Communities in Need: Legislation to Support Mental Health and Wellbeing
United States House Committee on Energy and Commerce
Subcommittee on Health
April 5, 2022

Written testimony of
Steven Adelsheim, MD

Director, Stanford Center for Youth Mental Health and Wellbeing
Associate Chair for Community Engagement
Clinical Professor of Psychiatry and Behavioral Sciences

Stanford Medicine/Stanford Children's Health

Chairwoman Eshoo, Ranking Member Guthrie, and Members of the Committee:

Thank you all for holding this important hearing and for your ongoing commitment to improving the mental wellbeing of our nation's youngest citizens. I also want to thank you, Chairwoman Eshoo, for your continued commitment to children's health.

My name is Doctor Steven Adelsheim. I am a child/adolescent/adult psychiatrist, a Clinical Professor & Associate Chair for Community Engagement at Stanford's Department of Psychiatry & Behavioral Sciences, where I direct the Center for Youth Mental Health and Wellbeing. Our Center is spearheading a new national vision for adolescent and young adult wellness and mental health support that includes early intervention for mental health, community education and advocacy, best practices for media and mental health, youth development, and suicide prevention. We envision a new culture of health for adolescents and young adults and are creating a model for the country to better support our young people in navigating the transition into adulthood and realizing their full potential as adults.

My career has focused on creating access to early mental health care through expanding early detection/early intervention programs for young people. This work has led me to focus initially on the development of school mental health services, including through the integrated care structures of school-based health centers (SBHCs). I have also worked on a local, state and national level on the development of programs for young people at clinical high risk for or facing an episode of early psychosis. Most recently I have been working to bring a model of integrated youth mental health care to the United States (U.S.) called allcove, which has been developed with international support from a model promoted by the World Economic Forum. I also founded and co-lead the Psychosis-Risk and Early Psychosis Program Network (PEPPNET), the national clinical network for early psychosis. In addition, I co-direct the Media and Mental Health Initiative in Stanford's Psychiatry Department and actively work in the areas of youth suicide prevention, tribal mental health, integrated care, and telehealth.

Prior to coming to Stanford, I spent over 25 years in New Mexico, where I served as a Clinical Professor at the University of New Mexico (UNM) Department of Psychiatry. While there I served for many years as the New Mexico State School Mental Health Officer, a Telehealth Commissioner, and the New Mexico Psychiatric Medical Director. I also developed and led the Center for Rural and Community Behavioral Health at the UNM Department of Psychiatry.

The Youth Mental Health Crisis

Data shows American youth are suffering and have been struggling prior to the onset of the COVID-19 pandemic. According to the National Center for Health Statistics (NCHS), the rate of suicide among those aged 10 to 24 increased nearly 60% between 2007 and 2017. Between 2007 and 2013, the suicide rate for young people grew at an average rate of 3% per year but between 2013 and 2017, that number shot up to 7% per year. For children aged 10 to 14, the suicide rate tripled between 2007 and 2017, after years of decline (Curtin & Heron, 2019).

According to the Centers for Disease Control and Prevention, more students experienced persistent feelings of sadness or hopelessness from 2009 through 2019, regardless of race/ethnicity; and more than 1 in 3 students and almost half of female students reported persistent feelings of sadness or hopelessness in 2019. (Centers for Disease Control and Prevention [CDC], 2020). According to recent CDC data, released last week, in 2021 those numbers rose to 1 and 4 teens reporting persistent feelings of sadness or hopelessness and 1 in 5 reporting that they have contemplated suicide (CDC, 2022).

Since the pandemic we have only seen increases in the need for mental health support for our children, youth and families across the lifespan. Looking at the period after COVID-19, there was a greater than 50% increase in suspected suicide attempts leading to emergency department visits among girls ages 12 to 17 in the beginning of 2021 as compared to the same period in 2019 (Yard et al., 2021). According to a recent study in Pediatrics, during the first 12 months of the pandemic, the number of hospital admissions among adolescents with eating disorders more than doubled (Otto et al., 2021). Suicide is now the second-leading cause of death for people ages 10 to 24 (The American Association of Suicidology, 2021). The status of youth mental health appears to be approaching a breaking point. Given the many losses that our young people and our families have faced over the past 2 years, whether losses of family members, losses of income, or losses of connection, we are facing an unprecedented mental health crisis when it comes to addressing the needs of our youth. As we know, rates of depression, anxiety, and suicide attempts have risen to rates we have not seen previously.

