Carolyn D. Gorman
Opening Statement
State of Texas, Health & Human Services Committee
September 18, 2024

Thank you for the opportunity to serve as a witness on the important topic of children's mental health. I'm Carolyn Gorman, I'm a policy researcher, and I currently work as a Paulson Policy Analyst at the Manhattan Institute, a non-partisan, non-profit think tank, where my research is focused on the impacts of US policy on mental health and illness. I am also a resident of Grapevine, Texas as of December of last year.

Today, I'll provide some background on a current, primary approach in mental health policy (nationwide and in Texas), which has been one of a public health model. I'll describe some effects of this approach on access to care and services available, and identify some downsides.

Today, more is grouped under the umbrella term of "mental health problems" than ever before. Here's one way to lay this out: 100 percent of youth (and adults) have emotions and experiences that are not pleasant or desirable but are a normal reality of human life—like feeling anxious or depressed, and facing failures and hardships. About 20 percent of youth may have mild or moderate emotional, behavioral, or developmental challenges that are classified as a diagnosis in the DSM, the main guide used in psychiatry. About 6 percent of youth have serious emotional disturbances that cause substantial impairment and disruption in everyday life. This is the group that any public mental health system has a primary responsibility to serve.

Most mental illnesses don't appear for most people until late teens and early twenties, so the term serious emotional disturbance is used, versus serious mental illness for adults, to avoid being too final in labeling a disorder or behavioral issue. Youth are still developing, so we don't know fully what's happening—but we do want to acknowledge it's serious.

The fact that more of what used to be considered normal problems of living are now called mental health problems comes in part from the dominant ideology in mental health and public policy since around the 1960s. Treatment and services for people with serious mental illnesses is deprioritized and more efforts have shifted toward a public health model of prevention and early intervention that aims to prevent mental illness in the few by using mental health treatment, like therapies and medications, to improve mental health and wellness in the masses.

Mental health programs in a public health model generally have the same goal: to direct more people into mental health treatment "upstream". Treatment access is expanded for all acuity levels, awareness efforts educate the public about signs and symptoms of mental disorders and promote paying attention to emotional states, and messaging encourages seeking treatment early on. Social issues like poverty, abuse, and poor education are also addressed through the mental health system, by giving people facing adversity mental health services with the intention of helping them better cope with their circumstances.

Since prevention and early intervention has been made a main strategy, access to mental health care has increased, but mental illness has not decreased, and in fact, we're seeing other troubling trends, like more diagnoses in the 20% group I mentioned, more kids and teens taking medications,

higher rates of reported distress, and even disturbing events like school shootings. So, what is driving these trends?

Some of what we're seeing—like more youth being diagnosed, taking medications, or reporting distress—is exactly what we'd expect from a public health model directing youth toward treatment. We've told kids to be aware of when they feel distressed and to seek treatment if they do—even if feeling distressed is a normal emotional response to their situation, like being isolated at home during the pandemic or facing abuse. While well-intended, a widespread push for treatment can have unintended consequences—it can make kids think something might be medically wrong with them if they experience unpleasant feelings that are normal, like boredom or a lack of attention while sitting in class all day. Medicalizing social problems also sends a message to kids that they are passive victims of bad environments that they have no control over, rather than sending a message that they can overcome their circumstances.

Most importantly, mental health resources are stretched too thin, and as a result, the 6% of youth with serious emotional disturbances do not get the support they need, but are at highest risk for self-harm, hospitalization, and involvement with systems like juvenile justice, foster care, or special education. And, yes, in extreme cases, some youth with serious needs may then be overlooked or get only superficial intervention but go on to bring a weapon to school with the intention of using it.

There are real shortfalls to a public health model focused too much on making mental health treatment available to everyone as prevention and early intervention. It might make sense to push treatment so widely if treatment worked well—but especially for youth, it doesn't. Mental health treatments are limited and can be harmful. These treatments don't cure or prevent mental illness. Only a few types of therapy and medication are proven to reduce symptoms for adults, and those treatments are less effective or ineffective for youth. Treatment can create new problems, and for those on the margin, a diagnosis alone can lower welfare. What's more, treatments are often provided without fidelity or without meeting clinical guidelines, putting youth at risk of low-quality and harmful care. Many disorders, like depression and anxiety, are transitory and go away on their own over time.

All these factors suggest that mental health interventions should only be used when problems are severe enough that the potential benefits outweigh the risks.

But despite these limitations, and the fact that the public health model hasn't reduced prevalence rates of mental illness over many decades, initiatives continue to receive funding that increase access to mental health treatment indiscriminately or direct more kids toward it as a magic "fix-all" for social problems and normal responses to the ups and downs of life. This diverts mental health resources away from kids who need mental health services most, to kids who will either get marginal benefit, no benefit, or harm from it.

Instead, more should be done to evaluate if the right kids are getting treatment and if that treatment was effective for improving meaningful outcomes, like reduced impairment and harm from mental illness, keeping families together, and keeping youth out of systems like juvenile justice. We should ask more often, "is this behavior definitely abnormal?", "is mental health the underlying problem?", "can we provide other services first?" and, as one prominent psychiatrist has put it, consider "no treatment the prescription of choice."

Often, mental health programs are delivered through schools—which sounds good in theory, but in practice causes direct and indirect harm. It misallocates resources because those with the most serious mental health needs are least likely to be educated in typical neighborhood public schools. Well-intended school- and teacher-driven action has been documented to induce overdiagnosis and misdiagnosis. Schools are under-resourced and dealing with their own crisis of historically low academic achievement. Importantly, delivering mental health services through schools confuses responsibilities in the mental health and education systems, which reduces accountability in both.

This is not to say that kids facing serious adversity do not warrant attention and services. They do. But mental health treatment is not what will be most effective for most youth. Especially for programs through schools, mental health interventions are often surface level, like giving kids worksheets asking them to identify emotions, or having a child speak once with a therapist they never hear from again. Kids facing adversity deserve solutions that help get to the underlying source of normal and expected distress.

For this, providing structural interventions as opposed to mental health interventions is an alternative approach to consider. Structural interventions might include giving kids after school programming to offer safety and respite from a bad home environment, nutritional meals for kids going hungry, setting and following school-wide behavioral expectations, reasonable monitoring by trusted adults in partnership with parents where there are potential issues, point-of-access solutions like banning weapons and phones, and remedial and literacy programs for kids distressed from struggling in school.

These solutions will be easier for schools to implement, spare kids from unnecessarily being categorized as “sick” or put at risk of low-quality or potentially harmful treatment and, importantly, reserve scarce mental health resources for kids who need that type of intervention most but are woefully underserved. Texas has fewer psychiatrists and psychologists than the national average and a state report from 2022 finds that state is meeting under 10% of local demand for high needs youth requiring the most intensive interventions like foster care beds and residential care. Casting a wider net ignores the kids who are already known to need substantive mental health support right now and aren’t getting it.

Thank you and I look forward to your questions.