A VISION FOR MENTAL HEALTH SYSTEMS OF CARE FOR YOUNG PEOPLE

The Adolescent Behaviors and Experiences Survey (ABES)

Conducted from January to June 2021, among students grades 9-12 attending public and private schools.

The survey found that overall

37.1 OF STUDENTS REPORTED THAT THEY EXPERIENCED POOR MENTAL HEALTH DURING THE PANDEMIC

31.1 EXPERIENCED POOR MENTAL HEALTH DURING THE 30 DAYS PRECEDING THE SURVEY

In addition, during the 12 months before the survey

44.2% OF THE TEENS REPORTED THEY HAD EXPERIENCED PERSISTENT FEELINGS OF SADNESS OR HOPELESSNESS

The survey found that almost

20% CONSIDERED ATTEMPTING SUICIDE

9 ATTEMPTED SUICIDE.[1]

EXECUTIVE SUMMARY

We are facing a mental health crisis, particularly among our young people.

While there are numerous measures of this crisis, one set of indicators comes from the Centers for Disease Control and Prevention (CDC), which published a one-time, online survey—the Adolescent Behaviors and Experiences Survey (ABES)—conducted from January to June 2021, among students grades 9-12 attending public and private schools.

The survey found that overall, 37.1% of students reported that they experienced poor mental health during the pandemic, and 31.1% experienced poor mental health during the 30 days preceding the survey. In addition, during the 12 months before the survey, 44.2% of the teens reported that they had experienced persistent feelings of sadness or hopelessness. The survey found that almost 20% considered attempting suicide and 9.0% attempted suicide.[1]

In response to these alarming statistics, numerous critical stakeholders, from government to provider organizations to advocates, have issued calls to action to address the growing mental health challenges facing our young people and their families. Dozens of reports highlight these challenges and the Biden Administration, Congress, states, and others continue to add resources and support new investments in mental health services across the country. These resources are in addition to the billions of dollars already dedicated to programs supporting the mental health of our nation's young people.

In the last fiscal year alone, Congress has taken landmark steps to address this growing and well documented mental health crisis, with additional bi-partisan draft legislation in development. In addition, the executive branch has taken significant actions to redirect funds and clarify policies to expand access to care and ensure payment policies for all categories of insurance coverage. In particular, the Department of Health and Human Services (HHS) has taken numerous actions to support programs to address this critical issue.

Despite these dramatic calls to action and substantial investments in programs across the country, the nation lacks a systematic way to guide these investments and address the broad range of issues—ranging from prevention to treatment—that impact the mental health of our young people. The time has come to bring together the wide range of stakeholders to rethink our approach to mental health for young people and to develop a new vision designed to respond to this crisis.

We are at a precipice of opportunity to fundamentally improve the mental health of our young people. There is now an unprecedented political will to improve the mental health system, new and uncharted recognition of mental health problems

OUR NATION LACKS A SYSTEMATIC WAY TO GUIDE INVESTMENTS AND ADDRESS THE BROAD RANGE OF ISSUES THAT IMPACT THE MENTAL HEALTH OF OUR YOUNG PEOPLE.

and systemic inequities that drive disparities, and significant investments by federal, state and local governments, as well as other organizations. MITRE stands ready to support this momentum and offers a vision of a foundation for an evidence-based youth mental health system that brings together federal agencies, states, and communities to systematically address this urgent issue.

> **In his first State of the Union Address, President Biden noted that:**
>
> "Our country faces an unprecedented mental health crisis among people of all ages. Two out of five adults report symptoms of anxiety or depression. And Black and Brown communities are disproportionately undertreated—even as their burden of mental illness has continued to rise. Even before the pandemic, rates of depression and anxiety were inching higher. But the grief, trauma, and physical isolation of the last two years have driven Americans to a breaking point.
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> Our youth have been particularly impacted as losses from the pandemic and disruptions in routines and relationships have led to increased social isolation, anxiety, and learning loss. More than half of parents express concern over their children's mental well-being. In 2019, one in three high school students and half of female students reported persistent feelings of sadness or hopelessness, an overall increase of 40 percent from 2009. Emergency department visits for attempted suicide have risen 51 percent among adolescent girls."

A WHOLE-OF-NATION APPROACH TO A MENTAL HEALTH SYSTEM FOR YOUNG PEOPLE

While numerous federal agencies, states, and localities are developing and implementing their own strategies to address this crisis, this report instead takes a "whole-of-nation" approach that looks beyond any one government agency and offers a complete reimagination of the way we address mental health among our young people. It builds on the ongoing calls to action and the work of numerous federal agencies, states, and localities as well as a broad range of investments in new and current programs designed to serve young people.

The objective of this report is to develop a strategic vision for federal, state, and local organizations to come together to more effectively utilize federal grant programs, as well as public and private coverage and payment programs. Our vision of an effective and equitable system is broad and designed to improve mental health prevention, access, services, and outcomes for young people and their families.

In addition, the report details new legislation and investments designed to address the current crisis. Finally, the report describes challenges and opportunities to immediately begin to improve the impact of current investments, as we move toward a system that meets the needs of our young people.

THERE IS ALSO BROAD CONSENSUS THAT THE NEED TO REDESIGN THE MENTAL HEALTH SYSTEM IS URGENT.

This report represents a snapshot at a time when, on a daily basis, new information is being published, new legislation is being proposed and implemented, and new understandings of the problems and solutions are being offered. By consolidating the vast array of information into some common themes, this strategic vision offers opportunities for near- and long-term solutions to the urgent problem of youth mental health.

KEY QUESTIONS TO DETERMINE A PATH FORWARD

Individuals, families, communities, providers, and advocates generally acknowledge that the mental health system for young people needs to be re-envisioned and redesigned to prevent mental health conditions and to better serve the needs of young people. There is also broad consensus that the need to redesign the mental health system is urgent.

A beginning step in reimagining an impactful system to serve our young people and their families is to identify the questions that should be addressed by every component of the current system and by those committed to designing a system that truly meets the needs of our young people.

To begin this process, there are several key questions for all stakeholders to consider:

The Broad Vision and Principles

- What should a mental health system in 2023 and beyond look like for young people?
- Who should we be serving in this mental health system?
- How do we build a workforce that meets mental health needs?
- How do we assure a system that is equitable and serves the unique needs of each individual?
- How do we address the social determinants of mental health in interventions and payments?

How the Mental Health System Works

- How do we organize core prevention and behavioral health services for young people?
- Where should interventions be provided and by whom?
- How can we ensure consistent, reliable linkages across service sectors?
- How do we shift from demonstrations of efficacious clinical practices and best system and policy practices to widespread sustainable adoption?

WE HAVE A GENERATION OF CHILDREN AND YOUTH WHO HAVE FACED UNPRECEDENTED CHALLENGES IN THEIR HOMES, THEIR SCHOOLS, THEIR HEALTHCARE SYSTEMS, AND THEIR LIVES.

The Funding and Payment Model

- What should we be buying and investing in for young people's mental health?
- How should we be paying for this system?
- How can federal funding and policy, combined with private sector mental health parity, support and sustain a high quality, modern mental health system for young people?

Evaluation and Accountability

- How can we assure quality of care?
- What data should be routinely collected to better understand the problems and evaluate the efficacy of interventions?

VISION FOR AN IMPROVED SYSTEM

As we continue to invest billions of dollars to care for our young people, we are utilizing the same traditional approaches to funding and building "systems of care" that are not meeting the needs of our young people.

We are at an unprecedented time, when every stakeholder, from the federal government to states and providers, as well as young people and their families, are demanding action.

Expectations are increasing that our significant federal investments, innovation, and technology must help improve the mental health of our young people and ensure a generation that benefits from mental well-being.

We may never again see a consensus across every sector to act now. There is also fundamental agreement that the current system is not working for our young people and their families concluding that:

- We cannot continue to invest in silos.
- We cannot continue to focus our funding on those with serious mental illness.
- We cannot sacrifice prevention to support treatment.

We must act now to promote health and well-being and provide access to care for all young people before the moment passes. This report lays out a call to action and recommends short term actions and a longer-term vision that is designed to initiate a constructive dialogue at many levels of the health system for moving forward with a more effective and accessible system. MITRE presents this vision to reimagine and build a future generation of resilient, healthy young adults.

Building on this fundamental consensus as well as our review of current strategies, new investments, and consideration of key questions for all stakeholders, we have identified **14 critical elements for a re-envisioned mental health system**.

THE BROAD VISION AND PRINCIPLES

1
Use a public health approach focusing on mental health promotion, prevention, early identification and intervention, treatment, and recovery supports.

2
Elevate family and youth-driven care.

3
Focus on equity.

4
Address the Social Determinants of Mental Health.

HOW THE MENTAL HEALTH SYSTEM WORKS

5
Expand the workforce serving children and young people.

6
Develop a comprehensive coordinated array of readily accessible services and supports.

7
Build on technology as essential infrastructure and a mechanism to improve access and delivery of care.

8
Ensure that timely innovations in mental health include a focus on children and young people.

THE FUNDING AND PAYMENT MODEL

9
Implement financing and payment systems to ensure a robust young people-focused benefit design.

10
Align federal funding and policies to optimize a mental health system for young people.

11
Re-establish an expectation in the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant that states submit a plan for children and young people's mental health.

EVALUATION AND ACCOUNTABILITY

12
Establish data standards, quality, and accountability in prevention, clinical care, and system performance.

13
Encourage a state governance structure for children and young people's mental health.

14
Designate a federal coordinator/unified plan for the behavioral health of young people.

CONTENTS

AN URGENT ISSUE

INTRODUCTION

The mental health crisis for young people in the U.S. has reached a critical point, presenting challenges not only to families, communities, and the mental health care system, but across all systems serving young people, including schools, primary care, early care and education, child welfare, and juvenile justice. All indicators of mental well-being for young people are trending in the negative direction.

The pandemic exacerbated these alarming trends with young people being seriously impacted by loss and disruptions in routines, relationships, and resources (e.g., food insecurity, family job loss) that have increased social isolation, anxiety, sleep problems, and learning loss.

In addition, prior to the pandemic, many young people with mental health needs received services and supports through their schools. With the closure of schools, these supports were inaccessible to youth.

In response to these challenges, numerous critical stakeholders, from government to provider organizations to advocates, have issued calls to action to address the growing mental health challenges facing our young people and their families. Dozens of reports address these challenges and the Biden Administration, Congress, states, and other key stakeholders are continuing to add resources and support new investments in mental health services across the country. These resources are in addition to the billions of dollars already dedicated to programs supporting the mental health of young people in our nation.

Despite these dramatic calls to action and substantial support for programs across the country, the nation lacks a systematic way to guide these investments and address the broad range of issues from prevention to treatment that impact the mental health of our young people. The time has come to bring together diverse and comprehensive stakeholders to develop a new vision to respond to this crisis.

While mental health challenges among young people existed prior to the COVID-19 pandemic, growing evidence shows that the pandemic disrupted our education and health systems, which impacted child development, exacerbated mental health problems for young people, disrupted care for those with existing mental health problems, and increased reported levels of anxiety, depression, and other mental health conditions. The pandemic fundamentally exposed the lack of a mental health system with the capacity to prevent and address these issues, as well as the lack of an adequate provider system to diagnose and provide care.

> **A 2021 white paper published by Senators Michael Bennet (D-Colo.) and John Cornyn (R-Texas) found:**
>
> "The federal government spends over $380 billion dollars a year on mental and behavioral health services. A large portion of those funds are programmed and allocated by the Centers for Medicare & Medicaid Services (CMS) through Medicare, Medicaid, and other federally subsidized health coverage programs like the Affordable Care Act. In addition, the Public Health Service Act…and other federal laws provide for billions more in funding for various health programs, like through the Health Resources and Services Administration and SAMHSA."[2]

The Pandemic Exposes an Inadequate and Inequitable System

The pandemic also turned a national spotlight on the inequitable access and disproportionate impact of these deficiencies on people from racial minority groups, tribal communities, and other segments of the population facing structural discrimination in our healthcare system. These issues are not new, but reflect growing trends in mental health starkly revealed by the pandemic.

For all of this spending, a unified strategy is not apparent for how these federal programs are to expend funds nor is there a clear goal of how they collectively advance our nation's mental health. Importantly, we

need a multipronged strategy for advancing mental health that includes a new approach to support a workforce (both licensed and unlicensed) and improving and establishing funding mechanisms that support innovative models of care delivery. Finally, we need a fundamental reframe of America's relationship with mental and behavioral health by redesigning local systems in communities all across this nation to empower them to have a greater and stronger response to the needs they are facing in the moment."[3]

We are at a precipice of opportunity to fundamentally improve the mental health of our young people. There is now an unprecedented political will to invest in mental health, new recognition of mental health problems and inherent systemic inequities that drive disparities, and significant investments by federal, state, and local governments, as well as other organizations. MITRE stands ready to support this momentum and offers a vision to help lay a foundation for an evidence-based child mental health system that brings together federal agencies, states, and communities to systematically address this urgent issue.

While numerous federal agencies, states, and localities are developing and implementing their own strategies to address this crisis, this report instead takes a whole-of-nation approach that looks beyond any one government agency to completely reimagine the way we promote and address mental health among our young people.

BACKGROUND

Children have long been regarded as a special, protected population. They have been viewed in this manner, not only due to their undeveloped and often physically vulnerable status, but also because of the development they go through as they age.

WE ARE AT A PRECIPICE OF OPPORTUNITY TO FUNDAMENTALLY IMPROVE THE MENTAL HEALTH OF OUR YOUNG PEOPLE.

Childhood is a Unique Developmental Phase

These developmental progressions present unique challenges and vulnerabilities that are rarely seen again outside of childhood. Further, this process goes beyond the traditional, physical growth phases that are easily visible in children, and includes the enormous mental and behavioral development that frequently defines childhood, adolescence, and youth in general. Meeting the needs of youth requires support for the whole child beyond just their physical health to also support and encourage their behavioral and mental health.

Behavioral versus Mental Health

The terms "behavioral health" and "mental health" are often used interchangeably in the literature, but they are not synonymous.

- Behavioral health is a far more expansive term than mental health and incorporates not only mental wellness, but the relationship between behaviors or habits (good or bad) and their effect on physical and mental health.[4]
- In this context, SAMHSA defines behavioral health as the "promotion of mental health, resilience, and well-being, and the treatment of mental and substance use disorders."[5]

The focus of this report will primarily be on the mental health disorders component of the definition, although references to substance use disorders may also be present.

- There is not one unified definition of mental health used across national or international agencies.[6]
- Common factors of definitions suggest that mental health as a concept includes a person's well-being and affects how we think and feel, how we act, and how we relate to others or handle stress.[7, 8, 9]
- Although there is no consensus around a singular definition of well-being as the primary component of mental health, there is general agreement that well-being is seen as comprising of positive emotional states (e.g., feeling good) and as having fewer negative emotional states.[10]
- Research suggests that well-being can be conceptualized across three broad areas: being (happy), having (rights, relationships, resources), and doing (having goals, making good decisions), and this definition applies to all people (adults and children).[11]

Defining Mental Health in Childhood

There are few examples in the literature that distinguish child or adolescent mental health from a definition of general mental health, adding complexity for agencies, payers, and programs that focus on mental health of young people specifically.

A Wide Array of External Factors Influence Children's Development

These developmental milestones are impacted by pre-existing factors such as:

- Biological and family influences
- Adopting healthy nutrition and sleep patterns
- Playing or exercising regularly
- Developing coping and problem-solving skills
- Learning to manage emotions[12]

Development may also be impacted by academic expectations, changing social relationships with family and peers, changing physical and emotional interactions with their surroundings associated with maturation, increased autonomy and independent decision making, and more.[13] Lastly, children are exposed to external factors that affect mental health including living in fragile settings, presence of climate and environmental stressors, and cultural considerations that place limitations on childhood, such as forced and early marriages, unsupported orphan populations, and ethnic or sexual discriminated groups.[14]

Childhood's Lasting Mental Health Effect

Patterns of behaviors established during various phases of childhood in response to these individual, social, economic, and environmental circumstances can continue into later adolescence, as well as adulthood. Since expectations and independence do not have a clear starting point, and continue to grow throughout childhood and adolescence, there is no clear beginning age for understanding and addressing mental well-being. Support for well-being starts well before birth and continues

> SINCE EXPECTATIONS AND INDEPENDENCE DO NOT HAVE A CLEAR STARTING POINT, AND CONTINUE TO GROW THROUGHOUT CHILDHOOD AND ADOLESCENCE, THERE IS NO CLEAR BEGINNING AGE FOR UNDERSTANDING AND ADDRESSING MENTAL WELL-BEING.

through each phase of childhood and adolescence, and spans from individual support to family, cultural, systemic, and environmental consideration.

Globally, the pandemic has issued a new paradigm on well-being, disrupting nearly all aspects of life for all ages across the world. The pandemic has made clear that the influence of the world around us on mental health continues to be underestimated.

Epidemiologists have recognized harm ranging from direct trauma of the virus to income disruption, loss of family, life routine, education, recreation, and more.[15] Society, politicians, healthcare workers, and individuals have found themselves in a very different environment, and with it, there is newfound innovation and political will to readdress well-being with a better understanding.

This report considered ages that encompass the entire human developmental period, from fetuses and infants through older adolescents and young adults, consistent with the National Academies of Science's national agenda for fostering health development.[16] In this report, the term "young people" includes the entire development period for children, youth, and young adults (to age 25).[17, 18]

PURPOSE AND APPROACH

The objective of this report is to develop a strategic vision that will help align the various federal grant programs supported by the U.S. Department of Health and Human Services (HHS), as well as public and private payment options, in a way that will more efficiently utilize resources to achieve the goals of improved mental health prevention, access, services, and outcomes for young people and their families.

In addition, the report highlights new legislation and investments designed to address the current crisis. Finally, the report describes challenges and opportunities to improve the impact of current investments that are necessary as we move toward a system that can ensure that our investments are meeting the needs of our young people.