The state of youth mental health is so dire that, last fall, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics and the Children's Hospital Association declared a national emergency in child and adolescent mental health. Together, they launched the Sound the Alarm for Kids initiative which continues to raise the visibility of the children's mental health crisis.

The dominant presence of social media in the lives of young people is another factor that appears to be influencing their mental health. Social media offers an important source of connection, entertainment, and emotional support for youth. On the flip side, exposure to online risks such as bullying, hate speech, graphic content, and unrealistic body images can degrade mental health, with risks seemingly higher for more vulnerable populations, including those in the LGBTQ+ community, youth of color, and those susceptible to self-harm and/or disordered eating. Efforts to reduce these harms have been slow and ineffective to date, leaving many young people to navigate these difficult challenges on their own.

While we have long known that half of all lifetime cases of mental illness have their onset by the age of 14 (Kessler, 2005), our country has yet to make the commitment to create the public mental health system our children and families have sorely needed. Even now, when it is clear that successfully identifying and treating youth with mental health issues early is key to fostering their lifelong emotional and mental wellbeing, the current U.S. health system continues to pose many barriers for youth to access the help they need.

The challenges we have faced for many years in developing the workforce to provide the critical support for our young people, decreasing the stigma surrounding mental health, and ensuring parity for mental health services have all contributed to the difficult situation we now face in addressing the needs of our young people and their families. If there has been any silver lining in this pandemic it is the current national recognition of the mental health needs of our children and young people and a renewed commitment to mental health support across the country. Many of the bills under consideration today reflect this recognition and prioritization. My colleagues and I are grateful for your leadership in recognizing these needs, which have been at a crisis point for so long, and appreciate the opportunity to successfully address them together.

Expanding Prevention and Early Intervention Services

School Mental Health and School-Based Health Centers

Addressing mental health conditions early is as important as early intervention for any other medical issue. Directing school mental health programs in New Mexico for many years, our focus was on creating early mental health services in the setting where students were found on a daily basis. Our screening efforts, built into our school-based health centers, allowed for early recognition and support for young people when issues began, rather than waiting for the need for crisis intervention, which is usually through an emergency room or crisis unit if one is available. It is exciting to see the legislation now supporting the expansion of school mental health programs rapidly across the US.

Integrating mental health and primary care access continues to be a major national priority through the evidence-based pediatric mental health access programs and the collaborative care model. Both are critical in expanding access to early mental health supports for our children and youth, while also expanding the capacity of our primary care providers to comfortably provide care to those with early mental health challenges through timely consultations with mental health professionals. While not often recognized as such, SBHCs are also important integrated care settings. In my 16 years working in SBHCs, it was clear that many young people preferred integrated care services for several reasons, even within schools. For example, youth are often more comfortable going to a center where those in the waiting room could be awaiting a visit for a multitude of services, rather than being seen walking into the "mental health clinic". Some young people have difficulty recognizing and acknowledging their mental health challenges, or present initially with somatic symptoms such as headaches or stomach aches. Seeing a primary care provider in the integrated center first and recognizing, with that provider's support, the underlying mental health issue, allows for a comfortable warm handoff and referral across the hall to the behavioral health specialist. Many mental health problems have both medical and mental health components such as eating disorders or traumatic incidents with medical outcomes. There is great value in creating centers where youth access the medical and mental health aspects of their conditions in one location.

allcove: Integrated Youth Mental Health Centers

While school mental health services are critical first access points, an additional component of the early intervention continuum is the community-based integrated youth mental health program. Modeled after the international success of headspace and Orygen Global in Australia, Foundry in British Columbia, and Jigsaw in Ireland, allcove is being developed in the U.S. by our Stanford Center team as a network of physical centers, designed by and for youth, where anyone can access a range of emotional, physical and social services-all on one's own terms. allcove centers engage youth with direct-to-youth marketing strategies, help detect, prevent, and treat mild to moderate mental health needs, and connect young people to the community behavioral health system for more intensive interventions. allcove centers are designed with, by, and for youth to reduce stigma, embrace mental wellness, increase community connection, and provide access to culturally-responsive services. allcove services include mental and physical health, substance use, peer support, supported education and employment, and family support. The first two allcove centers opened in the summer of 2021 in Santa Clara County, California, with 5 more centers currently being developed across the state. Communities in Arizona, Texas, Pennsylvania, Maryland, and Florida are also considering allcove implementation.

