CYBHWG School-based Behavioral Health and Suicide Prevention (SBBHSP) subgroup

Date: 8/4/23
Time: 9am-12pm

Leads: Representative My-Linh Thai, Lee Collyer

Members					
☒	Representative My-Linh Thai, Co-Chair (41st Legislative District)	☒	Elizabeth Allen (Tacoma Pierce County Health Department)	☐	MazzyRainn Janis (Peer Counselor)
☒	Lee Collyer, Co-Chair (Office of the Superintendent of Public Instruction)	☐	Elizabeth DiPrete (Parent)	☒	Megan Reibel (Forefront Suicide Prevention, UW-School of Social Work)
☐	Andy Wissel (Washington School Counselors Association (WSCA))	☒	Erin Wick (AESD) [Alternate: Mick Miller]	☐	Megan Veith (Building Changes)
☒	Ashley Mangum (Mary Bridge/Kids Mental Health Pierce County)	☐	Gwen Loosmore (Washington State PTA)	☒	Michelle Sorensen (Richland School District/WA Assoc. of School SWs
☒	Dr. Avanti Bergquist (WA State Council of Child and Adolescent Psychiatry)	☒	Jeannie Larberg (Whole Child Sumner-Bonny Lake School District)	☐	Prudence Chilufya (Washington Association of Community Health)
☒	Avreayl Jacobson (King County Behavioral Health and Recovery)	☒	Jeannie Nist (Communities in Schools of WA State Network)	☐	Rachel Axtelle (South Kitsap School District)
☐	Candi Blackford (Parent, Kittitas County Public Health)	☐	Jill Patnode (Kaiser Permanente)	☐	RoseLynne P McCarter (Parent)
☐	Cassie Mulivrana (Washington State Association of School Psychologists)	☐	Joe Neigel (Monroe School District)	☒	Roy Johnson (Parent, Okanogan Alternative Schools)
☐	Catherine MacCallum-Ceballos (Vancouver Public Schools)	☒	Kelcey Schmitz (UW SMART Center) [Alternate: Eric Bruns]	☒	Sandy Lennon (WA School-based Health Alliance) [Alternate: Michelle Mitchell]
☒	Chris Harnish, Mercer Island Youth & Family Services	☒	Kelsey Winters (WSSDA)	☐	Tasha Bunnage (Parent)
☐	Courtney Sund (Highland School District)	☒	Liliana Uribe (Parent)	☐	Tawni Barlow (Medical Lake School District)
☒	David Crump (Spokane Public Schools)	☒	Logan Endres (Equity in Education Coalition)	☒	Todd Crooks (Chad's Legacy Project)
☐	Donna Bottineau (Parent/Family)	☒	Marcella Taylor (Parent)		
☒	Elise Petosa (WA Association of School Social Workers)	☐	Mariana Marquez Sital (Parent)		

Youth Advisory Committee Members					
☒	Hanna Baker (K-12 Student)	☐		☐	

Staff: Christian Stark, Athena Ruggiero | OSPI

Meeting notes

Youth Regional Behavioral Health Navigator Program

Ashley Mangum, Edward Michael, Brook Vejo

See page 8 for accompanying slide deck for more info

- Leveraging Partnership to Transform Change

  - March 15, 2021 Gov. Inslee signed emergency proclamation
  - Factors that shape mental health
- HCA partnering with Kid's Mental Health Pierce County & DDA
  - Aimed at filling gaps in services to community
  - Cross-System Collaboration
- Community Multi-Disciplinary Teams (MDT)
  - Aimed at connecting Youth, Families and Systems
- Regional Resource Hub
  - Crisis Services
  - Intellectual and Developmental Disabilities Resources
  - Parent Support
  - Inpatient & Out patient Mental Health Services for youth and families
  - Substance use disorder
  - Black, Indigenous & People of Color Mental Health Resources
  - Find a Provider
  - Community MDT
  - Insurance
- DSHS Developmental Disabilities Administration
  - Megan.hopkins@dshs.wa.gov
- Youth Behavioral Health Navigator Rollout
  - Brook.vejo@carelon.com
  - Year 1 SFY 2022
    - Pierce
    - Salish
    - Greater Columbia
    - Southwest
  - Year 2 SYF 2023
    - North Central
    - Spokane
    - Great Rivers
    - Thurston-Mason
  - Year 3 SFY 2024
    - North Sound
    - King
      - Avreayl.jacobson@kingcounty.gov
  - Thurston-Mason
    - Start Year 2 instead of year 3 with ARPA funding

Discussion:

- Can you explain how this interacts with your local WISe initiative? Is this one and the same? A component of it?
  - What you describe sounds like how WISe should be working and what it should be doing for youth/families so it is a bit confusing at a system level.

  - A: I totally see what you are saying, I was thinking that as well when I first heard about this program but it is quite different and operates very separate from WISe we call our MDT's a "think tank" rather than ongoing services where there is a consist child and family team.
- Is this a program that families can ask for when they aren't feeling supported by the current services they are getting, or is a referral needed from a certain agency?
  - I think this is a great question. In theory what exists and in practice that looks very different in different communities. This is a community coalition that takes into perspective the needs of the community specific and connects the humans to build the relationships to support the humans we serve in the places they are
- It is great support and partner for a system deeply impacted with workforce challenges, and to support families that aren't Medicaid eligible. It will be interesting to see what we learn as (hopefully) workforce stabilizes in WISe and other programs.
- While King County doesn't roll out until 2024, how can we get involved in our region?
  - Avreayl Jacobson: King County has had three Community Resource Teams for quite a long time. They used to be the IST Teams when we were an RSN. Please email me and I'll connect you with the staff person who leads those three King County CRTs. Avreayl.jacobson@kingcounty.gov
- Proviso language that funds the program
  - Section 215 (113) $2,148,000 of the general fund—state appropriation for fiscal year 2023 and $499,000 of the general fund—federal appropriation are provided solely for the authority to contract for youth inpatient navigator services in four regions of the state. The services must be provided through clinical response teams that receive referrals for children and youth inpatient services and manage a process to coordinate placements and alternative community treatment plans. Of these amounts, $445,000 of the general fund—state appropriation and $79,000 of the general fund—federal appropriation are provided solely to contract for services through an existing program located in Pierce county.
- Getting the word out as far as possible I believe is important. There are entities that want to create new systems and it would help that they are more aware about the existing navigation resources in their region so they are not stressing on reinventing the wheel and finding funding. Kids Mental Health Pierce County/WA does great work with this. Work in progress.

