Addressing System Needs for Child Behavioral Health During the COVID-19 Pandemic

While youth seem to be at relatively limited physical health risk from COVID-19, the broad societal impacts of this pandemic, and the isolation caused by its associated shelter-in-place activities, have created a crisis for child and adolescent mental health. This crisis adds to an already complicated landscape of issues, including access to and payment for behavioral and mental health services for these populations. In this policy review, we detail areas of concern and offer potential opportunities for addressing the mental health crisis for children and adolescents within the COVID-19 pandemic.

What we know about the pandemic's impact on youth behavioral health

Crisis of any kind is known to increase mental health and substance use disorders, and the COVID-19 pandemic will be no exception. Many low-income individuals and families are faced with the challenge of protecting themselves and others from the virus without the option of flexible work schedules or the ability to work from home. This has been compounded by concerns about economic stability, housing, food insecurity and racial inequity.

Although physical distancing has been necessary to prevent the spread of COVID-19, it also means that many individuals are isolated from their support systems at a time when they need it most. According to an April Kaiser Family Foundation poll, nearly half of all U.S. adults say this pandemic has affected their mental health—a growing concern since we know that parental mental health can have significant impacts on the lives of their children. Similarly, a survey conducted by Save the Children found that 67% of parents are concerned about their child's emotional well-being during this time.

Children and adolescents are also grappling with isolation and concerns about the future. They are missing out on face-to-face peer interactions and interventions provided by schools and other social systems, all of which are crucial for their social and emotional development. Youth who rely on others outside of their family for guidance or support will feel the profound separation of physical distancing perhaps more intensely than others.

Early findings on the psychological effects of the pandemic and its shelter-in-place policies on youth are primarily from other parts of the world. Evidence from China indicates an increase in depression and anxiety symptoms among students. Similar findings are emerging from Italy and Spain, where the majority of parents (86%) surveyed reported changes in their children's emotional state, with 23% of parents reporting that their child was sadder than usual and 39% of parents reporting that their child was more irritable—two core symptoms of depression. Parents also relayed that their children were experiencing high rates of worries (30%) and loneliness (31%). Previous studies that examined the psychological effects following the H1N1 outbreak indicated that isolated and quarantined children met the criteria for post-traumatic stress disorder (PTSD) at rates close to those of children who had experienced disasters and other serious traumatic events.

While we do not yet have the full picture, crisis hotlines in the U.S. are beginning to reflect the growing need for support. The Substance Abuse and Mental Health Services Administration

(SAMHSA) saw **a fivefold increase** in calls to its National Helpline in March, and in Philadelphia, calls to suicide hotlines increased by 10% in April.

This early evidence on the pandemic's impact on youth combined with the children's mental health crisis that existed even before COVID-19 means that youth and their families will need access to quality, affordable and timely behavioral health services now more than ever. In the following sections, we outline five areas that are essential to improve the mental health system to ensure that all children and families receive the help that they need following the COVID-19 pandemic and beyond.

Addressing issues of Medicaid payment and reimbursement

Over the past several months, it has become increasingly clear that our economic landscape is set to be permanently altered by the COVID-19 pandemic and the measures that have been taken in response to it. During the height of the pandemic, unemployment rates were higher than at any point since the Great Depression. Although unemployment will likely decrease as we move forward, the continued economic uncertainty will inevitably drive the demand for social and behavioral health services, and many of these families will need to turn to Medicaid to meet their needs.

This increased demand comes as the behavioral health providers who serve the Medicaid population, and others, are in dire economic straits from the suspension of services during state shutdowns. Medicaid is a crucial revenue source for specialty mental health care providers, and historically low Medicaid reimbursement rates make it exceedingly difficult for these safety net providers, who are already operating on thin margins, to weather any kind of financial or business downturns. In some states, behavioral health providers have seen a nearly 50% loss of monthly revenues as operations have either been suspended or reduced amidst the crisis, and the National Council for Behavioral Health warns that "60% of mental health providers have already been forced to close one or more programs."

While the providers that rely primarily on Medicaid for payments struggle to keep their doors open, federal COVID-19 relief bills have focused mostly on systems that serve patients with Medicare or private health insurance. Additionally, mental health services have not been a priority for these relief bills. The CARES Act, a $2 trillion relief bill, included a paltry $425 million for SAMHSA. For comparison, that's less than 1% of the total amount invested in the airline industry in that same bill.