This report represents a snapshot at a time when, on a daily basis, new information is being published, new legislation is being proposed and implemented, and new descriptions of the problems and solutions are being offered. This report is intended to consolidate the vast array of information into some common themes that offer opportunities for near-term solutions and a longer-term vision.

The report generally focuses on programs supported by HHS, which has invested in over 300 initiatives to date. Supported by multiple agencies across HHS, many of these programs represent siloed funding mechanisms and target a wide variety of state, local, and community-based organizations that struggle to coordinate these efforts through a whole-of-government systems approach.

There is a critical need for cataloguing current efforts, as well as an overall vision for a national evidence-based mental health system that provides evidence-based approaches to prevention and care for the nation's young people. The proposed national system needs to be more innovative, better coordinated, more accessible, and deliver better outcomes in a more equitable and an economically sustainable way.

While the report focuses on programs at the federal level, it is important to recognize that funding moves to states, tribes, and communities, and innovations are occurring regularly at these levels. In addition, states, localities, foundations, and private payers are all investing in improved mental health services for young people. Therefore, going forward, it will also be important to assess promising models in states and localities that are effectively addressing the various barriers to better mental health and wellness outcomes, such as payment, policy, program integration, workforce, or technologies.

THE PANDEMIC HAS MADE CLEAR THAT THE INFLUENCE OF THE WORLD AROUND US ON MENTAL HEALTH CONTINUES TO BE UNDERESTIMATED.

Clearly, no single solution to addressing our current crisis suffices. In this report, we provide a vision for a future system of care, but also identify challenges and immediate opportunities to more effectively design investments that support states, tribes, communities, and families and ultimately support the health and well-being of our nation's young people.

This effort represents the first step in laying out a vision and providing high-level recommendations for a national strategic vision for mental health programs, grants, and approaches to coverage and payment, with the goal of improved access, better outcomes, greater efficiency of resource utilization, and more consistent metrics for measuring success. This approach to

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Our youth have been particularly impacted as losses from the pandemic and disruptions in routines and relationships have led to increased social isolation, anxiety, and learning loss. More than half of parents express concern over their children's mental well-being. In 2019, one in three high school students and half of female students reported persistent feelings of sadness or hopelessness, an overall increase of 40 percent from 2009. Emergency department visits for attempted suicide have risen 51 percent among adolescent girls."

rethinking federal mental healthcare programs for young people could serve as a cross-federal system model for future efforts to reimagine other critical parts of our healthcare systems.

WHY NOW?
CONDITIONS FOR SOCIAL CHANGE

National Calls to Action

Presidential Executive Orders,[19] new Congressional legislative activities, and a Surgeon General Call to Action[20] have raised numerous alarms about the mental health of our young people. In conjunction with transformative efforts in states, major efforts in philanthropy and national professional and advocacy organizations, there is a once-in-a generation opportunity to re-envision a modernized, functional mental healthcare system for young people that will promote mental wellness and produce good outcomes for those with mental illness.

In addition, Surgeon General Murthy issued a youth mental health advisory, marking the urgency of children's mental health as a public health issue requiring "the nation's immediate awareness and action."[21] Senators Michael Bennet and John Cornyn have released, "A Bold Vision for America's Mental Well-being." Further, Representatives Eshoo, Rochester, and Fitzpatrick and Senators Murphy and Cassidy have introduced legislation specifically expanding and protecting children's access to mental health services.

IT WOULD BE A TRAGEDY IF WE BEAT BACK ONE PUBLIC HEALTH CRISIS ONLY TO ALLOW ANOTHER TO GROW IN ITS PLACE.

Vivek H. Murthy, M.D., M.B.A, U.S. Surgeon General

In October 2021, HHS issued a press release noting that, "Behavioral health is fundamental to the well-being of our country's children and youth. That's why agencies and offices across the HHS are working together to advance behavioral health for children, youth, and their families, with an emphasis on improving access, promoting equity, and fostering innovation. These efforts have resulted in over 300 distinct initiatives."[22]

Current Legislation and Key Agency Actions

In the last fiscal year alone, Congress has taken landmark steps to address this growing and well documented mental health crisis, with additional bi-partisan legislation in development. The executive branch has also taken significant actions to redirect funds and clarify policies to expand access to care and ensure payment policies for all categories of insurance coverage. We have arrived at an inflection point where there is significant opportunity to turn this crisis into an opportunity to implement needed reforms and put tools in the hands of all stakeholders to create pathways to needed to services.

In addition, it is important to note that Medicaid is the single largest payer for mental health services. Medicaid and the Children's Health Insurance Program (CHIP) provide essential healthcare coverage for over 90 million[23] individuals and families, including over 40 percent of all children and youth in the U.S.[24] As a result, new legislation, legislative initiatives, and HHS regulatory and subregulatory policy reforms are heavily focused on how Medicaid can play an impactful role in payment policy and models for behavioral health services.[25] Medicaid—by design a partnership between the federal government, states, and localities—provides a primary policy lever for coordination, alignment, and collaborative problem solving.

Highlighted here are significant new Federal legislative and executive branch actions intended to address the fundamental challenges identified in the various calls to action and strategic plans described in this report.

New legislation currently being implemented

The **Bipartisan Safer Communities Act (BSCA)** passed in June of 2022 included several provisions targeted at expanding access to care for children, adolescents, and young adults, with a specific focus on expanding funding and access for mental health services.[26] Passed in direct response to the school shooting in Uvalde, Texas, the BSCA is the first piece of gun safety legislation in 30 years.[27] Lawmakers took the opportunity to include significant bi-partisan mental health provisions that had long been under discussion and included in a range of previous legislative proposals.

Some key behavioral health provisions of the BSCA include:

- Section 11001 *"Expansion of Community Mental Health Services Demonstration Program"* aimed at increasing access to community based behavioral health services. This provision of the new law expands the existing Medicaid certified community behavioral health clinic (CCBHC) demonstration program. Passed into law in 2014 and currently operating in nine states, the demonstration project created CCBHCs to provide a range of services including immediate screenings, risk assessments, and diagnoses, as well as 24-hour crisis intervention services. CCBHCs have a proven track record of improving access to care, reducing hospital and ER visits, and providing mental and behavioral health support to local law enforcement.[28] The new law authorizes up to 10 new states to opt into the demonstration every two years. CCBHCs can be supported through the CCBHC Medicaid Demonstration, through SAMHSA administered CCBHC Expansion (CCBHC-E) Grants, or through independent state programs.

- Section 11002 focuses on telehealth access and requires CMS to provide guidance to states on how they can increase access to healthcare, including mental health services, via telehealth under Medicaid and CHIP.

- Section 11003 *"Supporting Access to Health Care Services In Schools"* legislates the creation of critical tools and resources states and local education agencies need to implement, enhance, and expand school-based health programs under Medicaid.

- Section 11004 *"Review of State Implementation of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services"* is intended to strengthen implementation and oversight efforts to support better access to mental healthcare, including preventive, early intervention, and treatment services for children.

- Section 11005 reauthorizes the Pediatric Mental Health Care Access (PMCHA) program administered by HRSA that provides technical assistance to mental health providers and facilitates coordination of care support for pediatricians to identify and properly refer patients to appropriate services.[29]

The legislative provisions of the BSCA are intended to work in tandem with technical assistance efforts providing much needed clarity and support in maximizing available resources to meet the current coverage and access challenges.

New proposed legislation for 2023

Congress is continuing to develop additional legislative initiatives and over the course of 2022, Senator Ron

Wyden, Chair of the Senate Finance Committee, partnered with senators from both parties (Ranking Member Mike Crapo, R-Idaho, and Senate Finance Committee members Senators Michael Bennet, D-Colo., and Richard Burr, R-N.C.) and released discussion drafts of wide reaching bipartisan mental health legislation they hope to pass in 2023. Draft legislative language is directed at five primary areas of reform: telehealth, **youth mental health**, expanding the mental health workforce, integration of physical and mental health providers and, most recently, draft language on strengthening mental health parity (laws and policies intended to ensure mental and physical healthcare are covered equally by health insurance).[30] Development of these draft documents reflects a concerted bipartisan effort in the Senate

to address widely documented difficulties encountered across the healthcare payment and care delivery systems, and reflects an aggregation of reform recommendations with broad based agreement and support.

All of the identified topic areas in the draft legislation have a direct impact on the availability of quality mental health services for young people and strive to address many of the core challenges regarding providing the needed care. The specific section of the proposed law entitled "Youth Mental Health" focuses entirely on Medicaid reforms and proposes necessary statutory changes

intended to improve mental healthcare for youth covered by Medicaid, including the following:

- As a condition of receiving Medicaid funding, states must eliminate barriers to coordinated care by allowing all providers to receive Medicaid reimbursement for behavioral and physical health services delivered on the same day.

- Requires CMS to take further steps to support **mental healthcare in schools** by updating Medicaid guidance to states to clarify allowable payments and identify strategies to reduce administrative burden (although the existing Bipartisan Safer Communities Act has already legislated similar actions, this legislation would provide planning grants for states to help take advantage of these flexibilities and best practices).

DRAFT LEGISLATIVE LANGUAGE IS DIRECTED AT FIVE PRIMARY AREAS OF REFORM: TELEHEALTH, YOUTH MENTAL HEALTH, EXPANDING THE MENTAL HEALTH WORKFORCE, INTEGRATION OF PHYSICAL AND MENTAL HEALTH PROVIDERS AND, MOST RECENTLY, STRENGTHENING MENTAL HEALTH PARITY.

- Requires stronger enforcement and oversight by CMS of Medicaid's **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit** to improve access to comprehensive mental healthcare services. The draft legislation recognizes that EPSDT is a federally required Medicaid benefit and considered "the country's gold standard in children's health coverage."[31] Statutory improvements that allow more effective use of this existing benefit framework can help address some of the most pressing issues related to accessing and paying for services.

- The draft legislation would also require HHS and state Medicaid programs to report additional data on mental health and substance use disorder (SUD) services provided to Medicaid beneficiaries.

Calls for Improved Data

Collectively, stakeholders have emphasized the need for better data on population needs, critical provider shortages, and other information that would provide the clearest view into how new policies are impacting the field and what additional policy considerations are needed. The integral role of accurate data is highlighted by experts across domains, and is a pervasive issue addressed throughout this report. It is a step forward for new legislation to directly address closing identified data gaps that limit effective evidence-based and outcome-driven policy making.

Accurate data allows all levels of government, as well as key stakeholders, to better measure a community's mental health needs, access to care, and outcomes regardless of the differences between states' mental health policies. The state rankings often illustrate which states are more effective at addressing issues related to mental health and substance use and provides an opportunity to analyze similarities and differences across states and assess how federal and state mental health policies impact existing access challenges.[32]

Other Areas of Focus

The other four areas of focus in the draft legislation also speak directly to the challenges identified throughout

this report. For example, the draft language on telehealth includes a requirement for CMS to issue further guidance on best practices when furnishing behavioral health services via telehealth pathways. Plus, it specifically directs CMS to issue guidance outlining the flexibilities and strategies states can leverage under current law to provide care via telehealth under Medicaid and CHIP. Telehealth draft language also provides states additional flexibility to use limited CHIP dollars for initiatives that focus on telehealth access for school-based services.

Key workforce provisions provide planning grants to states for participation in a demonstration where additional Medicaid funding would be provided to build out mental health and SUD provider capacity. These mental health parity provisions include codifying in statute current regulatory requirements to properly maintain and update provider directories in both managed care and fee-for-service Medicaid programs. Although broadly applicable across all age groups, these provisions would have a direct downstream positive impact on the areas stakeholders have identified as significant barriers for young people to access timely and appropriate mental health services.

Agency Actions

The White House and HHS are partnering to direct resources across federal, state, and local governments to address the economic and social barriers that contribute to poor mental health for young people, families, and caregivers. There are many policy and regulatory actions that HHS and the states have taken to expand access to mental health resources in healthcare and school-based settings. However, many of these actions do not exclusively focus on the unique needs of children, and there is an opportunity to test approaches specifically for young people in behavioral health and primary care systems. HHS is focused on identifying and communicating existing policy tools and programs that can be used to immediately expand access to mental health services for children and youth.

For example, CMS and SAMHSA have issued both independent and joint guidance on accessing services

for mental healthcare in school settings as part of a larger policy response to the mental health crisis. Many of these policy changes are directed at states and designed to provide maximum flexibility for funding and access to mental health services through the Medicaid program.

In addition, effective Medicaid benefit design for mental health services for children, youth, and their families has been identified by the CMS Centers for Medicaid and CHIP Services (CMCS) as a priority.[33] CMS is currently highlighting how states can pursue alternative care and payment models in service of children with behavioral health needs through existing Medicaid payment model waiver flexibilities by providing guidance related to the Substance Use Disorder/Serious Mental Illness Demonstration Opportunity under Section 1115 waivers,[34] Medicaid Home and Community-Based Services under Section 9817 of the American Rescue Plan Act,[35] and Qualifying Community-Based Mobile Crisis Intervention Services under Section 9813 of the American Rescue Plan Act.[36] School-based state policy actions include state laws supporting strategic planning, allocating funding to support school-based mental health services, providing mental health education and resources, and guiding school mental health policies.[37]

For example, in August of 2022 CMCS issued an informational bulletin, "Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth." It highlights ways that Medicaid and CHIP funding can be used to provide high-quality behavioral health services to children and youth.[38] Specifically, the bulletin highlights relevant existing federal guidance on Medicaid flexibilities for state Medicaid agencies, agencies administering CHIP, state behavioral health agencies, state developmental disability agencies, and other stakeholders. It also provides examples of ways that Medicaid and CHIP funding can be used to deliver high-quality behavioral health services to children and youth.

CMCS also issued a parallel bulletin "Information on School-Based Services in Medicaid: Funding,

Documentation and Expanding Services"[39] in August of 2022 to remind states of the applicable federal regulations and policies related to Medicaid-covered school-based services (referring to Medicaid-coverable services provided to children and adolescents in a school setting). It focuses on helping states and school-based providers implement, maintain, and expand their school-based programs. The guidance includes a checklist of existing Medicaid flexibilities to assist state agencies in developing proposals that are consistent with federal requirements and policies. It also clarifies when and how schools can provide services to Medicaid eligible students.

A key challenge to Medicaid school-based payment policies is that there is no benefit category in Medicaid called "school-based services." School-based services are Medicaid-covered services that are provided in school settings by qualified Medicaid providers. As a result, it has been difficult for local education agencies and schools to identify which school-based providers can and should establish themselves as authorized providers of Medicaid services. To do so, they would need to meet the applicable Medicaid provider qualifications and establish provider agreements with state Medicaid agencies.[40] This is a critical step toward expanding opportunities for students to access covered Medicaid services in a school setting. This and other core building blocks of creating a mental healthcare delivery infrastructure in school-based settings will continue to be a primary focus of the "critical tools and resources" HHS is developing under the BSCA.

FUNDAMENTALLY, THE MEDICAID PROGRAM IS STRUCTURED TO CREATE MAXIMUM FLEXIBILITY FOR STATES TO BEST SERVE THE SPECIALIZED NEEDS OF THEIR POPULATIONS.

Fundamentally, the Medicaid program is structured to create maximum flexibility for states to best serve the specialized needs of their populations. In addition to federal Medicaid statutory requirements, Medicaid jurisdictions (50 states, the District of Columbia, and all U.S. Territories) have the option to cover benefits and offer eligibility to populations beyond what is mandated by federal law.

This state flexibility is captured in Medicaid and CHIP State Plans and State Plan Amendments, and CMS has long encouraged states to leverage these tools to innovate in benefit design, delivery system reform, and provider payment policies. Separately, Section 1115 of the Social Security Act provides waiver authority to states to innovate and prioritize critical issues.[41] In addition, section 1915(b) waivers (often called "freedom of choice" waivers because CMS allows states to waive statutory requirements for comparability, state-wideness, and freedom of choice) and section 1915(c) home and community-based services waiver programs are additional avenues for states to target specific populations for services such as intensive case management for children and coordination of services for youth with Serious Emotional Disturbance (SED). States regularly utilize this significant flexibility provided under Medicaid and the current administration is actively partnering with states to promote mental health services for children and youth.[42]

In December of 2021, CMS released a State Medicaid Director Letter with guidance on the scope and payments for qualifying community-based mobile crisis intervention services authorized by section 9813 of the American Rescue Plan Act of 2021.[43] The guidance highlights the flexibility states have to design coverage and services that best meet the needs of local communities, and can receive an 85 percent federal medical assistance percentage (FMAP) for expenditures on qualifying community-based mobile crisis intervention services.

In September 2022, the federal government granted Oregon the first of its kind approval for Medicaid

reimbursement of community-based mobile crisis intervention services.[44] Oregon used the flexibility under a new Medicaid State plan amendment that allows them to provide community-based stabilization services to individuals experiencing mental health and/or substance use crises throughout the state by connecting them to a behavioral health specialist 24 hours per day, every day of the year.

In their guidance, CMS incorporates a joint CMS/SAMHSA guidance released in May 2013 outlining payment policies and guidelines for providing coordinated crisis support. The guidance is intended to assist states in designing Medicaid benefits that meet the needs of children, youth, and young adults with significant mental health conditions.[45] The interventions discussed in 2013 are reiterated and emphasized in recommendations and policy guidance in subsequent years, including intensive care coordination, wraparound services, peer services, and trauma-informed systems and evidence-based treatments. Mobile crisis units are one piece of a larger set of delivery system reforms states can leverage to better serve children and their families and decouple community response to mental health crises from law enforcement intervention.

Finally, in August 2022, CMCS issued an informational bulletin to provide state Medicaid agencies with guidance on EPSDT requirements and other authorities they can use to deliver high-quality behavioral health services to children and youth through their Medicaid and CHIP programs.[46] First, CMCS outlines EPSDT coverage obligations. For example, states are reminded that EPSDT extends to prevention, screening, assessment, and treatment for mental health conditions. Additionally, CMCS provides guidance on other Medicaid and CHIP authorities that states can use to design mental health services and supports for children. These authorities include Health Services Initiatives (HSIs) to improve the health of low-income children and Home and Community-Based Services (HCBS), which can help supplement EPSDT-required services.