Clinical High Risk and Early Psychosis Programs

Having worked in early psychosis programs for over 10 years, I have seen many young people thrive in school and employment as a result of the early intervention services they received in clinical high risk and early psychosis intervention programs. I am grateful for the federal support of these critical models of early intervention, including funding from the Mental Health Block Grant, which has helped grow these programs from 25 in 2008 to over 350 today. This funding has been critical to keeping young people out of hospitals and in the community. One area where additional focus would be helpful in is in the expansion of these programs to recognize and support young people even earlier, such as in secondary schools. Expanding awareness of the early warning signs of psychotic illness to school health and mental health professionals, utilizing effective screening tools for earlier detection when appropriate, and expanding training for the youth mental health workforce in early symptom recognition will go a long way to even earlier identification of youth needing these critical services, leading to even better outcomes over time. While this year's omnibus appropriations bill allows for some focused funding for those at clinical high risk for psychosis, many more dollars are needed to create the opportunities necessary to bring young people into this care earlier, which has the potential to delay and, perhaps, even prevent movement into a psychotic illness.

Facilitating youth mental health care from school-based programs to integrated youth mental health programs to early psychosis programs together enables critical early support for the entire continuum of care. We have the opportunity to create this continuum in an integrated care structure that will allow for early intervention, decreasing the later need for more expensive and intensive services. At the same time, some of the legislation you are considering provides critical services for those with serious emotional disturbance and provides a critical

link between early intervention services and a higher level of care. Given the current focus on supporting the entire service continuum as seen in the **Strengthen Kids Mental Health Now Act,** it is also critical to create funding mechanisms that would allow for payment to providers for mental health supports and services even prior to the time of diagnosis. This financial restructuring process would allow for young people to not have to wait until their condition becomes very serious before accessing the preventive/early intervention care that could keep them on track, in school, at home, and out of trouble.

Infrastructure and Financing Challenges

Finances and Parity

The low reimbursement rates for mental health services are truly harming our children and youth who might be able to otherwise access mental health supports. Due to the requirement for a diagnosis to get reimbursement for mental health treatment and the very low rates, most programs and providers have no incentive to provide the preventive and early intervention care that would decrease the need for additional beds, hospitalizations, and more intensive services. We could be choosing to invest in the upstream system to help more children and youth become successful adults across our communities. Also, by raising Medicaid reimbursement rates to align with Medicare reimbursements we are making the choice to equally value the wellbeing of our youth early and increasing their opportunities for successful and productive lives. It is time we placed equal value on the treatment of our children so they will need less service and treatment as adults. We are overdue in providing our children and youth the opportunities they deserve to access the preventive mental health support they need, just as they might access other medical preventive interventions. Recent reports by the Government Accountability Office and others continue to demonstrate the violations of the Mental Health Parity and Addiction Equity Act (MHPAEA). We need to create better opportunities to ensure monitoring and compliance in order to improve access to mental health care by the insured community.

Higher Levels of Mental Health Care for Children and Adolescents

Since we have not yet expanded our public mental health early intervention system for our children and youth, we find that most people do not attempt to access mental health care until there is a crisis. Frequently these suicide attempts, drug overdoses, or other crises lead to visits to already overcrowded Emergency Departments. Due to the current lack of beds to support youth mental health needs and the lack of intensive outpatient programs, many of our young people are forced to board in emergency rooms awaiting placement. While boarding, children are not yet receiving the specialized treatment they need for their mental health conditions. Frequently, even after a hospitalization, young people struggle to find access to the appropriate level of outpatient behavioral health care, often leading to an endless cycle of returning emergency room visits. There is urgency in making these higher levels of care more accessible through investments in pediatric mental health infrastructure, including inpatient care for those

who require it, and funding for the creation of programs such as partial hospitalization, day programs, and intensive outpatient services, which can prevent hospitalizations and help children transition back home after a hospitalization.

