

MEETING THE MOMENT ON CHILDREN'S MENTAL HEALTH: RECOMMENDATIONS FOR FEDERAL POLICY

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I. Introduction

The mental health of children and youth is justifiably receiving a great deal of attention. Headlines in the nation's major newspapers have called out the crisis. This year's urgency is directly linked to the disruptions created by the COVID-19 pandemic, which brought new stressors, isolated children from their peers, and made treatment of symptoms and illnesses more difficult. But the crisis in kids' mental health predated the pandemic, as evidenced by the run up in the suicide rate among adolescents between 2010 and 2018 (Office of Juvenile Justice and Delinquency Prevention, 2022). There is therefore a new sense of urgency to address mental illness in children and youth.

Today, it is understood that over half of mental illnesses have their onset prior to age 18 (Kessler et al., 2007; Kessler et al., 2005). In addition to the direct troubling effects on children and youth health, mental illnesses in childhood cast a long shadow on the economic and social wellbeing of adults into their 50s (Fletcher, 2013; Hakulinen et al., 2019; Goodman et al., 2011). Childhood mental illnesses compromise educational attainment, career development, and the formation of social relations that, in turn, result in reduced employment, lower earnings, and a higher likelihood of becoming disabled. Still, the average gap between onset of symptoms and receipt of treatment is over a decade, with longer delays when symptoms begin in childhood (Wang et al., 2004). Moreover, treatment rates for children that meet diagnostic criteria are consistently under 50% (Substance Abuse and Mental Health Services Administration, 2021). These facts highlight the emotional, economic, and social urgency to preventing and treating mental illnesses in our children. Failure to do so will disadvantage a large share of a full generation and have lasting societal impact.

The President, members of Congress from both political parties, governors, and mayors have all come to recognize that addressing the mental health needs of American children requires mobilizing all levels of government, civil society, and our community institutions. In this paper, our focus is on actions that can be taken by the federal government. Federal policies can lay the foundation for change, though actions at other levels of government and other sectors is also needed. The President, through a set of proposals made this year, has sought to draw attention to measures that would wholistically address mental health in children. Congress has proposed several bipartisan efforts to expand services and intervene early to promote mental health in children. In this paper, we aim to: (i) clarify the nature and potential sources of the current problem of mental illnesses in children; and (ii) consider how we might effectively apply the policy tools of the federal government to address this crisis.

In what follows, we show that there is strong evidence of a crisis as reflected in rapidly rising rates of depression in teenagers. The upward trend predates the pandemic by a decade, yet our understanding of the forces driving the trend is very incomplete. Therefore, we do not offer any "purpose-built" interventions to address the trend. Nevertheless, there are a numerous evidence-based interventions that can prevent and treat mental illnesses in children and adolescents. We argue that schools can play a greater role in identifying need and engaging children in treatment. Treatment services can be delivered by a range of providers by integrating behavioral health services into a variety of settings facilitated by improved support from the Medicaid program.

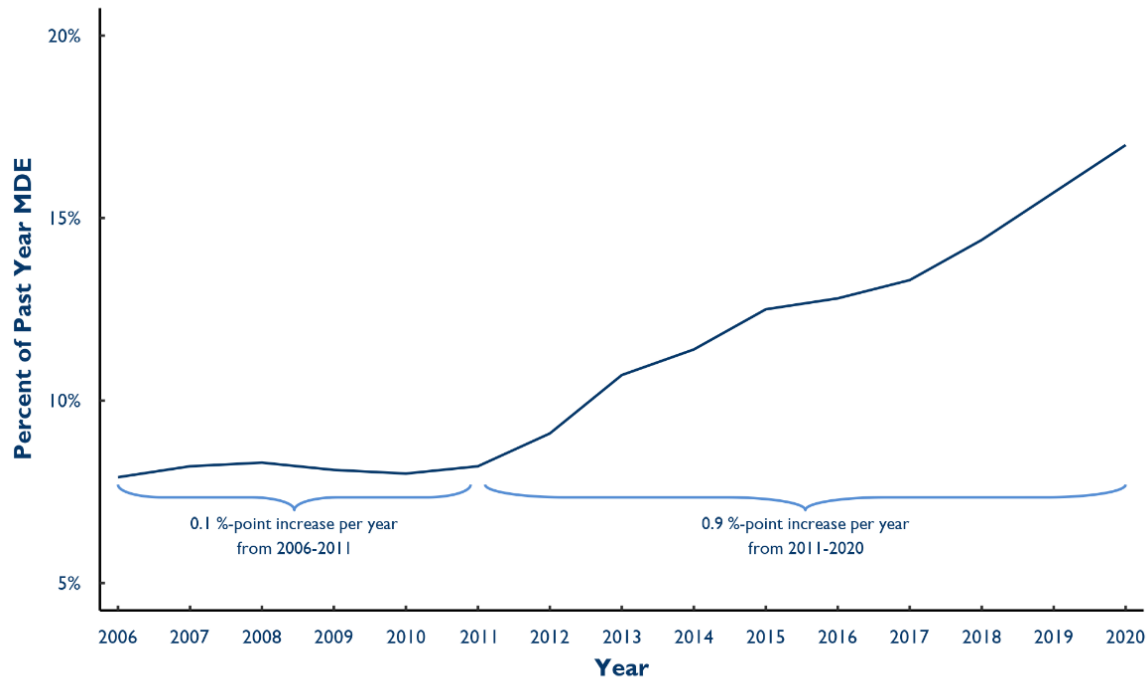
II. Children’s mental illness in the U.S.: Levels and trends

