



For Kids, a Short Supply Of Answers, Specialists

BY MARIE ROHDE

Just before Christmas 2012, a shooting rampage at a Connecticut grade school fueled the national debate over gun control measures and the need for better mental health services for troubled individuals. The 20-year-old gunman reportedly had mental health issues dating back to his childhood.

Mental illness is a factor shared by many of the gunmen in the 62 mass shootings in the United States since 1982, according to a 2012 *Mother Jones* magazine investigative project.¹ The investigation points out the difficulties authorities face in acquiring mental health records to be used in background checks for gun purchases.

Gun violence clearly has no straightforward cure; just as clearly, everyone with mental health issues is neither violent nor a potential killer. The federal government, individual states and advocacy groups are grappling with how best to keep guns away from people whose mental state could make them dangerous, yet there is no disputing a fundamental issue: the lack of treatment for mental illness in the United States is alarming, especially when it comes to screening and intervention in childhood, when treatment can be crucial.

The National Institute of Mental Health reports that in any given year, 1 child in 10 is diagnosed with a form of mental illness severe enough to cause impairment. Diagnoses and severity range widely and, in children, include attention deficit disorder, bipolar disorder, illnesses along the autism spectrum and depression. Untreated, these problems can escalate in adolescents and young adults and have a significant impact on their passage to adulthood. Yet, only half of those diagnosed receive any form of treatment.²

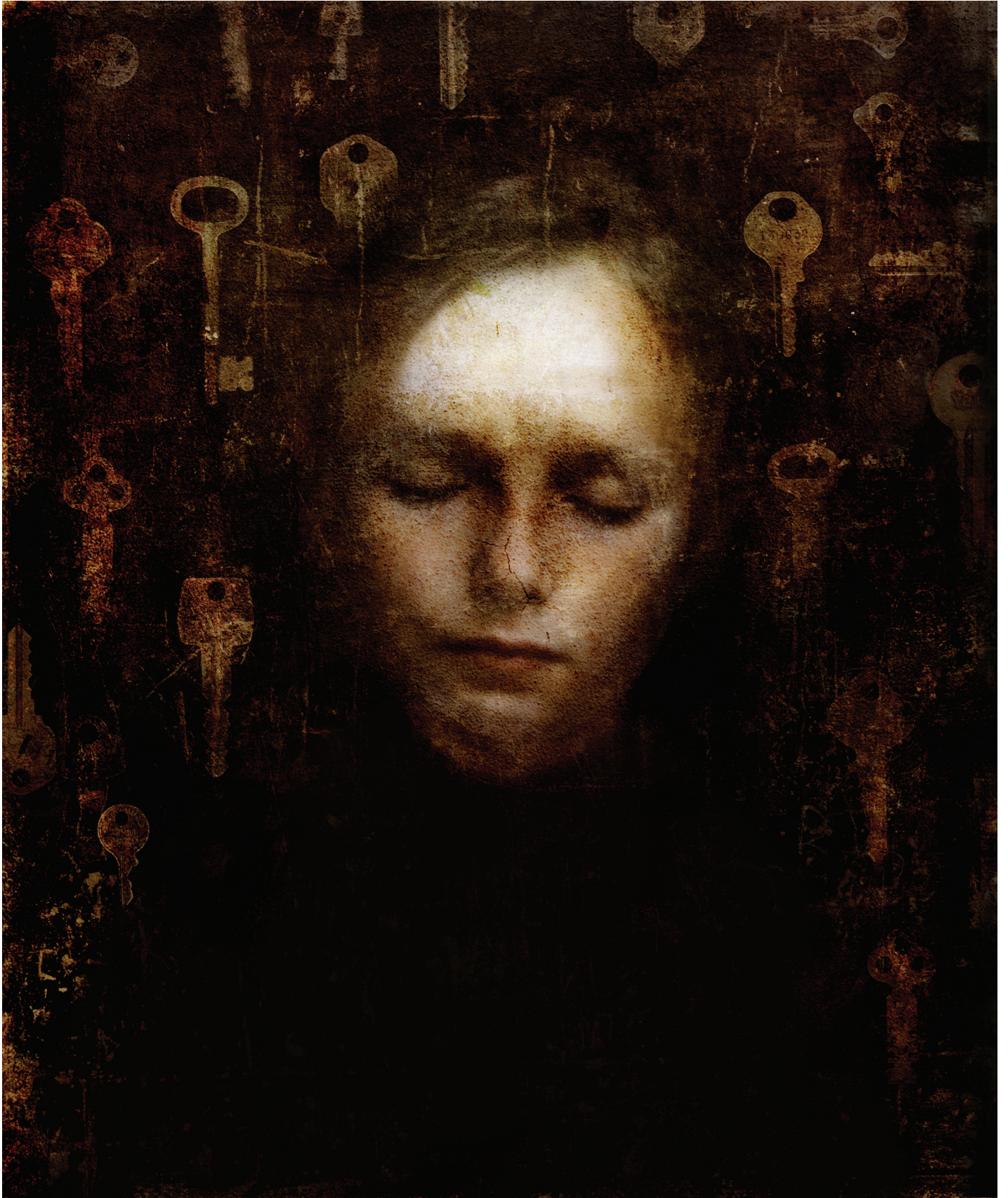
Experts say the major reasons are cost and lack

