



**AMERICAN
PSYCHOLOGICAL
ASSOCIATION**
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**Written Testimony
of
Arthur C. Evans, Jr., PhD
Chief Executive Officer
American Psychological Association**

Putting Kids First: Addressing COVID-19's Impacts on Children

**Before the U.S. House of Representatives
House Committee on Energy and Committee
Subcommittee on Oversight and Investigations**

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Chairwoman DeGette, Ranking Member Griffith, and members of the Oversight and Investigations Subcommittee, thank you for the opportunity to testify today on the vital topic of the COVID-19 pandemic's impact on the behavioral health of our nation's children and adolescents. I am Dr. Arthur C. Evans, Jr., Chief Executive Officer and Executive Vice President of the American Psychological Association (APA). APA is the nation's largest scientific and professional organization representing the discipline and profession of psychology. APA has more than 122,000 members and affiliates who are clinicians, researchers, educators, consultants, and students. Through the application of psychological science and practice, our association's mission is to have a positive impact on critical societal issues.

APA appreciates the Subcommittee's interest in and attention to child and adolescent behavioral health, which comes at an especially critical time. With the nation struggling to move beyond the COVID-19 pandemic, many children and their families continue to experience mental health impacts from the pandemic, such as increased stress from loss of income and trauma from the loss of a loved one, as well as social disruptions. Many of our nation's youth—particularly

those who are too young to receive the vaccine, those who are immunocompromised due to a disability or other medical condition, and those from rural communities and communities of color—remain at heightened risk of contracting COVID-19 or experiencing severe illness, which compounds the impact of both the disease itself and its effects on mental health.

The heightened vulnerability of children to the mental health after-effects of a crisis is not a new phenomenon. Data gathered from past public health crises and natural disasters, such as the outbreak of AIDS¹ or the aftermath of a hurricane², consistently show that children experience more frequent and more intense levels of stress and anxiety post-crisis. These issues are exacerbated by our current behavioral health system, which relies largely on an “acute care” or “crisis care” model that waits for early symptoms of unmet behavioral health needs to escalate to a point of crisis and reach a diagnostic threshold before treatment is begun.

A population health perspective is central to moving the nation’s behavioral health system beyond the current pandemic. Longstanding systemic health and social inequities place people of color and other marginalized communities at increased risk of contracting COVID-19 or experiencing severe illness.³ While Congress’s historic investments in mental health and substance use treatment during COVID-19, as well as expanded access to new modalities of treatment such as telehealth, have been essential to meeting the increased demand for such services, the data show that continued investment is still necessary. For example, while many schools are eager to increase the mental health services they provide, the temporary nature of much of the pandemic-related funding limits their ability to do so on the long-term basis that is needed. Considering the many

¹ Gullone, E. & King, N. J. (1993) The Fears of Youth in the 1990s: Contemporary Normative Data, *The Journal of Genetic Psychology*, 154:2, 137-153, DOI: [10.1080/00221325.1993.9914728](https://doi.org/10.1080/00221325.1993.9914728).

² Burnham, J.J., et. al. (2008) Examining Children's Fears in the Aftermath of Hurricane Katrina, *Journal of Psychological Trauma*, 7:4, 253-275, DOI: [10.1080/19322880802492229](https://doi.org/10.1080/19322880802492229).

³ Louis-Jean, J., Cenat, K., Njoku, C. V., Angelo, J., & Sanon, D. (2020). Coronavirus (COVID-19) and Racial Disparities: a Perspective Analysis. *Journal of Racial and Ethnic Health Disparities*, 7(6), 1039–1045. <https://doi.org/10.1007/s40615-020-00879-4>

competing priorities that schools have, this budget uncertainty is a barrier for some school districts, especially those located in low-resource areas, to creating permanent positions for a full complement of school-based mental health providers, as well as hiring more teachers and providing necessary professional development for educators.

