need of behavioral health assistance. Further, studies have shown that many communities in the United States lack sufficient behavioral healthcare resources. The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that at least 91 million Americans live in areas with severe shortages in behavioral health experts and professional institutions, meaning that individuals in these areas might need to travel significant distances even to access the most basic level of behavioral health care.

A further complication is the fact that because behavioral health care is considered optional in comparison to other types of medical care. Many physicians offering behavioral health services do not take certain kinds of insurance or require a higher level of out-of-pocket payment, and this is another barrier to effective behavioral health interventions. Studies indicate that, even in areas with sufficient resources, patients often experience difficulty affording behavioral health assistance because of a lack of insurance assistance.[5]

The most recent study on this issue, released in 2018, found significant disparities across the United States in terms of affordability and access. This was true not only with regard to basic psychotherapy and emergency mental health services but also with programs offering treatment and assistance with substance abuse, which often accompanies behavioral health issues. Jaqueline Hudson, director for the National Alliance for Mental Health in St. Louis, Missouri, provided an example in a 2018 interview regarding a family in which two children both suffer from chronic illness, one from diabetes and the other from some form of behavioral illness. While the child with diabetes will likely be afforded the opportunity to see physicians an unlimited number of times, the child with behavioral illness will often be restricted in terms of the number of visits and will face not having their illness taken as seriously despite the demonstrable impact of behavioral health on a person's overall wellbeing.[6]

Lack of access to affordable, quality mental health care, and the social, economic, and cultural barriers that prevent individuals from seeking mental health assistance, are primary contributing factors to what many experts in the field feel has become a mental health crisis in America. With nearly one fifth of Americans suffering from mental health issues, and fewer than 10 percent seeking or able to access care, mental health is one of the nation's most serious and yet least-talked-about social welfare issues. Because of this, one of the primary goals for mental health advocates has been to encourage legislation to provide higher levels of access to mental health professionals, while also combating the stigma to open the doors to mental health treatment to a larger share of Americans.

Dismantling Barriers

The COVID-19 pandemic saw a rapid increase in the number of Americans seeking behavioral healthcare assistance but it also created additional difficulties for those seeking care. One of the ways in which healthcare changed during the pandemic was through the expansion of "telehealth" or "telemedicine" options. Telehealth is a method in which individuals connect with healthcare professionals online, through

Increasing Access to Quality Mental Health Care Through Telepsychiatry

By Tracy K. Mullare
Psychiatric Times, September 20, 2021

The United States has been experiencing a critical shortage in access to mental health for years now. According to a 2018 study from the National Council for Mental Wellbeing, 38% of Americans seeking care had to wait longer than a week for necessary mental health treatments, and 46% either knew someone who had to drive an hour round trip to seek treatment or had experienced that challenge themselves.[1]

These challenges go hand in hand with our ongoing national psychiatrist shortage. According to the National Council for Mental Wellbeing's exhaustive 2017 report, by 2025, between 6090 and 15,600 additional psychiatrists would need to be added to the workforce to meet projected demand.[2] Those statistics could paint an even more drastic picture when taking into account the national mental health crisis brought on by the COVID-19 pandemic—particularly its effect on children.

Current Inequities in High-Quality Care Access

The current state of behavioral health boils down to this: we are in a crisis of access to care. However, while demand for care exceeds workforce supply nationwide, there are communities and specific demographics that are disproportionately impacted by access issues. The National Council report on the shortage found that 55% of counties across the US had no current practicing psychiatrists, and 43 of 50 states experienced a severe shortage in psychiatrists specializing in child and adolescent care.[2]

Currently, the system is so overwhelmed that patients have to wait months to access a clinician. While rural areas are still especially underserved, areas with an abundance of mental health practitioners have also been overwhelmed during the pandemic. This situation can be discouraging for families because when they do reach out for care, they do not get called back—or they do not know who to call.

COVID-19's Impact on Children's Mental Health

According to the American Academy of Pediatrics, 1 in 5 children or adolescents in the US have a diagnosable mental illness that requires some form of intervention

learning disorder and childhood-onset schizophrenia are not comparable diagnostically, by way of functional impairment or in the intensity of intervention required.

Some youth are clearly reporting heightened negative effects of the pandemic on their social, personal and educational lives.

