American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Testimony of Sandy Chung, MD, FAAP
President-Elect, American Academy of Pediatrics
On Behalf of the American Academy of Pediatrics

Before the U.S. House of Representatives
Committee on Energy and Commerce

"Communities in Need: Legislation to Support Mental Health and Well-Being"

April 5, 2022

Chairwoman Eshoo and Ranking Member Guthrie, thank you for the opportunity to testify here today. I am Dr Sandy Chung, President-Elect of the American Academy of Pediatrics. I am President of Fairfax Pediatric Associates, and the CEO of Trusted Doctors, a pediatric group with over 120 clinicians in 22 locations in northern Virginia and Maryland. I am the founder and medical director of the Virginia Mental Health Access Program and serve as medical director of informatics for the Pediatric Health Network at Children's National Hospital in Washington, D.C. I also serve as a clinical assistant professor at Georgetown University School of Medicine and associate professor at Virginia Commonwealth University School of Medicine and University of Virginia. On behalf of the AAP, a non-profit professional organization of 67,000 primary care and subspecialty pediatricians, thank you for inviting me to be here today.

The COVID-19 pandemic has had a profound effect on the emotional and behavioral health needs of children, adolescents, and families. There are many factors unique to this pandemic (e.g., duration of the crisis, rapidly changing and conflicting messages, need for quarantine and physical isolation, and uncertainty about the future) that have increased its effects on emotional and behavioral health. Groups with a higher baseline risk, such as populations of color, communities and families living in poverty, historically under resourced communities, children who are refugees or seeking asylum, children and youth with special health care needs, and children involved with the child welfare and juvenile justice systems, may be especially vulnerable to these effects. The impact of the pandemic is also compounded by the interruption in vital supports and services including school, health care services, and other community supports.

Emotional and behavioral health challenges were at a crisis point before the COVID-19 pandemic, and the public health emergency has acutely exacerbated these challenges. The pandemic highlights preexisting disparities in morbidity and mortality, access to health care, quality education, affordable housing, adequate nutrition, and safe environments, which create more challenges and stressors for many families and communities. Already high rates of anxiety, depression, and post-traumatic symptoms among children grew even faster during the pandemic, especially among young people of color.

Suicide is the second leading cause of death of youth ages 10-24 in the U.S. and rates have been rising for decades.[iii] Between March and October 2020, the percentage of emergency department visits for children with mental health emergencies rose by 24% for children ages 5-11 and 31% for children ages 12-17.[iii] The CDC also found a more than 50% increase in suspected suicide attempt Emergency Department (ED) visits among girls ages 12-17 in early 2021 as compared to the same period in 2019.[iv] Among female adolescents, ED visits for eating disorders doubled during the pandemic, while visits for tic disorders (ie, sudden twitches or repeated movements) tripled.[v] Stressors such as social isolation, loss and grief, academic and extracurricular disengagement, interruptions in social/health services, and financial hardships have impacted mental health. At least 10 million youth in the US experienced economic instability during the pandemic, with 14% of families with children reporting food insecurity.[vi]

More than 140,000 US children and adolescents lost a primary or secondary caregiver to COVID-19, with youth of color disproportionately impacted.[vii] Loss of a parent or caregiver is a significant trauma and adverse childhood event that can lead to poor long-term health outcomes into adulthood. Special attention must be paid to support these children who face higher risks to their health, safety, and well-being.

Compounding these challenges is our nation's ongoing reckoning with systemic racism and related violence, which disproportionately impacts the mental health, physical well-being, and trajectory of educational

achievement for children and adolescents from Black, Latinx, American Indian/Alaska Native, and Asian American/Pacific Islander communities.[viii] These ongoing stressors have the potential to impact children's development and resilience for years to come.

In light of the mental health crisis, the AAP, along with the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association, declared a National State of Emergency in Children's Mental Health last fall. The challenges facing children and adolescents are so widespread that we are naming the situation exactly what it is, a national emergency for children and adolescents. We must identify strategies to meet these challenges through innovation and action, using state, local and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment.

Most recently, the AAP and the American Foundation for Suicide Prevention, in collaboration with experts from the National Institute of Mental Health, released the Blueprint for Youth Suicide Prevention– an educational resource to support clinicians in identifying strategies to support youth at risk for suicide. The blueprint represents the first major interdisciplinary effort to infuse suicide risk reducing strategies into pediatric care and youth community settings.[ix]

Now more than ever, families and children from infancy through adolescence need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services, including trauma-informed care, to appropriately address their mental and behavioral health needs. Tackling the pediatric mental health crisis requires a comprehensive approach that addresses the full continuum of healthy mental development and includes promotion and prevention, early intervention and treatment, as well as crisis response. To do this, we must ensure that children are able to access care in the settings where they are: schools and early childcare settings, their pediatrician's office, community settings, and emergency departments. This is especially important given the serious shortages of pediatric mental health professionals, which is impeding access to care for children.

Unique Needs of Children and Adolescents

From prevention to early identification to treatment to crisis intervention, our mental health care system must address the full continuum of children's needs. Children are not little adults, and the behavioral health care needs of children differ from those of adults.

For example, when a young child experiences anxiety, they are more likely to show symptoms such as disrupted sleep, toileting issues, feeding refusal, regression in skills, or being more irritable. Young children may not be able to verbally express what they are feeling. Older children and adolescents may first show symptoms of anxiety or depression at the doctor's office with chronic stomachaches or recurrent headaches. Since children and adolescents are still developing skills, and treatments need to be appropriate for age, they may feel shame or be afraid to share what they are thinking since they may feel that they must meet expectations of their caregivers or shoulder the responsibility of solving their own problems. Because adolescents do not yet have as full functioning of an executive part of their brain as an adult does, they are less able to control impulses compared to adults, sometimes with disastrous consequences.

Solutions for adults are not the same as solutions for children. Half of the adults in the United States with a mental health disorder had symptoms by the age of 14 years.[x] And, 75% of mental health disorders occur before age 24.[xi] Children whose mental health needs go unaddressed grow into adults whose needs are also likely to be unaddressed and more severe.

