

Child and Adolescent Mental Health Principles

Principles Endorsed by:

American Academy of Pediatrics
American Association of Child and Adolescent Psychiatry
American Dance Therapy Association
American Psychological Association
Association of Maternal & Child Health Programs
Children's Hospital Association
Community Catalyst
Families USA
First Focus on Children
Georgetown University Health Policy Institute, Center for Children and Families
Mental Health America
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Pediatric Nurse Practitioners
National Association of State Mental Health Program Directors
School Social Work Association of America
Society for Adolescent Health and Medicine
The National Alliance to Advance Adolescent Health
The School-Based Health Alliance
United Way Worldwide
ZERO TO THREE

Families and children, from infancy through adolescence, need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services to appropriately address their mental and behavioral health needs. As many as 1 in 5 children in the U.S. suffer from a diagnosable mental disorder, with 50% of all lifetime cases of mental illness beginning by age 14 and 75% by age 24.¹ Yet, between half and two-thirds of this population receive no treatment. The human and economic toll of inadequately addressing childhood mental and behavioral health problems is significant. Untreated mental and behavioral health disorders are associated with family dysfunction, school expulsion, poor school performance and drop-outs, juvenile incarceration, substance use disorder, unemployment, and suicide.²

Our organizations, representing a diverse array of perspectives, are dedicated to promoting the mental health and well-being of children and adolescents, and we have identified five concrete opportunities to

¹ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 2005;62(6):593-602.

² National Research Council and Institute of Medicine. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2009.

improve and enhance mental health services for children. As a coalition, we offer a set of specific and actionable opportunities that strengthen the health care workforce, insurance coverage and payment, integration of mental/behavioral health into pediatric primary care, early identification and intervention, and mental health parity. Within each topic area, attention should be given to special populations including LGBTQ youth, children with disabilities, and youth involved in the juvenile justice and child welfare systems.

1. Child and Adolescent Mental and Behavioral Health Workforce

Challenge: Across the United States, there is a dire shortage of health professionals specializing in mental and behavioral health for children and adolescents. Currently, there are an estimated 8,700 actively practicing child and adolescent psychiatrists, well below the estimated need of 30,000.³ About 15 million children and adolescents are in need of their special expertise. Workforce shortages also persist in psychology, social work, marriage and family counseling, psychiatric nursing, substance use disorder counseling, and other behavioral health specialties, including school counseling, which severely impede access to needed care for children and adolescents with mental health and substance use disorders. The shortage of providers with specialized training to treat mental health disorders in infants and toddlers is even more extreme. Today, 50% of children with mental health problems receive no treatment at all.⁴ Expanding the child and adolescent mental and behavioral health workforce, as well as increasing cultural and linguistic competence, is critical for addressing the enormous unmet mental and behavioral health needs of infants, children, and adolescents.

Opportunities

- Expand loan repayment assistance programs such as the Pediatric Subspecialty Loan Repayment Program, for pediatric subspecialists, child psychiatrists, advanced practice nurses licensed or certified to provide pediatric behavioral health services, and other behavioral health clinicians with expertise in child and adolescent health.
- Expand workforce training programs like the Health Resources and Services Administration's Graduate Psychology Education Program, the Children's Hospitals Graduate Medical Education Program, and the Substance Abuse and Mental Health Services Administration's Minority Fellowship Program.
- Expand telehealth and teleconsultation mechanisms to expand access to mental and behavioral health services to underserved child and adolescent populations, including through bidirectional training of providers to foster telehealth use and expanded internet connectivity.
- Develop a nationwide strategy with public and private partners, including behavioral health organizations, to expand the supply and distribution of health professionals specializing in infant, child, and adolescent mental and behavioral health, including direct care workers.
- Support cultural and linguistic competency training for the mental and behavioral health and primary care workforce.

³ Harris J. Meeting the Workforce Shortage: Toward 4-Year Board Certification in Child and Adolescent Psychiatry. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2018;57(10): 722–724.