Contributing to the confusion about prevalence, parent or self-report scales often used in survey research reduce complex mental disorders to nonspecific, global ratings or a screening checklist of symptoms that are mistaken for being diagnostic. Summary reports may cite results of broad ratings of youth mental health, and even some peer-reviewed publications equate single-item queries such as "How is your child's overall mood?" with diagnoses like depression and anxiety. Such studies contribute to the inflammatory rhetoric pervasive in press reports of youth mental health.

Measuring COVID-19's Impact

With this brief historical context in mind, estimating the measured impact of the COVID-19 pandemic on youth mental health becomes even more difficult. Individual and meta-analysis studies are starting to appear in droves, and though helpful and informative, many are pre-prints (not peer-reviewed), very few use Canadian samples and many do not use longitudinal comparison samples before and during COVID-19.

Almost nonexistent are peer-reviewed studies that published reliable estimates of pre-COVID-19 youth mental health and used clinically valid measures to do so. However, some notable exceptions include a study with Québec and Ontario adolescents and another with young adults in Québec, both of which found only modest increases in mental disorders like anxiety and depression during COVID-19 compared to pre-COVID estimates.

Our COVID-19 Student Well-being and Resiliency Study of over 1,500 Alberta students ages 12-18 during the last school year confirms and adds to these recent Canadian studies. Students from multiple school divisions completed an online survey at separate times (September and December 2020, March and June 2021) about COVID-19 concerns, their levels of stress, behavioural and adaptive functioning and resiliency.

When schools reopened in September 2020, student functioning in these areas was generally found to be below the threshold of any clinical concern or risk. In short, youth were doing OK, but we wondered how this might change over the school year.

Comparing early to late school year, our Wave 4 data (June 2021) indicate the percentage of students who self-reported their COVID-19 stress reactions in the "above clinical cut-off" range rose to 29.9 per cent from 23.5. Percentage of students' who self-reported negative affect (feelings like worry and sadness) in the "high risk" range increased to 25.2 per cent from 17.3 per cent. Interestingly, students who were "very" or "extremely" concerned about catching COVID-19 decreased slightly

of a protective impact during the early months of the pandemic on suicide rates, as I had discussed could be the case in an invited *JAMA* commentary I published last year before this data was available.[3]

We also may not understand the entire impact of COVID-19 on suicide deaths for the longer term, as suicide mortality data takes time to collect and analyze in a meaningful way, research into the specific drivers and protectors of risk takes time, and the pandemic is not over. Additionally, we know there can be a time lag in the manifestation of distress even months after the acuity of a traumatic or stressful period is over.

PT: July had the highest number of suicides in 2020. As we look to 2022, what can clinicians do to help prevent another summertime increase?

Moutier: There may have been factors specific to 2020 at play, in light of the fact that March and April are typically the time of year when suicide rates are highest. It may have been that the early months of the pandemic from March to June, when the lockdown period was occurring, may have conferred a psychological girding of sorts with communal cohesion and feeling of being in it together that may have protected against the sudden changes in routines, employment, and sense of certainty. That said, clinicians should prioritize suicide prevention not only in the spring or summertime, but all year round! On an individual level, there a few steps clinicians can take to reduce suicide risk, including:

- Incorporate routine suicide and mental health screening/rating scales into their practice.
- Use the Safety Planning Intervention and Lethal Means Counseling as an ongoing practice with all patients who have any level of suicidal ideation or suicide risk factors.
- Become familiar with Counseling on Lethal Means, and practice this with patients during periods of increased suicide risk.
- Increase the frequency of outpatient visits or communication during periods of increased risk.
- Involve the patient's family in supportive actions to every extent possible with patient permission (for example, with helping make the home environment safe of lethal means).
- Have a referral list ready to go for CBT-, DBT- or CAMS-specific suicide risk-reducing forms of therapy.
- Learn the data related to treatments including medications and suicide prevention. You can read more here.
- Use AFSP resources to help patients and families learn more (e.g., After an Attempt, Surviving a Suicide Loss, Have a #RealConvo).
- Advocate with the leadership of your health care organization to make suicide prevention a priority of the health system.

