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THE JOURNAL OF PEDIATRICS • www.jpeds.com COMMENTARY

Mitigating the Impact of Coronavirus Disease-2019 on Child and Family Behavioral Health: Suggested Policy Approaches

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The coronavirus disease-19 (COVID-19) pandemic has exacted a significant toll on children and families and deepened an existing national child and family behavioral health ("Behavioral health" is used throughout the commentary to encompass mental health and substance use. When "mental health" is used specifically, it is done so purposefully so as not to inadvertently alter the presentation of specific research findings or the intention of authors and their work.) crisis.[1] Although we have not seen the full scope of the pandemic's effects on behavioral health, we have already witnessed negative impacts from social isolation, child care and school closures, grief and loss, and family economic insecurity.[1,2] And although children across the globe have borne pandemic distress, in many communities, children of color have been disproportionately burdened.[3]

Unfortunately, existing behavioral health care systems were inadequate before the pandemic, and they are certainly insufficient to address these increased behavioral health needs. Our child and family behavioral health "safety net," including pediatric primary care and the public school system, is underresourced to handle the surge in concerns, especially with staffing shortages caused or exacerbated by the pandemic.[4,5]

The pandemic nevertheless presents an opportunity. We must harness the national attention generated by the current crisis to advance equitable solutions that are family-centered and include a continuum of support from prevention to treatment. Leading experts on child health, including the American Academy of Pediatrics, declared a national state of emergency in child and adolescent mental health in October 2021, followed in December by a Surgeon General's Advisory to call for urgent attention to address the crisis.[6,7] We owe children and families a swift, comprehensive policy response that will lead to permanent strengthening of a behavioral health system that was already struggling before the pandemic, including promotion of policies to increase access to behavioral health services, expand and develop a culturally appropriate family-focused behavioral health workforce, promote the integration of behavioral health in pediatric primary care, and improve schools' ability to address behavioral health needs of students.

COVID-19	Coronavirus disease-19
CPAP	Child Psychiatry Access Program
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ED	Emergency department
MHPAEA	Mental Health Parity and Addiction Equity Act
PPCP	Pediatric primary care provider

Our commentary outlines suggested policy strategies, especially at the state and federal level, that could guide deliberations and action of policymakers. The suggested policy reforms also could provide a roadmap for pediatric providers who are in a position to engage in advocacy. For all child health practitioners caring for children and families during these challenging times, this commentary will provide a deeper understanding of the policy dynamics shaping the behavioral health care environment.

Behavioral Health Crisis Prior to Onset of COVID-19 Pandemic

For years, children and families in the US have been sounding the alarm bell: suicide is the second-leading cause of death among young people aged 10-24 years.[8] Concerning disparities among racial and ethnic subgroups exist, such as significantly higher incidence of suicide among Black children versus White children aged 5-12 years and disturbingly high rates of suicidal ideation and behaviors among special populations, such as LGBTQ youths.[9-12] Additionally, the incidence of behavioral health disorders has been increasing. A study found that one-half of US children with a treatable mental health disorder did not receive needed treatment from a mental health professional during the previous year.[13] Not surprisingly, emergency department (ED) visits for behavioral health concerns also have been rising, and without adequate inpatient resources to care for those youths with more severe and acute behavioral health concerns, patients may spend days in an ED before being admitted to an appropriate inpatient facility.[14] The shortage and maldistribution of licensed behavioral health care providers[15,16] and inadequate insurance networks for behavioral health[17] contribute to the difficulty children and families face in accessing timely treatment. Although not specific to pediatrics, a 2015 Department of Health and Human Services report projected that by 2025, there would be major behavioral

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health workforce shortages of 16 940 mental health and substance abuse social workers, 8220 clinical counseling and school psychologists, and 13 740 school counselors.[18]

Behavioral Health Impacts on Children and Families During the COVID-19 Pandemic

Although it is clear our behavioral health system was under significant strain prior to the COVID-19 pandemic, the needs have only intensified over the past 2 years, and evidence is accumulating that children's behavioral health has been negatively impacted by the pandemic.[19] Data show increases in children's mental health–related ED visits and rates of suicide ideation and attempts at various time periods during the pandemic.[19-21] Young children (birth to 5 years) also have been adversely impacted. Studies show that when caregivers experienced more financial and material hardship, they also reported more emotional difficulties in their young children.[22]

There is reason to be concerned that the negative behavioral health impacts from the COVID-19 pandemic might not be borne equally by all groups of children. Evidence shows that African American and Latinx adults have experienced more behavioral health symptoms during the pandemic than other groups, and studies report increased concerns about the impact of the pandemic on their children's education, ability to care for their children, and relationships.[23] Additionally, an estimated 140 000 children lost a primary or secondary caregiver during the first 14 months of the pandemic, and 65% of those were children of racial and ethnic minority groups.[24]