Similarly, many treatment systems hesitate to make necessary capital investments, especially as the emergence of the Delta variant has upended many initial plans on how federal relief funding would be spent. As state and local leaders plan for the future, ensuring a steady stream of funding from the federal government is critical. If we are to systematically reimagine the way we provide both physical and mental health care, our response cannot just be COVID-centric but must be sustainable, equitable, and forward-thinking.

My testimony today will outline evidence-based tools informed by psychological science that members of this Subcommittee can utilize in providing oversight of the federal response to COVID's impact on childhood and adolescent health, as well as the stewardship of taxpayer dollars. These include: (1) understanding the unique behavioral health challenges facing children and adolescents; (2) using a population health approach to ensure an effective and efficient national strategy for the behavioral health needs of children and adolescents; (3) connecting physical and behavioral health with evidence-based interventions; and (4) boosting school-based mental health services.

Unique Mental and Behavioral Health Challenges of Children and Adolescents

The COVID-19 pandemic is calling public and congressional attention to the large unmet behavioral health needs of children and adolescents that pre-dated COVID-19 and are being exacerbated by the pandemic. There exists a persistent gap between children who require mental

health treatment and those who receive it.⁴ Tragically, suicide rates among children aged 10 and older have climbed significantly each year since 2007, making suicide the second most common cause of death among adolescents before the pandemic.⁵

A growing body of evidence demonstrates that the mental health of children and youth continues to deteriorate in the current environment, including among those who did not previously exhibit symptoms of a behavioral health disorder.⁶ Social isolation, financial uncertainty, and disrupted routines place considerable stress on children and their families, significantly affecting their mental health and well-being, as demonstrated by disproportionate increases in the rates of suicide attempts and other forms of self-harm amongst children and youth—particularly among those from communities of color.

Minority stress and adverse experiences influence behavioral health within marginalized populations, such as those defined by gender, race and ethnicity, gender identity and sexual orientation, immigration status, disability, or chronic medical conditions. Behavioral health challenges in children and adolescents vary significantly by race and ethnicity, with higher rates of moderate and severe challenges among Hispanic and African Americans than among non-Hispanic Whites.⁷ In addition to the behavioral health burden experienced by racial/ethnic minority

⁴ Centers for Disease Control and Prevention. (August 21, 2020). Youth Risk Behavior Surveillance. Retrieved from: <https://www.cdc.gov/mmwr/volumes/69/su/pdfs/su6901-H.pdf>; Substance Abuse and Mental Health Services Administration (September 2020), Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFRPDFWHTML/2019NSDUHFR1PDFW090120.pdf>

⁵ Centers for Disease Control and Prevention. (2020). National Vital Statistics Reports. State Suicide Rates Among Adolescents and Young Adults Aged 10–24: United States, 2000–2018, <https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-11-508.pdf>.

⁶ 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: <http://dx.doi.org/10.15585/mmwr.mm6945a3>external icon; St. George, Donna & Strauss, V. (January 21, 2021). Partly hidden by isolation, many of the nation’s school children struggle with mental health. *The Washington Post*. Retrieved from: https://www.washingtonpost.com/local/education/student-mental-health-pandemic/2021/01/21/3d377bea-3f30-11eb-8db8-395dedaaa036_story.html.

⁷ Alegria, M., Green, J. G., McLaughlin, K. A., & Loder, S. (2015). Disparities in child and adolescent mental health and mental health services in the US. William T. Grant Foundation. <https://wtgrantfoundation.org/library/uploads/2015/09/Disparities-in-Child-and-Adolescent-Mental-Health.pdf>

children and adolescents, significant barriers exist in their access to and utilization of behavioral health services.⁸ LGBTQ youth face similar behavioral health disparities.⁹ Behavioral health disparities can occur for children with developmental and physical disabilities and chronic medical conditions due to discrimination, attitudinal and physical barriers, abuse and neglect, and lack of accessible and disability-sensitive services.¹⁰

