A Team Approach to Providing Care for Children and Adolescents with Complex Behavioral Health Challenges

Interview with Jeffrey Rowe, M.D. *by* Mary Mulvihill, Ph.D.

Dr. Rowe is the Supervising Psychiatrist at the Behavioral Health Services division of the County of San Diego Health and Human Services Agency. He is also the Chairman of the 2018 Critical Issues in Child and Adolescent Mental Health Conference, entitled, "Hidden in Plain Sight: Adolescent Brain & Identity Development."

Dr. Rowe, what is the purpose of the Critical Issues in Childhood and Adolescent Mental Health Collaborative that's being developed here in San Diego?

The San Diego CICAMH Collaborative is a joint project between the County of San Diego Health and Human Services Agency, San Diego Psychiatric Society, San Diego Psychological Association, San Diego Academy of Child & Adolescent Psychiatry, the San Diego Chapter of the California Association of Marriage & Family Therapists, UCSD Community Psychiatry, SDSU School of Public Health, and the American Association of Pastoral Counselors, Pacific Region. We hope to add social workers in the future.

There are three main purposes of the CICAMH Collaborative:

1. To provide an opportunity for five of the major mental health professional organizations to work together on a substantive project of benefit to the community. We don't often have the opportunity to get to know each other personally and professionally, so working on something we all feel is important helps us understand the various professional perspectives and talents and how we can best work together.
2. To provide the latest information on the treatment of children's mental health issues to our members, trainees, and to the San Diego mental health community.
3. To provide mental health professionals the opportunity to develop cross-professional relationships. This enables us to do a better job taking care of child/youth clients, especially in a crisis situation or when dealing with very complex problems. CICAMH also puts together the annual Summer Social in August for our collective memberships to foster these relationships.

Since you represent child/youth psychiatrists, what should other mental health professionals know about how you operate when doing psychopharmacology with children/youth?

There are four basic treatment principles in considering psychopharmacology for kids: (1) It is important to appreciate that no one likes to medicate kids. Medication done poorly can be a problem. (2) Some kids have problems that can be severe & disabling. (3) Children deserve the very best treatment of ALL kinds available to address the problems they are contending with. (4) Effectiveness and side effects must be carefully monitored in all treatment interventions.

Medications, even when necessary, are not a sufficient treatment in themselves. New learning experiences, such as therapy, school activities, skill building, and new relationships are also needed to create a complete treatment approach, capable of creating new brain pathways.

Tell me more about how new learning experiences complement the role of psychopharmacology for children/youth experiencing difficulties.

There are many misconceptions and fears about the use of medication in children/youth. Chemicals we use as medicine only "work" because there are receptors in the brain that they "work on." So, in this way medicine acts as a "dial turner"; it can make the receptors and neurons work more or work less, depending on their intended effect. Medicine can make a person more active or less active. It can diminish voices (hallucinations) or amplify them.

But medications cannot heal a person. They cannot create new brain connections, better integration of nervous activities, or a new understanding of one's self or relationships with others. New activities, relationships, and skills that emerge in their daily life are critically important. These can be achieved through therapy, but also school experiences, outside mentors, animal interactions, sports and arts participation, and so forth. Medication can help these therapeutic experiences and changes happen by fostering safety, decreasing suffering, and improving cognitive function and self-control.

Are there any new medications or treatments which child psychiatrists are able to use now that other mental health practitioners should know about?

It is important to realize that all the current medications we have, including the "latest and greatest" for depression, anxiety, attentional focus, psychosis, and mood stabilization are based on very old science. We haven't had any new breakthroughs, unfortunately.

However, there are some new developments in what some would consider "recreational" drugs, which are now being studied. An example of this is ketamine, which seems to be

beneficial for mood. It has the advantage of acting very fast; an infusion of ketamine can take effect in minutes to hours, but lasts only a day or two. There is a lot of research interest currently in this drug's potential effects and how best to use it.