Leading behavioral health groups from across the country have called on Congress to administer emergency funding for behavioral health organizations during the COVID-19 crisis stating that "without robust investment in behavioral health, behavioral health organizations will not be able to keep their doors open—leaving tens of thousands without access to vital mental health treatment and care." It is imperative that this funding also be made available to organizations that serve children.

We know that this pandemic will likely increase enrollment in Medicaid at a time when state budgets are increasingly strained, potentially resulting in changes to Medicaid programs across the country. We are beginning to see this in California's Medicaid program (Medi-Cal), where they are considering eliminating initiatives such as the postpartum mental health expansion and the behavioral health quality improvement program to address a $54.3 billion shortfall. In

Pennsylvania, Governor Tom Wolf has warned of a projected deficit of up to $5 billion. **Although we recognize the need to address these deficits, we are concerned that these cuts will inadvertently hurt children and families.**

Improving access through care delivery models

This pandemic has laid bare the deficiencies of the nation's current mental health policies and infrastructure, but in doing so also provides an opportunity to elevate the critical importance of mental health. The crisis now intersects with long-standing issues of mental health fragmentation, workforce shortages and access.

Data from the Kaiser Family Foundation shows that only about one-quarter of the nation's mental health needs were being met before COVID-19 and that mental health workforce shortages exist in every state across the U.S. Wait times for appointments are often considerable, and many patients have to travel long distances to visit a mental health provider. The American Association for Child and Adolescent Psychiatry estimates that there are 8,000 child and adolescent psychiatrists in the U.S. with current need at over 30,000, leading to average wait times of 7.5 weeks.

These workforce shortages, combined with thin margins and long-standing capacity issues, mean that children and adolescents in need of care often end up in emergency departments, waiting days or weeks for placement in settings that can meet their needs. In Philadelphia, advocates have long raised concerns regarding wait times for children accessing behavioral health services.

One solution to these access issues has been to deliver mental health services in non-traditional locations, such as schools, primary care and child care settings. For instance, 35% of youth who receive mental health services obtain these services in schools. However, the closure of schools during the COVID-19 crisis means access to these services has been lost or is limited, and there will likely be resource and capacity constraints when schools reopen. As such, we will need to think creatively about how to ensure continuity of care, for instance, by delivering services through telehealth, or establishing connections with outside mental health agencies so services can continue even if schools fluctuate between in-person and remote learning. In Philadelphia, a long-standing collaboration between the school district and the behavioral health managed care organization creates this ongoing connection, a model for consideration in other places. In the long-term, these relationships may also facilitate increased delivery of evidence-based mental health interventions in schools.

We must also keep in mind that while primary care provides an important opportunity for child, adolescent, and caregiver behavioral health interventions, COVID-19 has caused a steep decline in attendance at primary care well-child visits across the country. As a result, many individuals with mental health needs are not being identified through routine screening in these settings, at a time when they may be experiencing increasing symptoms. In the face of rising mental health concerns, we need an increased focus on screening for mental health problems in health care and community-based settings and greater discussion about how we manage the concerns that are uncovered as part of this process. **Moving forward, we will need a greater emphasis on regulations that support service linkage, delivery, and ongoing collaboration between providers, instead of a singular focus on screening, to ensure that**

identified youth access the services they need and that these services are well-integrated.

Innovation in payment and delivery models to support care coordination

Ultimately, to facilitate coordination of care across settings, **we will need a continued focus on payment approaches that consider and incentivize coordinated care and a greater emphasis on innovations that can keep pace with our evolving mental health needs.**

For examples, we should look to those who were innovating before the COVID-19 pandemic. Massachusetts was the first state to increase access to behavioral health treatment by making child psychiatry services—a scarce resource—available to primary care physicians across the Commonwealth via a system of regional children's behavioral health consultation teams. Other states, including Pennsylvania, have since implemented this approach. We can also look to North Carolina, where they have expanded the Centers for Medicare & Medicaid Services (CMS) psychiatric collaborative care (CoCM) payment codes, developed for adults, to pediatric primary care. This allows reimbursement for behavioral health integration in pediatric primary care settings, including coverage for care coordinators.

We should also continue to focus on information sharing between physical and mental health providers. In March, CMS announced a new requirement that hospitals notify related doctors if their patient is undergoing coronavirus treatment. This provision highlights the importance of health data exchange and could push the conversation forward on this important issue both for physical and mental health providers.

