Protecting Youth Mental Health: Part II
Identifying and Addressing Barriers to Care
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Written Testimony of
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Chairman Wyden, Ranking Member Crapo, and Members of the Committee:

My name is Dr. Tami Benton. I am Psychiatrist-in-Chief and Chair of the Department of Child and Adolescent Psychiatry and Behavioral Sciences (DCAPBS) at Children's Hospital of Philadelphia (CHOP) and the Frederick Allen Professor of Psychiatry at the Perelman School of Medicine at the University of Pennsylvania. I also serve as director of the Child and Adolescent Mood Program and the Youth Suicide Center at CHOP, a multidisciplinary clinical and research program focused on depression and suicide among children and adolescents, with an emphasis on minority youth. Finally, I am the President-Elect of the American Academy of Child & Adolescent Psychiatry (AACAP). Thank you for the opportunity to testify today about the crisis in the mental, emotional, and behavioral health[1] of our children.

CHOP was founded in 1855 as the nation's first pediatric hospital. Its long-standing commitment to exceptional patient care, training new generations of pediatric healthcare professionals, and pioneering major research initiatives has resulted in many discoveries that have benefited children worldwide. Its pediatric research program is among the largest in the country, and we conduct research focusing on all aspects of mental, emotional, and behavioral health, including preventing a child with elevated symptoms from moving into crisis. Based on this research and the work of others, we are greatly expanding both the type and the reach of our pediatric mental health efforts. *However, this crisis cannot be addressed without your help*.

Overview

I wish there were no need for me to appear before you today, but young children and adolescents in the U.S. are experiencing mental health stress at higher rates and with more dire consequences than ever before. Fifty-three percent of adults with children in their household are concerned about their children's mental wellbeing, and they are not wrong to have these concerns. In the first half of 2021 alone, children's hospitals reported cases of self-injury and suicide in ages 5-17 at a 45% higher rate than during the same timeframe in 2019, and, for children under 13, the suicide rate is twice that for black children than for white children.

I know you've heard many of these statistics before, but I see them play out firsthand in my daily work. A few recent examples come to mind: a five-year-old with suicidal ideation and a plan to follow through, an adolescent waiting months for a placement with appropriate services while occupying a medical bed needed by others, a youth sent several states away because finding a placement for children with both physical and mental health concerns is nearly impossible, and other stories too numerous to mention.

[1] For brevity, I will refer simply to "mental health" in my testimony, but the intention is to encompass mental, emotional, and behavioral (MEB) health throughout.

Clearly, our kids are falling through cracks in the system. While these cracks predate the COVID-19 pandemic, the additional traumas and challenges for children presented by the pandemic made them both worse and more visible. This dire situation led the Children's Hospital Association, the American Academy of Pediatrics, and the American Academy of Child and Adolescent Psychiatry to declare a national emergency in pediatric mental health, and they have joined together in an awareness campaign called Sound the Alarm for Kids.[i]

Already, more than 50 other national groups and 70 children's hospitals have joined the campaign, a clear acknowledgement that it is, indeed, time to sound the alarm. We have not one but two urgent tasks before us:

1. Addressing the immediate and undeniable crisis facing kids today; and
2. Reframing our pediatric mental health system to provide the right care, at the right place, and at the right time.

This latter point may sound obvious; however, the reality is that we commonly only address pediatric mental health *after* the onset of a crisis. Delayed care is costly in many ways, including:

1. Emotional burden and social cost to the patient and their family,
2. Strain on our childcare and educational systems,
3. Excess cost and poor outcomes associated with providing inadequate care,
4. Delays in pediatric health care when medical hospital beds are overutilized for boarding children in mental health crisis, and
5. Wrongful placement of children in the juvenile justice system.

The current state of care is unacceptable, and we must pivot to proven models of prevention to reduce the number of our children entering a period of crisis and assure access to appropriate pediatric services both across the entire continuum of care and close to home.

Shorter Term Solutions

In the immediate-term, this means greater reliance on those on the front lines—parents, teachers, general pediatricians, and other caregivers. They need whatever proven tools we can give them, and they need them as soon as possible. Examples include supplemental training, ready access to phone consultations and referrals, pediatric mobile crisis units to help children (and their caregivers) manage from home, and school-based interventions, including telehealth. While a good number of schools have a school psychologist, school counselor and/or nurse on hand, they tend to have untenable student ratios. While these providers may not have capacity at present, it makes sense to build on these existing models of care through evidence-based training and supplementing their efforts with telehealth.

