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DRAFT

Outline of Concerns

for presentation at “Child and Adolescent Mental Health Services: Issues and Solutions“

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I. The major concern that I want to focus on is my growing belief that we need to rethink our whole pattern of concern with mental health services. Delighted that this conference came up to give me an opportunity to express my concerns.

A. So far, researchers have focused on three issues: identifying those with mental illness, getting people to services, and effective mental health services

B. Wasted my career looking at the first two of those three factors—identifying mental illness, and service access. Others at this conference will deal with issue of effective mental health services.

1. What do I mean about wasted? Ignored large area that I know is important, that I even went into social work for because I think it is so important.--Environment

C. What did I do that was wrong?

1. Adopted a “white coat “ syndrome in approaching mental health in the same manner as physical health
2. In love with notion that doctors can wave a magic wand and solve the problem.
3. Assumed there existed a correct switch, medication, intervention
4. If it had a medical solution or authority, then it was real
5. Remember when working at WU dept of psychiatry and interviewers for research project put on white coats while interviewing when it had nothing to do with their job.

D. So what was wrong with the “white coat syndrome”?  

1. Ignores known complexity of anything behavioral
2. Ignores environment/brain connection
3. Leads to working with blinders on—using only a single paradigm for seeing world

E. Does medical approach do that?

1. Such simplicity is even outdated medically for physical health problems

II. Mental Health service Issues are not solely medical or physical

A. Why are we perseverating in an outdated model based only on diagnosis and access to treatment?

B. Look at evidence that we have been wrong in past

III. Examples for diagnostic issues

A. Homosexuality as mental disorder
B. Psychiatrist who said he had 6 children and at some point each met criteria for oppositional defiant disorder
C. Early diagnostic measures had no out for problems that were clearly due to life factors—illnesses, grief, and which did not majorly affect functioning.

D. We are still promulgating diagnoses in absence of much research-- United airlines PTSD psychologist said “those with greater immediate reactions are more likely to get PTSD” what nonsense

E. Measures that have little test retest reliability (DIS)—rates go down at time 2 dramatically but we use time one assessment rates and assume reduction in rates is due to interviewee fatigue

IV. Example for access to treatment issues:
   A. Who are we sending to treatment and why? If we would ever send all that we identify, we would bankrupt the entire system. Aren’t enough service providers to handle it
   B. Lactose intolerance unimportant in absence of milk drinking
   C. Diabetes when sugar unavailable in WWII
   D. Asthma when environment is filthy
   E. Recent extraordinary use of meds for depression in substantial portion of population

V. Lots of evidence that environment (personal, familial, peer, community, and even society) is important in mental health and illness
   A. Brain reshaped by environment—can be visualized
   B. Rates higher of certain disorders (depression, conduct disorder, antisocial behavior, anxiety disorders, addictions, violence) when environment is difficult
      1. We have opt-outs of a diagnosis for depression when grieving, what about when life presents no hope? Or when childhood is ruined by abuse? Or when family is homeless?
   C. We also have evidence that when environment is improved, some mental health problems decline—Here I want to cite my own research

VI. My own research: (I have slides and graphs to illustrate this part)
   A. AIMHI Study—rates of mental health problems were very high
   B. Services were offered in proportion to rates
   C. For those with extremely high and serious mental health problems, neither services nor environment affected rates over time---But that was a small group (n=5 out of 75 with problems)
   D. For others, who were over clinical cutting point, environmental changes, but not services, made a substantial difference—moved them from clinical to subclinical levels
   E. What were environmental changes?—economic opportunities, free time activities, alcohol and drug use prevention, leveraged responsibility (staying is school for payouts)
VII. So what is implication of this argument? Am I saying forget services and forget diagnosing?
   A. No.—I am saying that we need to rethink our paradigm
   B. Why aren’t we focusing on these potentially redeemable populations? We have defined them into Mental Illness, but in fact they might be more thought of as walking wounded, the fixable. Perhaps there should exist the equivalent of rehab and environmental modification for these people.
   C. We have little that is effective to offer the severely mentally Ill in terms of permanent change, but certainly can look at environment of those who are not irredeemably destroyed yet.

VIII. We are part of the problem for having created long lines for ineffective and costly interventions.
   A. We have been looking only in one assumed place for interventions—medical style treatments
   B. We need a new paradigm that recognizes environment and includes a narrower perspective on who can’t survive without mental health services, accompanied by a wider perspective on problem solving for the others.
Potential References:


