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A Crisis in the Mental Health of Young People

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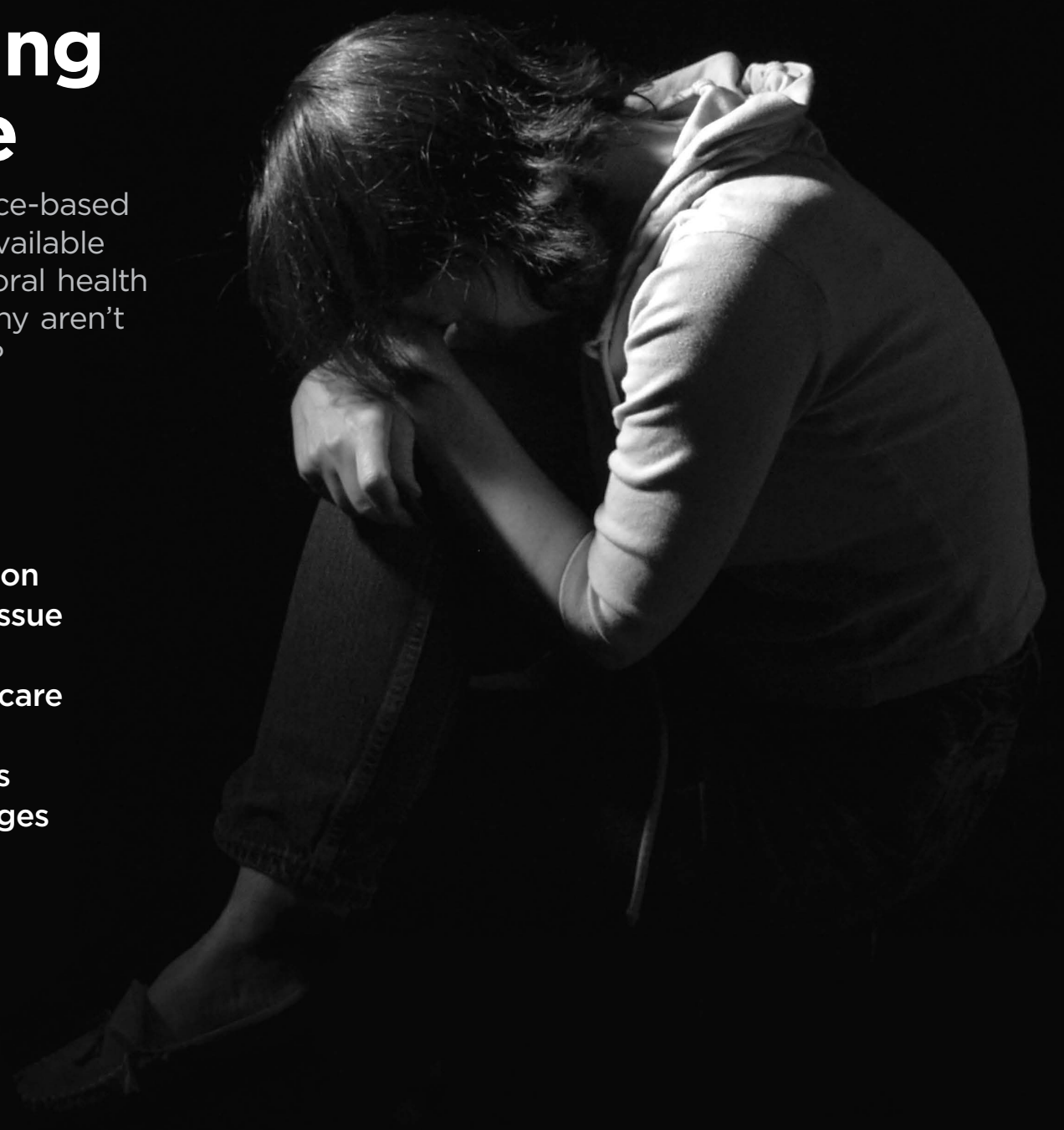

A Crisis in the Mental Health of Young People

While effective, evidence-based treatments are available for many behavioral health conditions, there is no routine process for connecting children and young adults with these mental health treatments **By Delia O'Hara**

"The government spends 750 times more money on the training and development of the medical workforce than on the entire mental health workforce."

