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EDITORIAL

Addressing the Youth Mental Health Epidemic

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In 2021, the US Surgeon General produced an Advisory, *Protecting Youth Mental Health* [1], indicating that the USA is in the midst of an epidemic of psychiatric disorders among young people. This proclamation was echoed by a joint statement from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association [2]. Both advisories noted the skyrocketing rates of psychiatric disorders in children, adolescents, and young adults and that these rates have been increasing since at least 2010 [1, 2], despite the common false belief that this dire situation is largely the outgrowth of the COVID-19 pandemic.

The Surgeon General's Advisory [1] noted that the factors associated with increases in psychiatric disorders are multifaceted and clearly shaped (for better or worse) by a combination of variables as follows ([1], p. 7):

> Individual: Age, genetics, race, ethnicity, gender, sexual orientation, disability, beliefs, knowledge, attitudes, coping skills
> Family: Relationships with parents, caregivers, and siblings; family mental health; financial stability; domestic violence; trauma
> Community: Relationships with peers, teachers, and mentors; faith community; school climate, academic pressure, community support
> Environment: Neighborhood safety, access to green spaces, healthy food, housing, health care, pollution, natural disasters, climate change
> Society: Social and economic inequalities, discrimination, racism, migration, media and technology, popular culture, government policies

Compounding this crisis is the well-documented shortage of child and adolescent psychiatrists [3, 4], along with difficulties filling all the graduate medical education slots available [5, 6]; difficulties in access to care [7]; distrust of the health care system, largely by people of color; people who are lesbian, gay, bisexual, transgender, queer (or questioning), asexual (or allied), intersex, and other identities; immigrants; and other populations that have experienced health care discrimination and marginalization [8, 9]; persistence of stigma of having a child with a psychiatric disorder [10]; and the relatively longstanding comorbid problem of loneliness that has significant implications for increased rates of depression, anxiety, stress, suicide, and substance use disorder, as well as other medical consequences [11].

It should be noted that 50% of psychiatric disorders begin before age 14 and 75% before age 24 [12]. As physicians, we know that the best medicine is prevention, followed by early intervention [13]. Without such efforts, young people are facing increasing episodes of psychiatric disorder, some of which will become chronic in nature, and these psychiatric conditions are more difficult to treat [14].

In short, this is a difficult and troubling situation with negative repercussions for both the present and future.

As a field, psychiatry has a professional, ethical, and moral obligation to mitigate this trend. In the American Psychiatric Association's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* [15], Sect. 7.2 states, "Psychiatrists may interpret and share

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with the public their expertise in the various psychosocial issues that may affect mental health and illness" (p. 9). Section 9 states, "A physician shall support access to medical care for all people" (p. 10).

In the American Academy of Child and Adolescent Psychiatry Code of Ethics [16], Principle IX, Advocacy, Equity, and Justice states:

> Child and adolescent psychiatrists support the principle that competent mental health care and a full array of services should be available for all children, adolescents, and their families, and support efforts to improve access to care at the individual, local community, national, and international levels… Further, the practitioner is urged and encouraged to advocate for provision of appropriate care and services for all youths. (p. 14)

Finally, the World Psychiatric Association explicitly addresses psychiatrists' obligation for prevention of psychiatric disorders [17]:

> In their commitment to advancing mental health, psychiatrists promote distributive justice, including equitable allocation of resources for the prevention, treatment and rehabilitation of psychiatric disorders. Psychiatrists advocate in particular for support for mental health programs, especially in but not limited to developing countries and in areas where care for persons with psychiatric disorders is non-existent or rudimentary. (p. 309)

The thoughtful papers in the June 2024 issue of *Academic Psychiatry* address some of these important issues. Access to care and novel ways of working with primary care pediatrics through integrated, collaborative, and/or embedded care is addressed comprehensively by Ouyang et al. [18]. Durette and colleagues [19] further consider an experience with a statewide access program. Pediatrics has been and continues to be the locus of behavioral health care, despite the long history of detachment from child and adolescent psychiatry (CAP), with only a few exceptions [20]. Some note that half of primary care pediatric practice is behavioral [21]. Most psychiatric problems are first brought to primary care pediatrics, and many of the multispecialty pediatric groups have had insufficient education, training, and consultation in CAP. Programs as exemplified by the Massachusetts Child Psychiatry Access Project [22], Project TEACH [23], and in-house programs [24] have a direct impact in addressing the workforce shortage, as well as educating pediatricians, nurse practitioners, and allied health professionals about child and adolescent psychiatric disorders.

