Epidemic Rates of Child and Adolescent Mental Health Disorders Require an Urgent Response

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A new Morbidity and Mortality Weekly Report (MMWR) from the Centers for Disease Control and Prevention (CDC) documents the high prevalence of mental health disorders among America’s children even before the pandemic.1 Pandemic era reports recently led the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children’s Hospital Association to issue a joint declaration of a national emergency in child and adolescent mental health.2 This new MMWR represents remarkable work compiling diverse information from 9 nationally-representative data sets. Findings indicate high rates of mental health disorders among US children and youth, including evidence that even very young children experience mental health conditions. Twenty percent of all children have an identified mental health condition annually while 40% of all children will meet criteria by age 18. The MMWR findings show that children living in poverty and minoritized children fare worse than their peers in access to care, identifiable risk factors, and prevalence of certain mental health conditions. Despite high rates of mental health conditions, the MMWR documents low rates of treatment (about 11.4% annually for White, 9.8% for Black, and 8.7% for Latinx children).

Public health surveillance typically focuses on assessments of prevalence rates and treatment access but less on antecedents and protective factors. Only one surveillance system, the National Survey of Children’s Health, provides indicators of child and adolescent wellbeing, such as affectionate (young children), curious to learn new things (school age), and working to finish tasks (adolescence).1 The MMWR report documents high prevalence rates and lower rates of access to treatment, but surveillance systems need to be more comprehensive, reporting key elements that can guide transformation in children’s mental health.

In this commentary, we focus on 3 major issues that surveillance systems currently lack. Two represent known preventable and modifiable risk factors for poor mental health in childhood and beyond: childhood adversity and trauma, and structural racism. The third outlines what is needed for a surveillance system supporting change and improvement.

Child Adversity and Trauma

The MMWR provides limited information on critical antecedents of childhood mental health disorders. Among these are intrafamilial adverse childhood experiences and social determinants of health (SDoH), which are known risk factors for poor outcomes. Adverse childhood experiences and SDoH, including housing instability, food insecurity, poverty, community
violence, and discrimination, can have a cumulative erosive impact via prolonged activation of neurohormonal stress responses, resulting in poor health, behavioral health, and social outcomes. Furthermore, adversity leads both to mental health conditions and chronic physical conditions, with high rates of these co-existing. The abiding presence of a safe, nurturing, responsive caregiver is any child’s best protection. Upstream preventive efforts to address social determinants can have a major impact on children’s health, in part by freeing a parents’ ability to spend time with and nurture their children. Enhanced surveillance that includes information about these adversities as well as positive childhood experiences that protect children, such as access to quality education, safe neighborhoods, and positive parent-child relationships will help upstream prevention.

**Structural Racism**

Because structural racism (defined as “a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity”) is pervasive in American society, it represents a unique and especially harmful type of trauma. For Indigenous and Black children, structural racism is a form of historical trauma.

The MMWR data lack enough numbers to reliably report many outcomes for Indigenous children. Nonetheless, available data suggest that suicide rates are highest among Indigenous children and adolescents, compared with other racial and ethnic groups. Historical trauma visited on Indigenous children included removal from their families and forced placement into Indian boarding schools or nontribal foster care. These structurally racist policies (historical trauma) have been transmitted intergenerationally and are expressed in Indigenous children today with depression and higher rates of suicide. Cultural practices and traditions have helped protect both Black and Indigenous children from the effects of toxic stress but have lacked resources for broader scaling. Traditional surveillance efforts typically ignore these interventions.

Structural racism has lasting and dangerous impacts on developing children. Experiences of racial discrimination in childhood are significantly associated with higher allostatic load in adulthood, indicating the lasting toxic effects of racism experienced during childhood and adolescence.

The MMWR also highlights the limited accessibility of mental health services for all children, but especially for lower income children and children from racial and ethnically minoritized backgrounds. Universal access to insurance and a diverse workforce will help counteract these forces, but even more important are policies and programs that prioritize preventing childhood trauma and promoting safe, secure environments for all children.

Important future directions involve promoting policies that actively undo structurally racist practices, including the consideration of reparations or other financial support for Black, Latinx, and Indigenous families to counteract the negative impacts of structural racism in these communities.

**Improving Surveillance**

The tremendously helpful work by the CDC to compile data on child and adolescent mental health from several data sources highlights the extent of mental health conditions in young populations as well as opportunities to improve data collection to support prevention and better interventions. Population surveillance data provide point-in-time prevalence but have limited information regarding the trajectory of disease and treatment. The ways that mental health conditions present and how children respond to treatment vary greatly by the age of the child. Many have called for improved longitudinal data regarding all chronic conditions for children and youth, such data will allow a better understanding of how mental and behavioral health conditions change over time and through different developmental stages, and greatly aid development of targeted preventive interventions.

A robust surveillance system can also help identify opportunities for improvement and intervention along key steps in the clinical process (beyond what is identified in the MMWR): risk identification, symptom appearance, condition identification and diagnosis, initiation of treatment, and maintenance and retention in treatment, along with clinical and developmental outcomes.

**CONCLUSIONS**

The recent joint American Academy of Pediatrics-American Academy of Child and Adolescent Psychiatry-Children’s Hospital Association declaration speaks to the urgency of the moment. The CDC has responded to this urgency with data that support the declaration’s recommendations of integrating evidence with structural and payment changes to support prevention, identification, treatment, and care coordination.
related to child and adolescent mental health conditions. If we are to rise to the challenge of the critical mental health crisis impacting our children and adolescents, we must reconsider the harmful impacts of childhood trauma and adversity and structural racism on the most vulnerable and precious members of our population. Direct attention to SDoH through household income support, housing, nutrition, and other areas will help lower rates of health conditions. Specific preventive interventions must be designed to protect children and adolescents from these harms, and to appropriately intervene with trauma-informed, antiracist care provided by a pediatric and mental health workforce with specific training on successful interventions, in a health care system designed to minimize these harms. Additionally, we must support the development of a robust public health surveillance infrastructure that tracks resilience and mental well-being in addition to prevalence of mental health conditions and access to care. We must act with the urgency that the circumstances demand.

**ABBREVIATIONS**

CDC: Centers for Disease Control and Prevention  
MMWR: Morbidity and Mortality Weekly Report  
SDoH: Social Determinants of Health

**REFERENCES**

6. The Aspen Institute. 11 Terms you should know to better understand structural racism. Available at: https://www.aspeninstitute.org/blog-posts/structural-racism-definition Accessed January 31, 2022