Transcranial Magnetic Stimulation is increasingly being studied, primarily for mood, but also for autism and anxiety. In this treatment, a magnetic force is applied across the skull to stimulate different brain areas or integrate their functions, so the brain works differently. This is a very exciting area.

Transcranial Electric Stimulation, the use of an electrical stimulus across the skull, is also being studied, but not as well or extensively. So, there are a number of new approaches on the horizon, which may provide new and effective intervention options for children/youth struggling with significant mental health issues which impair their function.

How can a child/family therapist find a good pediatric psychopharmacologist to work with?

This is difficult at present, unfortunately. We have 750,000 children in SD County, 500,000 of whom are over six years old. We only have about 100 child psychiatrists, supplemented by a number of excellent developmental behavioral pediatricians and some general psychiatrists who also work with adolescents. San Diego has two nurse practitioner programs for mental health, so we are also aided by excellent nurse practitioners locally, who serve a vital role in handling many cases. But there are just not enough practitioners to meet the demand.

One way we might start to meet this challenge of access to psychopharmacology treatment is by developing methods of determining which case is a "complex case," requiring the highest level of expertise and a collaborative team effort, versus a more straightforward or "simple" case, in which treatment by a "front-line" practitioner will suffice. We don't often think about or talk about cases this way, but we may need to start to do so in order to utilize our limited resources more wisely.

How can a child/family therapist and pediatric psychopharmacologist collaborate well together on a challenging child/youth case?

With any pediatric case, there are three basic aims: (1) to ensure safety, (2) to reduce suffering, and (3) to improve function. Each professional has their own role and expertise, based on a respectful collaboration.

The central focus must be on developing a good case conceptualization, ideally collaboratively. The child/family therapist often has critically important history and contextual information, which can help me, as a psychiatrist, understand what is dysregulating the child, and what might help achieve regulation again.

When a child/youth patient is having sufficiently severe symptoms for which medications are being considered, there is a lot of fear involved for everyone. The case conceptualization provides clarity, which is reassuring, and a road map to which evidence-based treatments may be helpful. This needs to be applied to both medications and to the other therapeutic interventions proposed. It might seem like we don't have good ways to do this now, but if you put together a solid formulation (or case conceptualization), you can begin picking out the targets of your treatments, work to get agreement with your patient/client and family, and then apply the treatment. Periodically, one could then pause treatment, reassess the target symptoms, see if the treatment is having the intended effect and, if not, change course. This process is useful for both medication treatment and psychotherapy.

What factors go into a developing a good case conceptualization for child/youth client?

It is helpful to get a good "lay of the land" first. To do that, a thorough interview should be conducted with the child, his or her caregivers, and other important people in his or her life. The idea is to get an initial sense of how many areas of difficulty we are dealing with, and whether the case is "complex" or "simple." If "complex," one should try to determine when the problems started, what the course has been, whether any family history can help with determining diagnosis, what treatments have been tried, what stresses have been experienced, what protective factors are present, and whether any serious recognizable conditions are present [e.g., Fetal Alcohol Spectrum Disorders (FASDs) are "complex"; they can have multiple clinical presentations, cause severe dysfunction but have a known course and prognosis].

By figuring out when the problems started, you can then assess if the child ever had the necessary functions at age five to "go out into the world." Basically, we are assessing three main areas in order to plan treatment: (1) self-regulation, e.g., eating, sleeping, attention, aggression, emotions; (2) mastery, e.g., self-esteem, confidence to take actions, perseverance at working toward a goal; 3) well-being, e.g., ability to feel good, sense that one is going to be ok, sense of belonging, purpose, spiritual awareness. All of these areas have to be functioning well by age five to allow a child to go off and succeed in our rather lengthy, demanding form of kindergarten. A therapist who knows the child and family will have a good idea of what is going on in all these areas.

