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ISSUE BRIEF

State Policy and Practice Recommendations to Advance Improvements in Children's Behavioral Health

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Introduction

Children are in crisis nationally at levels never seen before. In every community, children are languishing in emergency departments (EDs) and child welfare offices because too few beds are available to treat them. As a response, in federal fiscal year (FFY) 2023, the Substance Abuse Mental Health Services Administration (SAMHSA) awarded Transformation Transfer Initiative (TTI) funding to states and territories focused on implementing and expanding 988 access and crisis services for children and adolescents.

This is one of the top issues facing the TTI projects focused on children and adolescents this year. State child welfare, Medicaid, and behavioral health agencies often serve the same children, youth, and families in crisis. Given the increased need for services for children and youth with high acuity conditions or serious emotional disturbance, it is important that child welfare, Medicaid, and behavioral health collaborate effectively. Yet these three systems are siloed at the governance, service array, and financing levels, often leading to poor outcomes.

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Health Management Associates (HMA) developed this series of issue briefs to give technical assistance to these TTI projects to improve the need for child welfare, Medicaid, and behavioral health systems to better work together to tackle these issues.

This issue brief provides state policymakers and behavioral health leaders with a robust vision for coordinating and optimizing services to promote behavioral well-being, prevent behavioral health conditions, and ensure access to a coordinated continuum of behavioral healthcare.

The brief also presents concrete policy and practice transformation opportunities to advance a more responsive, coordinated, and optimal system of care. This vision for an integrated and seamless behavioral wellness continuum responds to the Surgeon General's 2021 Youth Mental Health Advisory and its call for a "whole of society response."[1]

Highlights

- The prevalence of children with significant behavioral health disorders is staggering and requires priority attention.
- Most children do not receive the behavioral healthcare they need.
- Stigma is the primary barrier for youth.
- Upstream prevention, particularly within pediatrician offices and schools, is critical.
- Several states offer a road map for activating and funding services at all points on the continuum.

[1] US Department of Health and Human Services. Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. 2021. Available at: https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf. Accessed September 23, 2023.

The Children's Behavioral Healthcare System Requires Urgent Attention

Our nation's children and youth are experiencing a profound behavioral health crisis. As the following statistics demonstrate, this crisis started years before the pandemic. Our national healthcare organizations, including the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and major medical journals continue to sound the alarm:

- One in three high school students and half of female respondents in this age group reported feelings of sadness or hopelessness, according to the CDC's Youth Risk Surveillance data.[2]
- The number of children ages 3−17 years old diagnosed with depression grew by 27 percent between 2016 and 2020.[3]
- Pediatric mental health hospitalizations surged 25.8 percent in 2009−2019. The reasons for hospitalization included attempted suicide, suicidal ideation, or self-injury diagnoses, which more than doubled during that 10-year period.[4]
- Rates of reported drug use rose 61 percent among eighth graders, with more than 20 percent of these individuals and nearly half of high school seniors (46.6%) reporting using an illicit drug at least once in 2016−2020.[5]
- Approximately 15 percent of adolescents ages 12−17 years old had experienced a major depressive episode in 2019, 37 percent had persistent feelings of sadness or hopelessness, and nearly 20 percent reported that they seriously considered suicide.[6]

Disparities Are Stark for Children and Adolescents at Elevated Risk

- LGBTQ+ youth are four times more likely to attempt suicide than their heterosexual peers; nearly half of LGBTQ+ youth (45%) and more than half of transgender and nonbinary youth seriously considered suicide in the past year.[7]

[2] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance Data Summary & Trends Report: 2009-2019. 2020. Available at: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBSDataSummaryTrendsReport2019-508.pdf. Accessed September 23, 2023.

[3] Lebrun-Harris LA, Ghandour RM, Kogan MD, Warren MD. Five-Year Trends in U.S. Children's Health and Well-Being, 2016-2020. *JAMA Pediatr*. 2022;176(7):e220056. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8922203/. Accessed September 23, 2023.

[4] Arakelyan M, Freyleue S, Avula D, McLaren JL, O'Malley AJ, Leyenaar JK. Pediatric Mental Health Hospitalizations at Acute Care Hospitals in the US, 2009-2019. *JAMA*. 2023;329(12):1000-1011. doi: 10.1001/jama.2023.1992.

[5] National Center for Drug Abuse Statistics. Drug Use Among Youth: Facts & Statistics. Available at: https://drugabusestatistics.org/teen-drug-use/. Accessed September 6, 2023.

[6] Bitsko RH, Claussen AH, Lichtstein J, et al. Mental Health Surveillance Among Children—United States, 2013-2019. *MMWR* Suppl. 2022;71(2):1–42. doi: 10.15585/mmwr.su7102a1

[7] The Trevor Project. Facts About LGBTQ Youth Suicide. December 15, 2021. Available at: https://www.thetrevorproject.org/resources/article/facts-about-lgbtq-youth-suicide/. Accessed September 23, 2023.