The literature on the epidemiology of childhood mental illnesses has relied on information from targeted epidemiological investigations and larger surveillance surveys. There is great heterogeneity across age groups in the composition of illness. Estimates generally focus on youth under age 18 and find that pre-2011 children overall have rates of diagnosable mental illness at around 13 to 20%, while youth 12 to 17 years old have rates of past year depression at about 8% (Younger, 2017). Depression and anxiety disorder tend to be more prevalent in the teenage years and young adulthood, whereas phobia and ADHD are more prevalent earlier in the life course. A central source of data for evaluating both level and trends in mental health problems is the National Survey on Drug Use and Health (NSDUH). This survey focuses on measuring depression in children from 12 to 17 years of age. Because the survey is relatively large and consistently measures depression over time, we will use those rates of illness as markers for mental illness in children and youth.

i. Trends in prevalence of depression for adolescents

Figure 1 represents annual rates of major depression in adolescents aged 12 to 17 years from 2006 to 2020. The rates reported in the 2006 to 2011 period align well with the prior literature at around 8%. The 2006 to 2011 interval displays little change in the rates of depression in adolescents (0.1% per year on average).

Figure 1. Adolescent Past Year Major Depressive Episode, 2006-2020

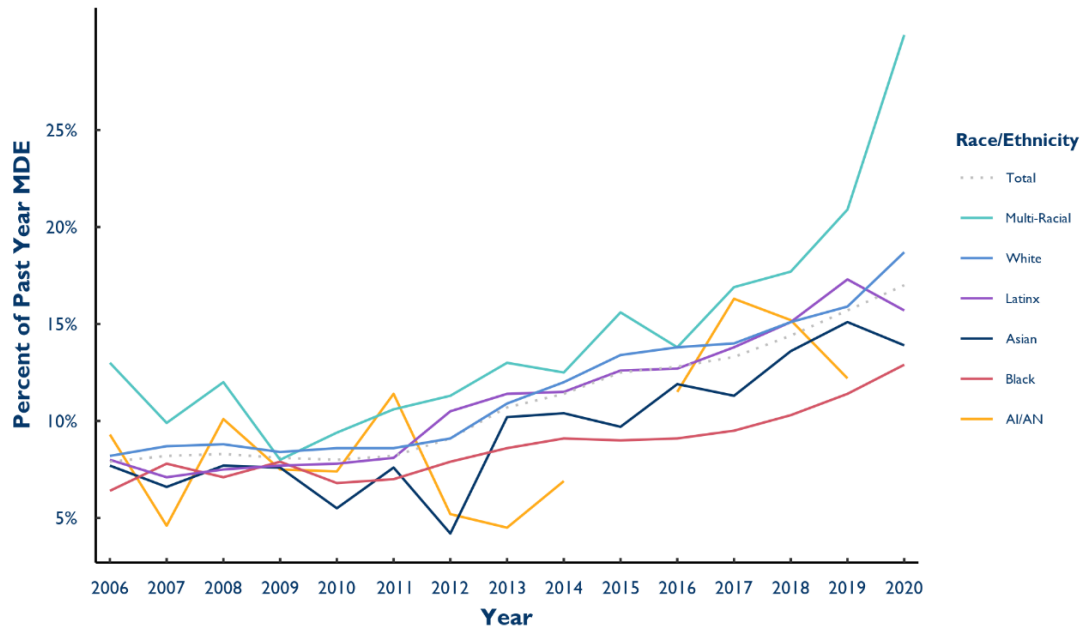


Based on data from the NSDUH Detailed Tables.
Percent of adolescents 12-17 who reported symptoms of a past-year major depressive episode (MDE).

Beginning in 2011, Figure 1 shows a relatively steep increase in rates of depression that continues through 2020. The average annual growth rate was 0.9% per year. As a result, the rate of depression has more than doubled from 2011 to 2020 to roughly 17%. Recent research on college students shows a similar pattern, with nearly a 50% increase in the prevalence of

depression from 2013 to 2021 (Lipson et al., 2022). It is important to note that the data from these surveys show that the increase in mental illnesses pre-dates the pandemic and has continued along a similar growth path.

Figure 2. Adolescent Past Year Major Depressive Episode by Race/Ethnicity, 2006-2020

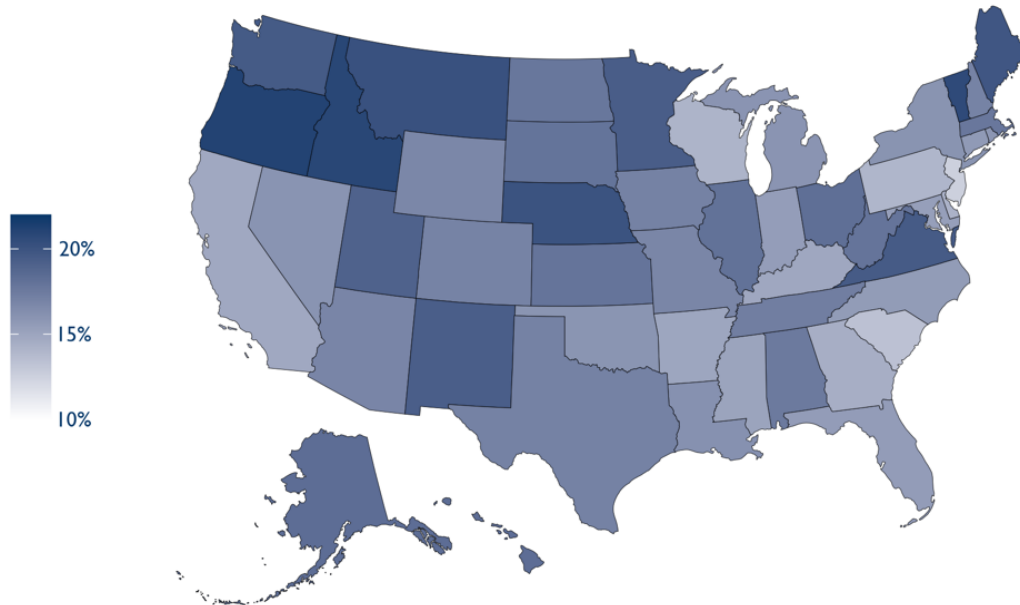


Based on data from the NSDUH Detailed Tables.
 Percent of adolescents 12-17 who reported symptoms of a past-year major depressive episode (MDE).
 Data on AI/AN adolescents are missing in 2015 and 2020. Except for Latinx category, racial/ethnic groups are non-Hispanic/Latinx.

