Remodeling Broken Systems: Addressing the National Emergency in Child and Adolescent Mental Health

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A national emergency in child and adolescent mental health was declared in the United States in 2021 in the wake of the COVID-19 pandemic. This Open Forum discusses potential solutions to better support child and adolescent mental health by improving or expanding school-based mental health services, child psychiatry access programs, virtual mental health services, and new models of care (e.g., integrated youth services hubs and crisis stabilization units). The success of such programs is dependent on stable funding, strong leadership and accountability, robust and well-trained workforces, systems integration, and attention to health equity.

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During the COVID-19 pandemic, the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, and Children's Hospital Association declared a national emergency in child and adolescent mental health (1), and the U.S. Surgeon General issued an advisory highlighting increased prevalence of mental health challenges among youths, impacts of the COVID-19 pandemic, and recommendations to address this crisis (2).

The pandemic and associated public health measures forced youths to isolate themselves from their peers and other community supports, navigate remote learning environments, and cope with grief and loss; some 140,000 children and adolescents in the United States experienced the death of a caregiver due to COVID-19 (3). Nearly every system that supports children was affected by the pandemic. Schools have historically been a main provider of child and adolescent mental health services in the United States, but delivery of many school-based mental health programs was disrupted by school closures, other strategies to decrease viral spread, and staffing challenges. Subgroups of children—for example, those with intellectual and developmental disabilities—were particularly affected by these disruptions to daily life, and their use of emergency services increased (4). Surges in psychiatric emergency department visits among children led to increased time waiting for hospital beds, reflecting unleveraged opportunities for early intervention to prevent crises and insufficient inpatient beds to accommodate increased demand. Families faced changes in child care, economic uncertainty, educational responsibilities, and increased rates of domestic violence (5). Communities of color were disproportionately affected in every way, from disease mortality to learning loss to increased school dropout rates.

ADDRESSING MENTAL HEALTH SYSTEM GAPS

Solutions to optimize the mental health of young Americans have been proposed in this journal (6) and elsewhere (1, 7). We propose that meaningful improvement in children's mental health will require remodeling broken systems to ensure that children are supported early, effectively, and equitably. Our suggestions to address gaps in the mental health system include leveraging school-based mental health programs, primary care, virtual care, and emerging models.

Implementing School-Based Mental Health Programs

Schools may be an ideal setting for universal mental health screening and intervention. Promising evidence exists that school-based interventions can decrease the incidence of suicide attempts and increase help-seeking behavior among students (8). The number of school-based mental health models and implementation supports is growing, with dozens of programs meeting the threshold for inclusion in the Collaborative for Academic, Social, and Emotional Learning's guide to effective social and emotional learning programs (https://pg.casel.org/review-programs). In addition, the positive behavioral interventions and supports framework is a federally funded, three-tiered approach to social, emotional, and behavioral support: tier 1 provides universal supports, tier 2 supports students at risk for serious problem behaviors, and tier 3 provides intensive,

individualized support (https://www.pbis.org). Although interest in mental health screening in schools has been present for many years, widespread implementation of such screening has not been achieved, given the significant resources required to both facilitate screening and effectively serve students who need additional support and in light of other concerns (e.g., ethics, consent). Mobile apps may be one solution to the problem of scalability of both screenings and interventions, but these initiatives should be implemented only within a stakeholder-engaged, family-centered, and multitiered model of behavioral support.

Other school-based initiatives include providing advice and training to teachers and school counselors and increasing access to mental health specialists, including school-based psychologists, social workers, nurses, and behavioral support workers as well as community-based mental health providers. The American Rescue Plan Act of 2021 included $170 billion for school funding, which many schools used to hire mental health workers. The Student Mental Health Helpline Act, if passed, will create helplines to support teachers as they assist students with addressing their mental health issues (9). Educators can be trained to identify mental health needs, address mild symptoms themselves, and refer students to more specialized services when needed. Specific training programs for educators include Classroom Well-Being Information and Strategies for Educators, Youth Mental Health First Aid, and other resources funded by the U.S. Department of Health and Human Services. In addition to educators, other people who are not mental health professionals but who interface with youths, including other youths, parents, clergy, coaches, and other community members, can be empowered with additional behavioral health knowledge and skills.

