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4/30/20

Treating and Preventing Childhood Onset Mental Health Disorders

As the prevalence of mental health disorders in children rises, the need for integrated support systems and evidence-based practice increases as well. Psychologists and psychiatrists recognize that childhood is the most effective time for intervention. Preventing severe and long-lasting mental health symptoms from developing also helps prevent crime, loss of productivity, substance abuse, family instability, and dependence on social services (Skokauskas, 2019). Therefore, this review explores how parents, educators, and healthcare providers can work together to both treat and prevent childhood-onset mental health disorders.

INTRODUCTION

Mental health disorders in children can be best handled through interdisciplinary collaboration between the fields of education and psychology, both of which provide valuable perspectives. This collaboration should focus on implementing school-based mental health resources in both primary and secondary schools, expanding the psychiatric workforce, promoting health educator certification, and advocating for public funding.

Healthcare providers, policymakers, and researchers in psychology and public health all share a common concern for children and adolescents living with untreated — and often undiagnosed — mental health conditions. However, the availability of care simply cannot be increased without an increase in the mental health practitioner workforce. The United States has

less than one-fourth the number of child and adolescent psychiatrists needed to address this critical public health concern (Skokauskas, 2019). One in five children in schools has a diagnosable mental health disorder, but about 70 percent of them do not receive the services they need (Searcy van Vulpen, 2018). The workforce shortage is one of several barriers to treatment that youth face.

Access to care is another significant issue. Policymakers and voters play a significant role when it comes to influencing the accessibility of mental healthcare for children. School-level health policies, combined with state-level assistance, can make a difference in school implementation of mental health practices and therefore students' health (Guerra, 2019). One review of the CDC data on school health policies and practices notes that "[US] states where agency personnel provided health educator professional development in mental health and suicide prevention to schools and districts had higher implementation of mental health policies and practices in schools" (Guerra, 2019). The same study reports that only 9.6% of health education courses are taught by certified health education specialists (Guerra, 2019).

Media sensationalization and stigmatization of people with mental health disorders has historically led to a culture of shame and secrecy surrounding mental health (Searcy van Vulpen, 2018). Despite increasing efforts from psychologists, educators, and advocates to eliminate stigma, the negative cultural connotations of a mental health diagnosis can continue to affect youth today. The fear of being labeled as (or simply feeling) "crazy" or "weak" can be enough to prevent a child or teenager from asking for help. In fact, a 2018 article from the *Children & Schools* education journal cites stigma as one of the primary barriers inhibiting youth from seeking mental healthcare (Searcy van Vulpen, 2018).

Based on the prevalence of these issues, it makes sense to identify their root causes. Understanding causation and risk factors for mental health disorders, such as childhood trauma, unstable home environments, neurochemical imbalances, and family history is essential to developing prevention strategies (Borsboom, 2017). Unfortunately, tracking the development of a mental health disorder is more complicated and ambiguous than determining the origins of a bacterial infection or source of a tumor. Research in neuroscience and psychology evolves constantly, but most experts concur that mental health disorders are caused by a combination of biological, psychological, and social factors which can follow common trends and patterns, but remain specific to each individual (Borsboom, 2017).

CAUSES AND RISK FACTORS

Tracking causes and risk factors builds the foundation for preventing mental health disorders from arising or progressing in severity. Implementing effective prevention modalities is the final major issue in solving this problem. Prevention begins with a childhood free from any sort of physical or emotional abuse or trauma, in which the child is well cared for and his or her needs are consistently met (Pantis, 2015). The responsibility for prevention also falls on educators, school systems, pediatricians, and other primary care providers.

How can healthcare providers, educators, and families work together to treat and prevent mental health disorders in children? Academic literature on the subject of mental health in children calls for a variety of investigations into the causes of disorders, treatments, and interdisciplinary approaches to lowering rates and improving outcomes. The disciplines of education and psychology are best equipped to solve the issue of treating and preventing childhood mental health disorders.

Psychologists and psychiatrists concentrate on clinical advances in treating children, furthering research, and establishing family support as well as comprehensive psychoeducation. They identify workforce expansion as a necessary step towards improving treatment. Psychology, as a discipline, views early diagnosis and immediate treatment of psychological symptoms as essential to recovery and positive health outcomes, but children often experience limited access to mental health services.