Figure 2 reports trends in annual rates of depression among youth by race and ethnicity. The figure shows that growth in rates of depression has occurred across all racial and ethnic groups. There is year to year variability for the smaller groups. Figure 3 shows that the prevalence of mental illnesses in children varies considerably by state, with rates of depression in 2019-2020 ranging from 13% to 21%. In assessing the geographic distribution of children’s mental illnesses and poverty rates, we observe little systematic correlation. Low-income areas are however at a disadvantage in their ability to marshal resources to address mental health needs of children.

In addition, it is important to note that among people with a past year depression, rates of treatment are consistently lower for minorities. In 2019, while 50% of White adolescents with past year major depression received mental health services, only 36% and 37% of Black and Latinx adolescents with past year major depression received services. These disparities relate to longstanding workforce gaps. The workforce of child psychiatrists and psychologists is insufficient for addressing the need and will be for the foreseeable future. For example, 70% of the counties in the U.S. have no child psychiatrists (McBain, 20019). Similarly, 81% of counties have no child and adolescent psychologists (Li and Stamm, 2020).

Figure 3. Prevalence of Past Year Adolescent Depression in 2019-2020 by State



Percent of adolescents 12-17 who reported symptoms of a past-year major depressive episode from 2019-2020. Based on the NSDUH State Estimates.

ii. Sources of illness: Risk factors and protective factors

There is a well-developed literature on the risk and protective factors for mental illnesses in children. However, as we show below, literature offers only limited insight into the drivers of today's crisis (Merikangas et al., 2009). Longitudinal follow up epidemiological surveys have been used to develop information on factors that predict the occurrence of mental illnesses in children. The predictors typically fall into child/self, parent/family, and environment categories of risk and protective factors. Here, we focus on family and parent attributes and the environmental circumstances surrounding children, as these are more amenable to policy interventions. Key among family or household attributes are poverty, exposure to intra-family violence, neglect, isolation, parental substance misuse, and parental depression (Fergusson and Horwood, 2001; Goodman et al., 1998). Community risk factors include bullying, violence, and poor access to treatment and other services. Most recent and emerging evidence points to excessive exposure to social media as a risk factor for mental illness in children (Riehm et al., 2019). Protective factors include parenting skills that support youth mental health, social supports from family and friends, physical security and a sense of safety, and economic security.

Risk and protective factors typically explain the level of mental illness in a population. To understand potential drivers of the observed trends, we must assess the extent to which specific risk and protective factors have been changing over time. Several important risk factors that could explain levels of mental illness in children have either remained constant or have declined. Childhood exposure to abuse, neglect, and bullying have remained steady or declined slightly over most of the decade 2011 to 2020 (Child Trends, 2019; Li et al., 2020). Use of illicit drugs among adults of prime child rearing age has remained constant since 2011 (Substance

Abuse and Mental Health Services Administration, 2021). Likewise, past year heavy alcohol use among adults has either declined (ages 18-25) or remained constant (ages over 26). Poverty rates have fallen by 20% since 2009 (Creamer et al., 2022).

Maternal depression has been shown to undermine child development and serves as a risk factor for children's mental illness. There is also more limited evidence of an effect of paternal depression on mental illness in children (Center on the Developing Child at Harvard University, 2009; Sweeney and MacBeth, 2016). The percent of adult mothers with any mental illness is significant but relatively constant: it has remained around 23% from 2008-2019.¹ The rate of mental illness among fathers is notably lower, steady around 13% from 2008-2019, reflecting well-established gender differences.

Risk factors that have changed include rates of adolescent homicide and high levels of online activity. While adolescents have had less exposure to family violence and bullying, the adolescent homicide rate has increased substantially since 2013 (Office of Juvenile Justice and Delinquency Prevention, 2022; Vasan et al., 2021). Exposure to gun violence and homicide is associated with indicators of increases in mental health problems. Finally, recent research findings indicate that over three hours per day of online activity is associated with higher rates of mental health problems. Surveys conducted by the Pew Research Center in 2014-2015 and again in 2018 show a large increase in the percentage of adolescents who report being almost constantly online (from 24% to 45%). This suggests a notable increase in the share of adolescents likely to be exceeding the 3 hour per day threshold.

Some protective factors have changed at the same time. The share of children living with two parents has declined slightly since 2010. The share living with only their mothers declined since 2010, while the share living either with only their father or with neither parent increased slightly. This coincides with a small decline in the average amount of parental time devoted to children.² Alongside reduced parenting resources is a trend showing that Americans are less connected with one another socially. The literature indicates that having non-family supportive adults present for children serves as a protective factor. Two surveys asked Americans about how many close friends they had not counting family (Cox, 2021). In 1990, 7% reported having either no friends or just one, while 33% reported having 10 or more. In 2021, 19% reported having either no friends or just one, and the share with 10 or more close friends fell to 13%. This represents a decline in sources of support other than family and an erosion of relational support systems.

The decline in children's mental health is not easily explained. Our review of evidence suggests changes in several key risk and protective factors that may contribute to increasing rates of mental illness among children, at least when it comes to adolescent depression. Treatment rates for major illness among kids remain under 50%. As levels of illness and poverty, typically correlated with low resource availability, vary geographically, some communities may be left with especially high unmet need. This is consistent with the findings of research on Adverse Childhood Events (ACEs).

