

Community Council
2008-09 Study Committee
Meeting Summary
January 20, 2009

Present: Eloise Phillips, Cindy Godard-Gross, Tom Sawatzki, Holly Howard, Lucy Gregoire, Aaron Randall, Pam Allen, Carmen Bernal, Cynthia Selde, Larry Mulkerin, Judy Mulkerin, Matt Eppelsheimer, Jason Pribilsky, Harvey Crowder, Becky Hermsen, Terry Heisey, Dorothy Knudson, Joe Huether, Donald Priest, Teri Barila, Nancy Carter, Jean Ann Mitchell, Alice Bagley, Miranda Baerg, C. Muse, Tim Meliah, Susan Day, Karen Wolf, Peggy Sanderson, William Sanderson, Karen Kirkwood, Melinda Brennan, Linda Dammarell, _____, Roger Baristow, Julie Reese

Roger Bairstow reviewed the remaining Study schedule, noting that an extra session has been added to make up for the “snow day” cancellation in December. May 5 will be the final session. Seven sessions remain before the group will begin the findings/conclusions/recommendations portion of its work. Roger reiterated that the findings recorded at each session will be key to that work. The November 25 meeting summary was adopted.

Two speakers talked about community mental health support. Michelle Coleman is a private practice counselor and Allison Kirby is a pediatrician. Both work in Walla Walla.

Michelle Coleman based her comments on her own experience and information solicited from fellow private practice counselors.

The mental health problems children in the region are experiencing, in order of prevalence, are: anxiety, depression, adjustment disorders, attention deficit hyperactivity disorder, eating disorders, autism spectrum disorders and bipolar disorder. Many of the problems overlap.

About 90% of the problems are the result of current or past emotional, physical or sexual abuse. Family stress (children are caught in the middle or there are parenting issues—either the child isn’t a priority or parenting skills are lacking), the child’s social issues (not fitting in with peers), low self-esteem and genetics are other causes. Just about every child struggles with anxiety.

To successfully work with children, it is necessary to treat the whole family, so Michelle provides family counseling. Individual counseling sessions for young children may be mixed with family counseling. Older children also have individual sessions. Some counselors in the region offer group therapy and many do consultant work. These services may include team meetings and/or communication with other agencies involved, such as school, the doctor, the Juvenile Justice Center, attorneys, and Child Protective Services; testifying and/or documentation for court; and evaluations.

Most of Walla Walla’s private counselors work in Walla Walla, College Place, Milton-Freewater, Dayton, Touchet, and Waitsburg. They may also have a few cases from the Tri-Cities and other cities in Oregon. While they typically average six to eight appointments daily, they often see fewer patients during the Christmas holidays and summer. Many children are referred for treatment because of their behavior in school.

Area counselors informally communicate with each about the services they offer. Mostly, information is shared by word of mouth, at professional group meetings and through flyers or email.

Collaboration with schools, doctors, attorneys, other therapists and other agencies depends upon the seriousness of the issue being treated.

There are six major gaps in services:

1. Sexual abuse evaluations are lacking. Often children share information that is disregarded and the child is sent back into the same situation.
2. There is little or no counseling available for young children, especially those under the age of six. Most counselors see children aged twelve or older.
3. Counselors, by the nature of their work, may become isolated, so they don't always hear about programs and needs.
4. There is a lack of reliable crisis services.
5. Treatment is a very expensive process, especially if the family does not have insurance.
6. Teen shelters are needed.

Finances are one barrier to service. Counseling is very expensive, about \$100/hour. Methods of payment include insurance (usually this is low payment) and private payment, and sometimes agencies pay. There are gaps in insurance benefits. If the family has medical coupons, they seek service through the County. Molina (Washington's Medicaid program for children) pays for 12 visits/year.

Michelle is a mental health consultant at Blue Ridge Elementary. Her services are funded through Head Start. Each Head Start family receives three counseling sessions. The school is considering expanding this program school-wide.

More counselors are needed. Licensing is an issue. It is required to be able to bill insurance. Many counselors do not complete the full course to achieve licensing. She is not sure how valued the Masters of Social Work degree is. She noted that Walla Walla University has a MSW program.

Another barrier is resistance to working with certain people or agencies. Michelle said this was characteristic of being in a "small town".

Three model programs were cited:

1. Project SAFE, a new program being started in Walla Walla, gives parents whose teens are out of control a place to call and talk with a counselor. The counselor can provide parenting ideas and help the parent develop a plan of action. The initial phone call lasts about 90 minutes. The counselor then makes a follow-up call to the parent in one to two weeks.
2. Families and Schools Together (FAST) brings parents and children together for a meal. While the children participate in planned activities, the parents are provided with parenting tips and the opportunity to talk with other adults.
3. Strengthening Families is similar to FAST.

Allison Kirby

Dr. Kirby identified the lack of pediatric psychiatrists throughout the state as a major problem. Families often have to travel to a major population center to access a physician to diagnose and treat a problem. The services in the Tri-Cities are overwhelmed so the next closest access would be Spokane, if the family has transportation. Then when the child is treated and returns home, they are away from the doctor who made the diagnosis and prescribed the medications and there is no one to properly monitor medications.

Suggested solution: "home-grown" pediatric psychiatrists who would take their training and return to their community to practice.

The mental health problem has to be severe to see a counselor at the Department of Human Services, so patients often wait to access services until the need is critical. Then, they go to the hospital emergency room. The DHS crisis worker determines whether the child's condition is serious enough to use one of the few available hospital beds, because they control the funding. Admittance is not based upon the doctor's medical judgment.