Additionally, children's emotional and behavioral health is greatly impacted by that of their parents and caregivers. Parents and caregivers experiencing their own mental health problems, health issues, substance use disorder, or increased stress due to loss of income, housing, and access to nutrition and other supports during the pandemic may impact the emotional health of children and adolescents. The mental health system must be prepared to meet the needs of whole families, not just individuals. Oftentimes it is impossible to treat a child's mental health issues without involving the family, especially if a parent or family member has their own mental health or substance use challenges. Dyadic/family-focused therapies (e.g., treatment for maternal depression or parental substance use) can be effective in treating the mental health needs of families. Parenting education is often the preferred first line of treatment for many pediatric behavioral concerns, especially for younger children, as the presence of a safe, stable, and nurturing adult in a child's life can buffer adversity and build capacity for resilience, potentially changing the trajectory of a child's outcome. Embedding multigenerational integrated behavioral health services in primary care settings, such as parenting/development/behavior specialists, could help to identify and address child, family, and community needs.

Role of the Pediatrician

Pediatric primary care clinicians have unique opportunities to improve the mental health of children and adolescents: preventing mental health problems by guiding parents in safe, stable and responsive caregiving that nurtures child resilience and appropriate responses to behavioral issues; identifying mental health symptoms as they emerge; intervening early, before symptoms have evolved into disorders; managing more common conditions themselves; facilitating referral of children, adolescents, and their family members when mental health or substance use specialty services are needed; collaborating with child and adolescent psychiatrists, developmental and behavioral pediatricians and other mental health professionals in caring for children with severely impairing mental health and substance use disorders; and coordinating the primary and specialty care of children with mental health conditions and substance use disorders, as they do for children with other special health care needs.

Primary care clinicians see children and their caregivers 15 times between birth and 5 years of age for well visits and at least annually thereafter. Because primary care clinicians are familiar with developmentally appropriate behavior, they are able to distinguish between typical behaviors and concerning behaviors as children grow and age and intervene to prevent disorders. Behavioral health screening should be a required standard of care, independent of provider, patient, or parent biases.

Given the workforce shortage and increased number of children and adolescents presenting in primary care offices with mental health symptoms, pediatricians have had to take on a larger role in the assessment and management of mental and behavioral health issues. However, pediatricians routinely report that their training programs did not adequately train them to provide this care, and they may lack the confidence to do so. For example, when I was completing my training in pediatrics, I was taught to refer any patients with mental health conditions, as pediatricians did not treat conditions like anxiety or depression in their patients.

However, with the shortage of pediatric mental health providers, it often takes 4-6 months on average for my patients to be connected with a mental health specialist who can treat their issues. This is true in my urban practice area, however, patients in rural areas face even longer wait times for specialized care.

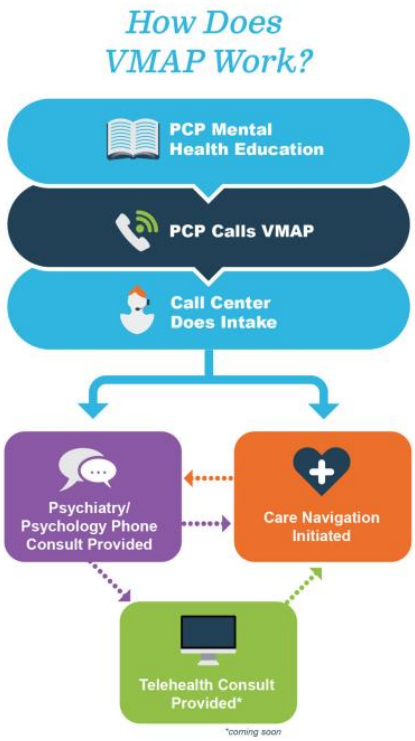
AACAP estimates that we need nearly four times the number of child psychiatrists as we have today to meet the demand for these services.[20] Wait times for pediatric mental health services are increasing across the country, pushing many families to sign up for multiple wait lists, to pay in cash instead of waiting for care that would take insurance, and ultimately to seek help at the emergency department.[21] This trend is increasing the strain on overtaxed emergency departments, which have seen significant increases in wait-times for pediatric mental health emergencies, with children and adolescents waiting hours—and often days—for treatment.[22,23] For many families, the barriers to pediatric mental health care are insurmountable: an estimated 50-75% of youth with mental health conditions receive no treatment at all.[24,25]

In this midst of this crisis, pediatricians are increasingly taking on the management of mental health symptoms and conditions in primary and subspecialty care practice. A study in *Pediatrics* found that primary care pediatricians are the sole physician care-managers for approximately one-third of US children with mental health disorders.[26] During the COVID-19 pandemic, pediatric practices reported a decrease in visits for acute physical illnesses, but an increase in visits focused on mental health concerns.[27] However, 2019 data from the AAP Periodic Survey of Fellows found that only 22% of primary care pediatricians have an on-site mental health provider in their practice.

Pediatric Mental Health Care Access Program

Several years ago, I had a 14-year-old patient who suffered from bipolar disease. His child psychiatrist had just retired and his family called our practice to see if we could refill his medications while they waited several months for the next available appointment with another child psychiatrist. He was on five very complex psychiatric medications which pediatricians do not typically prescribe or manage. So, instead of refilling medications that we did not know how to use, our staff called multiple places and helped the family find an earlier appointment in four weeks. Unfortunately, during that time, he ran out of his medications, and he had an exacerbation of his disease. In a parking lot near my office, he got into a fight with a man and, unfortunately, had a gun. He shot and killed the man. Now this adolescent is in jail. I believed this tragedy could have been prevented and I started to search for solutions.