¹ Authors analysis of NSDUH data from 2006-2019.

² Data from the Current Population Survey, Annual Social and Economic Supplements, 2010-2020.

III. What to do? Policy approaches to make progress on addressing kids' mental health

To address growth in rates of child and adolescent mental illness and historically high rates of unmet need, we propose a strategy to advance priorities that the Biden administration and Congress have set. Where possible, we propose ways to effectively leverage existing resources and policies, including some that Congress has recently enacted. Both Congress and the Administration have identified child and youth mental health as a key priority and authorized new policies and resources to address it. Our proposed strategy focuses on improving children's mental health by advancing access to services in schools, which reach most American children. We propose that policymaking and implementation with respect to schools prioritize low-income children by targeting grant funding toward low-income schools and by leveraging Medicaid, the insurer of low-income children in the U.S., to advance behavioral health services in schools. We also propose that new resources being dedicated toward school mental health align to advance evidence-based preventive interventions, as well as advance access to services and treatment. These would encompass early intervention and continuation care. This strategy would require some grant mechanisms to be more directive of states in how grant funds are allocated; doing so may require a combination of administrative and legislative action. We also propose that federal agencies increase efforts to coordinate Medicaid and grant programs and funding. In addition, we propose that the federal government undertake efforts to advance integration of behavioral health services into pediatric practices. Finally, we propose that the federal government review behavioral health screening and treatment services provided through Medicaid's pediatric benefit, the Early Periodic Screening Diagnostic and Treatment (EPSDT) program.

Thus, our goal is to prioritize the needs of low-income children, and to propose funding and policy approaches that direct new funds to prevention, screening, treatment, and referrals to schools in communities that have high risk of mental illness in children and relatively few resources available to address those illnesses.

i. Target federal grant resources to low-income schools

Strengthening access to mental health services in schools can plausibly help to identify mental illnesses earlier in their onset, potentially averting the development of more severe illness, increasing rates of treatment, and improving outcomes. To date, there is suggestive evidence that supports screening in schools and teacher training in identifying children in need. Over 90% of children between the ages of 6 and 17 go to school, and the vast majority attend public schools. Roughly 9.5% of children in school are enrolled in private schools, with the rest in public K-12 schools (Bouchrika, 2022). In the 2019-2020 school year, there were 98,469 public schools nationally enrolling over 50 million students (National Center for Education Statistics, 2022). Schools are settings of contact with the vast majority of children, where mental health issues can be identified and some interventions, particularly preventative interventions, can be implemented.

President Biden's mental health strategy recognizes schools as an under-utilized mechanism for strengthening the mental health of children, and the Secretaries of Education and Health and Human Services (HHS) have joined to encourage states to make progress and coordinate the resources of their respective agencies (The White House, 2022). Congress, through the Bipartisan Safer Communities Act (BSCA), the American Rescue Plan, and other recent COVID

relief legislation, has provided substantial funding increases for many mental health grant programs that include schools.

To maximize the impact of these new resources, and to guide policy with respect to any additional federal legislative action, we propose a policy and financing strategy to align diverse funding streams around a set of common goals that are most likely to advance the health and well-being of children. This strategy would prioritize directing federal funding towards low-income children and the school districts that serve them.

For example, the BSCA makes several investments in children’s mental health, including directing \$500 million to the Department of Education to increase school-based mental health services. It provides another \$500 million to train mental health service providers plus another \$1 billion to enhance school safety (over 5 years), a very large increase in funding by historical standards.

Yet even such a large infusion of money is modest relative to the need. For example, \$2 billion of new money would amount to \$197 per student with a mental illness. Addressing the needs of children with mental illness, along with mounting prevention activities, would require much more than \$197 per child with a mental illness. The new dollars reported here encompass treatment, safety expansion, and training of the workforce. The implication is that for the federal dollars to have a significant impact, the funds must be allocated in a targeted fashion.

We illustrate the general strategy with one approach to targeting that would prioritize funding Title I schools that are School Wide Program eligible in counties that have high risks of mental illness and high rates of poverty. Title I of the Elementary and Secondary Education Act distributes funds to “districts and schools with high numbers or high percentages of children from low-income families to help ensure that all children meet challenging state academic standards”. There are approximately 49,000 schools that are Title I School Wide Program eligible. We target Title I schools that are in Local Education Agencies (LEAs), where half or more schools are Title I School Wide grant eligible, in counties that are in the top tercile of poverty rates in the U.S., and in counties with an estimated high level of mental illness. Such a targeted approach would target roughly \$33,000 per school selected to receive grant funds instead of \$2,600 when all schools receive an equal share. A detailed example is provided in Appendix I.

ii. *Leverage Medicaid in coordination with grant funding to advance sustainably financed school services*

As the largest insurer of children in the country by far, Medicaid, along with its companion Children’s Health Insurance Program (CHIP), is essential to ensuring access to mental health services for low-income children. Medicaid and CHIP cover nearly 41 million children in the U.S. Medicaid has long played a role in financing some services in schools, and its role has grown significantly since 2014 federal policy revisions that removed barriers to doing so (Center for Medicaid & CHIP Services and Medicaid and CHIP Coverage Learning Collaborative, 2022).

Currently, 17 states have federal approval to finance a broad array of health services for students who are Medicaid beneficiaries; most include behavioral health services.³

Congress identified the need for greater progress – and provided new tools for making it – in the BSCA. This new law requires the Centers for Medicare and Medicaid Services (CMS) to update and simplify its policies to promote the delivery of health care services, including behavioral health services, to Medicaid and CHIP beneficiaries in schools. It also provides \$50 million in planning grants to states and established a new technical assistance center operated by CMS with the Department of Education to support state Medicaid programs, education agencies, and local school districts in promoting Medicaid coverage of services provided in schools.

