

Issue Brief

Child and Adolescent Mental Health

Overview

Within the last 20 years, the role of mental health care has become recognized as a critical component of America's health care system. A 2004 survey conducted by the Center for Health and Health Care in Schools

<http://www.healthinschools.org/sh/psychotropic.pdf> found that 19% of all pediatric visits involved a psychosocial problem requiring attention or intervention. In fact, psychosocial problems rank first, surpassing asthma and heart disease, as the chronic conditions that most often account for pediatric visits.

Childhood mental health issues can produce a negative effect on quality of life through adulthood, and the importance of early identification and treatment of mental health concerns cannot be overstressed. The economic impact alone of untreated mental health concerns is staggering. Untreated mental health disorders lead to higher rates of juvenile incarcerations, school dropout, family dysfunction, drug abuse, and unemployment. Societal costs can be alleviated by early detection and treatment of mental health conditions.

This issue brief focuses on 4 distinct topics:

- The establishment of parity between insurance coverage for mental health care and physical health care.
- The prevention of suicide in children and adolescents.
- The use of school-based mental health programs in identifying and treating mental health conditions.
- The administration of psychotropic medications to children and referral for psychotropic medications by school personnel.

Mental Health Insurance Parity

The National Institute of Mental Health (NIMH)

<http://www.surgeongeneral.gov/topics/cmh/> reports that it is estimated that less than 1 in 5 of the children and adolescents, who suffer from mental illness severe enough to cause some level of impairment, receive treatment for their condition.

According to the AAP Policy Statement "Insurance Coverage of Mental Health and Substance Abuse Services for Children and Adolescents: A Consensus Statement"

<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/860> it is currently estimated that at least 13 million children are in the need of mental health or substance abuse services, yet attempts to restrain health care costs have resulted in decreased availability of mental health and substance abuse services for children and adolescents.

The Mental Health Parity Act (MHPA) of 1996 prohibited employer-sponsored group plans larger than 50 employees, from imposing annual or lifetime maximums on mental health benefits that are lower than those imposed on other benefits. Despite the name, the law does not require parity between mental health benefits and other illness coverage benefits in the terms of deductibles, outpatient visit limits, inpatient day limits, and medical necessity requirements or prior authorization requirements. To fill in the gaps left open from the MHPA, every state except for **Wyoming** has enacted some form of mental health parity legislation. In February 2007, legislation was introduced in the U.S. House of Representatives that would require mental health substance and abuse treatment parity for employer-sponsored insurance plans with 50 or more employees. As of this writing, this legislation is still pending.

AAP Recommendations

Many children do not receive preventive or follow-up care for mental health conditions. The Academy makes the following recommendations in the consensus statement:

- Parity should be established between medical health services and mental behavioral and substance abuse services.
- The State Children’s Health Insurance Program (SCHIP), which has provided additional resources for children’s health care and has allowed for some flexibility in the distribution of resources, should be supported and expanded to include coverage for mental and behavioral health and substance abuse services.
- The number of qualified child mental health and substance abuse clinicians should be increased through support for training programs, better recruitment into these programs and job incentives.
- Managed care and behavioral health organizations should be required to provide adequate panels of culturally competent clinicians who are qualified to address child and adolescent mental and behavioral health and substance abuse needs.
- Competent, licensed providers with training and expertise in providing services to children should be equally included on panels, without limitations to specific disciplines.
- Professionals need to be accessible and available to families within a reasonable distance and time frame.
- Services provided by clinicians in alternative sites such as schools, homes, and centers must be reimbursed.
- Families and purchasers of health care plans need to be clearly informed about the adequacy of the health care coverage they are considering. The health plan should specifically identify mental health services provided to children, including child and adolescent psychopharmacology, child and adolescent psychological and neuropsychological assessments, child and adolescent psychotherapy, behavioral medicine (eg, pain management, chronic illness management, eating disorders), and substance abuse programs.

State Activity

Mental Health Parity Laws

Currently 5 states (**Connecticut, Maryland, Minnesota, Oregon, and Vermont**) mandate mental health parity, requiring that all mental health conditions and substance abuse disorders be covered at the same level as a physical illness.

