

STRENGTHENING THE SAFETY NETS FOR CHILD AND ADOLESCENT MENTAL HEALTH

Statement of the International Society for Psychiatric Mental Health Nurses

This position paper aligns with the mission of the International Society of Psychiatric Mental Health Nurses' (ISPN): *To support advanced-practice psychiatric-mental health nurses in promoting mental health care, literacy, and policy worldwide.* More specifically, it addresses the limitations of current safety nets, and highlights access barriers to services for children and adolescents to services that promote health and mental wellbeing and treat behavioral health problems. It is compatible with the October 2021 call by professional groups representing pediatricians, child and adolescent psychiatrists, and hospitals to recognize child mental health as a national emergency (American Pediatric Association, 2021). The purpose of this statement is to: 1) identify current mental health needs of children and adolescents; 2) recognize barriers inhibiting both access and service utilization; 3) describe existing mental health safety nets; 4) report culturally sensitive evidence-based strategies/services; and, 5) formulate recommendations for practice and policy to expand and strengthen the child and adolescent mental health safety nets.

Context:

While roughly one in five children has a diagnosable mental, emotional or behavioral disorder, only twenty percent of these children receive treatment from specialized mental health professionals (Center for Disease Control and Prevention [CDC, 2021a]). These figures illustrate a gap between need and treatment in our most vulnerable citizens and one that has grave consequences for society. The 2019 CDC youth risk surveillance survey (2021b) found that more than 1 in 3 high school students experienced feelings of sadness or hopelessness in 2019, a 40% increase since 2009, and approximately 1 in 6 reported making a suicide plan, a 44% increase since 2009. The number of Black students who contemplated suicide grew by nearly 50%.

The World Health Organization (WHO) identified the importance of one's home, school, family and community environment to overall health and well-being; adding that "these forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems". WHO (2021) identifies broad areas as social determinants of health (SDOH): access to quality healthcare, education, and housing; financial stability; social and community support; and, safe and healthy environments. The global COVID-19 pandemic with its social distancing, lockdowns, remote schooling and overarching insecurities has affected multiple SDOH, contributing to an increase in anxiety, depression and suicide as well a lack of care accessibility (Center for Medicare and Medicaid Services [CMS] 2021; U.S. Census Bureau, 2021). Recognizing the impact of SDOH on well-being, models for community-healthcare partnerships to expand focus "upstream" of healthcare delivery are currently being explored and promoted (National Academies of Sciences, Engineering, and Medicine, 2021).

Poverty, a component of one SDOH, can be viewed as a threat to all determinants of health. To prevent and reduce poverty governments worldwide have instituted safety nets, and since 1980, the International Monetary Fund and the World Bank have made significant loans to countries across the globe to establish safety networks for their citizens. Globally, extreme poverty (living at less than \$1.90/person/day) rose in 2020 by 100 million with children half of the total poor (World Bank, 2021).

In its analysis of the 2019 US census data on poverty, the Children's Defense Fund (CDF, 2020) found that 1 in 7 children in the US live in poverty. While national and state-level estimates of poverty in children in 2019 were down by 1.4 million, the CDF analysis suggests the large drop was misleading. A recent study (Parolin et al., 2020) found poverty up despite receipt of CARES Act income transfers; meanwhile statistics on the impact of the Children's Tax Exemption are unavailable. It is likely that rates of children living in poverty has risen, particularly in groups with the highest incidence: American Indian/Alaska Native children, 24.8% (U.S. Census Bureau, 2019), Black children, 26.4 %, and Hispanic children, 20.8%, (CDC, 2020). Poverty is the benchmark for access to safety nets, which include the targeted transfers of cash, vouchers, food, or other goods to poor or vulnerable households.

