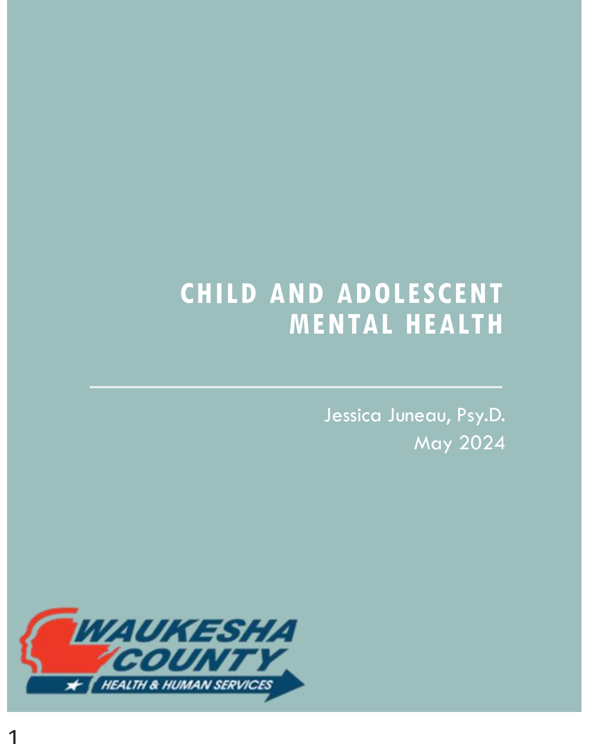


1

YOUTH MENTAL ILLNESS BY THE NUMBERS (NATIONAL DATA)

- 50% of lifetime cases of mental illness begin by age 14 and 75% by the age of 24.
- 1 in 6 kids between the ages of 2 and 8 have a diagnosed mental, behavioral, or developmental disorder.
- ADHD, behavioral problems, anxiety, and depression are the most common disorders in this age group.
- Suicide is the second leading cause of death for those between the ages of 10 and 14, and third leading cause of death for those between 15 and 24.

2

PREVALENCE OF MENTAL HEALTH ISSUES IN WISCONSIN

Wisconsin Youth Risk Behavior Survey (YRBS) – 2021 state results for high school students

- 52% reported anxiety
- Nearly 34% reported feeling sad, hopeless, or depressed
- 1 in 5 endorsed thoughts of self-harm
- 50% have troubles obtaining treatment
- 18% of teens reported seriously considering suicide

3

PREVALENCE OF MH IN SPECIAL JUVENILE POPULATIONS

Juvenile Justice System:
- 70.4% of youth meet criteria for a psychiatric diagnosis
- About 75% of youth experienced trauma
- 60% meet criteria for a substance use disorder
  - *Sources: Child Mind Institute 2015 Children's Mental Health Report; SAMHSA*

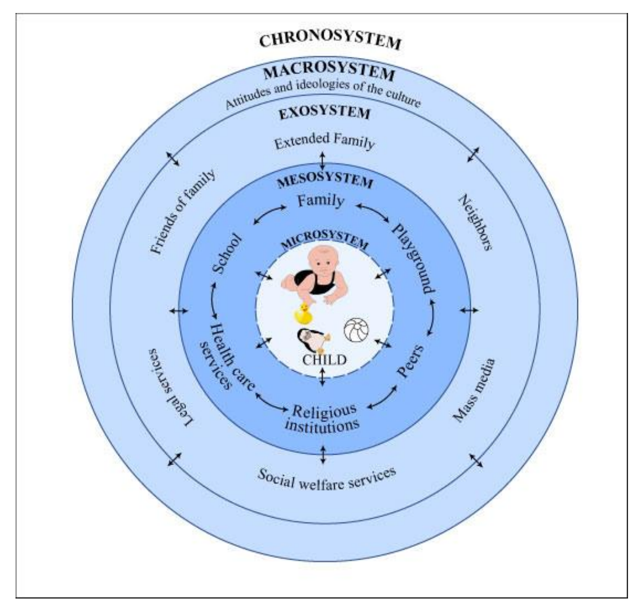
LGBTQ:
- Significantly higher risk for suicide: In 2022: 48% of LGBT youth considered suicide
- In 2022, 66% experienced depression and 80% experienced anxiety
  - *Sources: 2022 Wisconsin Office of Children's Mental Health 2022 Annual Report; 2022 Wisconsin Youth Risk Behavior Survey*

Child Welfare:
- 50% of children have mental health problems
- 15% receive treatment
  - *Source: American Psychological Association, Winter 2012*

4

SEEING A CHILD IN CONTEXT

Youth have fewer opportunities to change these external forces than an adult



5

LOTS GOING ON WITH CHILDREN AND ADOLESCENTS

- Physical Changes
- Hormonal Changes
- Developmental Milestones
- Peer Pressure
- School Pressure
- Societal Pressure
- Social Media
- Trauma
- Substance Use and Experimentation

