

Montana Access to Pediatric Psychiatry Network: Statewide Needs Assessment Final Report

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Introduction

At any given time, behavioral and mental health issues impact up to one in five children and adolescents in the United States¹. The most commonly diagnosed mental health disorders in youth are Attention Deficit/Hyperactivity Disorder (ADHD), behavioral issues, anxiety, and depression². However, there are demographic differences in diagnosed mental disorders. Prevalence increases with age for all mental and behavioral disorders except Autism Spectrum Disorders (ASD), and boys are more likely than girls to be diagnosed with most disorders; boys are also more likely to die by suicide³. Children age 6-11 years are more likely to be diagnosed with behavioral and/or conduct disorders while diagnoses of depression and anxiety are more prevalent in adolescents⁴. Poverty and socioeconomic inequality are also associated with increased prevalence of mental disorders in both children and adolescents.⁵

Approximately 22% of Montana's population is under 18 years old⁶; nineteen-percent (19%) of those live in poverty⁷. Recently, thirty-one (31%) percent of high school students in Montana reported symptoms of depression, 33% reported current alcohol use, and 21% of high school students considered suicide within the previous twelve months⁸. There is evidence that suggests prevalence rates for mental and behavioral disorders in Montana are similar to national data (See Behavioral Health Barometer Montana, Vol. 4)⁹. Montana is a frontier state in which small, socially isolated communities and sparse population in rural areas means there are significant access issues for children and adolescents needing mental and behavioral health services.

Montana's Approach

In Autumn 2018, the Montana Department of Public Health and Human Services (DPHHS) was awarded a U.S. Department of Health and Human Services, Health Services and Resources Administration (HRSA) grant to develop a pediatric mental health care access program. DPHHS partners at Billings Clinic and the University of Montana are collaborating to develop the Montana Access to Pediatric Psychiatry Network, or MAPP-Net.

MAPP-Net has three primary objectives:

- **Objective A:** Coordinate and connect psychiatric and mental health services across the state of Montana through a statewide provider network.
- **Objective B:** Enable primary care providers to conduct early identification, diagnosis, and treatment for children with behavioral health conditions.
- **Objective C:** Increase the delivery of psychiatric and mental health services through telehealth networks.

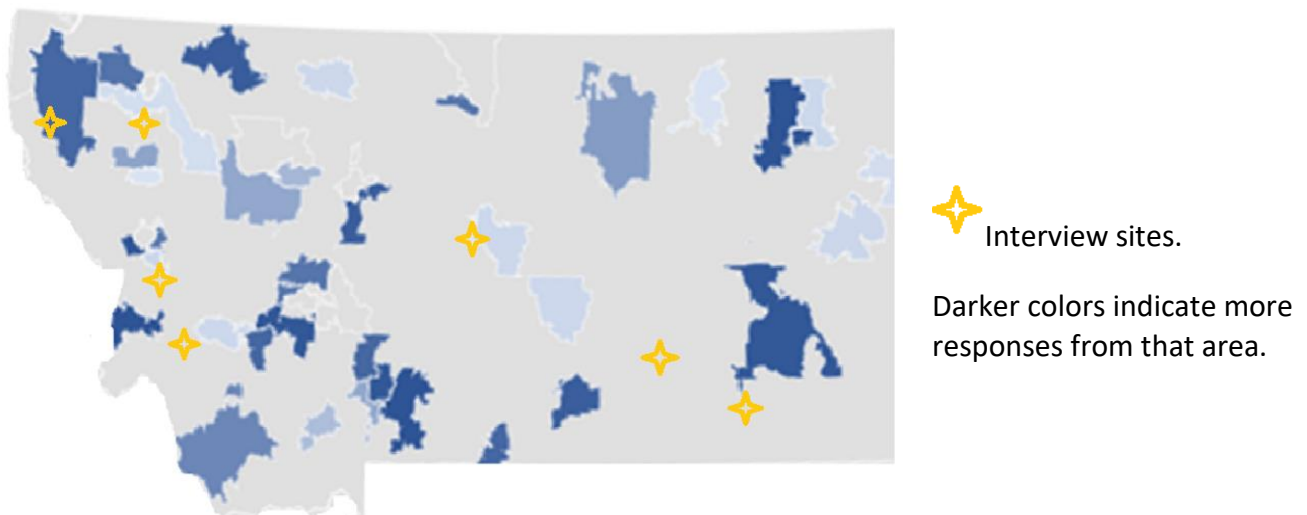
To better understand how to effectively accomplish these objectives, the MAPP-Net partners developed and implemented a statewide needs assessment initiative comprised of a review of relevant literature, two statewide surveys, and 17 key informant interviews. Results from the two surveys and the interviews reveal that the behavioral and mental health needs of youth in Montana are both similar—and different—from similar groups across the United States.