Links:

- Kidsmentalhealthpiercecounty.org
- Program Website: Kidsmentalhealthwa.org

JED High School by Forefront

Megan Reibel, UW Forefront Suicide Prevention

See page 17 for accompanying one-pager

- Housed in NYC
  - Comprehensive Suicide Prevention at School Level
- JED will work in tandem with LEARN
- mreibel@uw.edu

Youth Advisory Committee Update

Christian Stark & Francesca Matias, OSPI

See page 18 for accompanying slides

- Student Voice – Screening
  - Experiences with Screening
  - What are appropriate screening conditions
    - Small groups
    - Clear communication
      - Impact on student record?
      - Process for sharing with parents?
  - What should follow up look like?
    - If screening, need to know that trusted staff will intervene
  - Other ideas and thoughts
    - Staff capacity is important
    - Once a quarter have staff meet 1:1 with student's
    - Face to face conversations
  - Set aside time each week to check in and spend time with mentor groups
  - Screen in small groups with teachers who have spent time building relationships
  - Bring in staff from CBOs focused on queer issues to offer staff spaces on campus for students to talk
- Telehealth
  - Need to make sure students know about telehealth resources
- Like the idea of providing students access to resources outside just what's available locally
  - Can be individualized
  - How does it link to student medical record and local provider
  - Make sure it links to existing school supports
- Telehealth can feel impersonal
- Not one-size fits all
- Fentanyl Prevention/Intervention
  - Funding needs to be provided to schools to acquire Narcan and training
  - Incentive to keep price low?
  - Free Naloxone
    - Get Free Naloxone by Mail in WA State | Addictions, Drug & Alcohol Institute (uw.edu)
  - Comment: RE Narcan, I think it is important to note that this is not just a funding issue. Schools are not set up to be pharmacies and finding reliable sources of the medication has been a problem.

- Comment: There are free community Narcan trainings now in the state. Narcan is now more accessible due to the extent of the opioid crisis.
- BH Career Pathways
  - Improving access to higher education programs
    - Cost is a huge factor
  - Job shadowing with providers
    - School offered training program with MulitCare to offer internships
      - Compensation for internships
  - Giving space for students
- Resources for parents and guardians
  - Do you know of resources
  - Do you think resources impact stigma
  - How to make these accessible
  - Trainings for other adults
- Need to make sure supports are gender inclusive & gender-informed
- Staff mental health training
- Peer supports
- Mental health instruction for students

Discussion:

- Assuring links to existing school support is so critical! Lots of very critical perspectives and input here.

Policy Recommendations – Breakout Session #1:

- Breakout discussion (~40 minutes)
  - Room #1: Statewide Leadership
  - Room #2: Workforce Support
  - Room #3: Mental Health Education
- Group share out (~40 minutes)

The notes from these discussions is still be synthesized. We will share it in a separate email later in August.

Policy Recommendations – Breakout Session #2:

- Breakout discussion (~35 minutes)
  - Room #1: Statewide Leadership
  - Room #2: System Funding & Programming
  - Room #3: Workforce Support
- Group share out (~15 minutes)

See Grid documents attached.
Meeting Feedback Survey: https://survey.alchemer.com/s3/7462114/August2023-SBBHSP-Subcommittee-Feedback-Survey

Attendees:

State Agency + CYBHWG Staff:

- Annie Blackledge, OSPI
- Béné Bicaba, BH Catalyst
- Briana Kelly, OSPI
- Bridget Underdahl, OSPI
- Cindi Wiek, HCA
- Debra Parker, OSPI
- Delika Steele, OIC
- Diana Cockrell, HCA
- Jennifer Price, HCA
- Julee Christianson, OSPI
- Kerry Bloomquist, OSPI
- Monica Webster, HCA
- Rabeeha Ghaffar, DOH
- Shanna Muirhead, HCA
- Stacey Bushaw, HCA

State Legislators & Staff:

Representative Carolyn Eslick
Erika Boyd (Legislative Assistant for Rep. Lisa Callan)

Public Attendees:

- Amy Harley, Whatcom County
- Brandi Kingston, Parent/Mental Health Advocate
- Brittany Campbell
- Carolyn Solitaire
- Catherine Crawford
- Chelsea Stone, CHPW
- Clarissa Lacerda, AGO
- Connie Mom-Chhing
- Dr. Phyllis Cavens
- Hailey Shelton, ESD 113
- Julia Kemner
- Karen Pillar, TeamChild
- Kody Russell
- Laurie Lippold

Lizbet Maceda
Maame Bassaw
Maura K.
Meghan Hopkins, DSHS DDA
Raymond Gregson, FYSPRT
Renee Tinder
Roz Thompson, AWSP
Ryan Chindavong
Salliejo Evers, NE WA ESD 101
Scott Swan, Molina
Vanessa Adams
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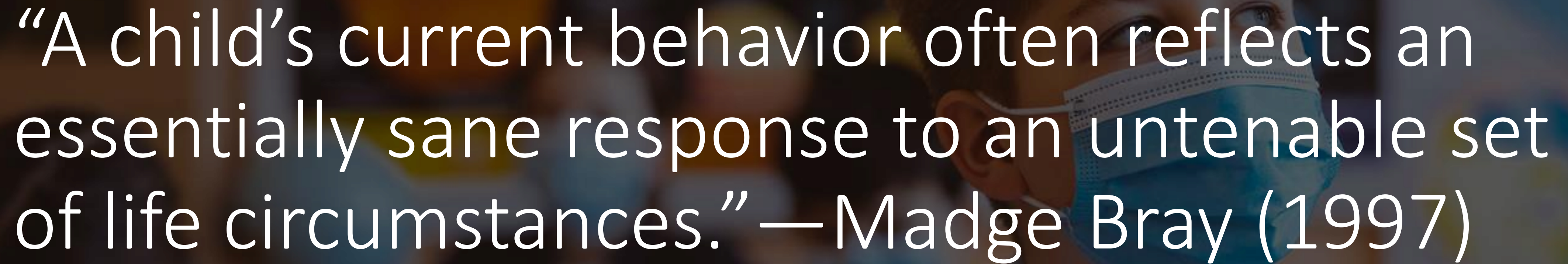
Youth Behavioral Health Navigators
Leveraging Partnership to Transform Change



“A child’s current behavior often reflects an essentially sane response to an untenable set of life circumstances.”—Madge Bray (1997)

- On March 15, 2021, Governor Jay Inslee signed an emergency proclamation recognizing the current mental and behavioral health emergency among Washington’s children and youth.
- Behavioral health crises come in many forms, and most do not fit neatly into a categorical service box.
- No single entity or system owns full responsibility for crises, and a single entity or system is not, on its own, sufficiently leveraged to address the multi-factored complexities necessary for a healthy system.
- Given the multifactorial determinants of psychiatric boarding in the ED, potential solutions will require a variety of hospital strategies, external community strategies, ideally in collaboration with one another.