Limited Mental Health Parity Laws

Three (3) states (**Indiana, Kentucky, and Maine**) require mental health and substance abuse treatment parity only in group insurance plans with 50 or more employees. **Rhode Island** requires that both mental health and substance abuse conditions be covered at the same rate as other physical illnesses, with some limitations on outpatient visits. Two (2) states (**New Mexico and Washington**) require mental health parity for group health plans with more than 50 employees, but do not include coverage for treatment of substance abuse in the mandate. Six (6) states (**Arizona, Arkansas, North Carolina, Oklahoma, Tennessee, and West Virginia**) require mental health parity within group health insurance coverage, provided that parity does not raise the cost of coverage by more than 1 to 2%. **Idaho** mandates mental health parity in coverage only for state employees and their families.

Eight (8) states (**California, Colorado, Delaware, Louisiana, Montana, New Hampshire, New Jersey, and South Dakota**) limit mental health parity to people determined to have “Severe Mental Illness” (SMI). The definition of SMI varies from state to state, but is generally accepted to mean a biological-based mental illness. Eight (8) other states (**Hawaii, Illinois, Iowa, Massachusetts, Nebraska, South Carolina, Texas, and Virginia**) limit mental parity to treatment of SMI in group insurance plans.

Mental Health Mandates

Twelve (12) states (**Alabama, Alaska, Florida, Georgia, Kansas, Michigan, Mississippi, New York, North Dakota, Ohio, Pennsylvania, and Wisconsin**) mandate mental health care coverage within private health insurance, but do not stipulate in these mandates that mental health care coverage and physical illness coverage be equal. Two (2) states (**Nevada and Utah**) have laws that limit out-of-pocket expenses for treatment of SMI within group health insurance plans and **Missouri** limits out-of-pocket expenses on coverage of all mental health conditions.

Recent Legislative Activity

During the 2007 legislative session, 10 states introduced bills that would require or strengthen mental health parity with medical benefits. **Colorado** passed legislation that will require insurers to cover coverage for mental disorders in addition to SMI. **New Mexico** passed a bill that will allow residents with an individual insurance policy, which does not include mental health benefits, the eligibility to buy into a pool policy to provide mental health services. **Washington** passed a bill that will require existing mental health benefits to be extended to small employer and individual plans. **West Virginia** removed the sunset clause for mental health parity laws for group plans.

School-Based Mental Health Programs

Access to mental health coverage is not the only barrier to children's mental health care. The AAP Policy Statement "School-Based Mental Health Services" (<http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics:113/6/1839>) reports that barriers also include lack of transportation, financial constraints, child mental health professional shortages, and stigmas related to mental health problems. These barriers might explain why 40% to 60% of families who begin therapy sessions end prematurely, and why most people only attend 1 to 2 sessions before terminating. School-based mental health services are evolving as a strategy to address these concerns by removing barriers to accessing mental health services and improving coordination of these services.

AAP Recommendations

The Academy recognizes that school-based mental health clinics can play an important role in addressing barriers to mental health services and makes the following recommendations:

- The mental health program (preventive strategies and mental health services) should be coordinated with educational programs and other school-based health services. School social workers, guidance counselors, school psychologists, school nurses, and all mental health therapists should plan preventive and intervention strategies together with school administrators and teachers, as well as families and community members.
- Preventive mental health programs should be developed that include a healthy social environment, clear rules, and expectations that are well publicized. Staff members should be trained to recognize stresses that may lead to mental health problems as well as early signs of mental illness and refer students to trained professionals within this setting.
- Mental health referrals (within the school system as well as to community-based professionals and agencies) should be coordinated by using written protocols, should be monitored for adherence and should be evaluated for effectiveness.
- School-based specific diagnosis screenings, such as for depression, should be implemented at school only if they have been supported by peer-reviewed evidence of their effectiveness in the setting.
- Roles of all the various mental health professionals who work on campus with students should be defined so that students, families, all school staff members, and

the mental health professionals themselves understand them.

- Group, individual, and family therapies should be included as schools arrange for direct services to be provided at school sites. Alternatively, referral services should be available for each of these modes of therapy so that students and families receive the mode most appropriate to their needs.
- It should be documented that mental health professionals providing services on site in school (whether hired, contracted, or invited to school sites to provide services) have training specifically in child and adolescent mental health (appropriate for student ages) and are competent to provide mental health services in school settings.
- Private, confidential, and comfortable physical space should be provided at the school site. Often, this is not difficult for schools if mental health services are provided after school hours. Having school-based services should not preclude the opportunity for mental health services to be provided at nonschool sites for situations in which therapy for a student may be ill advised (eg, student who feels uncomfortable discussing a history of sexual abuse in a school setting). During extended school breaks, schools must provide continued access to mental health services.
- Staff members should be provided with opportunities to consult with child psychiatrists or clinical psychologists (on or off school site) so that they may explore specific difficult situations or student behaviors and review policies, programs, and protocols related to mental health.
- Quality-assurance strategies should be developed for mental health services provided at school, and all aspects of the school health programs should be evaluated, including satisfaction of parent, student, and third-party payers and mental health professionals.
- Confidentiality of health information should be maintained as required by law.