Furthermore, CMCS provides states with four strategies, accompanied with state examples, for providing high-quality mental health services to children and youth.

- First, states are encouraged to improve prevention, early identification, and engagement in treatment, which are key components of EPSDT. This can be done by increasing access to behavioral health screenings, eliminating the requirement for a behavioral health diagnosis for EPSDT services, and developing referral networks of mental health providers.

- Second, CMCS recommends that states increase access to treatment across the continuum of care by expanding access to crisis stabilization services, ensuring coverage and reimbursement are available for services at intermediate levels of care, expanding telehealth options, offering recovery supports and services, providing enhanced care coordination, and developing systems to track which behavioral health providers accept Medicaid.

- Third, states are encouraged to expand provider capacity by recognizing an array of providers who can maximize access to behavioral health services, implementing provider recruitment and retention efforts, and leveraging additional funding, such as the 10-percentage point increase to the FMAP for HCBS made available under the American Rescue Plan Act of 2021.

- Finally, CMCS recommends that states increase integration between behavioral health and primary care to help ensure that individuals with behavioral health issues are identified earlier and connected with appropriate treatment sooner.

This guidance reflects a continued effort by executive agencies to support access to mental health services for children and youth. Over the past 25 years, agencies have issued numerous pieces of mental and behavioral health-related guidance, informational resources, and reports to encourage states and other entities to provide mental health services through Medicaid and other federal programs. They have echoed similar themes of care coordination, telehealth,

EPSDT services, crisis response services, telehealth, peer support services, HCBS, and school-based services among others.

(See Appendix E for additional information on legislative actions, waiver authorities, and HHS guidance.)

Mental Health Strategies

As we consider a new vision for a mental health system for youth and their families, the existing strategic plans of governmental agencies can help us understand the current context and inform a reimagined system.

The U.S. Departments of Education and HHS, the White House, and the Surgeon General, among others, have issued strategic plans and frameworks intended to address current issues driving the mental health crisis for young people (Appendix A). The strategic initiatives focus on implementation timeframes spanning FY 2019-2026 and describe key priority areas and outcomes. Promotion and prevention strategies were most frequently mentioned, followed by workforce augmentation, data, and treatment. The key priority areas identified across diverse strategic initiatives are reflected in many of the 14 recommendations we propose later in this report.

Consistent across the focus areas was the emphasis on the importance of equity to achieve every strategy and a need for collaboration.

Key Priority Areas of Governmental Mental Health Strategic Plans

- **Promotion/Prevention**—increasing public knowledge and understanding of mental health for young people through a combined promotion and prevention strategy.
- **Workforce Augmentation**—increasing the capacity and training of mental health professionals that specifically serve youth in clinical, school, and community-based settings to support the outcome of enhanced diversity, competency, and distribution of the mental health workforce.

- **Data**—increasing collection, storage, analysis, and deployment of data to bolster programs aiming to improve the delivery of mental healthcare services to young people as well as information technology, and strong cross-sector partnerships for data linkages.
- **Treatment**—supporting evidence-based and diverse treatment options to target integrated care models for young people with behavioral health conditions.
- **Financing**—integrating alternative payment models or federal grants and investments to fund and implement evidence-based best practices for integration of high-quality, clinically effective models of care.
- **Research**—increasing knowledge of evidence-based practices and policies that can improve the body of literature addressing topics in child and adolescent mental health.
- **Healthcare Coverage**—ensuring that all young people have access to comprehensive and affordable coverage for mental health preventive services and treatments.
- **Technology Modernization**—assuring access to appropriate technologies and developing safety standards for proper use of technology for certain populations.
- **Crisis Intervention**—increasing funding and allowing for flexible funding mechanisms to support implementation of crisis services at the state and local levels.
- **Social Determinants of Health (SDOH)**—investing in SDOH to achieve a reduction in barriers experienced by young people and accessing wellness and mental healthcare services.
- **Early Detection and Intervention**—improving identification of young people who may benefit from mental health and wellness care. This includes early identification, diagnosis, and treatment for pediatric behavioral health conditions, as well as the need for coordinated care and case management to increase early referrals and intervention.

Vision for an Improved Children's and Young People's Mental Health System

The mental health crisis for young people in the U.S. has reached a critical point, presenting challenges not only to families, communities, and the mental healthcare system, but across all systems serving young people, including schools, primary care, early care and education, child welfare, and juvenile justice.

The pandemic exacerbated these alarming trends with young people being seriously impacted by loss and disruptions in routines, relationships, and resources (e.g., food insecurity, family job loss) that have increased social isolation, anxiety, sleep problems, and learning loss.

In addition, prior to the pandemic, many young people with mental health needs received services and supports through their schools. With the closure of schools, these supports were inaccessible to youth.

ALL INDICATORS OF MENTAL WELL-BEING FOR YOUNG PEOPLE ARE TRENDING IN THE NEGATIVE DIRECTION.

A Crisis Long in the Making

The pandemic did not cause this crisis in mental health. For decades, we have struggled with an inadequate and fragmented system of services with poor access to care, limited services, and poor outcomes.

- Less than half of young people needing treatment get access to appropriate services.
- Young people from under-resourced, marginalized communities are even less likely to get access to care.
- Promotion and prevention efforts are inconsistent and unevenly implemented.

The pandemic precipitated the "big reveal"—there is no coordinated, systematic continuum of care for young people with mental health challenges, in spite of major federal and state investments and funding. It is apparent that there is no unified strategy for how to maximize and expend these investments in an effective and efficient manner, how to avoid redundancies, and most importantly, how to achieve collective goals for mental health well-being among children and young people.

In this report, MITRE articulates questions for consideration by all stakeholders to drive a redesign of the mental health system and recommends critical elements for a new system. The organization of the document enables the reader to first view organizing questions, preview a draft vision, then conclude with a delineation of challenges and opportunities for possible short and longer term solutions related to each of the proposed elements.

KEY QUESTIONS

There is general acknowledgement among individuals, families, communities, providers and advocates that the mental health system for young people urgently needs to be re-envisioned and redesigned to better serve the population. A first step in this redesign is to identify the questions that need to be addressed. Every individual and sector need to identify those questions that can help move them forward but ultimately, a new system of care must address all of these factors.

The following are key questions for all stakeholders to consider in reimagining an impactful system to serve our young people and their families.

The Broad Vision and Principles

- What should a mental health system in 2023 and beyond look like for young people?
- Who should we be serving in this mental health system?
- How do we build a workforce that meets mental health needs?
- How do we assure a system that is equitable and serves the unique needs of each individual?
- How do we address the social determinants of mental health in interventions and payments?

How The Mental Health System Works

- How do we organize core prevention and behavioral health services for young people?
- Where should interventions be provided and by whom?
- How can we ensure consistent, reliable linkages across service sectors?
- How do we shift from demonstrations of efficacious clinical practices and best system and policy practices to widespread sustainable adoption?

The Funding and Payment Model

- What should we be buying and investing in for young people's mental health?
- How should we be paying for this system?
- How can federal funding and policy, combined with private sector mental health parity, support and sustain a high-quality, modern mental health system for young people?

Evaluation and Accountability

- How can we ensure high-quality mental healthcare?
- What data should be routinely collected to better understand the problems and evaluate the efficacy of interventions?

CRITICAL ELEMENTS OF A VISION FOR AN IMPROVED SYSTEM

Envisioning a new system of care provides the luxury of rethinking our existing programs and designing a system that truly serves the needs of all young adults, regardless of income, insurance coverage, race/ethnicity, geography, or SDOH. We assert 14 critical elements that should be considered as we move to a re-envisioned mental health system for young people.

The Broad Vision and Principles

- Use a public health approach focusing on mental health promotion, prevention, early identification and intervention, treatment, and recovery supports.
- Elevate family and youth-driven care.
- Focus on equity.
- Address the Social Determinants of Mental Health.

How The Mental Health System Works

- Expand the workforce serving children and young people.
- Develop a comprehensive coordinated array of readily accessible services and supports.
- Build on technology as essential infrastructure and a mechanism to improve access and delivery of care.
- Ensure that timely innovations in mental health include a focus on children and young people.

The Funding and Payment Model

- Implement financing and payment systems to ensure a robust young people-focused benefit design.

- Align federal funding and policies to optimize a mental health system for young people.
- Re-establish an expectation in the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant that states submit a plan for children and young people's mental health.

Evaluation and Accountability

- Establish data standards, quality, and accountability in prevention, clinical care, and system performance.
- Encourage a state governance structure for children and young people's mental health.
- Designate a federal coordinator/unified plan for the behavioral health of young people.

THE BROAD VISION AND PRINCIPLES

Use a Public Health Approach

A key component of mental health promotion is encouraging and increasing protective factors and healthy behaviors that can help prevent the onset of serious mental disorders and reduce risk factors that can lead to the development of these disorders. There is also growing recognition that promoting mental health as it relates to the SDOH is key. This would include living conditions and environments that support mental health and allowing people to adopt and maintain healthy lifestyles.[29]

The federal website, Youth.GOV, calls for mental health promotion and prevention that:

- Engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive.
- Recognizes, utilizes, and enhances youths' strengths.
- Provides opportunities to foster positive relationships and build leadership strengths.

The public health approach calls for:

- **Primary prevention** programs and policies that promote mental well-being generally and prevention programs aimed at those at high risk of developing mental health conditions.

- **Secondary prevention** calls for programs that promote awareness of early symptoms and connecting young people and their families to early interventions.

- **Tertiary prevention** programs (e.g., treatment in an outpatient or inpatient setting and crisis intervention programs) should include programs that allow for continuing support to maintain mental health well-being following treatment.[47]

According to Youth.GOV, mental health prevention is defined as "intervening to **minimize mental health problems** by addressing determinants of mental health problems before a specific mental health problem has been identified in the individual, group, or population of focus with the ultimate goal of reducing the number of future mental health problems in the population." The organization emphasizes that **mental health promotion and prevention are at the core of a public health approach to children and youth mental health by balancing positive mental health**, as well as preventing and treating mental health problems.[48]

Elevate Family and Youth-Driven Care

- A comprehensive, coordinated array of treatment services should be provided for those with severe mental health issues and their families.

- Families and young people need to be able to access appropriate types of treatment and supports based on age and development.

- It is also important to design systems that reflect the priorities of young people and their families.[49]

Young people and their families bring their personal experiences to a range of mental health problems and this first-hand knowledge can help develop a more responsive care system. Improving services and systems that support positive growth and development is also driven by the voices of individuals and families with experience in various diverse cultures and systems, including mental health, child welfare, education, and juvenile justice.

Elevating the leadership and voice of young people and their families in both policy and practice has the potential to produce more effective solutions and community-driven priorities and initiatives. In an era of rapid technological, environmental, and social change, young people and their families must have substantive opportunities to provide input to a new, responsive mental health system.

USE A PUBLIC HEALTH APPROACH FOCUSING ON MENTAL HEALTH PROMOTION, PREVENTION, EARLY IDENTIFICATION AND INTERVENTION, TREATMENT, AND RECOVERY SUPPORTS FOR OPTIMAL OUTCOMES.

Youth-guided and family-driven care ensures that young people and families are full partners in all aspects of service delivery and have a primary decision-making role in their care.[50] Young people and their families should also play a significant role in the redesign of systems of care at the national, state, tribal, territorial, and community levels. Young people can also help inform key cultural and linguistic designs to ensure that all services, providers, and settings are designed and implemented to match their needs. In addition, young people centered evaluations, monitoring, and reporting should match their goals for each program.

- As noted by the National Center for Healthy Safe Children, engaging young people "ensures that those with lived experiences are involved in designing, developing, implementing, and evaluating programs and services. In youth-guided and family-driven systems, youth and family members are provided needed training and support and accurate, understandable, and complete information necessary to set goals, make informed choices about services, and partner in decision-making that impacts children and families."[51]

Focus on Equity

Addressing social/political constructs and historical systemic injustices, such as racism and discriminatory structures and policies that disproportionately impact the mental health of young people of color is essential. The current societal climate provides a once in a generation opportunity to dissemble policies and system structures that promote inequities.

While many organizations have raised concerns about assuring equity in all healthcare services, the Institute for Healthcare Improvement (IHI) notes that everyone should have a fair opportunity to attain their full health potential and no one should be disadvantaged from achieving this potential.[52]

IHI recommends the following strategies for reducing inequities:

- Make health equity a strategic priority.
- Develop structures and processes to support health equity.
- Deploy specific strategies to address the multiple determinants of health so that healthcare organizations can have a direct impact (e.g., healthcare services, socioeconomic status, physical environment, and healthy behaviors).
- Decrease institutional racism within the organization.
- Develop partnerships with community organizations to improve health and equity, as these partners know the community and its needs.[53]

In September of 2022, the Satcher Health Leadership Insititue released *The Economic Burden of Mental Health Inequities in the United States Report*,[54] which looked at a four-year period (2016-2020) finding that "national estimates chronically underrepresent the actual burden of mental healthcare inequities, which has crippling implications on policies, funding, access to care and resources. To put this into perspective, **nearly six million Americans** are not accounted for in national reporting estimates regarding mental healthcare." The report conservatively estimated that during the four-year time period studied **nearly 117,000 lives** could have been saved and "excess cost burden from

premature mental and behavioral health-related deaths among indigenous populations and racial and ethnic minoritized groups due to mental illness, substance use, and suicide" totalled **approximately $278 billion**.

The report suggests three "key pillars" to guide and ultimately impact policy decision making:

- Make sustainable, long-term investments into mental and behavioral health systems, including programs, treatments, supports, and interventions that will advance mental health equity.
- Develop socio-culturally tailored approaches to mental and behavioral health services and programs.
- Address the social and political determinants of health inequities.[55]

The Pandemic Exacerbated Health Inequities

- Black, Native American, Latino, Asian American, and Pacific Islander young people have historically faced greater challenges related to their mental health, as well as more barriers to accessing mental health services. The pandemic exacerbated those challenges

In the fall of 2020, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national emergency in child and adolescent mental health. The joint declaration said:

"Children and families across our country have experienced enormous adversity and disruption. The inequities that result from structural racism have contributed to disproportionate impacts on children from communities of color. 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."

from both an education and health perspective. In particular, the pandemic disproportionately impacted minority communities and their young people because they experienced more deaths among their caregivers.

■ In addition, many of these young people experienced greater economic instability, family illness, and other traumatic events, often with less support than young White people. Access to broadband and telehealth services were also more limited for certain populations, making it difficult for them to attend virtual classes and use online healthcare services.

Government and Other Partnerships Focus on Health Equity

Currently, equity investments and partnerships at the federal, state, and community levels are accelerating, in part due to stark disparities revealed by the pandemic and federal actions to remedy these alarming inequities. While every federal agency is committed to addressing health equity in their mental health programs, it is imperative to also include the voices of state and local community leadership, as well as youth and their families to represent all voices in the continuum of care.[56]

SAMHSA describes behavioral health equity as "the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons; Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality."[57]

SAMHSA notes that our behavioral healthcare systems need to be designed to address diverse populations and have the capacity to reduce disparities in mental health services for underserved populations and communities. In order to effectively improve mental health outcomes, SAMHSA notes that all individuals should have access to high-quality services that

recognize SDOH, including adverse childhood experiences, food and housing insecurity, proximity to services, and culturally responsive care—all of which have an impact on behavioral health outcomes.[58]

While every HHS agency emphasizes health equity, one approach used by SAMHSA requires that all grantees submit a Disparities Impact Statement that identifies how data on access, use, and outcome will be used to identify underserved ethnic and racial minorities and LGBTQ populations.

The **statement must describe** how the grantees include methods for the development and implementation of policies and practices to ensure adherence to the Culturally and Linguistically Appropriate Services (CLAS) standards and the provision of effective care and services. SAMHSA notes that states should provide resources and opportunities that support compliance.[59]

> Promoting children's mental and behavioral health underlies healthy development and health equity across the lifespan. Advances across broad areas of behavioral, social and neuroscience inform practice, programs, and policy in child and adolescent mental and behavioral health.[60]

Address the Social Determinants of Mental Health

There is growing recognition that the effectiveness of interventions is limited by social conditions that impact child and family well-being. Mental health requires looking beyond the traditional mental health system and taking a deeper examination of social and structural systems that are critical to support mental well-being. Trauma and Adverse Child Experiences (ACEs)— domestic violence, housing stability, family income and employment, poverty, neighborhood and school violence—have all been shown to impact children's mental health and health in general. Only more recently have funding entities started providing

resources to address SDOH. Research on the social determinants of mental health remains an ongoing priority, and recent research has looked at the intersection of the structural and social determinants to identify upstream interventions and attempts to use simulation models to represent these complex systems. Findings from a 2019 study noted "methodological challenges and inconsistent findings prevent a definitive understanding of which social determinants should be addressed to improve mental health, and within what populations these interventions may be most effective."[61]

Payment & Policies Related to SDOH

In 2021, CMS issued guidance to state health officials to encourage the adoption of strategies that address the SDOH of Medicaid and CHIP beneficiaries. The guidance, promoting integrated delivery and payment models that reward providers for coordinated high-quality care, highlighted approaches that integrate behavioral health services into the broader healthcare system.

Policies such as expanding the Earned Income Tax Credit (EITC)[62] or investments in universal basic income/cash transfers to families below the poverty level have moved these families out of poverty resulting in their children showing fewer behavioral health problems. More than 48 guaranteed income programs have been started in cities nationwide since 2020. Some efforts are publicly funded, and others have nongovernmental support. Engaging and partnering with community-based organizations that address mental health and related SDOH, (e.g. food insecurity, immigration issues, housing stability) will strengthen mental health outcomes.[63, 64]

The American Psychological Association (APA) notes, "Promoting children's mental and behavioral health underlies healthy development and health equity across the lifespan. Advances across broad areas of behavioral, social, and neuroscience inform practice, programs, and policy in child and adolescent mental and behavioral health." In addition, they note that minority stress and adverse experiences influence mental and behavioral health within certain populations defined by gender, race and ethnicity, gender identity and sexual orientation, immigration status, physical, developmental, and intellectual disabilities, or chronic medical conditions.