"Supporting the mental health of children and youth will require a whole-of-society effort to address longstanding challenges, strengthen the resilience of young people, support their families and communities, and mitigate the pandemic's mental health impacts."

FACTORS THAT CAN SHAPE THE MENTAL HEALTH OF YOUNG PEOPLE

Source: Adapted from WHO's Determinants of Adolescent Health Development: An Ecological Model, 2014 and Bronfenbrenner & Ceci (1994)

Society: Social and economic inequalities, discrimination, racism, migration, media and technology, popular culture, government policies

Environment: Neighborhood safety, access to green spaces, healthy food, housing, health care, pollution, natural disasters, climate change

Community: Relationships with peers, teachers, and mentors; faith community; school climate, academic pressure, community support

Family: Relationships with parents, caregivers, and siblings; family mental health; financial stability; domestic violence; trauma

Individual: Age, genetics, race, ethnicity, gender, sexual orientation, disability, beliefs, knowledge, attitudes, coping skills

These are examples and not a comprehensive list of factors

Youth Behavioral Health Navigator Program

Health Care Authority (HCA) is partnering with Kid's Mental Health Pierce County and Department of Developmental Administration (DDA) to stand up teams in three regions per year for the next three years.

Technical assistance and support, collaborative learning teams across the state, and pathways for real time input on regional strengths and needs will be developed as the first teams begin standing up.

Regional teams will build community in support of children, youth, and support families through Multi-Disciplinary Teams (MDT) pulling key members and providers from the community to support the family.

First three Behavioral Health Administrative Service Organizations (BHASO) regions standing up teams this SFY are Salish, Greater Colombia, and Southwest.

BHASOs are self-selecting start up regions each year based on readiness.

Website: https://kidsmentalhealthwa.org/

Youth Behavioral Health Navigator Rollout

Year 1 SFY 2022

- Pierce
- Salish
- Greater Columbia
- Southwest

Year 2 SYF 2023

- North Central
- Spokane
- Great Rivers
- Thurston-Mason*

Year 3 SFY 2024

- North Sound
- King

Thurston-Mason

- Start year 2 instead of year 3 with ARPA (American Rescue Plan Act) funding, then will move to state funding

Whatcom
San Juan
Skagit **North Sound**
Okanogan
North Central
Stevens
Ferry
Pend Oreille
Spokane
Clallam
Island
Snohomish
Salish
Chelan
Douglas
Jefferson
Kitsap
King
Lincoln
Spokane
Mason
Grays Harbor
Thurston-Mason*
Pierce
Kittitas
Grant
Adams
Whitman
Pacific
Lewis
Great Rivers
Yakima
Franklin
Garfield
Wahkiakum
Cowlitz
Skamania
Greater Columbia
Columbia
Benton
Walla Walla
Asotin
Clark
Southwest
Klickitat

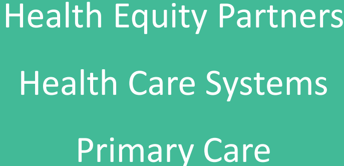
Cross-System Collaboration

Autism and Disability Partners

Child Welfare

School Districts

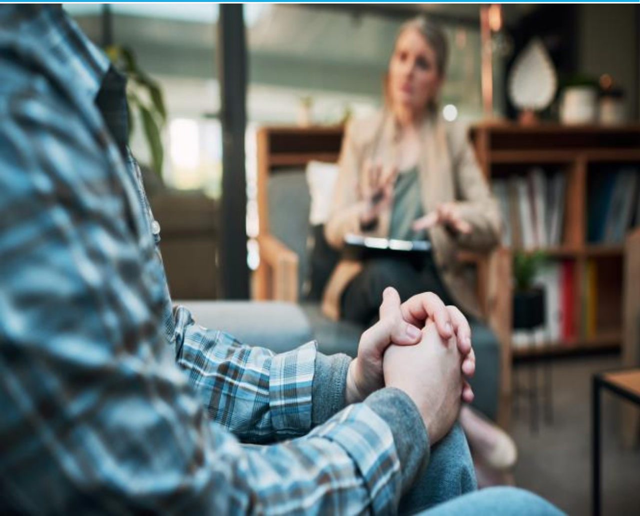
Youth Services

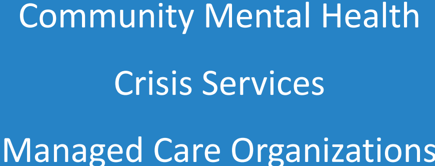


Health Equity Partners

Health Care Systems

Primary Care





Community Mental Health

Crisis Services

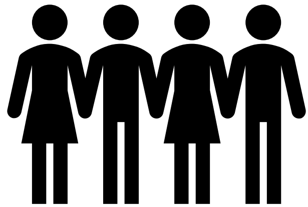
Managed Care Organizations

Law Enforcement

Juvenile Justice

EMS

Community Multi-Disciplinary Teams (MDT)

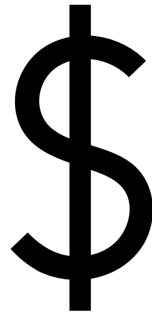


Natural Supports

Family

Peer/Parent Support

Mentors

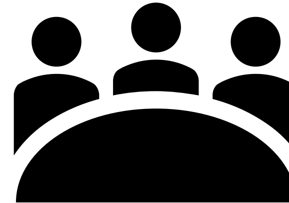


Payor

Insurance Provider

AS-BHO

HealthCare Authority



System Partners

Juvenile Justice

Child Welfare

School

Developmental Disabilities Administration (DDA)

Providers

Behavioral Health Providers

Specialist

Substance Use Providers

Consultants

Regional Resource Hub

Each regions will be developing a regional resource hub for comprehensive pediatric behavioral health information.