These new policies and resources create an unprecedented opportunity for Medicaid to drive expansions of health and mental health services in schools and coincide with substantial increases in grant funding through a variety of HHS and Education Department (ED) programs. HHS and ED have, through letters from their Secretaries to states, already encouraged collaboration between state Medicaid programs, state education agencies, local education agencies, and other educational entities to strengthen provision of health and behavioral health services in schools. The executive branch can, in implementing these new policies and allocating resources, maximize their impact by taking the following steps.

Deploying a coordinated, aligned technical assistance strategy

Technical assistance (TA) is a valuable, relatively low-cost tool that can promote adoption of best practices and direct school systems and states towards effective financing and investment strategies. The federal government has recognized this point and is establishing technical assistance activities in the Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), CMS, and the Department of Education.

States, local education agencies, and providers are more likely to use these TA resources effectively if they are carried out in a coordinated manner. State officials have noted the importance of cross agency alignment for achieving broader behavioral health goals (National Association of Medicaid Directors, 2022). As noted, coordination between HHS and the Department of Education has already occurred at the highest levels of those agencies and can be diffused throughout these agencies and their partners through an aligned TA approach. There is a history of successful behavioral health technical assistance activities associated with efforts to integrate care through a joint SAMHSA-HRSA technical assistance center that was initiated about a decade ago. Such organizational arrangements typically reduce inter-agency coordination problems and realize synergies by avoiding duplication of effort and inconsistent advice that can slow progress at the state and local levels.

We suggest that a similar children’s behavioral health technical assistance center be established across HHS agencies and include the Department of Education. This can build on the joint CMS-Department of Education TA center established in BSCA. That center is not specific to behavioral health, but behavioral health should be a primary focal point for the TA it

³ Prior to 2014, such coverage was effectively limited to services provided under the Individuals with Disabilities Education Act.

provides. The federal government should also encourage cross agency collaboration at the state level. One method of doing this would be to require states applying for the new BSCA Medicaid schools planning grants to apply in crosscutting, collaborative teams across Medicaid, public health, behavioral health, state education agencies, and local education agencies.

Supporting state and local braiding of federal funding sources

Financing of school-based mental health programming typically requires braiding funds from a variety of sources. In school services most commonly rely on local school district support, public grant funding, and Medicaid. Disparate federal funding sources support the provision of mental health services in schools. The Department of Education and the Department of Health and Human Services each operate multiple grant programs that support school-based mental health services in different ways. The Department of Education, for example, awards grants for school-based mental health services, full-service community schools, school-based health professionals, and a mental health service professional demonstration grant program. It also awards COVID relief funds, which can play a role in expanding school health service provision. SAMHSA runs Project AWARE and Cooperative Agreements for School Based Trauma-Informed Support Services, which are both directed at schools, as well as several non-school specific grant programs, such as mental health and substance abuse prevention block grants. HRSA offers grants through Project LAUNCH for young children through age eight, awards pediatric mental health access grants, and oversees several more general workforce development programs.

Although each of these programs has specific goals and policies that are not the same, the substantial number of these programs and the significant degree of overlap between them suggest that administering them with a degree of alignment may be one way of making faster progress in addressing the children and youth mental health crisis. To help ensure that services reach the people who need them and build sustainable ongoing financing, the federal government and states should rely on Medicaid wherever possible. Grant programs, as contrasted with health insurance financing programs, are well suited to paying for services that do not fit comfortably in health insurance-like programs and creating push incentives for new investments. Braiding funding sources in a way that prioritizes ongoing sustainability should be a priority area for federal policymaking and technical assistance.

Dedicating resources to supporting implementation in low-income schools

Even with the increased resources that Congress and the Administration have dedicated to school mental health, schools need support in building evidence-based services and Medicaid billing and service capacity. Schools, teachers, staff, and administrators have been under significant stress throughout the pandemic. It is important to recognize that many low-income schools that would be targeted by the type of approach to funding outlined earlier are least likely to have the capacity and expertise available to implement the types of interventions being proposed. Moreover, they are often located in communities that also lack the clinical and programmatic resources that so support them in developing new programming. This means that allowable uses of grant funds to schools should include retention of clinical consultations for teachers addressing significant emotional issues in their classrooms and those interested in implementing evidence-based prevention interventions like the Good Behavior Game discussed later in this paper. The school grants should also allow for investments into the infrastructure and technologies required to receive Medicaid funding (see later discussion of leveraging

Medicaid for sustainability). The ability to obtain Medicaid funding for behavioral health services in schools serves to ensure sustainable funding of those services. Finally, the school grants should be designed to support the establishment of tele-behavioral health capabilities, especially in rural and under-served communities.

Aligning to advance effective evidence-based prevention and early intervention

Federal grantmaking policy can identify and invest in a set of evidence-based prevention, promotion, and early intervention strategies that improve behavioral health and other outcomes. Several cost-effective prevention strategies appear in evidence-based intervention registries (SAMHSA, Office of Justice Crime Solutions, Office of Juvenile Justice and Delinquency Prevention Programs). The Good Behavior Game, for example, is a classroom-based prevention approach that costs roughly \$200 per classroom per year (Kellam et al., 2011; Washington State Institute for Public Policy, 2019). It has been shown to reduce rates of mental illness (internalizing conditions), subsequent use of illicit drugs and misuse of alcohol, and suicidal ideation (Smith et al., 2021; Kellam et al., 2011). I Can Problem Solve has also been well-tested in the U.S. (Shure, 2001). Focused early intervention programs have also been supported. For example, Bounce Back is a cognitive-behavioral, skills-based group intervention directed at elementary school children (ages 5-11) exposed to traumatic events including family or school violence, natural disasters, or traumatic separation from a family due to events like death, incarceration, or deportation, and has been shown to reduce symptoms of posttraumatic stress disorder (Langley et al., 2015; Santiago et al., 2018). Aligning federal grant policy across programs to actively prioritize these and other preventive interventions could be an effective way of promoting evidence-based services that can reduce the onset of mental illness.

