‘We Have Essentially Turned a Blind Eye to Our Own Children for Decades’

Why we need to stop politicizing children’s mental health

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We are deep in the grip of a children's mental health crisis.

That's one belief that everyone in our deeply divided country seems to share. The headlines have been terrible: "8-Year-Olds in Despair." "Their Tank is Empty." "No Way to Grow Up." Parents are frustrated, terrified — and increasingly angry. And they don't have to look far to find politicians and pundits who will channel their pain. Those with the loudest voices and the biggest platforms all appear to agree: The children's mental health crisis is a consequence of covid-era political decisions — the child-sacrificing outcome of too-rigid social distancing, too-lengthy school closures and too much mask-wearing. "The pandemic's disruptions have led to lost learning, social isolation and widespread mental-health problems for children," the New York Times' David Leonhardt

summed up back in January in a much-quoted newsletter. “Many American children are in crisis — as a result of pandemic restrictions rather than the virus itself.”

That’s an explanation that *feels* right, particularly if you’re one of the millions of parents trying to balance back-to-normal work expectations with the continued chaos of your school-age children’s lives. It feels especially right if you’re someone whose child, pre-pandemic, seemed basically fine (or fine enough) and then just … wasn’t.

But — as the shrinks say — feelings aren’t facts. The front-line providers who work with children have a different explanation: The pandemic hasn’t created a children’s mental health crisis out of nowhere; rather, it’s shone a spotlight on a catastrophe that has been hiding in plain sight for a very long time. “This is not a new problem,” Sandy Chung, a pediatrician in Fairfax, Va., and president-elect of the American Academy of Pediatrics, explained to me recently. “Over the last several decades, we’ve been seeing

an increase in mental health conditions in children and adolescents.”

[*‘The stigma is winning’: Parents strain to juggle jobs and their kids’ mental health*]

Chung illustrates her point with a story from about five years ago that still haunts her. A Northern Virginia child psychiatrist who had set up and monitored a complicated medication regimen for a 14-year-old boy with bipolar disorder had retired, and the boy’s parents hadn’t been able to find a replacement. So they reached out to their pediatrician’s office for help. But the doctors there, who’d had only a month or two of training in psychiatry during their residencies, decided they weren’t comfortable refilling prescriptions for medications they hadn’t prescribed, and for a condition they hadn’t diagnosed and didn’t treat. They did, though, feel very strongly that the boy needed help finding care.

So they started working their networks. Their staff worked the phones. But they kept getting the

same answer: It was a four- to six-month wait to see a child psychiatrist who participated in health insurance and would accept a new patient. Finally, one of the nurses struck gold: a psychiatrist within driving distance who had an opening in four weeks.

During that time, the boy ran out of his medications, and his condition worsened. He ended up in a fight, got his hands on a gun and shot a man.

"And that man lost his life, and that 14-year-old ended up in jail," Chung told me in the hushed and flattened tone of someone sharing a story that shocks her afresh every time she retells it. "It was horrible … absolutely horrible," she said. And then, as she reflected on the systemic failures so typical then in her state, her voice rose and sharpened. "It was terrible care."

Though that tragedy is unique, many of the doctors I spoke to for this article were similarly haunted by stories of mental health disasters — or near-misses — that long predated the pandemic. That is why so much of the current talk about the children's

mental health crisis makes people who have long been working in the field kind of, well, crazy. “We’re suffering from a crisis that until recently people didn’t dare to speak aloud,” Mitch Prinstein, the chief science officer for the American Psychological Association (APA), told me in a recent phone interview. “We have essentially turned a blind eye to our own children for decades. And because we’ve spent decades not doing anything for children, we’ve seen this escalation.”

By escalating a situation that’s been decades in the making, the pandemic has the potential to finally spark real change in how we think about and deal with children’s mental health. But for that to happen, we need to take a hard look at what we’re really talking about when we tell stories of kids “in crisis.” To start, we must tease apart what’s truly been new in the covid era from the bigger and deeper problems that have been present all along.

Much of the evidence that the pandemic has catapulted a generation of children from “normalcy” into a full-scale, broad-

based mental health crisis is anecdotal. What statistics we have from the past couple of years actually show a more nuanced story. Different populations of children have experienced the pandemic in different ways: Adolescent girls have fared particularly poorly. Low-income children have, too. The data shows a rapidly evolving situation that looks somewhat different according to when you look at it, how you slice and dice it, and what emphasis you put on the results.