Not only are these front-line workers lacking the support they need, in some cases there are financial *disincentives* to providing mental health services. For example, although up to half of all pediatric primary care office visits involve a mental health concern,[ii] primary care pediatricians who do additional training to offer a mental health assessment necessary for appropriate referral, do so without receiving compensation for the 1.3 to 2.8 times longer the mental health assessment takes, compared to other primary care visits.

We need more appropriately-trained pediatric mobile behavioral health crisis units. These provide mobile, short term, face-to-face, therapeutic responses to youth experiencing a behavioral health crisis and can help reduce psychiatric emergency department visits.[iii] Notably, there are effective models to build on in both urban and rural settings, and these mobile crisis units can be stood up almost immediately.

Twenty-four-hour crisis hotlines, staffed with those trained in child and adolescent mental health, can assist with de-escalation and assessment. If linked with updated local resource and provider information, these crisis lines can also refer to treatment facilities. Depending on how they are configured, the crisis lines could be utilized by providers, educators, families and even the kids themselves. They would work best if connected to a frequently updated collection of local resources. For this, it may be possible to build out the existing 211 network or expand on the 988-network established by the FCC last year to connect people to the National Suicide Prevention Lifeline.

Fixing a Broken System

In the longer term, the whole continuum of care must be addressed so that the right types and levels of care are available, e.g., the emphasis should not be on inpatient mental health beds (although more of those are also needed). If we are doing things right, children will be treated more and more *outside of a hospital inpatient setting*, but this will only be possible if intensive outpatient programs (IOPs), partial hospitalization programs (PHPs), day programs, a full range of additional step-down services, and preventive services are available. *Today, every one of these services are in short supply*. As a result, children often go without the services they need, or families find themselves seeking services for their child far from home (including out of state).

It is also important to acknowledge that there is a web of systems beyond health care that impact the wellbeing of children and adolescents. These include foster care, juvenile justice, childcare, education, food programs and more, layering on additional complexities to achieving the end goal of doing better by our kids. The many systems that touch our kids rarely collaborate, and, when they try to, these attempts are too often foiled by bureaucratic barriers or an unwillingness to acknowledge the interconnected nature of the services offered. Although a daunting prospect, we recommend a

thorough examination of how various agencies intersect in children's lives and policy recommendations aimed at making those intersections synergistic rather than counterproductive.

Workforce Shortages and Pediatric Behavioral Health Boarding

Not surprisingly, the shortage of pediatric mental health care providers and facilities means many children show up at emergency departments (EDs), brought there by distraught caregivers, sent there by overwhelmed schools, or taken there by police who see plainly in a particular case, that care, not confinement, is what is needed. EDs are not the ideal setting for these kids if they do not have medical needs. EDs can be stressful environments and starting a mental health journey that way often results in delayed care when children are "boarded" either in the ED itself or admitted to a medical patient bed. Neither option satisfies the "right care, right place, right time" mantra, and both can be detrimental.

At CHOP, we have up to 50 patients waiting for mental health beds on any given day. As we typically operate at (or over) capacity, this means that we cannot use that space for a child with more complex medical needs. The kids who are boarding are kept physically safe, but generally must wait for an appropriate treatment slot to open before having their mental health crises fully addressed. Sometimes this wait is only a few hours, but weeks of waiting is far too common, months is not unheard of, and there are even instances of a child or adolescent missing more than a year of their life, removed from school and family, while waiting for the services they need to safely return to home and school.

According to the American Psychiatric Association, there are an estimated 15 million children nationwide in need of care from mental health professionals. However, there are just 8,000 to 9,000 psychiatrists treating youth in the United States. Even when staffing ratios are reasonable, resources are not distributed evenly across the country, essentially resulting in pediatric mental health service deserts.

While I can speak most directly to the shortage of child and adolescent psychiatrists, there are also severe shortages of psychologists, mental health therapists, nurse practitioners, case managers and community mental health workers to support children in need.[iv] To increase the number of pediatric mental health providers available to care for these children, incentives, including educational funding and loan forgiveness programs should be directed at all licensed pediatric mental health providers in all settings across the continuum of care, including in schools. It is especially important to include mental health professionals of all disciplines. While there is a severe shortage of new pediatric psychiatrists coming into the system, and that must be addressed, increasing the number of clinical social workers with pediatric training, mental health therapists, psychologists, nurse practitioners, case managers and

community mental health workers, who are all needed to expand access to mental health care, could be done more quickly and in greater numbers.