The APA cites a report (written prior to the pandemic) on mental health disparities that identified four determinants of racial/ethnic minority mental health burden in young people that contribute to mental health disparities. They include:

Socioeconomic status—which can impact all children but disproportionately disadvantages racial/ethnic minority children including material deprivation, perceived minority status, and higher levels of family stress.

Family structure—such as single parent homes and stepfamilies, which contributes to mental health disparities through increased exposure to adverse childhood experiences, early transition to adult roles, and burdened parental capacities.

Adverse childhood experiences—particularly early and chronic exposure, which can have a negative impact on lifelong health.

Neighborhood and social stress—which can contribute to mental and behavioral health disparities including residential segregation, economic disadvantage, mobility, and violence and environmental toxicity.

The APA notes that childhood and adolescence provide critical opportunities for prevention, early detection, and intervention to promote child mental and behavioral health. At the same time, environmental risk factors—including socioeconomic status, adverse and risky environmental conditions, poor educational opportunities and outcomes, low socioeconomic status (SES), educational status, and poverty—are associated with greater risk of developing a mental and behavioral disorder among young people compared with individuals in middle or higher SES. Low SES, unemployment and low-wage jobs, and no or inadequate insurance coverage may impact families' ability to access and pay for physical and mental healthcare, leading to higher risk for mental and behavioral health problems and psychological disorders. Lower educational attainment for both parents and children may contribute to risk factors for the development of psychological disorders, which can lead to serious mental and behavioral health problems in childhood, adolescence, and adulthood.

Furthermore, when young people have a mental and behavioral health disorder, they may be more likely to face academic challenges which can then lead to educational underachievement, as well as frequent absences, higher rates of suspension or expulsion, or failure and drop out from high school.

Other challenges that may influence the development of mental and behavioral health disorders in young people include environmental risk factors such as prenatal exposure to toxins, maternal cigarette smoking and alcohol use, chemical contaminants in the environment, and maternal stress.

Conditions that may impact development include inadequate childcare, ineffective family discipline, family disruption, deviant peer influences, childhood trauma (e.g., maltreatment, discrimination, family separation, disasters), and neighborhoods with exposure to violence.

Race/Ethnicity and Low-Income

The APA notes that although most young people and their families have difficulty accessing and utilizing adequate and effective mental and behavioral health services, low SES and minority young people have greater difficulty in receiving quality mental healthcare with higher rates of challenges among Hispanics and African Americans than among non-Hispanic Whites. This is partially because there are fewer mental and behavioral health services in low-income, racially segregated neighborhoods.

It is also recognized that concerns about stigma can impact racial and ethnic minority families' decisions to seek treatment for their young people. These differences call for more culturally appropriate, evidence-based mental and behavioral health promotion, prevention, and early intervention programs that are readily available for all young people.

Gender

In addition to race and ethnicity, gender also serves as a determinant for experiencing mental and behavioral health difficulties that may affect girls and boys differently. For example, one risk factor is exposure to violence. Girls have an increased risk of experiencing sexual abuse and assault at any age whereas boys have an increased risk of experiencing physical violence and exposure to gang violence. Girls are at greater risk of poor mental health due to gender-based violence, low income and income inequality, low social rank, and socioeconomic disadvantage but boys are less likely than girls to access care or to seek help due to stigma, which is particularly challenging for Black adolescent males.

LGTBQ

It is also important to recognize the unique mental health challenges for LGBTQ young people who often face stressors associated with status, discrimination, prejudice, social stigma, internalized stigma, rejection, and/or victimization. Evidence shows that LGBTQ individuals are at an increased risk for mental and behavioral health problems and poorer physical health when compared with their heterosexual counterparts.

These problems include higher reported rates of anxiety and depression, low self-esteem, engaging in self-injurious behaviors, suicide, substance use,

homelessness, and eating disorders. Furthermore, LGBTQ students are more likely to face harassment, bullying, and a higher prevalence of dating violence compared to their heterosexual peers, which can lead to suicidal thoughts or attempts and lower academic achievement.

They are also less likely to access and utilize healthcare services, especially if the provider lacks the necessary tools and sensitivity to provide comprehensive care and is uncomfortable discussing sexuality and diversity in sexual orientation and gender identity with adolescents.

Rural Youth

Another gap in access to care for young people is the impact of living in rural areas. It is well recognized that rural areas have fewer health professionals, including mental health professionals, than urban areas. Rural areas also face socioeconomic and cultural factors associated with rural residence, including higher rates of poverty, geographic isolation, lower rates of connectivity, and transportation barriers.[65]

Disabilities & Medically Vulnerable

Finally, young people with developmental and physical disabilities and chronic medical conditions can face mental and behavioral health challenges. Mental and behavioral health disparities can occur within these populations due to discrimination, attitudinal and physical barriers, abuse and neglect, and lack of accessible and disability-sensitive services.

FUNDAMENTAL BUILDING BLOCKS FOR A SYSTEM THAT WORKS FOR YOUNG PEOPLE

According to the CDC, only 20% of young people with mental, emotional, or behavioral disorders receive care from a specialized mental healthcare provider. In addition, many children with other types of developmental and learning disorders may also have difficulty with emotions or behavior and need treatment.

To better understand the differences between the impact of mental health on young people in urban and rural areas, CDC studied parental views about their child's mental health, their own mental health, their neighborhood, and other personal and community factors. CDC found that parents of children with mental, behavioral, and developmental disorders in rural areas were more likely to report having trouble getting by on their family's income than parents of children with these disorders in urban areas. Parents were also more likely to rate their own mental health or their partner's mental health as "fair" or "poor" regardless of poverty level and race/ethnicity. They also were more likely to report living in a neighborhood in poor condition and without amenities, such as parks, recreation centers, and libraries.

The CDC notes that some families are unable to find mental healthcare because of the lack of providers in their area; others may have to travel long distances; and still others may be placed on long waiting lists to receive care. In addition, high costs, lack of insurance coverage, and the time and effort involved in finding qualified providers make it harder for parents to get mental healthcare for their young people.[66]

Of the young people with mental health concerns who receive treatment, most do so in schools or outpatient community mental health service sites.[67] A recent survey of youth-serving providers found that use of evidence-based treatment strategies, which are most likely to produce significant clinical outcomes, are widespread but not universal.[68]

A recent review of proposed strategies to improve care in child mental health treatment includes improving families' access to services, increasing use of evidence-based practices (EBP), and holding service sites accountable for demonstrating outcomes. The researchers noted that in addition, producing a workforce to implement

these strategies will require "cultivating providers who have developed specific competencies within a range of agencies that naturally interface with the daily lives of families and their children."[69]

Build the Workforce Serving Children and Young People

The behavioral health workforce has been consistently plagued by shortages, high turnover, lack of diversity, geographic unevenness, low wages and reimbursement, and concerns about its effectiveness. These issues are even more severe for young people and were further exacerbated during the pandemic, which contributed to an exodus of providers from the workforce.[70]

The current workforce remains stifled by workforce shortages and payment models that do not support a diverse array of delivery models, including preventive approaches, and community-based providers needed to make an impact.

In general, the lack of mental health providers, including those specializing in care for young people, as well as geographic gaps, lack of insurance coverage for families seeking care, and other workforce barriers continue to make it challenging for families to find quality mental healthcare for their young people.

Multiple calls for new efforts to address the urgent workforce issues will require rigorous efforts to:

- Increase the number and diversity of traditional mental health providers, using innovative recruitment, retention, loan repayment strategies, higher wages, and benefits.
- Augment the growth of providers that promote health equity, including community navigators, community health workers, natural helpers, and the faith-based community.
- Alter wage structures to fairly compensate practitioners providing bicultural and bilingual care.
- Broaden the workforce by enhancing the mental health skills of frontline workers who routinely come into contact with families (e.g., the Special Supplemental Nutrition Program for Women, Infants and Children

(WIC) workers, home visiting staff, visiting nurses) who can be trained to do simple screening and early identification of parents and young children experiencing or who are at-risk of mental health problems.

- Grow the capacity of nurse mental health practitioners with prescribing privileges.
- Improve the financial and technical assistance infrastructure to better support and sustain the workforce.[71, 72, 73]

There is also consensus that greater support and reimbursement are needed for a diverse community-based workforce that will help improve equity for young people and their families/caregivers. A diverse community-based workforce that understands the communities it serves can lead to improved equity and reductions in disparities.

Develop a Comprehensive Coordinated Array of Readily Accessible Services and Supports

- **A model service array should include the core set of essential services and supports outlined by SAMHSA and CMCS** in a Joint Informational Bulletin published by SAMHSA and the Center for Medicaid and CHIP Services[74] and further updated in *The Evolution of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Conditions and Their Families.*[75] One of the significant additions was the use of telehealth services, which proved to increase access, engagement, and reach during the pandemic, and the use of mobile crisis services.
- **Approve Mobile Crisis and Stabilization Services (MRSS) for all young people** to improve crisis response and suicide/overdose prevention and minimize use of emergency departments, particularly for children and adolescents. These types of settings can be retraumatizing and are often not suitable for the care of young people. MRSS is a child-, youth-, and family-specific crisis intervention model that meets the caregiver/parent sense of urgency.

- Studies have shown that MRSS plays a critical role in:
  - Preventing future crises
  - Reducing involvement with law enforcement, particularly for children and youth who are Black, Indigenous, and people of color
  - Providing care in the least restrictive environment appropriate to clinical needs
  - Maintaining children safely at home and in the community

- MRSS is a cost-effective alternative to emergency departments and inpatient care:
  - Providing mobile, on-site and rapid intervention for youth experiencing a behavioral health crisis
  - Allowing for immediate de-escalation of the situation in the least restrictive setting possible
  - Prevention of the condition from worsening
  - Timely stabilization of the crisis

MRSS provides time-limited, on-demand crisis intervention services in any setting where a behavioral health crisis is occurring, including homes, schools, child welfare, juvenile justice, etc.[76]

- Maximize access by providing services where children live, work, play, and pray including those most readily used by young people—schools and primary care. Young people receive most mental health services through schools and those receiving school connected services are more likely to complete treatment. Similarly, primary care is often the point of access to specialty mental health services for young people. Building on these naturally occurring access points, coordinating mental health and school-based services will generate a more accessible delivery system.

This is particularly the case for lower-resourced families and minority groups who more frequently use school-based services.

A range of models have emerged for blending school and mental health services, including school-based health centers, comprehensive school mental health programs, and specific school-based interventions such as positive behavioral supports.[77]

In February 2022, the Hopeful Futures Campaign released a Report Card on America's School Mental Health, grading each state on their policies supporting school mental health.[78]

Youth.GOV notes that school-based mental health is a key part of student support services to assure early identification, referral for treatment, training for teachers in early detection and response to mental illness, assistance for schools to address violence, and training for mental health professionals to provide mental health services in schools.[79] Schools provide an important venue to enhance early identification and connect students with mental health resources.

Young people spend the majority of their time in school, so the setting provides a safe, nonstigmatizing, and supportive environment for them and their families to have access to prevention, early intervention, and treatment through school-based mental health programs. Further, adolescents may be more comfortable and trusting accessing healthcare services through school-based clinics than traditional provider settings, and like the idea of accessing a range of health and social services in a single location.

There are numerous programs designed to support school-based mental health services including Medicaid, Federally Qualified Health Centers (FQHCs), and other grants. The Health Resources and Services Administration (HRSA), for example, provides grants designed to improve and strengthen access to school-based health services in communities across the country. Awards support local partnerships between schools and health centers to provide children and youth comprehensive physical and mental healthcare.[80]

SCHOOLS PROVIDE AN IMPORTANT VENUE TO ENHANCE EARLY IDENTIFICATION AND CONNECT STUDENTS WITH MENTAL HEALTH RESOURCES.

School-based health programs can support:

- Evidence-based programs to promote student skills in dealing with bullying and conflicts, solving problems, developing healthy peer relationships, and engaging in activities to prevent suicide and substance use.
- Early intervention services for students such as skill groups to deal with grief, anger, anxiety, and sadness.
- Treatment programs and services that address the mental health needs of students.
- Student and family supports and resources.
- Training for teachers and other support staff to recognize early warning signs of student mental health issues.
- A referral process to ensure that students have equal access to services and supports.

School mental health programs also help students achieve academically and build social skills, leadership, self-awareness, and caring connections. These programs may also improve truancy and discipline rates, increase high school graduation rates, and help create a positive school environment for student success. These school mental health programs can:

- Specify services that are appropriate for the needs of young people across the age spectrum, from early childhood to young, emerging adults. Expand mental health outreach and interventions in early care and education including the use of infant and early childhood consultation models. Recognizing that the onset of mental and substance use disorders most often occurs in late adolescence/emerging adulthood, invest in recently established evidence-based practices such as coordinated specialty care for first episode psychoses or those at-risk, and Screening Brief Intervention and Referral to Treatment (SBIRT) for identification of substance use disorders.
- Maximize integration of care by improving access to services and quality of care by integrating mental health and substance use services with other child-serving systems such as primary care, school-based services, child welfare, juvenile justice, and social services.
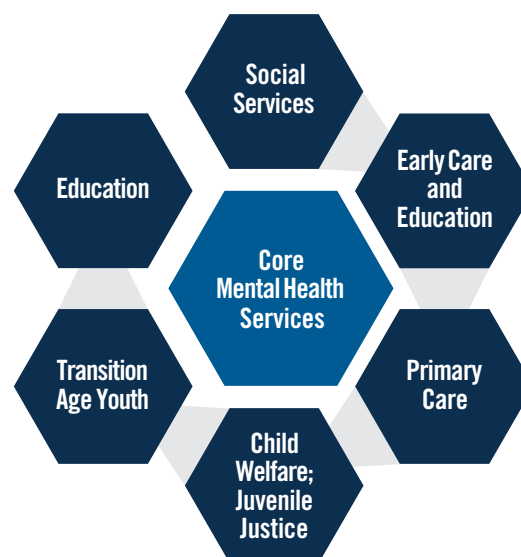
According to CDC data, nine in ten children receive regular medical care from a primary care provider, but only one in three pediatricians report that they have sufficient training to diagnose and treat children with mental disorders.[81] CDC defines "Behavioral Health Integration (BHI)" as "an approach to delivering mental healthcare that makes it easier for primary care providers to include mental and behavioral health screening, treatment, and specialty care into their practice. It can take different forms, but BHI always involves collaborations between primary care providers and specialized care providers for mental health." BHI can improve mental health outcomes; provide more efficient and coordinated care; yield higher treatment rates; reduce parental stress; and improve consumer satisfaction.

Barriers to care integration continue to exist, however. While pediatricians are on the front lines of caring for young people and are often positioned to provide early identification of and response to childhood health challenges, pediatricians report a lack of knowledge, time, and resources as major barriers to providing this type of care.[82]

Young people's mental health needs and challenges cross multiple service sectors. Collaboration across these sectors is critical in order to prevent the development of parallel mental health systems and structures in these various child- and young people-serving systems. Integration is also an important strategy for addressing racial, ethnic, and geographic behavioral health disparities. For people of color, integrated care can address many of the barriers that disproportionately limit their use of behavioral health services compared with their White counterparts.[83]

Different models have been developed for **integrating primary care and behavioral healthcare**. Some collaborative care models blend primary care and behavioral health staff with shared infrastructure, offices, billings, etc. Others use consultation models such as the Massachusetts Psychiatry Access Programs where designated child and adolescent psychiatrists provide telephone consultations to pediatricians handling children with more complex behavioral health disorders. The CMS Integrated Care for Kids (InCK) model is a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid through integration of prevention, early identification, and treatment of behavioral and physical health needs. Almost $126 million in federal funding was awarded to seven states and organizations for a seven-year program.

> Plans for providing comprehensive mental health services for young people almost always put forward the need for comprehensive and coordinated services, to replace the fragmented, disjointed and often bewildering system of care. However, the details for improving linkages and seamless coordination are often omitted. Integrating across sectors is difficult; each sector has its own language, jargon, goals and objectives, data and measurement strategies, and distinct staffing.

Different models of integrated primary care and behavioral health have emerged and are often organized along a continuum of "consultative to coordinated to co-located to fully integrated care." Identifying the "glue" that holds these efforts together and leads to better outcomes is essential. For some, this "glue" is considered: a trained workforce that can operate in team-based care approaches, and payment options, such as value-based or capitated payments that promote integration.

Build on Technology as Essential Infrastructure and a Mechanism to Improve Access and Delivery of Care

There are multiple roles for technology in building a mental healthcare system for young people. Technology is an untapped resource in creating an infrastructure for such a system. Technology provides essential data platforms for assessing quality and outcomes of care, for communicating across integrated care systems, for managing interprofessional and team-based care, and for administrative and financing operations.

Technology also provides the platforms for care delivery, whether through virtual telemental health visits or mobile apps. The pandemic accelerated the use of virtual video and audio mental health visits, including telebehavioral visits in school-based programs. Reimbursement for telehealth visits was similarly accelerated during the pandemic through temporary flexibilities in billing policies.

While these technologies offer promise for improving reach, access, and engagement for young people, and improving data collection, there are challenges and concerns regarding these tools, including the potential to expand the digital divide and access to care for certain populations and assuring the quality of care delivered through these technologies. And, as with many interventions, determining what technology-based services work best for which behavioral health conditions and clients still remains to be investigated. However, technology remains an important tool for moving the mental healthcare system into the twenty-first century.

To better understand this rapidly emerging field of mental health digital technologies, the National Institute of Mental Health (NIMH) published a paper, "Technology and the Future of Mental Health Treatment" to examine the advantages and disadvantages of using technology to expand mental health treatment and research.