One study asks why less than half of all youth with mental health disorders have actually received any treatment (Cummings, 2016). Researchers investigated psychiatric hospitals, general hospitals with a separate psychiatric inpatient unit, residential treatment centers for both children and adults, freestanding outpatient facilities, and non-hospital based mental health facilities (Cummings, 2016). Results showed that more than half of psychiatric hospitals offered youth services, but only about 30% of general hospitals with an inpatient psychiatric unit extended their services to children and/or adolescents (Cummings 2016).

A 2016 article from the *Social Psychiatry & Psychiatric Epidemiology* journal asks what developments have taken place in the field of youth mental health and how we can respond to the continuing challenges. The researchers hypothesize that thorough transformation of youth mental health systems will yield increasingly positive outcomes (Malla, 2016). They reviewed data from Australia, Ireland, the UK, and Canada, and found that each of these countries is actively increasing strategies for early intervention and seeing positive results (Malla, 2016). Researchers must conduct more longitudinal research in order to determine the actual efficacy of these changes (Malla, 2016).

Other researchers ask what factors put children and adolescents at high risk for mental health disorders or symptoms such as psychosis. In one 2018 study, researchers hypothesize that early detection of psychosis risk can improve outcomes. The researchers reviewed 48 articles and analyzed them by following systematic review and meta-analysis guidelines (Tor, 2018). Risk factors for psychosis include behavioral markers such as withdrawn and depressed mood states, preexisting mood and/or behavioral disorders, poor functionality, poor quality of life, illogical thinking, family history, and communication disturbances (Tor, 2018). This article represents the only systematic review of its kind and was limited by the availability of data on the development of psychosis and schizophrenia spectrum disorders (Tor, 2018).

A similar article asks if and how adverse events in childhood act as a risk factor for mental health disorders. The researchers focused their work on a sample of adolescent girls who were involved in the juvenile-justice system or received support services through schools or community organizations (Horn, 2019). They drew data from the post-intervention assessment for an ongoing randomized control study of a program called Safe, Healthy, Adolescent Relationships and Peers (SHARP). Their findings indicated "significant associations between childhood adversity, mental health pathology, and an elevated biomarker measure, F2-IsoPs, that may indicate oxidative stress in a female adolescent sample" (Horn, 2019). Preventing adverse events in childhood, such as divorce, abuse, neglect, parental incarceration, or parental substance abuse can also help prevent mental health disorders from arising in the child (Horn, 2019).

An article in *World Psychiatry* about the network theory of mental disorders expands upon the available data concerning risk factors. The network theory of mental disorders asks how disorder states arise and proposes an alternative means of conceptualizing mental health

(Borsboom, 2017). It uses the pre-existing literature in psychiatry, psychology, and neuroscience to develop the theory that disordered symptoms are connected through biological, psychological, and social mechanisms (Borsboom, 2017). If these relationships are strong enough, symptoms can "generate a level of feedback that renders them self-sustaining" and place the entire network in a persistent disorder state (Borsboom, 2017).

Children and adolescents suffering from mental health disorders may develop maladaptive coping mechanisms in response to psychological distress. Self-harm is an example of a maladaptive behavior that has demonstrated increasing rates among adolescents over the last decade (Griffin, 2018). Researchers hypothesize that the age of onset for self-harm is decreasing. This study analyzed trends in hospital-treated self-harm in Ireland over a 10-year period (Griffin, 2018). Results showed that during this time, the rates of self-harm as treated by hospitals increased by 22% (Griffin, 2018). The greatest increases occurred for females and those aged 10-14 years (Griffin, 2018). Psychologists and mental health counselors recognize that most self-harm does not ultimately result in hospitalization, indicating that data from emergency rooms only represents a portion of the affected population. Further research could include anonymous self-report questionnaires for school-aged children (Griffin, 2018).

TREATMENT

The family unit can support treatment and prevention of childhood mental health disorders. Researchers hypothesize that family-based services show evidence of improving clinical outcomes in youth, but more research is needed to determine this conclusively. One such synthesis of family based services in children's mental health represents a systematic review of 41 studies since 1980 meeting methodological criteria (Hoagwood, 2005). Researchers found

that family based services improve service retention, knowledge about mental health, self-efficacy, and improved family interactions (Hoagwood, 2005). However, more data on this subject is needed to determine the efficacy of family-based services, including longitudinal data (Hoagwood, 2005).