State Activity

School-based mental health centers are typically developed and run by individual school districts utilizing funding from federal, state, and local resources. According to a study by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), while school districts operating school-based mental health clinics are found in nearly every state, only 17% of school districts currently operate them. However, the number of school districts with mental health clinics is continuing to grow, fueled

in part by state initiatives. States are exploring options for achieving permanence and expanding to other school districts by passing legislation that authorize school-based mental health clinics, facilitating agency collaboration through an interagency memorandum of understanding, or through an executive order from the governor establishing mental health authority within the state education departments. States are also exploring establishing additional state funding, requesting additional federal funds, or establishing legislative task forces to determine the best methods to fund a statewide program.

In 2007, **Connecticut** introduced a bill that would provide 2 million dollars to create and fund school-based mental health clinics in the state. In 2006, **California and Colorado** allocated state funding specifically for school-based mental health centers for the first time. **Illinois** passed a bill that allowed school health centers to be considered as primary care providers to allow for Medicaid and private insurance payment of providers.

Federal Activity

In February of 2007, the U.S. Senate introduced a bill that would provide direct federal funding in the form of grants to school-based health centers. Currently, many school districts in local communities throughout the United States are utilizing federal funding from already established sources to pay for mental health services in school settings. Using braided or blended federal funds such as Medicaid (Early and Periodic Screening, Detection and Treatment (EPSDT), State Children's Health Insurance Program (SCHIP), or Individuals with Disabilities Education Act (IDEA) to finance these services within schools, allows school districts to incorporate existing school funds with potentially untapped resources to create or expand mental health programs within their schools. See more about the potential use of braided or blended federal funds to subsidize children's mental health services in "How Children's Mental Health Services are Financed" in the AAP Mental Health Chapter Action Kit.

Suicide Prevention

Suicide is the third leading cause of death of children between the ages of 15-19. In recent years suicide rates have been declining, but according to statistics from the Centers for Disease Control and Prevention (CDC) published in the February 2007 issue of *Pediatrics*, adolescent suicide rates increased by 18% from 2003 to 2004, making it the only cause of death for children that increased in this period.

These alarming rates are even higher among one segment of the adolescent population. The AAP Clinical Report, "Sexual

Orientation and Adolescents"

(<http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics:113/6/1827>) notes that school-based studies have found that adolescents who self-identify as gay, lesbian, or bisexual are 2 to 7 times more likely to attempt suicide compared with heterosexual peers. The report also notes that these psychosocial problems and suicide attempts in nonheterosexual youth are neither universal nor attributable to homosexuality per se, but they are significantly associated with stigmatization of gender nonconformity, stress, violence, lack of support, dropping out of school, family problems, acquaintances' suicide attempts, homelessness, and substance abuse.

AAP Recommendations

The AAP Policy Statement "Suicide and Suicide Attempts in Adolescents"

(<http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics:105/4/871>) urges that the following provisions be included in state suicide prevention plans:

- Promoting school-based initiatives.
- Gatekeeper training for those who are able to observe high-risk behavior among youth.
- School-based suicide prevention programs that incorporate screening and suicide prevention information into health and human services.
- Crisis intervention services for schools and communities that provide a rapid response to tragic events.
- Establishing statewide crisis hotline and information for consultation and education services.
- Increasing access to and the coordination of mental health and substance abuse services.
- Reducing child and adolescent access to lethal means of self-harm, such as firearms.
- Forming public and private partnerships to raise community awareness.

Because of the higher rate of suicide attempts among gay, lesbian, and bisexual youth, the AAP Clinical Report, "Sexual Orientation and Adolescents" notes, "It is critical that schools find a way to create safe and supportive environments for students who are or wonder about being nonheterosexual or who have a parent or other family member who is nonheterosexual." In addition, the report encourages community advocacy by pediatricians to:

- Help raise awareness among school and community leaders of issues relevant to nonheterosexual youth.

- Help with the discussion of when and how factual materials about sexual orientation should be included in school curricula and in school and community libraries.
- Support the development and maintenance of school- and community-based support groups for nonheterosexual students and their friends and parents.
- Support HIV and AIDS prevention and education efforts.
- Develop and/or request continuing education opportunities for health care professionals related to issues of sexual orientation, nonheterosexual youth, and their families.