NIMH notes that new technologies offer potential for both clients and clinicians, including:[84]

- **Convenience**: Treatment can take place anytime and anywhere (e.g., at home in the middle of the night or on a bus on the way to work) and may be ideal for those who have trouble with in-person appointments.
- **Anonymity**: Clients can seek treatment options without involving other people.
- **An introduction to care**: Technology may be a good first step for those who have avoided mental healthcare in the past.
- **Lower cost**: Some apps are free or cost less than traditional care.
- **Service to more people**: Technology can help mental health providers offer treatment to people in remote areas or to many people in times of sudden need (e.g., following a natural disaster or terror attack).
- **Interest**: Some technologies might be more appealing than traditional treatment methods, which may encourage clients to continue therapy.
- **24-hour service**: Technology can provide round-the-clock monitoring or intervention support.
- **Consistency**: Technology can offer the same treatment program to all users.
- **Support**: Technology can complement traditional therapy by extending an in-person session, reinforcing new skills, and providing support and monitoring.
- **Objective data collection**: Technology can quantitatively collect information such as location, movement, phone use, and other information.

At the same time, the use of technology in mental health is still evolving and requires ongoing attention to a range of concerns, including:

- **Effectiveness**: Obtaining scientific evidence that the digital methods work and that they work as well as traditional methods.
- **For whom and for what**: Understanding if apps work for all people and for all mental health conditions.
- **Privacy**: Assuring privacy for app users.
- **Guidance**: Introducing industry-wide standards to help consumers know if an app or other mobile technology is proven effective.
- **Regulation**: Determining who will regulate mental health technology and the data it generates.

Ensure that Timely Innovations in Mental Health Include a Focus on Children and Young People

As one example, there is a need to ensure that the new federal and state investments in Certified Community Behavioral Health Clinics and 988 emergency response are inclusive of young people with mental health issues and their families. With the current heightened focus on mental health and new investments from government and philanthropy, it is critical that innovations in the mental healthcare system are inclusive of young people and their age-specific needs. Keeping them as an afterthought undermines the well-being of families and communities.

As noted previously, in October 2021, HHS released a fact sheet noting that HHS is "working together to advance behavioral health for children, youth, and their families, with an emphasis on improving access, promoting equity, and fostering innovation. These efforts have resulted in over 300 distinct initiatives."[85] The fact sheet notes that HHS and the Department of Education have established an Interagency Workgroup for supporting the reopening and continued operation of schools and early childhood education. The fact sheet describes several categories of investment for young people including partnering with schools; improving access, capacity, and equity; and supporting research.

THE FUNDING AND PAYMENT MODEL

Implement Financing and Payment Systems to Ensure a Robust Young People-Focused Benefit Design

In order to ensure fair and equivalent public and private coverage for mental health and substance use disorders for all young people, all insurance should include a benefit design that advances access to and availability of the full continuum of children's behavioral health services. As the largest payer of mental health services, there are numerous mechanisms available for states such as Medicaid 1115 waivers, 1915 waivers, and State Plan Amendments (SPAs) to expand optimal behavioral health services.

Along with clear understanding of comprehensive Medicaid coverage, there is a need for greater technical support to practices/providers and easy to understand guidance on payment models for young people receiving services in health care as well as other child-serving systems. There is also a need for greater clarity and coverage for the full range of services for young people, including the broad range of individuals at-risk but without a mental health diagnosis. In general, payment systems must become better aligned with the range of diagnoses and access opportunities for all young people.

Align Federal Funding and Policies to Optimize a Mental Health System for Young People

No single federal agency is responsible for addressing the mental health needs of young people. Many operating divisions of HHS provide and oversee funding that supports programs to address the mental health needs of young people. In addition, the Department of Education and the Department of Defense provide mental health services and supports for young people and military-connected children respectively.

The federal government spends billions of dollars a year on behavioral health services.[86] CMS is the single largest payer for mental health services in the U.S. Medicaid and the CHIP collectively provide healthcare coverage for nearly 40 million children in the U.S. In addition, large sums of funding are provided by SAMHSA and HRSA for CCBHC and FQHCs, which provide behavioral health services to people of all ages. Billions of dollars are also provided through block grants, formula grants, and discretionary grants.

For many of these funding sources there are special policies, such as age, income, and disability criteria for recipients. Some of these funds go to states, others directly to communities, providers, and families. Federal grants comprise about one-third of total state government funding, and more than half of state funding for healthcare and public assistance.[87] Therefore, any analysis solely of federal funding will not provide the full picture of our nation's expenditures on mental health services for young people.

The Biden Administration and Congress continue to increase investments in mental health awareness, prevention, and treatment. However, there is no unified or coordinated strategy for how these federal programs, agencies, and departments are to expend funds, nor is there a well-articulated goal of how these funds collectively advance mental health for young people. So, the issue may not fundamentally be a lack of funds, but rather lack of coordination of funding and policies across departments, agencies, and programs. In addition, it is not clear whether we are investing in the "right" programs based on performance metrics.

Given the increasing investments in mental health, it is time for federal policy makers and funders to revisit their grantmaking process, and look for efficiencies and areas for coordination. The federal government should also reduce the burden on states and communities, who must often seek multiple sources of funding for the same population, and when the fundings ends, sustainability of the program is challenging. Federal agencies should also commit to assessing and supporting what works and ensure that their programs are based on the best available science and measured in a consistent manner to assure critical outcomes.

Aligning federal grants and policies that have an impact on the mental health of young people will potentially advance common agency goals. This requires not only examining services and interventions, but also attending to the SDOH, noting that those particularly impact young people.

While acknowledging that each federal agency has specific legislative and budget considerations and eligibility policies, **a single portal for all mental health programs for young people and a single core application that could be customized for each program could potentially relieve burden for applicants and better coordinate responsible agencies and programs**.

Additionally, federal agencies need to better coordinate technical assistance (TA) for their grant recipients. The proliferation of TA centers associated with different grant programs and agency initiatives is often confusing and duplicative, particularly for eligible applicants. Funding for these TA centers may be better spent on funding gaps in services and supports.

Foundational to aligning federal funding and policies to optimize a mental health system for young people is **a real-time inventory of the current state of key federal programs aimed at addressing the mental health needs of young people**. For each of these programs, it is also necessary to understand their various characteristics, including administering agency, population served, the services provided along the continuum of mental health services, funding levels, models for sustainability, performance measures, and intersections with other programs.

MITRE has conducted a taxonomic analysis to assess coverage and gaps of mental health programs for young people and the findings are summarized in a separate forthcoming report, *Analysis of Current Federal Programs for Addressing the Mental Health Needs of Young People.* This analysis will help identify areas of strength, gaps, duplications, and potentially inefficiencies in spending.

Re-Establish an Expectation in the SAMHSA Mental Health Block Grant that States Submit a Plan for Children's/Young People's Mental Health

This plan would be a requirement of the block grant application submission. Previously, states receiving SAMHSA mental health block grants funds were required to submit a plan specifically focused on children's mental health. Additionally, SAMHSA should review and update the block grant uniform data collection effort on children and young people to make sure it has utility in planning and policy decisions.

GIVEN THE INCREASING INVESTMENTS IN MENTAL HEALTH, IT IS TIME FOR FEDERAL POLICY MAKERS AND FUNDERS TO REVISIT THEIR GRANTMAKING PROCESS, AND LOOK FOR EFFICIENCIES AND AREAS FOR COORDINATION.

EVALUATION AND ACCOUNTABILITY

Establish Data Standards, Quality, and Accountability in Prevention, Clinical Care, and System Performance

Prevention, clinical care, and system structure must be accountable to evidence-based standards of care that are developmentally, clinically, and culturally appropriate for young people and improve outcomes. In addition, the standards should include:

- Prevention science should inform the collection of prevention-focused outcomes.

- Clinical care should be evidence-based whenever possible and reflect the emergence of measurement-based care.
- System-level performance management and analytics is critical for payers, clients, and on-going improvement and coordination of programs.

These standards and data drive program improvement, care coordination activities, and planning for social supports, which delivers value to payers and clients/consumers.

Various surveillance systems are available that measure categories of mental health diagnoses, mental healthcare use, or ascertain self- or family-reports of symptoms of mental well-being or negative emotional states. However, there is a general lack of consensus on definitions of mental health, and particular challenges applying definitions to young people's mental health.

At the national level, the CDC compiles measures of young people's mental health from several national surveys. The most recent report, from February 2022,[88] is based on national surveys of youth and parents from 2013 to 2019 (pre-pandemic) and from mortality data for suicides from two sources (the National Violent Death Reporting System [NVDRS] and the National Vital Statistics System (NVSS)).

A summary of the surveys and mental health conditions included in the CDC's 2022 report is presented in Appendix B.

Establish/Encourage a State Governance Structure for Children and Young People's Mental Health

While many states have established state children's cabinets, councils, and commissions to help coordinate and integrate programs for young people, the federal government should encourage each state to establish a state Youth Mental Health Office or facilitator to:

- Coordinate policy, payments, and system design for mental health for young people.
- Monitor an adequate, accessible and quality continuum of services.

- Provide a framework for performance monitoring, licensing behavioral health organizations, and addressing compliance and grievances.
- Submit a plan for mental health for young people for the SAMHSA Mental Health Block Grant.
- Coordinate across different federal block grants and other support for states for behavioral health prevention, promotion, and services.
- Ensure quality by mandating the use of evidence-based interventions and measurement-based care.
- Coordinate the sectors playing a role in young people's mental health (e.g., behavioral health, health, primary care, education, child welfare, Medicaid, and commercial insurance).

A 2021 survey by The Forum for Youth Investment found that many states have formed state cabinets that focus on children and youth.[89] The survey found that children's cabinets are composed of leaders from government agencies and may also include outside stakeholders. These organizations are designed to create a shared vision, goals, and strategies to be accountable for children and youth as they learn and develop. The survey found that while nearly all organizations address multiple areas related to young people, most include social-emotional learning, mental and behavioral health, postsecondary readiness, and physical health and well-being as their primary focuses.

Designate a Federal Coordinator or Unified Plan for the Behavioral Health of Children and Young People

As noted previously, the federal government spends billions of dollars in mental health services and treatment and for mental health medical education and training. However, there is no unified strategy for how to expend these funds, how to maximize investments and avoid redundancies, and most importantly, how to achieve collective goals for mental health well-being among young people.

As noted in a 2011 report calling for "Improving Children's Health and Well-Being by Integrating

Children's Programs," a federal coordinator could enhance coordination and integration of children's mental health programs across the federal government and proactively ensure that the mental health needs of our nation's young people are being addressed.[90]

The coordinator could:

- be charged with developing a comprehensive vision and strategy for the mental health of young people including consistent goals and outcome measures.
- be charged with integrating programs, promoting a common vision, engaging all stakeholders, creating shared accountability, and assessing and aligning policies and resource allocations.
- review all grant programs to states, counties, and community-based organizations to ensure that mental health programs are appropriately focused, coordinated, and improving across the life-spectrum of young people.

- be charged with identifying all relevant federal programs that impact mental health for young people and develop an annual coordinated budget to help assess program overlap, gaps, and opportunities for collaboration and streamlining of existing grant programs. This could include a model template for needs assessments, quality, and other outcome measurements.
- serve as a focal point for external relations with states and mental health stakeholders and be charged with assuring that all programs are designed and executed with a focus on equity and serve the full range of young people across the nation.

The coordinator could also convene a Behavioral Health Children and Young People Council that would consist of representatives from federal departments and specific federal agencies that have investments in the behavioral health of young people. The coordinator could conduct a finance mapping initiative that identifies the various entitlement, mandatory block grants, and discretionary grants awarded by these agencies. The coordinator could also conduct a policy mapping initiative across agencies to better understand the drivers of respective agency programs and funding. The Council could support establishing common and program-specific performance and outcome measures and regular submission of these measures to help determine what programs are achieving expected goals. The data from these periodic mapping exercises and regular reporting measures could identify gaps and strengths, duplications, and omissions in a public health approach to the behavioral health of young people.

The coordinator could also identify and elevate a focus on innovative local, community-based programs that are effective in meeting the mental health needs of the children, families, and young people in their respective communities. These are potentially important lessons learned that could be scaled. Finally, the coordinator could oversee the creation of a federal workforce assessment and development strategy.

THE FEDERAL GOVERNMENT SPENDS BILLIONS OF DOLLARS IN MENTAL HEALTH SERVICES AND TREATMENT AND FOR MENTAL HEALTH MEDICAL EDUCATION AND TRAINING.

IF NOT NOW, NEVER!

In this report, we cover the crisis our nation is facing in meeting increasing demand for mental health services for young people, as well as preventive services. We are at an unprecedented time when every stakeholder, from the federal government to states and providers, as well as youth themselves and their families, are demanding action.

The public increasingly expects that our nation's significant investments, innovation, and technology can help improve the mental health of our young people.

As we continue to invest billions of dollars to care for our young people's mental health, we are using the same traditional approaches to funding and building systems of care that are not meeting the needs of today's young people.

It is time to do something different. We should rethink how we use our fiscal and technological resources and rely on the abundance of research-driven expertise and accumulated wisdom of professionals, families, and advocates, to turn around a broken, dysfunctional system. We may never again see a consensus across every sector to act now. We cannot continue to invest in siloed programs and focus on those with serious mental illness while sacrificing mental health promotion and prevention. We have a generation of children and youth who have faced unprecedented challenges in their homes, their schools,

THE LIVES AND WELL-BEING OF YOUNG PEOPLE ARE AT STAKE.

their healthcare systems, and their lives. We must assure that we act NOW to promote mental health and wellness and provide access to care for all of our young people before it is too late.

This report lays out a call to action and recommends short term actions and a longer term vision that is designed to initiate a constructive dialogue for moving forward. MITRE joins the call to action by offering this vision and providing an opportunity to reimagine how we can serve our young people and build a future generation of resilient, healthy young people and adults.

The lives and well-being of young people are at stake.

SELECT OPPORTUNITIES AND OUTCOMES FOR CONSIDERATION

The following section describes selected opportunities and outcomes for consideration within the current system of care for young people. All of these issues will continue to represent barriers to effective care for young people and should be addressed as we move from the current state to a future system of care that serves all of the needs of young people and their families.

USE A PUBLIC HEALTH APPROACH	
Select Opportunities	**Outcomes for Consideration**
Children's mental health programs are often siloed.	Mental health funding for young people should use a multi-sector public health approach that acknowledges that young people are touched by sectors across health, education, and social services. Whenever feasible, programs should include a focus on a community-based population health approach.
There are numerous crisis intervention services relating to mental health; however, a central repository or cohesive funding structure is not present. Additionally, young people in crisis may need different access to these services and providers may need specialized response capabilities.	A comprehensive list of crisis intervention services should be created that lists available resources, populations served, and when they are available. This will better help those in crisis access the services they need. When launched, it will be important to understand if these should be combined under the 988 Suicide and Crisis Lifeline for consistency and whether the 988 line should include a dedicated line for young people.

ELEVATE FAMILY AND YOUTH-DRIVEN CARE	
Select Opportunities	**Outcomes for Consideration**
Most mental health programs supported by the federal government are not specifically directed to serve children and some programs are limited to children with severe emotional illness.	Allow/encourage all appropriate mental health programs to allocate a specific portion of their funds to serving young people.

FOCUS ON EQUITY	
Select Opportunities	**Outcomes for Consideration**
There is an unmet need for development of culturally appropriate, evidence-based mental and behavioral health promotion, prevention, and early intervention programs that are readily available for all young people.	Training and funding programs should be specifically designed to reflect the unique needs of young people, the unique points of entry (e.g., schools, pediatrics), and the unique types of providers and models of care (e.g., peer counseling) to fully address the complex mental health issues young people and their families face.
Attitudes and beliefs about mental health due to concerns about stigma can impact racial and ethnic minority families' decisions to seek treatment for their young people.	Identify effective ways to influence and change public understanding of, and attitude toward, mental health for young people, with attention to specific populations. Enhance support and partner with a range of different types of providers including traditional and nontraditional providers.
In addition to race and ethnicity, it is also necessary to encourage diversity for mental health services for young people in terms of gender, disability status, sexual orientation, and gender identity, to truly meet the needs of a diverse population.	Enhance professional education and training to address gender-specific concerns, including provision of clinical services, efforts to counter biased policy, efforts to highlight and remove barriers to psychological well-being, and to reduce bias based on perceived gender.

ADDRESS THE SOCIAL DETERMINANTS OF MENTAL HEALTH

Select Opportunities	Outcomes for Consideration
SDOH and other factors limit access to evidence-based prevention and treatment practices.	To increase capacity to serve all mental and behavioral health needs, the needs of young people and their families should be addressed where they live, play, work, pray, and grow.
There is an unmet need to meet the growing demand for development of culturally appropriate, evidence-based mental and behavioral health promotion, prevention, and early intervention programs that are readily available for all young people.	Client-therapist matching may be important to creating rapport and intervention success, which will also require more diversity of the professions serving young people. This can be addressed through grant and training programs that recruit diverse mental health professionals.
Stigma, attitudes, and beliefs about mental health can impact racial and ethnic minority families' decisions to seek treatment for their children.	Invest in identifying effective ways to influence and change public understanding of, and attitudes toward, mental health for young people, with attention to specific populations including knowledge and expertise of the roles of both traditional and nontraditional providers.
There is a growing demand for development of culturally appropriate and evidence-based mental health promotion, prevention, and early intervention programs that are readily available for all young people. There is an unmet need for a diverse workforce staff (including, but not limited to, gender, race, ethnicity, disability status, and sexual orientation) to meet the needs of the population they serve.	Continue to identify and train mental health professionals from diverse groups to address equity, fairness, and services to the public and to improve the pipeline, academic support, and recruitment and retention of a range of students and diverse faculty at the undergraduate and graduate levels. This can be addressed through funding grants and training programs that recruit diverse mental health professionals and provide education on culturally appropriate practices.

