Attachment—Additional Questions for the Record

Subcommittee on Oversight and Investigations
Hearing on
"Putting Kids First: Addressing COVID-19's Impacts on Children"
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The Honorable Paul Tonko (D-NY)

1. I had the opportunity to tour the Monte Nido & Affiliates eating disorder treatment facility in New York in 2019. What I learned about this complex mental illness and the incredible work of the team there, is something I will never forget. The mental health of our nation's children is so critically important and it is devastating to see the mental health declines of this population. Understanding that one of the mental illnesses with a sharp rise is eating disorders is heartbreaking. The National Eating Disorders Association based in New York has seen a 40% increase in their helpline with 35% of callers between 13 and 17 years of age. Dr. Beers, can you help explain why we think this trend is occurring?

Response

Thank you for that question. As you noted, pediatricians are seeing dramatic increases in eating disorders, a very complicated condition that requires multi-disciplinary treatment. My adolescent medicine and child psychiatry colleagues tell me that not only are they seeing many more cases of eating disorders, but they are more severe and are starting at even younger ages, even down to the age of 8 or 9, and that because of the complexity of the treatment for eating disorders, it is extremely difficult to access fully comprehensive care for patients.

As a result of the economic hardships and inconsistent access to school breakfasts and lunches because of virtual, half-day, and/or hybrid learning, many children and adolescents may not have had regular access to nutritious foods over the course of the pandemic. Families may have experienced shifts to high-calorie snack foods and nonperishable processed foods; there may have been significant increases in the consumption of unhealthy snacks and sugary sweetened beverages. Both food insecurity and food scarcity can negatively affect nutrition, lead to increased risk for disordered eating, and increase consumption of nonnutritive, calorie-dense foods that can lead to unhealthy weight gain and contribute to obesity.

Closures of recreational sports, gyms, and schools as well as important safety and mitigation measures related to reopening recreational activities and resuming organized sports and physical education have resulted in less access to opportunities for organized physical activities. In-person organized sports and physical education classes may be modified or limited because of physical distancing requirements and space issues in schools and recreational buildings. Families report

that during COVID-19 mitigation, time spent in physical activity and sports has decreased while sleep time and screen time have increased.

Mood disorders and experience of trauma can have impacts on eating and physical activity, and relatedly on the incidence of eating disorders. In the setting of the pandemic, changes in nutrition/weight may be indicators of more significant mental health issues. Mood disorders and other mental health concerns may interfere with the ability to promote a healthy lifestyle. It is uncertain what the impact of social media has been, however it is very plausible that increased use of social media over the pandemic has exposed youth to content that has exacerbated all of these issues.

In sum, the coalescing of the impacts of the pandemic on nutrition, physical activity and mental health have created increased risk for pre-teens and teens of experiencing an eating disorder. For further information on addressing eating disorders, please refer to the Academy's Policy Statement Identification and Management of Eating Disorders in Children and Adolescents.

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 (QTRP) 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?

Response

In recognition of the significant mental health crisis children and young people are currently facing, on October 19, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national emergency in child and adolescent mental health. The COVID-19 pandemic and ongoing inequities around structural racism have exacerbated the mental health crisis that existed before the pandemic. AAP is encouraging policymakers at all levels of government to take swift action to ensure children and young people have access to critical supports to address this national state of emergency in mental health.

Certainly, children and young people in foster care have felt the weight of the mental health crisis compounded by the existing trauma of removal from their families. AAP has long advocated to keep children and families together whenever safe to do so, as the research is clear that children fare best in families. When that is not possible, it is paramount that children have access to family-based care where they are able to build critical connections that allow them to heal from their trauma and build resiliency. Therefore, AAP has long supported the *Family First Prevention Services Act* (Family First) and it's three fundamental principles: 1) Helping families remain safely together; 2) Ensuring children in foster care can live with family; and 3) Ensuring residential treatment programs provide trauma-informed services to address a demonstrated time-limited need that cannot be met in a family setting.

Family First made important changes to reform congregate care with the establishment of the Quality Residential Treatment Program (QRTP) model, which establishes safeguards to ensure children can receive appropriate, time-limited treatment that meet the child's needs and help them to reach permanency in a family-based setting. AAP strongly supports these reforms and has been concerned by the ongoing effort to create sweeping exemptions to the longstanding Medicaid Institutions for Mental Disease (IMDs) policy based on concerns about whether QRTPs will be considered IMDs. The IMD policy predates Family First, which did not make any changes to Medicaid law.

AAP opposes proposed legislation (S. 2689/H.R. 5414) that would create a categorical federal exemption from Medicaid law for all QRTPs. The Medicaid IMD exclusion generally prohibits Medicaid payments to facilities primarily providing mental health and substance use disorder treatment services if they have more than 16 beds. One of the reasons the IMD exclusion was created was to incentivize community-based services, with an understanding that large, restrictive institutions were counterproductive in mental health treatment. Decades of research and lived experience has shown the same is true in child welfare; children fare best in the least restrictive settings possible, preferably with families, and institutional placement is often traumatic and lacks the setting and supports to help a child to flourish.