Misdiagnoses are another result of not having doctors who can do thorough evaluations. One example is that juvenile bi-polar disorder is being falsely identified as Attention Deficit Disorder. If a pediatric

psychiatrist were available, pediatricians would refer depressed children with bipolar disorders in the family. What may seem to be depression may be early bipolar disorder. Other problems that need specialized diagnoses/treatment are behavior problems that don't seem to fit ADD or psychotic criteria and children who hallucinate or who are hurting themselves or others. It would also be helpful to have a pediatric psychiatrist's perspective when treatment has been unsuccessful.

Another area of concern is the lack of an assessment team for sexual abuse victims who are small children. The team provides both physical exams and psychiatric services. Those who provide these services have a high stress/burnout rate because of what they are hearing, working with adults who are not truthful, having to deal with court, and the frustration of children changing their story to avoid being "in trouble". Walla Walla once had such a team.

Teen sexual abuse treatment is particularly difficult for the victim. They have to navigate three agencies (funded by federal, state, and local monies and the funding streams change frequently) and tell their story three different times to different people: 1) the YWCA who provides an ombudsman to go to the hospital and police with them; 2) during initial counseling; and 3) as they're healing and need treatment to deal with post-traumatic stress, sleep disruption, and fear of the opposite sex.

Suggested solution: funnel all funds to one place to provide all services for children birth through teen.

Many cases of autism are being diagnosed. Children's Village in Yakima is the closest place for diagnoses.

One positive development is that ADHD have become much more specific, so it is easier to identify families who need help with parenting.

Dr. Kirby works at Walla Walla Clinic. The physicians there see about 8,000 patients annually. Of those, 436 (5 to 8% of their caseload) are mental health issues About 73 were referred to a mental health practitioner and the rest the pediatricians treated.

A recent survey at Lincoln High School found that 90% of the teens feel that their lives are out of control. Half of them had considered suicide in the last year. Eight of ten had been sexually assaulted.

Spanish-speaking population is undertreated because it is difficult to work through an interpreter. It is difficult to obtain the needed information.

A new school-based health center is being developed in Walla Walla. Dr. Kirby is working with Holly Howard who is the coordinator.

Psychiatric nurse-practitioners can provide a certain level of mental health treatment. They have advanced training and can diagnose some disorders, but can't prescribe medications. Pendleton has a nurse-practitioner.

Adverse Childhood Experiences (ACEs), a study that has determined that the brains of children exposed to multiple stressors develop differently than normal brains and their decision-making abilities later in life are affected. It is necessary to help children so that they do not become impaired adults.

Both speakers noted that the federal HIPAA rules regulating the transfer of records and the exchange of information are barriers to service. It is necessary to have parents sign forms authorizing communication (one-way or two-way) with everyone who may be involved in the child's case. Sometimes the parents balk because they do not want their child to be labeled. Obtaining needed information is challenging because of the overwhelming amount of paperwork.

Methamphetamine is an emerging problem in the region. It is easy to make and easy to obtain. The desire for it is stronger than the maternal bond and mothers will do whatever it takes to get the drug.

Intervention is critical. At a time when people are losing their jobs and abuse of alcohol and other substances is rising, funding for in-patient treatment is being cut.

Findings (What We Heard)

1. Meth is an emerging problem in the area. The bond to meth is stronger than the maternal bond.
2. When sexual abuse occurs, it is difficult to reach a resolution that makes a difference.
3. Mental health problems in children are difficult to diagnose because they are usually related to broader family issues.
4. 5% to 8% of Walla Walla pediatric clinic patients are there for mental health issues.
5. Pediatric psychiatrists who treat patients with insurance are 100+ miles away.
6. Sexual abuse evaluation is lacking.
7. It is particularly difficult for teens to navigate services, partly due to different funding streams (state, local, federal).
8. Michelle Coleman can provide up to three counseling sessions to Head Start participants at Blue Ridge, funded through Head Start.
9. The criteria (from County) for accessing limited in-patient crisis resources is extremely high, and the County criteria determines who gets the beds.
10. There are few teen shelter services.
11. People are accessing mental health services at a “crisis level”. Limited funds to handle these crises and stress are causing high burnout among mental health providers.
12. A “one-stop shop” is needed to consolidate mental health services including counseling, medication monitoring, ombudsman, and sexual assault issues.
13. Medication monitoring is a major issue in this area.
14. There are no mental health in-patient beds in Walla Walla, and when patients receive care out-of-town, there is poor coordination of treatment upon their return home.
15. Chemical dependency funding is being cut, resulting in staff cuts at Serenity Point.
16. There are cultural barriers to receiving mental health services.
17. There is a gap in service for the working poor because they do not have Medicaid or insurance.

Questions still to be answered:

1. What are the leading causes for the rise in anxiety levels? Is WASIL a stressor?
2. What statistics support the claim of rise in anxiety?
3. Do other practitioners/providers coordinate with County Human Services? If so, how?
4. How many children go untreated?
5. Is there mental health assistance for Spanish-speaking clients? What mental health treatment is available at the Family Medical Center and other medical centers?
6. What precludes the area from hiring a pediatric psychiatrist?
7. How many children have died in the last five years due to lack of available services?
8. Can you provide a source for “medical assistance 101”—how people qualify for different programs; how people pay; and what are the systems?