

Examining Our COVID-19 Response: Using Lessons Learned  
to Address Mental Health and Substance Use Disorders

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Written Testimony of  
Tami D. Benton, MD

Psychiatrist-in-Chief  
Executive Director and Chair  
Department of Child and Adolescent Psychiatry and Behavioral Sciences  
Children's Hospital of Philadelphia

Associate Professor of Psychiatry  
Perelman School of Medicine  
University of Pennsylvania

Chair Murray, Ranking Member Burr, and Members of the Committee:

My name is Dr. Tami Benton. I am Psychiatrist-in-Chief and Chair of the Department of Child and Adolescent Psychiatry and Behavioral Sciences at Children’s Hospital of Philadelphia (CHOP) and the Frederick Allen Professor of Psychiatry at the Perelman School of Medicine at the University of Pennsylvania. I also serve as director of the Child and Adolescent Mood Program and the Youth Suicide Center at CHOP, a multidisciplinary clinical and research program focused on depression and suicide among children and adolescents, with an emphasis upon minority youth. Thank you for the opportunity to testify today about the effects the COVID-19 pandemic has had on the mental health of our children and youth.

Children's Hospital of Philadelphia (CHOP) was founded in 1855 as the nation's first pediatric hospital. Through its long-standing commitment to providing exceptional patient care, training new generations of pediatric healthcare professionals, and pioneering major research initiatives, Children's Hospital has fostered many discoveries that have benefited children worldwide. Its pediatric research program is among the largest in the country. In addition, its unique family-centered care and public service programs have brought the 595-bed hospital recognition as a leading advocate for children and adolescents.

The Department of Child and Adolescent Psychiatry and Behavioral Sciences at CHOP provides emotional and behavioral health services for infants, children and teens. Our experts conduct thorough evaluations with all patients and use a biopsychosocial model to identify biological, environmental, psychological and academic factors that contribute to a child's condition. We focus on the experience of your whole family by involving everyone in the evaluation process and care planning, and conduct research focusing on all aspects of mental, emotional and behavioral health, including efforts focused on preventing a child with elevated symptoms moving into crisis.

There were extreme shortages in pediatric behavioral health prior to the pandemic and access to care was further complicated by high demand and complicated payor networks. It is estimated that 1 in 6 U.S. children between ages 2-8 years have a diagnosed mental, behavioral or developmental disorder.<sup>1</sup> Unfortunately, COVID-19 has exacerbated the mental health stress on children and youth, highlighting the nation’s acute shortage of mental health services and the need to reinforce and expand the pediatric mental health delivery system and infrastructure. According to a November 2020 report by the CDC, between March and October

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<sup>1</sup> Cree RA, Bitsko RH, Robinson LR, Holbrook JR, Danielson ML, Smith DS, Kaminski JW, Kenney MK, Peacock G. Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years — United States, 2016. *MMWR*, 2018;67(5):1377-1383.

2020, the number of mental health visits for adolescents ages 12 to 17 was 31% higher than over the same period in 2019; for children ages 5 to 11, it was up 24%.

The pandemic also has highlighted significant disparities related to access to mental health services, particularly in underserved communities. Studies show the limitations of the current system is affecting all children, but minority children, particularly Black and Hispanic children often face inequitable access to and continuity of care. As a result, these children are more likely to present in the emergency rooms for mental health issues and less likely to access child and adolescent psychiatrists and other mental health professionals in the community.

Emerging data about long term impacts of the pandemic on children's mental health suggest that we will continue to see the heightened impact on youth mental health for some time. Like other children's hospitals, CHOP is seeing increasing numbers of children and families coming to the emergency department (ED) in crisis. Our psychiatric emergency visits have increased by 60% over the last few years. Since the onset of the pandemic, more than 30% of our ED visits are resulting in hospitalizations for psychiatric treatment. When the pandemic struck, we initially saw an overall decline in emergency department visits due to COVID-related restrictions, but we are now seeing a surge of children and adolescents coming to the ED. These patients come to us at a greater level of acuity, requiring more immediate, intensive treatments as well as hospitalizations. Those impacted the most have been youth with autism and other neurodevelopmental disabilities, as well as those with depression, anxiety and eating disorders.

Many of the children that we are seeing were managing well in their communities before the pandemic, receiving care in their local mental health agencies, schools and primary care offices but are now presenting for emergency care due to worsening symptoms. We are also seeing some shifts in the ages of young people who are seeking mental health treatment. More children between the ages of 6-12 years are complaining of severe anxiety, depression and suicidal feelings. We are also starting to see large numbers of children and adolescents who had no prior mental health concerns showing up in the emergency department in larger numbers due to disruptive behaviors, anxiety, depression, suicidality and eating disorders. Families who were resilient and effective before the pandemic are struggling to manage children's emotions while facing remote learning, work-related changes and their own emotions during these times.

Even before COVID, the shortage of options, particularly across the continuum of care, were staggeringly limited. It is, in fact, hard to overstate this concern. One clear indicator is that we and other children's hospitals nationwide often are forced to send children covered by Medicaid several states away so they can access

appropriate care not available closer to home. Needless to say, this separation from family, community and regular health care providers is inadvisable.

The increased stress experienced by families during the pandemic occurred at the same time that mental health services became more limited because of COVID-related restrictions on access to hospitals and primary care clinics. Requirements for social distancing, as well as COVID outbreaks among staff and children in these facilities, reduced capacity even further. These challenges increased the demand for emergency and crisis services such as inpatient psychiatric settings as lower levels of care were unavailable, even to those children for whom another setting would have been more appropriate.

