MODULE 7: MENTAL HEALTH: CHILDREN AND ADOLESCENTS

Mental Health: Children and Adolescents

Jonathan B. Singer, Ph.D., LCSW
Assistant Professor
College of Health Professionals and Social Work
Temple University
Module 7: Mental Health: Children and Adolescents

Part 2:

Children & Adolescent Mental Health
What do we know?

22% of youth meet criteria for lifetime prevalence of psychiatric disorder

• 32% anxiety disorders, 19% behavior disorders, 14% mood disorders and 11% substance use disorders
• 40% of youth diagnosed with a disorder meet criteria for more than one disorder.
• Median age of onset: 6 years (anxiety), 11 years (behavior), 13 years (mood), and 15 years (substance use disorders).

20% of those who meet criteria receive services

• Gap between need and service use.

Mental health services are most commonly delivered in schools, followed by specialty mental health, child welfare, and juvenile justice settings.
Screening

• The purpose of screening is to identify those at risk for mental health issues and refer for a thorough assessment

• Screening is part of the intake process at mental health facilities, child welfare and juvenile justice systems.
Screening in Schools and Primary Care

Primary care

• Holds potential as the best place to screen youth.
• Limited by current screening tools, referrals, workload

Schools

• Parent concerns; need to opt-in for suicide risk screening
• Administrator concerns about overburdening mental health staff, or not having appropriate referrals
Referrals

Following screening, providers need to make appropriate referrals for youth in need of assessment and intervention.

Referral is challenging for a number of reasons:

- **Functional barriers** (payment, geographic location, transportation)
- **Systemic barriers** (cultural mistrust, disagreement on “the problem”)
- **Agency barriers** (staff turnover, different staff for intake and provider, long waits for appointments)
- **Family barriers** (child doesn’t want to attend, parent cannot make the time)
- **Professional barriers** (providers are not trained, or not trained to competence, in the specific problem area)
Referrals

Making referrals

• Screen potential providers to determine if they work with children and adolescents, what their training is, where they practice (office or home), how they interface with other agencies.

Infrastructure issues

• Types of payment accepted, accessible through public transportation, wait time for new clients, location.
Schools

There is a movement to incorporate social-emotional learning into schools

- Educational goals cannot be achieved when there are social / emotional / behavioral problems

Schools address learning disabilities separately from mental health issues. This is in part a function of there being little overlap between providers trained in their respective disciplines.
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.
- Psychiatric emergencies, such as suicide risk need to be considered in tandem with school violence.
- The National Association of School Psychologists developed the PREPaRE model to preventing, preparing for, and acting in crisis situations.
PREPaRE

P—Prevent and prepare for psychological trauma
R—Reaffirm physical health and perceptions of security and safety
E—Evaluate psychological trauma risk
P—Provide interventions
a—and
R—Respond to psychological needs
E—Examine the effectiveness of crisis prevention and intervention
Bullying and Suicide

- Victim-perpetrators offline bullying significantly increases risk for long-term mental health problems and death by suicide.
- Lifetime risk for suicidal thoughts and behaviors:
  - 12% of youth report serious suicidal ideation, 4% report making a plan, and 4% report making an attempt. (Nock et al, 2013)