⁴ Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. *JAMA Pediatrics*. Published online February 11, 2019. doi:10.1001/jamapediatrics.2018.5399

2. Insurance Coverage and Payment

Challenge: Medicaid and CHIP, which now cover more than 45 million children, are vital sources of insurance coverage for mental health and substance use disorder services. These programs, along with private insurance expansions, have resulted in historic levels of coverage for infants, children and adolescents. However, in 2017, for the first time in a decade, the number of uninsured children under age 19 increased.⁵

To better optimize access to the behavioral health workforce, participation by behavioral health clinicians in both private and public insurance plans should be given heightened attention. Adequate payment rates for mental and behavioral health services should be a greater priority. The use of behavioral health carve-outs, lack of payment for emerging childhood mental health conditions and non-face-to-face aspects of children's mental health care, and restrictions on same day billing of medical and mental health services create additional barriers to children's access to mental health services. Even though private insurance, CHIP, and Medicaid managed care are subject to mental health parity requirements, access to timely and qualified behavioral health providers is often limited because cost-sharing requirements are too high, access to out-of-network providers is prohibited, and essential behavioral health services are often not covered.⁶ Public and private payers should work to remove barriers to implementing therapeutic approaches that are evidence-based, evidence-informed, or promising practices. Services must also be provided in a culturally and linguistically appropriate manner, including interpreters as needed for children and/or their parents/guardians.

Opportunities

- Preserve and extend public and private insurance coverage for infants, children, and adolescents so that the historic coverage gains for children are regained and sustained. Ensure all plans have comprehensive, affordable coverage for mental health and substance use disorder services so that infants, children, and adolescents can access the care that they need including through a variety of home and community settings.
- Encourage private and public payers to allow same-day billing for medical and mental health services; to recognize and adequately pay for codes pertaining to behavioral and developmental and postpartum screening and assessment (using validated instruments), behavioral health counseling, telehealth, family therapy, care management services, and consultation services; and to ensure sufficient support for team-based, interprofessional approaches to screening and preventive care, care management, and service coordination.
- Ensure payment to pediatric primary care providers for developmentally appropriate mental and behavioral health services, including prevention and care for children whose conditions have not risen to the level of a diagnosis. Study current child and adolescent well-visit payment and personnel policies to ensure that they support full, universal implementation of the Bright Futures Guidelines and research-

⁵ Kaiser Family Foundation. *State Health Facts: Health Insurance Coverage of Children 0-18, 2008-2017*. Retrieved from: <https://www.kff.org/other/state-indicator/children-0-18/?dataView=1&activeTab=graph¤tTimeframe=0&startTimeframe=9&selectedDistributions=uninsured&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁶ National Alliance on Mental Illness. *The Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care*. Arlington, VA: NAMI; 2017. Available from: <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf>.

based social emotional learning standards and benchmarks as they relate to psychosocial development and mental health and follow-up referrals and case management. Encourage adoption of developmentally appropriate, research-based diagnostic criteria specific to young children.

- Ensure that all medically necessary mental and behavioral health services and interventions for infants, children, and adolescents can be delivered in adequate quality and quantity, including access to out-of-network providers as needed, and ensure an adequate safety net system to provide mental and behavioral health services for uninsured infants, children, and adolescents.
- Commission a national study of private and public insurance participation by child and adolescent mental and behavioral health specialists, including infant and early childhood mental health specialists. Included in this study should be a set of recommended payment policies that would be necessary to ensure the participation of child and adolescent psychiatrists, psychologists, social workers, certified substance use counselors, and other behavioral health professionals in private and public insurance networks.
- Increase support to schools, school districts, and education agencies to implement strategies to access and utilize Medicaid payment to support provision of school-based mental and behavioral health services to children and adolescents, including performance incentives to managed care health plans for collaborating with schools and school-based health providers.
- Ensure any payment reform efforts fully integrate mental health needs of children and adolescents and acknowledge that cost savings should not be the primary goal for improving children’s outcomes—savings are longer-term in nature. Also, address real or perceived barriers to treatment, including sharing of information.