Available Resources:

- Crisis Services
- Intellectual and Developmental Disabilities Resources
- Parent Support
- Inpatient and Outpatient Mental Health Services for Youth and Families
- Substance Use Disorder
- Black, Indigenous & People of Color Mental Health Resources
- Find A Provider
- Community Multi-Disciplinary Team (MDT)
- Insurance

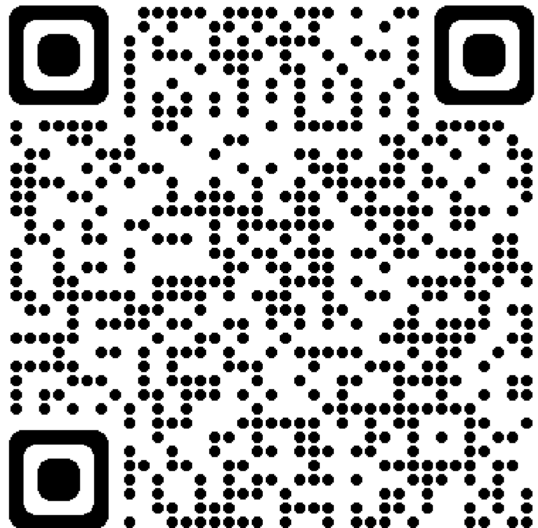
Kids' Mental Health Washington

Supporting the behavioral health needs of Washington kids, youth and families.

LEARN MORE

JOIN US

Contacts



The Health Care Authority (HCA)	Kids’ Mental Health Pierce County (KMHPC)
Diana Cockrell, MA, LMHCA, SUDP Section Manager, Prenatal to 25 Lifespan Behavioral Health & Substance Use Diana.Cockrell@hca.wa.gov	**Ashley Mangum, MSW, LICSW** Director, KMHPC Ashley.Mangum@multicare.org
Ruth Leonard, MA, SUDP Section Manager, Strategic Design & Program Oversight Ruth.Leonard@hca.wa.gov	**Vanessa Adams, MSW, LICSW** Program Coordinator—KMHPC Vanessa.Adams@multicare.org
Edward Michael, MS Statewide Youth Behavioral Health Access Administrator Edward.Michael@hca.wa.gov	**Gina Cabiddu, MSW** Program Coordinator Gina. Cabiddu@multicare.org www.kidsmentalhealthpiercecounty.org

JED High School by Forefront Suicide Prevention:
A Comprehensive Mental Health Initiative in Washington State

Delivered By

Program Summary

JED High School is a systematic public-health approach schools and districts can use to assess and strengthen their policies, programs, and systems that support emotional well-being and suicide prevention for students. JED High School is an adaptation of JED Campus, a national higher-education initiative implemented in nearly 400 colleges and universities. JED High School is a 36-month technical assistance program that partners with high schools and districts to assess and strengthen their efforts in the following key areas: 1) developing life skills, 2) promoting social connectedness and a positive school climate, 3) encouraging help-seeking behavior, 4) improving recognition and response to signs of distress and risk, 5) ensuring student access to effective mental health treatment, 6) establishing and following crisis-management procedures, and 7) promoting means safety. We tailor our strategic planning process to each school or district using an approach that promotes equitable implementation.

JED is excited to partner and collaborate with Forefront Suicide Prevention, a Center of Excellence at the University of Washington School of Social Work, to launch JED High School by Forefront. Through this multiyear partnership, Forefront in the Schools staff (FIS) will be trained to implement JED High School free of charge to a select number of schools across Washington. Program participation fees for JED High School typically range from $35,000 to $42,000 per school. Our organizations look forward to working together to offer suicide prevention practices, strategic planning, and technical assistance to Washington schools.

What to Expect

1. Each school creates an **interdisciplinary team** to work on the JED High School program.
2. The school completes three initial surveys and assessments:
   a. **JED High School Self-Assessment**, which evaluates school policies, programs, and systems that promote student mental health
   b. **JED High School Student Survey**, which assesses student attitudes, awareness, and behaviors related to mental health
   c. **Staff and Faculty Assessment**
3. Each school receives a **comprehensive feedback report** with recommendations for enhancement based on the data collected from the surveys and assessments.
4. Your School Mental Health Specialist (SMHS) provides **customized support and technical assistance** throughout the 36-month program.
5. A **second administration** of the **JED High School Self-Assessment**, **Staff and Faculty Assessment**, and the **JED High School Student Survey** will be completed.
6. A **detailed summary report** with pre- and post-data analysis after the second administration of the assessments is provided, highlighting the impact of **system changes** on student outcomes.
7. Each school participates in the **JED High School Learning Community** with other JED High Schools, consisting of webinars, monthly newsletters, and other resources.
8. Each school has access to a comprehensive online resource library consisting of sample policies, programs, educational campaigns, research, and professional journal articles.

Please reach out to our JED by Forefront School Mental Health Specialists anytime with questions regarding next steps.

Sam Pacampara, MA Ed: samkpac@uw.edu **Michelle Flores, M.A., MFT: miflores@uw.edu**

www.jedfoundation.org JED High School Comprehensive Approach www.intheforefront.org

Child and Adolescent Mental and Behavioral Health Principles

April 5, 2023

Endorsed By:

American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Foundation for Suicide Prevention
American Psychiatric Association
American Psychological Association
Association of Maternal & Child Health Programs
Center for Law and Social Policy (CLASP)
Children's Hospital Association
Family Voices
First Focus on Children
Futures Without Violence
Georgetown University Center for Children and Families
Jewish Federations of North America
Mental Health America
National Alliance on Mental Illness (NAMI)
National Association for Children's Behavioral Health
National Association of Pediatric Nurse Practitioners
National Association of School Psychologists
National Federation of Families
National Health Law Program
Nemours Children's Health
Sandy Hook Promise
Save the Children
School Social Work Association of America
School-Based Health Alliance
The Jed Foundation (JED)
The National Alliance to Advance Adolescent Health
Youth Villages
ZERO TO THREE