Health care safety nets in the US were established during the 1960's War on Poverty initiative and include Medicaid and Federally Qualified Health Centers (FQHC). The 1997 state and federally funded Children's Health Insurance Program (CHIP) expanded healthcare services to children whose parents' income is too high to qualify for Medicaid but not enough to buy private health insurance. Both Medicaid and CHIP are administered by individual states and eligibility is based on annually established federal poverty guidelines. Medicaid and CHIP vary by state and, as of 2020, 12 states had not accepted Affordable Care Act (ACA) Medicaid expansion and eligibility for CHIP (CDF, 2021, p. 51). In 17 states, immigrant children who are lawful residents must wait 5 years before they can receive coverage.

Safety Net Programs for children and adolescents are required to pay for behavioral health services on parity with physical health, however, the most recent information on FQHCs, which see about 9 million youth yearly, indicate that most primary care sites do not have integrated mental health care and few provide substance abuse services (National Association of Community Health Centers, 2011). Unfortunately, in 2019, despite a significant reduction of uninsured children following implementation of the ACA in 2010, the total of uninsured rose to 4.4 million, leaving one in twenty-one under 6 years and one in sixteen 6-19 year olds without coverage (CDF, 2021) and making safety net facilities even more important.

Underutilization of health safety nets is a problem for several groups. Here, the potential overlap between groups characterized as children of immigrants and Hispanic/Latinx children in various studies requires consideration. Health safety nets for children of undocumented US residents expanded after the adoption of the ACA in 2010 expanded CHIP programs to this group. It is reported that the percentage of uninsured Hispanic/Latinx children is more than double that of other racial/ethnic groups despite the fact that over half of all uninsured children are Medicaid or CHIP eligible (CDF, 2021).

While health care is an entitlement available for members of recognized American Indian Alaskan Native (AIAN) via the Indian Health Service, a part of the US Public Health Service, and military families via TRICARE (<https://branchta.org/tricare-healthcare-military-families/>), access to culturally appropriate behavioral health care for children and adolescents is often limited. It is reported that 57% of AIAN rely on the IHS for healthcare (NoStigmas, 2018), yet the remote rural location of many AIAN restricts access to mental health providers. Similarly, military families with TRICARE reported worse health care access and quality for complex health and behavioral health care needs than civilian families (Seshadri et al., 2019). The Branch Military Family Technical Assistance Center (MFTAC, n.d.) notes that mental health care for children whose parents are on active duty is limited because of the priority given to active duty service members at military treatment facilities (MTF). Unfortunately, mental health concerns are high for both AIAN and military groups who are at high risk for trauma, both current and, in the case of AIAN, generational. Recent advances suggest that tele-mental health care may provide a safety net for individuals distant from services. However, effectiveness of remote programs, particularly for children and adolescents with emotional and behavioral challenges, has not been well studied. Although tele-mental health may increase access to care, the recipients of care must also have access to technology for this mode of delivery to be effective.

Prevention

Half of all adult mental illnesses begin before age 14 (Colizzi et al., 2020) and it is estimated that between 25 and 50% of adult mental illness may be prevented with early intervention and health promotion (Kim-Cohen et al., 2003). Promotion of wellness through public safety net initiatives is critical in preventing crippling effects of lifetime mental illness.

The World Health Organization (1998) identifies that “health promotion is the process of enabling people to increase control over, and to improve, their health” (p.11). The focus on health promotion moves upstream in an effort to affect health-promoting changes within the environments that children live, play and attend school. The CDC notes that establishing healthy behaviors during childhood and adolescence is easier and more effective in preventing chronic disease in adulthood.

Child and adolescent social and family protective factors (consistent with SDOH) that promote mental health include access to healthy nutrition, safe housing, physical exercise and safe outdoor play spaces, positive parenting and social connections, prevention of child abuse, and access to primary health care. Culturally grounded prevention programs for traditionally marginalized youth can effectively promote health equity and strengthen protective factors. Examples include *The Strong African American Families Program* (SAAF), *Keepin’ it R.E.A.L.*, *Ho’ouna Pono*, and other prevention efforts targeting prevention of substance use, HIV/AIDs and STIs, diabetes, teen dating violence and pregnancy prevention (Lauricella et al., 2016). These and other health promotion efforts are found to have significant positive effects on youth’s health behaviors, attitudes and serve to prevent future mental health problems.