But also…

- Resilience
- Optimism
- Innovation

6

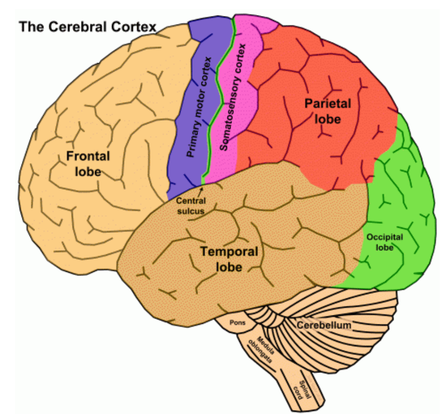
ADOLESCENT BRAIN UNDER CONSTRUCTION

We Know…

The adolescent brain is DIFFERENT than adult brains

The brain has significant growth spurts around adolescence making it more responsive to learning but also more vulnerable

Brain structure and connections continue to change through about age 25



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BRAIN MATURATION

In adolescence, parts of the brain involved in emotional responses and gratification (limbic system) are very active.

Parts of the brain that keep emotional and impulsive responses at bay (prefrontal regions) are slower to develop

Leads to appetite for novelty, acting on impulse with less regard for risk

- Struggle with considering consequences of decisions – not wired to weigh pros and cons in a logical manner
- Not all risk taking is negative

8

OBSTACLES TO GETTING CHILDREN AND ADOLESCENTS MENTAL HEALTH TREATMENT

- Difficult to distinguish "kid problems" from mental health issues (chronic disorders)
- Lack of awareness by parents of symptoms or treatment options
- School district lack of support staff and mental health resources
- Shortage of child and adolescent mental health providers, particularly in rural areas
- Lack of available community programs to support youth with emotional and behavioral problems
- Half of teens diagnosed with mood disorders don't adhere to treatment
- STIGMA regarding mental health issues

9

WHO IS NOT GETTING TREATMENT?

- 40% of youth with diagnosable ADHD
- 60% of youth with depression
- 80% of youth with a diagnosable anxiety disorder

-Child Mind Institute, 2015 Children's Mental Health Report

10

BUT…TREATMENT AND OTHER INTERVENTIONS WORK!

- With treatment, a large percentage of teens get better
  - 81% of teens with anxiety
  - 71% of teens with depression
  - 85% of teens with ADHD
  - 50% reduction in recurring episodes with early intervention for psychosis
- School-based education and anti-stigma programs improved attitudes about mental health by 68%
- School-wide high school interventions reduced the number of actively suicidal students by 36% in one study
- Mindset matters. 90% improvement in treatment with positive attitude; 33% improvement with ambivalent attitude

-*Child Mind Institute, 2017 Children's Mental Health Report*

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DIAGNOSING CHILD AND ADOLESCENT MENTAL HEALTH ISSUES

- Early identification and treatment can turn lives around
- Pediatricians are best first step and resource for parents
- Mental health issues are diagnosed by a medical doctor, psychiatrist, or psychologist
- There are no blood tests or other tests that can determine certainty of diagnosis
- Diagnosis may change over time and depending on presenting symptoms and assessment of provider.

12

BEHAVIORAL RED FLAGS IN CHILDREN/ADOLESCENTS

- Marked change in behaviors
- Significant change in mood
- Problems across multiple settings
- Self-harm behaviors
- Suicidal thoughts
- Isolation from peers
- Increase in risk-taking behaviors
- Decreased interest in activities
- Physical complaints

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MOST COMMON CHILDHOOD PSYCHIATRIC DISORDERS

-BASED ON DIAGNOSTIC INTERVIEWS DONE BY PROFESSIONALS WITH A LARGE, REPRESENTATIVE SAMPLE OF ADOLESCENTS

ANXIETY DISORDERS – 31.9% (8.3% with severe impairment)

ADHD AND DISRUPTIVE BEHAVIOR – 31.9% (9.6% with severe impairment)

DEPRESSION AND BIPOLAR DISORDERS – 14.3% (11.2% with severe impairment)

EATING DISORDERS – 2.7%

Source: Child Mind Institute, 2015 Children's Mental Health Report

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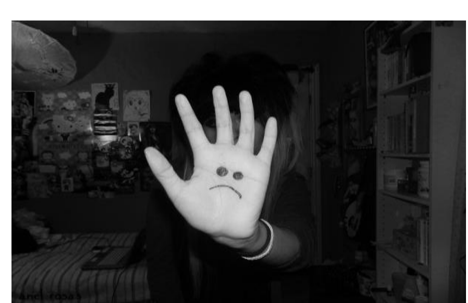
MOOD DISORDERS