Methodology: Surveys

Two online surveys were developed and implemented utilizing Qualtrics® to assess perceptions of behavioral and mental health needs among youth, provider confidence in meeting needs, and the available resources to meet identified needs. The surveys were targeted to two different populations: Medical Healthcare Providers and Mental Health Providers. Both surveys were brief and straightforward to encourage participation. The Medical Healthcare Provider survey included 28 questions, including respondent demographics. The Mental Health Provider survey included 25 questions, including respondent demographics.

One thousand seven hundred eighty-five (1,785) survey invitations were sent to medical healthcare and mental health providers through email (just over 700) with the remainder via a surface mail postcard. Contact information was obtained through freely available public sources. At least two state organizations, the Montana chapters of the National Association of Social Workers and the American Academy of Pediatrics, sent the survey invitation via email to their entire membership. It is likely that many of the associations' members were also contacted through the direct invitation process. Additional survey invitations were made at several provider and family conferences. Two hundred ninety-eight (298) individuals across Montana initiated the surveys, although not all completed all items. Seventeen individuals participated in key informant interviews. See Figure 1 for a geographic distribution of survey responses and interview sites.

Figure 1. Survey Responses by Montana Zip Code

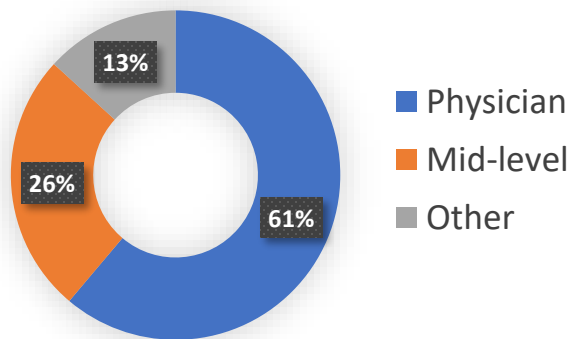


Survey Respondents

Medical Healthcare Providers

One-hundred and twenty-one (121) respondents completed at least two-thirds of the Medical Healthcare Provider Survey. Sixty-one percent (n=74) were physicians and an additional 26% (n=31) of the respondents were mid-level providers, including Nurse Practitioners and Physician Assistants (see Figure 2). Respondents represented 52 separate zip codes.

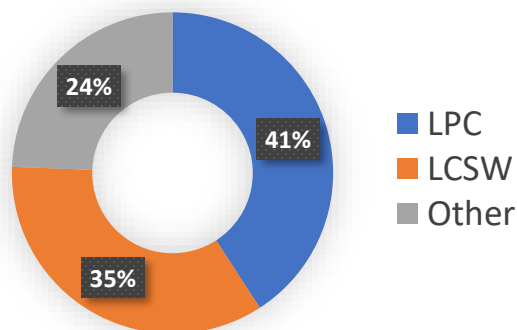
Figure 2. Medical Healthcare Respondents



Mental Health Care Providers

One-hundred and seventy-seven (177) respondents initiated the Mental Health Provider Survey. Respondents were primarily Licensed Professional Counselors (41%; n=67) and Licensed Clinical Social Workers (35%; n=57); 24% (n=40) of the respondents identified their discipline as “Other” and this included Licensed Addiction Counselors, and pre-licensure social workers and counselors (see Figure 3). Mental Health Provider respondents represented 54 Montana zip codes.

