November 5, 2021

Response to Additional Questions for the Record Subcommittee on Oversight and Investigations Hearing on "Putting Kids First: Addressing COVID-19's Impacts on Children" September 22, 2021

Arthur C. Evans, Jr., PhD, Chief Executive Officer, American Psychological Association

Questions: The Honorable Scott H. Peters (D-CA)

1. It is clear that the covid pandemic has been harmful to the mental health of children for a variety of reasons, but even more so for foster children, who often have higher need for mental health services. As a result of the pandemic, mental health appointments, placement appointments, and other in-person activities were suspended or delayed, disrupting the routines of these vulnerable children. Across the country, including in my district in San Diego County, qualified residential treatment program (QRTP) facilities currently provide placement, educational, and supportive services, including mental health treatment, to youth experiencing foster care. QRTPs with more than 16 beds will soon be deemed to be "institutions of mental disorders" (IMDs) by the Centers for Medicare and Medicaid Services. This means congregate foster care facilities will be unable to receive Medicaid funding to care for these children. Can you talk about whether you agree with CMS that QRTPs are not IMDs in practice?

The question of sufficient and sustainable funding for congregate foster care facilities is an important one. In short, it matters less where the funding comes from, and more what regulations and restrictions are in place around how the money is spent. Depending on the source, funding sometimes comes with strings attached that are overly rigid or, equally as problematic, lacking any guidance. Proper funding regulations need to be in place to ensure money is spent on the highest quality services that are both culturally appropriate and informed by the best science to get the best possible outcomes for children. If these congregate foster care facilities are no longer being funded by CMS, we need to make sure that there is adequate and immediate funding to continue supporting the services these facilities provide. The current lack of standardized expectations for residential care programs is problematic. Moreover, we know that approaches outside of residential care – like involving the child's family (e.g., through multisystemic family therapy – are important in explaining children's variable outcomes.

There is robust behavioral science and psychological research that speak to the connection between characteristics and quality of residential care and children's variable outcomes, as well as children's differential susceptibility to environmental factors and social determinants of health. The existing literature on residential care makes clear that certain factors foster a more therapeutic environment and thus, are associated with better outcomes for children in these settings. One is the inclusion of behavioral approaches to care. For instance, using a "token economy" system to reinforce desired behaviors and dissuade undesired behaviors has been effective among pre-delinquent youth in residential care and children in foster care settings.

Another factor is the inclusion of evidence-based behavioral health approaches to care, which stresses the importance of infusing approaches into residential foster care settings that consider the 'whole child' (i.e., both individual *and* environmental effects on health and wellbeing). The literature suggests that numerous factors impact the effectiveness of implementing these types of behavioral health approaches, such as the ratio of staff to children, availability of wraparound care, and adequate funding. A third important factor is the inclusion of non-behavioral components of care. Currently, many residential foster care settings are grossly understaffed and rely primarily on medication management. These settings are in dire need of funding to support the training of staff and the use of evidence-based approaches, such as Trauma-focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT uses the science on trauma to ensure posttraumatic growth and improve emotion regulation in children, and has been shown to be effective among diverse youth, including those in foster care and those who have experienced parental abuse or neglect.

Additionally, we must consider the broader environmental factors affecting children's behavioral health and how these are addressed in residential care settings or using other approaches. Many of these factors – such as a lack of adequate services in the community and social stigma – existed long before the pandemic's arrival. Psychological research consistently demonstrates that the behavioral health of children is closely tied to the health of their surroundings, including their homes, schools, and neighborhoods, such that if traumatic events occur in these settings, they frequently have a downstream impact on children's wellbeing. The stakes of untreated behavioral health challenges are especially great for children and adolescents, with the potential for adverse outcomes to compound over time and negatively impact the overall trajectory of their development. This includes a greater likelihood of learning difficulties, substance use, unemployment, and involvement with the criminal justice system later in life.

Many children living in foster care come from unstable families, have been abused, neglected, or experienced other trauma, and as a result, are more likely to have mental health problems. Yet the pandemic lessened detection of child abuse or mistreatment. Traditionally, schools—where teachers and other school-based professionals, including mental health providers, are trained to spot warning signs—have served as safe spaces for children living in abusive homes. COVID-19 took away several systemic safety nets for millions of Americans and with child abuse reports, investigations, substantiated allegations, and interventions declining. Moreover, there has been increased exposure to trauma among kids living in unsafe home environments over the past 18 months.

