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EDITORIAL

Thinking the future of child and adolescent psychiatry: what are we talking about?

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Introduction

It is surprising to see to what extent the term *mental health* is used on a daily basis by politicians or the media in most countries of the world, while the word psychiatry is gradually being banned. This seems particularly true in the field of child and adolescent psychiatry: while one in three humans is a child or adolescent and psychiatric disorders are at the forefront in this age group, investments in child psychiatry are notoriously massively insufficient [1].

Certainly, there has always been a reluctance to use the word psychiatry. Since psychiatry has existed, there has even been an antipsychiatry, particularly active with regard to children and adolescents. Thus, it is not uncommon to hear that children cannot have psychiatric problems, the latter being the prerogative of adults, prey to existential doubts or overwhelming responsibilities. Others will argue that it is psychiatrists who invent diseases such as ADHD or child depression. Some, finally, will consider that if children can indeed experience psychological distress, it is up to their families, especially their mothers, to take care of this, medicine and psychiatry having nothing to do with it.

However, antipsychiatry does not explain alone the striking discrepancy between the pervasive discourse on young people's mental health and the obvious lack of efforts to develop a satisfying child and adolescent psychiatry healthcare system. To overcome such a paradoxical and dramatic situation, it is important to try to understand why.

Where does this obsession with the mental health of our youth come from?

It is the result of at least two factors.

The first of these factors is very commonplace, but its importance is underestimated: our societies are undergoing extraordinary changes and these changes have a particular impact on the lives of our young people. Development of the Internet, with unlimited access to knowledge and the growing importance of virtual social networks; individualism becoming the standard lifestyle and ideology; economic competition and its corollary of educational and professional pressure. These changes obviously have an impact on the way families live, on the place of children and adolescents in our societies and, ultimately, on the very development of children and adolescents. We are all acutely aware of this and this makes us worried about the future of the younger generations. Epidemiological data are there to confirm this: psychiatric problems are now among the leading causes of loss of Disability Adjusted Life Years (DALYs) in children and adolescents.

The second factor comes from the emergence, in recent decades, of a "right to happiness" with a curious corollary, that of the amalgam of health, mental health, and happiness. Indeed, in 1946, WHO proposed a new definition of health that became famous: "a state of complete physical, mental and social well-being". Later, in 2001, mental health was defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Finally, it is noticeable that in the United Nation Declaration of Human Rights of 1948, article 25 states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family". There is thus an amalgam between health, mental health and well-being as well as the solemn proclamation of a right to well-being and, therefore, the right to good health and mental health.

These two factors have resulted in a headlong rush, the frantic quest for good mental health for our young people. There is sometimes even a real injunction of good mental health (the concept of happycracy being proposed by some

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authors) with plans launched with much fanfare in which everyone is involved: parents, teachers, social workers, animators, educators, school doctors, psychologists, and child psychiatrists of course. Child psychiatry has thus dissolved in mental health. Child psychiatry is everywhere (just look at the place of child psychiatrists in the media), so it is nowhere (i.e., as a medical specialty).

What can be done about the dissolution of child psychiatry in mental health?

First, we have to be lucid. Our societies are changing, we are afraid for the future of our young people, and they have a right to happiness and duly noted. However, all this has nothing to do with psychiatry. It is now essential to clarify what is and is not part of psychiatry.

On one hand, there are mental health issues. It is about improving well-being, cognitive and emotional development, personal achievement, and integration into society. The whole population is concerned. The dedicated institutions are families, schools, societies as a whole. Strategies for action include primary prevention, teacher and parental training, mass information.

On the other hand, there is child and adolescent psychiatry. The objective here is to treat patients, that is young humans who experience a break in their psychological functioning, who suffer in their mind or behavior. Psychiatric treatments are basically provided by doctors, most often working with a team.

Between mental health and psychiatry, there is a grey area that is becoming increasingly important. It is dedicated to the management of stabilized chronic patients, of disability and of sub-syndromic clinical problems. The dedicated institutions will depend on the organization of each health-care system: special education, rehabilitation, social and medico-social structures, independent psychologists, and, why not, psychiatrists too. The objective is to improve functioning, inclusion, empowerment and recovery.

What ,are the main challenges for the future of child and adolescent psychiatry?

Here too, it is essential to distinguish actions related to the psychiatric health-care system, from those intended to promote mental health.