State Activity

Forty-three (43) states (including the **District of Columbia**) have suicide prevention plans, and 7 states have plans in development. **North Carolina** is the only state without a suicide prevention plan or without one in development. In addition to suicide prevention plans, **Tennessee** has introduced legislation requiring teachers to undergo suicide prevention training.

Federal Activity

The federal Garrett Lee Smith Memorial Act enacted in 2004, authorized \$82 million in federal spending for suicide prevention in fiscal years 2005, 2006, and 2007. Through the Substance Abuse and Mental Health Services Administration (SAMHSA), the law appropriates funding to assist states and educational institutions in establishing early intervention and detection programs for suicide prevention.

Psychotropic Medications

An estimated 4 million U.S. children have been identified as having attention deficit/hyperactivity disorder (ADHD), while 1% of children and 5% of adolescents have been diagnosed with depression. Within the past 20 years, advances in medication have allowed these conditions formerly treated with behavior modification therapy to be treated with drugs designed to regulate the brain's chemistry. Recent studies showing the increased threat of suicidal thoughts from the administration of antidepressants to children and adolescents, have cautioned physicians in the use of specific psychotropic medications in treatment of mental health disorders. A backlash from the perceived "over-prescription" of psychotropic medications for children with ADHD among some groups added to a public policy debate about the merits of psychotropic medication to treat ADHD and other mental health disorders in children. These controversies have the potential to stigmatize the use of psychotropic drugs, which have been proven to be safe and

effective in the treatment of mental health disorders, and may cause parents to become hesitant to administer these medications to their children.

AAP Recommendations

While the Academy supports the use of caution when prescribing antidepressant medications to children and adolescents, the Academy's main concern is to ensure access to the best therapies for children who suffer from mental disorders. The Academy has expressed concerns through communications with the Federal Drug Administration (FDA) that "black box" warnings may discourage pediatricians from prescribing needed medications to children and adolescents. The decision to prescribe medication to address depression or other mental health conditions in a child should be left up to the child's physician in consultation with the parents and the child.

Academy policy concerning treatment of ADHD outlined in "Clinical Practice Guideline: Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder," (<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/4/1033>) recommends that the treating clinicians work in conjunction with parents and teachers to target appropriate outcomes to guide the management of ADHD. It is important that school personnel not be subjected to a real or perceived "gag order" when discussing the presence and appropriate response to ADHD. While teachers should not be diagnosing ADHD in children, the teacher and other school personnel should work in conjunction with a child, their parents, and the child's medical home when a biological cause is suspected of hindering the child's academic performance or creating behavioral disturbances. Teachers and parents should both actively monitor target outcomes and adverse effects.

State Activity

State legislatures are using mandates directed at schools, state child custody systems, and child welfare services as a mechanism to limit access to psychotropic drugs. Two (2) states (**Connecticut** and **Utah**) have enacted laws that stipulate that failure or refusal to administer psychotropic medications to children does not warrant neglect or abuse. Seven (7) states (**Colorado, Delaware, Florida, Illinois, Minnesota, Texas, and Virginia**) have passed laws limiting nonmedical school personnel from recommending that a student be prescribed medications or place sanctions on a child whose parents refuse to administer psychotropic medications. Meanwhile, 2 states (**California** and **Illinois**) allow school personnel with medical training to recommend that a student be examined for ADHD and/or prescribed psychotropic medications to treat the

disorder. Nine (9) state legislatures (**California, Connecticut, Florida, Hawaii, Louisiana, North Carolina, New Mexico, Texas, and Washington**) have authorized studies monitoring the use of psychotropic medications to children in state custody. Five (5) states (**Delaware, Georgia, New Hampshire, North Carolina, and Virginia**) have established legislative committees/tasks forces to study the number of children within their states diagnosed with ADHD and/or administered medication. Two (2) state boards of education (**Colorado and Texas**) passed resolutions promoting the use of academic management to address behavioral problems rather than a psychiatric approach. Finally, **Indiana** requires all medical practitioners prescribing psychotropic medications to children to follow the AAP Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity while evaluating children for ADHD.

In 2007, **Utah** enacted legislation that would prohibit school personnel from recommending that a child be prescribed psychotropic drugs or prohibiting a child from a classroom based on a parent's refusal to administer psychotropic drugs. **California** enacted legislation that allows only a judicial court officer to make orders regarding the administration of psychotropic drugs. **Hawaii** passed legislation that prohibits the Department of Human Services from restricting coverage or access to psychotropic drugs.