Figure 3. Mental Health Respondents



Survey Results

Medical Healthcare Providers

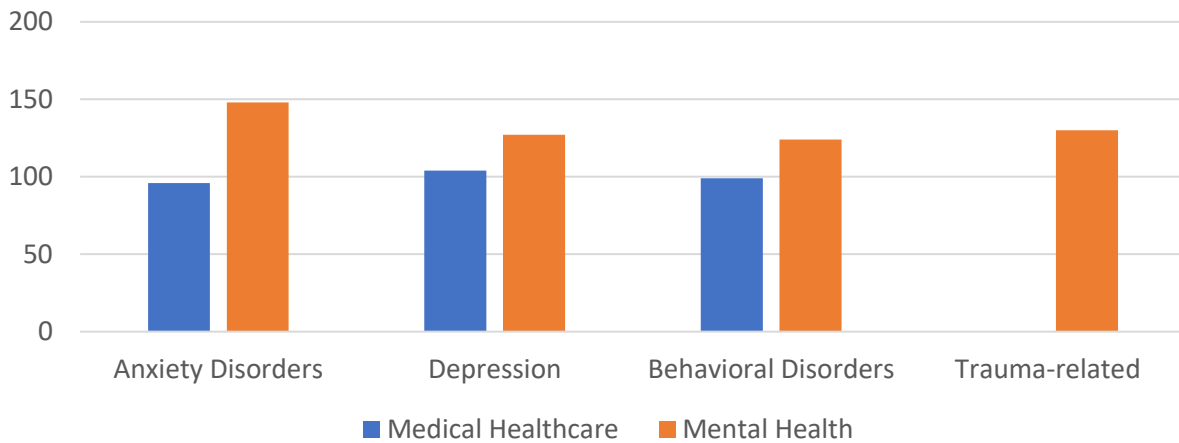
Respondents were asked to select up to six mental health disorders that they commonly see in child and adolescent patients from a list of 16 disorders (see Table 1). An open-ended item allowed respondents to identify other disorders not included in the list (see Appendix A).

Table 1. Survey Options for Mental Health Disorders

Anxiety Disorders
Autism Spectrum Disorder
Behavioral Disorders
Bipolar Disorders
Depression/ Depressive Disorders
Eating Disorders
Family Conflict
Gender Dysphoria
Learning Disabilities
Obsessive-compulsive Disorders
Psychotic Disorders
Sleep Disorders
Substance Use Disorders
Suicidal Ideation
Self-harm
Trauma-related Disorders

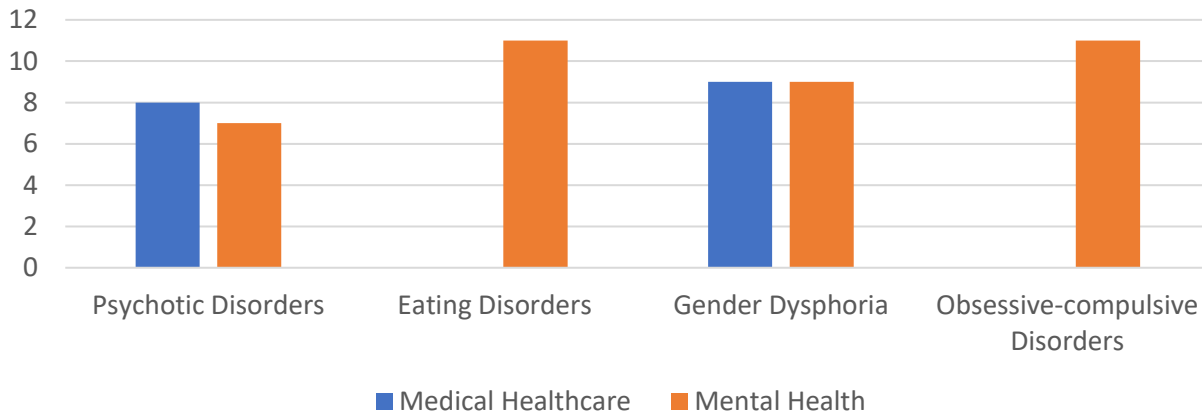
The most common mental health issues the Medical Healthcare Provider respondents reported seeing in their child and adolescent population were Depression/Depressive Disorders (n=104), Behavioral Disorders (n=99), and Anxiety Disorders (n=96); Figure 4 summarizes these results. The comparison to Mental Health Provider responses is explained in the next section. The first column is Medical Healthcare Providers; the second and comparison column for each issue is Mental Health Providers.

Figure 4. Most Common Mental Health Issues Seen



The least common mental health issues the Medical Healthcare Provider respondents see in their child and adolescent population are Psychotic Disorders (n=8), Eating Disorders (n=9), and Gender Dysphoria (n=9); Figure 5 summarizes these results.