Most of the media coverage has skirted that complexity. A November 2020 finding from the Centers for Disease Control and Prevention showed that between April and October of that year, the proportion of mental-health-related emergency room visits for children ages 5 to 11 had increased by 24 percent over the same period in 2019, while visits by 12- to 17-year-olds rose 31 percent. That finding has ricocheted through news reports and commentary ever since.

But that same study contained important caveats that needed to be heard, too. Most notably, mental health emergencies were still only 1.4 percent of all pediatric ER visits in 2020, up from 1.1 percent in the same period of 2019. This important point, which could have brought some comfort to parents, was largely relegated to the equivalent of a journalistic footnote, if it was noticed at all.

Throughout the pandemic, there has also been data, surprisingly enough, that suggests signs of hope. “There is some cause for optimism,” the U.S. Surgeon General Vivek H. Murthy wrote in December in a barely cited portion of a much-hyped children’s mental health advisory. “Increases in distress symptoms are common during disasters,” he continued, “but most people cope well and do not go on to develop mental health disorders.” He noted that “several measures of distress” that had increased early in the pandemic seemed to have returned to their pre-pandemic levels by the summer of 2020; that rates of “life satisfaction

and loneliness” stayed “largely unchanged” throughout the first covid year; and that, while the data on youth suicide rates was “limited,” the available evidence did not show “significant increases.” And he concluded that “some young people thrived during the pandemic. They got more sleep, spent more quality time with family, experienced less academic stress and bullying, had more flexible schedules, and improved their coping skills.”

Although the surgeon general’s strikingly positive words were all but ignored in news coverage, they did echo other recent research. In 2021, the Child Mind Institute — a high-profile New York City mental health treatment center with an ostensible interest in driving home the need for care — published poll results showing that most U.S. teens (67 percent) agreed with the statement, “I am hopeful that I will adapt and rebound from the challenges of the pandemic.” The authors tied this to the “innate resilience of young people that has been a key finding of the broader research landscape.”

[How parents can help themselves, and their children, feel okay again]

It's always tricky to make arguments about changes in the prevalence of mental health disorders, particularly when it comes to kids; so much depends on who is surveyed and how, what questions are asked, and what use is made of the answers. That said, there is a huge body of research that consistently and unambiguously shows that children's mental health in the United States was already really bad before the pandemic. Epidemiological studies throughout the 2010s indicated that depression in particular was hitting kids more frequently and at younger ages. By 2019, a year before the pandemic, 1 in 3 high school students, and about half of all high school girls, reported "persistent feelings of sadness or hopelessness."

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Theories as to why children’s mental health was so bad pre-covid abound. A prominent subset — popularized most notably by San Diego State psychologist Jean Twenge’s 2017 Atlantic story, “Have Smartphones Destroyed a Generation?” — blames technology. That theory — regretfully, I’m tempted to add, because it’s one of those ideas that, no matter how wrong, still feel perfectly right — has been extensively refuted. Then there’s the view that part of what we’re seeing is a greater awareness and openness about children’s mental health on the part of a new generation of parents, the first to grow up at a time when it was common for kids to be diagnosed with issues like attention-deficit/hyperactivity disorder, and to come of age in a world where

celebrities talked publicly about their struggles with depression or addiction. But most experts feel that this hypothesis doesn't tell the whole story. Beyond the research evidence, their gut-level take tells them that young people truly have become more anxious and despairing.