Mental and behavioral health concerns in children and teens have been on the rise for many years. Suicide is the second leading cause of death for youth ages 10-18 in the United States.[i] The COVID-19 pandemic worsened the ongoing children's mental health crisis and increased the fragility of the mental health safety net system for children and adolescents. In 2021, 42% of high school students reported feeling persistently sad or hopeless, and 29% reported experiencing poor mental health.[ii] Additionally, 20.1% of youth ages 12 - 17 had a major depressive episode in the past year, compared to only 15.7% of youth in 2019.[iii]

Risk factors associated with childhood mental health conditions remain of key concern, including family mental health and substance use issues, adverse childhood experiences, racial disparities, social isolation, trauma, food and housing insecurity, economic stress, and poverty.[iv v vi] The impact of racism on child and adolescent mental health demands acknowledgment. Racism operates at the level of individual experiences of discrimination by youth of color and can be a root cause of mental health concerns. Racism also impacts the ways in which youth of color have differential access to mental health services and diagnosis and treatment for mental and behavioral health conditions.[vii] Youth of color, facing discrimination and barriers to care, had increased suicide rates between 2018 and 2021. While the rate of suicide for white youth ages 10-24 decreased by 3.9%, suicide rates for American Indian or Alaska Native, Asian, Black, Hispanic, and multiracial youth increased dramatically. The rate of increase was highest among non-Hispanic Black youth at 36.6%.[viii]

Now more than ever, 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. Yet, even prior to the pandemic, the U.S. was falling woefully short of meeting these needs.[ix] Nearly half of youth suffering with mental health disorders do not receive treatment from mental health professionals.[x] A lack of access to treatment options is contributing to greater numbers of children presenting to emergency departments in crisis. These children and adolescents too often wind-up boarding in hospitals – waiting for placements in appropriate treatment settings to become available.

The problem of children going without needed mental health services, and facing delays when they do seek out care, is inextricably linked to shortages in pediatric mental and behavioral professionals across disciplines. Significant investment will be needed to grow the children's mental health workforce as well as to better support provider participation in Medicaid and CHIP programs, which covers more than 40 million children in the U.S.[xi]

The human and economic toll of inadequately addressing childhood mental and behavioral health problems is significant. Untreated and undiagnosed mental and behavioral health disorders are associated with family dysfunction, school expulsion, poor school performance and disconnection from school, juvenile incarceration, substance use disorder, unemployment, and suicide.[xii]

The ongoing child and adolescent mental and behavioral health crisis necessitates a systematic, sustained, and coordinated approach from all federal agencies that addresses the opportunities and funds the essential programs outlined below. Interagency collaboration is essential to ensure that existing opportunities are leveraged, and funding-related gaps are identified and addressed. Collaboration across federal agencies is key to developing a comprehensive system of care across the continuum to address mental and behavioral health needs for infants, children, and adolescents.

Our organizations, representing a diverse array of perspectives, are dedicated to promoting the mental health and well-being of infants, children, adolescents, and young adults. In this document, we have identified nine concrete opportunities to improve and enhance mental health services for this population. As a coalition, we offer a set of specific and actionable opportunities that increase access to evidence-based prevention, early identification, and early intervention; expand mental health services in schools; integrate mental/behavioral health into pediatric primary care;

strengthen the child and adolescent mental and behavioral health workforce; increase insurance coverage and payment; ensure mental health parity; extend access to telehealth; support children in crisis; and address the mental health needs of justice-involved youth.

Within each topic area, attention should be given to special populations, including youth of color and historically underserved youth, LGBTQ youth, children with chronic or complex conditions and disabilities, and youth involved in the juvenile justice and child welfare systems.

1. Prevention, Early Identification, and Early Intervention

Challenges: 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.[xiii] 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 and behavioral health conditions using evidence-based practices as well as the many barriers that exist to accessing services once a need has been identified. It is also due to underlying social and community factors, such as child poverty, racism, lack of health coverage, lack of safe, stable, and affordable housing, unemployment, and limited educational opportunities that make it difficult to obtain services.

Opportunities:

- Ensure new and existing federal investments in mental health are tailored to include prevention and early intervention services for children.
- Expand training of health care providers, child care workers, home visitors, early intervention providers, teachers, school personnel, school behavioral health providers, first responders, and others to increase awareness and use of the most developmentally-appropriate, research-based screening and diagnostic tools for children of all ages, including tools to assess social determinants of health, to reliably identify mental health conditions and suicide risk at an early age, and link children in need with developmentally-appropriate services.
- Incentivize screening for behavioral health needs at well-child visits, the provision of parental supports, and other early intervention services necessary to address needs early.
- Ensure Medicaid's pediatric benefit, EPSDT, is implemented in a way that aligns with the preventive and developmental needs of children including the removal of barriers in access to mental health services for children who may have mental health risk factors, including family history of mental health issues or poverty, but whose needs do not yet require a formal diagnosis.
- Address the growing prevalence of anxiety and depression in children.
- Strengthen linkages with social services to address the intersecting needs of children and families.
- Address and mitigate underlying factors that can contribute to mental health problems in children, including poverty, racism, housing needs, and gaps in health insurance coverage.
- Remove barriers that prevent children and caregivers from receiving services together.
- 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-informed 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.

2. School-Based Mental Health

Challenges: Across the nation, there is a shortage of mental health supports and professionals in schools. In fact, many students have no access to school counselors, psychologists, nurse practitioners, or social workers. Furthermore, 1 in 6 of school-aged children has a mental health diagnosis,[xiv] yet according to one study approximately 80% of this population did not receive care.[xv] School-based mental health services represent an important mechanism to ensure children and adolescents receive the health and mental health supports they need. In fact, youth are six times more likely to complete mental health treatment in schools than in other settings.[xvi] School-based mental health includes prevention, intervention, and treatment services provided in on-site clinics as well as efforts to strengthen the school climate and teachers/administrators' abilities to serve students with mental health concerns. When schools lack supportive mental health services, youth are more likely to receive punitive discipline, which can lead to an increase in pushouts and the school to prison pipeline.[xvii] Existing payment structures for school-based mental health services such as School-Based Health Centers limit the type of services many schools can offer including for culturally appropriate services.