Children and adolescents are routinely screened in school and pre-school preventatively for physical health issues (e.g., vision, hearing). Mental health and developmental disorders such

as anxiety, depression, attention deficit hyperactivity disorder and learning disabilities often begin in early childhood and can impact the life-long trajectory of health and well-being. However, mental health issues are generally detected after they have already emerged. Family can be the first source of support for a child's mental health, but stigma continues to present barriers to parental problem recognition and impacts help-seeking behaviors. Increased societal demands make it imperative that academic settings partner with families and other community stakeholders to help students thrive. Schools and pre-schools provide an opportunity for prevention of illness and promotion of mental health, for example, the successful integration of social emotional learning (SEL) programs within the curriculum (Taylor et al., 2017). SELs such as *Second Step*® have demonstrated outcomes related to improved emotional skills, attitudes, behavior, and academic performance. Schools can strive to develop the capacity to focus on prevention, while reinforcing students' natural mental health strengths or protective factors and to respond to students increasing suffering from the more acute mental health disorders.

Embedding mental health professionals within the academic setting can assist in dismantling stigma. There is growing need to provide access to mental health services and evidence-based support to children and adolescents where they spend the majority of their time: in school. Expanding school-based Medicaid programs could be an opportunity to provide additional resources to meet increased demand for mental health services, particularly for underserved and underrepresented populations. Unfortunately, actions taken because of the 2014 free care policy reversal may differ from state to state (CMS, 2014). Only 13 states have authorized to enact this policy reversal. Further examination with stakeholder involvement on a state level is essential to pursue changes to school Medicaid programs. More work is needed in states that have not made the policy shift to implement the free care reversal policy and use federal Covid-19 relief dollars to support sustainable evidence based long-term solutions to address child and adolescent mental health needs

Another opportunity for schools to address issues related to accessing care includes the use of funds from the 2021 American Rescue Plan's Elementary and Secondary School Emergency Relief (ESSER) program, which allocated \$122 billion for state and local education leaders to implement mental and social health programs. Growing concerns related to workforce shortages particularly in mental health arena will require increasing community involvement. In addition to healthcare personnel, is important to consider leveraging school administrators, parents, teachers, local law enforcement and the development of lay health workers as part of the intervention to promote mental health where individuals live, learn, work and play.

Population based strategies at the state and county level are needed to engage in safety net programs that significantly impact co-existing social determinants of health to achieve optimal mental health. Widespread mental health promotion requires strategies that alleviate poverty in children and families and promote health equity.

Solutions to Improve Safety Nets

In response to the pandemic, the U. S. Health and Human Services (2021) released a document detailing recent initiatives to fund behavioral health services for children and adolescents,

including a targeted focus on school partnership and building access, capacity and equity. Due to cost concerns, many of these initiatives are time limited and many are grant dependent. Other initiatives require state buy-in or administration, and many are not easily accessed by those most in need. It is important that we remain mindful that insufficiency and inaccessibility of services that promote health and mental health has long been a problem. We must seize this opportunity to ensure sustainable changes that are effective in improving the safety net for all children and adolescents.

Therefore, the International Society of Psychiatric Mental Health Nurses puts forward the following:

Recommendations

- Systematic study of the gaps in care for children and adolescents with diagnosed challenges to their behavioral and emotional health and collection of data related to the social determinants of mental health on children receiving services.
- Policy shift of view from health care to health and wellness. This will require funding for preventive services and public health initiatives in communities that are not dependent upon diagnoses.
- Advocate for mental health parity, funding for evidenced based mental health child and adolescent services and continuation of services that reduce poverty.
- Protect schools as a safety net by building partnerships with mental health providers. Explore the feasibility of public funding for evidenced based programs in schools and pre-schools. Work with schools and communities to reduce the stigma associated with acknowledging the need for mental health services
- Universal access to quality health care (including behavioral health) for children and adolescents across all social economic strata.
- Fund research into the effectiveness of telehealth interventions for children and adolescents with behavioral and emotional challenges.

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