One important but unforeseen outcome has been that children with mental health concerns are being admitted to pediatric medical facilities while awaiting psychiatric inpatient care and treatment. This is not only contrary to the treatment for that child but also nearly always means they are in a bed that that a sicker child needs. If the system were not overloaded, specifically designated crisis centers would provide evaluation and placements for children and youth in mental health crisis. Now, families turning to these centers can find themselves waiting, sometimes for days, to have any assessment, let alone an appropriate care placement. Many of these families understandably go to the ED instead. As a result, at CHOP, where 95% of the behavioral health care is provided in outpatient settings, we have up to 50 patients waiting for mental health beds on any given day. As we typically operate at capacity, this means that we cannot use that space for a child with more complex medical needs.

To address this, we are in the process of expanding our services in the hospital and our community. Even doubling our outpatient capacity, partnering with other providers to address the full continuum of needs and looking into establishing in-patient capacity, does not fully meet the demand for care. While not the primary problem, regulatory hurdles, including the restrictions on the colocation of adult and pediatric services make it difficult to collaborate with other providers to use existing space to meet the ever-growing needs of our community.

### **Recommendations**

The good news is that there have been lessons learned during the pandemic that will help advance children's mental health care going forward. We recommended retaining those things that have effectively supported access to care, while addressing other issues that have been long-standing.

First, care provided in communities through schools and primary care clinics provides the opportunity for early identification and intervention for children and families with mental health challenges at the right level and at the right time. We must invest in care in these settings as the continuity of relationships between children, families, care providers and educators helps address mental health challenges before they become crises. Effective families and effective schools are two of the most important elements for building resilience, prevention of poor mental health outcomes and promotion of effective, psychologically healthy children.

Second, we strongly recommend making permanent the telehealth flexibilities allowed during the pandemic, particularly those that would allow providers, including Medicaid providers, to care for patients across state lines. Bills like the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act, which would provide temporary licensing reciprocity for health care professionals for any type of services provided to a patient located in another state during the COVID-19 pandemic, can help us serve patients wherever they are located, and we encourage Congress to pass that legislation.

Telehealth has significantly advanced our ability to reach more patients and to engage them in treatment. CHOP providers have completed more than 238,000 telehealth video visits with over 108,000 unique patients since the onset of the pandemic. The departments utilizing telehealth most frequently are general pediatrics (46,000 visits) and behavioral health (44,000 visits). Through telehealth, patients have been able to receive care in their homes, preventing the travel time and costs. While in-person visits are still required, the expansion of telehealth services has enabled us to reach more youth and families, made it easier for them to participate in care, expanded our reach to vulnerable underserved populations and increased families' abilities to keep their appointments, which, in turn, helps us maximize the limited resource that is mental health service providers.

Telehealth has been a boon in other ways. Notably, it has allowed increased family engagement and participation, empowering and supporting families to be able to support their children's emotional health. Clinicians can also provide expertise for areas of severe shortages by consulting with community clinicians via telehealth as well as school psychologists and counselors. Areas with severe shortages of mental health clinicians can utilize consultations with clinicians in areas where there are more providers with appropriate expertise, if we can ensure that there is broadband access for rural and other underserved areas to make such collaboration accessible.

Behavioral telehealth provides so many advantages to children, families and providers that it should be a not only permitted but required in Medicaid programs. Also, to allow for appropriate sharing of health information between school psychologists and a student's external health team and thereby maximize coordination among

caregivers, educators and families, it will also be important to harmonize the education and health care privacy standards.<sup>2</sup>

Third, we must address workforce challenges. According to the American Psychiatric Association, there are an estimated 15 million children and adolescents nationwide in need of care from mental health professionals. However, there are just 8,000 to 9,000 psychiatrists treating children and teenagers in the United States, and shortages abound across other pediatric mental health professionals as well. There are severe shortages of child and adolescent psychiatrists, impacting care for youth with the highest levels of need. But there are also shortages of mental health therapists, nurse practitioners, case managers and community mental health workers who are all needed to expand access to mental health care. All of these professions could benefit from loan forgiveness programs to incentivize participation in these fields.

But efforts to strengthen the pediatric behavioral health workforce must go beyond attracting new mental health providers at all levels to include cross-training current providers. Improvements could include broadening the skills of the primary care workforce, ensuring school psychologists use evidence-based techniques, properly training psych techs and psychiatric nurses, as well as adding many more licensed clinical social workers to the workforce.

Finally, we must advocate for changes to payment structures that support the full continuum of care necessary to address the mental, emotional and behavioral distress our children face. Getting this right will mean children receive the care they need at the appropriate level, maximizing the likely success of the treatment, ensuring that they are taking a higher acuity spot desperately needed by another child, and more wisely spending health care dollars.

Greater payment parity in Medicaid for mental, emotional and behavioral health services, would make it possible to resource the continuum of care our children and youth need, such as intensive outpatient, partial hospitalization and limited residential treatment facilities—and, importantly, bring that care closer to home.

An investment in earlier treatment is also needed. In particular, we must continue to improve access to care in the community through schools and primary care in order to identify mental and behavioral health problems early, before crises emerge. If we prevent a crisis, we not only improve the health of our nation's children, but also decrease unnecessary utilization of costly services.

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<sup>2</sup> The Health Insurance Portability and Accountability Act (HIPAA) and the Family Education Rights and Privacy Act (FERPA) have differing privacy standards, limiting information sharing and creating barriers to care.

Improvements in these areas would improve the care of our nation's children, empower families and schools to promote the emotional health of our children, provide the right level of care to those in need, and reduce unnecessary utilization of costly emergency and hospital services.

Children throughout America are in crisis. Unlike many physical illnesses, mental health illnesses are not often visible to the untrained eye. While conversation about mental health is becoming more comfortable, there are still many children and their families who need help but choose to stay silent for fear of embarrassment. By elevating the dialogue here, in Congress, and providing the resources they need, you can help us treat these children and provide them with a pathway towards resilience and happiness.