of providers and services — obstacles that often serve as barriers to diagnosis as well. For instance, in 2010, there were only 7,000 child psychiatrists practicing in the United States, according to the American Academy of Child and Adolescent Psychiatry, whereas in 1990, two decades earlier, it had been projected that the country would need 30,000, according to the group. Currently there are about 7,500 child and adolescent psychiatrists, according to the American Academy of Child and Adolescent Psychiatry website.

“Pediatricians are the ones who are prescribing most of the psychotropic drugs to kids,” said Gary Rosenberg, MD, a child psychiatrist and executive medical director for behavioral health services at St. Clare’s Health System in New Jersey. “They usually are not in the best position to do that in terms of their knowledge and training.”

Rosenberg chairs a committee that is trying to find funding for the second year of a statewide program that integrates behavioral health care

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and general medicine. It is modeled in part after programs in Washington and Maryland that also train pediatricians and provide ongoing support as they provide mental health treatment.

Jerry Fletcher, MD, a child and adolescent psychiatrist and director of youth psychiatric services for St. Vincent Health in Indianapolis, said that while there have been a number of efforts to fully integrate treatment of mental illness into health care systems, most have been frustrated by barriers that prevent primary care doctors from doing assessments and providing care. Insurance policies frequently stand in the way, Fletcher said. “Often times they [pediatricians] don’t get paid for mental health care. There is no coding that allows for payment [to primary care doctors.] That’s true even of the state-run Medicaid providers.”

The lack of information and treatment resources for childhood mental illness prompted Susan Resko to found the Balanced Mind Foundation, a nonprofit support group in Chicago. Resko said she struggled to find help for 5-year-old son when he appeared depressed.

“It was a difficult choice to take my child to a psychiatrist,” Resko said. “There was an attitude that children do not have the ability to experience mental illnesses in way that adults do. The belief is that it has to be the result of parenting, abuse or poverty.”

Despite the barriers to treatment, Resko urges parents to fight for it on behalf of their children. “Some children never get better, that is the sad truth,” she said. “But many do, and there is hope.”

She said she spent years going to doctors, dealing with social workers and contending with a

PROVIDENCE REACHES OUT TO STRESSED STUDENTS

BY RONALD SORENSEN, M.S.H.A.

California’s San Fernando Valley — part of the northeast portion of Los Angeles County — is served by the Providence Health & Services system’s Holy Cross, Saint Joseph and Tarzana medical centers. In 2000, Providence Holy Cross Medical Center launched a school nurse outreach program for a group of Catholic elementary schools located in underserved communities and low-income neighborhoods in the area. The schools had lost funding for school nurses and asked the medical center for help making health screenings, education and other resources available.

While addressing the physical health of the students, the program’s staff identified a need for counseling services in the schools, as well. Indeed, the need for affordable and accessible mental health services in the San Fernando Valley has been an ongoing issue. A 2010 Valley Care Community Consortium study reported that mental health conditions were the top reason for hospital inpatient admissions (based on volume of cases) for those persons between the ages of 5 and 19.¹

The Catholic schools in the nurse

outreach program operate on very tight budgets and could not afford to hire counselors. However, Providence Holy Cross’ sister facility, Providence Saint Joseph Medical Center, ran a successful senior peer counseling program, and, using it as a model and a resource, a collaborative counseling project for the schools was born.

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— Barbara Silverberg

Initiated in 2008, the Providence Healthy Minds and Healthy Bodies Project put volunteers from the senior peer counseling program and California State University graduate social work students to work providing on-site counseling services at four Catholic elementary schools.

“There is so much need in our school

communities for this type of a program,” said Suzanna Wood, RN, M.P.H., who oversees the school nurse outreach program. “When starting the project, it was hard to identify which schools would benefit most, because the students at all of the schools we serve could benefit by having counseling made available to them. The school nurses now have resources available to them when they are dealing with children who are facing some type of emotional or mental stressors. Many times these issues impact the students’ physical health and also pose barriers to their ability to learn.”

