



DEBATE

What's in a Name? It's Time to Reconsider the Name of the Academy

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Abstract

It is important the Canadian Academy of Child and Adolescent Psychiatry (CACAP) change its name to the **Canadian Academy of Child and Youth Psychiatry**. This name change will match the organization's goals to enhance its future mandate, scope and reach, to include youth in its mandate while consolidating its existing mandate. There is an ethical and moral imperative for the Academy to indicate strong leadership as an organization to support the needs of youth mental health. The Academy can achieve this by facilitating greater continuing professional development and the sharing of research, scholarship, education and advocacy. Key reasons to support a name change are reviewed in this article and include the contextual history of CACAP and the idea of a name change; the epidemiology of mental health concerns in youth; the need for youth specific services within a biopsychosocial understanding; a focus on development and its importance for youth engagement and transitions as a topic of training, curriculum and service design. Finally, potential perceived threats or concerns that may exist are explored and argued as unwarranted. CACAP's vision to include youth is an act of true leadership for all engaged in mental health in Canada, and will serve as a model for other global psychiatric organizations, by fostering collaboration, partnership, curiosity and a greater understanding of colleagues' perspectives within both the child and adult mental health communities.

Résumé

Il est important que l'Académie canadienne de psychiatrie de l'enfant et de l'adolescent (ACPEA) change de nom pour l'**Académie canadienne de psychiatrie de l'enfant et des jeunes**. Ce nouveau nom correspondra aux buts de l'organisation qui consistent à améliorer son futur mandat, sa portée et son rayonnement, pour inclure les jeunes dans ce mandat tout en consolidant le mandat existant. Sur le plan éthique et moral, il est impératif pour l'Académie de faire preuve d'un leadership d'organisation ferme afin de répondre aux besoins de santé mentale des jeunes. L'Académie peut y parvenir en facilitant un développement professionnel continu plus imposant et en partageant la recherche, les bourses, l'éducation et le plaidoyer. Les principales raisons d'appuyer un changement de nom sont examinées dans le présent article et comprennent l'histoire contextuelle de l'ACPEA et l'idée derrière le changement de nom; l'épidémiologie des problèmes de santé mentale chez les jeunes; le besoin de services spécifiques pour les jeunes au sein d'une culture biopsychosociale; un accent mis sur le développement et son importance pour l'engagement et les transitions des jeunes,

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comme sujet de formation, de programme d'études et de conception de service. Enfin, les menaces perçues potentielles ou les problèmes qui peuvent exister sont explorés et jugés injustifiés. La vision de l'ACPEA d'inclure les jeunes est un geste de véritable leadership pour tous ceux qui œuvrent à la santé mentale au Canada, et elle servira de modèle à d'autres organisations psychiatriques mondiales, en favorisant la collaboration, le partenariat, la curiosité et une meilleure compréhension des perspectives des collègues des communautés de santé mentale tant pour enfants qu'adultes.

Introduction

Recently, the Board of the Canadian Academy of Child and Adolescent Psychiatry (CACAP) has shared a plan to review its mission, vision and values. This will involve the renewal of a strategic plan, which will include key input from all members in 2021. The plan might involve a broadening of CACAP's scope to include not only all of our current academic and clinical pursuits, but to expand membership to those who primarily work with youth, and to have that new mandate reflected in a modification of the name for the organization – the **Canadian Academy of Child and Youth Psychiatry/Académie canadienne de psychiatrie de l'enfant et des jeunes**.

The idea to broaden the organization's scope to include youth (defined as 16-25 years by the Transitional Aged Youth Mental Health and Addictions [TAYMA] Advisory Committee Final Report, 2015) reflects a growing international consensus that sees transitional youth/emerging adults benefitting from a continued developmental approach as they transverse this very vulnerable period. A commentary in the November 2020 issue (Davidson & De Souza, 2020), shared that with a shift in mandate, scope and reach of the organization, the change in name would be needed to connect to what the organization is currently doing with what it intends to do in the future.