BUILD THE WORKFORCE SERVING CHILDREN AND YOUNG PEOPLE

Select Opportunities	Outcomes for Consideration
There is a movement toward more allied mental health professionals and peer support groups, but coverage and reimbursement may not match.	Identify current payment barriers and opportunities to expand coverage to more provider types and services.
Some states create barriers to allied health providers and new technologies (e.g., telehealth) while others have innovated in this space.	Develop and publish a guide on state innovations in payment and coverage designed to support allied mental health professionals. This will allow for an understanding of the landscape as well as provide a tool to identify potential gaps and opportunities in innovation coverage and payment strategies for a broad array of providers.
There is increased recognition of the importance of improving the amount and variety of touchpoints for young people to include primary care physicians and teachers, but these providers face burdens of time, training, and lack of payment for these expanded roles.	Develop case studies and a guide on how to address these three points: burden, training, and financing for touchpoints specifically through primary care physicians and teachers.
Some school-based providers may not be eligible to provide mental health services unless they enroll as Medicaid providers and meet state-based provider requirements.	A threshold requirement for schools to leverage Medicaid in school settings is ensuring all school-based providers are enrolled as Medicaid providers in their state. CMS provides significant resources on this topic directed at states to ensure compliance with Federal regulations,[91] but local education agencies require clear, concise directions to ensure providers employed by schools or contract providers of school services are properly enrolled.

BUILD THE WORKFORCE SERVING CHILDREN AND YOUNG PEOPLE *(CONTINUED)*

Select Opportunities	Outcomes for Consideration
Efforts are needed to ensure all licensed mental health providers are eligible to provide Medicaid and school-based services and enroll as Medicaid providers in the jurisdiction in which they practice.	CMS should mirror regulatory actions taken in the Medicare program to expand the number of available licensed Medicaid mental health practitioners to the extent federal authority allows and incentivize states to seek demonstration waivers and amend state Medicaid plans to maximize the use of available mental health workforce providers in individual states.

DEVELOP A COMPREHENSIVE COORDINATED ARRAY OF READILY ACCESSIBLE SERVICES AND SUPPORTS

Select Opportunities	Outcomes for Consideration
The mental and behavioral health treatment enterprise is not currently interdisciplinary enough to fully understand and address the complex issues families face in the care of young people.	All programs targeting mental health for young people should strive for collaborations and integration across systems of care, including mental health services and parenting consultations, as part of serving all children and families in places they commonly interact including where they live, work, play, and pray. These include primary/specialty care, schools, early childhood education, childcare, and home visiting programs.

BUILD ON TECHNOLOGY AS ESSENTIAL INFRASTRUCTURE AND A MECHANISM TO IMPROVE ACCESS AND DELIVERY OF CARE

Select Opportunities	Outcomes for Consideration
Every federal program has its own requirements for systems and reporting and does not allow information exchange and combining resources across programs for IT support and infrastructure.	Allow a portion of administrative funds to be used for infrastructure development, such as systems development, staffing, and data exchange where appropriate.
Telehealth may be a powerful tool to reach young people where they are, but coverage and reimbursement are still not consistent and potentially permanent.	Develop a consolidated list of critical telehealth coverage benefits, available providers, and baseline technical tools available for delivery of mental health services to share across state Medicaid agencies as well as private payers.
FDA approved health and wellness apps can be used as potential treatment solutions but may not be appropriate for young people.	Invest in further examination of apps designed for young people to include not only current FDA-approved apps and those that could fall into the FDA's scope of regulation, but also apps for young people addressing new mental health topics that do not fall within the FDA's regulatory scope (i.e., apps that focus on wellness). New app development would also benefit from including a range of users, including young people, in the designs and testing of new apps.
Licensing requirements for professionals who practice across state lines continues to slow or limit the expansion of telehealth for mental healthcare services.	Continue to encourage states to establish options for licensing telehealth practitioners including accepting conditional or telehealth licenses from out-of-state physicians; establishing registries that permit qualifying out-of-state physicians to practice in other states; and adopting the Federation of State Medical Boards' compact, which allows an expedited license for out of-state practice for doctors, including psychiatrists and potentially for other mental health professionals such as psychologists.
Technologies are emerging as a positive component of mental health services to help meet the unmet need for high-quality mental health services for young people.	Promote partnerships across the public and private sectors to encourage development and evaluation of digital mental health innovations.

BUILD ON TECHNOLOGY AS ESSENTIAL INFRASTRUCTURE AND A MECHANISM TO IMPROVE ACCESS AND DELIVERY OF CARE *(CONTINUED)*

Select Opportunities	Outcomes for Consideration
There is limited oversight and regulation of telehealth and apps, particularly those targeting young people, including quality measures and assurance of privacy.	SAMHSA has called for refining clinical guidelines for telemental health services, including broader adoption of telehealth for mental and substance use disorders.
States expanded Medicaid telehealth coverage in response to the pandemic, with nearly all states covering and paying for audio-visual and audio-only mental health and substance use disorder visits in their fee-for-service Medicaid programs. While many states plan to maintain all or some of these expanded telehealth policies post-pandemic, especially flexibilities for behavioral health, some states are reversing that coverage, so coverage varies by state.	States should be encouraged to maintain Medicaid and private coverage and payment for telehealth for mental health services.
There continues to be dramatic growth in the use of digital technologies such as wearable devices, clinician support tools, digital therapeutics, and mobile health applications, for both young people and providers but these are not always regulated and assessed to assure quality and effectiveness.[56]	Support rigorous development protocols for digital technology to ensure that they are implemented as intended and shown to be effective. Support additional research to improve accessibility, implementation, and effectiveness of these interventions.

ENSURE THAT TIMELY INNOVATIONS IN MENTAL HEALTH INCLUDE A FOCUS ON YOUNG PEOPLE

Select Opportunities	Outcomes for Consideration
There are numerous existing programs and new programs for mental health being funded but they do not always allow and/or require funding specifically for young people.	The federal government should allow all mental health programs to provide services to young people, as appropriate. There is a need for the development of a comprehensive mental health strategy and budgets for young people, complementary eligibility and service definitions, common conditions of participation for service providers, similar approaches to calculating program payments and project awards, and performance accountability measures.
There are hundreds of programs targeting support for mental health for young people (which have a variety of requirements, eligibility, reporting, etc.) and may be targeting the same grantees who may receive funding from several sources.	The federal government should assess related funding for mental health programs for young people and encourage integrated/coordinated funding across agencies.

IMPLEMENT FINANCING AND PAYMENT SYSTEMS TO ENSURE A ROBUST YOUNG PEOPLE-FOCUSED BENEFIT DESIGN

Select Opportunities	Outcomes for Consideration
Programs that identify children in need of mental health services may focus disproportionately on children with serious emotional disturbance. This represents only a small segment of children, leaving the bulk of children needing mental services ineligible for many programs, including insurance reimbursement.	Expand availability of mental health funding to emphasize prevention and connect children and youth with less severe mental health conditions to needed outpatient services through community or school-based Medicaid providers.
Advocates support primary care mental health integration, but providers may not have the training or have time and are not reimbursed for additional mental health related services.	Expand training for primary care providers and reimbursements to fund enhanced primary care. Adapt payment policy to encourage, not create barriers, to integration.

IMPLEMENT FINANCING AND PAYMENT SYSTEMS TO ENSURE A ROBUST YOUNG PEOPLE-FOCUSED BENEFIT DESIGN
(CONTINUED)

Select Opportunities	Outcomes for Consideration
Medicaid is a key source of support for school-based mental health services but there continues to be confusion about coverage opportunities.	CMS is in the process of updating their school health guidance but should consider an immediate release indicating that additional details and technical assistance is coming next year. CMS should also promote their policies to a broad range of stakeholders including state Medicaid agencies, public health education agencies, primary care associations, and FQHCs to assure widespread understanding and adoption of these important coverage policies. CMS should also consider working with the national school health organizations to help promote the policies.
Schools do not understand how Medicaid can be used to support school health without billing private payers.	CMS has updated their payment policies for schools and this information should be transmitted in an easy-to-understand manner to states and schools to assure that all children have access to Medicaid coverage and services.[92]
Parents, caretakers, and providers do not easily understand their benefits under Medicaid/EPSDT, including mental health coverage.	CMS could issue an easy-to-understand guide to EPSDT for parents, caretakers, and providers to help them understand their benefits, including mental health benefits, and maximize their opportunities for comprehensive care.
Provide easy to understand resources for providers and schools to expand the number of Medicaid providers. Provide similar resources for parents and their support networks so that they better understand the scope of the benefits available under federal and state Medicaid rules.	CMS should continue to strive for communications with beneficiaries, providers, and other stakeholders to be written in clear, easy to understand language. Two examples of resources published by HHS and available on the HHS website are Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents and Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits. Geared toward states but specifically crafted to ensure parents and providers could utilize the information to identify available benefits, these documents provide a model for HHS to partner across components and provide easy to understand and actionable steps to access care.
Medicaid has limited coverage for inpatient psychiatric services, which may be critical for some young people.	CMS should continue to identify opportunities for greater flexibility for states (1115 demonstrations, etc.) to allow coverage for inpatient care for selected patients. CMS has provided states the opportunity to seek waivers to receive authority to pay for short-term residential treatment services in an institution for mental disease, currently prohibited under federal Medicaid law for adults 21-65. Confusion caused by the prohibition and subsequent waivers led CMS to issue a State Medicaid Director Letter in November 2018, clarifying the opportunity to design Section 1115 waivers focused on adults with a serious mental illness and children with a serious emotional disturbance as well as outlining the existing option for states to cover inpatient psychiatric services for those under the age of 21.[93]

ALIGN FEDERAL FUNDING AND POLICIES TO OPTIMIZE A MENTAL HEALTH SYSTEM FOR YOUNG PEOPLE

Select Opportunities	Outcomes for Consideration
States and communities have opportunities to apply for dozens of separate programs to serve the same populations and may be addressing the same needs.	Develop a single portal for all mental health programs for young people and allow a single core application that can then be customized for individual programs.
There are hundreds of programs designed to support mental health services for young people, but they often work in siloes (applications, reporting, etc.), creating a burden on applicants who seek multiple sources of funding for the same organization.	Federal agencies should collaborate on the development of children's mental health funding announcements to assure multi-sectoral input starting at the beginning of the program design. Review panels should also be multi-sectoral (e.g., health, family support, education) to assure comprehensive approaches to program selection and implementation.
Funding continues to increase for mental health services for young people but may not reflect the priorities of key stakeholders across states and localities as well as families and providers.	Mental health program applications for young people should reflect engagement by key stakeholders such as the governor, other state and local leaders of child related programs, key provider and family organizations, the head of state children's boards and partner organizations. This can be done through user-centered programs designed to understand the needs of families and providers as well as a community forum for other stakeholders.
Siloed grant programs lead to lack of coordination, and potential duplication at the federal and local level.	Funders should rethink the grant approach to funding mental health for young people that involves multiple short-term, low-budget grants that can leave grantees without a sustainable model. Consider several key models that allow grantees to choose priorities from a list of grants (menu style) but are managed by a few central organizations that are longer term and sustainable.

RE-ESTABLISH AN EXPECTATION IN THE SAMHSA MENTAL HEALTH BLOCK GRANT THAT STATES SUBMIT A PLAN FOR CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

Select Opportunities	Outcomes for Consideration
SAMHSA previously required the submission of a plan for young people under the SAMHSA Block Grant.	This requirement should be re-established and coordinated with other state efforts designed to improve coordination of mental health programs for young people.

ESTABLISH DATA STANDARDS, QUALITY, AND ACCOUNTABILITY IN PREVENTION, CLINICAL CARE, AND SYSTEM PERFORMANCE

Select Opportunities	Outcomes for Consideration
There is no consistent definition of young people for the multiple programs addressing child and adolescent mental health.	Develop a consistent definition to be used (including age ranges) for all child and adolescent mental health programs.
There are no consistent definitions of mental health and behavioral health across the different programs serving young people.	Develop consistent mental and behavioral health definitions to help states and communities consistently design and serve their populations.
Mental health programs targeting young people have different outcome measures and reporting requirements. This includes the programs funded at the federal government level.	The federal government should lead the development of a common evaluation framework with a core set of process, quality, and outcome measures, a core needs assessment, and outcomes that can be used consistently across mental health programs serving young people. This framework can be adapted and tailored to state or locality-specific programs.

ESTABLISH DATA STANDARDS, QUALITY, AND ACCOUNTABILITY IN PREVENTION, CLINICAL CARE, AND SYSTEM PERFORMANCE
(CONTINUED)

Select Opportunities	Outcomes for Consideration
Mental health population health measures for young people are largely only available at the state and county level and do not capture the variation and differences at the community level (zip code and census tract).	Provide support for comprehensive data surveillance systems for mental health services for young people that samples at the census tract level through grant funding to states and localities for data collection.
There is a need for positive mental health indicators related to mental well-being for young people.	Understanding positive indicators of mental health can provide important information about behaviors and skills that can be promoted to improve overall outcomes. Ensure positive constructs use inclusive language that considers cultural differences.
Timeliness (how often surveys are collected), delays, and a lag in reporting inhibit point-in-time estimates and comparisons across surveys.	Emphasize timely data collection and reporting that allows for benchmarking and comparisons over time.
There is a lack of measures that are consistent and include a full set of specific disorders for young people.	Develop and standardize surveillance indicators that cover the comprehensive spectrum of disorders with consistent age definitions that align with child development milestones.

ESTABLISH AND ENCOURAGE A STATE GOVERNANCE STRUCTURE FOR CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES

Select Opportunities	Outcomes for Consideration
While many states have established state children's cabinets, councils, and commissions to help coordinate and integrate programs for young people, not all states have established coordinating entities to oversee mental health services for young people.	The federal government should encourage each state to establish a state-level Youth Mental Health Office or facilitator to coordinate policy, payments, and systems design for mental health for young people. This office could: ■ Provide a framework for performance monitoring, licensing behavioral health organizations, monitoring compliance, and addressing grievances. ■ Submit a plan for mental health for young people under the SAMHSA Mental Health Block Grant program. ■ Coordinate across different federal block grants and other support for states for behavioral health prevention, promotion, and services. ■ Ensure quality based on use of evidence-based interventions and measurement-based care. ■ Coordinate sectors involved in young people's mental health (e.g., behavioral health, health, primary care, education, child welfare, Medicaid, and commercial insurance).
There are significant variations across states on payment and coverage as well as workforce, telehealth, and other key components for quality mental health services for young people.	State Youth Mental Health offices or facilitators could help coordinate policy, payments, and systems design for mental health services for young people.

DESIGNATE A FEDERAL COORDINATOR AND UNIFIED PLAN FOR THE BEHAVIORAL HEALTH OF YOUNG PEOPLE

Select Opportunities	Outcomes for Consideration
There are multiple technical assistance centers across programs serving child and adolescent mental health.	Create a single coordinated center, perhaps with regional presence. Congress has recently mandated a new model by CMCS and the Department of Education.
Hundreds of programs supporting the mental health of young people are funded by the federal government with different types of eligible recipients, some of whom may not have the capacity to effectively apply for and use funds.	The federal government could consider a single portal for all similar types of mental health program applicants (e.g., states, NGOs, counties).
There is no single coordinator across the federal government charged with identifying all relevant programs across federal departments that impact mental health for young people.	A model similar to the Office of National Drug Control Policy could develop an annual coordinated budget to help assess program overlap, gaps, and opportunities for collaboration and streamlining of existing grant programs.
There is no national coordinator who serves as a focal point for external relations with states and mental health stakeholders.	A national coordinator could be charged with assuring that all mental health programs for children and youth are designed and executed with a focus on equity and serve the full range of young people across the nation.

APPENDIX A: SELECT DEPARTMENT OF HEALTH AND HUMAN SERVICES MENTAL HEALTH STRATEGIES

The table below summarizes a range of strategic plans related to mental health issued by numerous federal agencies, the White House, the Surgeon General, and Senators Bennet and Cornyn. While there are common themes, each strategic plan has its own content focus and timeline. Plans that were selected for evaluation focused either on mental health, health of young people, or the intersection of mental health for young people.

STRATEGIC PLAN	TIMEFRAME	CONTENT FOCUS
White House Strategy to Address Our National Mental Health Crisis	FY 2023	■ Mental health for all populations ■ A few objectives were child-specific
U.S. Department of Health and Human Services Strategic Plan	FY 2022-2026	■ Focused on health, generally ■ Objective 1.4 focused on behavioral health ■ Not child-specific
SAMHSA Strategic Plan	FY 2019-2023	■ Behavioral health for all populations ■ Priority 2 is child-specific and focuses on serious mental illness and serious emotional disturbance
CMS Behavioral Health Strategy	No timeframe listed	■ Behavioral health for all populations ■ A few initiatives are child-specific
Protecting Youth Mental Health, U.S. Surgeon General's Advisory	No timeframe listed	■ Child and adolescent mental health
National Institute of Mental Health Strategic Plan for Research	2020-2025	■ Mental health for all populations ■ Not child-specific
U.S. Department of Education—Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs	No timeframe listed	■ Child and adolescent mental health
Administration for Children and Families Strategic Plan	2022	■ Overall well-being of children and families ■ Three strategic goals related to behavioral health
CDC Suicide Prevention Strategic Plan	FY 2020-2022	■ Suicide-specific ■ Not child-specific
CDC Division of Adolescent and School Health—The Path Forward—DASH Strategic Plan	2020-2025	■ Youth-specific, not only focused on behavioral health ■ A few points were behavioral health specific
CDC Division of Human Development and Disability—DHDD Strategic Plan	FY 2021-2025	■ Focused on disabilities ■ Not child-specific ■ One mental health related strategy
HUD Strategic Plan	FY 2022-2026	■ Focused on sustainable and affordable housing ■ Makes a slight connection between housing and mental health ■ Not child-specific
Indian Health Service Strategic Plan	FY 2019-2023	■ Overall health for Indigenous people ■ Many objectives relevant to mental health ■ Not child-specific

APPENDIX B: YOUTH MENTAL HEALTH EPIDEMIOLOGY

Table B-1 summarizes the self-reported (or parent-reported for the National Survey of Children's Health) prevalence of depression, anxiety, suicidality, use of mental health services, and positive indicators by source. For many of the survey results, prevalence rates summarized by demographic and risk factors (age, sex, race/ethnicity, federal poverty level [FPL], parent education, health insurance coverage and type, and geographic location—rural/urban), are presented in the CDC (2022) report.