With regard to child and adolescent psychiatry, it is necessary to gradually move into a post-EBM (evidence-based medicine) and post-neuroscientific era. Said in a less provocative way, EBM and neurosciences have to be included in a more global epistemological perspective. These two areas of research have, of course, led to considerable progress in the understanding and treatment of psychiatric diseases. There is no doubt that further progress will be made in the coming years and decades. However, the exclusive use of biological and statistical studies in child and adolescent psychiatry has led to harmful effects. The denial of cultural diversity, the denial of complexity in the mechanisms of mental disorders in children and adolescents, the failure to take into account the economic sustainability of treatments in their evaluation, all of this has resulted in research that has not led to the expected progress. It is high time to fight against hegemonic theories, once psychoanalytical, now biological or statistical, which over time are transformed into ideologies, even dogmas. This is definitely not a pure academic discussion. The risk of over-prescription of psychotropic medications is an issue that cannot be overlooked. This risk is not alone. A simplistic appreciation of what statistics tell about the efficacy of treatments in given disorders might suggest that child and adolescent psychiatry is not a so complex discipline. The president of WHO herself wrote a few years ago, in the introduction of the MHGap program, that "There is a widely shared but mistaken idea that improvements in mental health require sophisticated and expensive technologies and highly specialized staff". "The reality is that most of the mental, neurological and substance use conditions that result in high morbidity and mortality can be managed by non-specialist health-care providers". There is here a misunderstanding. Well-designed flowcharts can indeed be useful to help nurses or general practitioners to deal with young patients in countries where child and adolescent psychiatrists are lacking. Putting symptoms into the context of a family, a culture and a patient's specific development requires much more than that, and this is the day-to-day activity of a well-trained physician.

With regard to mental health, it is essential that the actors who claim to be in this field have in mind a clear definition of what they mean by it. If it is about well-being, according to the WHO definition, then this is not psychiatry. The distinction is essential. Essential for ethical reasons (a doctor has a certain social legitimacy to deal with the suffering of others, he has none to decide how people can be happy) as well as for economic reasons (most often the financing of well-being is based on taxation, that of medicine on an insurance system, public or private). In the same line, primary prevention of mental disorders is essential, but it is much more a matter of mental health than psychiatry. Child and adolescent psychiatrists can testify that domestic violence, war, forced migration, and sexual abuse can lead to dramatic psychiatric disorders. However, these same psychiatrists must also be able to stand in their place in these debates, and they are ultimately citizens like the others.

It is also necessary, today, to better think about this "grey area" that separates mental health from child and adolescent psychiatry. There is a genuine work of conceptualization

and delimitation to be carried out to understand better the specificity of this new domain. The involvement of patients and of parents will take an essential place. More generally, the struggle against corporatism, the ability to make possible a coexistence, a synergy between people with different positions, professional origin and culture is likely to be the main challenge. The integration of technological developments is an aspect of this challenge. Connected health and e-Health technologies have indeed a great potential in the management of chronic and stabilized psychiatric patients, of residual disability or the treatment of sub-syndromic problems. Hopefully, several years ago, many researchers have perceived the necessity to engage studies in this domain and we benefit from their work in the most recent issues of the Journal: Alakortes et al. [2] investigate the recognition of social–emotional and behavioral problems in 1-year-old infants; Wu et al. [3] analyze the relationship between screen time, nighttime sleep duration, and behavioral problems in preschool children, and Klausen et al. [4] investigate the relationship between assisted reproduction technologies and categorical or dimensional aspects of psychopathology in young people. These three papers typically tackle subclinical situations that cannot be considered nevertheless belonging to the field of mental health situations (at least according to the WHO definition).

Conclusion

Epidemiological data now clearly show that child and adolescent psychiatry must be a public health priority in most countries of the world. However, this is all too rarely the case. This dramatic gap between need and resources is at least partly explained by the confusion surrounding the notions of well-being, mental health, and psychiatry.

Since the beginning of the century, we experience impressive societal changes that have had a considerable impact on social relationship, family life, and, more generally, all aspects of child and adolescent development. Because of this, we are worry concerning the future of our youths, and in response to this, many nations have engaged in mental health programs. In this context, child and adolescent psychiatry appears often as outdated and inefficient, if not dangerous. Unfortunately, children and adolescents with mental disorders or diseases do exist and what these young person face is indeed different from any sort of mental health issues. It is essential to recognize that child psychiatry is a medical discipline, with a couple of specificities but no more than that. This is a matter of justice and equity for our patients.

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