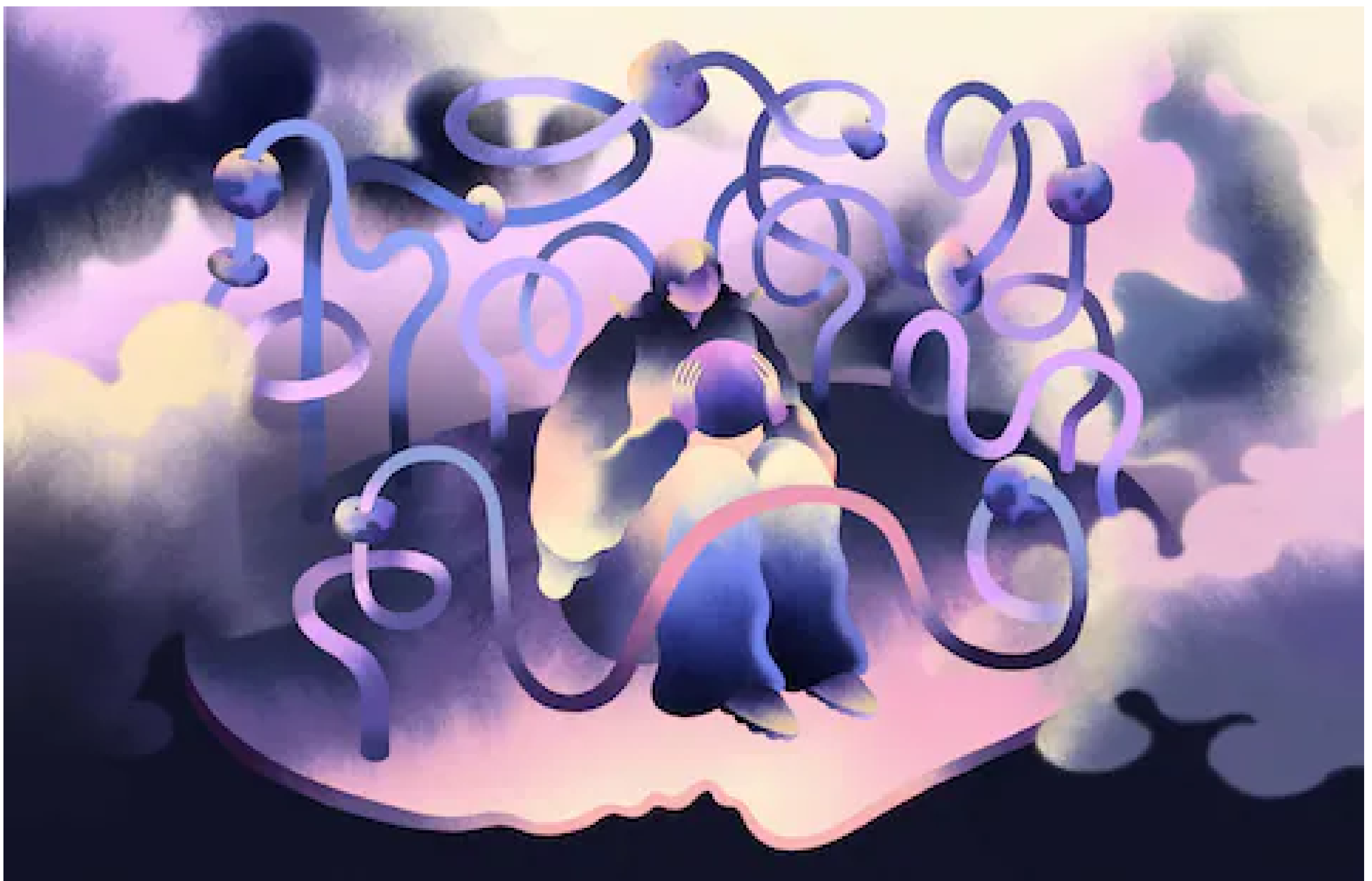
Wading into questions of why kids are mentally unwell can be somewhat treacherous. Children's mental health has a very long history of being used as a political football in the United States. At the turn of the 20th century, for example, opponents of extended education for teenage girls and young women argued that too much school damaged not just their reproductive capacities, but their emotional health as well, producing "tense neurasthenics, limp neurasthenics, melancholics," in the words of the enormously influential Clark University psychologist G. Stanley Hall. Historians and mental health experts alike have frequently noted the many ways that perceived declines in children's mental health have been used to feed "moral panics" about

social and political issues that at base have nothing to do with kids at all.

Complicating the matter further now is the interplay between high parental anxiety during the pandemic and what parents have been reporting about their kids' well-being. However ambiguous the research on children's mental health during covid may be, the data on adults is crystal-clear: We have been having a very, very tough time. In October 2020, a study in the journal Pediatrics revealed that 27 percent of parents said their mental health had worsened in the early months of the pandemic — a proportion that was, interestingly, much higher than the 14 percent who said their children's behavioral health had gotten worse. In written testimony to a Senate Health, Education, Labor and Pensions Committee hearing in early February, the APA's Prinstein cited studies showing adult emergency room visits for mental health crises surged during this time, along with eating disorders, sleep disruptions, problem drinking and illegal substance use. Parents' tolerance of stress — including their

own children's — is lower when they themselves are anxious. "Perception is different and behavior is different," said Alan E. Kazdin, the longtime director of the Yale Parenting Center.