- Questions about **depression** are asked in four different surveys. Depending on the survey and the way the question is worded, estimates of depression range from 3.4 percent in the National Survey of Children's Health for parents answering "yes" to ever having been told by a healthcare provider that their child has depression to 36.7 percent of teen respondents in the National Youth Risk Behavior Survey (YRBS) saying that they had felt sad or hopeless almost every day for at least two weeks in a row that caused them to stop doing some usual activities. This wide range for the prevalence of depression illustrates that the rate depends on who is asked (parent or child/adolescent) and the definition used (diagnosis by a healthcare provider or self-reports of persistent feelings for at least two weeks).

- Symptoms of **anxiety** are only measured in one survey, the National Survey of Children's Health, and is reported by parents answering the question about whether their child has ever (9.4 percent) or currently (7.8 percent) been told by a healthcare provider that their child had anxiety.

- **Suicide** rates among young people ages 10-19 years old are measured in two mortality reporting systems and while the rates of this relatively rare event are similar (approximately seven deaths per 100,000 population), the number of deaths included by each surveillance system differs by over 800 youth suicide deaths (with more counted in the NVSS than the NVDRS). Suicidal thoughts and attempts are measured in the national YRBS and show that almost nine percent of youth surveyed had attempted suicide at least once in the 12 months before the survey.

- Estimates of **the use of mental health services** also varies widely depending on the survey. The National Survey on Drug Use and Health estimates that approximately 26 percent of respondents had received mental health services from specialists and non-specialists (e.g., pediatricians or primary care physicians). Prevalence rates for mental health services were similar, but lower in other surveys; approximately 10 percent of young people or parents of young people reporting consultation or treatment for mental health services in the National Health Interview Survey and the National Survey of Children's Health. Medication use for mental health treatment was similar in the two surveys that measured this outcome, approximately seven to eight percent (the National Health and Nutrition Examination Survey and the National Health Interview Survey).

Table B-1: Self- or Parent-Reported Prevalence (%) of Child and Adolescent Mental Health Conditions, 2013-2019 (CDC MMWR February 2022)[94]

U.S. NATIONAL SURVEY	DEPRESSION	ANXIETY	SUICIDALITY	MEDICAL HEALTH SERVICES
National Health and Nutrition Examination Survey (NHANES)	Current: 5.8			Consultation with mental health professional: 9.8 Past year mental health medication use: 6.6
National Health Interview Survey (NHIS)				Consultation with mental health professional: 9.6 Consultation with medical doctor: 5.2
National Survey of Children's Health (NSCH) [conducted by HRSA]	Current: 4.4 Ever: 3.4	Current: 7.8 Ever: 9.4		Mental health treatment: 10.1 Past year mental health medication use: 7.8
The National Survey on Drug Use and Health (NSDUH) [conducted by SAMHSA]	Past year major depressive episode: 15.1 Ever major depressive episode: 20.9			Mental health services (specialty + non-specialty): 25.9
National Violent Death Reporting System (NVDRS)			Annual suicide death rate: 7.0/100,000 (n=4,903 deaths)	
National Vital Statistics System (NVSS) [ages 10-19 years old]			Annual suicide death rate: 6.9/100,000 (n=5,744 deaths)	
National Youth Risk Behavior Survey (YRBS) [ages 10-19 years old]	Sadness/hopelessness for ≥2 weeks: 36.7		Seriously considered: 18.8 Made a plan: 15.7 Attempted ≥ once: 8.9 Attempted ≥ once resulting in injury: 2.5	

Table B-2 presents positive indicators of mental health, measured in the National Survey of Children's Health, with specific questions posed to parents for different age groups. The lowest prevalence for any of the measures was for self-control. According to the parent respondents, this positive behavior was exhibited by approximately 77 percent of their children.

Table B-2: Prevalence (%) of Positive Mental Health Indicators Reported by Parent Respondents in the National Survey of Children's Health (NSCH), 2013-2019 (CDC MMWR February 2022)[95]

POSITIVE INDICATORS OF CHILD MENTAL HEALTH	AGES	PREVALENCE
Affectionate (usually or always affectionate and tender with parent)	6 months–5 years	97.3%
Resilient (usually or always bounces back quickly when things do not go their way)	6 months–5 years	89.8%
Positivity (usually or always smiles and laughs a lot)	6 months–5 years	99.0%
Curious (usually or always shows interest and curiosity in learning new things)	6 months–17 years	91.3%
Persistent (usually or always works to finish tasks)	6 years–17 years	84.5%
Self-control (usually or always stays calm and in control when faced with a challenge)	6 years–17 years	76.8%

All of the survey data from the CDC (2022) are presented in the report by demographic, risk, and protective factors such as age, sex, race/ethnicity, household income (measured as a percent of the FPL parent education level, and health insurance coverage and type—public/private). These SDOH can impact both the risk of mental health conditions and access to medical services,[96] and rates of mental health conditions and healthcare usage differed by these factors. For example, rates of depressive disorders measured in the NSCH were lowest for Asian children and adolescents aged 3-17 years. Both the NSCH and NHANES measures of depressive disorders and symptoms found an association with household poverty level, with the lowest prevalence among the households with income greater than 200 percent of the FPL.[97] Not surprisingly, rates of mental health treatment for those with health insurance, either public or private, were at least double the rates of those with no health insurance coverage. In the NHANES survey (2013-2018), 8.6 percent of children and adolescents with any health insurance were receiving a psychotherapeutic agent for mental health conditions compared to 0.9 percent of those with no health insurance.

To capture current rates, especially since the onset of the COVID-19 pandemic, the CDC conducted a one-time, online survey, the Adolescent Behaviors and Experiences Survey (ABES), conducted January to June 2021 among students grades 9-12 attending public and private schools. A portion of the survey questions addressed mental health, suicidality, and connectedness. Overall, 37.1 percent of students reported that they experienced poor mental health during the pandemic, and 31.1 percent experienced poor mental health during the 30 days preceding the survey. In addition, during the 12 months before the survey, 44.2 percent of the teens reported that they had experienced persistent feelings of sadness or hopelessness. This represents a 20 percent increase when compared to the prevalence reported in the YRBS findings from 2013-2019 (Table B-1), the prevalence of this same affect (feelings of sadness or hopelessness) was reported by 36.7 percent of teens. The ABES survey found comparable rates of seriously considered attempting suicide (19.9 percent versus 18.8 percent prior to the pandemic) and for attempted suicide (9.0 percent in ABES compared to 8.9 percent prior to the pandemic).

Rates were higher among teens who did not report feelings of closeness or connected to school or others (friends, family or other groups by computer, telephone or other device), prompting a recommendation that "comprehensive strategies that improve feelings of connectedness with others in the family, in the community, and at school might foster improved mental health among youth during and after the COVID-19 pandemic."[98]

In addition to the online survey to examine the effects of the COVID-19 pandemic on child and adolescent mental health, data collected from mental-health related pediatric (<18 years old) emergency room visits have been used to document its effects.[99] Early in the pandemic (April and May 2020), CDC researchers found that when compared to the same period one year earlier, the rise in suicidal ideations or attempts increased in 2020 by more than 30 percent.[100] The authors of the CDC studies concluded that the current trends in the number and proportion of mental healthcare-related emergency department visits (combined with previous research), "indicate that the mental health effects of the pandemic might be particularly high among adolescent girls."

APPENDIX C: WORKFORCE

The workforce that serves young people with mental health needs should reflect the settings where they receive such services. A 2020 review on **the rates of mental health service utilization by young people in schools and other service settings**[101] found that generally:

- 7.28% of young people received school mental health services
- 7.26% in outpatient settings
- 1.76% in primary care
- 1.80% in inpatient
- 1.35% in child welfare
- 0.90% juvenile justice

For youth with elevated mental health symptoms or diagnoses:

- 22.10% were served by school-based mental health services
- 20.56% in outpatient settings
- 9.93% in primary care
- 9.05% in inpatient facilities
- 7.90% in child welfare
- 4.50% in juvenile justice

The authors conclude that schools and outpatient settings are the most common source for mental health care for the general population of young people, as well as those with symptoms or clinical diagnoses. This may lead to more focused attention to resource allocation, legislation and policy, intervention development, and research. At the same time, the authors note that mental health services are delivered across many settings, which supports the need for more coordination across sectors, particularly in schools and outpatient clinics.

Licensing, training, and payment for different types of providers are also barriers to care for young people but provide opportunities for states to enhance access to care by a range of providers and different settings. On behalf of state governments, the National Governors Association (NGA) issued a report describing how governors and their state agencies have developed strategies to recruit and retain mental health providers.[102] The NGA describes tools and state efforts specifically designed to address mental health provider shortages including:

- **Align curriculum between two-year community colleges and four-year colleges** to guarantee seamless credit transfer for mental health-related degrees, such as social work and psychology.
- **Offer creative incentives** to offset the higher cost of programs requiring certifications and/or higher education and to attract workers into high-demand fields, such as social work.
- **Adapt apprenticeship models to support the social services and mental health workforce** to create mental health provider pathways that provide valuable experience for students, lessen the financial burden of education, and provide support to existing full-time social workers.

In addition, the National Academy for State Health Policy (NASHP) recently issued a report describing innovative state efforts designed by states to enhance school-based services, crisis intervention services, and recruitment and support of pediatric mental health providers. NASHP notes that in the first six months of 2022, 30 states enacted laws to address workforce shortages in children's mental health services.[103]

NASHP notes that shortages and turnover that existed pre-pandemic have been amplified during the pandemic across all health professions, in large part due to provider burnout and trauma. They describe that there are currently 155 million Americans living in mental health professional shortage areas, staffing of school psychologists is well below recommended levels, and there are less than four percent of clinical psychologists who specialize in youth.

The Biden Administration and Congress have taken steps to address provider shortages including passage of the Bipartisan Safer Communities Act, passed on June 26, 2022, which sets aside nearly $1 billion in mental health supports for children. The Biden Administration announced that they will use this funding to double the number of mental health professionals serving all populations, such as school counselors and social workers. In addition, the American Rescue Plan of Act of 2021 provided enhanced funding for Medicaid home and community-based services. Some states are using this funding to support the children's mental health workforce by recruiting pediatric behavioral health providers and building the capacity of existing professionals to deliver mental health services.

State Laws to Support the Children's Mental Health Workforce

In their review of recent state laws designed to support the children's mental health workforce, NASHP found that 30 states enacted laws from January through June 2022 to address mental health provider workforce shortages for youth. State laws included assessing workforce gaps and vacancies, enhancing recruitment and support of providers, establishing trainings and resources for behavioral health professionals, and modifying policies around the provision of mental health services.[104]

- Eight states enacted laws supporting efforts to monitor the capacity of the pediatric mental health workforce and identify and assess potential policy recommendations through the convening of work groups or task forces.

- Twenty-one states enacted laws to expand and improve the pediatric mental health workforce. These laws include support for schools in hiring and retaining providers and for primary care providers, such as pediatricians, in delivering mental healthcare.

- Eight states enacted laws to enhance education, training, and staff resources for providers and ancillary staff (e.g., school staff) in delivering mental health supports.

- Eleven states enacted laws updating policies around the provision of services. These measures include creating new positions for professionals working with youth, modifying workforce standards and licensure requirements, and allowing telemental health services.

Table C-1: State Laws to Support the Children's Mental Health Workforce (January 1 – June 31, 2022)

APPROACH	STATES
Data and Assessment of Provider Availability and Capacity	
Collecting and monitoring data.	CT, GA, IL, KY, NJ
Convening work groups to assess needs	CO, GA, IL, NJ, NM, TN
Investments in Provider Recruitment, Retention, and Support	
For providers generally*	AK, CA, CO, CT, ID, IN, MD, ME, NE, NH, NM, OR, RI, WA, WY
For school-based providers	AL, CA, CO, CT, KY, MD, NE, NJ, NY, UT, VT

Provider Training and Resources on Mental Health Supports	
For providers generally**	CO, GA, NH
For school-based providers and staff	ME, NE, NY, OK, WV
Provider and Service Provision Policies	
Establishing or requiring new positions	AL, AZ, CT, FL, NE
Modifying standards and licensure	AZ, CT, DE, GA, KY, NY, OH
Permitting telehealth services	IN, OH

Finally, the nonprofit, Children Now, spent almost a year interviewing various providers across child-serving sectors to better understand opportunities and challenges towards supporting mental health services for young people. Children Now identified several major findings from these interviews including:[105]

- Formal education alone does not prepare providers to work with kids, especially kids with trauma. **Continuing education and specific trainings and professional development** opportunities are needed to equip providers to assist children, youth, and families.

- **Suicide prevention training** is critical for all provider training to allow adults to recognize signs that a young person is considering suicide and get them the resources and help they need.

- **Adults can benefit from skills** related to common mental health challenges for young people, better understanding of typical adolescent development, and actions designed to help young people in both crisis and non-crisis situations. The training should include issues related to anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders, and eating disorders.

- Educating providers to **recognize lived experience** is key to effectively connecting and empathizing with young people and their families. Lived experience is particularly important to support understanding of the environmental challenges young people and families faced that potentially impact their mental health.

- School professionals require **skills specifically related to suicide and homicide impact assessments** to assure rapid and effective response after a suicide or homicide impacts a school, either occurring in the school or in the neighborhood. In addition, clinician training around suicide assessments is needed to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment. Suicide assessments are also used to help develop treatment plans and track the progress of individuals who have been assessed as being at risk for suicide.

- Training to help providers understand the **nuances of culturally sensitive and empathetic communication** with both a parent and their child can be essential to developing strong partnerships between families and their providers.

- Providers often cite **administrative** barriers to retention in the field of children's mental health including paperwork and administrative responsibilities.

- **Low pay and reimbursement** for the full range of child mental health providers is a major barrier to access to care. Pay and reimbursement are particularly challenging for non-traditional workers (community health workers, promotors, indigenous healers, etc.) who often play a critical role in meeting cultural and linguistic gaps of the traditional healthcare system, as well as in enhancing communication between communities

and healthcare systems, provide guidance on how to navigate systems of care, and serve as a liaison between communities, individuals, and coordinated care organizations.

■ There are also major **disparities in income** between mental health providers in public systems, such as psychiatrists who work for counties, compared with those in private practice. These pay gaps create disincentives for public providers to participate in public systems including school-based care, resulting in poorer access for families who are uninsured or lack resources to seek other sources of care.

■ There is a need to **expand scope of practice** for some healthcare professionals such as nurses in order to increase the availability of providers to treat the mental health of young people. These may include support for behavioral health counselors and coaches, as well as training for pediatric primary care and other healthcare providers.

APPENDIX D: MENTAL HEALTH TECHNOLOGIES

Mobile Apps

The use of mobile app technology to improve access to care, quality of care, and data collection is rapidly emerging. The use of mobile devices such as smartphones are giving the public, doctors, and researchers new ways to access help, monitor progress, and increase understanding of mental wellbeing.[106]

Mobile mental health support ranges from the ability to send a text message to contact a crisis center to the use of a device sensor to detect behavior changes that may signal the need for help before a crisis occurs. Other apps may help the user connect to a peer counselor or to a healthcare professional. While there are thousands of mental health apps available, there is very limited industry regulation as well as information on app effectiveness, with limited guidance for providers and consumers on which apps they can trust.

Telemental Health

Another important development to increase access to care, particularly for young people in rural and other underserved areas, is the expanded use of telebehavioral health. A significant number of Americans live in communities without appropriate mental health support systems and providers, so called "desert communities." In some states, **there is only one mental health provider for every 1,000 residents**.[107]

These shortages are even more profound when addressing mental health needs for young people and their families who often face limited options when they are seeking care. Currently, all states face severe shortages, with many communities lacking even one qualified child and adolescent psychiatrist.[108]

Telebehavioral health is emerging as a convenient, accessible model of care that appears to yield high satisfaction rates for young people and their families. Given the comfort that young people have with technologies, some studies indicate that telebehavioral health might actually be a preferred model of care for young people and their families compared with traditional models of delivery.

Some of the potential advantages of telebehavioral health include:

Comfortable Surroundings—Allows young people to remain in their own environment surrounded by familiar possessions or in reach of pets who may offer comfort and allows the therapist to see the home environment, which cannot occur in an office visit.

Familiar Modes of Communication—The majority of teens own a smartphone and are more comfortable and trusting of telehealth sessions compared to traditional office visits.

Easier Scheduling—Professional shortages and scheduling challenges often cause students to miss school to attend therapy sessions. Telebehavioral health provides easier scheduling and may actually occur during school hours, so the individual does not have to miss school or risk seeing someone they know in a waiting room.

Although there is great enthusiasm for expanding the use of telehealth to improve access to mental health services, there are several barriers to widespread adoption and use, which may also slow increased adoption, including for young people.

CDC provides a detailed description of some of these barriers and opportunities to address them.[109]

Insurance Coverage for Telemedicine Services—Telehealth services are governed by federal and state laws with each state defining telehealth and coverage differently, and these definitions determine the services that qualify for reimbursement under Medicaid and private insurance. CMS encourages states to use their Medicaid flexibility to provide services that integrate telehealth technology and most states provide some level of Medicaid reimbursement for telemedicine as well as reimbursement for telemental health services. Private payers also provide some coverage for telehealth, but policies differ in what services are covered and how much providers are reimbursed. Some states and the District of Columbia require that payments for telemental health services be equivalent to those received for in-office treatment.

Licensure Requirements—Each state establishes licensure requirements for their healthcare professionals and many states' requirements limit care across states. While there has been some movement allowing more flexibility for telehealth across states, there is still no universal compact that consistently allows cross state telehealth services.

Evidence of Effectiveness—Although more studies are being published that support the effectiveness of telehealth, including telemental health services, more evidence is needed to support the use of telemental health for young people, including diverse populations and the range of mental health conditions. There is also a great need to understand those populations who may not benefit from telehealth or may require a hybrid approach to improve outcomes.

Privacy Concerns—It is important for telehealth providers to ensure the security of the data stored and transmitted via telehealth as well as compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Cost—While the cost of technologies are generally coming down, there continue to be costs associated with establishing and maintaining a telehealth practice that may prohibit some providers from engaging in these practices. Costs include equipment and installation and rental cost of telecommunications lines; salary, wages and administrative expenses; and data transmission costs, service fees, and maintaining and upgrading equipment. In addition, there remain geographic areas that do not have adequate connectivity to support telehealth.