WHEN U.S. Surgeon General Vivek Murthy, MD, MPH, issued a general advisory on the crisis in children's mental health late in 2021, he drew national attention to a situation that Chicago physicians, like others around the country, have been dealing with for years.

Up to one in five American children and teenagers has a mental, emotional, developmental, or behavioral disorder, according to the report, but only about half the 7.7 million children with treatable conditions actually get treatment. Meanwhile, suicide has become the second leading cause of death for people ages 10-14 and 25-34, and the third for teenagers and young adults.

"We're talking about the future of our country, an entire generation and their offspring," says Mitchell Prinstein, PhD, a psychologist, researcher and chief science officer for the American Psychological Association, based in Washington, DC, of the potential effects of the crisis.

Covid-19 dumped an array of hardships on the most vulnerable families and has taken a tremendous toll on young people, but the pandemic has been more of an "intensifier" than a primary driver of the crisis, says John Walkup, MD, chair of psychiatry and behavioral health at Lurie Children's Hospital in Chicago.

"Covid exposed the weakness of our system," Dr. Walkup says.

Mitchell Glaser, MD, a psychiatrist who sees children, teenagers and young adults at Ascension Saints Mary and Elizabeth Medical Center in Chicago, saw suicide attempts spike significantly; in his practice, children who needed structure to function, like those with autism, and young people just out of college, were "the canary in the coal mine" for the pandemic's psychological fallout.

But practitioners agree with Dr. Murthy's report: The crisis has long been brewing. In the decade or so before the pandemic, the proportion of high school students reporting "persistent feelings of sadness or hopelessness" increased by 40% and suicides among young people ages 10-24 jumped by 57%. Boarding, or holding young psychiatric patients in the emergency department or on a medical floor because no appropriate behavioral health care is available, increased 60%, according to a 2021 study in the *Journal of the American Medical Association*.

The Present System Doesn't Work for Children

Prinstein says the system we have now simply doesn't work for children. "Kids don't report their [behavioral health] symptoms the way adults do, and their symptoms are embedded in their families, their schools, their communities, the media they're exposed to, in ways that are very different" from adults, he says.

Prinstein favors elevating behavioral health to equal status with physical health, and advocates for more public support for training the mental health workforce, including psychologists; counseling is an integral part of treatment. "The government spends 750 times more money on the training and development of the medical workforce than on the entire mental health workforce," he says.

Indeed, while effective, evidence-based treatments are now available for many behavioral health conditions, there simply aren't enough clinicians to go around. Money is a major factor in the shortage, especially when it comes to underserved communities. While commercial insurance reimbursements can be skimpy, Medicaid payments are downright "abysmal," advocates say. Many mental health practitioners do not take insurance, which means their services are available only to relatively affluent people. Improving reimbursement rates to reflect the market and the value of behavioral health services could bring skilled professionals back into clinics, says Dr. Walkup, who was part of an advocacy group that recently met with government leaders in Washington, DC. "The time to invest is now."

The U.S. Congress has responded to these calls, recently approving funds for school-based interventions, awareness and community outreach; for increased access to behavioral health services through Medicaid and the Children's Health Insurance Program; and for the development of knowledge bases in emergency departments, educational agencies and schools. Other federal proposals are in the pipeline.

In Illinois, in the past year or so, measures have been enacted to streamline the process of connecting children with mental health services, and to ensure that medically necessary behavioral health care is covered by insurance.

These measures are not equal to the present

LEFT: Mitchell Prinstein, PhD, is chief science officer for the American Psychological Association. RIGHT: John Walkup, MD, is chair of psychiatry and behavioral health at Lurie Children's Hospital in Chicago.

crisis. Niranjan Karnik, MD, PhD, director of the Institute for Juvenile Research at the University of Illinois College of Medicine in Chicago, says, "We have to think outside the box. We've tried for 30 years to increase the [mental health workforce]. We're never going to meet our needs using traditional methods."

Treatment Takes a Team

The psychiatrist is typically the behavioral health team leader, Dr. Glaser says, meeting with a patient perhaps monthly for "some brief therapy," and to prescribe and manage mental health medications that include antidepressants, anti-anxiety medications, stimulants, antipsychotics and mood stabilizers.