Opportunities:

- Increase resources available to schools, including colleges, for child, adolescent, and young adult mental health services. Increasing the availability of resources and access to mental and behavioral health providers in school settings meets children, adolescents, and young adults at a critical care access point.
- Build infrastructure for schools through national, state, and local resources to include on-site clinics and an array of in school services that are accessible to students, families, and communities during the day as well as during evening, weekend, and summer hours.
- Support financing for school-based health centers and other school mental health programs through a combination of federal and state funding, private grants, Medicaid, private health insurers, and direct payment. Services must be available to all, regardless of insurance coverage.
- Advance mechanisms and opportunities through Medicaid for payment for school-based mental and behavioral health services, including through CMS guidance and technical support.
- Incentivize school mental health programs to build strong partnerships with School-Based Health Centers, Federally Qualified Health Centers (FQHCs), Behavioral Health Organizations (BHOs), and community-based mental health providers to ensure timely access to needed care.
- Provide incentives to ensure school-based health providers are adequately trained to recognize the mental and behavioral health needs of students and to offer culturally sensitive and responsive evidence-based services. In addition, incentives should be available to provide basic training for all school staff on indicators of mental and behavioral health concerns and who to notify within schools to connect children to needed supports.

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

Challenges: 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 and subspecialist training in behavioral health and suicide risk and integrated, team-based care is needed to ensure that behavioral health services can be delivered in the pediatric primary care setting. Ensuring linkages to primary care as part of routine and specialty mental health care is also critically important.

Opportunities:

- Continue to fund the Health Resources and Services Administration's (HRSA) Pediatric Mental Health Care Access Program. HRSA currently funds programs in 48 states and territories that increase access to mental health care for children. Federal investments to substantially expand child psychiatric telephone consultation programs could significantly increase the number of children receiving mental health services.
- 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.
- Implement Medicaid and CHIP coverage and payment for interprofessional consultation consistent with CMS' January 2023 guidance.
- Ensure payment, without co-pays, co-insurance or deductibles for families, for care coordination activities such as time spent by pediatricians discussing a child's mental health with a behavioral health specialist, school staff, or family member whenever the consultation occurs.
- Fund primary care practices to hire care coordinators or navigators to help families navigate the complex mental health care system.

4. **Child and Adolescent Mental and Behavioral Health Workforce**

Challenges: Across the United States, there is a dire shortage of practitioners specializing in mental and behavioral health to care for infants, children, adolescents, and young adults. Prior to the pandemic, in 2020, SAMHSA estimated that 4.5 million additional behavioral health practitioners are needed to address the needs of children with serious emotional disturbances and adults with serious mental illness, including an additional 49,000 child and adolescent psychiatrists.[xviii] The gap between currently available child and adolescent providers and what is needed to provide evidence-based mental and behavioral health care for this population is stark. New incentives and opportunities are needed to quickly expand a diverse child and adolescent mental and behavioral health workforce. The shortage of providers with specialized training to treat mental health conditions in infants and toddlers is even more extreme. Today, many children with mental health conditions receive no treatment at all. 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, adolescents, and young adults. While some existing programs support the child and adolescent behavioral health workforce, new and greater investments specifically designed to grow the pediatric workforce are needed in order to address the scale of shortages across both clinical and non-clinical professions.

Opportunities:

- Develop a nationwide strategy with public and private partners to expand the supply, diversity, and distribution of the behavioral health workforce to address infant, child, adolescent, and young adult mental and behavioral health needs.

- Ensure adequate coverage of and appropriate reimbursement for pediatric mental health services within Medicaid, to better support provider participation and improve access to care for children covered by Medicaid across the continuum.
- Expand opportunities for practicing clinicians to increase competency and capacity in identifying and providing treatment for mental and behavioral health needs.
- Increase funding for the Pediatric Subspecialty Loan Repayment Program to address high student loan debt among child mental health professionals that serves as a barrier to expanding the behavioral health workforce.
- Expand loan repayment assistance programs for clinicians such as pediatric subspecialists, child psychiatrists, advanced practice nurses licensed or certified to provide pediatric behavioral health services, psychologists, social workers, and other behavioral health clinicians with expertise in child and adolescent health.
- Expand workforce training programs like the HRSA Graduate Psychology Education Program, the Children's Hospitals Graduate Medical Education Program, and the SAMHSA Minority Fellowship Program.
- Identify gaps and opportunities within existing HRSA programs to support growth within the children's mental health workforce.
- Identify new and expanded opportunities for accelerated behavioral health training programs for pediatric residents, pediatricians, and pediatric nurse practitioners, including the Triple Board Program.
- Recognize peer supports and community health workers as integral behavioral health practitioners to increase the supply and address health disparities and barriers to access care.
- Support fellowship training and college programs to encourage diverse groups of students to pursue careers in behavioral health, and embed education about infant, child, and adolescent behavioral health into these programs.
- Support cultural and linguistic competency training for the mental and behavioral health and primary care workforce.

5. **Insurance Coverage and Payment**

Challenges: Medicaid and CHIP, which now cover more than 40 million children,[xix] 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, beginning in 2017, the child uninsurance rate began to climb, jumping to 5.7% in 2019.[xx] While the number of uninsured children declined slightly during the pandemic due to federal law which protected access to coverage for children and individuals covered by Medicaid, such coverage gains are at risk when the continuous coverage protections lift.[xxi] Monitoring the unwinding and ensuring children do not fall into coverage gaps or get left behind will be critical to ensuring continued access to essential coverage including mental health services.

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 mental and behavioral health providers is often limited because cost-sharing requirements are too high, access to out-of-network providers is prohibited, and essential mental and behavioral health services are often not covered (e.g., family counseling).[xxii] Services must also be provided in a culturally and linguistically appropriate manner, including interpreters as needed for children and/or their parents/caregivers.

Opportunities:

- Protect the structure and integrity of Medicaid and CHIP so that children are able to access affordable, comprehensive coverage and care.
- Preserve and extend public and private insurance coverage for infants, children, adolescents, and young adults including monitoring of the unwinding of Medicaid's continuous coverage protections 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, adolescents, and young adults can access the care that they need, including through a variety of home and community settings.
- Invest in payment models that support integrated, team-based care for children and families.
- Encourage private and public payers to allow same-day billing for medical and mental and behavioral 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 the provision of developmentally appropriate mental and behavioral health services, including prevention and care of children whose conditions have not risen to the level of a diagnosis.
- Ensure that all medically necessary mental and behavioral health services and interventions for infants, children, adolescents, and young adults can be delivered in adequate quality and quantity including access to out-of-network providers as needed.
- Implement payment strategies that increase the participation of child and adolescent mental and behavioral health specialists, including infant and early childhood mental health specialists, in public and private insurance.
- Increase support to schools, school districts, and education agencies to implement strategies to access and utilize 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.