The Centers for Disease Control and Prevention (CDC) data likewise indicate that between April and October of 2020, hospitals experienced a 24% increase in the proportion of mental health-related emergency department (ED) visits by children ages 5 to 11, as well as a 31% increase for adolescents ages 12 to 17. In a follow-up study, CDC found that, beginning in May 2020, ED visits for suicide attempts began to increase among adolescents ages 12 to 17, with visits 39% higher than during the same period in 2019.¹¹ With the ongoing spread of the Delta variant, these trends continue to stress our already-overworked systems to aid youth in crisis. A growing number of children are “boarded” in hospital EDs awaiting treatment because there are no alternative placement options. Exacerbated by shortages of mental health professionals across disciplines, there is insufficient capacity to provide the level of care needed and to support the more effective integration of services across the continuum.

⁸ Austin, A., & Wagner, E. F. (2010). Treatment attrition among racial and ethnic minority youth. *Journal of Social Work Practice in the Addictions*, 10, 63-80.

⁹ Cohn, T. J., & Leake, V. S. (2012). Affective distress among adolescents who endorse same-sex sexual attraction: Urban versus rural differences and the role of protective factors. *Journal of Gay & Lesbian Mental Health*, 16(4). 291-305; Eisenberg, M. E., & Resnick, M. D. (2006). Suicidality among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors. *Journal of Adolescent Health*, 39(5), 662-668; Mustanski, B., Garofalo, R., & Emerson, E. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health*, 100(12), 2426-2432.

¹⁰ American Psychological Association. (2011). Task Force on Guidelines for Assessment and Treatment of Persons with Disabilities. Guidelines for Assessment of and Interventions with Persons with Disabilities. <http://www.apa.org/pi/disability/resources/assessment-disabilities.aspx>.

¹¹ Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. *MMWR Morb Mortal Wkly Rep* 2021; 70:888–894. https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s_cid=mm7024e1_w; Science Friday (August 20, 2021), Pandemic Unveils Growing Suicide Crisis For Communities Of Color, <https://www.sciencefriday.com/segments/suicide-crisis-communities-of-color/>

Many of these phenomena are attributable to the fact that our traditional “acute care” model of mental health treatment simply does not work for children and adolescents. First, the mental health of a child is frequently tied to surrounding environmental structures and systems as well as familial dynamics—such as parents’ work demands, the health of the home environment, and the supportiveness of the school environment—that are often outside of the child’s control.

Second, even relatively small investments in children’s mental health early in their lives can have clear positive long-term effects. Most common disorders, including those with the greatest morbidity, have onset in childhood or adolescence.¹² Childhood and adolescence provide critical periods for prevention, early detection, and intervention to promote lifetime wellbeing. Rather than activate resources only when a child experiences a crisis, which may inhibit the long-term effectiveness of treatment, our behavioral health system must focus resources earlier in a child’s life and address the factors that led to the child experiencing a crisis in the first place.

Applying a Population Health Approach

The COVID-19 pandemic and the societal issues it has exacerbated clearly illustrate the limitations of the traditional mental health treatment model for children and adolescents. Epidemiological data suggests that at least 25% of the U.S. population has a diagnosable mental health disorder or severe mental illness and may receive at least some degree of treatment.¹³ The remaining 75% of the population who have not received a formal mental health diagnosis—but who may be experiencing subclinical or more minor symptoms of behavioral health needs—are

¹² Kessler, R.C. & Wang, P.S. (2008). The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annual Review of Public Health*, 29, 115-129.

¹³ Substance Abuse and Mental Health Services Administration (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Centers for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

virtually ignored by our behavioral health care system until they reach a point of crisis. (See Figure 1: Current U.S. Treatment Approach).