- Suicide death rates for Black children and adolescents nearly doubled to 4.8 per 100,000 population in 2018 from 2.6 per 100,000 population in 2017.[8]
- Latina youth in the United States also are at higher risk; 10.5 percent of Latina adolescents ages 10–24 years old attempted suicide in 2017, compared with 7.3 percent of White females, and 5.8 percent of Hispanic teenaged/young adult males, and 4.6 percent White males in the same age group.[9]
- Suicide was the leading cause of death in 2020 among Asian and Pacific Islander (API) and American Indian or Alaska Native (AI/AN) youth ages 10−14 years in 2020.[10]
- Children and youth in foster care are especially vulnerable; 80 percent have significant mental health issues, compared with approximately 20 percent of their peers.[11]

The Situation in EDs Has Become Dire

Over the past decade, ED visits for mental health reasons approximately doubled, and visits related to suicide have skyrocketed to five times higher in the last 10 years.[12]

In 2021, the AAP declared that youth mental health is a national crisis,[13] and the US Surgeon General issued a formal public health advisory making a similar pronouncement.[14]

- Suicide is now the second leading cause of death for children ages 10−24.[15]
- Overdose death rates have increased 500 percent since 1999 among teens and young adults ages 15−24.[16]

[8] Congressional Black Caucus. Ring the Alarm: The Crisis of Black Youth Suicide in America. Available at: https://theactionalliance.org/sites/default/files/ring_the_alarm-_the_crisis_of_black_youth_suicide_in_america_copy.pdf. Accessed September 23, 2023.

[9] Kann L, McManus T, Harris WA, et al. Youth Risk Behavior Surveillance—United States, 2017. *MMWR Surveill Summ*. 2018;67(No. SS-8):1–114. doi: 10.15585/mmwr.ss6708a1

[10] Agency for Healthcare Research and Quality. 2022 National Healthcare Quality and Disparities Report. October 2022. Available at: https://www.ncbi.nlm.nih.gov/books/NBK587174/. Accessed September 23, 2023.

[11] National Conference of State Legislatures. Mental Health and Foster Care. November 1, 2019. Available at: https://www.ncsl.org/human-services/mental-health-and-foster-care/. Accessed September 23, 2023.

[12] Bommersbach TJ, McKean AJ, Olfson M, Rhee TG. National Trends in Mental Health-Related Emergency Department Visits Among Youth, 2011-2020. *JAMA*. 2023;329(17):1469-1477. doi: 10.1001/jama.2023.4809.

[13] American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry & Children's Hospital Association. Declaration of a National Emergency in Child and Adolescent Mental Health. October 2021. Available at: https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/. Accessed September 23, 2023.

[14] The US Surgeon General's Advisory. Protecting Youth Mental Health. December 2021. Available at: https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf. Accessed September 23, 2023.

[15] Centers for Disease Control and Prevention. About Multiple Cause of Death, 2018-2021. 2023. Available at: http://wonder.cdc.gov/mcd-icd10-expanded.html. Accessed January 23, 2023.

[16] National Center for Drug Abuse Statistics. Drug Use Among Youth: Facts & Statistics. Retrieved from https://drugabusestatistics.org/teen-drug-use/. Accessed September 13, 2023.

Few Children Receive Necessary Treatment

Approximately eight in ten children and youth who have behavioral health needs are unable to receive necessary care.[17] Even among children known to be at elevated risk because of their involvement with the child welfare system, three in four children *do not receive these services*.[18]

Consequently, boarding children and youth who are experiencing acute mental health crises in the ED of local hospitals is a national challenge that was recently highlighted in The Wait to Nowhere: When a Crisis Goes Untreated, a short-form documentary from the Children's Hospital Association.[19] Boarding in residential programs remains an obstacle for children and youth in foster care, 10 percent of whom live in institutional settings. Children and youth who have resided in these setting describe their experiences as "prison-like and punitive" or "traumatic."[20]

Local and state efforts have focused on enhancing the availability of community-based treatment and services. Nonetheless, access to care remains far from adequate. The percentage of youth who received mental health services in outpatient settings increased to 17.3 percent in 2020 from 11.8 percent in 2002, and from 2.7 to 3.7 percent in medical settings during the same period; the percentage who received mental health services in an educational setting increased to 15.4 percent in 2019 from 12.1 percent in 2009.[21]

The Supply of Behavioral Healthcare Providers Is Insufficient

In 2022, the American Academy of Child and Adolescent Psychiatry announced a severe shortage of child and adolescent psychiatrists. The national average is 14 psychiatrists per 100,000 children,[22] and more than 50 percent of US counties lack a psychiatrist.[23]

Most behavioral health organizations report difficulty hiring and retaining providers,[24] creating significant gaps in care for youth at the highest risk. Only 5.08 percent of mental

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[17] Koppelman J. Children with Mental Disorders: Making Sense of Their Needs and the Systems That Help Them. Washington, DC: National Health Policy Forum. 2004 Available at: https://www.ncbi.nlm.nih.gov/books/NBK559784/ . Accessed September 23, 2023.