The Unique Needs of Military Families

Children in military and veteran families are experiencing mental health challenges much like their civilian counterparts, but also face some unique challenges due to the nature of their parents' service such as frequent moves, prolonged separation resulting from parents' deployments, and exposure to returning parents who themselves have been affected by the trauma of combat deployment. How these children can be connected to the full continuum of care described above must be determined and then implemented.

Improved Access to Integrated Care & Preventive Services

For an overwhelmed system in which training enough providers will, at best, take time, easing pressure on the system now is essential. The best way to do this is support for both preventive services as well as care that is integrated into settings where youth are likely to be, such as the pediatrician's office, school, or other community-based centers to help stem the tide of youth entering crisis.

When care isn't easily accessible (the ideal being true integrated care, with a warm hand-off to someone in the same building), too often a referral to mental health services ends in no services. When patients are referred from primary care to free-standing mental health clinics, only 25-50% of patients attend an appointment. When behavioral health providers are on site, as part of the primary care team, treatment initiation is dramatically improved.[v] The pediatric patient-centered medical home model offers opportunities for family-centered, team-based care, and pediatric mental health providers are increasingly being recognized as key members of primary care teams.[vi] Insurance carve outs for behavioral health care are among the barriers to implementation, but targeted incentives related to integrated behavioral health could further speed expansion and serve as a pathway to mental health parity.

Certified Community Behavioral Health Clinics (CCBHCs) are another important access point to mental health care for children and youth, particularly for those in underserved communities. In a recent survey, 79% of CCBHCs reported coordinating with hospitals to support diversion from emergency departments and inpatient care[vii], and a similar proportion of CCBHCs directly employ child and adolescent psychiatrists as part of their care teams. Providing these clinics with additional resources could be another way to have more appropriate care available closer to home. For kids in need

Ultimately, of course, prevention is the best approach as it both serves are children better and it helps to alleviate an over-burdened system. Preventive mental health interventions reduce the risk of a child suffering a mental health crisis and are cost-effective,[viii] [ix] but it is not well understood how early these

interventions can and should start. Remarkably, just by giving parents and other caretakers tools to effectively address behaviors and emotions as they come up, better trajectories are started as early as infancy. Early intervention, services for young children that build upon the natural learning opportunities that occur within the daily routines of a child and their family, can effectively give children tools to overcome delays and manage disabilities.[x] [xi] For older kids, there are several effective depression prevention programs, which, if more widely delivered, could prevent 22-38% of depression episodes.[xii] [xiii]

Unfortunately, current mental health payment models do little to support prevention services. Most billing codes required for use by behavioral health clinicians usually necessitate the presence of a diagnosed psychiatric condition. This means that a mental health concern that could have been resolved relatively quickly can devolve into crisis, which is far worse for the child and far more costly, both literally and figuratively, for society. Even with early intervention, which is inexpensive and effective, there are barriers that can significantly delay services.

Although we understand the challenges of fully realizing savings in a ten-year legislative budget window, it is nonetheless essential to increase funding for and access to preventive services for our children. To this end, dedicated grant programs could further enable community-based systems of care. Additionally, increasing health care payment flexibility with new billing codes that support preventive services without a diagnosed psychiatric condition would better enable these services to be embedded into pediatric primary care (where most families already visit regularly) and other settings that children and families frequent. Also, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for youth in Medicaid provides an important opportunity to support early identification even before diagnosis. The Department of Health and Human Services should be instructed to working with states to test innovative strategies and sustainable payment models within Medicaid's EPSDT services[xiv] to allow children at risk of mental health concerns, but without a diagnosis to receive preventive services.[xv]

Setting Children Up for Success from the Earliest Years & Addressing Equity Concerns

Early care and education programs, childcare, and preschool prevention programs have been overlooked and underfunded. As noted above, these services have a key role in prevention. When using proven techniques, they help young children build social-emotional life skills, which can set the child on a pathway to greater resilience and prevent mental health crises at later ages.