Data reveal that large proportions of the population experienced significant and persistent distress during the pandemic, including disturbances

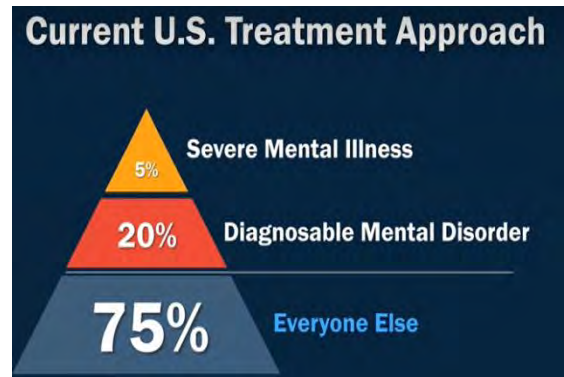


Figure 1: Current U.S. Treatment Approach

in sleep and eating, significant weight gain and increased substance use¹⁴. The CDC reports that this proportion of the population experiencing symptoms of depression and anxiety is now three to four times than the rate before the pandemic.¹⁵ Children and adolescents are not immune to this phenomenon, and ignoring children because they fall below an acute crisis threshold portends many missed opportunities for early intervention and prevention. In addition to their obvious wasting of human potential, these missed opportunities pose a real fiscal cost to society as a whole.¹⁶

Improving the health of the entire population requires an expansion of where we see interventions occurring across the entire continuum of behavioral health needs and how they are carried out. In contrast to the 25%/75% split described above, a population health perspective involves a multi-tiered approach, including: 1) effective and efficient clinical care for those experiencing behavioral health disorders; 2) mitigating the impact of risk factors for those individuals who have elevated risk for behavioral health disorders and intervening early if those

¹⁴ American Psychological Association. (2021). Stress in America: One Year Later, A New Wave of Pandemic Health Concerns. Washington, DC. <https://www.apa.org/news/press/releases/stress/2021/sia-pandemic-report.pdf>

¹⁵ Vahratian, A., Blumberg, S.J., Terlizzi, E.P., Schiller, J.S. (2021). Symptoms of anxiety or depressive disorder and use of mental health care among adults during the COVID-19 pandemic: United States, August 2020- February 2021. MMWR, 70(13), 490-494.

¹⁶ Conduct Problems Prevention Research Group. (2011). The effects of the Fast Track preventive intervention on the development of conduct disorder across childhood. Child Development, 82(1), 331-345.

efforts are not successful; and 3) providing tools and resources that promote wellness for those who are relatively healthy.¹⁷ (See Figure 2, Population Health Approach).

This perspective includes moving behavioral health beyond specialists in specific clinical settings and beyond healthcare itself, into the places where people live, work and play; away from a sole focus on treatment towards greater reliance on preventative “upstream” interventions; and into



Figure 2: Population Health Approach

communities that – when properly empowered – play a pivotal role in shaping solutions to their unique challenges.

In the next 12 months, the physical and mental health of our nation’s youth will depend heavily on maximizing vaccine uptake and engagement in other COVID-19 preventative behaviors among youth and their families. To address these needs, CDC awarded APA a \$2 million grant supplement to engage in a multitiered partnership that leverages psychological science to address COVID-19 priorities, including supporting informed vaccine decision-making and combatting misinformation. This partnership leverages behavioral science to address the largest public health crisis in a century, and the application of behavioral science will significantly advance several of CDC’s key priorities. In addition, APA is also partnering with CDC to produce educational materials for teachers on pandemic-related topics of resilience, working with communities, teaching and learning issues, school-family engagement, educational disparities, and the science of persuasion, as well as mental health-related topics, such as grief and trauma.

¹⁷ Evans AC, Bufka LF. The Critical Need for a Population Health Approach: Addressing the Nation’s Behavioral Health During the COVID-19 Pandemic and Beyond. *Prev Chronic Dis* 2020; 17:200261. DOI: <http://dx.doi.org/10.5888/pcd17.200261externalicon>

Connecting Physical and Behavioral Health with Evidence-Based Interventions

Physical and behavioral health are inextricably connected, and efforts to address physical health needs without adequate attention to co-occurring behavioral health conditions are less likely to be effective. This assertion is supported by three bodies of literature. First, there is a high level of comorbidity between physical and mental health disorders, with ample evidence illustrating that the presence of a mental health disorder is a significant risk factor for the onset of a physical health disorder, and vice versa.¹⁸