This led me to work with stakeholders across our state to found the Virginia Mental Health Access Program (VMAP), which is a statewide initiative that helps health care providers take better care of children and adolescents with mental health conditions through provider education and increasing access to child psychiatrists, psychologists, social workers, and care navigators. VMAP gives primary care providers the training and tools they need to serve children and young adults with mental health needs. This includes year-round education opportunities and access to on-call child and adolescent psychiatrists 40 hours a week. Now, if a primary care provider encounters a patient with depression or anxiety and has a question about how to manage care, they can be connected with a child and adolescent psychiatrist who can answer their question within 30 minutes and enable the primary care provider to manage care for the patient nearly immediately without a referral.



In 2018, Virginia received a HRSA grant to support VMAP. Virginia is just one of the 45 states, D.C., tribal organizations, and territories that have received a grant from HRSA to create or expand this type of program through the Pediatric Mental Health Care Access (PMHCA) program. The Pediatric Mental Health Care Access Program supports pediatric primary care practices with telehealth consultation by child mental health teams, thereby increasing access to mental health services for children and enhancing the capacity of pediatric primary care to screen, treat, and refer children with mental health concerns. Integrating mental health and primary care has been shown to substantially expand access to mental health care, improve health and functional outcomes, increase satisfaction with care, and achieve cost savings. Expanding the capacity of pediatric primary care providers to deliver behavioral health through mental and behavioral health consultation programs is one way to maximize a limited subspecialty workforce and to help ensure more children with emerging or diagnosed mental health disorders receive early and continuous treatment.

Congress's investment in the HRSA Pediatric Mental Health Care Access Program is paying off. A recent RAND study found that 12.3% of children in states with programs such as the ones funded under this HRSA program had received behavioral health services while only 9.5% of children in states without such programs received these services.[xii] The study's authors concluded that federal investments to substantially expand child psychiatric telephone consultation programs could significantly increase the number of children receiving mental health services. Programs funded by HRSA have increased pediatric provider capacity to screen, refer, or treat children's mental health, increased screening, incorporated health equity, and supported quality improvement.

Our state of Virginia has many examples of how programs funded by the HRSA Pediatric Mental Health Care Access Program are an effective investment in enhancing mental health care for children. A mother in Virginia came up to me to tell me how she has seen this impact firsthand. Several years ago, she went to her

pediatrician with her older child who was having mental health issues. At that time, the pediatrician did not know how to treat the child and referred them to a mental health specialist. We did not have VMAP. The parent had to do most of the work herself to find someone who would accept her child's insurance and it took almost a year for her child to receive treatment. This year, this same mother brought her younger child to the same pediatrician because the child was also showing signs of mental health issues. This time her child's pediatrician was able to connect with VMAP for a consult and treated her child right there in the office without a wait or need for referral to a psychiatrist.

AAP is a strong supporter of the *Supporting Children's Mental Health Care Access Act of 2022* (H.R. 7076), as it will reauthorize the HRSA Pediatric Mental Health Care Access Program for another five years at a level that allows HRSA to maintain all existing grantees and allows programs to expand the services they offer to additional settings, including schools and emergency departments. These are critically important sites for enhancing the availability of pediatric mental health team consultations because they are sites where children may present with mental health needs but there may not always be a pediatric mental health provider on site.

Prevention and Early Identification

We recommend Congress focus on comprehensive approaches to getting children, adolescents, and their families the supports they need to maintain emotional and behavioral health including trauma-informed care and community supports and services. By some estimates, as many as 19% of children have mental health symptoms that impair their functioning without meeting criteria for a disorder. Programs and funding that are limited to children with serious emotional disturbance miss a key opportunity to support early prevention and early intervention. For young people who have experienced significant or complex trauma, such as those in foster care, our current system makes it difficult to access services without applying diagnoses that do not fully capture their needs and can lead to fragmented and unnecessary care that does not address the root need they have. Similarly, lack of insurance payment for services for children and adolescents whose needs do not yet rise to the level of a diagnosis is a major barrier and contributes to the mental health crisis we are confronting. While some symptoms my patients have may ultimately become a diagnosable condition, the rigidity of federal funding and lack of insurance payment prevents support for those children and adolescents with emerging problems. As a pediatrician, I see this in my practice every day.

For example, nearly every day, I see children and adolescents who do not score high enough on our screening and diagnostic tools to warrant a formal diagnosis for anxiety, depression, or ADHD. However, they are clearly struggling at home, at school, with social interactions, or dealing with stress. Because they do not yet have a diagnosis, they do not qualify for programs at school where accommodations could be made to reduce triggers, or for therapy where insurers require a diagnosis of a disorder before treatment can begin. So, instead, these children and their families are left to struggle alone instead of receiving professional help and services.

AAP urges Congress to revisit funding restrictions such as those in the Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Services Block Grant that prevent federal funding from being able to support prevention and early identification. The current statute constrains federal funding of services for children to children with serious emotional disturbance. We would recommend expanding that definition to children with, *or at risk of*, serious emotional disturbance. We would also urge Congress to support major new investments in mental health promotion, prevention, early intervention and treatment for children and adolescents.

The Infant and Early Childhood Mental Health (IECMH) Grant Program administered by SAMHSA, improves outcomes for children aged zero to twelve by developing, maintaining, or enhancing evidence-informed, culturally appropriate IECMH services. The goal of the program is to ensure that children and families have access to a continuum of services, including prevention, early identification, early intervention, and treatment activities. **AAP strongly supports the *Supporting Children's Mental Health Care Access Act* (H.R. 7076) which reauthorizes the SAMHSA program for five years at a level that would allow for additional grantees.**

Increasing Integration, Coordination, and Access to Care

Important research shows that the integration of mental health and primary care makes a difference for infants, children, and adolescents in terms of expanded access to mental health care, improved health and functional outcomes, increased satisfaction with care, cost savings, and improved coordination among primary care clinicians and behavioral providers in clinics and school-based and community settings. Integration also allows for the primary care clinician to receive training that enables them to practice more advanced mental health care. Most integrated care efforts are funded through a patchwork of short-term public and private grants, limiting their reach and sustainability.