A change in the name of the organization is vitally important and essential for several reasons. First, the name of the organization has a unique function as it conveys the initial key message or summary that serves as a preview or “elevator speech” and prepares us for the full mandate of the organization. Second, the name change will reflect the needed respect the organization owes to the young people we serve, who identify more readily as youth, rather than adolescents. The frame of “child and adolescent” in the name, is perceived as restrictive and almost exclusive to that age group and does not open the possibility that the organization supports increasing the depth and breadth of its age mandate. Third, we as a psychiatric community need to do everything we can to improve access to service, training and education for the transition-aged youth. The current mental health context for youth is dire; youth are currently the “gap” in our system and scream out as a burning platform

to prioritize immediately. We acknowledge that there needs to be a multi-pronged approach to address this issue, and in addition, many decisions around care delivery are made at a local level by hospitals, community agencies and policy makers, which are not the mandate of a professional organization like CACAP. However, as a professional organization we have an ethical and moral imperative to stake a claim that this is a major and pressing issue that needs to be solved. Without a name change, we don't stake a claim in any way. We know that we cannot do all this work on our own as child and adolescent psychiatrists, but by adopting a name change to incorporate youth, we set the stage to broaden our membership so that general psychiatrists with special interest in youth can join us and collaborate around youth mental health. Furthermore, our national organization provides the important opportunity for networking with health professionals with like-minded interests, regardless of whether they are child psychiatrists, general psychiatrists, psychologists or any other healthcare professional. We cannot do this important work by ourselves, and so a name change will facilitate broadening our membership so that we can collaborate with our general psychiatric colleagues who are interested in youth.

At the next Annual General Meeting, there will be vote of the membership to decide whether the CACAP will adopt this name change. This commentary represents an argument in favour of the name change.

As authors, we are three psychiatrists: an adult psychiatrist who works with youth (AL), a child and adolescent psychiatrist who clinically only works with youth (SD), and a child and adolescent psychiatrist who works with both children and youth, with a primary focus on working with very young children with neurodevelopmental disorders under the age of five (PS). We believe we reflect the diversity of the psychiatric workforce that currently works with children and youth. Child and adolescent psychiatrists will continue to care for patients in the current scope of their practice (which for some will include youth), and youth psychiatrists (that is, those psychiatrists with general training who have chosen to work specifically with youth) will continue to work within their scope of practice. However, by all working together we can do a much finer job in

supporting the seamless transitioning of our patients from child and youth-oriented services to adult services.

In this article, we will cover several key areas that support a name change: contextual history of CACAP and the idea of a name change; relevant epidemiology and definitions; the need for youth specific services within a biopsychosocial understanding; a focus on development and its importance for youth; the inclusion of youth engagement and transitions as a topic of training, curriculum and service design. We conclude with a recognition of potential perceived threats or concerns that may exist for those that are wary of a name change that includes youth in our mandate. We argue that these fears are unwarranted.

History

Historical context around the idea of a name change adds some light to the current debate. Twenty years ago, at an AGM meeting, held on November 19th 2001, there was a motion to change the name of the Canadian Academy of Child Psychiatry to the Canadian Academy of Psychiatry for Children and Youth (English) and to Academie canadienne de psychiatrie de l'enfant et de l'adolescent (including "adolescent" in the French name). This was defeated, and no change occurred. However, at the same AGM of November 19, 2001, a motion to change the name to the Canadian Academy of Child and Adolescent Psychiatry/Academie canadienne de psychiatrie de l'enfant et de l'adolescent was carried. This motion was not official, as advance notice to the membership had not been provided. The motion was made again at the November 4, 2002 AGM and was carried by the membership. It was at this time, that the official start date of the current name of the Academy occurred. All this occurred prior to Royal College recognition of our sub-specialty status when Academy membership conferred legitimacy on one's practice as a child and adolescent psychiatrist.