Prevention services must also be part of this discussion and are a fundamental necessity if we want to flatten the behavioral health curve. Expanded access to evidence-based prevention programming can promote well-being and stem the flow of youth and families who overwhelm the health care system after reaching crisis levels. Our current approach of waiting to act until a disorder is well-established misses the opportunity to prevent that disorder and to build healthy development in young people. There have been recent movements to support coverage of services focused on mental health promotion and prevention—we support these efforts and encourage expanding this coverage for other prevention services.

This pandemic is a prime opportunity to rethink our approach to mental health care—to create integrated systems of care, establish true parity and accelerate novel approaches. However, to accomplish these things, enhanced funding for mental health and prevention services must be made a priority.

Supporting digital health

We must also consider how rapidly and drastically health care delivery has changed as a result of COVID-19. Tech-enabled care will no longer be viewed as a "special service line," but will be expected as an integrated part of delivery systems. For behavioral health services, this has the potential to reduce the inadequate distribution of professionals and to improve access to mental health treatment across the country.

However, this evolution toward more connectivity must be counterbalanced by an understanding of diverse needs and perspectives, particularly as it relates to the digital divide in the United States. Roughly 29% of households with annual incomes below $30,000 do not own a smartphone, and more than 44% don't have home broadband services or a computer. This means regulations and payments must keep expanding to allow for audio-only interventions to assist those who don't have access to technology and, for adolescents especially, we must continue to consider privacy and safety concerns as providers deliver care in homes where it may be challenging to find the space to talk in private.

Although virtual visits are not a solution for everyone, telehealth can make it possible for more children to get the care they need, when they need it, right in their communities. This can be particularly important for low-income families who often face financial and transportation barriers. Telehealth can save families time traveling to appointments and prevent them from having to take kids out of school and miss work.

The American Psychiatric Association has long endorsed the use of video-based sessions, deeming them equivalent to in-person care. Yet, insurance coverage for telehealth has been inconsistent and a patchwork of state regulations has prevented its widespread use. Given the ongoing pandemic, the federal government and major health insurers updated legislation and reimbursement policies to make it easier for communities to receive the care they need, but many of these policies are set to expire this summer. **Federal and state regulations should continue to embrace the changes brought about by COVID-19 to support the sustainability of this critical resource. We must allow this crisis to drive innovation, embracing the benefits that technology can offer while keeping our eye on issues of inequity.**

Addressing inequities

This pandemic has sharpened the focus on racial/ethnic inequities in our systems of care and the profound impact that health disparities and racism have on the emotional and physical well-being of communities of color. Health disparities stemming from structural racism have added to COVID-19's devastating toll on black and Latino populations in America. Communities of color have larger proportions of individuals who are essential workers, use public transportation, are uninsured and have limited access to high-quality health care—all factors that contribute to increased risk for COVID-19 infection and fatalities. When people of color seek care, they often come up against medical racism with the dismissal, denial or minimization of their symptoms. As a result of all of these factors, this pandemic has disproportionately impacted communities of color.

Unfortunately, racial and ethnic disparities in mental health services also exist. Members of racial and ethnic minority groups are less likely to receive necessary mental health care and more likely to receive poor-quality care when treated. Black and Latino patients are also less likely to get culturally competent care with a troubling lack of racial diversity in our behavioral health workforce, continued stigma about mental health and a distrust of the health care system. There are also barriers in seeking and delivering appropriate care for individuals with limited-English proficiency, which often results in the underutilization of mental health services for children and adolescents who have a primary language other than English.

As COVID-19 continues to take its toll, **it is essential that we recognize and address the mental health consequences of this pandemic for children and families of color, ongoing health disparities, and racial trauma and commit to improving our mental health infrastructure in ways that are responsive to diverse people in the U.S.**

A system-wide response

As experts around the country continue attempts to safely reopen society, it is clear that things will look very different from how they did in early 2020. Just as the U.S. took steps to prevent hospitals from being overwhelmed by COVID-19 cases, we must take steps to bolster the country's mental health infrastructure, recognizing that mental health parity and access problems will likely worsen as a result of this pandemic. To contend with this reality, and to prepare for the coming surge of behavioral health needs, we must focus on incentivizing coordinated care, emphasizing innovations and supporting our mental health infrastructure with increased funding.

Without an adequate infrastructure that can meet the needs of our children and families, our health care systems will only be further strained. We need a cross-system approach that addresses people at the right level of care, starting with prevention and early intervention to tackle problems before they reach crisis levels. *In the coming months and years, it will be more critical than ever that mental health services remain viable and intact, and that we close the gaps of inequities within our systems of care.*

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