Another key component of the mental health system is inpatient care. Identifying which qualities of brief psychiatric hospitalization are perceived as helpful by adolescent patients can help psychiatrists and healthcare organizations design more effective programs. By collecting feedback from formerly hospitalized adolescents, ideas for program improvement can be collected. Interviews from 82 adolescents within one week of discharge from an inpatient psychiatric unit (Moses, 2011) suggested that helpful features of treatment include interpersonal support from peers and staff, learning coping strategies, group therapy, and the safety of the hospital environment (Moses, 2011). Some also found aspects of their hospitalization unhelpful, such as excessive room time, restrictions and confinement, and unhelpful staff (Moses, 2011). This study has some limitations in regard to the diversity of the sample. Further research could involve more inpatient facilities across different geographic regions where patient demographics such as age, gender, or socioeconomic background may act as variables.

A common treatment used for anxiety disorders in children is cognitive behavioral therapy (CBT), however, research was needed to determine efficacy compared to medication. In a randomized study of children and adolescents with a variety of anxiety disorders treated with CBT, pharmacotherapy, or a combination of both, researchers found that both selective serotonin reuptake inhibitors (SSRIs) and CBT had a significant effect in reducing childhood anxiety

symptoms. Selective norepinephrine reuptake inhibitors (SNRIs) were also effective, but the evidence was less consistent (Review, 2017).

One group of researchers, representing a variety of countries, focused on how changing the public health field could serve to meet the mental health needs of children in the future (Skokauskas, 2019). The authors hypothesize that if we increase the workforce and further research in psychiatric epidemiology, diagnostic methods, therapeutics, and prevention; pediatric mental health services will broaden and improve (Skokauskas, 2019). They found that because of the lack of mental health resources in the US, only the most acutely ill individuals are consistently treated, and there are limited resources for early intervention (Skokauskas, 2019). The researchers call for further inquiry into the breadth and variation of childhood onset psychiatric disorders, diagnostic systems, and therapeutic approaches (Skokauskas, 2019).

The United States in particular can work towards overcoming the psychiatric workforce shortage by better utilizing psychiatric mental health nurse practitioners (PMHNP) (Chapman, 2018). Underutilization of PMHNPs may be due to "system-level barriers to hiring PMHNPs, lack of role-appropriate job descriptions, confusion related to scope of practice/supervision requirements, and challenges in recruitment and retention" despite the fiscal benefits of hiring nurse practitioners versus MDs (Chapman, 2018).

PREVENTION THROUGH ACADEMIC RESOURCES

Educators tend to focus more on the policy side of this issue, advocating for certified health educators in every school, nationwide mental health awareness initiatives, and a focus on expanding school-based mental health services. They are also acutely aware of the workforce shortage and see employing more school psychologists, counselors, and health educators as an

essential step. Education as a discipline has traditionally perceived mental health disorders in children through the lens of classroom disruption, focusing primarily on children with behavioral issues that impact the learning environment of their peers. However, increasing awareness about mental health has revealed the myriad of symptoms experienced by young people with mental health disorders and how those symptoms can impact their personal school experience as well as academic performance.

Strategies for improving school-based mental health services include interdisciplinary collaboration (Kutash, 2015), utilization of "Place2Be" style therapeutic intervention for children's social and emotional well-being (Lee, 2009), or modeling a program similar to Massachusetts' Project Linking Actions with Unmet Needs in Children's Health (MA_LAUNCH) initiative (Molnar, 2018). Healthcare researchers developed LAUNCH as a mental health intervention program in pediatric primary care settings (Molnar, 2018). Results showed a significant improvement in social, emotional, and behavioral health for both children as well as the mental health of their caregivers after one year of participation in the program (Molnar, 2018). Similar strategies could take place in schools, where children are likely to interact more frequently with a school nurse or school psychologist than with their primary care physician.

Elementary school-age children interpret and cope with stress in a variety of ways. Third grade students in one study reported that their main stressors were linked to learning and social obstacles at school (Sotardi, 2017). This indicates that daily school life is having a direct and powerful influence on student mental health. Program interventions like Place2Be and

LAUNCH, which allow students' mental health and factors such as specific stressors to be tracked over time, can help researchers better understand childhood stress (Sotardi, 2017).

The secondary school period is also a critical time for intervention. Coordination between school programs and state-level assistance is essential as "health educator certification, school use of data during school improvement planning, presence of a health/safety coordinator, presence of a health council and state‐provided health educator professional development were each significantly positively associated with schools' implementation of mental health policies and practices" (Guerra, 2019).