Best practices for integrating behavioral health with pediatric primary care recognize the medical home as a critical component of mental and behavioral health in a whole-person care approach. Mental health professionals should be included as members of the medical home team with participation in preventive, acute, and chronic care visits. Working in partnership with mental health practitioners to practice integrated care can improve care, enhance preventive services, lower costs, and strengthen the medical home. Incentives to integrate behavioral health with primary care should be created and funded, such as providing enhanced payment for services housed within a primary care setting. Co-location of mental health providers in primary care offices and schools is the gold standard of care and allows for warm handoffs and brief interventions at visits and effective referrals to psychiatric care when needed.

Pediatric primary care clinicians have a longitudinal, trusting relationship with patients and their parents. Given this special relationship, parents often seek joint visits with their trusted primary care physician and a mental health specialist. However, there is currently no payment model to support this type of visit. Allowing a specialist to provide a brief intervention with a pediatrician will increase access, allow intervention before symptoms reach the level of a disorder, and train pediatricians to better provide mental health care. Payment should be provided for behavioral health services embedded within primary care, on the same day as other primary care services. **AAP supports provisions of the *Strengthen Kids' Mental Health Now Act* (H.R. 7236) and the *Helping Kids Cope Act (H.R. 4944)* that would create grant programs to support pediatric behavioral health care integration and coordination.**

Barriers to the provision of integrated care should be eliminated. For example, in many clinical settings, co-located behavioral health providers cannot bill for a patient on the same day that the primary care clinician sees that patient (at least for the same mental health problem), making warm hand-offs extremely difficult. Different kinds of providers need to be able to bill for the same patient for the same diagnosis on the same day in order to promote integrated care.

Payment mechanisms that minimize fee-for-service/volume-based payment and encourage value-based, high-quality care, such as bundled or capitated payments or meaningful per member per month (PMPM) models, could encourage integration of behavioral health with primary care. It is critical that pediatric alternative payment models are designed to appropriately measure quality of care, long-term health outcomes, and the value of prevention to ensure that financial incentives support primary care practices investing in preventative care, early intervention, and behavioral health services.

Collaborative Care

The Collaborative Care Model integrates behavioral health care within the primary care setting and features a primary care physician, a psychiatric consultant, and care manager working together in a coordinated fashion. It is one of several models of integrated care that need a greater federal investment. Policies and models that expand the capacity of front-line pediatric and family medicine clinicians to respond to the mental health needs of children and adolescents, such as the HRSA Pediatric Mental Health Care Access Program and models that integrate a mental health or developmental specialist within a primary care practice, such as the Primary Care Behavioral Health Consultation model (PCBH), should also be supported. Unfortunately, billing for these models of integrated care often trigger a co-pay, co-insurance, or deductible for families. That should be eliminated as it serves as a barrier to access for families.

Care Coordination

Significant barriers exist to care coordination between mental health professionals and primary care clinicians. While coordination and communication take a lot of time, time spent coordinating care is often not paid for. Non-physicians are rarely able to be paid for care coordination and physicians are only able to bill for coordination with a specialist if the conversation with the specialist occurs on the same day as the patient's visit—which often proves to be impossible to schedule. Payment, without co-pays, co-insurance or deductibles for families, should be provided for care coordination activities such as time spent by pediatricians discussing a child's mental health with a behavioral health specialist, school staff, or family member whenever the consultation occurs.

Further, administrative barriers frequently prevent standardized communication between mental health professionals and primary care clinicians. Pediatricians report difficulty in care coordination in the school setting due to real or perceived barriers under Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA). Behavioral health specialists are often reluctant to share information with primary care clinicians, believing HIPAA proscribes such communication. Because mental health information is considered to be more protected than information about physical health, the rules for sharing information are perceived to be stricter. If a patient consents to having their provider or care team speak to other health professionals about their care, mental and behavioral health information should be included—separate consent should not be required for behavioral health information.

Navigators

Funding should also be available for primary care practices to hire care coordinators or navigators who help families navigate the often-complex mental health care system. Systems for care linkages and follow-ups, including referral to outpatient and community behavioral health centers should be created. Payment should also be provided for time spent addressing social drivers of health, such as nutrition, safety, transportation, and housing, which often impact mental health.

Family navigators and family support providers are key partners in addressing the spectrum of mental health needs in children and adolescents. Navigating the landscape of behavioral health care can often be difficult for families: dealing with limited provider networks, insurance, calling offices, finding appointment times are all time-consuming tasks. Family navigators, partnering with primary care and mental health, assist families in understanding and keeping up with their array of services, identifying community resources, and following up with recommendations. Home visitors similarly help with screenings, referral to other services, and coordination, and also support implementing strategies in the home environment. These providers should collaborate and communicate with both the medical home and the family and should not serve as a substitute for high quality behavioral health intervention.

Workforce

Across the United States, there is a dire shortage of practitioners specializing in mental and behavioral health to care for infants, children, adolescents, and young adults. Prior to the pandemic, in 2020, SAMHSA estimated that 4.5 million additional behavioral health practitioners are needed to address the needs of children with serious emotional disturbances and adults with serious mental illness, including an additional 49,000 child and adolescent psychiatrists.[xiii] The gap between currently available child and adolescent providers including developmental-behavioral pediatricians and what is needed to provide evidence-based mental and behavioral health care for this population is stark. New incentives and opportunities are needed to quickly expand a diverse child and adolescent mental and behavioral health workforce. The shortage of providers with specialized training to treat mental health conditions in infants and toddlers is even more extreme. When working with children and families, it is very important for the provider to be trained in child development—children are not little adults.