Providing screening and connections to treatment when needed

In addition, screening for mental illness in schools at once presents opportunities to expand access to care and engagement in treatment, but is challenging logistically, ethically, and economically. Screening policy raises complex issues related to the availability of treatment resources and concerns of parents about their privacy and control. In addition, false positives are common, which serves to make case finding less efficient and can have consequences for the child. Screening has been estimated to cost between \$9 and \$13 per child (Kuo et al., 2009). That would make very large claims on new funds for children's mental health if screening were to be universal. The budget costs can be constrained by targeting higher risk groups of children based on information from teachers and other sources.

Screening best practices indicate that protocols should be established for triaging identified children. Some relatively uncomplicated cases would be treated by school personnel either at the individual or group level. Where the illnesses are complicated and there are significant functional impairments, best practices imply that cases should be addressed through partnerships between schools and community providers of care. This means that schools should invest in establishing partnerships that enable them to connect students facing mental health problems with the full continuum of services. This would involve partnerships with community-based behavioral health services and establishing links through technology if such services are not immediately available in the local community.

One effective way of promoting screening, prevention, and treatment in school settings, including the practices described above, is to support comprehensive school mental health systems (CSMHS) (Mays et al., 2022). CSMHSs incorporate tiers of support, advancing

behavioral health promotion and prevention, early intervention, and targeted and crisis response services, through collaborations between schools, behavioral health providers, and community organizations (Hoover and Bostic, 2020). Under this framework, states, districts, and schools can build systems of support that help promote student wellbeing, keep track of mental health needs, and have multiple degrees of services available to students who screen positive for behavioral health conditions (Hoover et al., 2019). In 2019 guidance, CMS recognized the role that such systems can play in meeting the behavioral health needs of children who are Medicaid beneficiaries (McCance-Katz and Lynch, 2019).

iii. Integrating behavioral health into pediatric settings

Most children, especially early in life, make visits to a pediatrician for well child visits. The CDC reports that 87% to 92% of young children (0-4 years), 74% to 87% of children aged 5 to 11 years, and 68% to 82% of those 12 to 17 years of age receive a well child visit each year (Black, 2020). Young children are typically accompanied by their parents or other caregivers. This presents an opportunity for behavioral health screenings of children and their parents or caregivers, and to provide treatment when problems are identified. Recognizing this, the U.S. Preventive Services Task Force recently recommended that children aged 8 to 18 be screened for anxiety (U.S. Preventive Services Task Force, 2022). Pediatric practices are an appropriate setting for behavioral treatment if the appropriate infrastructure and physician extenders are present. Recognizing this, Congress increased resources for and slightly expanded the scope of Pediatric Mental Health Access grants in BSCA.

To help overcome workforce shortcomings, strategies that leverage primary care, and especially pediatrics, might usefully be explored. There are two classes of models that can bring expanded behavioral health capabilities to pediatric practices. One set is focused on early childhood and includes well-tested models such as Healthy Steps and Help Me Grow (Minkovits et al., 2003; Minkovitz et al., 2007). In each of these models, physician time is augmented through the availability of specially trained staff that can screen, support treatment plans, and follow-up with children and families experiencing mental illnesses. The second class of models offers integrated behavioral health services based on the types of treatment required for older children. Those approaches are built on a well-tested approach of integrating behavioral health services into primary care practices known as collaborative care and the Child Psychiatric Access Network program (Gilbody et al., 2006). TeamUp for Children is an example of a program built on collaborative care principles that serve children in Federally Qualified Health Centers. Adequate payment for these models of services will be essential to ensuring their adoption. In the past, when those models have been adopted, Medicaid fees seldom cover the costs of providing the enhanced behavioral health services⁴. In August, CMS guidance identified how, by paying more, state Medicaid programs can promote expanded availability of integrated mental health and substance use disorders (SUD) services and evidence-based models of care.

Coordinated grantmaking and Medicaid policy could be powerful levers for progress in pediatric behavioral health integration, as in advancing school health services. SAMHSA grant funds, for example, could help build integration infrastructure through push incentives, while Medicaid

⁴ This is based on interviews, conducted by one of the authors (Frank) and staff from Manatt, with over a dozen such programs across the U.S.

value-based payment incentives, including those carried out through MMCO contracting, can potentially create pull incentives. Specific steps for promoting integration of behavioral health in pediatric practices could include both financial incentives and the establishment of performance standards in the context of Medicaid Managed Care contracts. CMS could develop model contract language to promote integration of behavioral health services for children. This could, for example, identify structural characteristics of practices that represent essential elements of behavioral health integration. CMS could also establish behavioral health integration quality measures/standards, for example, such as following the pediatric guidelines that all children and youth receive a social-emotional screen and having those results be linked to evidence-based early interventions. States could incentivize the achievement of those measures through payment incentives for managed care organizations (MCOs) and providers (Burke et al., 2021). Congress could provide even stronger incentives by providing an enhanced federal matching rate for integrated behavioral health services for children. These policy interventions are new and should be carefully tracked so that those that have the greatest impacts can be identified and receive continued support.