Australian researchers, observing similar trends in childhood mental health decline to the United States, conducted research to investigate a means of increasing mental health literacy nationwide (Tully, 2019). They reviewed literature to determine that despite the many new evidence-based intervention models, rates of psychological disorders in children are not decreasing, and parental knowledge surrounding means of seeking help is low (Tully, 2019). They argue that a national initiative focusing on increasing mental health literacy for childhood disorders, supported and promoted by the federal government, could help more children receive help in the first place (Tully, 2019).

There are several barriers preventing children from receiving school-based mental health services. These include the work demands of teachers, limited access to training, lack of funding, limited school mental health professionals, and the fact that these services can be limited to special ed students (Searcy van Vulpen, 2018). Other factors include medicaid enrollment among students, the proportion of uninsured students, state funding or lack thereof, racial composition of district, local poverty rate and income level, urbanacity, geographic location, and school size

(Slade, 2003). Additional research could explore the specific services offered by different schools based on geographic location and community demographics, the types and numbers of school-based healthcare providers, and the quality (and efficacy) of care provided (Slade, 2003).

In order for a school to offer mental health services, it must be equipped with the appropriate personnel. However, the United States has a shortage of school psychologists, due in large part to hiring incentives (NASP, 2019). The National Association of School Psychologists (NASP) advocates for salary incentives for school psychologists who meet National Certification of School Psychologists (NCSP) standards, or NCSP parity. This means that school psychologists holding national certification should be treated equally to teachers and administrators holding national certification (NASP, 2019). Research from the National Association of School Psychologists indicates that these stipends are beneficial for recruitment and retention tools; promote employing of highly qualified individuals; and encourage higher quality mental health services (NASP, 2019).

One of the most important ways school districts can help solve this problem is by providing mental health screening (Slade, 2003). Screenings function as both a preventative measure and an opportunity for early intervention. Ideally, every child would have the opportunity to meet with a school psychologist at the beginning of each school year for a mental health screening. As psychologist Eric Slade stated in his article,

> Approximately half of all schools do not have any on-site access to mental health counseling… by comparison, more than 90% of schools provide hearing and vision screening, even though severe mental illnesses can be as impairing in school settings as impaired sight or hearing, and are frequently not diagnosed or treated (2003).

Prolonged, chronic, or acute stress is a common trigger for the exhibition of disordered cognitive and behavioral symptoms (Sotardi, 2017). Researchers found that the main stressors for elementary school aged children were linked to their learning and social obstacles at school (Sotardi, 2017). This is important for educators to consider because it demonstrates that daily school life is having a direct and powerful influence on student mental health, perhaps even more so than the home environment.

Mental health support is an important component of general health services in schools. Unfortunately, many school districts in the U.S. operate without any in-school health system in place. Socioeconomic factors such as local poverty rates, insurance status of students, and urbanacity all influence school district and state decisions to offer and/or finance school-based health services (Slade, 2003). Individual school and state policies are important — simple policy changes like requiring certification for health educators and mental health related professional development training for educators can make a difference when it comes to identifying mental health concerns in children early on (Guerra, 2019). Early detection systems also provide the opportunity for school health officials to notify a child's parents and primary care provider of any concerns so that all three main facets of the child's support system — parental, school, and healthcare — can communicate and problem-solve most effectively.

PREVENTION THROUGH MEDICAL RESOURCES

The American Hospital Association has estimated the need for child and adolescent psychiatrists in 2020 at around 12,624 (Satiani, 2018). However, the projected supply is only 8,312 psychiatrists and nearly 55% of those are near retirement age (Satiani, 2018). Only four percent of U.S. medical students in recent years have been applying for psychiatric residency

training, so workforce projections are not encouraging (Satiani, 2018). Researchers in psychology and healthcare propose that one way to combat the workforce shortage is to train and utilize more Psychiatric Mental Health Nurse Practitioners (PMHNPs). Nurse practitioners are less expensive to both educate and hire than traditional medical doctors, despite still undergoing rigorous specialized training and operating under a similar (if not the same) scope of practice in psychiatry (Chapman, 2018). Pushing for competitive salaries for child psychiatrists, school psychologists, and health educators could help fill the void of mental health specialists willing to work with children.

Workforce needs also extend to healthcare providers and healthcare managers willing to expand psychiatric facilities. Only half of all youth with diagnosable mental health disorders ever actually receive treatment, and the vast majority of general hospital-based psychiatric units in the United States will *only* treat adults (Cummings, 2016). According to data collected in 2016, just over 20% of urban/suburban counties had a youth-serving hospital based facility, compared to only 1% of rural counties (Cummings, 2016). Mental healthcare is even more inaccessible for children than it is for adults, despite their relative vulnerability and dependency on adult caregivers.