Workforce Issues

The need to expand the child and adolescent mental health workforce cannot be overstated. And as a result of COVID, many behavioral health providers are struggling to stay afloat after years of supporting overwhelming numbers of families in need, while also working to support their own families and individual wellbeing. Every mental health provider will tell you about the daily calls and requests from colleagues, relatives, or friends begging for help in finding someone to see their child in crisis, "even within the next month". This lack of access to urgent pediatric medical care would not be acceptable for asthma, diabetes or any other medical condition but is the current situation for those trying to access treatment for even severe depression, anxiety, or other mental health challenges. We urgently need to build out the workforce quickly and effectively. We must do better.

A critical component of workforce development will be the importance of creating behavioral health workforce pipelines to support those from underserved communities. The pandemic has highlighted existing disparities for children of color in mental health outcomes and access to high-quality mental health care services. For example, the Congressional Black Caucus found that the rate of death by suicide was growing at a faster rate among black children and adolescents, and that black children were more than twice as likely to die by suicide before age 13 than their white peers. (Ring the Alarm). Studies of Latino communities have found higher reported rates of depression symptoms and thoughts of suicide among Latino youth, but comparatively lower rates of mental health care utilization. As reported in Pediatrics in October of 2021, more than 140,000 children in the United States lost a primary or secondary caregiver to COVID-19, and youth of color were more likely to have experienced a loss. (NIH article on study). As legislation is approved to address the crisis in child and adolescent mental health, it is critical to ensure that behavioral health workforce opportunities as well as interventions reach communities of color, thereby connecting children with culturally competent, developmentally appropriate care.

Critical Program Supports

Suicide Prevention Efforts

Having worked for many years in youth suicide prevention and postvention in New Mexico and California, I have come to appreciate the importance of the Garrett Lee Smith suicide prevention efforts. Having been a recipient of the very first round of this funding to support rural New Mexico, we were able to expand suicide prevention efforts by funding rural suicide prevention coordinators in schools, in addition to on-site school therapists, with the addition of televideo child psychiatry backup from the UNM child psychiatry team. This structure allowed

for many young people from rural and tribal communities in the state to obtain culturally appropriate services, while also supporting the capacity of rural providers to have access to additional supports when necessary. In both New Mexico and California, I have had the opportunity to partner with Native health and mental health agencies on their Garrett Lee Smith grants and have been fortunate to learn the importance of grounding intervention and support for youth and families in the culture and traditions of each individual community. These suicide prevention programs are critical and need to be expanded, especially given the isolation COVID has brought to many tribal families and rural communities.

Furthermore, as someone who has worked closely with communities in both New Mexico and California in responding directly to the challenges of youth suicide contagion, it is urgent for us to directly address the impact of media in increasing youth suicide risk. While our suicide prevention organizations have developed and disseminated effective guidelines for media to use in writing about suicide, these guidelines are frequently not followed, often leading to increasing risk of more losses of young people to suicide. It is imperative for us to partner with the media in educating journalists about their potential power to save lives by simply following these guidelines or increasing the risk of suicide contagion by not following them. The recent release of the TEMPOS Tool (Sorenson et al 2022) provides a simple and rapid way for those writing about suicide to ensure their articles effectively meet the guidelines and minimize the potential to harm youth. Furthermore, evidence-based guidelines like #chatsafe, developed with youth across Australia (Robinson et al) and shared now internationally, provide a roadmap for young people to safely discuss suicide related topics online. More training, evaluation and integration with media platforms is needed to reduce harms at scale.