Figure 5. Least Common Mental Health Issues Seen



Medical Healthcare Provider Respondents’ highest levels of “comfortable treating independently” are Anxiety Disorders (52%), and Depression/Depressive Disorders (51%).

Medical Healthcare Provider Respondents’ highest levels of “uncomfortable; would refer” are Psychotic Disorders (78%), Bipolar Disorders (60%), Gender Dysphoria (50%), and Eating Disorders (49%). Table 2 summarizes provider comfort treating the sixteen diagnoses. The comparison to Mental Health Provider responses is explained in the next section.

The most common places Medical Healthcare Provider respondents refer pediatric patients who need further mental health services are Emergency Departments (n=74), In-state inpatient psychiatric facilities (n=70), and Mental health providers in their clinic (n=59).

Medical Healthcare Provider respondents were asked to respond to specific items about MAPP-Net activities. First, respondents were asked to rate their first and second choice for how they would like the MAPP-Net physician to respond to Access Line calls. Eighty-seven percent (n=105) indicated their first choice for return contact was by telephone. The most frequently mentioned second choice for return contact method was email (48%; n=57).

Second, respondents were asked to choose a preference for return contact following a call to the Access Line between, “a return contact anytime within 30 minutes” or “a set appointment for a return contact within 60 minutes.” Respondents indicated a preference to be contacted within thirty minutes (48%; n=58) but 29% (n=35) found either option acceptable.

Third, respondents were asked if they had attended a Project ECHO session in the previous 12 months; 23% (n=28) indicated they had attended a session. See Table 3 for a comparison between the two provider groups.

At the conclusion of the survey, Medical Healthcare Provider respondents were invited to share thoughts about the mental health needs of children and adolescents in Montana or about the project; 43 comments were offered. Respondents identified lack of access to resources as a significant issue impacting the abilities to meet the mental health needs of children and adolescents in Montana. For example, one respondent observed, “we are lacking the professionals to help these children and the ones we have available are overloaded with waitlists of up to one year.” Another shared, “services are scarce and inadequate, especially for Medicaid patients.”

The common themes represented in the qualitative survey comments include:

1. Project ECHO is helpful but not readily accessible;
2. Same-day consultative services for primary care providers are needed (e.g., Access Line);
3. Wait times for evaluation, placement and services are too long. Individuals and families suffer in the interim;
4. Access to 24-hour consultation is desirable, particularly for emergency department staff; and,
5. Resource information related to services, and provider expertise and quality, is lacking. Resource information may be available, but it’s not qualified or prioritized; it should be.

Table 2. Provider Comfort in Treatment

Mental Health Disorder	Comfortable treating independently		Comfortable treating with consultation		Uncomfortable; would refer	
	Medical Providers	Mental Health Providers	Medical Providers	Mental Health Providers	Medical Providers	Mental Health Providers
Anxiety Disorders	52	88	34	11	14	1
Autism Spectrum Disorder	11	28	54	50	34	22
Behavioral Disorders	24	75	50	23	25	3
Bipolar Disorders	6	35	34	55	60	10
Depression/ Depressive Disorders	51	83	39	16	10	1
Eating Disorders	7	14	44	45	49	42
Family Conflict	32	80	47	13	21	7
Gender Dysphoria	6	23	43	53	50	23
Learning Disabilities	15	30	55	52	29	18
Obsessive-compulsive Disorders	15	48	56	40	29	12
Psychotic Disorders	2	18	20	50	78	33
Sleep Disorders	29	38	54	43	17	18
Substance Use Disorders	11	30	53	32	36	39
Suicidal Ideation	10	67	50	29	39	4
Self-harm	13	68	57	28	30	4
Trauma-related Disorders	8	74	55	21	37	6

Table 3. Project ECHO Participation in the Last 12 Months

	Yes	No
Medical Healthcare Provider	23% (28 of 121)	77%
Mental Health Provider	15% (26 of 173)	85%

Mental Health Providers

Mental Health Provider respondents were asked to select up to six mental health disorders that they commonly see in child and adolescent patients from a list of 16 disorders (refer to Table 1 above). An open-ended item allowed respondents to identify other disorders not included in the list (see Appendix B for results).