Building up the psychiatric and behavioral health workforce is a necessary step towards lowering rates of mental health disorders in children and adolescents, improving accessibility, and lowering suicide rates. However, the treatments provided by these professionals must be effective in combating the myriad of biochemical and cognitive disruptions that contribute to mental health disorders. For instance, the simultaneous utilization of selective serotonin reuptake inhibitors alongside cognitive behavioral therapy consistently proves effective for treating

depression and anxiety (Brown University, 2017). These medications also tend to have minimal adverse side effects and are approved for use in children (Brown University, 2017).

Pharmacotherapy is also a common treatment for attention deficit hyperactivity disorder (ADHD). Past research has demonstrated the efficacy of drugs such as Atomoxetine and Methylphenidate in combating ADHD symptoms in children and improving social, behavioral, and cognitive functioning (Milea & Cozman, 2012). However, current scholars argue that the best intervention for ADHD combines pharmacological treatment with multimodal psychosocial intervention (Milea & Cozman, 2012). This claim is supported by research showing the multimodal intervention, which also involved students' families and teachers, to be more effective than medication alone (Milea & Cozman, 2012). Overall, scholars in psychology agree that the most effective interventions for moderate to severe mental health disorders involve a combination of therapy and medication. In some cases, either medication or non-pharmacological therapy can be effective without necessitating both.

PREVENTION THROUGH FAMILY RESOURCES

Social and family support also play a significant role in recovery. Research suggests that one of the best ways to prevent mental health disorders from developing is to address risk factors. Although scholars know that genetic predisposition has a significant influence on potential mental health concerns, they also recognize the role of the child's environment when it comes to "pulling the trigger" on some of these traits. Facilitating a safe and healthy childhood begins with the child's caretakers, and their support remains necessary throughout adolescence.

Medical researchers in Romania explain that "the likelihood of developing anxiety disorders is influenced by familial, genetic, neurobiological, cognitive predisposing factors,

susceptible temperament traits (e.g. inhibited, shy child), and environmental factors" (Pantis, 2015). They listed primary risk factors for anxiety disorders as: "family and parenting factors, [such as] parental rejection and the hyper-protective parenting style [as well as] parental stress, anxiety and depression; low self esteem; bullying and victimization; and childhood abuse or psychotraumatic events such as divorce, death of a family member, emotional abuse, and separation experiences" (Pantis, 2015). The results of this study showed that adolescent females are two times as likely as males to develop an anxiety disorder and there was a strong correlation between anxiety disorders and adverse life events such as the death of a parent, parents' divorce, school stress, and emotional and physical abuse (Pantis, 2015).

Generally, scholars believe that early detection of risk factors for any mental health disorder can improve outcomes. A combined awareness of these risk factors from family members, educators, and primary care providers can encourage preventative measures or facilitate early intervention if the child begins to exhibit symptoms. For example, a child exhibiting a withdrawn and depressed mood state should immediately begin therapeutic intervention with a mental health professional to address that primary symptomatology. If the intervention is successful in remedying the depressed mood state, then the child becomes significantly less at risk for developing a schizophrenia symptom disorder (Tor, 2018).

PREVENTION THROUGH POLICY

Childhood-onset mental health disorders can be treated before they escalate and cause catastrophic effects. In some cases, onset itself can be prevented. The first concrete step towards improving the lives of children in the United States and lowering psychiatric illness morbidity across all age groups is the institution of a licensed school psychologist in every primary and

secondary public school in the country. Licensure requirements differ from state to state, but according to the National Association of School Psychologists, the basic requirements include completion of a specialist-level or doctorate degree program, completion of a year-long supervised internship, and national level certification through the National School Psychology Certification Board (NASP, 2019). School psychologists can supervise the administration of annual or biannual mental health screenings for the student body and begin intervention as soon as areas of concern arise. Of course, additional personnel costs can be a strain on already tight school budgets. This could be resolved through state and federal governments adjusting their priorities for school funding and recognizing mental health as an integral factor for student success, which could actually lower costs long-term.