In addition, untreated caregiver depression can affect brain development in infants and hinder social-emotional development leading to mental illness later in childhood. This important risk factor could be addressed in connection to well child visits through screening parents and other caregivers for depression, and subsequently, referral to assessment and possible treatment for those that screen positive. This is a critical component of integration for children's mental health care. To date, policies, research, and programs have largely focused on maternal depression; the impact of emotional well-being of fathers and other caregivers on infants and young children has been less explored. In 2016, CMS clarified that states could cover screening for maternal depression in connection to well child visits. As a result, 37 state Medicaid programs permit, encourage, or require reimbursement of screening for maternal depression in pediatric practices, and some states, like California and Colorado, are promoting care models that include dyadic care for an infant or child and caregiver (Department of Health Care Services, 2022; Tsai, 2022). Yet a recent survey by the American Academy of Pediatrics showed that roughly 54% of pediatricians screen new mothers for depression (National Academy for State Health Policy, 2021; Kornfiend et al., 2020). Formal screening and referral of positive cases for assessment and treatment and pediatrician follow-up could therefore be profitably added to performance indicators and financially rewarded. Referral is facilitated in many states and by national perinatal psychiatry access programs.

iv. Strengthening behavioral health screening and treatment under EPSDT

The foundation of comprehensive care for low-income children covered by Medicaid is its pediatric benefit, the Early and Periodic Screening Diagnostic and Treatment program (EPSDT). EPSDT requires Medicaid to cover all screening, testing, diagnostic and treatment services that are necessary to meet a child's health and developmental needs. Specifically, federal law requires states to provide services that are necessary "to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services..." This requirement pertains to services whether a state covers those services in its state Medicaid plan or not. Both the screening and the follow up services that EPSDT requires are necessary to ensure children's mental health and wellbeing. Yet the extent to which states are covering

behavioral health screenings and treatment for children through Medicaid is not clear. The BSCA creates an opportunity to inform these questions and address any gaps. The BSCA requires HHS to review and provide technical assistance and guidance to states regarding their EPSDT programs within the next 18 months and every five years thereafter, and to report to Congress on its findings and actions. This requirement pertains to all services that EPSDT covers and creates an opportunity for HHS to work with states to substantially strengthen behavioral health service provision through EPSDT where needed. With respect to behavioral health, HHS could productively explore four areas in its state EPSDT reviews that can help ensure that states are providing needed mental health services for children:

- 1) *Screening*: HHS could identify the extent to which children are consistently receiving screenings to identify mental health conditions, or their risk for developing them, as well as how frequently children connect to services when they are identified as needing them.
- 2) *Opportunities to reduce service access barriers*: As CMS noted in recent guidance, states can increase access to EPSDT services by removing requirements that beneficiaries be diagnosed as having a mental health condition before receiving services, or by using diagnostic criteria that are specific and appropriate to specific age groups (Tsai, 2022). This could be particularly beneficial in improving access to prevention and early intervention services. Children’s developmental needs frequently evolve; waiting for a diagnosis of a specific condition can miss important opportunities to intervene to reduce the likelihood of onset of a specific disease. CMS could also identify model medical necessity standards that states can use to ensure appropriate treatment and service utilization without creating unnecessary barriers to access and ensure that states are not placing hard caps on services that limit children’s ability to obtain treatment and are not consistent with EPSDT (Tsai, 2022).
- 3) *Provision of “sentinel services” that can treat mental health conditions for children and youth*: Some children enrolled in Medicaid and CHIP with serious mental illnesses are going without needed services, and adolescents in these programs are more likely to use institutional rather than community services than are privately insured children. In addition, rates of unmet need are higher for children of color (MACPAC, 2021). To identify the extent to which states are covering services that children need in a way that is administratively straightforward for CMS and states to carry out, CMS could identify a subset of services that are likely to benefit children with mental illness and review the extent to which states are offering these services. CMS and SAMHSA should publicly report the results of the review. For example, CMS and SAMHSA have identified a set of home and community-based services that are clinically effective, cost effective, and can help states meet obligations under EPSDT and the Americans with Disabilities Act. These services include intensive care coordination, family and youth peer support services, intensive in-home services and support, respite care, therapeutic mentoring, and crisis services (Mann and Hyde, 2013). In addition, multisystemic therapy is an evidence-based practice that serves children aged 12-17 who have been involved with the justice system (Timmons-Mitchell et al., 2006). CMS could identify these and other services as priorities in their state EPSDT reviews.
- 4) *Coordination of prevention and treatment across settings*: Finally, CMS should examine how states and the managed care organizations with which they contract that organize delivery of Medicaid services are ensuring access to follow up and treatment when children are identified as needing them. This requires coordinating across multiple

settings, including schools, primary care, specialty services, and home and community-based services. States and MCOs should have clear coordination mechanisms to support beneficiary access to care and reduce the administrative burdens that children and families face in navigating systems. The Government Accountability Office is also reviewing the provision of EPSDT services through Medicaid managed care.

IV) Conclusion

The year 2022 has brought unprecedented attention to the mental health of children. Such focus is long overdue. While the pandemic added stress to American children, harmed schooling, and interfered with caregiving, the evidence we reviewed suggests that the emergence of the current crisis in children's mental health pre-dates the pandemic by a decade. The sources of the doubling of prevalence in mental illness in children over a decade are not well understood. Though there are a variety of well-established prevention and early treatment interventions, they are seldom applied in the nation's schools. Moreover, treatment rates for diagnosable cases of illness remain under 50%, and low income-high need communities lack the basic infrastructure and supports necessary to serve their children. Given the magnitude of the problem, we offer a set of ideas for a federal children's behavioral health policy and implementation strategy. Specifically, we propose that the federal government continue and strengthen its recent commitment to addressing children's behavioral health by prioritizing low-income children and schools in its grantmaking and policy, and by prioritizing expanding Medicaid's ability to support the provision of behavioral health services in schools in implementing new Medicaid school resources Congress provided. We also suggest that the federal government maximize the effectiveness of new Medicaid and grant resources by promoting alignment between Medicaid and federal grant programs, with 1) Medicaid financing health and mental health services for low-income children and 2) grant programs funding prevention programs and critical investments in human, physical and technological infrastructure to support schools and communities to address the mental health needs of their children. We underscore the importance of structuring federal grantmaking for mental health in schools to prioritize evidence-based preventive interventions, as well as to support screening and connections to treatment. Finally, we believe that the federal government should redouble efforts to review the provision of behavioral health screening and services in Medicaid.

