

Statement of Mark Olfson, MD, MPH
Before the Federal Commission on School Safety
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I am Dr. Mark Olfson, Professor of Psychiatry and Epidemiology at Columbia University. I am pleased to have an opportunity to discuss improving the use of psychotropic medications for children and adolescents in the United States.

As someone who studies patterns and trends in psychotropic medications, I am often asked whether young people in the US are undertreated or overtreated with these drugs. To which I always answer “Both!” which generally provokes consternation, so let me explain.

First, I would like to make a few points about undertreatment.

There is compelling evidence that US children and adolescents are undertreated with psychotropic medications. Adolescent depression provides a case in point. Depression is highly distressing and puts young people at increased risk not only for suicide,^{3,4} but also and much more commonly increases their risk of educational failure,⁵ obesity,⁶ smoking and other drug problems.⁷ In recent years, we have seen an increase in depression among adolescents¹ that has coincided with rising national rates of youth suicide.² In any given year, around one in nine US adolescents suffers from depression, but only around 40% of them receive any treatment and only about half of those receive an antidepressant medication,¹ although antidepressants are known to be effective for adolescents with moderate or severe depression.⁸ Even larger gaps exist in the treatment of anxiety and substance use problems.⁹

Many factors contribute to under recognition and under treatment of mental health problems in young people. The barriers are complex and rooted in biological, economic, social, attitudinal, and geographic factors. In my brief remarks this morning, I will not attempt to describe them all,

but rather focus on two important barriers: first, difficulties in recognizing a need for mental health care and seeking it out; and second, critical shortages in the availability of mental health professionals who treat young people.

In general and varying with the stage of development, children may not have sophisticated language for describing their feelings. One way to group features of mental illness is to use the terms externalizing and internalizing features. Examples of externalizing features that may indicate a mental illness include fighting and truancy. Externalizing behaviors readily attract the attention of teachers, parents, and sometimes law enforcement. Internalizing problems, such as social withdrawal, loss of interest in activities, and difficulty concentrating are much harder to detect and are commonly ascribed by parents and teachers as the young person simply “going through a phase.” Even when these more difficult to detect problems are recognized, however, the young person often does not receive effective mental health treatment.

When a child or adolescent first begins to experience mental health symptoms, there are many potential barriers and missteps that can occur as the young person moves towards receiving care. These barriers delay treatment delivery and result in needless suffering and worsening of symptoms. Let’s think about all the steps that need to occur to get a child into specialty mental health treatment.

First, adults who are concerned, but who are not professionals in assessing mental health conditions, attempt to evaluate the significance and likely consequences of the problem.¹Second, they must seek to determine whether the problem requires treatment. Third, they try to assess the benefits and costs of various treatments. Finally, they need to search for an appropriate, accessible, and affordable health care professional. When viewed from this perspective, it is not at all surprising that most children and adolescents, even most with severe mental health impairment, do not receive treatment.

¹⁰ Substance Abuse and Mental Health Services Administration. Behavioral health barometer: United States, 2015.

¹¹ Thomas KC, Ellis AR, Konrad TR, Holzer CE, Morrissey JP. *Psychiatr Serv.* 2009;60(10):1323-8.

¹² Olfson M, Druss B, Marcus S: *New Eng J Med* 2015;372:2029-2038.

¹³ Ibid

Beyond barriers related to becoming aware of a mental health problem and then seeking treatment for it, there are critical shortages in health care professionals trained to treat child and adolescent mental health problems. National shortages in psychiatrists and psychologists are exacerbated by geographic maldistribution. Mental health professionals tend to aggregate in urban rather than rural areas and in affluent rather than poor communities. On a per capita basis, there are roughly three to five times as many psychiatrists and psychologists in urban than rural states.^{10,11} As a result, rural families seeking mental health care for their children face particularly difficult challenges that often involve long travel distances and long wait lists which leave many of their children's problems either untreated or reluctantly treated by nurse practitioners or pediatricians. Even in urban areas, qualified child and adolescent mental health professionals are often unavailable for low-income and middle-income families.