For example, state governments spend 1.7 billion dollars per year on standardized testing (Ujifusa, 2012). Yet at the same time, many experts believe that standardized testing is inaccurate, ineffective, and can actually harm student progress (Popham, 1999). This system creates a consistent profit for testing companies at the expense of taxpayer dollars, under the guise of education funding (Stauffer, 2017). In 2011, the president of the College Board (proprietor of the SAT), received a 1.3 million dollar salary (Stauffer, 2017). Even state or regionally based tests, at every level of education, use tax dollars meant to improve schools to pay corporations for an unreliable snapshot of student performance. Redirecting the use of that $1.7 billion could offset hiring costs for every public school district in America, giving them a greater budget to meet a new requirement for school psychologist staffing *without* increasing the burden on taxpayers.

A school psychologist requirement in public schools combined with NCSP parity (hiring incentives for nationally certified school psychologists equivalent to those for teachers and administrators) would create more job security and financial incentive for aspiring psychologists to pursue a career in this specific field (NASP, 2019). Similarly, higher education as well as healthcare institutions can achieve workforce expansion in child psychiatry through systematic reform. First, inpatient as well as outpatient hospital-based psychiatric units must adjust their scope of practice to treat children in addition to adults, creating an opportunity for child psychiatrists to start their careers with the benefits of working for a hospital versus starting out in private practice. However, this expansion will only succeed if medical students, who often graduate with overwhelming debt, have a financial incentive to specialize in psychiatry. Child and adolescent psychiatrists currently earn less than other medical doctors, making the field less desirable (Skokauskas, 2019). Offering competitive salaries for child psychiatrists will ultimately bring more business to hospitals, as researchers already emphasize the need for care as grossly underserved and constantly increasing (Satiani, 2018).

Another way to expand the psychiatric workforce that is less expensive for both employers and prospective students is the further integration of Psychiatric Mental Health Nurse Practitioners in healthcare. Operating under virtually the same scope of practice as a psychiatrist, but without the burden of medical school debt and corporate overheads for hiring MDs, PMHNPs specialize and enter the workforce sooner with the flexibility to work both in or outside of a hospital setting (Chapman, 2018). In order to train more PMHNPs, nursing programs across the country should consider expanding their postgraduate programs to include certification for Nurse Practitioners in psychiatry. Students considering a career in mental health

or psychiatry may see NP programs as a less financially and time demanding alternative to medical school, bringing their business to graduate schools with nurse practitioner certification tracks instead.

All of these changes will also address the accessibility issue by making psychiatric services available in more physical locations, as well as ensuring psychological care in every public school at no cost to the student's family, similar to the services of a school nurse. Another way of making mental health services more accessible for children — especially those in rural areas — is to implement and expand telemental health programs (Hilty, 2013). Telemental health involves connecting an individual experiencing psychological or emotional distress with a licensed behavioral health provider, such as a mental health counselor, through video chat, email, or phone call. By eliminating the need for transportation to a provider's office, telemental health decreases the stress on caregivers and allows for efficient, direct communication with the child or teenager. Research published in the *Telemedicine Journal and E-Health* concludes that telemental health is effective for diagnosis and treatment of many mental health disorders and can be used in a variety of settings (Hilty, 2013). Telemental health services may be best utilized by implementing them at every level of childhood mental health care — home, school, and healthcare facilities. If finances allow, caregivers can find licensed mental health counselors through various web-based platforms and work with their child to find the best counselor for their needs. There is no commitment to long-term treatment, and even obtaining a baseline diagnosis via telemental health can facilitate better collaboration between the child's school psychologist, teachers, and primary care provider. Schools also have the option to implement telemental health services that are available to all students, regardless of socioeconomic status.

Such programs could limit the quantity of sessions based on school budget, but at the very least, telemental health availability in schools could aid school psychologists and guidance counselors with early intervention. Finally, emergency departments across the United States can and should have telemental health services on-call for psychiatric intakes. When a suicidal teen is transported to the emergency department of a hospital, he or she rarely encounters a mental health professional who has the time and understanding to initiate proper care. Linking a patient in severe psychological distress with a mental health counselor over video chat provides the opportunity to begin necessary treatment sooner.

CONCLUSION

Children and adolescents comprise a highly vulnerable demographic and rarely receive mental health treatment in the absence of proper support networks. Without the ability to care for themselves completely, children learn to rely on their parents, school, and doctors to help them navigate the world. These people and systems designed to care for children have an innate responsibility to act in the best interest of every child, no matter the circumstance. Mental health is not an accessory to wellness, but rather the core of a fruitful existence. With this in mind, we must address the needs of our children with respect, compassion, clarity, and resolve to ensure for every hurting child an opportunity for healing.

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