The pediatricians, clinical psychologists, psychiatrists and researchers I spoke to for this piece — connecting by phone or Zoom with those based in Los Angeles, Atlanta, Brooklyn and New Haven, Conn., and in person with those practicing in D.C. and Bethesda — made it clear that they didn't have hard numbers to back up their perceptions. But they did have clinical experience with thousands of patients, over many decades. And that accumulation of experience — like the data — told a complicated story about how, during covid, vastly higher levels of both adult and kid distress had essentially poured gasoline on long-simmering pain, acting less as a cause than an accelerant of the children's mental health crisis.



With its round-edged plastic furniture, muted violets and sea-foam greens, the inpatient psychiatry unit at Children's National Hospital in D.C. felt less locked down than hermetically sealed on a recent rainy Friday morning. There were Rice Krispies and chocolate milk on a tray in the hall. Board games and books. You could almost, at moments, forget where you were and that the patients couldn't leave — provided you didn't think too much about the small art exhibit displayed outside the heavily guarded door. It included crayon drawings of

raindrops with short therapeutic messages: “We all feel sad,” “Your actions lead to consequences.” And, in a central spot on the wall, a page of very pretty blue-and-white-striped crayon letters that read, “Please learn to love me again.”

Morning rounds began at 8:15.

An 8-year-old female, presented after aggressive outburst against mom, was teary and homesick in the evening.

A 12-year-old female, presented after pulling a knife on mom after mom took phone away.

A 13-year-old transgender patient, admitted for self-harm.

A 13-year-old female, presented after telling parents she wanted to kill herself; still threatening, after three weeks, to kill herself when she goes home.

A 14-year-old male, presented with depression, anxiety and undiagnosed ADHD. Doesn’t want to be a burden

to the family. Feels better on the ward — says it's less stressful.

A 14-year-old female, presented after taking more than 40 tablets of Tylenol. A friend died by suicide and she blames herself for not doing more.

The psychiatric staff at Children's National is used to treating the Washington region's most severely affected kids, and these cases were not untypical of those the doctors and nurses on the inpatient unit had been seeing before the pandemic. But what had changed with covid, they said, was that common issues had been amplified. "Before, we saw a lot of depression, anxiety, cutters, suicidal ideation and suicide attempts. With the pandemic, the anxiety is at heightened levels," said Elva Anderson, an art therapist who has spent the past 19 years at Children's National. "Mild depression is leading to major depression."

The most worrisome and dramatic effects were occurring among the many, many children — 1 in 5 is the

proportion that has commonly been cited for the past two decades — who already had diagnosable mental disorders. This is not surprising. Mental health experts know that conditions like severe depression don't pop up out of nowhere. They may seem to — particularly to parents when they're first becoming aware of the signs in their kids — but there are pretty much always antecedents. At Children's National, it can take days, and careful teamwork by experts and their trainees, to find and understand them. But at the recent morning's rounds, the antecedents were starkly on display: histories of depression, anxiety, trauma, self-harm.

Even in the world of typical, office-based psychiatry and psychotherapy, doctors and therapists treating less extreme cases know that by the time a child lands in their office they — and their families — have usually been struggling for a long time. On average, it takes eight to 10 years from the time when a child first starts having symptoms for them to receive treatment, which is why Thomas Insel, the former head of the National

Institute of Mental Health and the author of the just-published book "Healing," once told me that many children don't get care until they're in a "late stage" of their disorders.

The kids treated on the inpatient psychiatric unit come from all the very different families and neighborhoods in the Washington region — and yet, curiously enough, they have often come to Children's National in waves of common diagnoses, said Priya Punnoose, the attending psychiatrist leading morning rounds. What was new during covid, however, was that, for the first time, those waves seemed to make sense. Kids slightly younger than usual had presented with bipolar disorder in the pandemic's first terrifyingly stressful and chaotic months, she said. Then over the summer of 2020 came a wave of children with autism, overwhelmed, sometimes explosive at home, she and her colleagues figured, because they'd gone months without their usual school supports, and behavioral therapy and online treatments weren't yet available for them. A spike in kids with anxiety and depression showed

up in September or October, many of them, Punnoose observed, children with previously undiagnosed ADHD; they'd always been successful in school but couldn't handle the distractions and greatly heightened organizational demands of online learning. By 2021, she was seeing a big increase in obsessive-compulsive disorder as anxiety that was previously manageable or passed under the radar ramped up in the face of the covid's seemingly endless uncertainties.

