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For Immediate Release
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STATEMENT – NO EASY FIXES: DISPARITIES IN HOW AMERICA ADDRESSES CHILDREN'S MENTAL HEALTH ABOUND

Researchers at Rutgers and Columbia universities recently examined the disparities surrounding the prescription of antipsychotics to children. Their analysis suggests that the poorer the child, the more likely that he'll be given antipsychotics to handle a problem that may or may not be best handled by such medication. Their research might suggest that it is easier for some practitioners to throw drugs at a problem involving poor kids because it's the least expensive, most hassle-free fix. For those kids lucky enough to come from more well-to-do families, medications may be more judiciously used, and less likely to be prescribed for conditions for which they were not originally intended.

Indirectly, the study also points to our society's concerns – some would say squeamishness – about the use of medications to treat children's behavioral and emotional disorders. Given increasing knowledge about the impact of such antipsychotic medications on children's growth and development, such concerns are well-founded.

Discussion about prescribing such drugs to children is appropriately qualified with concerns about costs, trade-offs between the use of psycho-pharmaceuticals and psychotherapy, and comparisons between what the poor receive relative to the middle class. Yet to understand the full story we suggest that one must disentangle the issues further, so that government, community, and health care planners reach coherent policy conclusions.

For example, one ready interpretation explaining the prescribing disparity might be that children with Medicaid coverage get too much medication. Yet another interpretation might be that middle class children do not get enough treatment: despite a law passed last year mandating parity of coverage for mental health conditions with other health problems (already a reality within Medicaid), equal treatment between mental health and other disorders remains a distant dream among commercial insurance programs. Such facts must be taken into account when trying to understand these prescribing disparities.

While we believe passionate concerns about such disparities are absolutely valid, we also believe that American society needs similar passion and concern about the impact of other, more prevalent and powerful, factors on children's health and development: poverty, neighborhood factors, trauma, parental mental illness and substance abuse, unskilled parenting, and absence of early, nurturing relationships during critical periods of brain development.

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Sadly, America's approach to child mental health care is handicapped by systemic failure: we lack a comprehensive public health strategy for mental health conditions among children and families that addresses the impact of *all* of these intertwined issues. This failure is exposed daily in our juvenile prisons rolls, in our poor educational statistics – including expulsion rates among preschoolers – in emergency rooms, and on the streets of our cities and towns where some of our most troubled youngsters end up homeless. Without a more comprehensive approach, important single issues (such as whether children get appropriate medications) can inadvertently drive public policy to fast, hard, (and cheap) fixes like "black box" warnings – which ironically, recent research suggests has not led to increased access to appropriate care, but has likely led to increases in youth suicide.

Instead, we need a public policy overhaul that includes mental health promotion and early identification of children's problems, beginning with the youngest children and their families; effective treatment strategies available for all children with mental health disorders; and fiscal and accountability measures that ensure all children and youth get what they need when they need it.

However, to provide this level of care, we need to address the urgent problem of *provider capacity*. We simply do not have sufficient mental health providers to address the nation's current needs. If all of our currently trained and available doctoral-level child mental health specialists (child and adolescent psychiatrists, child psychologists, behavioral pediatricians, etc.) were to attempt to evaluate and treat each of the 12 to 14 million children with moderate to severe mental health disorders (based on Surgeon General estimates), each of these children could be seen by a specialist for just over one hour each year.

Worse yet, *provider capacity* per se does not take into account *provider competency*. Do providers in primary care and even in specialty settings have the knowledge to do a thorough assessment before prescribing a psychotropic medicine or another course of action? Do they have the competence to use scientifically proven non-medication therapeutic methods, or know, how, when, and where they can refer children and families to such services? Available evidence suggests that the answer to this question is "no" or at best, "not often."

Adding further complexity to these layered problems are *provider barriers*: for example, are they supported by reimbursement, training and clinical monitoring systems that both require and pay for more than minimal evaluations, allotting the necessary time to assess and understand the complexity of children's problems that arise within their own, complex, multi-layered environments? Again, the answer is largely "no."

Fixing provider problems alone will fail if *family barriers* are not also addressed. Families and communities need accurate information, supports and service options to ensure that children get what they need. For some families that might mean addressing parents' own health problems that impact their ability to support their children and help them to develop, especially for families with young children. For all families it must means empowering parents to play a central role in their child's treatment planning, service delivery and any needed after care and supports. In this

era of information abundance and doctors' difficulties keeping abreast of new findings, the adage "the doctor always knows best" may have outlived its usefulness.

Given the complex array of factors affecting whether a child does or does not get a particular medication, all quick fix, "band-aid" solutions should be viewed with skepticism, Instead, local, state, and national leaders must support more comprehensive (and effective) strategies to address children's mental health problems. While daunting, delays in taking these critical steps now will only extract greater costs on us and generations to come.

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