Module 7: Mental Health

Part 2: Children and Adolescents

So what do we know about emotional cognitive behavioral disorders in children and adolescents? Well, based on the most current national epidemiological surveys, approximately 22 percent of youth meet criteria for lifetime prevalence of psychiatric disorder. This breaks down to approximately 32 percent meet criteria for an anxiety disorder, 19 percent meet criteria for behavior disorders, 14 percent for mood disorders, and 11 percent for substance use disorders. Now 40 percent of youth meet criteria for more than one disorder which suggests that psychiatric illnesses are highly co morbid.

The median age of onset is 6 years for anxiety disorders, 11 years for behavioral disorders, 13 years for mood, and 15 years for substance use disorders. Now of those who meet criteria, only 20 percent actually receive services, and this suggests that there is a huge gap between need and service use.

So where are mental health services delivered? Well, they're most commonly delivered in schools followed by specialty mental health centers such as outpatient community mental health or psychiatric institutions, child welfare settings, and juvenile justice settings.

So the first step in identifying psychiatric illnesses or psychiatric disorders is a screening. And the purpose of screening is to identify those at risk for mental health issues and then refer for a more thorough assessment. And screenings is a standard part of the intake process of mental health facilities, child welfare, and juvenile justice systems.

Now this image on the slide is an image of a physical screening. And what we have here is somebody who is trying to filter out a bunch of dirt looking for something specific. And I like to think of screening as if you have a thousand kids in school, how do you know which kid you need to focus in on?

Which are the promising children, the kids that might be the diamonds in the rough that would really benefit from a more thorough assessment? Well, you do it by screening. And once you've identified those folks, then you can go out and say, "Look, we realize that you might benefit from somebody digging in a little bit deeper and finding out what's going on." And so that's how I like to think about screening.

Screening in Schools and Primary Care. Now primary care holds the potential to be one of the best places to screen youth for emotional and behavioral problems. Up to 70 percent of kids visit a primary care doctor annually for a well-visit exam. But one of the problems with screen in primary care settings is that there are not appropriate screening tools.

For example, many screen tools ask about symptoms in the past two weeks which is fine unless your period of assessment is one year as in an annual exam. There's also the problem of not having enough referrals and having additional workload for primary care providers to address mental health concerns that are identified after the screening.

Schools. Schools are perhaps the best place to screen for mental health issues, because far more than 70 percent of kids show up at schools. However, parents have many concerns about screening in schools.

And one of the main concerns is that if the child gets screened and then gets referred for an assessment, and then gets a diagnosis, and that diagnosis is associated with psychiatric medications, that the school will then be able to say to the parents unless you get your child medicated, your child is not allowed back in school. And so there's a large segment of the American population that says, "You know what, I don't want to screen my child, because I don't want the school to have that kind of power to say medicate my child or they can't come back for an education."

Now there are a lot of issues with that argument, and a lot of people would say that doesn't actually happen in reality. But that's a significant barrier to being able to screen in schools.

Another example is for suicide risk there is a requirement in the Garrett Lee Smith Act which says that in order for a school to screen students for suicide risk, parents have to opt in. And functionally that looks like sending a note home to parents and saying on this date we are going to screen for suicide risk, and the parent has to give their approval.

Well, as you can imagine, there are lots of parents that either don't send the note back or don't give the approval explicitly or implicitly. Implicitly by keeping their child home on that day. Now, there's also concerns from administrators about overburdening mental health staff in schools or not having appropriate referrals which is the same concern that primary care providers have.

So just a little bit more about referrals, because referrals seem to be the biggest barrier between screening and assessment in treatment. So following screenings, providers need to make appropriate referrals for youth in need of assessment and intervention.

And a referral is challenged for a number of reasons. There are functional barriers such who's going to pay for services? Are there services within the geographic location of the child? Is there transportation? There are systemic barriers such as cultural mistrust between people who would be receiving services and those providing the services?

There might be a disagreement on what is the problem. Is it that my child has a behavior disorder or is it that the teachers and the administration don't understand my child?

There are agency barriers such as staff turnover, different staff providing the intake and providing the treatment. There are also long waits for appointments.

There are family barriers such as the child doesn't want to attend the appointment or the parent can't make the time to get to the appointment.

And then there are professional barriers. So sometimes providers are not trained adequately to provide the services needed, or they're not trained to competence, meaning they might have gotten a three-hour lecture in their graduate program, but actually when it comes to providing the services in a real context, they can't do it. And additionally some service providers just are not treated in that specific problem area.

Now when you make referrals, you want to screen for potential providers to determine if they work with children and adolescents. And I know that sounds obvious, but there are a lot of providers out there who say, yes, I can deal with anxiety and depression. But you have to ask explicitly do you deal with anxiety and depression in kids, because it looks differently in kids than it does in adults. You want to find out, well, what's their training? Where do they practice? Do they do office-based services or do they do home-based services? And how do they interface with other agencies?

There are also infrastructure issues that you should inquire about such as what types of payments are accepted? Are your services accessible through public transportation? What's the wait time for new clients, and where are you located?

As I mentioned a few slides ago, the largest provider of mental health services in the United States is schools. And there is a movement to incorporate social emotional learning into school settings so that there's not such a large distinction between addressing mental health issues and addressing educational issues. There a growing awareness that educational goals can't be achieved where there are social, emotional, or behavioral problems that are left unaddressed.

Now schools address learning disabilities separately from mental health issues. This is in part a function of there being little overlap between providers trained in addressing learning disabilities and mental health issues.

Mental health crises in schools. Schools are best equipped to manage crises when they have crisis teams and protocols in place prior to a crisis, so psychiatric emergencies such as suicide risk needs to be considered in tandem with school violence. Following the massacre at Columbine High School, many schools jumped onboard and said that we need to have a plan in place to address this same kind of violent crisis.

Few schools recognize suicide risk as violence which it is. And so the National Association of School Psychologists developed the PREPARE Model to prevent, prepare, and act in crisis situations for schools. And this includes both violence such as homicidal ideation and psychiatric crises such as suicidal ideation.

PREPARE stands for Prevent and Prepare for Psychological Trauma. Reaffirm physical health and perceptions of security and safety. Evaluate psychological trauma risk. Provide intervention, and Respond to psychological needs and Examine the effectiveness of crisis prevention and intervention.

One of the hottest topics in the news these days is the relationship between bullying and suicide. Journalists have a very difficult job in that they show up in the morning, and they're given an assignment, and within a matter of hours, they have to make sense of an enormously complex situation, and present it to the public in a way that makes sense.

One of the problems with suicide is that reporters have come across this formula which says that bullying plus something else equals suicide. And the data don't support that. While bullying, or a history of bullying, including cyber bullying is a known factor in suicide, it is not typically a causal determinant of death by suicide among kids.

What we know is that victims of bullying, perpetrators of have poor outcomes and both need to be addressed when addressing issues of bullying. Research has also suggested that youth who are both victims and perpetrators of bullying, including offline bullying, are at significantly increased risk for long-term mental health problems and death by suicide once they get into adulthood.

Suicide risk is a significant problem among youth. It is the second or third leading cause of death depending on what age range you're looking at, either 10 to 24 or 15 to 24. The lifetime risk for suicidal thoughts and behaviors is approximately 12 percent for suicidal ideation, 4 percent for making a plan, and 4 percent making an attempt.