The pandemic also had a very real impact on adult caregivers and their ability to support children in crisis. "Higher rates of distress" in adults had "behavioral ramifications," such as more alcohol consumption, especially by women and parents of young children, and more yelling at kids, particularly among parents who'd lost income, according to the 2021 Child Mind Institute report. On the Children's National psych unit, in-person parent education groups had to stop meeting and didn't pick up again online; there were too many equity issues, given that some parents didn't have laptops or iPads, or lived in areas

with shaky broadband. Covid created other, more deeply painful access issues, too: Families could no longer enter the unit to spend time with their children; all visits and family meetings had to take place by phone or video call. In an era when parent participation is considered essential to children's progress, this was anything but therapeutic. Particularly since some kids were staying on the unit for weeks or even months.

That was never supposed to happen. At Children's National, the typical length of stay is five to seven days, a limit dictated in large part by insurance companies; during this time doctors are expected only to stabilize the child (which often means taking them off whatever cocktail of meds they've come in with), come up with a diagnosis and create a treatment plan. But all the residential facilities and step-down programs that patients normally moved on to once they'd used up their days were full. Logjams were creating logjams. As was the case across the country, where only about 10 percent of hospitals offer psychiatric services for kids and only

about 7 percent provide inpatient care, the hallways of the Children's National emergency department were often lined with psychiatric patients waiting for beds, sometimes for weeks on end.

Where to find help for a struggling child

Before the pandemic, finding help for children struggling with mental health issues was a painful, confusing, exhausting, expensive and often exceedingly frustrating parental experience. Over the past two years, it has become much harder. The following list is meant to help. It is highly curated and based on expert recommendations. All resources are free.

The Society of Clinical Child and Adolescent Psychology's Effective Child Therapy website can help parents discern what mental health treatments have robust data behind them, and which are most strongly recommended for specific disorders.

The American Psychological Association allows you to search by Zip code, patient age group, doctor or therapist specialty, type of therapy provided, insurance and telehealth participation, and whether there are openings for new patients.

The Association for Behavioral and Cognitive Therapies' search tool specifically helps locate psychologists, psychiatrists and clinical social workers who are trained (and ABCT-licensed) in the evidence-based cognitive and behavioral techniques most frequently

cited by experts as beneficial for children.

The National Alliance for Mental Illness has **an article** on becoming a discerning consumer of the ballooning array of new mental health apps, including those aimed at young people. If you have college students, be sure not to overlook **Active Minds**.

Alan E. Kazdin, the longtime director of the Yale Parenting Center, has boiled down his 40 years of child behavioral research and clinical experience into a guide for parents on his website. It includes what to do if you suspect your child might need expert help, tips on how to find high-quality care, and an essential list of questions to ask any provider you're considering entrusting with your child's mental health.

Out in the community, it was equally impossible to find psychologists, psychiatrists and licensed clinical social workers who were taking new patients. The wait list was so long to see the psychologists and psychiatrists at the bright, airy and stylishly renovated Children's National Takoma Theatre outpatient site — reaching nine to 12 months at the worst points — that some providers at times paused adding names because it didn't seem fair to give families false hope.

[*After struggling to get treatment for her mentally ill son, a mother's act of desperation: giving up custody*]

In this sense, the children's mental health crisis seems like a variation on a familiar covid theme: supply-chain issues. But this wasn't simply a mismatch between a limited supply and a newfound demand, like orders for dumbbell sets and outdoor heaters. Even before the pandemic, there was an obscene shortage of mental health practitioners: about 8,300 child and adolescent psychiatrists, and 4,000 child and adolescent clinical psychologists, for the pre-pandemic approximation of 15 million kids with treatable mental health issues.

That shortage, in part, accounts for another consistency in the backstories of the kids at Children's National: histories of shoddy care. Many of the patients had come into the unit taking combinations of medications that made no sense to the doctors. It was very hard for the staff to figure out why — particularly when the original prescribing physicians didn't return phone calls. A fair number of the

patients Punnoose was treating had never been seen by a child psychiatrist; there were just too few to go around.

