as a result of our program. We believe that if we reach just one student, then our work is well worth the effort.

Most of our presentations are done in high schools, but we have presented to elementary (even kindergarten!) and middle schools with some college level classes thrown in. While we have only scratched the surface of the program's potential, we believe that we have made a difference and we will continue our outreach efforts with younger and more students. We have some teachers who ask us to come back every semester. We have also been extremely active with NAMI's *Parents and Teachers as Allies* in-service education program for school professionals.

Another school year is upon us and we hope that this year will be bigger than ever for our outreach work in the schools.

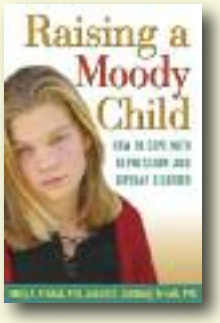
To learn more about NAMI Orange County's outreach program for students, please contact Donna Pollard at (714) 544-8488 or dpollard@namioc.org.

BOOK REVIEW

Raising a Moody Child: How to Cope with Depression and Bipolar Disorder

by Mary Fristad, Ph.D. and Jill S. Goldberg Arnold, Ph.D.

List Price: $16.95
Soft Cover: 260 Pages (2004)
Publisher: Guilford Press



What a fitting title for a book that provides families with the essential tools to cope with the challenges of raising a child with depression or bipolar disorder. Dr. Mary Fristad and Dr. Jill Goldberg Arnold understand the extreme day-to-day difficulties experienced by families when a child is living with bipolar disorder or depression.

This book provides families with numerous practical approaches on how to effectively address the needs of their child, along with the needs of other family members impacted by the existence of these serious illnesses.

Early in the book, the authors help families understand what is happening with their child and the steps necessary to get good treatment and a proper evaluation. The book covers effective treatment options for depression and bipolar disorder, including medication, psychotherapy, and combined interventions. The real benefit of this book is the practical tips for parents, family exercises, and coping skills for the child. Families will also greatly benefit from the chapter on strategies for helping students with depression and bipolar disorder succeed in school.

Dr. Mary Fristad and Dr. Jill Goldberg Arnold understand and appreciate the vital role that families play when children are diagnosed with depression and bipolar disorder. This book is chock-full of guidance and practical advice that promises to make life easier for families raising children with these conditions.

Anti-Bullying Website Targets Youth

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) developed an interactive website for youth that teaches them about bullying and how to prevent it. The website is part of HRSA's anti-bullying campaign, *Take A Stand. Lend A Hand. Stop Bullying Now!,* which aims to educate more Americans about how to prevent bullying and youth violence.

The website includes animated stories, games, quizzes, fact sheets, and an "ask the expert" section to help youth identify what bullying is and what they can do about it, whether they are witnessing it, being bullied, or are the bullies themselves. A team of youth experts, ages 9 to 13, provided input on the campaign's website to ensure it reflected real life and would appeal to youth.

Parents can also visit the website to learn how to become a part of the anti-bullying campaign and bring activities and resources that help address the issue of bullying to their local school and community.

To access the anti-bullying website visit www.stopbullyingnow.hrsa.gov.

National Children's Mental Health Awareness Day

NAMI, a founding partner in a coalition of national mental health, counseling and education organizations, jointly hosted the second annual Capitol Hill briefing in honor of National Children's Mental Health Awareness Day. The program emphasized the critical importance of effective school and community-based mental health services for children, youth, and their families.

The briefing, *Children's Mental Health: Key to Achieving Success in Schools and the Community,* was held on May 8th and focused on raising awareness about effective programs for children's mental health needs, demonstrating how children's mental health initiatives promote positive youth development, recovery and resilience, and showing how children and youth with mental health needs can thrive in their communities.

Guest speakers included:

- *Moderator:* Carl C. Bell, M.D.
- *Honorary Consumer Spokesperson:* Howie Mandel
- *Honorary Family Spokespersons:* Deborah Marriott Harrison and her son Scott
- *Honorary Youth Spokesperson:* Marvin Alexander
- *Honorary Education Spokesperson:* Mark Weist, Ph.D.
- *Substance Abuse and Mental Health Services Administration Spokesperson:* Gary M. Blau, Ph.D.

The briefing was an enormous success! Mark your calendars for next year's National Children's Mental Health Awareness Day on May 8th, 2008! Stay tuned for more details.

NAMI's Executive Director, Mike Fitzpatrick (far left), poses with Howie Mandel (middle and also featured on the cover), the host of NBC's hit show "Deal or No Deal," along with (from left to right) Robert Bernstein, Executive Director of the Bazelon Center for Mental Health Law, Sandra Spencer, Executive Director of the Federation of Families for Children's Mental Health and David Shern, President and CEO of Mental Health America.

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