Epidemiology of mental health concerns in youth

Since that time, there has been increased recognition of the unique characteristics and needs of those individuals during the developmental stage when adolescents transition into adulthood (Holmbeck & Devine, 2010, Schulenberg et al., 2017). More than one in five children and youth experience mental health difficulties, and Canadian youth (aged 15 to 24) are more likely to experience comorbid mental health and substance use disorders than any other age group (Pearson, Janz & Ali, 2013; Rush et al., 2008). Unlike physical health concerns, most mental health disorders begin by age 25, with age of onset for most common disorders

between the ages of 12 and 24 (Kessler et al., 2005). Large epidemiologic studies have revealed that 75% of mental illnesses emerge before the age of 24, and 50% emerge before the age of 18 (Kessler et al., 2005). Suicidal ideation and attempts are common among emerging adults, youth with suicidal ideation have a greater lifetime risk for suicide attempts, and those with attempts have an increased risk of completed suicide (Fergusson et al., 2005; Latimer, Garièpy & Greenfield, 2014). Recent Canadian data from five provinces illustrate that those between the ages of 15 and 19, and 20 and 24 have the highest suicide attempt rates of all age groups (Palay et al., 2019). There can be no argument that transitional age youth (TAY) represent a very vulnerable population that require special attention when it comes to service delivery (Wiens et al., 2020).

Youth specific service provision

Despite the clear need for mental health services, youth often do not receive developmentally sensitive, evidence-based, services in a timely, effective manner (Fante-Coleman, & Jackson-Best, 2020). There have been long-standing problems including system fragmentation, poor access to evidence-based services, discontinuation of support at the transition to adulthood and lack of an informed developmental perspective (Cleverley et al., 2020). Integrated care approaches, using models of care that bring traditionally separate services together into one community-based setting to meet youth's specific needs and span the transition to adulthood, have gained national and international attention of researchers, service providers and policy makers. These can be referred to as "youth wellness hubs" or "one-stop shops" serving youth (both adolescents and young adults) providing early access to care in a non-stigmatizing, youth-friendly environment (Malla et al., 2018; Settapani et al., 2019). Many of these programs in Canada have been developed by child and adolescent psychiatrists working together with general psychiatrists and represent a Canadian response to this welcome implementation.

Child and adolescent psychiatrists are acutely aware that the current, adult oriented, service system is not optimally designed for youth. It is all too apparent that the "child" and "adult" systems are not "talking to one another" in a coordinated manner. Our organization, CACAP, and our adult colleagues as members of the Canadian Psychiatric Association (CPA) need to align to facilitate an integrative, holistic, recovery-oriented approach to service coordination. Many youth have never managed their healthcare independently, used pharmacy services appropriately, managed their appointments and in turn they tend to terminate their treatment at eight times the rate of mature adults. 60-80 % of youth with a mental health challenge are not in treatment

(MacLeod & Brownlie, 2014) and are less likely to access specialty psychiatric care than their younger adolescent peers (Radez et al., 2021). These aspects of engagement in care and retention in care need astute developmentally-informed input (including policy, education, assessment, care coordination and research) from those who are most trained in best practices for meeting these developmental needs and that includes child and adolescent psychiatrists.