The most common mental health issues the Mental Health Provider respondents reported seeing in their child and adolescent population are Anxiety Disorders (n=148), Depression/ Depressive Disorders (n=127), Behavioral Disorders (n=124), and Trauma-related Disorders (n=130); Figure 4 above summarizes these results and enables comparison with Medical Healthcare Provider responses.

The least common mental health issues are Psychotic Disorders (n=7), Gender Dysphoria (n=9), Obsessive-compulsive Disorders (n=11), and Eating Disorders (n=11); Figure 5 summarizes these results and enables comparison with Medical Healthcare Provider responses.

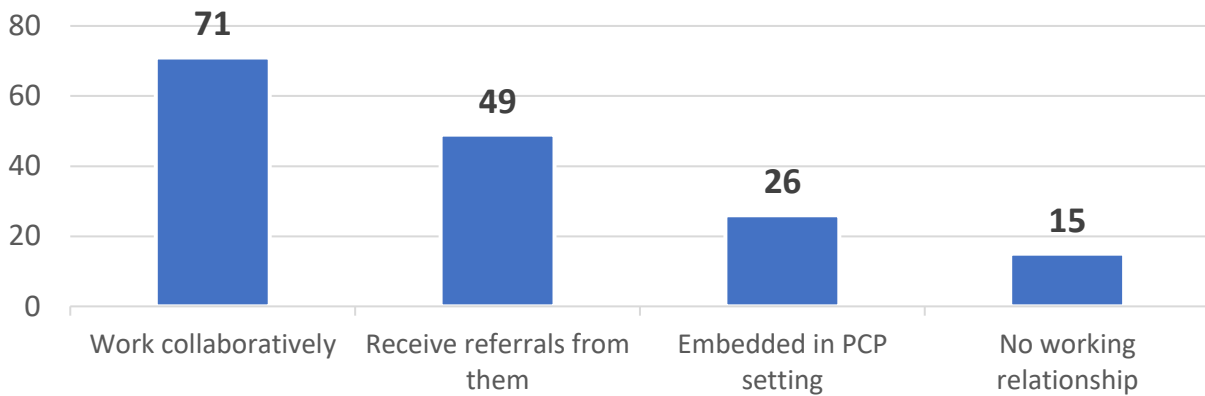
Mental Health Provider Respondents' highest levels of "comfortable treating independently" were Anxiety Disorders (88%), Depression/ Depressive Disorders (83%), and Family Conflict (80%).

Mental Health Provider Respondents' highest levels of "uncomfortable; would refer" were Eating Disorders (42%), Substance Use Disorders (39%), and Psychotic Disorders (33%). Table 2 above summarizes provider comfort treating the sixteen diagnoses and offers a comparison with Medical Healthcare Provider responses.

The most common places respondents refer pediatric patients who need further mental health services were In-state inpatient psychiatric facilities (n=95), and Emergency Departments (n=86).

Mental health providers were asked to share their perceptions of working relationships with local primary healthcare providers who serve children and adolescents. Forty-two percent (n=71) reported that they work collaboratively with their local healthcare providers who serve children and adolescents, 29% (n=49) receive referrals from the providers, 15% (n=26) are embedded in a primary health care setting, and 9% (n=15) reported they had no working relationship with local medical providers who serve children and adolescents. See Figure 6.

Figure 6. Mental Health Collaboration with Primary Care Providers



Respondents were asked if they had attended a Project ECHO session in the previous 12 months; 15% (n=26) indicated they had attended a session. See Table 3 above.

Finally, Mental Health Provider respondents were invited to share thoughts about the mental health needs of children and adolescents in Montana or about the project; over 80 respondents offered comments. Many of the responses mentioned the challenges associated with lack of resources. For example, one respondent noted that, “the significant cuts to Medicaid benefits for children have had a tremendously negative impact on the welfare of clients on my caseload.” Another shared, “the needs are high and services are lacking in the aftermath of Medicaid cuts” while another opined, “it is shameful how underserved kids are.”

The common themes represented in the qualitative comments include:

1. Families should be the focus of therapy services, not just the children;
2. Services for very young children are severely limited. Montana lacks expertise for this very vulnerable population;
3. Schools and education systems need to be better connected into the behavioral health system. School staff is not prepared to address increasing behavioral health needs in school-age children; and,
4. Sexual abuse is a growing family concern with generational consequences on the mental health, particularly for females.