Increasing Capacity in Primary Care

A number of programs are designed to improve knowledge of and skills in children's mental health among primary care providers. For example, Project Extension for Community Healthcare Outcomes uses a "hub" of specialists, typically at an academic medical center, to provide didactic lectures and case presentations for primary care "spokes" via teleconferencing (10), and the REACH Institute uses interactive group learning, followed by ongoing coaching and case-based training.

Collaborative care models known as child psychiatry access programs engage child and adolescent psychiatrists to support primary care management of psychiatric disorders. Consultations may be direct or indirect and may involve telepsychiatry or in-person care. These models are available in most states and increase access to mental health care, expand the capacity of the existing workforce, and decrease stigma and inconvenience for patients. Collaborative care models have been shown to lead to improved patient and family satisfaction, reduced utilization of emergency departments and fewer inpatient hospitalizations, and improved clinical outcomes. Off-site integrated care models (vs. colocated care) may serve larger and more geographically dispersed populations, minimize changes to existing infrastructure, reduce travel costs for clinicians, and decrease isolation of specialists (11). These programs are feasible, desirable, and sustainable. Currently, participation of patients' primary care providers in these models is free, because these models are supported by state, local, or insurance payers in addition to federal funding. Financially sustainable models are essential to ensure equitable access to these services in the future.

Leveraging Virtual Care

Although virtual care facilitated the continued delivery of mental health services throughout the pandemic and is an essential component of most collaborative care models, its use risks exacerbating disparities in access; for example, Black children are less likely to be scheduled for telehealth visits compared with White children (12). Ensuring access to technology and digital literacy among target users and addressing biases among providers and administrators are critical to avoid widening gaps in mental health service utilization. Community hubs, including within school districts, that offer use of the necessary technology (a reliable Internet connection and appropriate devices) and technical support represent one solution to the provision of equitable access to virtual care. Increased broadband access, particularly in rural areas, is essential to leveraging the full potential of virtual care. The American Psychiatric Association and the American Telemedicine Association have published a guide to best practices in synchronous videoconferencing-based telepsychiatry to support the provision of high-quality care (13).

Exploring New Service Models

For adolescents and young adults, integrated youth services hubs such as those that have emerged in Australia, the United Kingdom, Canada, and (more recently) the United States may be particularly appealing. These hubs emphasize rapid access to care and early intervention, youth and family engagement, youth-friendly settings and services, evidence-informed approaches, and partnerships and collaboration (14). In addition to mental health services, these "one-stop shops" offer general medical health care, vocational supports, and case management to support basic needs. They address a particular mental health system gap by providing services for transition-age youths rather than suspending care for people >18 years old, as many children's mental health services do.

Emerging solutions to the rise in children's mental health–related emergency department visits include mobile and community crisis response teams and the use of pediatric crisis stabilization units, which are community-based, short-term outpatient units that provide immediate care to children experiencing a mental health crisis and their families. The goal of crisis stabilization units is to quickly stabilize an individual—often within 72 hours—and refer that individual

to available community resources (15). This model may also reduce police involvement in mental health crises, which may be particularly important for racially minoritized populations. Rigorous evaluations of this model for youths are needed.

REMODELING BROKEN SYSTEMS

Beyond innovative programs, stronger systems to support children's mental health will require robust and well-trained workforces, systems integration, leadership and accountability, government support, and adequate and stable funding. To provide equitable access to these resources, it is particularly important that mental health care be prioritized by the federal government and adequately funded through Medicaid. Within primary care, support for collaborative care models such as child psychiatry access programs is essential. The child and adolescent psychiatry workforce could be expanded by availability of higher reimbursement rates, which may help incentivize medical students and psychiatric residents to specialize in child and adolescent psychiatry and may spur trained child and adolescent psychiatrists to focus their practice on treating children and participating in the insurance market. Further, transforming temporary funding for virtual care into permanent policies can help support telepsychiatry use in the long term.

CONCLUSIONS

The thoughtful implementation and stable funding of evidence-based models can help schools, the health care system, and communities more effectively support children's mental health in the wake of the COVID-19 pandemic. Only with sufficient investments in the mental health system and other systems designed to support children and families, as well as careful consideration of unintended consequences for equity-deserving populations, will we see an end to this crisis.

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