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**March 1, 2022**
**First Focus on Children**
**Statement for the Record**
**U.S. Senate Finance Committee**
**Hearings on Protecting Youth Mental Health: Parts I & II - An Advisory and Call to Action & Identifying and Addressing Barriers to Care**
**Held on February 8 and February 15, 2022**

Chairman Wyden, Ranking Member Crapo, and Members of the Senate Committee on Finance, we thank you for the opportunity to submit this statement for the record. First Focus on Children is a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions.

Our country is facing a youth mental health crisis, and the COVID-19 pandemic has only sharpened the lens on an existing issue. Even before the pandemic, 13-20% of children under the age of 18 experienced a mental disorder, and the suicide rate among youth aged 10 to 24 has increased nearly 60% since 2007. The issue has only worsened due to the pandemic. In the first 6 months of 2021, children's hospitals reported a 45% increase in the number of cases of self-injury and suicide in children ages 5 to 17 compared to the first 6 months of 2019. While children from all backgrounds have been impacted by mental health challenges during the pandemic, children of racial and ethnic minorities are disproportionately impacted.

Unfortunately, demand for services has gone up, but there is a severe lack of resources available to children and teens. Currently, there are 10 child psychiatrists per 100,000 kids; it is estimated that we need 47 per 100,000 to address the current crisis. Many parents, regardless of whether they have private insurance or are covered through Medicaid, are not able to find providers for their children because insurance networks are limited and there is a severe workforce shortage. These issues must be addressed to get our children the care they need.

In addition to school closures and isolation, the COVID-19 pandemic has caused 175,000 children and youth in this country to lose a primary caregiver, exacerbating the mental health crisis even further and disproportionately impacting children of racial and ethnic minorities.

In December 2021, the Surgeon General issued a report on youth mental health, citing the alarming increases in the prevalence of mental health challenges. We appreciated his powerful testimony at the February 2022 hearing before this Committee, in which he outlined what steps need to be taken to address this crisis for our children.

Below are a few of our recommendations to address the youth mental health crisis in America.

**Expand and improve the mental health workforce**

Demand for mental health services has gone up dramatically, but there is a severe lack of providers to meet this increased need. The federal government should bolster training programs for providers in children's mental health. Currently, the government spends $15 billion on health care workforce development but only 1% of that is spent on children's mental health workforce development.

Some ideas to address the workforce shortage include:

- Expand loan repayment programs, access to scholarships, and training programs for mental health professionals committed to practicing in rural and other underserved communities.
- Raise the Medicaid reimbursement rate for mental health providers.
- Integrate mental health services with primary care.
- Encourage young people to consider the mental health profession as a career to expand the pipeline of behavioral health providers.

**Invest in community based mental health services**

Children need improved and increased access to community-based mental health services. These are often more appropriate and effective for children and youth than in-patient care, and they are less expensive. The Certified Community Behavioral Health Clinics (CCBHCs) model is an example of a program that increases access to comprehensive mental health and substance use disorder services for populations including children. This model encourages collaboration between social service systems and school-based settings, reaching children where they are. Making mental health services as accessible as possible is vital to decreasing the stigma attached to these services and allowing children to continue living their lives in their communities, with their families.

**Invest in school-based mental health models to meet children where they are**

School based mental health models are an extremely effective way to deliver mental health services to children. However, such programs vary across states and many schools are underfunded and understaffed. These programs need additional investments and support to ensure they are reaching all children who need help.

Schools should provide a continuum of supports to meet student mental health needs, including evidence based prevention practices and trauma-informed mental health care. Tiered supports should include coordination mechanisms to ensure students get the right care at the right time.

The school based mental health workforce needs to be expanded. This can be done through the sustained use of local, state, and federal funds to hire and train additional staff, such as school counselors, nurses, social workers, and school psychologists, including dedicated staff to support students with disabilities.

School districts should be encouraged to access Medicaid funding for health and mental health services. The Centers for Medicare and Medicaid should update guidance to states that will enable them to

equitably access Medicaid reimbursement and require Medicaid to simplify the billing process for schools to ensure access and decrease the money spent on administration expenses.

Mental health needs to be fully integrated into our education system. Social and emotional learning should be integrated into K-12 curriculums, and discussions on mental health should be included in health discussions the way schools currently do for nutrition, exercise, cancer prevention, and other physical health topics.