Second, compromised behavioral health is a significant determinant of overall health behavior and health decision-making, such as adherence to medical regimens. Emerging evidence suggests that psychological factors also substantially explain an individual's degree of compliance with COVID-19 mitigation behavior such as social distancing and vaccination. Third, psychological factors—including, but not limited to, social stress, poor sleep quality, and interpersonal conflict—substantially influence the immune system, with potentially dire physical health outcomes, such as inflammatory disease, viral infection, and health morbidity and mortality.^{19, 20} Attempts to improve children's physical health outcomes must therefore attend to their co-occurring behavioral health needs to maximize the likelihood of a successful intervention.

As children return to school environments with elevated stress levels due to the pandemic, parents and school systems alike can utilize strategies based in psychological science to help manage that stress and simultaneously address students' physical and mental health needs, whether students continue learning in a virtual environment or return to campus-based education. For

¹⁸ Australian Institute of Health and Welfare, 2007 (2012). Comorbidity of mental disorders and physical conditions, Cat. no. PHE 155. Canberra: AIHW, <https://www.aihw.gov.au/getmedia/05a9c315-7576-4c3f-aa2a9ccb14964c3e/10953.pdf>

¹⁹ Cohen, S. (2021). Psychosocial vulnerabilities to upper respiratory infectious illness: Implications for susceptibility to coronavirus disease 2019 (COVID-19). *Perspectives on Psychological Science*, 16(1), 161–174. <https://doi.org/10.1177/1745691620942516>

²⁰ Slavich, G. M., & Cole, S. W. (2013). The emerging field of human social genomics. *Clinical Psychological Science*, 1(3), 331–348. <https://doi.org/10.1177/2167702613478594>

example, school systems can train educators and support staff in using evidence-based, culturally appropriate trauma-informed practices for teaching and learning, which recognize adverse childhood experiences (ACEs) as well as their impact on a child's health and development. These are often deployed as trauma-informed approaches to managing student behavior, as well as mental health screenings and follow-up protocols administered by qualified mental health personnel.

Fortunately, members of this subcommittee have supported additional funds for research programs when it appeared the need was greatest. The 21st Century Cures legislation, for example, included a significant boost in funding for National Institutes of Health (NIH) research, and we anticipate the upcoming CURES 2.0 bill drafted under the leadership of Chair DeGette will shape the new NIH Advanced Research Projects Agency for Health (ARPA-H) agency. Research on children's mental health is urgently needed as we see how the pandemic has uniquely and disproportionately affected children. Scientific research is our best tool for improving public health and educational systems to help children overcome the challenges of the pandemic, and preparedness for subsequent crises.

Regrettably, funding for mental health research has not seen the same boost that other areas of science have enjoyed. While the National Institute of Mental Health and National Institute of Child Health and Human Development are currently funding an initiative on COVID-related impacts of school closing and lockdown issues, a larger effort is needed. We encourage Committee members to support funds to NIH specifically for research on mental health and substance use. H.R.1716, the COVID Mental Health Research Act, could advance research on topics including: (1) Population health research to develop primary prevention programs in emotional regulation, social relationships, mindfulness, and scientific literacy to misinformation; (2) Research on large

scale, electronic-based delivery of evidence based psychosocial treatment for youth; (3) Suicide prevention research; and (4) Training support, especially for more scientists of color.

Emphasizing the Value of School-Based Mental Health Services

Students across the nation spent the last year grappling with the fallout of a global pandemic and a national reckoning on race.²¹ Parents report higher-than-normal levels of behavioral issues in their young children,²² and teens are experiencing elevated stress, anxiety, and symptoms of depression.²³ Many school-age children have had to cope with social isolation, loneliness, and struggles with family financial insecurity. Others have faced unthinkable loss and severe trauma.²⁴ Many youths are turning to social media to retain a sense of connection to their peers and communities. While the current data suggest that the length of time children participate on social media may not be associated with deleterious outcomes, emerging research suggests that the capacity to influence youth towards maladaptive behavior is often greater online, and some patterns of social media use of have been associated with engagement in unhealthy behaviors, such as anorexia or self-cutting, and mental health challenges, like depression.