3. Integration of Mental and Behavioral Health into Pediatric Primary Care

Challenge: Pediatric primary care is the setting where families regularly access care for their children and where identification, initial assessment, and care of medical, mental, and behavioral health conditions occur. Most integrated care efforts are funded through a patchwork of short-term public and private grants, limiting their reach and sustainability. Important research shows that the integration of mental health and primary care makes a difference for infants, children, and adolescents in terms of expanded access to mental health care, improved health and functional outcomes, increased satisfaction with care, cost savings, and improved coordination among primary and behavioral providers in clinics and school-based settings. Increasing support for primary care training in behavioral health and integrated, team-based care is needed to ensure that behavioral health services can be delivered in the pediatric primary care setting.

Opportunities

- Support statewide behavioral health integration programs for infants, children, and adolescents, like the Massachusetts Child Psychiatry Access Project, Maryland’s Behavioral Health Integration Program, and other similar projects that operate in nearly 30 states.⁷ Sustainable funding mechanisms are needed to help states develop organized state networks of child and adolescent behavioral health specialists, conduct training of pediatric primary care providers in evidence-supported, linguistically, culturally, and developmentally appropriate, screening, diagnosis and intervention, and monitor increased access to behavioral health services in coordination with other state behavioral health resources.

⁷ National Network of Child Psychiatry Access Programs. The Network: US CPAP Coverage by State. Retrieved from: <https://nncpap.org/thenetwork.html>.

- Establish and promote behavioral health integration in the pediatric medical home, through training of primary care providers and behavioral health professionals, to ensure that prevention, early identification, and intervention can be delivered in the primary care setting.
- Foster the development of new, and support existing, sustainable models of co-location or integration of mental health providers in all pediatric primary care settings.

4. Early Identification and Intervention

Challenge: Roughly half of lifetime cases of mental illness begin by age 14 and nearly three quarters by age 24, making early identification and intervention a key child and adolescent health issue. Although the onset of most mental disorders occurs during childhood, effective treatment is typically delayed despite the positive evidence of early intervention. This is due, in large part, to the fact that health care professionals, child care workers, and teachers often lack specialized knowledge and age-appropriate referral sources to identify and treat the early signs of mental health problems, as well as the many barriers that exist to accessing services once a need has been identified.

Opportunities

- Expand training of health care providers, child care workers, home visitors, early intervention providers, teachers, school behavioral health providers, first responders, and others to increase awareness and use of the most developmentally-appropriate screening and assessment tools to reliably identify mental health problems at an early age and link children in need with developmentally-appropriate services.
- Support Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment provisions and protections for children to ensure the early identification and medically necessary treatment for mental and behavioral health conditions.
- Support implementation of successful demonstration models for the prevention of psychosis and create similar models to prevent and treat other forms of serious emotional disturbance.
- Increase culturally and linguistically appropriate public awareness, screening, and treatment for maternal depression, infant mental health disorders, and trauma and toxic stress in children of all ages as part of routine preventive and primary care.
- Encourage implementation of evidence-based suicide prevention and mental health programs in schools and on college campuses.
- Fund programs aimed at developing, maintaining, or enhancing culturally and linguistically appropriate infant and early childhood mental health promotion, intervention, and treatment.

5. Mental Health Parity

Challenge: Despite enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its subsequent expansions to Medicaid managed care, CHIP, and the insurance marketplaces, there are many opportunities to improve oversight and compliance with the requirements of MHPAEA. Currently, many children and adolescents still face barriers in access to mental health and substance use disorder treatment due to insurance discrimination that singles out these services. In addition, consumer and provider awareness about mental health parity protections and remedies are not well understood.

Opportunities

- Maintain applicability of MHPAEA in the current public and private insurance markets, including individual and small group markets.
- Expand MHPAEA to children and adolescents enrolled in Medicaid fee-for-service arrangements and encourage more robust enforcement of the parity requirement in Medicaid MCOs and CHIP, eliminating the more restrictive limits and barriers that are placed on mental health and substance use disorder services as compared with medical and surgical services.
- Partner with state agencies, such as Attorneys General and insurance commissioners, to ensure compliance with existing MHPAEA protections for children and adolescents in the private *and* public insurance markets, including Medicaid and CHIP.