U.S. Senate Finance Committee Hearing on Children's Mental Health

Senate Committee on Finance
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Written testimony submission, respectfully submitted by:
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Chairman Wyden, Ranking Member Crapo, Senator Hassan, and Members of the US Senate Committee on Finance, I want to thank you for the opportunity to testify and submit a written statement regarding pediatric mental health.

In March of 2020 life for all of us changed as we once knew it. As adults, we made many quick pivots to respond and adapt to the COVID-19 pandemic. As we made many adaptations in both our personal and professional lives, we had our past experiences to reflect upon. When faced with the new and often unpredictable challenges the pandemic created, we pulled from our toolbox of coping strategies. We knew who we could turn to for the extra support we might have needed as we navigated those challenges. But, for most of the youth in our country, they were left feeling paralyzed, stymied, hopeless, and scared. For many youth, this was their first experience with grief, trauma, depression, or anxiety. Life for them had completely changed and their worlds were turned upside down. The uncertainty, social isolation, and stressors related to the pandemic, have left many kids unable to cope or understand the breadth and depth of this experience. For some youth, there is no trusted adult to support them during this critical developmental period. Many lack a social support network. Many remain isolated from peers and other trusted adults. And, for too many youth, their only means of symptom relief is contemplating death.

We are learning that teenage girls have begun to demonstrate an increase in the acuity of their symptom presentation. Data from the Centers for Disease Control and Prevention indicates a 51% increase in suicide attempts by teenage girls ages 12 to 17. LGBTQ+ youth continue to have higher rates of suicide than their heterosexual peers. And, according to a Wisconsin NPR piece in March 2021, data from 2020 demonstrated that "the percentage of emergency department visits for mental health emergencies rose by 24% for children between the ages of 5 and 11 and 31% for those 12 to 17, compared with 2019." Youth mental health has become the secondary pandemic to the COVID-19 pandemic.

As mental health needs rose for pediatric patients, the availability of services continues to become more scarce. Youth are presenting to hospital emergency rooms in a state of psychiatric crisis. Many who are assessed and meet the criteria for psychiatric inpatient level of care will be faced with boarding in an emergency room for days, weeks and sometimes months until a bed becomes available. Emergency

room boarding often creates more distress, decompensation in psychiatric symptoms, and increased traumatic exposure, while receiving no mental health care until the inpatient bed becomes available. Staffing shortages in both outpatient and inpatient settings due to an exhausted, depleted, and underpaid mental health workforce has only prolonged access to care for pediatric patients. Without adequate funding and reimbursement structures from both Medicaid and private payers, mental health providers are left with the difficult decision to leave the nonprofit world and enter the for-profit world in order to make a livable wage. During the pandemic, there were two 3% increases to Medicaid rates. And while that is appreciated, prior to those two increases there had not been meaningful increases in Medicaid rates in over 20 years. Without a realistic reimbursement structure based on current cost of living, centers are losing staff who can no longer afford to work in mental health settings. Some mental health centers are reporting a 40% turnover in staffing, during the pandemic, leaving no workforce available to attend to the critical and fragile needs of pediatric patients. And for the mental health workforce that remains, they are often left supporting higher caseloads than their private practice peers, with limited time while attending to significant administrative tasks that private mental health providers are not expected to complete.

While we can discuss an ideal service array, evidence-based practices, and the ideal care setting, none of this can be provided without a robust, well-trained, adequately compensated, and sustainable mental health workforce from all professional disciplines and degree levels. Simply put, we need to be able to adequately compensate the mental health workforce in order to have a sustainable and robust mental health workforce to provide high quality, timely, adequate care to our pediatric population.

Mental healthcare needs to be both accessible and realistic. A continuum of care must include prevention, intervention, and education. As schools return to in-person learning environments, teachers, paraprofessionals, guidance counselors, and building administrators are witnessing the exacerbated mental health needs of the students entering school buildings every day. Faced with the added pressures of testing students and overwhelming them with missed academic instruction, teachers report feeling professionally stretched and uncertain of how to support the social and emotional health needs of students. Teachers are not provided training on pediatric mental illness. Teachers do not know how to intervene. A component of prevention should be affording schools the professional development time needed to better understand pediatric mental health and for educators to become certified in Youth Mental Health First Aid. Youth Mental Health First Aid would provide educators with a foundational understanding of the signs and symptoms of an emerging mental health need, how to offer timely support, and bridging a student to the appropriate mental health professional and level of care to attend to the student's mental health needs.

There is no one size fits all option for mental healthcare. The pandemic created the opportunity to reduce barriers to accessing care with the expansion of telehealth services. In addition to telehealth, mental healthcare provided in the office, home, community, and school settings needs to be supported and adequately reimbursed for by both Medicaid and private payers. Different levels of care need to exist within the intervention continuum. Traditional office-based therapy does not meet all mental health needs and not all pediatric mental health patients will require an inpatient level of care. Intensive outpatient or partial hospitalization programs need to be established and adequately funded to be sustained in the mental health treatment continuum. Mental health providers should be adequately reimbursed by all payers to sustain a variety of treatment and programming options. And,

evidenced based practices should be reimbursed at enhanced rates to account for the required clinical consultation, professional development, and time to complete required fidelity implementation reviews.

A bipartisan spirit to adequately fund pediatric mental health services is one of many ways to address the growing pediatric mental health surge. Care must be affordable, available, and mental health providers must be adequately reimbursed to sustain a mental healthcare workforce. Telehealth and telephonic services must remain an option within the service array to reduce barriers to accessing care, but not be the primary option for care delivery. But we must erase the stigma associated with mental illness to make a meaningful impact! The stigma and shame that continues to persist for individuals struggling with mental illness continues to be a significant barrier to recognizing the need for and accessing mental healthcare. Respect, compassion, and patience must be afforded to every person struggling with their mental health. We must all act as ambassadors for reducing the stigma associated with having a mental illness and accessing appropriate care. One in five individuals will struggle with a serious mental illness, yet most individuals will delay accessing care for ten years after the onset of symptoms. Fifty percent of all lifetime mental illness begins by age 14 and 75% by age 24. We have an obligation to provide prevention and early intervention and to offer hope and recovery for all children and adolescents struggling with their mental health. We know that suicide is the second leading cause of death among people age 10-34, yet we continue to stigmatize those who seek care. We continue to shame those with struggle. Until we can acknowledge, treat, and offer respect to all individuals with mental illnesses and offer mental health patients the same respect we would provide any individual receiving care for a physical health issue, we will never be able to make a meaningful difference. We all need to challenge the stigma that persists. We all need to advocate on behalf of those who are struggling with their mental health because at any moment, they could be us, our child, or a loved one.

Respectfully submitted,

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