Traditional talk therapy—counseling patients in how to identify and modify problematic thoughts, emotions and behaviors—is conducted at least in the acute phase of a disorder by psychologists, licensed social workers and other licensed counselors.

"Then there are more intensive levels of treatment," Dr. Glaser says—outpatient programs of a few half-days a week; or partial hospital programs that comprise full days of therapy every day for a prescribed period. The most intensive level, he says, is an inpatient stay in a freestanding psychiatric hospital, like Riveredge Hospital in Forest Park, or in a dedicated mental health program in a general hospital like Saints Mary and Elizabeth Medical Center. Long-term residential care may be suitable for debilitating conditions, Dr. Glaser says.

One source of frustration for youth mental health practitioners in the face of the suffering they see is that effective, relatively short-term treatments that could help most patients are available. Nearly two-thirds of anxious patients are symptom-free after a 12-week course of treatment for anxiety, Dr. Walkup says, and similar courses of up to 20 weeks have been developed for depression, mood disorders and other conditions that have outcomes that are at least as good as those seen with longer courses. (Notably, treatment doesn't work for all patients.)

Facts About Mental Health Disorders in U.S. Children

ADHD, anxiety problems, behavior problems, and depression are the most commonly diagnosed mental health disorders in children. Estimates for ever having a diagnosis among children aged 3-17 years, in 2016-19, are given below.

- ADHD 9.8% (approx. 6.0 million)
- Anxiety 9.4% (approx. 5.8 million)
- Behavior problems 8.9% (approx. 5.5 million)
- Depression 4.4% (approx. 2.7 million)

Some of these conditions commonly occur together. For example, among children aged 3-17 years in 2016:

- Having another mental health disorder was most common in children with depression: about 3 in 4 children with depression also had anxiety (73.8%) and almost 1 in 2 had behavior problems (47.2%).
- For children with anxiety, more than 1 in 3 also had behavior problems (37.9%) and about 1 in 3 also had depression (32.3%).
- For children with behavior problems, more than 1 in 3 also had anxiety (36.6%) and about 1 in 5 also had depression (20.3%).

Source: U.S. Centers for Disease Control and Prevention

DR. PRINSTEIN PHOTO COURTESY SOMER HADLEY; DR. WALKUP PHOTO COURTESY JAN TERRY, LURIE CHILDREN'S HOSPITAL

LEFT: Niranjan Karnik, MD, directs the Institute for Juvenile Research at UIC College of Medicine. RIGHT: Julie Holland, MD, is VP of pediatric primary care at Advocate's Chicagoland Children's Health Alliance.

The mental health field is indeed beginning to think outside the box, and coming up with workarounds for the shortage of professionals. Telehealth, for example, which burst onto the scene at the beginning of the pandemic, can bring the services of clinicians to patients who can't access them in person.

Researchers are also looking at "massed treatments," which bundle counseling sessions vertically—12 sessions in five days, for example, as opposed to three months. Outcomes appear to be good, Dr. Karnik says, and "people don't want to suffer" with mental health conditions any longer than necessary.

Group therapy is another, more established alternative, one that bundles patients instead of sessions—five to 15 patients treated at once (the average is about eight patients), often for a specific disorder or life crisis. A 2016 meta-analysis of 46 randomized clinical trials showed that, in terms of outcomes, group therapy works as well as individual therapy for many disorders. Group therapy, for which practitioners undergo specialized training to become certified, is well researched, less expensive than individual therapy, augments providers' capabilities, and is effective for young people as well as adults.

Training non-professional community members to handle first-line behavioral health interventions for patients with mild to moderate anxiety or depression, for example, is another model that has come to the fore, says Dr. Karnik, who is also a visiting professor of psychiatry at UIC medicine. These "mental-health first-aid" interactions could help sustain patients between appointments, and keep them connected and accountable for managing their treatment.

Models of care that bring mental health and primary care providers together include coordinated care, in which clinicians communicate about shared patients but might never even meet; co-located care, with onsite collaboration but more or less separate systems; and integrated care, in which providers work in teams to co-manage patients.