Now, let's think about overtreatment

Alongside widespread undertreatment and underuse of effective psychotropic medications, we have seen recent increases in psychotropic medications prescribed to children and adolescents. Over a recent 15-year period, there was a six-fold national increase in children and adolescents treated with antipsychotic medications and a near doubling of those treated with antidepressants and stimulants.¹² Although rising numbers of medication-treated children and adolescents do not necessarily mean that young people are being overtreated, there are concerns that many young people are being unnecessarily treated with these medications because approximately two-thirds of the increase in psychotropic medication use in the US has occurred among young people with less severe impairment.¹³

These concerns have focused most intensively on antipsychotic medications, particularly their use in young children and young people in foster care. In addition to uncertainty over their long-term effects on the developing brain, side effects of antipsychotic medications include weight gain, high cholesterol levels, and increased risk of diabetes.¹⁴ As compared to a young person who is not treated with an antipsychotic medication, one who is treated with an antipsychotic has a more than a three-fold increased risk of developing diabetes because of side effects.¹⁵ Simply

put, these medications should be prescribed only when the potential benefits clearly outweigh the chances of bad or adverse effects.

Concerns over drug safety are compounded by evidence that these medications are sometimes prescribed in a less than judicious manner. According to the US Food and Drug Administration, antipsychotic medications are only indicated in young people for schizophrenia, bipolar disorder, irritability associated with autism, and Tourette's disorder. Yet most young people who are prescribed antipsychotic medications are not diagnosed with any of these conditions.¹⁶ In one study of children, ages 12 and younger in a Medicaid program, the top diagnosis for antipsychotic prescribing was "unspecified mood disorder" that accounted for nearly one quarter of the treated children and the top target symptom was aggression which accounted for nearly half of the treated children.¹⁷ In another study, most youth in the Medicaid program who were starting antipsychotic medications had not received any counseling or psychotherapy services in the preceding three months.¹⁸ These patterns suggest that some health care professionals jump to antipsychotic medications before trying safer alternative treatments.²

Summary

To summarize, while many young people in our country with serious mental health problems who would benefit from psychotropic medications do not receive them, others are prescribed medications they may not need. There are no simple solutions to this complicated mismatch. To help address this problem, I recommend expanding voluntary school-based mental health screening, providing incentives to help reduce the geographic maldistribution of mental health professionals, and strengthening quality measurement of psychotropic medications. More specifically, I urge the Commission to consider the following three recommendations:

¹⁴ Baeza I, Vigo L, de la Serna E, Calvo-Escalona R, et al.. *Eur Child Adolesc Psychiatry*. 2017;26(1):35-46.

¹⁵ Galling B, Roldan A, Nielsen RE, Nielsen J, et al. *JAMA Psychiatry*. 2016;73(3):247-59.

¹⁶ Alexander GC, Gallagher SA, Mascola A, Moloney RM. *Pharmacoepi Drug Safety* 2011;20:177-184.

¹⁷ Christian RB, Farley JF, Sheitman B, et al. *Psychiatr Serv*. 2013;64(9):893-900.

¹⁸ Finnerty M, Neese-Todd S, Pritam R, et al. *J Am Acad Child Adolesc Psychiatry* 2016;55(1):69-76.

¹⁹ Olfson M. *Health Affairs* 2016;35:983-990.

1. Increase screening for mental conditions in schools. Because youth often do not spontaneously disclose emotional distress and parents are often unaware of their child's mental health problems, voluntary mental health screening either in schools or primary care offices offers a feasible means for identifying and connecting high risk young people to school and community mental health services. I urge the Commission to support extending the availability of voluntary mental health screening for young people.

2. Expand opportunities to support professionals to work in public schools and with children in underserved areas. To help address critical regional shortages of child and adolescent mental health professionals, I urge the Commission to recommend broadening eligibility for National Health Service Corps training sites, a federal loan repayment program that offers financial incentives to attract health care professionals to underserved areas. Over the last several years, this program has included mental health professionals such as psychiatrists, psychologists, psychiatric nurse practitioners, and clinical social workers.¹⁹ Increasing the range of facilities that are eligible to become NHSC sites and placing greater emphasis on recruiting child and adolescent mental health professionals would help alleviate local shortages of these professionals.

3. Strengthen standards and quality metrics so that more children have access to high quality treatment that matches their needs. Because of the uneven quality of psychotropic medication treatment, there is a need to coordinate federal, state, and local approaches to measuring the quality of mental health care for children and adolescents including use of psychotropic medications. Private insurance plans, Medicaid programs, and child welfare agencies, all need to attend to these quality of care concerns. The recent adoption by the National Committee on Quality Assessment of a measure of first line psychosocial care for children and adolescents on antipsychotic medications is just the sort of standard that is needed to improve use of psychotropic medications by young people.²⁰ I urge the Commission to support broad adoption of evidence-supported quality measures of psychotropic medication use for children and adolescents.

I appreciate the opportunity to speak with you about child and adolescent mental health and I am happy to respond to any questions.