Key Informant Interviews

In order to better understand the experiences of professionals providing mental health services to children and adolescents in Montana, interviews were conducted by telephone or in-person with seventeen individuals. Five of the interviewees were mental health professionals and twelve were medical healthcare providers, including seven physicians. Providers from two Montana reservations were included in the interviews, as well as individuals who work within tribal communities. Interview findings mirrored the survey findings. The following list outlines the primary themes identified in the interview process. A detailed summary of each immediately follows. They appear in no particular order.

- Anxiety and depression
- Impact of trauma and family issues
- Suicide and suicidal ideation
- Lack of resources

Anxiety and Depression

Anxiety and Depression were mentioned frequently as the common issues seen in the interviewees' client/patient populations, but the conversations allowed for additional detail. For example, anxiety and depression are common in older age groups but in younger children, some clinicians identified ADHD and anxiety as more prevalent.

Most medical care providers are not especially challenged by what one called the “run of the mill” diagnoses of depression and anxiety, believing that they have the skills and knowledge to manage these disorders, and especially in older adolescents. However, medical care providers are often challenged when their first-line medication plans do not work and also when dealing with depression and anxiety in younger adolescents and children; this is primarily due to concerns about what medications can be safely used in younger populations. Children and teenagers who live with Autism Spectrum Disorder were not identified as a prevalent issue but some providers made a point to share how these youth present special challenges to them and their communities, and especially when higher levels of care are needed.

Impact of Trauma and Family Issues

Almost every person interviewed discussed the **impact of trauma and family issues** on their clients. One medical care provider noted that there is “no medicine” for parenting issues and trauma. Abuse, neglect, family violence, alcohol abuse, drug use, parental stress, custody issues, loss and grief – providers described a variety of traumatic experiences that face the children and adolescents they serve. Many of the providers do try to treat families as a system, but there are significant barriers to this, including lack of available resources. One provider described how parents who know they need treatment are scared to seek it due to concerns about losing their children, either through Child and Family Services (CFS) and/or other family members. Other providers described overwhelmed adult caregivers, living in poverty and struggling with alcohol and/or drug use. One provider offered that she had “no pill” for the family problems that she sees in her practice every day.

Suicide and Suicidal Ideation

Suicide and suicidal ideation were mentioned by several of those interviewed as a significant challenge in working with adolescents in their communities. Emergency Departments, although

not typically equipped with specially trained staff or optimal facilities to manage mental health crises, are where many suicidal teens receive crisis care. One provider described the challenges associated with transporting suicidal youth to specialized care, sharing one circumstance in which family members drove a teen in crisis over 80 miles to the nearest facility who could take him.

Lack of Resources

Lack of resources was a theme in the survey responses and also in the key informant interviews. The perception that there are insufficient resources creates multiple issues for providers and the families they serve. Most providers shared that there are simply not enough counselors for patients, especially for younger children, and that access to existing providers can be problematic. For example, one provider described how the nearest mental health resources for children and adolescents were at least 80 miles away—in an area where many families do not have transportation. Out-of-state placements are being utilized for children and adolescents with high levels of need either because similar services either do not exist in Montana and/or the services are not available due to demand. One provider shared that there was a year-long wait to get children tested in order to ensure an accurate diagnosis, including for learning disabilities. This lack of ready access to neuropsychological evaluations was mentioned repeatedly. One provider shared that he works hard to get parents to agree to have the testing done. Then they wait 12-15 months. Parents have moved on by that time and do not always follow through with their long-scheduled appointments.

Perceived MAPP-Net Benefits

The interviewees were positive about the **benefits that MAPP-Net** will offer them, and especially for assistance in managing medication. As previously mentioned, providers shared that they typically feel comfortable with their first-line treatments for the common mental health issues they see in patients but would appreciate consultation when those first line medications do not seem effective and/or the patient is too young for the usual first-line medications. Another area that interviewees identified as a potentially valuable service is helping with differential diagnosis. More than one mentioned the difficulty in assessing younger children for ADHD versus anxiety versus PTSD. Multiple interviewees mentioned that the Access Line could also be beneficial for mental health providers.