Positive and stable caregiver–child relationships are crucial for the behavioral health and well-being of children. Emerging evidence is revealing the extent of the strain that the pandemic has put on caregivers' mental health.[25,26] Compared with adults without children, caregivers—especially maternal figures—with minor children have experienced higher levels of stress, mental health diagnoses, and rates of mental health treatment.[26] Although general stress levels in caregivers decreased over time, stress specific to care-giving responsibilities continued to increase.[27] Research also shows that caregivers' coping during the pandemic and the caregiver–child relationship is strongly related to children's and adolescents' emotional and behavioral functioning,[28,29] an association consistent with reports from previous pandemics and disasters.[30] Although for many the pandemic has been conducive for strengthening family relationships,[31,32] for others it has strained caregiver–child relationships and led to punitive, psychologically abusive, or high-conflict interactions owing to increased caregiver stress and depression experienced during the pandemic.[1,33,34] Conversely, a close caregiver–child relationship was found to be protective against mental health difficulties for adolescents.[28]

These data underscore that adult and family behavioral health should be considered inextricable from children's behavioral health. A multifaceted approach attending to the behavioral health needs of children, their primary caregivers, and the entire family unit will be paramount to a successful COVID-19 behavioral health mitigation strategy.

Four Key Suggested Policy Approaches

Policy changes at federal, state, local, and institutional levels are needed to address the child and family behavioral health crisis in the immediate and long-term recovery phases from this pandemic. Our nation must bolster our health care, school, and community systems to be better positioned to deliver high-quality and developmentally and culturally appropriate behavioral health care through new or amended federal, state, and local policies. These solutions will need to address existing behavioral health conditions exacerbated by the pandemic, the onset of new behavioral health conditions resulting from the pandemic, and pandemic-induced behavioral health symptomatology that does not result in a disorder but should be supported with appropriate early intervention. Additionally, a racial and health equity framework should be applied when crafting and advancing behavioral health policies. Existing inequities have been exacerbated by COVID-19 and will not be rectified without intentional effort. Numerous frameworks exist[35,36]; regardless of the exact framework, an intentional process that prioritizes the voice of those most impacted by the proposed policy in solution development is a critical step in advancing equitable behavioral health policies.[37]

Furthermore, as our society responds to this crisis, we should guard against a singular focus on the elements of our behavioral health care system most often utilized when individuals are in crisis: EDs, inpatient facilities, and outpatient treatment services. Ensuring an adequate supply of these types of services is paramount but must not be done to the exclusion of investing in and prioritizing upstream approaches, including revised financing and payment structures. Behavioral health conditions and concerns, including those exacerbated and/or brought on by the pandemic, need not be life-long or long-term. Prevention, early intervention, and timely treatment when indicated can propel children and families toward a lifetime of thriving.

Leverage Existing Federal Laws to Improve Access to Behavioral Health

From a systems perspective, behavioral health, and especially children's behavioral health, remains a "second class citizen" compared with physical health conditions. Nationally, a child's mental health office visit is 10.1 times more likely to be out-of-network than a primary care office visit and twice as likely to be out-of-network than an adult mental health office visit.[17] As cited previously, more than one-half of children with a treatable mental health disorder are not receiving necessary treatment from a mental health professional.[13]

Yet, a high proportion of children are covered by insurance. Medicaid and the Children's Health Insurance Program (CHIP) insure more than 38 million children (more than one-half of US children),[38] and >95% of children are enrolled

in some type of health insurance program.[39] Given these numbers, there is potential to improve access by ensuring implementation and enforcement of current federal laws, particularly the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) federal Medicaid benefit for children and adolescents and the Mental Health Parity and Addiction Equity Act (MHPAEA).

EPSDT is the legally required benefit for Medicaid eligible children that provides a comprehensive set of health benefits, including payment for pediatric screening services and for all Medicaid-coverable health and behavioral health care services that are medically necessary to correct and ameliorate health and behavioral health conditions (including those detected by screening).[40] It can be an important source of public financing of children's behavioral health care. The unique focus of EPSDT on prevention, early intervention, and treatment coverage makes it an ideal current law to focus on robust and consistent enforcement (including across all settings, such as schools), clarification, and/or enhancement. Studies show that state-level enforcement of EPSDT mental health benefits can demonstrate measurable, positive changes in patterns of use of mental health services, with intensity of outpatient treatment increasing over time and rates of emergency care declining, at least initially, and increases in overall behavioral health screening and treatment.[41,42]