With older children/youth, there are more factors to consider. Often the psychotherapist or assessor has critically important information for me about what kind of stress or trauma the child is experiencing, when it started, and what the course has been over time. Formal assessments by psychologists may be very helpful. If a child is not doing well in school, understanding any learning differences or capacities can obviously be important. Projective testing is also often helpful with children, since some kids do not talk very much

nor engage in much creative play, so are hard to assess. Projective testing gives a window into their internal world, what they ruminate about, what they are anxious about, etc., which may help understand them better and guide treatment.

With complex cases, both the child's psychiatrist and therapist have important, complementary roles to play. Each has to trust and respect the other's input, and carry out their role effectively. Going back to my initial remarks, if we professionals rarely work together and don't get to know each other's viewpoints and expertise, it is harder to collaborate optimally when confronted with a challenging pediatric case within the time constraints and demands of clinical practice.

Can you tell me what we can expect at the upcoming 3rd Annual CICAMH conference on March 23rd and 24th, 2018 at the Towne & Country Conference Center in Mission Valley?

This is our third year – we have had a tremendous response from local mental health professionals to this combination of cutting edge information and networking. It's been a fun conference to attend. We have grown from 200 to 400 attendees. This year, we have expanded to 2 days for the first time. The focus of each day is a bit different.

The first day will feature a 3-hour morning workshop on teen suicide with forensic and troubled teen expert, Dr. Lisa Boesky; she will focus on how to assess suicidal teens, how to respond effectively, common mistakes to avoid, and how organizations can prepare for suicidal teens in their programs.

The afternoon will be devoted to the current state of psychopharmacology with children/youth, starting with the basics, to bring everyone on board. This will be followed by a focus on complex cases, which means cases where there are multiple issues, sometimes contradictory, which require a high level of expertise to address. We have two amazing experts coming: Dr. Gabrielle Carlson, from SUNY Medical School, who is an expert on complex presentations of ADHD and mood disorders and Dr. Glenn Elliot from Stanford University Medical School, who is an expert on managing aggressive and self- injurious behavior in children/youth.

The second day, the focus will be on how the brain's development unfolds during adolescence, and how it undergirds and integrates with important developmental experiences during adolescence. Much of this is going on before our very eyes, yet we often don't appreciate its significance – this process is "hidden in plain sight."

We will start with Dr. Jay Giedd, from UCSD, a longtime NIMH researcher who will outline the latest findings on adolescent brain development and its implications for therapists. Dr. Luis Nagy, psycho-analyst and computer scientist, will talk about new technology as part of daily life, and how this impacts identity formation, boundaries, and

the conduct of therapy with teens. He will focus on how social media creates a developmental trajectory in a new dimension of identity pertaining to the virtual world, where many kids spend a lot of their time.

After lunch, we move onto some of the important modalities needed to generate those critical new learning experiences. Dr. Bonnie Goldstein will talk about the importance of creative movement and free play, integrating these sensorimotor and expressive aspects with their impact on brain development. Kids need to be physically active to develop in a healthy way. The Boys to Men program, which provides community based mentoring to fatherless boys, will discuss the important role of adult relationships in development – how to be a good mentor and what benefits that provides.

Finally, Vinny Ferraro, renowned youth activist and mindfulness teacher from the Bay area, will address the emotional and spiritual benefits of deeply connecting with troubled kids. His experience "being there - fully present" with incarcerated teens and bringing mindful awareness into schools and institutions is inspiring. We will end with an illustration of how music can foster a sense of belonging, inspiration, and expression.

We are incredibly lucky, in part through the generous support of a grant from The County of San Diego Behavioral Health Services, to be able to bring these internationally renowned speakers here to San Diego, so we can create an affordable conference with two networking lunches and a Friday evening reception to foster community.

We will also have a number of exhibitors from local programs which serve children/youth so it's a great way to survey many available community resources and meet their clinicians. It should be an enjoyable, informative day. Please consider joining us and adding your voice to our developing interdisciplinary professional community.