For now, there is an alarming lack of a routine process for connecting children and young adults with the mental health treatments they need. They and their parents are often on their own. Faced with an expensive and bewildering system, many

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What Healthcare Providers Can Do to Support Adolescent Mental Health

- Ask adolescents about family relationships and school experiences as a part of routine health screenings.
- Encourage positive parenting practices.
- Engage parents in discussions about how to connect with their adolescents, communicate effectively, and monitor activities and health behaviors.
- Educate parents and youth about adolescent development and health risks.

Source: CDC Division of Adolescent and School Health https://www.cdc.gov/healthyyouth/mental-health/index.htm.

families simply opt out.

Says Dr. Walkup, "When you don't treat these conditions, they get worse or kids accumulate functional impairments that will last a lifetime."

Indeed, while effective, evidence-based treatments are now available for many behavioral health conditions, there simply aren't enough clinicians to go around.

The Pediatrician as Linchpin

The clinician most likely to see children in need of mental health care is a pediatrician, and those specialists are being viewed more and more as the linchpin in the behavioral health project for children and adolescents. "What I like about the pediatrician is that every child has one at some point," Dr. Walkup says.

Julie Holland, MD, vice president of pediatric primary care at Advocate Health Care's Chicagoland Children's Health Alliance in Wilmette, and vice chair of pediatrics for the NorthShore University HealthSystem, says she believes pediatricians for the most part understand and agree that behavioral health will be in their purview to some extent from here on out.

But pediatricians, especially if they have been practicing for a while, may not have much training in psychiatry. "We're working on increasing that knowledge so that becomes part of what a pediatrician can do," Dr. Holland says.

Advocate and NorthShore have undertaken a "combined collaborative care project" to teach primary care physicians how to diagnose and treat some common conditions, Dr. Holland says. The two systems offer evening education programs in behavioral health. One goal is to make pediatricians more knowledgeable about the drugs used to treat mental health conditions, and possibly more comfortable prescribing them in their own practices.

Programs based on Project ECHO (Extension for Community Health Outcomes), developed at the University of New Mexico in Albuquerque, offer virtual rounds for primary care physicians who want to learn to treat various conditions they see in their practices, including behavioral health conditions. There are other continuing education modules for primary care physicians as well.

But not all pediatricians may be motivated to add a rigorous training program in behavioral health to their already busy schedules, Dr. Walkup says. Lurie's collaborative care program connects pediatricians who identify patients with symptoms of mood disorder, anxiety or ADHD, and their families, with psychologists and psychiatrists for assessment and treatment.

Right now, pediatricians can screen for mental health disorders. Family history is a strong indicator of some conditions, Dr. Walkup notes. Pediatricians can take and hold those histories, and be on the lookout for disorders when they are likely to appear—ADHD (attention deficit hyperactivity disorder) between the ages of four to seven, for example; anxiety between the ages of six and 12. The American Academy of Pediatrics, which has issued its own alarm at the emergency in children's mental health (along with the American Academy of Child and Adolescent Psychiatry and Children's Hospital Association) has screening guidelines and other aids for physicians.

That might seem like enough, but mental health screening can't be viewed as a discrete tool, Dr. Walkup says. "The pediatrician has to take that screening information and understand what it means" for the patient, he says.

Resources for Health Care Organizations and Health Professionals

Mental Health Initiatives
(American Academy of Pediatrics): Information and guidance on supporting the healthy mental development of children, adolescents, and families. For example, see here for information on developing age- appropriate screening processes.

HealthySteps Model
(Zero to Three): A primary care model that brings together child development experts, specialists, and pediatric primary care providers to promote healthy child development.

Evidence-Based Practices Resource Center
(Substance Abuse and Mental Health Services Administration): Information to incorporate evidence-based practices into communities and clinical settings

Behavioral Health Integration Compendium
(American Medical Association); Steps for integrating behavioral health care into a clinical practice.

Telemental Health Resource Center
(Western Regional Children's Advocacy Center): Information and tools to set up telehealth programs for mental health.

ACEs Screening Tools
(California's ACEs Aware Initiative): Offers tools to screen for adverse childhood experiences (ACEs).

Trauma Screening Tools
(Childhood Trauma Toolkit, Centre for Addiction and Mental Health): ACEs questionnaire and developmental trauma symptom screening checklist.