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A Better Youth Mental Health Policy

Stop devoting resources to broad-based programs and focus instead on the most seriously ill kids.

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Concerns about youth mental health have exploded in the wake of the Covid-19 pandemic. School shootings, suicides, self-harm, anxiety and depression, and disruptive behavior are all on the rise, prompting the Surgeon General to issue an advisory and clinical organizations to declare a national emergency.

In response, the federal government has expanded funding for universal mental-health programs, particularly school-based interventions. Such policies, which don't target seriously mentally ill youth but instead try to improve all students' "wellness," may be well-intentioned, but they are not effective. Policymakers should pursue triage instead.

Over the past-half century, mental-health policy has deprioritized treatment of mental illness and adopted a "public health" approach that aims at preventing mental disorders by promoting general well-being. After the Sandy Hook Elementary School shooting in 2012 and Covid-19 pandemic, policymakers recommitted to this framework by expanding school-based mental-health services. Lawmakers hoped that widespread efforts to raise awareness of emotional states, screen for mental-health issues and deploy Social Emotional Learning (SEL) programs would improve students' overall wellness.

The U.S. Substance Abuse and Mental Health Services Administration boosted grant funding for these programs. Including only its Projects AWARE and LAUNCH, mental-health awareness training, and suicide prevention aimed generally at youth, funding requests have grown from $122 million in fiscal year 2015 to nearly $296 million in fiscal year 2025—a 140 percent surge. For Social Emotional Learning efforts, the federal government offers at least 12 federal grants, many through the Department of Education, and the amount available nearly doubled between 2021-22.

Decades of research have found little rigorous evidence that universal school-based mental-health programs prevent youth mental illness or suicide. These programs do not direct clinical resources based on the severity of a child's condition. Instead, students least in need of mental-health services get outsized attention, while those who most need psychiatric care fall through the cracks.

"All sorts of so-called universal interventions, in which a big group of teens are subjected to 'healthy' messaging from adults, have failed," writes Olga Khazan in *The Atlantic*. In fact, she highlights, some studies

find that such interventions result in *worse* outcomes, even when the programs were developed from evidence-based approaches like dialectical behavior therapy and cognitive behavioral therapy.

Why aren't these programs working? One reason may be the difficulty of adapting new versions of evidence-based programs outside of a research context. Another reason, as Abigail Shrier has documented, may be the iatrogenic effects of such anticipatory therapeutic interventions—that is, the treatment itself can make things worse. "Awareness" programs, for instance, can make kids glamorize or ruminate on mental states they previously hadn't been inclined to indulge, to sometimes harmful ends. Just as D.A.R.E. didn't succeed in reducing drug use and WebMD has not made people healthier, educating kids on a wide-range of disorders won't prevent them from developing psychiatric issues.

This hasn't prevented SAMHSA from encouraging these types of superficial approaches. To measure success, the agency cites the number of individuals "trained in mental health promotion", or the number of kids screened and referred for services. None of these metrics tells us how many students received services that they didn't need or wouldn't have received otherwise, or whether the services were relevant or effective—all key metrics for effective triage.

"Mental health screening is great in theory but awful in practice," says Allen Frances, a prominent psychiatrist and chair of the task force for the fourth version of the *Diagnostic and Statistical Manual of Mental Disorders*. "It creates a vast army of false positive kids who are stigmatized and overtreated, while diverting resources away from the kids who really do desperately need help." This is true of universal programs more broadly.

It's easy to sympathize with overburdened educators who might believe that more mental-health programming could address the growing number of students exhibiting signs of distress. But applying a public health-style approach to mental-health policy raises unrealistic hopes that serious mental illness can be prevented by "catching it early" or by preemptively treating kids who face adversity.