The lack of sufficient providers, including child and adolescent psychiatrists, developmental-behavioral pediatricians, psychologists, and social workers, prevents patients from accessing needed behavioral health care services. Today, 50% of children with mental health conditions receive no treatment at all.[xiv] Pediatric patients trying to access services often face long wait times for a behavioral health appointment, long travel times to providers, or are unable to find a provider who accepts insurance. **AAP supports provisions of the *Strengthen Kids' Mental Health Now Act* (H.R. 7236) and the *Helping Kids Cope Act* (H.R. 4944) that would create pediatric behavioral health workforce training programs that would accelerate the time to licensure or enhance capabilities of the existing workforce for practitioners. Given the demand for such training by pediatricians, as well as the financial and other barriers to being able to receive it, we urge Congress to ensure that pediatricians are listed as eligible providers for behavioral health workforce training programs.**

Low payment rates for the provision of behavioral health services heavily contributes to the workforce shortage. For example, the fields of developmental and behavioral pediatrics and psychiatry have become more popular but the interest in these fields has not grown in part because of the length of training without the subsequent increase in salary. Trainees report economic disincentives to entering pediatric subspecialties because of the debt they will accrue. Providers must be adequately paid for the care they provide. Feedback from providers reflects that payment for mental and behavioral health services does not reflect the difficulty of the work performed by these providers. For example, I am paid better for treating a wart that takes 5 minutes than I am for spending an hour helping a child who is thinking about suicide.

Better utilizing pediatricians to provide care for behavioral health issues would also help to reduce the negative impacts of the behavioral health workforce shortage. Training programs should be established for general pediatricians and those going into subspecialty care to gain additional expertise in mental health promotion, prevention, diagnosis, and treatment so that pediatricians are competent to assess and manage mild to moderate mental and behavioral health conditions. Training in trauma-informed responses is critical for pediatricians, health systems and school personnel. The educational curriculum for pre-hospital personnel, emergency department physicians, staff, nurses, and trainees, including emergency medicine residents and pediatric emergency medicine fellows should include training to provide patient/family-centered, trauma-informed, and culturally appropriate mental and behavioral health care.

Access Considerations

Children and adolescents with behavioral health needs often face waiting times of several months to get an appointment (even in large cities with more developmental and behavioral pediatricians or child psychiatrists than most parts of the country), and this wait time often extends to many more months for children whose preferred language is not English. While more providers are needed to address the mental health needs of the pediatric population, payment rates for these services are a key barrier to both building the workforce and building practices. Many providers choose to work in cash-only practices that do not accept insurance because payment rates for mental health services are so low, especially for patients on Medicaid and CHIP. **AAP is strongly supportive of provisions in the *Strengthen Kids' Mental Health Now Act* (H.R. 7236) that would ensure payment parity for health care providers by matching Medicaid and Medicare payment rates for pediatric behavioral health services.**

Medicaid is designed to meet children's unique needs, particularly through its Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT). Together, the Medicaid equal access provision and the EPSDT benefit should ensure that children enrolled in this essential program have timely access to needed care, including mental health services. However, state Medicaid programs implement EPSDT and medical necessity determinations differently, a challenge exacerbated by the proliferation of Medicaid managed care plans with varied benefit designs and coverage limitations. In addition, previous rulemaking has failed to include guidelines for or assessment of mental health network adequacy and access to services for children. **AAP also strongly supports provisions of the *Strengthen Kids' Mental Health Now Act* (H.R. 7236) that would require HHS to issue guidance to states on how to support the provision of mental, emotional, and behavioral health services covered by state plans**.

In addition, to address the real and perceived barriers to payment for mental health care for children by Medicaid, **Congress should require CMS to provide guidance to states on Medicaid payment for evidence-based mental health services for children including those that promote integrated care.** The medical and behavioral health screenings provided to Medicaid-eligible children and adolescents under EPSDT are of particular importance for those being released from incarceration in the juvenile justice system. **AAP supports provisions of the Keeping Incarceration Discharges Streamlined for Children and Accommodating Resources in Education Act (H.R. 7233) that would help increase the timely provision of screening and needed referrals to these children to ensure continuity of care during the crucial community reentry period.**

Additionally, despite enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its subsequent expansions to Medicaid managed care, CHIP, and the health

insurance marketplaces, there has been a persistent need to improve oversight and compliance with the requirements of MHPAEA. Further, MHPAEA still needs to be expanded to children and adolescents enrolled in Medicaid fee-for-service arrangements. While new compliance measures included in recently passed legislation are promising, many children and adolescents still face barriers in accessing mental health and substance use disorder treatment due to insurance discrimination that singles out these services. Increased oversight is needed to ensure that insurers are complying with mental health parity laws to promote broader mental health insurance networks.

Children and Adolescents in Crisis

Clinicians are witnessing an alarming number of children and adolescents in behavioral health crisis, with emergency departments seeing increases in suicidal ideation and self-harm. From April to October 2020, hospitals across the U.S. saw a 24% increase in the proportion of mental health emergency department visits for children ages 5 to 11, and a 31% increase for children and adolescents ages 12 to 17. Behavioral health clinicians have reported over the last several years that children and adolescents are increasingly "boarding" in emergency departments for days because they do not have sufficient supports and services including inpatient hospital beds in psychiatry. In addition, research shows significant disparities in suicide rates, risk, and care for youth across cultures and communities; support is needed to enhance suicide prevention efforts for youth of color, youth who identify as LGBTQ, and youth from communities that have been marginalized or medically underserved.

AAP was pleased to support legislation expanding the Suicide Prevention Lifeline and is eager to see a successful, nationwide rollout of 988. To be successful, 988 should have 24/7 availability and be a crisis response system that is prepared and staffed to meet the needs of children in crisis. It needs to be able to connect children and adolescents to urgent mental and behavioral health services within a day if they are not emergent enough to go to the emergency department. It should account for how crisis symptoms present in children and adolescents across cultures and communities, must have specific pediatric and family-based training for crisis intervention teams, engage peer support, be able to refer children and adolescents to pediatric-specific care, and coordinate with the pediatric medical home.