6. Mental Health Parity

Challenges: 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 has been a persistent need to improve oversight and compliance with the requirements of MHPAEA. In late 2020, Congress passed new legislation aimed at improving parity compliance by granting the Department of Labor new powers to audit health plans to determine whether they comply with MHPAEA, recommend changes the plan should make to gain compliance, and require plans to notify beneficiaries of their noncompliant status if corrections are not made. While these new measures are promising, 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, and enact more robust enforcement requirements.
- 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, including burdensome prior authorization requirements.
- Partner with state agencies, such as Attorneys General, insurance commissioners, and Medicaid agencies, to ensure compliance with existing MHPAEA protections for children and adolescents in the private *and* public insurance markets, including Medicaid and CHIP.

7. **Telehealth**

Challenges: Changes in telehealth policy in Medicaid, CHIP, and commercial insurance in response to the COVID-19 pandemic greatly expanded access to and continuity of care for children and families across the country. These changes proved to be a critical lifeline for the rising numbers of children and adolescents struggling with mental and emotional problems,[xxiii] offering an efficient way to support their mental health needs, especially those in rural, underserved, and low-income communities who continue to face the most barriers to care. The tremendous surge in telehealth utilization during these challenging times demonstrated as never before the significant promise continued access to telehealth offers for reducing barriers to care even beyond the current emergency. Moreover, emerging data is demonstrating that telehealth -- particularly telehealth for mental health and substance use care – can maintain and even improve the quality and comprehensiveness of patient care while expanding access to evidence-based care for children with mental and behavioral health needs. However, while quality telehealth care promises to increase access and mitigate barriers to care for patients, this must be done in support of and integrated with the medical home, not in place of it.

Opportunities:

- Make certain that beyond the pandemic, telehealth, particularly for mental health and substance use treatment, continues to be part of a comprehensive set of care options available to provide the right care in the right place at the right time. Use of telehealth should be based on the health condition, preferences of the patients, families, and provider, resources available, integrated with the medical home, and available through both video-enabled and audio-only devices as appropriate and in accordance with patients' preferences and needs.
- Ensure that providers who deliver health care services through telehealth, as well as referring clinicians and participating facilities, should receive equitable payment for their services to increase the availability of health care services for all children and families. Providers should receive payment for services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical or clinical practice; payment should not be determined by the technology used to deliver these services. Patients should have access to telehealth services regardless of their geographic location.
- Expand telehealth and teleconsultation mechanisms to expand access to mental and behavioral health services to child and adolescent populations, including through bidirectional training of providers to foster telehealth use and expanded internet connectivity. Broadband access will be critical to ensure equitable access to telehealth.

8. **Infants, Children, and Adolescents in Crisis**

Challenges: Providers are witnessing an alarming number of children and adolescents in behavioral health crisis, with emergency departments seeing increases in suicidal ideation and self-harm. In 2021, nearly 60% of female students and nearly 70% of LGBTQ students experienced persistent feelings of sadness or hopelessness. 10% of female students and more than 20% of LGBTQ students attempted suicide.[xxiv] Behavioral health clinicians have reported over the last several years that children and adolescents are increasingly "boarding" in emergency departments for days because they do not have sufficient supports and services.

The increasing need for behavioral health services due to the traumatic impacts of the pandemic on infants, children and adolescents has highlighted the existing gaps in access to services across the continuum of care, challenged in part by shortages of mental and behavioral health providers and alternatives to inpatient hospital care, such as intensive community-based supports and services, mobile crisis intervention, therapeutic foster care, and intensive case management services. These access challenges are a barrier to early intervention services that minimize or prevent the need for crisis care interventions and to other community alternatives for children who need more support. Hospitals have been able to stabilize children during a crisis situation; however, they have identified gaps in their ability to counsel patients, identify the best referral care option, or follow up with families to make sure they found necessary, ongoing care.

Opportunities:

- Designate funding specifically intended to target the behavioral health needs of infants, children, and adolescents with flexibility to fund a range of activities across the continuum of care, including crisis care needs e.g., pediatric training for crisis response and initiatives to relieve the stress on emergency departments and inpatient units, including mobile crisis intervention, intensive community-based supports, and intensive case management services, and therapeutic foster care. Also consider supports for family caregivers, such as respite care.
- Support access to step-down programs (e.g., partial hospitalization and intensive outpatient programs) that support infants, children, and adolescents that may be necessary following crisis stabilization before safely returning to their communities.
- Ensure ongoing and sufficient funding for 9-8-8, the national suicide prevention and mental health crisis lifeline, and ensure that the lifeline is able to respond to the unique needs of youth, including through implementation of SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care.[xxv]
- Support federal legislation to enhance the promotion and accessibility of crisis response services, including current congressional efforts to enhance public education regarding crisis services and help-seeking, reinforce quality assurance provisions and standardized services, and provide Medicaid and Medicare coverage for the crisis care continuum.

9. **Justice-Involved Youth**

Challenges: Although estimates vary, the prevalence of mental health disorders among justice-involved youth ranges from 50% to 75%.[xxvi] Common mental and behavioral health disorders include depressive disorders, anxiety disorders, disruptive behavior, attention-deficit/hyperactivity disorder, posttraumatic stress disorder, and substance use disorders. The high prevalence of mental health disorders among juvenile-justice involved youth is interconnected with the high prevalence of trauma and adverse childhood experiences (ACEs) they experience. Most justice-involved youth experience trauma and polyvictimization from a young age. These experiences and resulting toxic stress response often result in maladaptive behaviors, such as increased stress reactivity, impulsivity,

hyperarousal, and decreased ability to self-regulate. Youth who have experienced multiple traumatic events are at increased risk of delinquency, contact with law enforcement, involvement with the juvenile justice system, school suspension, disconnection from school, volatile relationships, and substance use. Polyvictimized youth are also more likely to receive diagnoses of externalizing disorders such as conduct disorders, oppositional defiant disorder, and antisocial behaviors. There is increasing recognition that for many youth, these diagnoses may be rooted in complex trauma and polyvictimization.