The pandemic multiplied the problem exponentially. Clinicians in private practice told me that their pre-pandemic wait lists had become much longer, in large part because their existing patients weren't leaving. "Families that were on track to 'graduating' from therapy didn't," said Erin Sadler, a clinical psychologist and the co-director of the Mood Disorders Program at Children's, who sees patients in the new Takoma location in Northwest Washington. The majority of her patients struggle with depression, she said, and much of her work involves teaching them skills and strategies they can use to "spark joy" on bad days, such as going to the park or spending time with friends. During the pandemic, "a lot of those options went away very, very quickly," Sadler told me.

Covid wasn't the only stressor of the past few years. The majority of Sadler's teenage patients are Black,

and in the summer of 2020, with racial justice protesters being kettled and gassed in the nation's capital, they and their parents worried about their safety. "It added an extra layer of complexity for a lot of families," Sadler recalled. "Being out with friends, going to grab ice cream, just being out in the community — that is absolutely necessary just for their own mental health," she said. "But now even if they were out, there was added stress about 'How do I present myself out in public when we are out ... to be safe and be able to get home?' "

Independent of the pandemic, children of color have long been less likely to receive mental health care. The lack of diversity among providers — just 4.4 percent of psychiatrists are Black — coupled with a very solid history of racism in psychiatry, psychology and school counseling, have played a big role in feeding distrust of doctors and therapists as well as skepticism about the value of the "helping professions" as a whole. Psychiatrists of color told me that the families they work with had been greatly relieved to find them after

previous experiences with White practitioners who either couldn't relate to their stories or — far worse — gravely misunderstood them, sometimes with potentially disastrous results.

Child psychiatrist Malena Banks told me a chilling story of one White therapist who'd made assumptions that could have landed a young Black patient in child protective services: The child's mother had told the therapist that the child had enjoyed a meal right down to the "pot liquor" — the juice that's left in a pot after cooking collard greens. The therapist thought the mom was referring to some kind of alcohol. "And then instead of asking multiple questions, we sort of bumped to the worst-case scenario," said Banks, who is Black and was able to intervene before the problem escalated.

"It's a heavy lift" to undo lifelong patterns of thinking and perceiving in a nearly homogenous profession, she said. " 'Diversity and inclusion' is the thing now. ... You can take a class — but it has to be more than that."

Banks has been shouldering that heavy lift for many years. She attended medical school at Howard University, then completed her training as chief resident in the child and adolescent psychiatry clinic at majority-White Georgetown University Hospital. In March 2020, she and her practice partner, Otema Adade, opened a children's psychiatry practice on a quiet and sunny block of rowhouses in Hill East, a neighborhood adjacent to Capitol Hill. Both had worked as child psychiatrists for the city; they were well acquainted with the indignities — shouting security guards, dirty hallways that double as patient waiting rooms — that D.C.'s poorest residents routinely put up with when they seek care.

All of that, Banks said, makes patients feel "less than" — particularly after years of being ignored, punished or pathologized by adults at school or in the medical system. So she and Adade named their practice Lotus, after what Banks describes as the "gorgeous flowers that are grown in muddy, murky water," and set it up to look more like a spa than a doctor's office.

There’s filtered water, bright accent pillows and vintage children’s books, color-coordinated with the office’s white, gray-green and blue decor.

“It’s all intentional,” Banks told me. Perhaps most intentional of all: She and Adade participate in health insurance. They take private insurance — commercial PPOs and managed-care plans alike — and even accept D.C. and Maryland Medicaid.

[73 doctors and none available: How ghost networks hamper mental health care]

Anyone who has ever tried to find a child psychiatrist in the Washington area, where out-of-pocket appointments tend to run in the ballpark of $250 to $300 (and therapy sessions with psychologists or licensed clinical social workers around $175 to $225) will know how extraordinarily rare this is. High costs and lack of access to in-network providers are a major problem nationally as well.

All of that means that mental health care for children — a lifesaving essential service in many cases — is as

out of reach for most families as a luxury vacation. To make it accessible to their patients, Banks and Adade basically have to pay — in lost income. The payments they receive from both public and private insurers are just one-half to one-third of what their local colleagues earn in out-of-network practices. (The same proportion holds true for what insurance companies typically pay social workers, who provide an ever-increasing share of therapy in the United States, the Wall Street Journal reported last year.)

And then there's the unpaid time they spend on the phone, convincing managed-care representatives that their medical degrees and advanced training do indeed out-qualify those reps' cost-cutting expertise when it comes to making treatment decisions.