It is interesting to note that supporting a Montana-based MAPP-Net psychiatrist(s) consultant was viewed favorably by several interviewees. One shared how frustrating it is when consulting with a psychiatrist outside of Montana who has no concept of what it means to live in a frontier state where there are literally no resources within the community. Another provider's response to hearing that psychiatric consultation would be available from a Montana psychiatrist was, "AMAZING." This provider went on to describe an experience in which she made 10 phone calls over a three-week period before finally being able to consult with a specialist about a critical case. It is important to note that some providers indicated that the need for consultation is not simply during business hours. One provider shared that resources for him outside of business hours were "non-existent" and given reliance on Emergency Departments for mental health crisis, he viewed the daytime business hour Access Line schedule as highly problematic.

Most of the survey respondents were unaware of Project ECHO, and this was true of the interviewees as well. However, most expressed interest when they learned how they could be involved in Project ECHO sessions. Many offered ideas for Project ECHO session topics, and the diverse topics suggested reflects the multiplicity of challenges faced by providers across Montana (see Table 4).

Table 4. Project ECHO Topics Suggested by Interviewees

ADHD vs. Anxiety
Aggression
Alcohol use
Anger management
Autism Spectrum Disorder
Behavioral disorders
Behavioral issues
Burn-out /Compassion Fatigue (for providers)
Creating community connections for youth
Cyberbullying
Depression
Family relationships
Generational trauma
Grief and loss
Hopelessness
Interfacing with schools
LGBTQ youth
Medication management
Navigating custody conflicts
Pathology vs. Normal development
Relationship disruptions (divorce, loss of custody, etc.)
Runaway youth
Substance Use Disorder
Suicide and suicidal ideation
Supporting overwhelmed parents
The lifelong implications of a diagnosis
Trauma
Working with abused children
Youth who were prenatally drug impacted
Youth with Head Injuries

Conclusion

Findings from the two surveys and the 17 key informant interviews support previous work designed to understand the mental health needs of youth, both nationally and in Montana. Depression and anxiety are the most commonly diagnosed mental health disorders nationally, especially in teenagers, and the providers who completed our surveys identified these disorders as ones they see most frequently in their own patients. National data indicates that ADHD is more typically seen in younger children. That was also reflected in our findings. The congruence of our results with national and state data supports the validity of our findings.

While we are confident in our findings, we recognize the limitations of our assessment. Our survey response rate, even with a follow-up invitations, was about 15%. We attempted to reach potential respondents through direct invitations at conferences and meetings, and with direct invitations from trusted professional organization collaborators. Second, we had participation from providers who serve tribal communities, but we are unsure how many work for tribal health clinics vs. public (i.e., State of Montana) or private clinics. We believe that the results may have been richer if we had a clearer sense, beyond zip codes, of the day-to-day experience of survey and interview participants. Finally, the “other” survey response options resulted in long lists of topics, ideas and issues that we hadn’t fully considered. We underestimated the breadth of concern in the pediatric mental health community. A fuller estimation of these concerns may have resulted in different survey and interview questions.

This project was designed not only to assess provider perceptions of frequently seen mental health disorders in children and adolescents in their practices, but also to assess provider comfort with treatment. Both the interviews and the two surveys suggest that providers are comfortable treating the more frequently diagnosed mental health disorders in youth they see in their practices. In spite of this expressed comfort, some of the respondents and interviewees highlighted the need for continuing education in the treatment of depression, anxiety, and other mental health disorders that providers see more frequently. This information, and the suggested topics generated from interviews, will help the MAPP-Net team design targeted Project ECHO sessions to meet the needs of Montana providers.

The expressed lack of comfort in treating some of the more serious mental health disorders identified in the survey not only identifies areas of need for increased training, but also suggests the important role the MAPP-Net Access Line can play in Montana. For example, less than ten percent of the Medical Healthcare Providers are comfortable independently treating a child or adolescent presenting with suicidal ideation. Many want treatment consultation and nearly a third prefer to refer the patient. Given that Montana has one of the highest rates of suicide in the country, it is critical that providers have the ability to consult and that referral options are available to providers. The MAPP-Net Access Line will address these needs.

Findings from this project amplified the importance of MAPP-Net services in Montana. There is a clear need to support providers across the state who are working in rural communities, often without resources, to meet the needs of children, adolescents and their families. By increasing access to evidence-based information and training, enhancing coordination of care systems, and offering access to timely consultative services, MAPP-Net will address needs identified in Montana.

