BC youth are in a mental health crisis—we must invest in prevention

The US Surgeon General recently issued an advisory on the youth mental health crisis, which was worsened by COVID-19, calling for swift, coordinated actions.[1] The situation in BC is similar. It is time for BC and Canada to create comprehensive strategies for child and youth mental health and substance use (CYMHSU), emphasizing prevention.

In 2018, one in six BC youth seriously considered suicide in the prior year, one in five self-reported anxiety disorders, one in eight engaged in purging, and one in seven were depressed. All rates increased more than 50% since 2013, with the worst rates among female and LGBTQ+ youth.[2] Even pre-COVID-19, BC was not on track to meet its mental health and substance use targets. The situation is similar across Canada, which ranked 31st of 38 high-income countries in children and youth well-being and mental health.[3] Unlike in Canada, many countries are showing improvement, highlighting the systemic failure and that something can be done.

The pandemic exacerbated the situation further. An Ontario study found that approximately 70% of children and adolescents experienced deterioration in at least one mental health domain (anxiety, irritability, hyperactivity, attention, depression, or obsessions/compulsions).[4] The BC COVID SPEAK survey confirmed a disproportionate impact on families living with children.[5] In 2021, opioid overdoses were the third-leading cause of death for BC children under age 19, with a record 29 deaths.

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The majority of CYMHSU disorders begin before the age of 15.[3] They are a leading cause of disability and are underfunded compared with other causes of disease burden.[3,6] Beyond disease burden, CYMHSU problems early in life lead to impairment across family, social, and academic domains, creating socioeconomic inequities.[3] BC's investments in early childhood education, social and emotional learning, poverty reduction, and mental health services are commendable but insufficient, as noted by Jennifer Charlesworth, BC's representative for children and youth.[7] Furthermore, both BC and Canada lack funding for evidence-based CYMHSU prevention.

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Much more can be done, from better prevention of intergenerational trauma to systematically delivering a suite of effective preventive interventions **[Table]**, including parenting programs, school-based programs, and cognitive-behavioral-therapy-based interventions, both universal and targeted. CYMHSU preventive interventions are highly cost-effective, with societal savings of $6000 to $14 000 per participant.[8] Preventing a single case of conduct disorder is estimated to yield lifetime savings of $5 million per child.[8] However, evidence-based preventive interventions are far from being implemented systematically in BC or Canada, with little reporting on the impact of current strategies. Therefore, an immediate scale-up of evidence-based measures is needed.

During the pandemic, we have seen that public health, the health care system, and the government can collaboratively monitor, act, and adjust to address a population-level health threat. We must do the same for the CYMHSU crisis. Physicians can play a role by raising awareness of the crisis, demanding action, or joining the CYMHSU Community of Practice voices. Physicians can also identify and refer children, youth, and families using resources available from https://openmindbc.ca.

To solve the crisis, it is crucial for the provincial and federal governments to establish a comprehensive strategy that includes prevention, with increased publicly reported surveillance and evaluation. The future well-being of our province and country rests on how we support and invest in the next generation's mental health. ■

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TABLE. Prevalence of child and youth mental illnesses, including substance use disorders and associated preventive interventions, adapted from Schwartz and colleagues.[8]

Disorders and prevalence* in BC	Effective prevention interventions and supporting evidence
Anxiety disorder 5.2% or 38 800 children (4–18 years)	Four interventions using cognitive-behavioral therapy (CBT) (five randomized controls trials [RCTs]). • Effective in a variety of formats, such as teaching parents, delivering CBT to groups of children, and self-delivery. • Effective for children 4–17 years old. • Large effect size; e.g., odds of anxiety disorder diagnosis 8 times lower.
Depression 1.3% or 9700 children (4–18 years)	Four targeted CBT interventions (six RCTs). • Two provided to children, one to families, and one to youth reading a book.
PTSD 0.1% or 700 children (4–18 years)	Four targeted CBT interventions (five RCTs) in children who had been maltreated. • Three programs included parents. • Two delivered in groups, two to individual families.
Substance use disorders 2.3% or 8200 children (12–18 years)	Six universal and three targeted programs (10 RCTs). • Multicomponent interventions included child education, CBT, motivational interviewing, parent training, communication skills, resistance skills, and/or social skills training.
ADHD 3.7% or 27 600 children (4–18 years)	Three targeted parent-training interventions (four RCTs). • All programs applied to families with young children. • Usually teaching parents to encourage their child's positive behaviors through providing attention and praise while ignoring minor misbehaviors.
Oppositional defiant disorder 3.3% or 24 600 children (4–18 years) **Conduct disorder** 1.3% or 9700 children (4–18 years)	Parent training (10 RCTs) (parent teaching similar to above). Multicomponent interventions (five RCTs). • Including combinations of behavior therapy, enriched school curricula, parent-school collaborations, parent training, and/or social skills training.
Eating disorders 0.2% or 700 children (12–18 years)	Four multicomponent interventions (five RCTs). • One universal and three targeted, including combinations of discouraging unhealthy weight control practices, encouraging positive body image and healthy lifestyle planning, and/or media literacy training.

*Estimated numbers are for children 4–18 years old, except for eating disorders and substance use disorders, which are for children 12–18 years old.

Continued from page 179

health care providers. Read the full story at www.coyotestory.ca.

Access to quality care closer to home

Indigenous populations in rural BC communities face significant barriers to accessing quality care, including having to travel long distances to and from appointments, a lack of providers and services in rural communities, and a lack of access to culturally safe care. These hurdles were further emphasized with the start of the COVID-19 pandemic. In April 2020, the First Nations Virtual Doctor of the Day program was launched by the FNHA and the Rural Coordination Centre of BC (RCCbc), which is funded by the JCCs. The program is one of three Real-Time Virtual Support pathways offered by the RCCbc to enhance health equity in BC rural, remote, and Indigenous communities.

Operating 7 days a week, the program enables Indigenous people who have limited or no access to a doctor to receive culturally safe primary care virtually; it also supports community-based nurses and other health professionals to deliver primary care. In the program's first year, there were more than 6000 encounters between doctors and hundreds of patients who accessed the service. All physicians have training or experience in cultural safety and humility, and many of the doctors have Indigenous ancestry. Access the service and learn more at www.fnha.ca/what-we-do/ehealth/virtual-doctor-of-the-day.

The JCCs commit to keeping the conversation going with and between Indigenous communities and BC doctors, as well as collaborating with health care partners to develop solutions that address systemic health equity issues. Learn more about the JCCs at www.collaborateonhealthbc.ca. ■

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