To afford what they do, the doctors have used some of their personal funds. They've received grants. They have to limit the patients they can see at Lotus and supplement their income with second jobs; Banks by working with kids in a group-home setting,

Adade by seeing patients at the cash-only Ross Center in upper Northwest D.C.

“I’ll pick up another side gig if I have to,” Banks told me, in a phone conversation. She picked up the theme again a few days later, when we met in person so I could tour Lotus. “There are some things we just aren’t going to compromise on,” she said. “Am I going to have the large house that I thought about when I was younger? Maybe not. Not if I want to do this.”

For Banks to potentially have to work three jobs to afford to practice accessible, patient-centric medicine is mind-boggling — the physician equivalent of underpaid teachers in underfunded schools using their paychecks to buy classroom supplies. We tend to love stories of one-person bootstrapping in this country (particularly if we're not the ones having to do the pulling-up). But they don't add up to a scalable model for change.

Most practitioners aren't willing or can't afford to do what Banks does. After eight to 10 years of post-undergraduate medical education and specialized training, child psychiatrists whose parents didn't pay their way through college or medical school are entering the workforce hundreds of thousands of dollars in debt. The situation is similar for child psychologists, who complete five years of PhD programs, followed by another two or three in little-funded or sometimes unfunded residencies.

Contracting with big and profitable companies like Cigna, Aetna and Blue

Cross Blue Shield shouldn't amount to charity work. Yet economic realities make it so. Nationwide, insurance payment rates for primary care physicians (who consistently rank among the lowest paid doctors) are almost 24 percent higher than for mental health practitioners — including psychiatrists. In 11 states, that gap widened to more than 50 percent, a report from the Bowman Family Foundation noted in 2019.

That discrepancy points not only to the historical devaluing of psychiatry as a discipline, it also sheds light on a major problem with the relative status of different kinds of interventions. In the health-care world, where values are defined by insurance company reimbursement rates, *talk* — the essential component of thoughtful medication management, therapy or counseling, and, for that matter, any successful form of healing — has long been compensated at rates that trail far behind those that insurers pay for medical procedures. "Our system is set up so that I get paid more to see a child and do an asthma breathing test than I do to spend an hour with the

family of a child who might be thinking about hurting themselves," noted Chung of the American Academy of Pediatrics.

That dollars-and-cents reality plays an enormous role not only in who gets care, but in who can afford to provide it, and how. Mental health parity laws adopted over the past 26 years were supposed to directly address this issue. But the insurance industry has been almost diabolically adept at skirting those laws; as one of the largest contributors to PACs, political parties and candidates, they're not likely to face real pressure to change anytime soon. Another seemingly obvious big fix for the supply-chain issues plaguing children's mental health care — tuition reimbursement incentive programs for medical students who choose to specialize in child psychiatry and are willing to commit to working with underserved populations (a definition that really ought to include all families that can't afford to shell out hundreds of dollars for every out-of-pocket visit) — has never worked in the past. And even if those programs were to be expanded

and improved, they'd take so long to show results that they'd do nothing for the children who are struggling right now.

[*This is why it's so hard to find mental health counseling right now*]

Fortunately, families don't have to wait. Over the past decade, a growing number of frustrated practitioners and researchers have taken matters into their own hands, creating and often collaborating on low-cost solutions that work around the current system. At base, they all center on creating a new mental health workforce, which means training the people who are already on the ground day-to-day with kids — primary care providers, school nurses and counselors, teachers, and, yes, parents — in elemental forms of mental health care.

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Unlike current care models, these new approaches focus on prevention. They are widely accessible and mostly cheap, with some offering program materials that are free to the public online. And, also unlike most of the care kids currently receive, they are informed by the latest brain science, said Peter Jensen, the former associate director of child and adolescent research at the National Institute of Mental Health.

In 2006, Jensen stepped back from his decades-long academic career to focus on founding a nonprofit, the REACH Institute, which trains primary care providers to spot the early signs of children's mental illness, prescribe and manage medication for

the most common disorders, and share useful insights and skills with parents and kids so they can better manage mental health challenges. (Disclosure: I served as a largely unproductive member of REACH's unpaid board, on and off, in the late 2010s.)