Terminology: transitional aged youth or emerging adulthood

The term *transitional age youth (TAY)* is often misunderstood. It originated from the Substance Abuse Mental Health Services Administration (SAMHSA) in the USA because of early awareness of the lack of developmentally appropriate services and supports for youth exiting foster care (www.samhsa.gov/data/). The term “emerging adult” was first used in 2000 by psychologist Jeffery Arnett (Arnett, 2000) to describe a discrete developmental phase for ages 18 to 25 years with its own developmental milestones and challenges. Not all clinicians and researchers agree about when the transitional age period starts and ends. Terms such as TAY, emerging adult, late adolescence and early adulthood have been cited as interchangeable entities. The period is characterized by the need to achieve greater independence and to establish careers, start new families and develop a new set of core values potentially distinct from one’s parents. The degree of independence from parents and the establishment of adult roles achieved, varies within the group greatly, underscoring a need to assess and respond to the developmental needs of each youth. Child and adolescent psychiatrists have been at the forefront of recognizing young adulthood as a unique stage (Wilens & Rosenbaum, 2013) but also many psychiatrists with general training have championed this developmental epoch, especially those working in first episode psychosis programs (McGorry et al., 2018). As those programs have moved more and more into early detection and treatment for more common forms of psychopathology such as depression, anxiety and substance use, an increasing number of adult psychiatrists are interested in working with TAY.

A developmental perspective

The overarching need to incorporate a developmental perspective into our understanding of mental health in TAY is essential (Chan et al., 2019). Developmentally targeted health promotion, prevention and intervention strategies for youth should be integrated into our policy frameworks within a life-span perspective. Child and adolescent psychiatrists are superbly positioned to support predisposing dynamic and multi-layered relations among youth, family

and peers, as they continue to evolve through adolescence into the period of emerging adulthood (Chan et al, 2019). Pao (2017) notes that the concept of a “successful” transition to adulthood is both contextually and culturally dependent, stating that there is “not one specific pathway to successful adulthood”. It becomes even more important that youth, their parents, their clinicians, educators and policy makers recognize, clearly articulate and evaluate their vision together and clarify common goals of “success”. This can be done where organizations, like CACAP, take a leading position in the work of transitions, and include all players in this collective dialogue.

The awareness of how developmental age and experience can influence self-awareness and interpretation of mental health concerns is very relevant to working with youth, and child and adolescent psychiatrists are uniquely positioned to appreciate this. The adolescent may have had the additional story-telling and collateral history that was shared by their parents and family in the past. Yet, a newly graduated high school student heading off to college or university does need and values the guidance of their child and adolescent psychiatrist in pre-planning and exploring accessible mental health treatment services for youth on and off campus. Adolescent psychiatrists along with the youth are in a position to be engaged in the shift the young person needs to make towards more autonomous health care as an adult, while maintaining the awareness of prior vulnerability of the young adult who may deteriorate under stress in a more unsupervised environment. The child and adolescent psychiatrist can take a lead in planning around confidentiality laws when the youth turns 18. This would involve pre-emptive discussions about confidentiality, treatment planning and parental involvement that will support the youth and their family with future communication and decision-making. All too often, a youth’s inability to cope with transitions may be interpreted as “psychopathology” in the adult mental health system, if development is not considered. Further consideration of the ongoing neurobiological development that occurs well into the twenties in youth, has implications for assessment of risk, impulsivity and other cognitive aspects. Child and adolescent psychiatrists are in a position to provide great impact in using their rich developmental training in all biopsychosocial aspects of their patient’s life trajectories by providing anticipatory guidance, treatment and resources through a developmental lens.

Youth engagement

One of the key benefits of this expanded scope and mandate would be the engagement of youth in the co-design of the organization’s activity in continuing professional development and the sharing of research, scholarship, education

and advocacy. There are many different terms to describe youth or young adults, with the “transition-aged youth,” “transitional age youth,” “young adults,” or simply “youth” used as descriptors (Carver et al., 2015). Historically, young people do not identify with the “adolescent” terminology. They far more readily identify with the term “Youth”. If an organization does not include meaningful youth engagement that is inclusive, intentional, mutually respectful and authentic in its engagement efforts, it will not be able to fulfill its purpose and goals effectively. Engagement of the patient/consumer is even more key in this transition-aged youth group, to match their developmental transition in managing their mental health autonomously. The proposed name change would honour both this group of people we serve as well as the fundamental principles of Youth Engagement. CACAP’s broadening of scope to include youth psychiatrists, other mental health clinicians, researchers and educators working with youth, would most importantly invite youth to have a key voice within the organization. Youth need to have a central and active participatory role in the transition process, and all aspects of mental health access, ongoing care, and overall mental health engagement.