Pediatric crisis intervention should be accessible for children, families, and pediatricians and be designed to meet the needs of particularly vulnerable populations such as LGBTQ youth, children with disabilities, children in foster care, and children of color including children and families with limited English proficiency. Access to professional interpreter services and/or interpreters trained in crisis management should be made available for patients and families with limited English proficiency. It is also important to recognize that pediatricians' offices are likely to utilize 988 as we frequently encounter children in crisis in our offices. **The *9-8-8 and Parity Assistance Act of 2022* (H.R. 7232) takes important steps towards ensuring that crisis response standards and capacity will address the needs of children and adolescents. We look forward to working with Congress to ensure we have the right system in place for children and adolescents.** In addition, funding for crisis services for children should not be limited to children with serious emotional disturbance (SED). The SAMHSA definition for children with SED requires that a child or adolescent has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria. Children or adolescents in crisis deserve appropriate crisis intervention services to meet their needs regardless of whether they have a prior diagnosis that results in functional impairment.

Trained crisis response teams should be used as an alternative to having law enforcement respond to a mental or behavioral health emergency in the community. **Services like those that would be supported by the *Mental Health Justice and Parity Act of 2022* (H.R.7254) more appropriately address the needs of people in crisis and prevents injury and death.** These models, by having staff who are knowledgeable about and connected to community resources can facilitate warm handoffs. Universal implementation of such models should be a goal. Mobile health crisis teams should be available to respond to schools, physician offices, homes, or wherever children are. These interventions can also support placement stability for young people in foster care who are experiencing crisis, so they can receive needed supports while remaining with the family caring for them. Given the current workforce shortage and that crisis intervention services tend to be underpaid positions, professionals who do this work should be given a competitive wage to ensure a high-quality workforce and improve retention.

Because of the lack of available pediatric behavioral health services, children and adolescents experiencing suicidal ideation or other mental health crises often end up in the emergency department seeking care. Prehospital personnel should be trained in acute management of pediatric behavioral health emergencies. Emergency department staff should be supported and trained in recognizing and providing initial care to youth with potentially increased risks of behavioral health concerns, including LGBTQ youth, victims of maltreatment, abuse, or violence, including physical trauma, mass casualty incidents, and disasters; and those with substance use-related problems (e.g., acute intoxication, overdose), pre-existing conditions (e.g., autism spectrum disorder, developmental delay, intellectual disability), post-traumatic stress, depression, and suicidality.

Prompt consultation with a well-trained mental health professional and interpreter services should be available in the emergency department. Standards should be established for documentation, communication, and appropriate billing and payment for inpatient and outpatient psychiatric care by mental health specialists consulting on emergency department patients (including telemedicine consults), as well as for emergency and prolonged emergency department care for children boarding in the ED. Interfacility transfer agreements should be created to refer children to care, including simplification of psychiatric bed search for patients requiring inpatient care or community mental health centers where available, to help limit ED boarding. Currently, patients face delays to get into outpatient care. The increased availability of "step down" services such as partial hospitalization and intensive outpatient programs would promote effective care transitions. Upon discharge from hospitals or emergency departments, navigators should help families connect to community services including family supports.

Community services should be expanded to include mobile crisis intervention, intensive case management, respite services, bridge programs upon discharge from an ED or psychiatric hospital, and emergency department diversion programs such as psychiatric urgent care centers. Outpatient care services should be designed to serve children and adolescents with unique needs, such as those with autism spectrum disorder, substance use disorders, and eating disorders. Schools also play a critically important role in supporting the mental health of children and adolescents. Although not the subject of today's hearing, AAP **supports the *Youth Mental Health and Suicide Prevention Act* (H.R. 1803)**, which provides direct funding to schools for a variety of mental health promotion and suicide prevention purposes, such as educational seminars, awareness campaign materials, peer-to-peer program support, telehealth, and training programs.

AAP supports the *Garrett Lee Smith Memorial Reauthorization Act* (H.R. 7255) which would reauthorize programs established under the Garrett Lee Smith Memorial Act that support community-based youth and young adult suicide prevention efforts and make treatment options for opioid use disorder more accessible. States, Tribal communities, and college campuses have used funds from this program to support education and mental health awareness programs, screening activities, gatekeeper training events, improved community partnerships and linkages to service, programs for suicide survivors, and crisis hotlines. A study found counties implementing Garrett Lee Smith programs had significantly lower suicide rates for youth and young adults following implementation, which was estimated to have averted 79,000 suicide attempts.

School-Based Mental Health Care

Children must be able to access care in the settings where they are, particularly in schools. Lack of mental health professionals in schools is another significant barrier to children's access to needed services. Comprehensive school mental health systems provide an array of supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness.[xv] By having mental health services available in schools, children can have access to the care they need with minimal disruption to their school day, and in the case of acute behavioral health crises in school, they could receive urgently needed services and de-escalation on site.

At the very least, every school should have a staff member with mental health training, including trauma-informed responses, who can recognize behavioral health issues and is able to facilitate connection to appropriate resources. Ideally, schools should have an on-site therapist who can provide trauma-informed psychotherapy to children free of charge and education to teachers, staff, parents, and students about mental wellness, stress management, basic Cognitive Behavioral Therapy principles to cope with anxiety/depression, and Mental Health First Aid. Increased funding is needed to support multi-tiered systems that promote mental health and help reduce the prevalence and severity of mental health disorders in schools. There is a large need for school-based mental health professionals to serve the needs of children and adolescents; providers must be adequately trained and supported. Consideration should be given to payment for support groups for children and adolescents living with chronic illnesses such as cancer and children and adolescents dealing with the loss of a parent or caregiver.

The AAP supports provisions of the Keeping Incarceration Discharges Streamlined for Children and Accommodating Resources in Education Act (H.R. 7233) that would help reduce administrative barriers to Medicaid and CHIP reimbursement for school-based health and mental health services.