There have been calls to update EPSDT regulations,[43] and some states have initiated processes to clarify their public insurance policies.[44] Massachusetts, directly citing the adverse impact of COVID-19 on children and family behavioral health, including racial inequities, released Medicaid guidance in August 2021 stating that Medicaid managed care plans "must cover medically necessary preventive behavioral health services for members from birth until age 21…[E]ligibility requirements for preventive behavioral health services ...include members...if they have a positive behavioral health screen (or, in the case of an infant, a positive post-partum depression screening), even if they do not meet criteria for behavioral health diagnosis and therefore do not meet medical necessity criteria for behavioral health treatment."[44] Now is the time to undertake revisions to such policies, with an emphasis on behavioral health.[45] Coupled with a focus on EPSDT, bolstering access to behavioral health services also could be aided by increasing the federal share of Medicaid costs for behavioral health during the COVID-19 pandemic.[46,47] For example, the federal Medicaid Bump Act, if enacted by Congress, would increase the federal reimbursement rate for mental and behavioral health care services under Medicaid.[48]

Mental health parity has yet to be achieved, and network adequacy for behavioral health demands attention and action, especially as a critical response to the COVID-19 children's behavioral health crisis. The MHPAEA, which mandates that health plans and insurers offer mental health and substance use disorder benefits that are comparable with their coverage for general medical and surgical care,[49] has produced mixed results regarding efficacy for increasing access, yet most studies have focused largely on adults. A study of middle-income children and youth suggests that enactment of the MHPAEA improved access to care and mental health outcomes.[50] Federal actions to advance actualization of the MHPAEA could include extending the Act's authority to include Medicaid fee for service and enhancing parity enforcement for both Medicaid managed care and private insurance;[47] and utilizing US Department of Labor enforcement authority to penalize states and payors that do not comply with federal parity requirements.[51]

Expand a Culturally Responsive Behavioral Health Workforce

Although not sufficient to address the behavioral health crisis, an important component of a comprehensive solution will be to expand the pool of qualified behavioral health care professionals.[52] Additionally, given the family stressors, shared trauma, and relational strain experienced by children and caregivers during the pandemic and the importance of addressing the behavioral health of caregivers within the pediatric behavioral health care system,[53-55] it will be imperative to bolster the ability of the behavioral health workforce to use a family systems approach.[56] Unfortunately, workforce shortage data[57,58] demonstrate that even with laudable and necessary policies, such as loan repayment, the current and projected supply will not meet demand, and the diversity of the behavioral health workforce is woefully inadequate.[59]

We must continue to prioritize broadening the workforce and the settings in which behavioral health occurs, as well as improving overall access to care for children and the adults in their lives. Examples of such efforts include increasing the behavioral health workforce in nontraditional settings, such as through early childhood mental health consultation in early childhood education centers. Multiple federal and state funding and workforce pipeline policy solutions exist.[60] Additionally, passage of the federal Excellence in Mental Health and Addiction Treatment Act would expand nationwide reach of Certified Community Behavioral Health Clinics. Certified Community Behavioral Health Clinics receive flexible funding to improve available behavioral health treatment services. Results show expanded access to care, drastically reduced wait times, and increased hiring of behavioral health professionals.[51,61]

We must work to increase substantially the racial, ethnic, cultural, and linguistic diversity of the behavioral health care workforce; many recent recommendations are worthy of immediate action.[47,51,62] Examples of federal action include support of tuition waiver programs to encourage young people of color to enter the behavioral health workforce[51] and passage of the Pursuing Equity in Mental Health Act, which "would improve training in culturally and linguistically appropriate care, incentivize a more diverse workforce pipeline and proactively engage BIPOC [Black, Indigenous, people of color] communities in mental health care".[47]

Additional innovative strategies to broaden the workforce include using lay health worker models to address low-acuity common mental health conditions in adults and youth, such

as the Friendship Bench program that originated in Zimbabwe[63,64]; exploring promising, scalable strategies such as youth-initiated mentorship, a preventive approach in which youth and their families receive support to recruit caring adult mentors from within their existing social networks to bolster access to non–primary caregiver adults[65]; and allowing billing (achieved through state level policy change, such as Medicaid reimbursement) for the services of community health workers or navigators who can link families to behavioral health care and reinforce treatment recommendations.[45,62]

Implement Financing and Payment Structures to Support Integrated, Family-Focused Pediatric Primary Care

With the shortage of specialized child behavioral health professionals,[57,58] pediatric primary care providers (PPCPs) have been increasingly called on to address the mild to moderate behavioral health concerns of their patients.[66-68] There are opportunities to better support PPCPs in this role.