Opportunities:

- Recognize incarceration as a last resort only for youth who have committed serious crimes and cannot be safely placed in community-based programs.
- Invest in funding for diversion programs as an alternative to incarceration for justice-involved youth, including programs specializing in addressing mental health and substance use care needs.
- Ensure confined youth receive the same level and standards of care, including mental health and substance use care, as nonconfined youth accessing care in their communities, including initial mental health screenings for all youth confined for more than 1 week.
- Provide robust funding for the Juvenile Justice and Delinquency Prevention Act (JJDPA) and its core protections which include improving conditions for detained youth, reducing detention of status offenders, and reducing racial disparities to ensure conditions of confinement are developmentally appropriate.
- Ensure that states fully implement the statutory changes to Medicaid included in the SUPPORT Act to ensure that youths' Medicaid eligibility is not terminated upon incarceration, and that youth are enrolled and benefits are fully reinstated upon release, and the successful implementation of the Medicaid and CHIP provisions included in the Consolidated Appropriations Act, 2023 to support youth in incarcerated settings.
- Support funding for juvenile facilities to implement a comprehensive suicide prevention program that includes ongoing suicide risk assessment.
- Support detention facilities and juvenile justice systems in implementing a trauma-informed approach that responds to the needs of justice-involved youth and their families.
- End the use of isolation and solitary confinement for children and adolescents.

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[i] National Vital Statistics System. Leading Causes of Death, United States. Centers for Disease Control and Prevention; 2020 https://wisqars.cdc.gov/data/lcd/home.
[ii] Youth Risk Behavior Survey Data Summary & Trends Report, 2011-2021. Centers for Disease Control and Prevention; 2023. https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm
[iii] Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. US Department of Health and Human Services; 2020. https://www.samhsa.gov/data/report/2019-nsduh-annual-national-report; Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. US Department of Health and Human Services; 2023. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
[iv] Henderson MD, Schmus CJ, McDonald C, Irving SY. The COVID-19 pandemic and the impact on child mental health: a socio-ecological perspective. *Pediatric Nursing*.2020; 46(6).
[v] Shen J. *Impact of the COVID-19 Pandemic on Children, Youth and Families.* Boston: Judge Baker Children's Center, September 2020.
[vi] National Academies of Sciences, Engineering, and Medicine 2019. A Roadmap to Reducing Child Poverty. Washington, DC: The National Academies Press. https://doi.org/10.17226/25246.
[vii] Trent, M, Dooley, DG, Dougé, D. The impact of racism on child and adolescent health. *Pediatrics.* 2019;144(2).

[viii] Stone DM, Mack KA, Qualters J. Notes from the Field: Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group — United States, 2021. MMWR Morb Mortal Wkly Rep 2023;72:160–162. DOI: http://dx.doi.org/10.15585/mmwr.mm7206a4

[ix] Substance Abuse and Mental Health Services Administration. Behavioral Health Workforce Report. US Department of Health and Human Services; 2022.https://www.samhsa.gov/sites/default/files/behavioral-health-workforce-report.pdf

[x] Study: One in Six U.S. Children has a Mental Illness. American Academy of Family Physicians; 2019. https://www.aafp.org/news/health-of-the-public/20190318childmentalillness.html

[xi] Medicaid & CHIP Enrollment Data Highlights. Medicaid; 2023. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[xii] 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.

[xiii] Kessler RC, Berglund P, Demler O et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*; 2005; 62(6):593-602. Doi:10.1001/archpsyc.62.6.593.

[xiv] Study: One in Six U.S. Children has a Mental Illness. American Academy of Family Physicians; 2019. https://www.aafp.org/news/health-of-the-public/20190318childmentalillness.html

[xv] Kataoka, S, Zhang L, Wells K. Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status. Am J Psychiatry. 2002; 159(9): 1548-1555. https://doi.org/10.1176/appi.ajp.159.9.1548

[xvi]West-Bey N, Tawa K. Unlocking Transformation and Healing: Community-based Care Policy Options for Accessible Youth and Young Ault Mental Health Care. CLASP; 2020. https://www.clasp.org/sites/default/files/publications/2020/06/2020.06.15%20Unlocking%20Transformation%20and%20Healing%20-%20CBC.pdf

[xvii] Whitaker A, Torres-Guillén S, Morton M, et al. Cops and No Counselors: How the Lack of School Mental Health Staff Is Harming Students. ACLU; 2019. https://www.aclu.org/sites/default/files/field_document/030419-acluschooldisciplinereport.pdf

[xviii] Substance Abuse and Mental Health Services Administration. Behavioral Health Workforce Report. US Department of Health and Human Services; 2022.https://www.samhsa.gov/sites/default/files/behavioral-health-workforce-report.pdf.

[xix] Medicaid & CHIP Enrollment Data Highlights. Medicaid; 2023. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[xx] Alker J, Corcoran C. Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade. Georgetown Center for Children and Families; 2020. https://ccf.georgetown.edu/2020/10/08/childrens-uninsured-rate-rises-by-largest-annual-jump-in-more-than-a-decade-2/

[xxi] Alker J, Osorio A, Park E. Number of Uninsured Children Stabilized and Improved Slightly During the Pandemic. Georgetown Center for Children and Families; 2022. https://ccf.georgetown.edu/wp-content/uploads/2022/12/ACS-Uninsured-Kids-2022-EMB-1-pm.pdf

[xxii]The Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care. National Alliance on Mental Illness; 2017. https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut

[xxiii] The CDC recently reported dramatic increases in the numbers of children and adolescents seeking mental health treatment in emergency rooms: Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI:https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm; see also 2020 Children's Mental Health Report. Child Mind Institute. https://childmind.org/awareness-campaigns/childrens-mental-health-report/2020-childrens-mental-health-report/

[xxiv] Youth Risk Behavior Survey Data Summary & Trends Report, 2011-2021. Centers for Disease Control and Prevention; 2023. https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm

[xxv] Substance Abuse and Mental Health Services Administration. National Guidelines for Child and Youth Behavioral Crisis Care. US Department of Health and Human Services; 2022.https://store.samhsa.gov/product/national-guidelines-child-and-youth-behavioral-health-crisis-care/pep22-01-02-001

[xxvi] Underwood LA, Washington A. Mental Illness and Juvenile Offenders. *Int J Environ Res Public Health*. 2016 Feb 18;13(2):228. doi: 10.3390/ijerph13020228. PMID: 26901213; PMCID: PMC4772248