The impact of the pandemic on children and youth from traditionally underserved populations, including communities of color, appears to be more severe.²⁵ Even before the

²¹ 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: [http://dx.doi.org/10.15585/mmwr.mm6945a3external icon](http://dx.doi.org/10.15585/mmwr.mm6945a3external%20icon); Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., Linney, C., McManus, M. N., Borwick, C., & Crawley, E. (2020). Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19. *Journal of the American Academy of Child and Adolescent Psychiatry*, 59(11), 1218–1239.e3. <https://doi.org/10.1016/j.jaac.2020.05.009>.

²² Barnett, W.S., & Jung, K. (2021). Seven Impacts of the Pandemic on Young Children and their Parents: Initial Findings from NIEER’s December 2020 Preschool Learning Activities Survey. New Brunswick, NJ: National Institute for Early Education Research. Retrieved from: https://nieer.org/wp-content/uploads/2021/02/NIEER_Seven_Impacts_of_the_Pandemic_on_Young_Children_and_their_Parents.pdf.

²³ American Psychological Association. (2020). Stress in America 2020: Stress in the Time of COVID-19. Retrieved from <https://www.apa.org/news/press/releases/stress/2020/report-october>.

²⁴ Kidman R, Margolis R, Smith-Greenaway E, Verdery AM. Estimates and Projections of COVID-19 and Parental Death in the US. *JAMA Pediatr*. Published online April 05, 2021. doi:10.1001/jamapediatrics.2021.0161.

²⁵ Government Accountability Office. (2020). Distance Learning: Challenges Providing Services to K-12 English Learners and Students with Disabilities during COVID-19. Retrieved from: <https://www.gao.gov/products/GAO-21-43>; Harvard Medical

pandemic, these children were at a higher risk of depression and substance misuse, while also having less access to behavioral health services.²⁶

These are the experiences that students will bring with them as they return to in-person instruction, which will affect their ability to meaningfully engage in learning.²⁷ Untreated mental health issues make it more difficult for students to learn and are highly correlated with chronic absenteeism, school failure, and school dropout, which can lead to possible underemployment, financial instability, or involvement with the juvenile and/or criminal justice system.²⁸ This spring, the Department of Education included APA recommendations on addressing the social, emotional, mental health, and academic impacts of the pandemic on students, educators, and staff in its COVID-19 reopening guidelines.²⁹ APA further recommends that Congress, through its oversight capacity, encourage stronger collaboration and partnerships between the Department of Education, the Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration. This must extend to any data collection efforts as it pertains to the impacts of COVID-19 on children and adolescents' behavioral health and emotional well-being.

In many communities, schools are an essential—and often the only—source of meeting the physical and mental health needs of students and families. Many school districts leverage Medicaid funds to stretch scarce resources and create school-based mental health programs. However,

School Center for Primary Care. (August 2020). LGBTQ Youth Face Unique Challenges Amidst COVID-19. Retrieved from: <http://info.primarycare.hms.harvard.edu/blog/lgbtq-youth-challenges-covid-19>.

²⁶ Agency for Healthcare Research and Quality. (2017). 2017 National Healthcare Quality and Disparities Report. Retrieved from: <https://www.ahrq.gov/research/findings/nhqdr/nhqdr17/index.html>; Irwin, C. E., Jr, Adams, S. H., Park, M. J., & Newacheck, P. W. (2009). Preventive care for adolescents: Few get visits and fewer get services. *Pediatrics*, 123(4), e565-72. doi:10.1542/peds.2008-2601.

²⁷ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, CDC-Kaiser ACE Study, H.R. Rep. (June 4, 2016). Retrieved from <https://www.cdc.gov/violenceprevention/acestudy/about.html>.