Federal Activity

In 2004, the Federal Drug Administration (FDA) required all antidepressant medications to include a "black box" warning prominently displayed on the label providing information regarding potential medical complications associated with the drugs, including increase in suicidal thoughts and behaviors.

In early 2005, the FDA's Drug Safety and Risk Management Advisory Committee met and recommended that the FDA label certain stimulant prescription drugs for ADHD with a black box warning. However, a separate pediatric advisory committee rejected the call for a black box warning on ADHD medications and instead recommended adding more information to the labels for the benefit to the doctors, parents, and patients, providing parents with a medication guide that would tell parents to discuss with their doctors if their child experienced hallucinations, and alerting parents that ADHD medications can increase the risk for a heart attack and a stroke among people with undiagnosed heart problems.

Advocacy Considerations

- **Emphasize the Impact of Early Detection on a Child's Life.** Mental health disorders can have a negative impact of the quality of a child's life for years to come. If addressed early in childhood, the child will be less likely to exhibit poor school performance, less likely to commit crimes later in life, and will exhibit increased self-esteem and confidence that will allow them to become healthy, productive adults. (<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/860>)
- **Seek Pediatrician Appointment to State Mental Health Advisory Committee.** When considering mental health policy, state policy makers may overlook the role of the primary care provider. Pediatricians are often the first stop in diagnosing and developing a plan to treat mental health conditions, and therefore should become actively involved in formation of state health mental policy by working with their chapters to seek appointments to state advisory boards and committees.
- **Use Patient Stories to Illustrate Need for Change.** Individual stories, when utilized with appropriate confidentiality measures, can be the best tool for advocating changes to the current system. Policy makers are often swayed more by an individual case than statistics that point to the same conclusions. Identify a family with a poignant story who would agree to share their story with state officials through testimony. If the family would prefer not to testify, have them share their story through letters to or meetings with their legislator. Letters from children and adolescents affected by a mental health condition accompanied by a parent's letter are often the most effective advocacy tools.
- **Highlight Improved State Budgets as Opportunity to Improve Access to Health Care for Children.** Legislators are no longer facing the barren coffers within their state budgets that plagued them the early part of the decade. For the first time since 2000, almost all states are expecting a budget surplus. This presents an excellent opportunity to expand current and fund new children and adolescent mental health programs.

Resources

AAP Consensus Statement: Insurance Coverage of Mental Health and Substance Abuse Services for Children and Adolescents: A Consensus Statement
(<http://aappolicy.aappublications.org/cgi/content/full/pediatrics:106/4/860>)

AAP Policy Statement: Suicide and Suicide Attempts in Adolescents
(<http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics:105/4/871>)

AAP Policy Statement: Sexual Orientation in Adolescents
(<http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics:113/6/1827>)

AAP Policy Statement: School-Based Mental Health Services
(<http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics:113/6/1839>)

AAP Mental Health Task Force Chapter Action Kit: “Strategies to Improve Children’s Mental Health Financing”

Bazelon Center for Mental Health “Way to Go: School Success for Children with Mental Health Care Needs”
(<http://www.bazelon.org/newsroom/2006/6-7-6-WayToGo.html>)

National Conference of State Legislatures, “Table: Full Parity, Mandated Benefit and Mandated Offering State Laws”
(<http://www.ncsl.org/programs/health/Mentalben.htm>)

National Mental Health Association “What Have States Done to Ensure Parity”
(http://www.nmha.org/state/parity/state_parity.cfm)

NAMI Policy Institute Task Force Report, “Children and Psychotropic Medications”
(http://www.nami.org/Content/ContentGroups/CAAC/NAMIs_Report_on_Children_and_Psychotropic_Medications.htm)

The Robert Wood Johnson Foundation (RWJF) “Making the Grade: State and Local Partnerships to Establish School-Based Health Centers”
(<http://www.rwjf.org/reports/npreports/MakingGrade.htm>)

For more information on federal activities and advocacy, please contact: AAP Department of Federal Affairs at kids1st@aap.org or 202/347-8600 (<http://aap.grassroots.com/>)

NOTE: Issue briefs provide AAP chapters with an introduction to state government issues and additional background information that can be used when communicating with legislators or other public officials. While they are not intended as a presentation for, or to be distributed to, legislators, the media, or the general public, excerpts of nonstrategic information may be utilized in your advocacy work.

July 16, 2007