AAP agrees that more progress is necessary to address the mental health needs of children and youth in foster care. We urge Congress to provide more supports for community-based trauma-informed mental health services for this population, to continue supporting high-quality kinship and non-relative family foster care, and and to continue prioritizing prevention services that ensure that fewer children come into foster care unnecessarily. These needed reforms would further reduce over reliance on congregate care and support the implementation of Family First.

2. As we discuss the impacts of covid-19 on children, I want to raise the issue of the surge in the serious mental illness of eating disorders among children. We've seen a 25% increase in adolescent hospitalizations due to eating disorders, and admissions at Children's Hospitals have doubled across the nation. Additionally, a recent analysis of the Suicide Lifeline found that callers with eating disorders were less likely to have resolved their suicidal ideations at

the end of the call, in comparison to callers presenting with depression. However, ED treatment availability is limited, creating a dire need for more access to care.

a. What can Children's Hospitals do to work to address the rise in eating disorders cases given the strain on treatment capacity?

Response

The pediatrician often is the first professional consulted by a parent or the school when there is a concern about a possible eating disorder (ED). Early diagnosis and intervention are associated with improved outcome. EDs are best evaluated and managed by a multidisciplinary health care team, with the pediatrician as an important member of that team. A thorough physical examination and review of systems can help to identify any underlying medical and psychiatric causes for weight loss.

EDs are the third most common chronic condition in adolescents, after obesity and asthma. The prevalence of childhood obesity has increased dramatically over the past few decades in the United States and other countries, and obesity during adolescence is associated with significant medical morbidity during adulthood. Most adolescents who develop an ED did not have obesity previously, but some adolescents may misinterpret what "healthy eating" is and engage in unhealthy behaviors, such as skipping meals or using fad diets in an attempt to "be healthier," the result of which could be the development of an ED. Messages from pediatricians addressing obesity and reviewing constructive ways to manage weight can be safely and supportively incorporated into health care visits. Avoiding certain weight-based language and using motivational interviewing (MI) techniques may improve communication and promote successful outcomes when providing weight-management counseling.

MI is defined as "a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." A study conducted through the AAP Pediatric Research in Office Settings (PROS) network assessed the effect of MI delivered by pediatricians and found that pediatricians and dietitians who used MI to counsel families with overweight children were successful in reducing children's BMI percentile by 3.1 more points than a control group in which MI was not used. Pediatricians can successfully facilitate their patients' lifestyle behavior changes. Concerns from pediatricians and parents that obesity counseling can lead to an ED can be addressed by understanding the effectiveness of family-centered MI to promote healthy behaviors. Continued support and training for pediatricians to use MI in this context, as well as on how to identify EDs and co-manage them as part of a multi-disciplinary team would be very useful and impactful.

Obesity prevention and treatment, if conducted correctly, does not predispose to EDs. On the contrary, randomized controlled trials of obesity prevention programs have shown a reduction in the use of self-induced vomiting or diet pill use to control weight and a decrease in concerns about weight in the intervention groups. Family involvement in the treatment of both adolescent obesity and EDs has been determined to be more effective than an adolescent-only focus. An

integrated approach to the prevention of obesity and EDs focuses less on weight and more on healthy family-based lifestyle modification that can be sustained.

Pediatricians can encourage parents to be healthy role models and supportively manage the food environment by creating easy accessibility to healthy foods (eg, fruits, vegetables, whole grains, beans and other legumes, and water) and by limiting the availability of sweetened beverages, including those containing artificial sweeteners, and other foods containing refined carbohydrates. Discussions between pediatricians and parents about increasing physical activity and limiting the amount of total entertainment screen time to less than 2 hours/day are important and may lead to changes in family behavior. Another area of prevention is avoiding the presence of a television in the teenager's bedroom, because having a television in the room predicts significantly less physical activity as well as poorer dietary intakes compared with not having a television in the room. Other evidence-based approaches encourage parents to include more family meals, home-prepared meals, and meals with less distractions as well as fewer discussions about weight and about dieting. Understanding that poor body image can lead to an ED, parents should avoid comments about body weight and discourage dieting efforts that may inadvertently result in EDs and body dissatisfaction.[i] Children's hospitals can help support the pediatricians in their community to do this essential health promotion work that can decrease the incidence of EDs through providing education and training, consultation and facilitating collaborative partnerships that increase access to healthy foods and safe physical activity.

b. What additional resources are needed to adequately treat eating disorders in children and adolescents?

Response

Efforts to prevent eating disorders can take place both in practice and community settings, such as schools. A variety of successful programs for preventing eating pathology have been developed for various settings. While treating disordered eating, it is also important to address the mental health challenges that may be co-occurring in the child or adolescent. More federal resources must be dedicated to ensuring all families and children, from infancy through adolescence, can access evidence-based mental health screening, diagnosis, and treatment to appropriately address their mental health needs, with particular emphasis on meeting the needs of under-resourced populations. This includes fully funding comprehensive, community-based systems of care that connect families in need of behavioral health services and supports for their child with evidence-based interventions in their home, community or school.

[i] Golden NH, et al. Preventing Obesity and Eating Disorders in Adolescents. *Pediatrics.* 2016; 138 (3): e20161649.