Press Release: Rep. Porter Reintroduces Bill to Reduce Violence Against Individuals with Mental Illness and Disabilities

By Katie Porter
US House of Representatives, February 25, 2021

Congresswoman Katie Porter (CA-45), along with Congresswoman Ayanna Pressley (MA-07), Congressman Tony Cárdenas (CA-29), and Congresswoman Mary Gay Scanlon (PA-05), today reintroduced legislation to reduce violence against individuals with mental illness and disabilities. The Mental Health Justice Act would make it easier for state and local governments to send trained mental health professionals instead of police when 911 is called because an individual is experiencing a mental health crisis. Fifty-seven members joined Rep. Porter in introducing the bill, and companion legislation was introduced in the Senate by Senators Elizabeth Warren (MA), Amy Klobuchar (MN), and Cory Booker (NJ).

"We should be connecting people in crisis to care, not tossing them in jail," Congresswoman Porter said. "Mental illness is not a crime, and we have to stop treating it like one. Most police officers are not trained to care for individuals experiencing mental health crises, which too often tragically leads to unnecessary violence. I'm proud to reintroduce this legislation that would make our communities safer for all."

The Mental Health Justice Act would create a grant program to pay for hiring, training, salary, benefits and additional expenses for mental health provider first responder units. Grant recipients will receive technical assistance from experts through the Disability Rights Section of the Civil Rights Division at the Department of Justice (DOJ) and from the Substance Abuse and Mental Health Services Administration (SAMHSA). States and localities that choose to use their own funding for program costs would also be able to apply for access to this expertise.

The Treatment Advocacy Center estimates that 1 in 4 fatal police encounters involve someone with a severe mental illness, making the risk of death 16 times greater for these individuals than for others approached or stopped by law enforcement. Those who are arrested are often charged with minor, nonviolent offenses. As a result, jail and prison systems are overcrowded with thousands of individuals who would be far better served by other community resources.

"We should be sending culturally competent and trained mental health

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like they need it to calm down enough so they can walk into a group where they're going to feel exposed and criticized."

A teen with anxiety might start by smoking marijuana to calm down before social events, and soon find himself smoking every morning just to get to school. "I've had very stressed-out kids say, 'I get high before I go to school because I'm so anxious when I think about the start of the school day,' says Ms. Friedman. "'If I smoke a little weed, I don't feel so anxious.'"

Kids who are depressed may use alcohol or marijuana to cheer themselves up, Dr. Taskiran notes, and blunt the irritability that is a symptom of adolescent depression. "They know there's something wrong with them," he says. "They're not taking pleasure in things, they're not feeling happy. So if their peers are offering a drug that makes you happy, that's often the first thing they turn to." Substance use can quiet negative thoughts that plague depressed kids.

It's also common for children with mental health or learning disorders to develop self-esteem problems, a sense that there's something wrong with them or that they're flawed. When these children reach *adolescence,* with its focus on fitting in, notes Ms. Friedman, "they really want to be normal and they don't feel normal. And that means they're more vulnerable to somebody passing around a drug, because they're just trying to feel better."

Why Is Alcohol Use Riskier for Teenagers?

Alcohol affects teens differently from adults. While adults tend to get more subdued and slowed down by alcohol, in adolescents it's the opposite. They tend to become more energetic, engage in more risky behavior and get more aggressive.

Dr. Taskiran uses the example of driving. "When adults drink and drive you worry about slowing of the reflexes and lapses in attention, like missing a stop sign," he explains. "But with adolescents, we're worried that they're going to get *more* activated. It's not that they won't see the red light, but they might try to run it."

This is especially dangerous for kids with ADHD, who are already impulsive. And substance use makes depressed teenagers more prone to impulsive suicidal behavior. "The adolescent will still be depressed," says Dr. Taskiran, "but the things that usually hold him back won't be there while he's intoxicated, like love for family or the belief that he's going to get better."

Why Teenagers Get Addicted Sooner

Adolescent alcohol or drug use accelerates very quickly when an untreated mental health disorder is present. "Within months we can see problematic use," says Dr. Taskiran.

Why are they different than adults? In the adolescent brain, pathways between regions are still developing. This is why teens learn new things quickly. This "plasticity" means the brain easily habituates to drugs and alcohol. "If you start drinking at 30, you don't get addicted nearly as fast as if you start drinking at 15," adds Ms. Friedman.