Training

The topic of transition as a training and educational priority has been cited as a much needed area to address in training of psychiatry residents, medical students and other health professionals. Few countries include “transition” as a mandatory topic in training, with a recent publication citing Ireland and the United Kingdom as the only two countries in the European Union to include it in mandatory resident training (Milestone Consortium, Russet et al., 2019). While CACAP is not responsible for the training of child and adolescent psychiatrists anymore (this was taken over by the Royal College of Physicians and Surgeons), CACAP’s role in continuing professional development can have real influence over training, sharing a comprehensive developmental approach that includes knowledge of environmental support, decision making and consent, family support and professional sensitivity to psychosocial issues as key factors in a successful transition (Blum et al, 1993). CACAP’s proactive approach to include youth in its name and mandate, will foster more dialogue around training and education in transitional work within Canada. Continuing medical education activities, courses, conferences and the educational mandate within CACAP’s mandate will be able to host joint adult and child/adolescent training events to enable shared training, relationship building and collaboration and dialogue.

Threats

We understand that some of our colleagues in the Academy may be wary of a name change that includes youth in our mandate. Some concerns expressed include a fear of becoming overwhelmed with the clinical demand, as there are not enough child and adolescent psychiatrists in Canada to care for children and adolescents let alone another whole demographic. Some may be concerned that after a long struggle to attain sub-specialty status, child and adolescent psychiatry will lose its identity. It is important to note that subspecialty status is under the Royal College of Physicians and Surgeons of Canada and would not be affected in any way by a name change of the Academy. This was not the case prior to obtaining subspecialty status. There may be concern that a name change may seem to prioritize one developmental stage over another, with a concern raised that the young cohort of children prior to adolescence will somehow get “short-changed”. Finally, in the year of the pandemic, it may appear that we as a profession have other priorities to highlight. While we appreciate these concerns, we feel they miss the point. The prevalence of mental disorders in children and youth from infancy to emerging adulthood is so large that there will never be enough mental health professionals to deal with that number. We are not saying that child and adolescent psychiatrists should be uniquely responsible for this new demographic but that we should work together with “youth” (general) psychiatrists to develop evidence based, developmentally informed services for this age demographic. Currently, we are in an extended crisis in the context of the Covid pandemic, and child and youth mental health needs are increasing exponentially. Youth is a cohort in threat, with high risk of morbidity and mortality and a public health domain of the most vulnerable sector, which needs to be addressed. The purpose of a professional organization, such as the Academy, is to provide a forum for networking, coming together, and teaching each other how best to reduce the burden of suffering associated with mental disorder of all young people, regardless of age. TAY need services tailored to their developmental stage and we need to be part of that conversation, not create it by ourselves. If we are not offering to be part of this important discussion, we are not rising to the obvious opportunity of taking national and international leadership, in an area where we have much to offer. If we do not take on this challenge, we fear we shall be left behind by policy makers and clinicians who will take up this challenge without us, and design services that do not have a developmental perspective. Instead of losing our identity as a profession, a name change that recognizes one of the most vulnerable segments of the population will, in fact, strengthen our claim to relevance in the years to come.

Conclusion

CACAP's discussion to include youth and expand the scope of individuals it serves is an act of true leadership for all involved in mental health in Canada. It will serve as a model for other psychiatric organizations, facilitating a goal of reaching a greater understanding of colleagues' perspectives on either side of the great divide between child and adult. The *Canadian Academy of Child and Youth Psychiatry/Académie canadienne de psychiatrie de l'enfant et des jeunes* will necessitate a goal of flexibility across previously artificially constructed age boundaries, requiring collaboration, partnership and curiosity. We can all only gain by taking on this responsibility to share our wisdom with others who wish to join us in this exciting new venture.

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