MEDIAN AGE OF ONSET: AGE 13
-CHILD MIND INSTITUTE, 2015 CHILDREN'S MENTAL HEALTH REPORT

Significant mood shift and symptoms creating impairment in daily life

Mood Disorders we will cover:

- Depression
- Bipolar Disorder
- Disruptive Mood Dysregulation Disorder



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DEPRESSION – COMMON SYMPTOMS

Loss of interest, energy, motivation

Hopelessness

Increased/decreased sleep and/or appetite

Slowed thinking or response

Poor concentration

Guilt

Suicidal thoughts and/or attempts

Children and adolescents

- **Irritability**
- **Behavioral outbursts/aggression**
- **Self-harm behaviors**

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DEPRESSION (CONTINUED)

Major Depressive Disorder

- Major Depressive Episode develops over weeks, not hours/minutes
- Major Depressive Episode is at least 2 weeks of symptoms
- May or may not be triggered by life events
- High suicide risk, especially early in treatment

Persistent Depressive Disorder (Dysthymia)

- More chronic
- Depressed mood for much of the day, every day, for at least one year in children/teens
- Early onset (before 21 years) is associated with a higher likelihood of co-occurring personality disorders and substance use disorders

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BIPOLAR DISORDER

- Distinct periods of depression and mania/hypomania
- Manic Episode may last weeks to months

May present with a mixed state – with Depressive Episodes

Hyperactive
Easily agitated
Irritable, angry
Hypersensitive to stimuli

- Average age of onset for first manic, hypomanic, or major depressive episode is about 18 years for Bipolar I Disorder

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DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD)

A relatively new diagnosis that tries to account for those youth that the bipolar diagnosis does not "fit"

Describes children age six and above who experience:

- Severe recurring temper outbursts out of proportion to situation
- Mood in-between temper outbursts is irritable or angry
- Inconsistent with developmental level
- Across settings or environments

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ANXIETY DISORDERS
MEDIAN AGE OF ONSET: AGE 6
-*CHILD MIND INSTITUTE. 2015 CHILDREN'S MENTAL HEALTH REPORT*

Pattern of excessive worry or anxiety that is difficult for the child to control

Causes a significant impairment in the child's daily functioning

Common symptoms: nervousness, *physical health complaints*, verbal or physical aggression, difficulty concentrating, agitation, irritability, school/social refusal (avoidance), substance use, isolation, self-harm (cutting)

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OVERVIEW OF COMMON ANXIETY-BASED DISORDERS

Generalized Anxiety Disorder: *chronic and excessive worry about multiple parts of their life*

Social Anxiety Disorder: *Severe worry and avoidance of social situations (i.e. school refusal)*

Panic Disorder: *Sudden onset of extreme worry and physiological symptoms (i.e. heart racing)*

Obsessive Compulsive Disorder: *Intense obsessions (thoughts) and/or compulsions (repetitive behavior/ritual) that cause severe discomfort and interfere with day-to-day functioning*

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AUTISM SPECTRUM DISORDER

- Affects social and communication skills
  - Troubles developing or maintain relationships
  - Struggles with mood regulation/easily overwhelmed by stimuli
  - Black and white thinking
  - Sensory struggles
  - Self-soothing/stimming behaviors
  - Difficulty adapting to changes
- Pervasive Developmental Disorder
- We can provide support to the youth and the family, but there is no "cure"
- When distressed, the youth may need external support for soothing themselves
- Can have accompanying intellectual impairment

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IAN, 15 YEARS OLD

HTTPS://WWW.YOUTUBE.COM/WATCH?V=CORDZOHET24&T=2S

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TRAUMA AND STRESSOR RELATED DISORDERS

Reactive Attachment Disorder (RAD) *Problems in attachment with parent/caregiver. Difficulty with peer relationships. Various behavioral issues – i.e. lying, stealing, oppositional toward authorities *Diagnosed during childhood*

Posttraumatic Stress Disorder (PTSD) *Uncontrollable and intrusive thoughts about traumatic event. Avoidance of memories associated with trauma, hypervigilance, negative thoughts/moods about self and the world.*

Treatment and Intervention

Specialized psychotherapeutic interventions

Some psychiatric medications may be prescribed to assist in symptom management related to co-existing disorders

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TEENAGE BRAIN & ADDICTION

Addiction

- It's a form of learning
- Synapses in the reward seeking areas of the brain are being strengthened
- There is more material for substances to lock on to
- Addiction is more efficient in teens
- Early drug use dramatically increases the risk of dependence

Alcohol

- Sedative effect blocks excitation so process of learning does not get started
- Binge drinking is particularly harmful to teen brain
  - Actually kills brain cells
  - Does not happen to same extent in adult brain

Marijuana

- Stays on targets longer
  - Many days out they are still impaired in their learning
  - In adults the effect is more fleeting

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ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