In combination, these measures can begin to address the troubling growth in the prevalence of mental disorders and impediments to treatment for children affected by those illnesses. The long-term consequences of failing to address mental illness in children will threaten the well-being of the next generation. These proposals – and other effective measures for serving the needs of children – will take time to implement and ultimately affect outcomes. Acting as swiftly as possible can promote the economic and health-related well-being of a significant segment of the next generation.

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Appendix I

Our exemplary targeting approach seeks to provide a mechanism for targeting schools and communities that have both high risks of mental illness in children and relatively few resources as measured by indicators of community level poverty and concentrated childhood poverty. We target low resource schools and communities by selecting Title I schools, in LEAs with 50% or more Title I School Wide program eligible schools, and in counties in the top tercile of poverty.⁵ Because there are no direct measures of mental illness in children and youth that cover all counties in the U.S., we measure the risks of mental illness in children and youth using three sets of county level indicators. They are 1) the rate of behavioral health related youth mortality measured as the rate of suicide, homicide, and overdose deaths under the age of 25; 2) counties in the top 50% of rates of adult “poor mental health days” derived from the CDC Behavioral Risk Factors Survey; and 3) counties with the highest quartile of adults over 25 that did not complete high school.⁶ As noted earlier, mental illness in adulthood is often the result of mental illness emerging in childhood. On the community level, high rates of adult poor mental health may follow poor mental health among youth. Additionally, children with mental illness are less likely to graduate high school. Therefore, our approach selects only Title I schools within these targeted counties and LEAs, representing places of concentrated childhood poverty and need. This approach to targeting yields 15,225 schools located in 942 counties that enrolled 6.9 million students. To put this targeting method approach in context, consider allocation of a hypothetical \$500 million. If the money were evenly spread across schools, it would result in grants of about \$2,600 per school. Under the allocation scheme described each selected Title I school would receive about \$33,100.

⁵ Title I School Wide Program eligibility based on Common Core of Data from the 2019-2020 school year. Percent of population in county with household income below 100% of the Federal Poverty Limit based on 5-year American Community Survey estimates from 2016-2020.

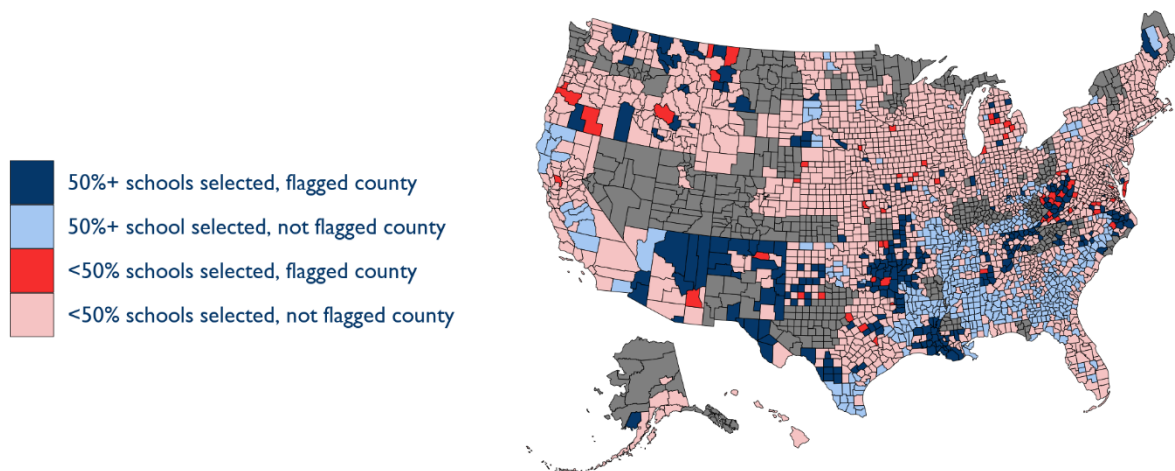
⁶ Rate of suicide, homicide, and overdose deaths per 100,000 people up to 25 years old by county based on National Vital Statistics System data from 1999-2020.

Percent of population 18 and older who report 14 or more “poor mental health days” over the last 30 days based on Behavioral Risk Factor Surveillance System data from 2018 and 2019. (2019 for all states except New Jersey. For New Jersey, 2019 BRFSS estimates are not available due to low response so 2018 BRFSS data is used instead.)

Percent of population over 25 with less than a high school degree or equivalent (GED), based on 5-year American Community Survey estimates from 2016-2020.

⁶ Percent of 12–17-year-old children that screen as having a past-year major depressive episode based on the National Survey on Drug Use and Health 2018-2020 substate estimates. Estimates for Connecticut, Massachusetts, and Rhode Island are on the state level because substate to county crosswalks were not possible.

Appendix Figure 1. Checking Selection Mechanism with High Prevalence Youth MDE and Poverty Flag



In Appendix Figure 1, we examined the targeting accuracy of this approach against the counties flagged as high-need/low-resource, in the top half of youth depression and top tercile of population in poverty, from Figure 3 (among counties with estimates available from the NSDUH survey). As noted earlier, these data are available for a subset of substates in the nation and therefore offer an opportunity to test the likely effectiveness of the proposed approach to targeting of funds. Comparing the targeted funding allocations to areas with high need and low resources shows that 79% of high need-low resource counties had 50% or more schools targeted, and 86% of counties that were high need low resource had at least one school identified. The targeting approach performed less well along two dimensions. It targeted 65% of all schools in high need-low resource areas, and it targeted 11% of schools (all Title I) that were not in high need-low resource areas but enrolled high shares of low-income children.