²⁸ Sacks, V., & Murphey, D. (2018). The prevalence of adverse childhood experiences, nationally, by state, and by race/ethnicity. Bethesda, MD: Child Trends; National Collaborative on Education and Health. (2015). Brief on chronic absenteeism and school health. Chicago, IL: Healthy Schools Campaign.

²⁹ U.S. Department of Education. (April 2021). COVID-19 Handbook, Volume 2: Roadmap to Reopening Safely and Meeting All Students' Needs. Retrieved from: <https://www2.ed.gov/documents/coronavirus/reopening-2.pdf>.

shortages of school-based behavioral health professionals continue to persist. While the recommended ratio of school psychologists is 1 for every 500 students, the current national ratio is approximately 1 school psychologist for every 1,400 students.³⁰ Other school-based mental health professionals, such as school counselors and social workers, face similar shortages. Schools—especially those that are under-resourced and serve high numbers of low-income students and students of color—must receive more support to address these needs by increasing and retaining an adequate workforce of diverse, culturally competent school-based mental health professionals to provide accessible services.

Accordingly, APA recommends enacting the Increasing Access to Mental Health in Schools Act (H.R. 3572), which supports partnerships between institutions of higher education and local education agencies to increase the number of school-based mental health professionals, as well as the Mental Health Professionals Workforce Shortage Loan Repayment Act (H.R. 3150), which authorizes a student loan repayment program to increase mental and behavioral health professionals, including in schools and community health centers. In addition, we urge Congress to fund an additional \$1 billion for school-based mental health providers, as included in the House-passed FY 2022 Labor-HHS-Education Appropriations bill.

As educators, administrators, and policymakers work to mitigate the impacts of unprecedented levels of learning loss,³¹ improving the behavioral health and emotional well-being of all students is a critical component of achieving that goal.³² This includes instituting

³⁰ National Association of School Psychologists. (2017). Shortages in school psychology: Challenges to meeting the growing needs of U.S. students and schools. Retrieved from: <https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-psychology/shortages-in-school-psychology-resource-guide>.

³¹ McKinsey & Company. (December 8, 2020). COVID-19 and learning loss—disparities grow and students need help. Retrieved from: <https://www.mckinsey.com/industries/public-and-social-sector/our-insights/covid-19-and-learning-loss-disparities-grow-and-students-need-help>.

³² American Psychological Association. (2020). Recommendations on Starting School During the COVID-19 Pandemic. Retrieved from: <https://www.apa.org/ed/schools/teaching-learning/recommendations-starting-school-covid-19.pdf>.

comprehensive behavioral health systems in schools to reduce the frequency and severity of mental health and substance use disorders among students. This holistic approach provides a full complement of supports and services that establish multi-tier interventions, and promote positive school climates, social and emotional learning practices, and overall mental health and well-being. They are built on collaborations between students, families, community health partners, school districts, and school professionals, such as administrators, educators, and specialized instructional support personnel, including school psychologists.

Comprehensive school-based behavioral health services are critical to effective teaching and learning. Integrating evidence-based, culturally competent social and emotional learning programs and trauma-informed approaches to teaching and student well-being, throughout all aspects of the school ecosystem, help foster positive school climates and develop skills such as motivation and engagement, problem-solving, emotional intelligence, resilience, agency, and relationship building.³³ An interactive approach to academic achievement, instruction, and social and emotional learning will help ensure that all children, including some of the most vulnerable, receive a more equitable and higher quality public education.³⁴

Such universal programs also help address student behavioral challenges by implementing positive, non-punitive, restorative measures rather than retributive and exclusionary practices. In the aftermath of a crisis, it is not unusual to see students exhibiting what would typically be considered behavioral concerns. Data show that increased school-based mental health services, along with evidence-based training and ongoing professional development for educators on social

³³ American Psychological Association, Coalition for Psychology in Schools and Education. (2015). Top 20 principles from psychology for preK–12 teaching and learning. Retrieved from <https://www.apa.org/ed/schools/teaching-learning/top-twenty-principles.pdf>.