Building a comprehensive system for early screening and intervention, as well as addressing social determinants of health, requires a coordinated response from multiple governmental entities, agencies, and departments. APA has recommended stronger collaboration and partnerships—including coordination of ongoing data collection efforts on the impact of COVID-19 on the behavioral health of children—between the Department of Education, the Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration.

2. Dr. Evans, I'm curious about the impact on distance learning and the increased social isolation seen in the pandemic has had on mental health in children and adolescents. It seems that some of the stressors typically seen in school aged children, like bullying and social comparison, may be lessened in distance learning. However, numerous new stressors have obviously taken hold, such as fear of the virus, illness,

grief, and lack of social interactions which may harm development. Could you speak as to trends you're seeing in mental illness among children and adolescents in the times of covid?

Although we have still not seen the full extent of the pandemic's impact on children, current data suggest increased levels of behavioral health challenges, such as anxiety, depression, and suicidal ideation among children with and without a pre-existing behavioral health diagnosis. Social isolation, financial uncertainty, and disrupted routines have placed considerable stress on children and their families, which both directly and indirectly affect children's mental health and well-being. Many children have experienced significant traumatic events, such as the loss of a parent, caregiver or loved one and exposure to maltreatment or abuse, that can undermine their sense of safety and stability. Data also illustrate that these impacts disproportionately affect traditionally vulnerable populations, including children of color, LGBTQ+ youth, and those with physical or developmental disabilities.

In March 2020, schools had little choice but to pivot to a virtual learning environment. This was a critical move to ensure that children were physically safe, given how much we did not know about the transmissibility of the virus. Despite some of the demonstrated shortcomings of distance learning in meeting children's diverse needs (e.g., less peer interaction, lack of necessary equipment and/or internet access for those in low-income and rural communities, differential levels of caregiver support and availability, etc.), this approach was essential to protect children's physical health in the midst of a pandemic.

Since then, we have learned and adopted necessary safety and mitigation protocols, making safe in-person learning possible and reducing the acute pressure of the distance learning shortcomings noted above. However, this experience with distance learning should open our nation's eyes to the fact that some characteristics of distance learning were indeed beneficial to children, particularly those with existing social anxieties or who struggled to concentrate in overloaded classrooms. In short, children can thrive in both in-person *and* virtual/distance learning environments, and there are positive and negative implications of both approaches. Our primary job is to ensure that we are addressing the concerning broader trends in children's behavioral health and determining the school- and distance learning-related factors contributing to these adverse outcomes (e.g., bullying, overuse of social media, more loneliness, etc.).

As I mentioned in my written testimony, this requires utilizing a population health approach, which recognizes children's behavioral health along a continuum of need and the need for a broader set of strategies – informed by public health and psychological science – to intervene appropriately along that continuum (i.e., providing effective and efficient clinical care for those with a diagnosed behavioral health condition; mitigating risk or intervening as early as possible for those at-risk for behavioral health challenges; and keeping well those children who are relatively healthy). While a more 'traditional approach' involves waiting for children to reach a point of crisis and then intervening in their learning environments to address their behavioral health needs, a population health perspective extends beyond this reactive approach to shape children's learning environments themselves. This means bringing forth the best scientific thinking to make a child's learning environment and school climate as safe and effective as possible.

In many communities, schools are an essential—and often the only—source of meeting the physical and mental health needs of students and families. They must be provided the resources to (1) increase the school-based mental health workforce, including school psychologists; (2) foster

necessary community partnerships; and (3) provide training to educators on culturally competent social and emotional learning and trauma-informed teaching practices. Fostering positive school climates and developing skills among students such as motivation and engagement, problem-solving, emotional intelligence, resilience, agency, and relationship building will be critical.

To allow schools to build necessary long-term capacity in these areas, federal investments must be both equitable and sustainable. Two bills mentioned in my written testimony would help accomplish this goal: the Comprehensive Mental Health in Schools Pilot Program Act (H.R. 3549) and the Increasing Access to Mental Health in Schools Act (H.R. 3572). Additionally, the Mental Health Professionals Workforce Shortage Loan Repayment Act (H.R. 3150)—which authorizes a new student loan repayment program for behavioral health care professionals who commit to working in an area lacking accessible care—would help address mental health workforce shortages, including in schools. Finally, the committee should build on the distance learning investments made through the American Rescue Plan's Emergency Connectivity Fund by passing the Securing Universal Communications Connectivity to Ensure Students Succeed (SUCCESS) Act (H.R. 4663), which provides funding for devices and broadband connectivity to the 12 to 17 million students who do not have home internet access following the COVID-19 pandemic.