Within early education, there is another distinct crisis that exists as the result of suspensions and/or expulsions of babies and toddlers from childcare and Pre-K settings for behavioral concerns, and this problem falls disproportionately on black boys. If you take a moment to imagine being told that nothing can be done for your two-year old's behavior, and he is being expelled from childcare—the message to both the child and the parents is damaging in the moment longitudinally. Promptly

investing in basic behavioral health technique training for childcare providers and Pre-K teachers will give our educators the support they need to teach our youngest the social-emotional life skills and regulation tools they need to participate in these important developmental settings and enter kindergarten ready to learn and thrive.

Care provided in communities offers the opportunity for early identification and intervention for children and families with mental health challenges at the right level and at the right time. It also helps to address longstanding access disparities and overcome stigma. Instead of this, our current system relies heavily on private facilities which often pick and choose their patients. While they are entitled to do so under current law, additional standards could be set nationwide both to ensure kids get to open pediatric mental health slots in facilities that accept federal funding and to reduce bias in these decisions.

Of course, inadequate Medicaid reimbursement for mental health services disproportionately impacts communities that are already medically underserved, in which those services are especially needed. Better reimbursement for mental health services in Medicaid would make it possible to resource the full continuum of care our children and youth need, such as intensive outpatient, partial hospitalization, and limited residential treatment facilities—and, importantly, bring that care closer to home.

How Telehealth Can Enhance Care:

Tele-mental health services have been described as an ideal application of digital health services, and since the onset of the COVID-19 pandemic, behavioral health providers at CHOP have completed more appointments via telehealth than any other specialty; nearly 83,000 across the CHOP Care Network. This is an essential tool for addressing the pediatric mental health crisis. To reach the underserved, we recommend the inclusion of audio-only services as well as coverage across sites of care including a child's home, school, or childcare center. Increased reimbursement rates for telehealth services supported the rapid expansion of telehealth and should be continued at an appropriate level to maintain children's access to tele-behavioral health services.

Telehealth across state lines is also an important way to improve access to pediatric mental health services, particularly in states where there is a shortage of providers. However, the process is both complicated and expensive for providers to become licensed in multiple states and/or obtain the credentials (like PsyPact) that allow care provision across state lines. There is also no longer a state-by-state standard of care, making state-based professional licensure a barrier to care that is difficult to justify, especially in federally recognized health professional shortage areas (HPSAs) and the dearth of providers accepting Medicaid.[xvi]

Improving Reimbursement Through Both Payment Reform and Higher Rates

The behavioral health payment system is archaic and convoluted, further restricting access to care. As it stands today, arranging for care and payments can be confusing and administratively burdensome. There is often disagreement as to which payor is responsible and where the care can be provided. For boarded children, the result is something close to nonpayment, where neither insurer assumes responsibility when the services assigned to them are not being provided or not in what they consider to be the approved setting. The disfunction is only greater when a child or adolescent reports with both a medical and mental health issue,[xvii] and few settings are equipped to address these complex cases.

Many key pieces of the needed continuum of care are simply not covered or are reimbursed at such low levels that too few providers will offer them. Day programs[xviii], which provide trauma-informed, behaviorally based therapeutic services, which teach children how to develop safe adaptive behaviors, emotional self-regulation, and pro-social skills, are an important example. Without a significant enough increase in rates for pediatric mental health services, we will never be able to provide the full continuum of care that our youth need. This is not acceptable, especially when getting this right will mean our children receive the care they need at the appropriate level, maximizing the likely success of the treatment, ensuring that they are not taking a higher acuity spot desperately needed by another child, and more wisely spending health care dollars.