In another interesting article, Ramaraj and colleagues [25] described the feasibility, acceptability, and self-reported effectiveness of a 3-year Extension for Community Health Outcomes (ECHO) teleconferenced educational program in teaching geographically dispersed obstetrics, primary care, and mental health clinicians about perinatal mental health and substance use conditions. These conditions are encountered in a variety of clinical settings, including, but not limited to, child and adolescent psychiatric specialized settings.

Other issues, such as fostering interest in CAP by bolstering the general residency experience in this subspecialty, are considered by Kim et al. [26], who demonstrate the value of a robust CAP clinical experience in general psychiatry residency. The importance of teaching advocacy and mitigating stigma is addressed by Francois et al. [27]. As a pediatrician receiving psychiatric training, Makala [28] described the importance of a firm grounding in the child and adolescent, prevention-oriented perspective in empathetically and effectively caring for adult patients who are among the most marginalized, often without family, shelter, or recent experience of clean and sober living. Family stability and constellation are vital for the wellbeing of children and adolescents [29]. Of interest, Adıgüzel Akman [30] described the use of riddles in teaching CAP curricular content, including clinical diagnosis and psychopharmacology. Such an approach would appear to be useful in piquing interest in the specialty among medical students and general psychiatric residents.

Modern CAP training must encompass both breadth of exposure and depth in certain areas where specialized knowledge and skills are needed to comprehensively care for special populations. Toward this end, Katz and colleagues [31] described the positive impact, for both track and non-track participants, of an autism spectrum and intellectual developmental disorders specialty track within CAP fellowship training. Celano and colleagues [32] outlined the implementation—the first of its kind to be described—of an objective structured clinical examination (OSCE) designed to provide formative assessments of fellows' family therapy skills, including "establishing a systemic alliance, reframing presenting problems into systemic terms or goals, and successfully managing negative interactions."

Additional Ways to Bolster CAP Care

There are several ways psychiatrists can enhance the care of children, teens, young adults, and their parents and caregivers, as well as all those who work with youth, including teachers, coaches, clergy, community and spiritual leaders, mentors, law enforcement officers, and more. The initiatives outlined below, which may well mitigate the epidemic and are clearly in line with the ethical and professional codes noted above, can be supported in our communities and even led by medical students, residents,

faculty, and allied health professionals. Many of these options can improve the workforce shortage, help those in need, provide access to care, and even provide experiences for young people to entertain a career in mental health. Consider the following, which will be described further in the next sections: public mental health education, peer supervision, social emotional learning and therapeutic skill building in schools, and online parenting modules and therapy services.

Public Mental Health Education

Few parents and caregivers, and even health professionals, have even rudimentary knowledge about child and adolescent mental health challenges and disorders. Amazingly, the point prevalence of psychiatric disorders in all ages is about 1 in 4 and 1 in 2 over a lifetime [12]. Many US public health campaigns have been successful and have saved millions of lives, for example, the use of sunblock, mammograms, the Papanicolaou test (i.e., PAP smear), smoking bans in public places, and legislation for using seat belts and car seats. Yet the USA has never had an effective public mental health campaign, although psychiatric disorders are more common than strep throat. Everyone remembers the slogan "This is your brain on drugs," with the image of a fried egg in a cast iron pan, yet the Drug Abuse Resistance Education (D.A.R.E.) project, which produced this image, was a failure [33]. The only other campaign that was somewhat successful was "Friends don't let friends drive drunk," by the Ad Council in 1983 [34].

Almost every television station has a "Health Beat." But how many have "Mental Health Beats"? Typically, psychiatrists get called for a media spot when there is a horrifying tragedy, such as a mass shooting, but psychiatrists are not often called by the media for common psychiatric problems.

If psychiatry as a field advocates for the promotion of sound, evidence-based, mental health guides for parents and caregivers and teach them the "three Ws" (What to look for, When to Worry, and What to do" [35]), their awareness and observations about their kids would substantially improve, and their conversations with their primary care physicians or mental health professionals would become vastly more precise, nuanced, and sophisticated. Psychiatrists need to teach residents and fellows how to do this work effectively, which requires both role modeling by faculty and required experiences as a resident and fellow during training. Doing so would help integrate the value of public education into the professional identity of each psychiatrist. Further, it should be a core objective for faculty development, since the media often call upon academic and practicing psychiatrists for their opinions.