American Indian/Alaska Native and Tribal Mental Health Support

I have had the opportunity to work with and learn from many Native and Tribal members over my career. For those in rural communities , COVID has increased disparities in access to clinical services at a time of increasing loss, trauma and isolation for many families. Programs and funding that serve to increase rural mental health, telebehavioral health, connectivity to rural communities, and expansion of the Native workforce, need to be implemented immediately. Furthermore, both urban and rural Native-focused health and mental health programs need the opportunity to directly access enhanced federal funding to support their communities and programs. Particularly in rural Tribal communities, access to longer term treatment for Native youth with more intensive mental health needs are difficult to find, especially if looking for programs that are grounded in Native culture and have a co-occurring disorders treatment component. In some cases, where federal block grant programs run directly through states, access to critical mental health funds is challenging for smaller or isolated Tribal mental health programs. For rural communities it is important to create more local training opportunities for development of peer support specialists who might help other community members navigate their way to care and healing. Having worked in partnership with Indian Health Service (IHS) colleagues in developing the IHS Center of Excellence in Telebehavioral Health, the importance of enhancing both access to direct televideo behavioral health care and consultation and training, such as through Project ECHO models, must be enhanced to reach those Tribal

partners and Native community members with increasing need. Furthermore, we must support each Tribal program and community in providing the appropriate healing ceremonies and traditions for their people and find ways to financially support reimbursement for these critical cultural interventions when requested by the community.

Rural Mental Health Supports

Rural communities have been especially hard hit during the pandemic. Many children lost contact with friends and many families faced additional losses, such as lost loved ones due to COVID, lost jobs, and opportunity. The lack of equity in terms of connectivity for internet and televideo access for rural schools and mental health providers has also created additional challenges. Legislation that will support expanded televideo access and allow for the capacity to build connectivity support for rural communities is critical, especially during this period. Due to the difficulty finding and retaining skilled mental health specialty providers in rural areas, models such as pediatric behavioral health support for primary care providers and the collaborative care model take on additional urgency in rural communities. Furthermore, for those rural communities with behavioral health support, expanding televideo backup and consultation becomes a critical strategy to provide isolated and occasionally overwhelmed rural providers with the support they need to remain in their critical community roles, providing urgently needed care by a familiar and trusted community member.

Engaging Youth Voice in Service Systems

Finally, it is essential to bring youth into the conversation and planning processes of standing up new community-based services and systems. As our team has developed the allcove program we have based the entire program, including the name and design, on the vision and voice of young people. We have found listening to the voices of young people to be crucial in the advocacy and design of youth-friendly spaces. When organizations and centers delegate resources to involve youth in the development process, all parties benefit in this exchange. When collaborating with young people who match the diversity of their community, providers are given an inside understanding of the unique challenges and experiences of youth as they navigate the world. Improving the youth friendliness of mental health and substance use services includes incorporating youth voice in organization, policy, environment, service providers, and treatment services, and has implications for treatment uptake, engagement and satisfaction (Hawke et al., 2019). Furthermore, it has become increasingly important to recognize the important roles youth play in supporting each other. Young people often turn to each other first to get support when facing mental health challenges rather than their families, school professionals, or others. Since so many youth go to their friends first, one important opportunity we have now is to equip our youth with the skills they need to provide safe support to each other, including the knowledge and understanding of when and how to link that friend to a caring and supportive adult for a higher level of intervention.

Many of our Youth Advisors have lived experience of their own with mental health issues or are relatives of someone living with a mental illness. Those with lived experience who have navigated mental health systems or have found ways to effectively move to wellness, resiliency, and recovery have much to offer all of us in facing mental health challenges. As a result of serving as allcove Youth Advisory Group members, several of our advisors have gone on to begin careers as peer support specialists in the behavioral health workforce. This transition has proven a valuable one in bringing diverse young people into behavioral health, with the hope they will choose to move on to obtain additional training and expertise to better serve their own communities. We have also come to realize that the type of peer support youth find helpful when involved in early intervention programs may involve a slightly different skill set that one focused on supporting those facing higher levels of care. In either situation, the role peer support specialists play are key in helping many youth comfortably navigate the mental health system.

Conclusion

While we are constantly reminded that half of all mental health conditions have their onset by the age of 14, we have never made the effort in this country to create the continuum of public mental health supports our young people need to grow and thrive. We faced a pediatric mental health crisis before COVID, which has only been exacerbated by this pandemic. Today we have a tremendous opportunity as a nation to take the critical steps to recognize the voice, wishes and pleas of our children and families to create the opportunities for mental health access, service, and infrastructure we have needed for so long. I hope you will take this important opportunity to see prioritization of the mental health needs of our pediatric population as an investment in the future adults of our country. I thank you all for the opportunity to share these concerns and recommendations today.

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