Conclusion

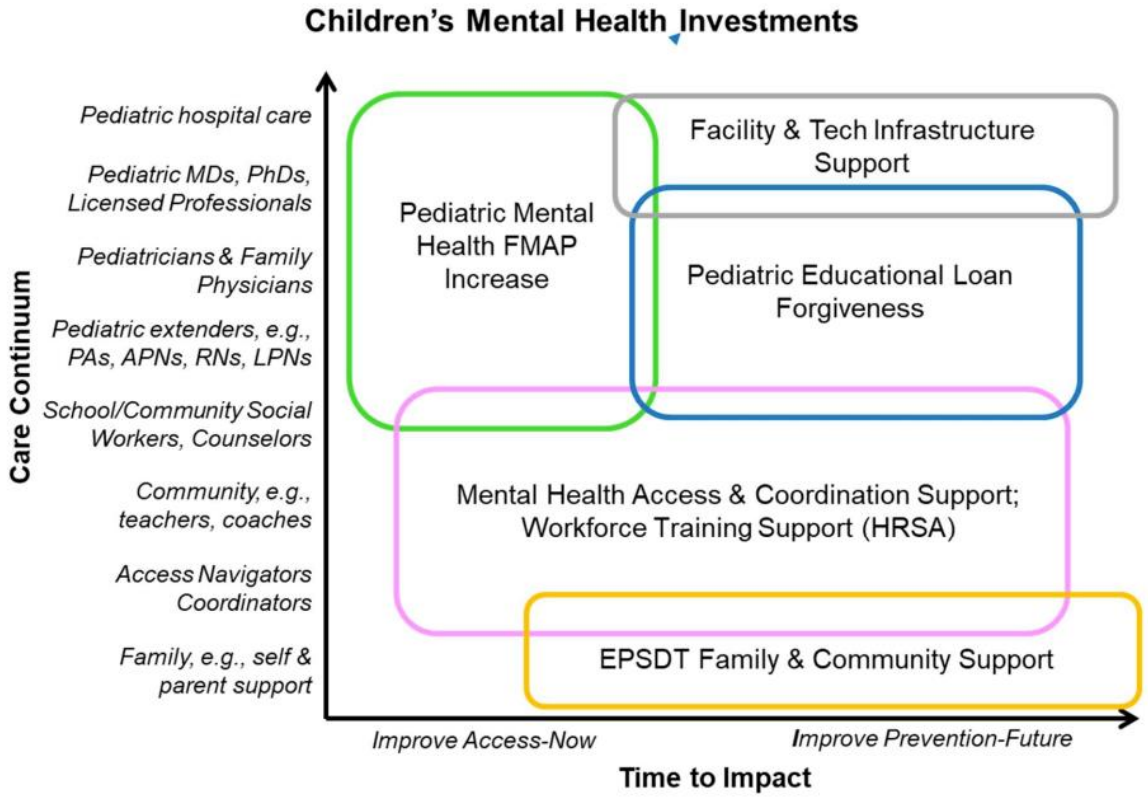
Our mental health care system is not equipped to give our children the support they need when they need it. If the right interventions are put in place, they would build on our children's remarkable resilience and place them on a better trajectory. Our children are in crisis, which means we are in crisis as a nation. Although the pandemic deepened the crisis, it has raised awareness on this issue, creating an important and rare opportunity to make fundamental changes in the way we care for our children.

Thank you again for the opportunity to provide this testimony. I urge you to take this opportunity to act swiftly and decisively to save children in crisis and diminish the chances of a repeated emergency of this magnitude.

Appendix A: Organizations Participating in the *Sound the Alarm for Kids* Campaign, along with the Children's Hospital Association, American Academy of Pediatrics, American Academy of Child & Adolescent Psychiatry, and 70+ Children's Hospitals

- AIDS Alliance for Women, Infants, Children, Youth & Families
- American Academy of Family Physicians
- American Foundation for Suicide Prevention
- American Hospital Association
- American Mental Health Counselors Association
- American Muslim Health Professionals (AMHP)
- American Psychiatric Association
- American Psychological Association
- America's Essential Hospitals
- Association of Children's Residential & Community services (ACRC)
- Catholic Health Association
- Center for Law and Social Policy (CLASP)
- Child Welfare League of America
- Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
- Children's Defense Fund
- Clinical Social Work Association
- Eating Disorders Coalition for Research, Policy & Action
- Exceptional Families of the Military
- Family Voices
- Federation of American Hospitals
- First Focus on Children
- Global Alliance for Behavioral Health & Social Justice
- International Society of Psychiatric Mental Health Nurses
- Juvenile Protection Association (JPA)
- Mental Health America
- National Alliance on Mental Illness (NAMI)
- National Association for Behavioral Healthcare
- National Association for Children's Behavioral Health
- National Association for Rural Mental Health
- National Association of County Behavioral Health and Developmental Disability Directors
- National Association of Pediatric Nurse Practitioners
- National Association of School Psychologists
- National Association of State Mental Health Program Directors
- National Council for Mental Wellbeing
- National Latinx Psychological Association
- National League for Nursing
- National Military Family Association
- On Our Sleeves - The Movement for Children's Mental Health
- Psychotherapy Action Network (PsiAN)
- REDC Consortium
- RI International, Inc.
- Sandy Hook Promise
- School Social Work Association of America
- School-Based Health Alliance
- Social Current
- Society for the Prevention of Teen Suicide
- Society of Adolescent Health and Medicine
- The Baker Center
- The Barry Robinson Center
- The Jed Foundation
- The Kennedy Forum
- The National Alliance to Advance Adolescent Health
- The Trevor Project
- Tricare for Kids Coalition
- Trust for America's Health
- United Way Worldwide
- WellSpan Health
- Youth Villages