Appendix A: Responses¹ from Medical Healthcare Providers

Other psychiatric or behavioral disorders consultation or referral options needed:

1. Medication and Counseling
2. Managing kids who are awaiting placement at inpatient facilities (it would be great to be able to start their treatment when they are awaiting placement)
3. aggression
4. Binge Eating
5. na
6. most
7. Autism, developmental delay
8. Unclear diagnosis
9. Dual occurring d/o. I.e substance use w/ concomitant mood disorder
10. Bipolar, some autism spectrum, severe depression/SI, psychotic disorders
11. Referral options are limited for most pediatric behavioral and psychiatric disorders.
12. na
13. none
14. see the above
15. ADD/ADHD
16. N/A
17. Use of anti-psychotic, need for input on a diagnosis with underlying complexity (chronic medical issues, developmental delays involved)
18. We only feel comfortable treating mild cases.
19. Defiant disorders
20. Antisocial and personality disorders
21. Defiant disorders
22. Complex cases not responding to usual therapies I've tried everything I know and it isn't working)
23. None
24. Developmental delay
25. We need more timely access to ped psychiatry for mood disorders that fail first line therapy
26. The ones marked above and any I consider routine that are not responding well to usual treatment
27. gender dysphoria
28. Suicide
29. If unresponsive to initial treatment
30. Any that present
31. Developmental delay
32. unsure
33. bipolar, schizophrenia, anytime I'm considering adding atypical or typical antipsychotic medications or 1st & 2nd line agents didn't result in improvement

¹ Responses are unedited and included here as they were provided by survey participants. This is the same for both appendices.

34. neuropsych evaluations, diagnosis evaluations for disorders such as autism, bipolar, etc

Comment Review

It appears that issues related to aggression and antisocial/ oppositional defiant disorder, developmental delay and autism, and medication management are the most common themes. The most common words generated² from this list: Disorders, Diagnosis, Treatment, Delay, Developmental.

² Using a Wordcloud tool

Appendix B: Responses from Mental Health Providers

Other psychiatric or behavioral disorders consultation or referral options needed:

1. children & age 10
2. Active acts of Suicide attempts
3. I think all kids deserve fellowship trained Peds psychiatry for anything beyond simple SSRI
4. none
5. none
6. Parent-coaching
7. when two or more meds are prescribed, or if several meds have failed
8. None
9. I am a licensure candidate so am largely supported through supervision during this time.
10. Psychosis/ Hallucinations and Delusions
11. Cognitive Disorders
12. In the school structure I work with a Team of professional with all the disorders encounter.
13. psychosis/severe depression/addiction
14. Trauma/ relationships
15. NA
16. substance abuse, autism, eating disorders
17. Eating disorders
18. Consultation is a good idea even if I am confident of the treatment plan.
19. Schizophrenia
20. sexual offenders (refer out)
21. Dissociative Identity Disorder
22. Gender issues
23. dissociative identity disorder
24. All for follow up referral options. I work in ER
25. complex, multi diagnosis children and teens
26. homicidal ideation
27. those that need medication
28. Active suicidal clients are referred to the hospital for a higher level of care
29. Sexual misconduct
30. none
31. Drug abuse. Alcohol abuse
32. na
33. Trauma/PDSO
34. psychosis in children; specific autism treatment interventions
35. Evaluations
36. Those who need MSOTA
37. N/A
38. General medication consultations; neuropsychological assessments; other developmental disabilities
39. Autism with other dx ie psychosis, bipolar, depression, etc.
40. Medical trauma/needs

41. N/A
42. see above
43. Genetic disorders causing behavior issues.
44. Very young children
45. extreme aggression
46. none
47. Clients with severe mood swings are referred for psychiatric medication assessment
48. Sexual trauma
49. Learning disabilities, substance abuse
50. mostly substance abuse disorders.
51. NA
52. None
53. see above
54. medication management
55. Substance use and psychotic disorders
56. I prefer to work with primary care providers and school for all clients. I refer to other therapist most other types of disorders
57. Oppositional Defiant Disorder or Conduct Disorder
58. Problematic sexual behaviors,
59. anything requiring medication.

Comment Review

It appears that issues related to psychosis, violence to self and others, sexual violence and sexually aberrance, substance use and abuse, and medication management and prescription concerns are the most common themes. The most common words generated from this list, in order: Disorders, Medication, Abuse, Children, Substance.

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