Finally, while there is great enthusiasm and advancement in the use of technology to improve access and care for mental health, it will require continual advancements to assure that products are easy to use, useful, equitable, effective, and appropriate for different user groups. Designing product development with the needs of the young people and settings that use those products will continue to be necessary to improve technology specifically designed to improve mental health services for young people.[110]

APPENDIX E: CURRENT LEGISLATION AND KEY AGENCY ACTIONS

Senate Finance Committee Proposed Mental Health Legislation: Working Drafts

The Senate Finance Committee issued the report "Mental Health Care in the United States: The Case for Federal Action" after conducting public fact-finding efforts through three hearings specific to behavioral health (described in Appendix A) and a bipartisan request for information (RFI), as well as information gathered from constituents, subject matter experts, and a literature review on behavioral health care published by federal agencies and researchers.

As stated in the first chapter of this report: "The Senate Finance Committee is responsible for developing legislation and providing oversight of federal programs that finance and provide health coverage for more than 120 million Americans under Medicare, Medicaid,

the Children's Health Insurance Program (CHIP), Affordable Care Act (ACA) marketplace coverage, and group health plans as defined by section 5000(b)(1) of the Internal Revenue Code of 1986. The Committee has an obligation to study the health challenges facing the individuals with coverage under these programs and to propose modifications and reforms as needed."

Sen. Wyden requested fellow member of the Senate Finance Committee to serve as co-chairs, one from each party, to lead efforts to identify bi-partisan legislative steps to improve the mental healthcare system. The result is the working draft released over the course of 2022, and the committee is intending to bring a negotiated comprehensive mental health bill to the floor as part of the legislative agenda for 2023."

Table E-1: Focus Areas and Co-Chairs

FOCUS AREAS	DRAFTERS	DRAFT LANGUAGE
Strengthening the workforce	Sens. Debbie Stabenow (D-Mich.) and Steve Daines (R-Mont.)	Enhancing The Mental Health Workforce
Increasing integration, coordination, and access to care	Sens. Catherine Cortez Masto (D-Nev.) and John Cornyn (R-Texas)	Improving Integration, Coordination, and Access to Care
Ensuring parity between behavioral and physical health care	Sens. Michael Bennet (D-Colo.) and Richard Burr (R-N.C.)	Mental Health Parity
Furthering the use of telehealth	Sens. Ben Cardin (D-Md.) and John Thune (R-S.D.)	Ensuring Access to Telemental Health Services
Improving access to behavioral health care for children and young people	Sens. Tom Carper (D-Del.) and Bill Cassidy (R-La.)	Improving Access to Physical and Mental Health Care for Children and Youth Under Medicaid and CHIP

Table E-2: Highlighted Legislative Provisions and Implementing Agencies

LEGISLATION	AGENCY	DESCRIPTION
American Rescue Plan Act of 2021	HRSA	Improves access to pediatric mental healthcare
	SAMHSA	Funds national Child Traumatic Stress Network, Project AWARE, Youth Suicide Prevention
Consolidated Appropriations Act of 2021	SAMHSA	Funds crises care initiative within the Mental Health Block Grant, specifically expanding support for children and youth's mental health, Project AWARE, National Child Traumatic Stress Network
Bipartisan Safer Communities Act of 2022	CMS	Improves oversite of state implementation of Medicaid Early and Periodic Screening, Diagnostic, and Treatment benefit
	DOE	Funds school-based mental health grant programs (increase the number of providers and train and diversify the pipeline of school mental health resources)
	DOJ	Adds review of juvenile and mental health records for those under 21 years of age purchasing firearms
	HRSA	Supports pediatric primary care providers to access specialist expertise and provides training for primary care clinicians
	SAMHSA	Improves trauma care services and funds programs that increase awareness of mental health issues with school-aged youth
Consolidated Appropriations Act of 2022	SAMHSA	Funds Project AWARE, National Child Traumatic Stress Initiative, Infant and Early Childhood Mental Health, Youth Suicide Prevention Grants, Abuse Prevention

Agency Guidance Quick Reference

A review of guidance documents, reports, and informational resources was conducted to examine the scope of key agency actions related to child and youth mental health. These documents provide recommendations and information to state Medicaid directors, state health officials, Congress, and the public on how to promote child mental health, comply with requirements under Medicaid and other federal programs, and implement effective service delivery systems. They discuss a broad range of topics including, school-based services, health home services, home- and community-based services (HCBS), early and periodic screening, diagnostic and treatment (EPSDT) benefit under Medicaid, crisis response and stabilization services, telehealth, peer support services, and the FMAP or federal financial participation (FFP). Agency documents were also developed in response to several pieces of legislation, such as the American Rescue Plan Act of 2021, 21st Century Cures Act, Bipartisan Safer Communities Act, SUPPORT Act, and Individuals with Disabilities Education Act (IDEA). Although not exhaustive, Table E-3 Summarizes the content and topics of the 18 agency actions.

Table E-3: Content and Topics of the 18 Agency Actions

AGENCY ACTION	DATE RELEASED	SUMMARY	TOPICS DISCUSSED
Medicaid and School Health: A Technical Assistance Guide by HCFA (now CMS)	August 1997	The guide provides information and assistance regarding the specific federal Medicaid requirements associated with implementing a school health services program and seeking Medicaid funding for school health services. It also discusses: the implications of mandatory implementation of Medicaid managed care on school-based health providers; Federal Medicaid payment requirements; Medicaid free care and third-party liability requirements; administrative claiming; payment of transportation; and case management provisions.	School-based Services; EPSDT; Medicaid Free Care; Transportation Services; Individualized Education Plan (IEP); Individualized Family Service Plan (IFSP); Rehabilitative services; FQHC services; Medicaid Managed Care; Case Management
HCFS (now CMS) State Medicaid Director Letter: School-based Health Services Reimbursement	May 1999	The letter clarifies HCFA policy in three areas: (1) Use of a bundled rate to pay for medical services provided to Medicaid-eligible children in schools; (2) State claiming for school health-related transportation services for children with IEPs under the IDEA; and (3) State claiming for school health-related administrative activities.	School-based Services; FMAP/FFP; Transportation Services; Administrative Claiming
Medicaid School-based Administrative Claiming Guide	May 2003	The guide informs schools, state Medicaid agencies, and others on the appropriate methods for claiming federal reimbursement for the costs of Medicaid administrative activities performed in the school setting. Specifically, it provides a clear articulation of the requirements for school-based administrative claiming and helps schools prepare appropriate claims for administrative costs under the Medicaid program.	School-based Services; EPSDT Benefit; Administrative Activities; Case Management, FMAP/FPP; IEP; Family Planning Services; Transportation Services; Translation Services; Interagency Agreements
CMCS Informational Bulletin: Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders	December 2012	The document provides states with information regarding services and supports to meet the health needs of individuals with mental health or substance use disorders. Specifically, it provides states with resources on community integration, mental health parity, and the integration between physical and behavioral health.	Integration of Primary Care and Mental Health; Mental Health Parity; Community Integration; Early Identification and Treatment
CMCS Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions	March 2013	The bulletin informs states about resources available to help them meet the needs of children under EPSDT, specifically with respect to mental health and substance use disorder services. It describes clinical guidelines and recommendations for screening, resources for professional development and training, clinical quality reporting programs, and examples of state initiatives to improve screening and quality.	EPSDT; Screening; Quality Reporting; Professional Development; Care Coordination; Integration of Primary Care and Mental Health
SAMHSA & CMS Joint Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions	May 2013	The informational bulletin assists states in designing successful home and community-based services for children and youth with significant mental health conditions and provides guidance on how states can cover these services through their Medicaid program, using examples from other states.	HCBS; Care Coordination; SDOH; Crisis Response & Stabilization Services; Health Home Services; Peer Support Services

AGENCY ACTION	DATE RELEASED	SUMMARY	TOPICS DISCUSSED
EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (CMS)	June 2014	The guide helps states, providers, and others to understand the scope of services that are covered under EPSDT. The guide outlines (1) EPSDT screening requirements; (2) scope of services covered; (3) access to EPSDT services and providers; and (4) limitations of EPSDT service coverage.	EPSDT benefit; HCBS; School-based Services; Crisis Response and Stabilization Services; Rehabilitative Services; Culturally Competent Care; IEP
CMS State Medicaid Director Letter: Medicaid Payment for Services Provided without Charge (Free Care)	December 2014	The letter provides updated guidance on Medicaid's free care policy. CMS is withdrawing its prior guidance on the "free care" policy as expressed previous CMS guidance (1997 Guide above). Under the new guidance, Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large. As a result, Federal Financial Participation (FFP) is available for Medicaid payments for care provided through providers that do not charge individuals for the service.	Medicaid Free Care; School-based Services; FMAP/FFP
CMCS Informational Bulletin: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children and youth in managed care	January 2017	The document provides guidance to states on how to construct their Medicaid managed care plan contracts to avoid confusion about what the EPSDT benefit includes and what entity is responsible for delivering it to ensure that eligible youth have access to the full EPSDT benefit. The guidance encourages states to be clear in their managed care contracts about the scope of services the state expects the plan to provide to children.	EPSDT Benefit; Medicaid Managed Care
SAMHSA Report to Congress 2017: The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (CHMI) Program	2017	The report discusses findings of the CMHI Program, which demonstrate that CMHI grantees continue to provide effective, evidence-based services in the community that improve the clinical and functional outcomes of children, youth, and young adults with SED and their families. It includes recommendations for future programming related to CMHI and systems of care.	CHMI Program; Peer Support Services; Systems of Care; Evidence-Based Practices; Trauma Informed Care; School-Based Services; Care Coordination
CMS State Medicaid Director Letter: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance	November 2018	The letter announces opportunities to design innovative service delivery systems for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED) who are receiving medical assistance, as mandated by section 12003 of the 21st Century Cures Act. It also includes opportunities for demonstration projects under section 1115(a) of the Social Security Act to improve care for adults with SMI or children with SED.	HCBS; Care Coordination; School-Based Services; SDOH; Crisis Response & Stabilization Services; Health Home Services; EPSDT benefit; Data Sharing; Telehealth; FMAP/FFP; Peer Support Services

AGENCY ACTION	DATE RELEASED	SUMMARY	TOPICS DISCUSSED
CMCS & SAMHSA Joint Informational Bulletin: Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools	July 2019	The bulletin provides states and school systems with information about addressing mental health and substance use issues in schools. Specifically, it includes examples of approaches for mental health and SUD related treatment services in schools and describes some of the Medicaid state plan benefits and other Medicaid authorities that states may use to cover mental health and SUD related treatment services.	School-based Services; Crisis Response & Stabilization Services; Health Home Services; EPSDT benefit; Telehealth; FMAP/FPP; Integration of Mental and Primary Care
CMS State Health Official Letter: Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children's Health Insurance Program	March 2020	The letter describes new provisions related to section 5022 of the SUPPORT Act and provides guidance to states with separate CHIPs on the actions necessary to implement the requirements of the Act.	EPSDT Benefit; Screening and Preventive Services; Culturally and Linguistically Appropriate Services (CLAS); Mental Health Parity
CMS State Medicaid Director Letter: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-based Services during the COVID-19 Emergency	May 2021	The letter provides guidance to states on the implementation of Section 9817 of the American Rescue Plan Act and describes opportunities for states to strengthen the HCBS system in response to COVID-19.	HCBS; School-based Services; Health Home Services; FMAP/FPP; Rehabilitative Services; Long-term Services and Support
DOE Informational Resource: Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs	October 2021	The document provides information and resources to enhance the promotion of mental health among children and youth who are students across early childhood, K-12 schools, and higher education settings, and presents seven corresponding recommendations.	School-based Services; SDOH; Crisis Response & Stabilization Services; EPSDT benefit; Data Sharing; Telehealth; Multi-tiered Systems of Support framework
CMS State Director Letter: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services	December 2021	The letter provides guidance on the scope of and payments for qualifying community-based mobile crisis intervention services authorized by section 9813 of the American Rescue Plan Act of 2021.	Community-based Mobile Crisis Intervention Services; HCBS; Care Coordination; Peer Support Services; FMAP/FPP
ISMICC Report to Congress 2022: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers	April 2022	The report reviews the advances made by federal agencies in addressing the recommendations articulated in the ISMICC 2017 The Way Forward Report to Congress. It also identifies emerging areas of focus that may be addressed through continued collaboration and coordination among federal agencies.	School-based Services; SDOH; Crisis Response and Stabilization Services; Telehealth; Health Disparities; Federal Coordination; Mental Health Parity

AGENCY ACTION	DATE RELEASED	SUMMARY	TOPICS DISCUSSED
CMCS Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth	August 2022	The document reminds State Medicaid Agencies of the federal requirements for the EPSDT benefit. It also provides state agencies with existing federal guidance and examples on ways that Medicaid and CHIP funding can be used in the provision of high-quality behavioral health services to children and youth.	EPSDT benefit; HCBS; Care Coordination; School-based Services; SDOH; Crisis Response and Stabilization Services; Health Home Services; Telehealth; FMAP/FPP; Data Sharing; Peer Support Services
CMCS Informational Bulletin: Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services	August 2022	The document reminds states of the applicable federal regulations and policies related to Medicaid-covered school-based services and helps states and school-based providers implement, maintain, and expand their school-based programs. Specifically, the bulletin directs states to relevant existing guidance and strategies to consider, in the form of a "checklist," which is intended to assist states in developing proposals that are consistent with federal requirements and policies.	School-based Services; EPSDT benefit; Care Coordination; Telehealth; IEP; Individualized Family Service Plan (IFSP); Medicaid free care policy
CMS State Medicaid Director Letter: Health Homes for Children with Medically Complex Conditions	August 2022	The letter provides guidance on the implementation of section 1945A of the Social Security Act, enacted as part of the Medicaid Services Investment and Accountability Act of 2019, which authorizes states to cover an optional health home state plan benefit for Medicaid-eligible children with medically complex conditions. Under this provision, beginning October 1, 2022, states have the option to cover health home services for Medicaid-eligible children with medically complex conditions.	Health Home Services; Care Coordination; HCBS; School-Based Services; FMAP/FPP; Transportation Services; Culturally and Linguistically Appropriate Services (CLAS)

LMHC Licensure and Reimbursement

Licensed mental health counselors (LMHC), also referred to as Licensed Professional Counselors (LPC) or Licensed Professional Clinical Counselors (LPCC) depending on the state, are mental health providers trained to work with individuals, families, and groups in treating mental, behavioral, and emotional issues and disorders. LMHCs comprise a sizeable portion of the mental health workforce; HRSA estimated that there were 140,760 mental health counselors in 2017. By 2030, HRSA projects a 17% increase to 164,320 mental health counselors.[111] While licensing requirements vary across the country, all states require LMHCs to obtain a master's degree in counseling or psychotherapy, a minimum number of supervised work hours in a clinical setting, a background check, and a passing score on a state-administered or state-recognized counselor exam.

Some states are taking steps to change LMHC licensure requirements in an effort to increase the availability of outpatient mental health services. In September 2021, the California state legislature passed the Licensed Professional Clinical Counselor Act to remove the marriage and family education and training requirements for LPCCs. It also removes the requirement that Associate Professional Clinical Counselors (APCCs) complete 150 of their 3,000 training hours in a hospital or community mental health clinic setting as part of their training to become an LPCC. Assemblywoman Wendy Carrillo, the bill's sponsor, believes that these licensure changes will expand the pipeline of mental health professionals, making it easier for all individuals, especially children, to access mental health services.[112]

APPENDIX F: ACRONYMS

ABES	Adolescent Behaviors and Experiences Survey
ACE	Adverse Child Experience
ACF	Administration for Children & Families
APA	American Psychological Association
AWARE	Advancing Wellness and Resiliency in Education
BG	Block Grant
CAA	Consolidated Appropriations Act
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program
CMHI	Children's Mental Health Initiative
CMS	Centers for Medicare & Medicaid Services
CW	Child Welfare
DOE	Department of Energy
DOL	Department of Labor
EBP	Evidence-Based Practice
EBPI	Evidence-Based Psychosocial Intervention
ED	Emergency Department
EITC	Earned Income Tax Credit
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FCC	Federal Communications Commission
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HIPPA	Health Insurance Portability and Accountability Act
HLSA	High Level Service Areas
HRSA	Health Resource and Services Administration
IDEA	Individuals with Disabilities Education Act
IHS	Indian Health Services
InCK	Integrated Care for Kids
LAUNCH	Linking Actions for Unmet Needs in Children's Health
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LMHC	Licensed Mental Health Counselor
LPC	Licensed Professional Counselor
LPCC	Licensed Professional Clinical Counselor

MCPAP	Massachusetts Child Psychiatry Access Project
MD	Medical Doctor
MFT	Marriage and Family Therapist
MH	Mental Health
MMWR	Morbidity and Mortality Weekly Report
MRSS	Mobile Response and Stabilization Service
NASHP	National Academy for State Health Policy
NGA	National Governors Association
NHANES	National Health and Nutrition Examination Survey
NIMH	National Institute of Mental Health
NSCH	National Survey of Children's Health
NVDRS	National Violent Death Reporting System
NVSS	National Vital Statistics System
OSHA	Occupational Safety and Health Administration
PHE	Public Health Emergency
SABG	Substance Abuse Prevention and Treatment Block Grant Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening Brief Intervention and Referral to Treatment
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SES	Socioeconomic Status
SMI	Serious Mental Illness
SPA	State Plan Amendment
SSBG	Social Services Block Grant
SU	Substance Use
SUD	Substance Use Disorder
TA	Technical Assistance
TAGGS	Tracking Accountability in Government Grants System
TANF	Temporary Assistance for Needy Families
USDA	U.S. Department of Agriculture
VA	U.S. Department of Veterans Affairs
WHO	World Health Organization
WIC	Women, Infants, and Children
YRBS	Youth Risk Behavior Survey
YRBSS	Youth Risk Behavior Surveillance System

APPENDIX G: ENDNOTES

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