We don't know what causes the most severe mental illnesses, such as schizophrenia and bipolar disorder, and we can't effectively prevent them. Even among kids who face the greatest hardships, such as poverty, homelessness, violence, and abuse, statistically few of them will develop a psychotic disorder that leaves them gravely disabled or at risk of harming themselves or others. Those disorders are rare, affecting likely less than 5 percent of adults. Kids facing serious adversity and mental illness warrant effective social services and supports—not emotion-labeling worksheets, or questions about wellbeing. Youth with serious emotional disturbances should have access to high-quality psychiatric treatment at the appropriate intensity. And implying that children's adverse circumstances make them more vulnerable to mental illness has been shown to erode kids' resilience.

These universal programs have forced teachers to serve as pseudo-therapists, and school counselors as pseudo-psychiatrists, attempting to predict and diagnose who might need what level of intervention. These

initiatives draw resources away from kids known to be in genuine need.

Schools are starting to see the futility of these efforts and the need for more out-of-school interventions. In the 2021-2022 school year, 88 percent of schools surveyed said that they didn't strongly believe they could provide effective in-school mental-health services to needy students. When the *New York Times* spoke to hundreds of school counselors on the pandemic's effect, many described referring more children to outside providers when those students needed more than a counselor's initial intervention. (Unfortunately, even then, the students often find it hard to get the services they need.)

Ironically, as policymakers fund expensive "wellness" programs, the U.S. faces a national shortage of pediatric psychiatric beds. A Manhattan Institute report by coauthor Dziengelski found that between 2010 and 2022, psychiatric residential treatment programs for youth—less restrictive than inpatient hospitalization but more intensive than outpatient care—have decreased by almost 70 percent. Available beds in these programs are down 66 percent, and youth served down by nearly 78 percent. As of 2023, only 34 states had a single psychiatric residential treatment facility for children, meaning many parents with high-needs kids must send them out of state. The reduction in youth residential treatment is the result not of less need but of ideological opposition to this setting of care. While residential treatment is never a first option, it serves as an important intermediate setting between inpatient hospitalization and outpatient care, and the American Academy of Child and Adolescent Psychiatry asserts that it can help kids "whose health is at risk while living in their community" or whose educational needs can't be met in a traditional school setting.

For youth with depressive disorders, the decline in residential treatment has occurred alongside significant growth in more restrictive inpatient hospitalization at acute-care hospitals. Such children often languish in hospitals if less restrictive, residential-care beds are unavailable. It's perhaps unsurprising that the suicide rate for youth aged 14 to 18—the target age range for residential treatment—grew by 49 percent between 2010 and 2021, just as residential-treatment capacity declined.

Mental-health visits to pediatric emergency departments increased by 8 percent annually between 2015 and 2020, compared with just 1.5 percent for all other visits. Because of psychiatric-bed declines, children are often stuck ("boarded") in EDs when they are at risk of harm if sent home, waiting days on average to get transferred or admitted to an appropriately intensive inpatient setting. Between 2007 and 2016, youth boarding grew by 60 percent; in 2021, 98.9 percent of acute-care hospitals reported boarding youth patients. Disturbing reports suggest that some children are abandoned in EDs by parents who can no longer manage "increasingly aggressive, increasingly ill" behavior and feel they have no other options.

Universal school mental-health programs and pediatric psychiatric-bed cuts have a similar effect: they place kids into the wrong level of care. Mental-health interventions work best when well targeted. Focusing on kids in distress, as opposed to the general population of students, will help all kids and schools themselves.

The tide appears to be shifting. Jonathan Haidt's work exposing the harms of social media, for example, suggests ways to address youth malaise without draining resources that should be reserved for kids with the most severe cases of mental illness. Haidt's work, complemented by Shrier's, which suggests that parents should pursue therapy for their children only when the benefits clearly outweigh the risks, bolsters our conclusion that the pediatric mental-health system should triage clinical resources toward the most severe cases.

Just as jails and prisons should not be the de facto mental-health system for adults, schools should not serve a similar function for children. We've already seen what ignoring the most serious cases has done to severely mentally ill adults: disproportionate rates of homelessness, repeat hospitalizations, violence, and incarceration. If we don't change course, we can expect comparable results for our most vulnerable young people.

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