Whether one is a medical student, intern, resident, fellow, or faculty member, few have had seminars that prepare them for television, radio, or online roles as experts. There are ways to learn the requisite skills for media interviews, but little training. Yet the media is very interested in talking with those in training or practice. There are a few guides for this kind of work [36–38].

Peer Supervision

While Students Against Destructive Decisions (SADD) [39] and Active Minds [40] are extremely helpful, there are few other peer counseling programs in most organizations where young people live, such as communities, schools, and colleges. In addition, peers who provide supervision or lead group discussions may be students or college graduates. With minimal training and the availability of experts as supervisors, peer supervision can be an incredible safety net to determine who is at risk and may need more intensive services. A great example is the 12-step program, which is highly successful [41], although even this program does not provide training for peer supervisors (i.e., sponsors).

Social Emotional Learning and Therapeutic Skill Building in Schools

Social Emotional Learning (SEL) had been sorely neglected before the COVID-19 epidemic, despite demonstration that evidence-based models of SEL enhance academic performance as well as social and emotional well-being in children and adolescents [42]. The pandemic had a detrimental impact on learning, social, communication, and behavioral skills. These deficits could be ameliorated by SEL curricula [43]. As a consequence, many US schools have been urged to provide remediation and intervention by increased school staff with mental health and/or SEL training [44]. A longstanding proponent, however, is the Collaborative for Social Emotional Learning (CASEL) [45]. Many new online programs are developing SEL curricula. While these are largely geared toward students during classroom time, parent programs are available and can be invaluable.

Several schools are increasingly focusing on other areas of prevention, such as exercise, nutrition, meditation, and yoga [46]. Psychiatrists can encourage and contribute to this work both directly and indirectly by advocating for these interventions in schools locally and nationally and by working at schools as consultants.

Other programs that focus on therapeutic skills in schools are cognitive behavior therapy skills [47], anger management modules [48], and programs dealing directly with mental health challenges [49].

While there is a paucity of research on the causes of loneliness among children and adolescents, many postulate that the overuse of social media as a substitute for face-to-face connection is one contributing factor. Furthermore, the overscheduling of children and teens, in the pursuit of high-level academics,

excelling at sports, learning an instrument, providing community service, and securing internships—even to the point of working 24/7—all takes precious time away from giving young brains a rest and having the opportunity to simply spend time with peers, process their experiences, or pursue creative hobbies. Finally, the dependence on social media may be used negatively for bullying, exclusion, or supporting comparisons with others in ways that promote low self-esteem and isolation. The bottom line is that we need to consider ways of fostering connection, supporting self-care, and defeating youth burnout.

This is not to say that all social media use is negative. The 2023 Surgeon General Advisory on Social Media and Youth Mental Health [50] acknowledges both benefits and pitfalls to social media use and a need for greater research in this area. Psychiatrists should be familiar with the social media landscape, contributing to research in this area and having conversations with patients about their social media use and its impact on functioning and wellbeing.

Online Parenting Modules and Therapy Services

Although many parents and young people want to meet in person, waiting lists are generally quite long for therapy services. Online programs for parents, families, and kids themselves have grown immensely, largely as an outgrowth of the COVID lockdown. While there are pros and cons of remote learning, such programs can be highly effective [51] in teaching skills such as collaborative problem-solving [52] and obtaining professional help that is more easily accessible. Research is still needed to compare remote versus in-person treatment. However, online methods have been extremely popular, cutting down on both no-show and cancellation rates in many clinics [53] and may become more standardized in the future.

Conclusion

Leaders in academic psychiatry can do a lot more to defeat the epidemic of youth mental illness through delivering education and training to a wide range of learners: the public through media; medical trainees; allied health professionals; teachers; coaches; attorneys; law enforcement officials; political leaders; administrators at local, state, and national levels overseeing public mental health; parents; and youth themselves. Psychiatrists' moral, ethical, and professional obligations require this. Many of the considerations mentioned in this editorial can be instituted with minimal cost, and all should be rigorously studied by both quantitative and qualitative methods to find novel, evidence-based ways of promoting the mental health of young people.

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