Jensen's hope, from the start, was that REACH's trainees would go on to train others who might, he hoped, become trainers themselves. That model was on display one weekend in early January, when I tagged along (via Zoom) to observe a group training of about 50 pediatricians from the greater Atlanta area. The doctors, nearly all women, were mostly young and very serious. They paid rapt attention throughout three long days. The stakes were very high. "I kind of feel like every sick visit is turning into a mental health mini-crisis, and I don't have the knowledge to deal with it," one said.

The point of the weekend was to convince her and her fellow attendees that they could. They observed a few role-plays, during which one of

REACH's psychiatrist- or pediatrician-instructors demonstrated how to casually screen for mental health issues during a checkup or sick visit. They learned how to deal with the mom who shows up in the office with a plastic baggie full of meds, confused and asking for help. They were taught what to do with a suicidal patient. (If the threat is acute, send them immediately to the emergency room. Call an ambulance if there's the slightest doubt that the parents will follow through on driving them there.) And they were shown how casual talk about the pandemic could be an opportunity for mental health check-ins: "I know that covid has been hard for a lot of families," they were advised to say. "How has yours been handling things? Any special concerns today?"

REACH isn't the only program for training pediatricians. There's also Project ECHO. First developed in New Mexico during a widespread outbreak of hepatitis C to connect doctors and nurses in remote areas with top specialists, it has since been adapted to teach primary care doctors in Virginia to provide the basics of top-

quality mental health care. “Early intervention is really the focus here,” said Chung, who in 2018 made Project ECHO a key part of a massive statewide initiative aimed at training and supporting pediatricians to identify and treat children’s mental disorders. “So we can identify a child who’s suffering from anxiety when they’re 8 or 9 years old when they’re seeing their pediatrician, and before they become that 15-year-old who’s struggling and perhaps is experiencing a crisis,” she said.

The common element in all the new programs is a focus on skills — tools and techniques, validated by decades of science, that build resilience and enhance mental health. Skills that help kids be mindful of their feelings. Skills that enable them to calm themselves and pause to think before acting or speaking. Skills that empower them to take action — in positive ways — when they’re feeling down, or anxious, or angry, or overwhelmed. And skills that help them understand other people’s perspectives, and communicate their own needs, feelings and perceptions in

ways that are both more thoughtful of others and more likely to be effective.

While pediatricians can teach some of these skills, they generally can't devote a whole lot of time to doing so; if they did, they'd never be able to see all their patients with strep throat or broken bones or, for that matter, covid. But doctors and other experts aren't the only people who can use the best science to help kids. The basic skills and insights that are part of the treatments with the most evidence behind them, like cognitive behavioral therapy, can be a normal part of our children's daily lives, if the people who spend the most time with them — parents, teachers and other school staff — learn and reinforce them.

Thanks in part to the pandemic, some of this is already happening. Denver's public schools are now spending at least 20 minutes a day on ramped-up social-emotional learning, using mental-health-enhancing techniques such as specially adapted games of Red Light, Green Light to teach kindergartners impulse control and self-regulation skills, or mindfulness

meditation to help eighth-graders deal with stress.

For that kind of work to spread, however, the idea that good mental health can and should be taught, not just at home but in school, has to become a valued and normalized part of our culture. And that's far from a given in a country where social-emotional learning has already in some districts become the same sort of school-board-disrupting bugaboo as mask-wearing and critical race theory. Mitch Prinstein told me his own efforts to bring more mental health screening, skill building and staff training to schools have at times been dismissed as "part of the wokeness industry."

It's hard to apply the words "silver lining" to anything having to do with a disease outbreak that has claimed nearly 1 million American lives and brought a secondary epidemic of loss, grief and fear to even more survivors. But it's nonetheless true that, when it comes to children's mental health, the past two years of collective trauma have had some unexpectedly positive

side effects: The subject has come out of the shadows to be part of the conversational mainstream. It has bridged what was once a seemingly impassible gulf between parents of children with and without emotional, behavioral or learning issues. By creating an unprecedented amount of shared pain, it could inspire a very real demand for change that's based on compassion and clear-mindedness, not on fearmongering and division.

That's why it's dangerous to allow the children's mental health conversation to get stuck in the toxic loop of pandemic politics. The acute traumas of the covid era will end, and with them some of American families' situational distress. But the children's mental health crisis won't. If we don't open our minds to its totality, then all the new and ramped-up attention from the past two painful years will end up little more than "mealy mouthed statements … like the 'thoughts and prayers' after a school shooting," as Peter Jensen put it. That is to say: just talk.

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