³⁴ American Psychological Association. (2020). Dynamics of Learning. Retrieved from: http://d3dkdvqff0zqx.cloudfront.net/groups/apaadvocacy/attachments/apx_dynamics-of-learning_200707_v2.pdf.

and emotional learning practices and positive discipline methods, improves students' educational outcomes and reduces the risk of suspension and expulsion.³⁵

Moving forward, there will be a greater need for educators and other school staff to understand how to work with students who have experienced a traumatic event. Without training, educators may inadvertently exacerbate students' trauma, rather than provide appropriate support. To help accomplish this, APA recommends enacting the Comprehensive Mental Health in Schools Pilot Program Act (H.R. 3549), which provides resources for low-income schools to develop a holistic approach to student well-being by building, implementing, and evaluating comprehensive school-based mental health programs. This bill includes training for educators and other school staff to integrate social and emotional learning and evidence-based, trauma-informed practices into all aspects of school environments.

Furthermore, as the third-largest stream of federal funding for school-based health care services, Medicaid is a critical mechanism for meeting many of these needs among our most vulnerable students. It broadens access to physical and mental health care available through school-based health centers. School districts can use Medicaid reimbursement to fund health professionals and specialized instructional support personnel (e.g., school psychologists),³⁶ purchase and update specialized equipment, and connect eligible students with providers outside of school settings.³⁷ It covers a broad range of medically necessary services for children, including

³⁵ Reyes, C., & Gilliam, W. (2021). Addressing challenging behaviors in challenging environments: Findings from Ohio's early childhood mental health consultation system. *Development and Psychopathology*, 33(2), 634-646. doi:10.1017/S0954579420001790.

³⁶ Pudelski, S. (2017). "Cutting Medicaid: A Prescription to Hurt the Neediest Kids." AASA, The School Superintendent's Association Retrieved from:

https://www.aasa.org/uploadedFiles/Policy_and_Advocacy/Resources/CuttingMedicaid2018Addendum.pdf.

³⁷ Centers for Medicare and Medicaid Services. (2003). "Medicaid school-based administrative claiming guide." Retrieved from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf>.

certain screening, diagnosis, and treatment services.³⁸ Medicaid can also be used to pay for services described in a Medicaid-enrolled student's individual education plan (IEP) under the Individuals with Disabilities in Education Act.

To meet the growing need for physical and behavioral health services, including in schools, APA supports increasing the Medicaid Federal Medical Assistance Percentages (FMAP), as well as updating CMS' guides on Medicaid in schools to ensure that Medicaid reimbursement can be utilized for school-based physical and behavioral health care. In addition, we oppose restriction of Medicaid payments to schools for necessary services and the implementation of per-capita caps or block grant funding for Medicaid. Finally, we support the Committee's efforts to permanently extend the Children's Health Insurance Program (CHIP).

As we work together on these critical issues, we must also not force schools, families, and communities into a false choice between their children's education and mental well-being and their physical health and safety. Ideally, all students should be in physical classrooms with their teachers and peers. We can and should be doing everything possible to reopen schools safely, adhering to proven public health measures, while also providing students and families with virtual learning options in the event they become necessary. Federal, state, and local governments should be working in concert to ensure that all children receive continued access to equitable education and needed support services, while also staying mentally and physically healthy.

In summary, APA asks Congress to acknowledge the long-term impact of the COVID-19 pandemic on children's behavioral health and acknowledge how the nation's current approach to and infrastructure for behavioral health is failing to meet the critical needs of our children – this was true before the pandemic while the need has only increased. APA and its membership stand

³⁸ MACPAC: Medicaid and CHIP Payment and Access Commission. (April 2018). Medicaid in Schools Issue Brief. Retrieved from: <https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf>.

ready to assist the Subcommittee with improving the health, safety and prosperity of children and adolescents in our nation.

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Advocating for APA members and psychology

750 First Street, NE

Washington, DC 20002-4242

202.336.5800

202.336.6123 TDD