Appendix B: Visual Representation of Recommendations Along the Care Continuum and Time to Impact (Now vs. Future)[xix]



[i] See list of Sound the Alarm for Kids campaign partner organizations in Appendix A

[ii] Martini, R., Hilt, R., Marx, L., Chenven, M., Naylor, M., Sarvet, B., & Ptakowski, K. K. (2012). *Best principles for integration of child psychiatry into the pediatric health home*, American Academy of Child & Adolescent Psychiatry.

[iii] Fendrich, M., Ives, M., Kurz, B., Becker, J., Vanderploeg, J., Bory, C., Lin, H., Plant, R. (2019) Impact of Mobile Crisis Services on Emergency Department Use Among Youths With Behavioral Health Service Needs. Psychiatric Services: 70 (10) 881-887.

[iv] National Projection of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025. U.S. Department of Health and Human Services. Health Resources and Services Administration. Bureau of Health Workforce. Published November 2016. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf

[v] Blount A. Integrated primary care: organizing the evidence. (2003) *Families, Syst Health*. 21:121–133.

[vi] Asarnow, J., Kolko, D. J., Miranda, J., & Kazak, A. E. (2017). The pediatric patient-centered medical home: Innovative models for improving behavioral health. *American Psychologist*, *72*, 13–27. https://doi.org/10.1037/a0040411.

[vii] According to a 2021 impact report that surveyed 128 CCBHCs, 79% report coordinating with hospitals/emergency departments to support diversion from emergency departments and inpatient care. Additionally, according to a 2020 ASPE implementation report, 76% of CCBHCs employs child and adolescent psychiatrists.

[viii] Mihalopoulos, C., Vos, T., Pirkis, J., Carter, R. (2012) The Population Cost-effectiveness of Interventions Designed to Prevent Childhood Depression. *Pediatrics* 129 (3): e723-e730.

[ix] Bodden, D. H. M., van den Heuvel, M. W. H., Engels, R. C. M. E., Dirksen, C. D. (2021) Societal costs of subclinical depressive symptoms in Dutch adolescents: a cost-of-illness study. *Journal of Child Psychology and Psychiatry* https://doi.org/10.1111/jcpp.13517

[x] Bailey, D. B., Hebbeler, K., Spiker, D., Scarborough, A., Mallik, S., & Nelson, L. (2005). 36-month outcomes for families of children with disabilities participating in early intervention. Pediatrics, 116, 1346-1352

[xi] Richard C. Adams, Carl Tapia and THE COUNCIL ON CHILDREN WITH DISABILITIES. Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practice and Best Outcomes Pediatrics October 2013, 132 (4) e1073-e1088; DOI: https://doi.org/10.1542/peds.2013-2305.

[xii] Cuijpers, P., van Straten, A., Smit, F., Mihalopoulos, C. Preventing the Onset of Depressive Disorders: A Meta-Analytic Review of Psychological Interventions (2008). *The American Journal of Psychiatry*; ; 165, 10; ProQuest Social Sciences Premium Collection pg. 1272

[xiii] Cuijpers, P., Muñoz R. F., Clarke G. N., Lewinsohn, P. M. (2009) Psychoeducational treatment and prevention of depression: The "coping with depression" course thirty years later. *Clinical Psychology Review* 29 449–458.

[xiv] Early and Periodic Screening, Diagnostic, and Treatment. Medicaid.gov. Access here.

[xv] We can look to Massachusetts for innovation in this area. Revisiting and realigning health insurer capitated payment rates to reflect expanded preventive services would also facilitate earlier interventions. Please refer to the relevant MassHealth Bulletin.

[xvi] Health Professional Shortage Areas. Data.HRSA.Gov. Access here.

[xvii] We have been able to provide limited relief of this latter problem by providing full-time medical staff to a facility that otherwise only address MEB issues, but this only works when the medical issue is relatively easily managed, like diabetes, not for more severe comorbidities.

[xviii] More information on CHOP's Intensive Emotional and Behavioral Services can be accessed here.

[xix] Strengthening Kids' Mental Health Now. Children's Hospital Association. Access here.