Although there has been a trend toward increasing integration of behavioral health services in pediatric primary care, only 52% of pediatricians report working in settings with a colocated behavioral health provider.[69] Child Psychiatry Access Programs (CPAPs) can be a valuable source of support for PPCPs who are managing their patients' behavioral health concerns and have been shown to be efficacious.[70,71] They are regional or state-level programs that allow PPCPs to access a centralized team of professionals (eg, psychiatrists, psychologists, social workers) for real-time indirect (curbside) consultation, as well as educational support to bolster providers' child behavioral health competencies and technical support to improve identification of behavioral health concerns on a practice-level. In response to the anticipated worsening of the behavioral health crisis during the pandemic, the American Rescue Plan Act of 2021 included provisions for $80 million for expansion of CPAPs.

Sufficiently addressing the child behavioral health crisis will be impossible without further transformation of the financing and payment infrastructure to support the role of PPCPs in the delivery of behavioral health services. Policies must support their ability to effectively integrate behavioral health services, collaborate with a consultative psychiatric provider and/or team, and engage in family-focused care. Recent policy recommendations by Wissow et al to promote integrated behavioral health care with a singular focus on the unique needs of children, adolescents, and families are immediately impactful and relevant to address systemic needs wrought by the COVID-19 pandemic.[62]

State level policies that could be enacted include the following: allow for billing for behavioral health care on the same day as a primary care service; allow for expanded billing codes that support collaborative work so that primary care and psychiatric providers can be paid for indirect consultation, case review, and referral coordination; and allow for first-line behavioral health treatment by colocated or collaborating behavioral health providers of all disciplines as part of medical benefits (without additional copays).

Policy change at the federal level and/or through private insurance could build upon guidance for maternal depression screening and treatment and allow wider billing latitude for pediatric practices to bill through the child's insurance for services that, even though directed at the child's caregiver, also positively impact the child. Finally, expanding and institutionalizing federal support through the Health Resources and Services Administration for CPAPs would ensure that all states can benefit from these essential programs.

Support Comprehensive School Behavioral Health Systems

The pivotal role of K-12 schools and their associated professionals in the identification, early intervention, and treatment of children's behavioral health needs has long been recognized and continues to drive nationwide expansion of school-based behavioral health programs.[72,73] Offering behavioral health supports in schools has been part of a safety net strategy to increase access to care and utilization of services for children and families living in poorly resourced communities.[74] School-based health centers represent a model of integrated care in which comprehensive health care services (typically including primary and behavioral health services) are offered to students through a partnership between schools and a sponsoring community agency or health system.[75] These collaborations have not only expanded standard and specialized treatment options delivered in schools, but also have enriched positive school climate efforts, expanded social and emotional learning opportunities, improved classroom management practices, and enhanced crisis responses.[74]

The need for behavioral health services in schools and other supportive structures and environments will grow in the immediate and longer-term aftermath of the COVID-19 pandemic, and requires policy attention, which includes centering youths in the policy formulation and advocacy processes.[76] There are four potential policy approaches. First, enact state law or policy regarding mandated or recommended maximum student-to-counselor ratios. Evidence exists that states with those types of policies in place have greater access to school behavioral health professionals for students than those without such a policy.[76] Second, leverage Medicaid policy for school behavioral health services. The Centers for Medicare and Medicaid Services allows states to bill for school health and behavioral health services for any Medicaid-eligible child.[77] Now is an opportunity for more states to utilize this Medicaid policy, which has shown promising initial results.[76,78] Third, ensure policy support for telehealth provision of behavioral health services, especially in schools. Continuation of existing policies that increased access in health and school settings via telehealth is critical, along with prioritizing other federal and/or state changes that may need to occur to maximize insurance reimbursement, improve equitable technology access, and advance

licensure reciprocity.[79] Finally, advance collaboration among the health and education sector, including among PPCPs, specialty behavioral health providers, and schools. Numerous barriers to collaboration have been documented,[80] including thorny policy issues such as the interplay between the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA). Numerous resources are available to collaboratively navigate current policy and proffer recommendations in this arena.[78,81-83]

Future Directions

Many important and efficacious policy solutions exist to support the well-being of children and families and to address the current behavioral health crisis. Pediatric providers are not always at the forefront of policy negotiations, but they are most certainly on the frontline of the child and family behavioral health crisis. Pediatric providers can be a powerful voice influencing policy at local, state, and federal levels, illuminating such discussions with their on-the-ground experience caring for families whose well-being has been impacted by the COVID-19 pandemic. We encourage pediatric providers to engage with their professional societies and other child advocacy groups to advocate for an improved, integrated, and family-focused behavioral health system. ■

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