Providence Saint Joseph Medical Center’s Senior Peer Counseling Program is supervised by a licensed clinical social worker who recruits, trains and supervises adults from the community to serve as volunteer peer counselors working with seniors. Among the volunteers were retirees with professional experience in the mental health/counseling field who expressed interest in helping elementary school students. Joining them were California State University graduate social work students who were completing their field work with the program.

The graduate students and volunteer peer counselors made a perfect match



series of hospitalizations, special schools, treatment facilities and a variety of diagnoses. “He was diagnosed with depression, ADHD [Attention Deficit Hyperactivity Disorder], bipolar and then depression again,” she said.

Too often, children suffering mood and behavior problems are not diagnosed or not diagnosed accurately, according to a report by Hastings Center research scholars Erik Parens, Ph.D., and Josephine Johnston, M.B.H.L. The Hastings Center is a bioethics research institute in Garrison, N.Y.

In *Troubled Children: Diagnosing, Treating and Attending to Context*, published in 2011, the authors maintained behavioral treatment commonly consists only of prescribing medications without addressing the environmental factors that are the source of the child’s problems. Parens and Johnston noted intense debate over whether

the increased diagnosis and treatment with psychotropic medications is appropriate for children.

“While the extreme end of mood and behavioral continua may be clear to almost everyone,” they wrote, “there will always be some disagreement about whether a given cluster of moods and behaviors is best understood as disordered, about how exactly to describe some symptoms of disorder, about which particular diagnosis or diagnoses an individual warrants, and about whether some mildly affected individuals are best served by receiving no diagnosis at all.”

At the same time, they wrote, “As important and inevitable as our disagreements are regarding the boundaries of ‘normal’ children, we make a profound mistake if we let them distract us from agreeing that we need to remove the barriers that stand in the way of optimal care for those children

for the Healthy Minds and Healthy Bodies Project. By working in partnership, the school nurses, graduate students and senior peer counseling volunteers have been able to serve students’ physical and mental health needs at no cost to the schools. The three Providence medical centers in the Valley (Providence Holy Cross, Saint Joseph and Tarzana) provide the financial support to sustain the project.

The Providence Healthy Minds and Healthy Bodies Project serves schools located in low-income neighborhoods where students commonly face myriad issues that provide mental stress. Economic issues, family violence, behavioral problems, unstable family environments, peer pressure, community violence and family drug/alcohol addiction are just a few; the availability of a counselor at school to assist the children in dealing with these issues can make a huge impact on their ability to learn. What’s more, the school nurses report seeing improvements in students’ physical health after counseling.

Presently, the counseling program is staffed by two mental health professionals (a social worker and a marriage and family therapist) and a part-time assistant. The paid staff provide an intake assessment on each child referred for

counseling, supervise the volunteers and graduate students and work closely with the principals and teachers at the schools.

However, people significant in the child’s life all need to be part of the process. Gaining participation from family members has been a key challenge. As project supervisors Norma Villalobos and Barbara Silverberg noted, “The counseling process must be a collaborative effort between the student, school, family unit and counselor. As a counselor, this sometimes proves to be challenging for reasons beyond our control.”

BENEFITS AND SUCCESSES

By using volunteer adult peer counselors and graduate students, the Healthy Minds and Healthy Bodies Project offers an efficient, cost-effective way to bring counseling resources to schools that are unable to pay for these services. In 2011, the project provided a total of more than \$104,000 in free counseling services at four schools. Data collected from students receiving counseling showed that 93 percent rated the program as excellent. What’s more, all of the graduate students who have worked with the project have noted the experience had a positive impact on their professional training.

At Guardian Angel School in Pacoima,

Calif., the principal expressed his gratitude at having the project on campus. “The counseling services provided by Providence have been vital to helping our students reach their potential,” he said. “Very often, our students’ ability to learn is hindered by the many difficulties they have at home, in their families, with their friends or other experiences that have marked their lives. At our school, our counselors bring peace, guidance and healing.”

One of the school nurses summed up the benefits this way: “By receiving counseling, either individually or in a group,” she said, “the students are able to face their lives with more determination and better life skills.”

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NOTE

1. Valley Care Community Consortium, *Assessing the Community’s Needs: A Triennial Report on the San Fernando and Santa Clarita Valleys* (Van Nuys, Calif.: Valley Care Community Consortium, 2010), 122.

who are suffering from moods and behaviors that no one would consider normal or healthy.”

The important thing is to get a good assessment and early treatment for the child, said Peter Jensen, MD, professor of psychiatry and vice-chair of research at the Mayo Clinic’s Division of Child Psychiatry and Psychology, Rochester, Minn. He noted that, with the exception of bipolar disorder, research has produced reliable treatments, at least one medicine and one psychotherapy method, that can help almost every child with a mental or behavioral illness.