Maternal Depression

Maternal mental health conditions -- including depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder, and substance use disorder -- are serious illnesses that begin during pregnancy or the year following pregnancy and affect 1 in 5 pregnant and postpartum people.[xvi,xvii,xviii] These illnesses are the most common pregnancy complication, adversely impacting 800,000 families each year in the United States.[xix] Unfortunately, as many as 75% of those affected never receive treatment,[xx] resulting in potential long-term negative consequences for the health and well-being of parents, infants, and families. Moreover, the cost of untreated maternal mental health conditions is $14.2 billion each year (or $32,000 per mother-infant pair) in health costs as well as lost wages and productivity of affected parents.[xxi] The COVID-19 pandemic has pushed

an existing maternal mental health and substance use crisis to catastrophic levels, with pregnant and postpartum patients reporting a threefold increase in symptoms of anxiety and depression.[xxii,xxiii]

The well-documented racial inequities in maternal health outcomes also extend to maternal mental health. Individuals facing racial or economic inequities are more likely to be affected by these conditions but have less access to screening or treatment.[xxiv] In the United States, more than half of infants in low-income families are being cared for by a mother with some level of depressive symptoms.[xxv] These same infants are also likely to suffer intergenerational effects: maternal mental health disorders increase the likelihood of preterm birth, low birthweight delivery, and infant mortality; impair parent-infant bonding; and can lead to behavioral, cognitive, and emotional impacts on the child.[xxvi,xxvii]

Maternal depression affects the whole family and can lead to increased costs of medical care, inappropriate medical treatment of the infant, discontinuation of breastfeeding, family dysfunction, and an increased risk of abuse and neglect. AAP supports the HRSA Screening and Treatment for Maternal Depression program that helps address mental health conditions that arise during and after pregnancy. For example, this program funds Maternal Mental Health Psychiatric Access Lines, which allow providers, including pediatricians, real-time psychiatric consultation in which a specialist guides screening, brief intervention, and referral for maternal mental health conditions.

AAP supports the *Into the Light for Maternal Mental Health Act of 2022* which would reauthorize and expand the HRSA program and so that more individuals would be able to access care. Currently, HRSA funds seven state programs, however this legislation would expand the reach of the program to 30 states, enabling more pregnant and postpartum individuals to receive the care they need. The legislation would also authorize trainings for providers in providing culturally appropriate care and enhance technical assistance from HRSA to help state grantees with implementation. Further, the legislation would authorize the maternal mental health hotline, allowing for a nationally operated 24/7 real-time voice and text access resource for emotional support, information, and brief intervention for individuals and families affected by maternal mental health conditions.

Eating Disorders

Interruptions in regular access to healthy, nutritious foods and the impact of isolation and increased screen time have impacted children's health and wellbeing on both extremes. Recent CDC data show a rise in childhood obesity during the pandemic – about 22% of children and teens with obesity last August, up from 19% a year ago. Relatedly, we are also seeing dramatic increases in eating disorders, a very complicated condition that requires multi-disciplinary treatment. Eating disorder diagnoses have also increased 25% overall for youth ages 12 to 15 since the onset of the pandemic.[xxviii] Adolescent medicine and child psychiatry clinicians are seeing many more cases of eating disorders that are more severe and are starting at even younger ages, even down to the age of 8 or 9. Because of the complexity of the treatment for eating disorders, it is extremely difficult to access fully comprehensive care for patients. Despite increasing prevalence rates, most pediatric and adult primary care physicians lack training in eating disorders, with only 20% of medical schools offering any elective trainings in the subject.[xxix]

There is a need for more services, and the training of more providers, to treat children and adolescents with eating disorders, as well as outpatient care services designed to meet the needs of this population. **AAP supports the *Anna Westin Legacy Act* which would authorize the SAMHSA Center of Excellence for Eating**

Disorders that trains providers in screening, intervention, and referral for eating disorders, and has trained over 7,000 primary care providers since 2019. This legislation aims to give the Center of Excellence a more permanent home and expand its funding so it can create the nation's first pediatric protocol for eating disorders in a primary care setting and establish protocols for vulnerable populations at higher risk for eating disorders.

Substance Use Disorder

Adolescence is a critical period in the prevention of substance use disorder (SUD). Adolescents are the age group at greatest risk of experiencing substance-use related acute and chronic health consequences, making a targeted approach to SUD prevention and treatment for adolescents imperative. The neurodevelopmental changes during adolescence confer particular vulnerability to addictions. Of particular concern, the age at first substance use is inversely correlated with the lifetime incidence of developing a substance use disorder.[xxx] [xxxi] In other words, adolescents face increased risk of opioid dependence and SUD due to their unique developmental and physiological characteristics, posing a threat to lifelong health and well-being for adolescents who develop SUD prior to entering adulthood. Policies to expand access to SUD treatment options are therefore essential to mitigate the impact of SUD on young people. Research demonstrates that youth who reach adulthood without ever using substances are unlikely to develop a substance use disorder in their lifetime. Programs that can help identify youth at risk of SUD and intervene upstream before a problem occurs as well as programs that provide treatment to those who need it are smart approaches to improving the health and well-being of adolescents now and in the future.

The AAP supports provisions of the *Continuing Systems and Care for Children Act* (H.R. 7248) that reauthorizes a program for substance use disorder treatment and early intervention services for children and adolescents. The AAP also strongly supports the Sober Truth on Preventing (STOP) Underage Drinking Act which is reauthorized in the Summer Barrow Prevention, Treatment and Recovery Act (H.R. 7234). The STOP Act would reauthorize an important program that would provide grants to train pediatric providers in alcohol use screening, brief intervention, and referral to treatment for children and adolescents.

It is also important to note that the majority of youth with substance use disorder have one or more co-occurring mental health condition. Substance use disorder and mental health conditions can also exacerbate one another. Recognition of this interplay is essential in understanding how to build systems of care for children and adolescents with or at risk of substance use disorder. In addition, providers of care to adolescents with substance use disorder are also in short supply, resulting in adolescents being much less likely than adults to receive the most effective evidence-based care, such as medication for opioid use disorder.

Thank you for the opportunity to testify before you today. AAP looks forward to working with the committee to improve mental health care for children and adolescents.

---

[i] Centers for Disease Control and Prevention. Facts About Suicide. Published February 24, 2022. Accessed February 25, 2022. https://www.cdc.gov/suicide/facts/index.html

[ii] National Vital Statistics Reports. State Suicide Rates Among Adolescents and Young Adults Aged 10-24: United States, 2000-2018.; 2020. Accessed February 25, 2022.