- 30-40% of children with ADHD have a relative with ADHD
- Diagnosis has dramatically increased since the early 2000's
- More than twice as many boys as girls are *diagnosed with* ADHD
- Symptoms typically arise between ages 3-6, and diagnosis is usually made during elementary school.
  - Age of diagnosis is typically younger with increasing severity
  - Age 8 for mild ADHD; age 7 for moderate ADHD; age 5 for severe ADHD
- Three ADHD presentations
- Three hallmark symptoms:
  - Inattention
  - Hyperactivity
  - Impulsivity

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CHILDHOOD BEHAVIORAL DISORDERS

Oppositional Defiant Disorder

- Pattern of disobedient, hostile, and defiant behavior toward authority figures.
- Symptoms
  - Actively does not follow adults' requests
  - Angry and resentful of others
  - Argues with adults
  - Blames others for own mistakes
  - Has few or no friends, or has lost friends
  - Is in constant trouble in school
  - Loses temper
  - Is spiteful or seeks revenge
  - Is touchy or easily annoyed

Conduct Disorder

- Pattern of behavior that shows a persistent disregard for norms and rules of society.
- Symptoms (3 or more symptoms over 12 months)
  - Stealing
  - Constant lying
  - Deliberate fire setting
  - Truancy
  - Theft
  - Property destruction
  - Physical cruelty to animals or humans
  - Forcing others into sexual acts
  - Starting fights
  - Running away

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SCHIZOPHRENIA

Positive symptoms

- Hallucinations –perception-like experiences without external stimuli
- Delusions – fixed false belief
- Disorganized speech & behavior-
  - Derailment, loose associations
  - Tangential
  - Incoherence—word salad

Negative Symptoms

- Diminished speech or thought
- Lack of facial expression
- Lack of motivation
- Lack of connectedness

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NON-SUICIDAL SELF-INJURY

Behaviors include cutting, scratching, burning	More often in girls, starting in puberty	Most often not a suicidal behavior – symptom of another problem (i.e. depression, anxiety, stress, personality issues)
Function of behavior is largely to relieve emotional distress	Maladaptive coping method that has risk to person	Social media fuels copycat /normalizing effect with those who self injure

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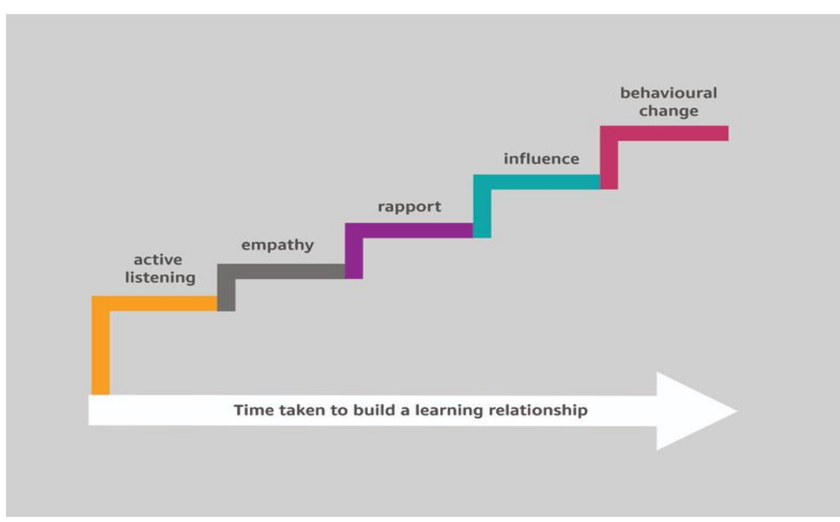
BEHAVIOR CHANGE STAIRWAY MODEL



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BEHAVIOR CHANGE STEPS

Active listening	Paraphrase, mirror, reflect Avoid ordering, arguing, asking why, or criticizing
Empathy	Ability to demonstrate that we understand the other person's experience
Rapport	Develop a collaborative relationship with the youth
Influence	Guide and support youth towards a decision

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CHILD AND ADOLESCENT RESOURCES TO CONSIDER

Refer families back to pediatricians for info about symptoms/medication referrals.

Wisconsin Family Ties – (800) 267-6801 Parent Peer Advocates – with lived experience to help navigate services/schools, etc.

NAMI.org

HOPELINE – The Center for Suicide Awareness of WI 741741

988 Suicide and Crisis Lifeline

The Trevor Project – LGTBQ youth, parents, or community members that need info/support http://www.thetrevorproject.org

Trans Lifeline – 877-565-8860; peer ran support line

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WRAP UP

Mental illness is common and widely misunderstood

The youth you are likely to encounter lead complicated lives

- Trauma
- Substance abuse
- Mental illness – often untreated
- A changing brain

Early Intervention is key

By understanding child and adolescent mental health, you can play a role in responding in a compassionate way and making referrals for needed care