“The best combination is medicine and therapy,” he said. “It almost always involves teaching parents to react differently and to teach kids to use their brains differently.”

Getting an accurate assessment can be a challenge, however. For example, “the prevalence of bipolar diagnosis [among children] has greatly increased,” he said. “If you just look at the insurance databases of kids treated [for bipolar disorder] 10 years ago versus now, there has been a 40-fold increase. That’s an amazing statistic.”

It also is a statistic that is difficult to interpret. “Ten years ago, a kid might have been called ADHD and today is called bipolar,” Jensen said. “We could have been wrong before and right now, or right before and wrong now.”

“That’s not to say that the kid’s fine,” he noted. “That is to say that the bipolar kid may be just a messy case of ADHD. That kid with autism may have retardation with a few other symptoms, but the much nicer thing is to call it autism.”

Jensen said he worries less about the children

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who are being treated for a problem they don’t have than he does about those being “misdiagnosed with the diagnosis that is the trend of the day.”

It can take decades for research and scientific knowledge about brain development, mental health problems and treatment to come into general use in diagnosing and treating children and adolescents, Jensen said. To help address that gap,

he founded the REACH Institute to train and support pediatricians in making early assessments of children with mental health or behavioral issues and prescribing treatment.

Since its launch in 2007, REACH has provided 1,000 pediatricians and 500 therapists with year-long, hands-on training that also gives them ongoing access to those with greater expertise in mental health.

The program starts with small peer learning groups of pediatricians led by trained psychiatrists and therapists. They discuss difficult cases, role play, are coached and taught how to interview a patient, how to use a rating scale and how to discuss the importance of getting treatment for their child with a family worried about the stigma of a mental illness diagnosis.

“You should see how most doctors stumble when they try to explain that stuff,” Jensen said of doctors dealing with such families. “They can’t do it until you coach them.”

The REACH-trained pediatricians represent only 1.5 percent of the total pediatric population, but it’s a start toward meeting a demand, Jensen said.

Massachusetts and Washington are among states that have adopted programs similar to REACH to get accurate, early assessments of children with mental or behavioral health problems. Steve Holsenbeck, MD, a psychiatrist and vice president for ValueOptions Health Care Innovations in Colorado Springs, credits Jensen’s REACH work, at least in part, for the fact that fewer kids are hospitalized for mental illnesses in Colorado. “Kids treated in our system were much less likely to deteriorate to the point of needing hospitalization,” he said. “It’s been 50 percent or more less likely.”

In Minnesota, the Mayo Clinic has teamed with the Minnesota Department of Human Services to provide guidance to pediatricians and other primary care providers who prescribe psychotropic medications for children.

The two-year program is expected to reduce costs for inpatient hospitalization for those on the state’s medical assistance program, Jensen said.

The nation’s largest rural health services organization, the Geisinger Health System, based in Danville, Pa., began a pilot project in 2011 using REACH as its model for training pediatricians how to screen their young patients and refer them for behavioral treatment within a Geisinger clinic.



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Tawnya Meadows, a psychologist, said three of Geisinger’s 40 clinics in northeastern Pennsylvania are part of the pilot. REACH has played a role in results so promising that Geisinger is developing a plan to expand the program to the system’s other clinics.

“The preliminary results are promising,” said Meadows. “We have found that 84 percent [of the patients] come in for the first visit after being referred by a pediatrician. Traditionally, only 46 percent show up for a first visit, according to the literature.” But because the pediatrician has learned how to establish a relationship with the family, his or her word carries greater currency regarding treatment for a child’s mental health issues. “The pediatrician is giving a personal

endorsement of the treatment and those who will provide it,” Meadows said. “We try to see the patient [in the same clinic] immediately after the pediatrician makes the referral.”

She said there has been a huge increase in the use of the screenings by pediatricians and that they are becoming more comfortable with their assessments and referrals.

Families are also more comfortable with mental health screenings and treatment offered in the clinic setting. “This is a rural area,” Meadows said. “Everyone knows your car, and some people are reluctant to park outside the local mental health agency for just that reason. But everybody comes to the clinic. There’s no stigma to that.”

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NOTES

1. Mark Follman, Gavin Aronsen and Deanna Pan, “A Guide to Mass Shootings in America,” *Mother Jones*. See www.motherjones.com/politics/2012/07/mass-shootings-map#update.
2. U.S. Public Health Service, *Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda* (Washington, D.C.: Department of Health and Human Services, 2000), 11.

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