[iii] Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3external icon

[iv] Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. MMWR Morb Mortal Wkly Rep 2021;70:888–894. DOI: http://dx.doi.org/10.15585/mmwr.mm7024e1

[v] Radhakrishnan L. Pediatric Emergency Department Visits Associated with Mental Health Conditions Before and During the COVID-19 Pandemic — United States, January 2019–January 2022. MMWR Morb Mortal Wkly Rep. 2022;71. doi:10.15585/mmwr.mm7108e2

[vi] Center on Budget and Policy Priorities. Bolstering Family Income Is Essential to Helping Children Emerge Successfully From the Current Crisis. Center on Budget and Policy Priorities. Published 2021. Accessed February 25, 2022. https://www.cbpp.org/research/poverty-and-inequality/bolstering-family-income-is-essential-to-helping-children-emerge

[vii] Susan D. Hillis, Alexandra Blenkinsop, Andrés Villaveces, Francis B. Annor, Leandris Liburd, Greta M. Massetti, Zewditu Demissie, James A. Mercy, Charles A. Nelson III, Lucie Cluver, Seth Flaxman, Lorraine Sherr, Christl A. Donnelly, Oliver Ratmann, H. Juliette T. Unwin; COVID-19–Associated Orphanhood and Caregiver Death in the United States. Pediatrics December 2021; 148 (6): e2021053760. 10.1542/peds.2021-053760

[viii] Trent, M, Dooley DG, Douge J, Section on Adolescent Health, Council on Community Pediatrics, Committee on Adolescence. The Impact of Racism on Child and Adolescent Health | Pediatrics | American Academy of Pediatrics. Pediatrics. 2019;144(2):e20191765.

[ix] Gorzkowski J, Calabrese T, Lau M, et al. Blueprint for Youth Suicide Prevention. Published online 2022. Accessed March 4, 2022. www.aap.org/suicideprevention

[x] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE.Arch Gen Psychiatry. 2005 Jun;62(6):593-602. doi: 10.1001/archpsyc.62.6.593.

[xi] Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustün TB. Age of onset of mental disorders: a review of recent literature. Curr Opin Psychiatry. 2007;20(4):359-364. doi:10.1097/YCO.0b013e32816ebc8c

[xii] Stein, Bradley D. et al. A National Examination of Child Psychiatric Telephone Consultation Programs' Impact on Children's Mental Health Care Utilization, Journal of the American Academy of Child & Adolescent Psychiatry, Volume 58, Issue 10, 1016 – 1019. https://www.rand.org/news/press/2019/07/15.html

[xiii] https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health

[xiv] Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389–391. doi:10.1001/jamapediatrics.2018.5399

[xv] https://downloads.aap.org/dochw/dshp/Supporting_Mental_Health_in_Schools_Final_Report-June_2021.pdf

[xvi] American College of Obstetricians and Gynecologists. ACOG Committee Opinion 7575: Screening for Perinatal Depression. Obstet Gynecol. 2018:132(5):E208-12.

[xvii] Fawcett EJ, Fairbrother N, Cox ML, White IR, Fawcett JM. The prevalence of anxiety disorders during pregnancy and the postpartum period: a multivariate Bayesian meta-analysis. J Clin Psychiatry. 2019:80(4):18r12527.

[xviii] Gavin NI, Gayness BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol. 2005;106(5 Pt 1):1071-83.

[xix] Ibid.

[xx] Byatt N., Levin LL, Ziedonis D, Moore Simas TA, Allison J. Enhancing participation in depression care in outpatient perinatal care settings: a systematic review. Obstet Gynecol. 2015;126(5):1048-58.

[xxi] Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States (mathematica.org)

[xxii] Davenport MH, Meyer S, Meah VL, Strynadka MC, Khurana R. Moms Are Not OK: COVID-19 and Maternal Mental Health. Front Glob Womens Health. 2020 Jun 19;1:1. doi: 10.3389/fgwh.2020.00001. PMID: 34816146; PMCID: PMC8593957.

[xxiii] Lebel C, MacKinnon A, Bagshawe M, Tomfohr-Madsen L, Giesbrecht G. Elevated depression and anxiety symptoms among pregnant individuals during the COVID-19 pandemic. J Affect Disorder. 2020;1(277):5-13.

[xxiv] Sidebottom A., Vacquier M, LaRusso E, Erickson D, Hardeman R. Perinatal depression screening practices in a large health system: Identifying current state and assessing opportunities to provide more equitable care. Arch Womens Ment Health. 2021;24(1):133-44.

[xxv] CLASP: Maternal Depression and Young Adult Mental Health
[xxvi] Maternal anxiety, mother infant interactions, and infants response to challenge (psu.edu)
[xxvii] A Meta-analysis of Depression During Pregnancy and the Risk of Preterm Birth, Low Birth Weight, and Intrauterine Growth Restriction (nih.gov)
[xxviii] Dave Little, MD, Adrianna Teriakidis, PhD, Eric Lindgren, JD, Steven Allen, MD, Eric Barkley, Lily Rubin-Miller, MPH, April 2021, https://epicresearch.org/articles/increase-in-adolescent-hospitalizations-related-to-eating-disorders
[xxix] Mahr F, Farahmand P, Bixler EO, Domen RE, Moser EM, Nadeem T, Levine RL, Halmi KA. A national survey of eating disorder training. Int J Eat Disord. 2015 May;48(4):443-5. doi: 10.1002/eat.22335. Epub 2014 Jul 22. PMID: 25047025.
[xxx] Hingson RW, Zha W. Age of drinking onset, alcohol use disorders, frequent heavy drinking, and unintentionally injuring oneself and others after drinking. *Pediatrics*. 2009;123(6):1477–1484pmid:19482757
[xxxi] Chambers RA, Taylor JR, Potenza MN. Developmental neurocircuitry of motivation in adolescence: a critical period of addiction vulnerability. *Am J Psychiatry*. 2003;160(6):1041–1052pmid:12777258