**Ensure all children have access to high-quality and affordable mental health care by addressing parity**

By law, children (whether on Medicaid or covered by private insurance) are entitled to preventive services which include mental health diagnosis, prevention and treatment but they are often not receiving services because these laws are not being strongly enforced. Therefore, millions of children are falling through the cracks and unable to receive the care they need. On average, nearly 11 years lapse between the presentation of mental health disorders and the professional diagnosis of symptoms. We are failing our children when we force them to wait on average 11 years for treatment.

Three laws are important to the improvement of our mental health system for children. The Social Security Amendments of 1967 included provisions to ensure that early and periodic screening, diagnostic, and treatment services (EPSDT) are available to children in Medicaid. Over forty years later, the Affordable Care Act (ACA) defined "essential health benefits" for children as mental health, preventive care and pediatric care, as well as requirements to ensure the adequacy of provider networks to offer those services. For children covered by private health insurance, these provisions guarantee access to a relatively similar scope of preventive services as EPSDT under Medicaid. Finally, the passage of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) promotes equal access to treatment for mental health and substance abuse disorders by prohibiting coverage limitations that apply more restrictively for mental health and substance abuse than for medical and surgical benefits.

The high rates of depression, anxiety and suicides are a result of these laws not being enforced, a lack of investment in the mental health workforce and the failure of our school systems to provide more support to children with mental health needs. Together, these laws provide the framework for a more comprehensive and equitable system. We have the right laws, we simply need to implement and enforce them.

Network adequacy is a critical piece to the mental health continuum of care. It is important to all children to have access to a range of services from qualified providers in a geographic area – whether the children are on Medicaid or have private health insurance. Without adequate networks, parents may not be able to find providers who accept Medicaid or their particular type of private insurance. Oftentimes, once a provider is identified, wait lists can be one to four months which is not acceptable when a crisis occurs for a child, teen or adolescent. Or, parents with Medicaid may only be able to find in-patient care for their children when research suggests that in most cases, community-based care delivers better outcomes. Those parents with private insurance might find a "provider network list" but cannot find anyone in their geographic area, or the list might only have a few names on it, or the providers may not be taking new patients, or lists may be outdated – all of which can lead to roadblocks and barriers to finding viable provider options for their children.

**Improve Crisis Response Services**

We have seen the numbers of children in mental health crises increase dramatically in recent years, and we must ensure that these children and youth are able to access services when and where they need them.

This year, states must implement the new 988 behavioral health crisis response system. This should be a more responsive crisis system that avoids unnecessary and often harmful interventions such as a police presence and visits to emergency rooms. This approach is especially important for children and youth and for achieving equity in mental health. These crisis systems must address the special needs of children, youth, and young adults as well as be culturally competent and able to help populations including LBGTQ youth.

One helpful tool in responding to mental health crises for children and youth in appropriate and accessible ways is the mobile crisis response unit. Several states, including Oregon, are implementing mobile crisis response systems that increase equity and accessibility for children and youth in addressing their mental health needs, and these should be incorporated into states' implementation of the new 988 number.

**Address the Needs of Children Who Have Lost Caregivers Due to COVID-19**

In October 2021, even prior to the arrival of the Omicron variant, the number of children who had lost a parent or grandparent primary caregiver due to COVID-19 was 175,000, a staggering statistic. And over five million children worldwide have lost a parent or primary caregiver. Children of racial and ethnic minorities accounted for 65% of those who lost a primary caregiver, while making up only about 50 percent of the child population. These children currently have great needs and will continue to have many into the future.

The needs of this population of children should be met in a comprehensive way after identifying who they are. These children should have expanded access to mental health services, including in schools, regardless of their insurance coverage (public or private.) We must ensure that children who have lost caregivers during the COVID-19 pandemic receive the benefits that they are entitled to under current law and make them categorically eligible for other public programs and economic aid including early learning programs like the Child Care and Development Block Grant and Head Start, the Temporary Assistance for Needy Families, the Supplemental Nutrition Assistance Program, Medicaid, the Child Tax Credit, and others.

**Conclusion**

We appreciate the Committee's focus on the mental health crisis of our country's children and youth and the two valuable and impactful hearings that the Committee hosted in February 2022. First Focus on Children commends the Committee's bipartisan approach to this topic and we look forward to seeing the proposals that emerge from the five work groups that the Committee has established. We share your concern for the mental health of America's children and youth and we look forward to continuing to work with you as you craft legislation and funding proposals.

For questions or comments, please reach out to Averi Pakulis, Vice President of Early Childhood and Public Health Policy (AveriP@firstfocus.org), Elaine Dalpiaz, Vice President of Health Systems and Strategic Partnerships (ElaineD@firstfocus.org) or Olivia Gomez, Director of Health and Nutrition Policy (OliviaG@firstfocus.org).