[18] Child Welfare League of America. CWLA National Factsheet. 2017. Available at: http://www.cwla.org/wp-content/uploads/2017/03/2017-National-factsheet-final.pdf. Accessed September 23, 2023.

[19] Children's Hospital Association A Documentary on Mental Health: 'The Wait to Nowhere.' Available at: A Documentary on Mental Health: 'The Wait to Nowhere'. Accessed September 23, 2023.

[20] Ware A, Taylor B, Fathallah S, Sullivan S, Cancel S. Away From Home: Youth Experiences of Institutional Placements in Foster Care. Think Of Us. 2021. Available at: https://www.thinkofus.org/case-studies/away-from-home. Accessed September 23, 2023.

[21] Substance Abuse and Mental Health Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results From the 2019 National Survey on Drug Use and Health. 2020. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm. Accessed September 23, 2023.

[22] American Academy of Child & Adolescent Psychiatry. Severe Shortage of Child and Adolescent Psychiatrists Illustrated in AACAP Workforce Maps. August 31, 2023. Available at: https://www.aacap.org/aacap/zLatest_News/Severe_Shortage_Child_Adolescent_Psychiatrists_Illustrated_AACAP_Workforce_Maps.aspx. Accessed September 23, 2023.

[23] Weiner S. A Growing Psychiatrist Shortage and an Enormous Demand for Mental Health Services. *Association of American Medical Colleges News*. August 9, 2022. Available at: https://www.aamc.org/news/growing-psychiatrist-shortage-enormous-demand-mental-health-services. Accessed September 23, 2023.

[24] National Council for Mental Well-Being. Nearly 80% of National Council for Mental Wellbeing Members Say Demand for Treatment Has Increased Over the Past Three Months. September 1, 2023. Available at: https://www.thenationalcouncil.org/news/nearly-80-of-national-council-for-mental-wellbeing-members-say-demand-for-treatment-has-increased-over-the-past-three-months/. Accessed September 23, 2023.

health providers, for example, are Black/African American,[25] and youth and adults who receive treatment frequently experience microaggressions, stereotyping, and misgendering.

Stigma Remains a Formidable Access Barrier

A recent meta-analysis of 53 studies that examined barriers to youth accessing mental healthcare found that nearly all (96%) of the studies reported barriers to care related to individual factors. Examples include "limited mental health knowledge and broader perceptions of help-seeking." Most (92%) of the studies identified stigma and humiliation. More than half (68%) of the reports described barriers related to concerns about confidentiality and the ability to trust an unfamiliar person. More than half (58%) of the studies referred to costs of services, logistical barriers, and availability of professionals.[26]

Stigma also is ingrained in community systems. Mental health screening and education remain rare in pediatric settings and schools, and symptoms of serious emotional disturbance and substance use disorder (SUD) are commonly viewed as problem behaviors requiring corrective action or remediation. Two-thirds of justice-involved youth have one or more untreated, diagnosable mental illness.[27] Children and youth receiving treatment in juvenile justice settings may experience harm when placed in the very systems intended to help them.[28] Avoiding institutional settings is a best practice, but reforms in congregate and residential treatment settings remain a critical need, as highlighted in the Annie E. Casey-funded report, Away from Home.[29]

[25] American Psychological Association. Demographics of U.S. Psychology Workforce. 2022. Available at: https://www.apa.org/workforce/data-tools/demographics. Accessed September 15, 2023.

[26] Radez J, Reardon T, Creswell C, Lawrence PJ, Evdoka-Burton G, Waite P. Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. Eur Child Adolesc Psychiatry. 2021 Feb;30(2):183-211. doi: 10.1007/s00787-019-01469-4. Epub 2020 Jan 21. PMID: 31965309; PMCID: PMC7932953.

[27] Office of Juvenile Justice and Delinquency Prevention. Intersection Between Mental Health and the Juvenile Justice System. Literature review. 2017. Available at: https://www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf. Accessed September 23, 2023.

[28] Fialkowski A, Shaffer K, Ball-Burack M, Brooks TL, Trinh NT, Potter JE, Peeler KR. Trauma-Informed Care for Hospitalized Adolescents. *Curr Pediatr Rep*. 2022;10(2):45-54. doi: 10.1007/s40124-022-00262-3.

[29] Ware A, Taylor B, Fathallah S, Sullivan S, Cancel S. Away From Home: Youth Experiences of Institutional Placements in Foster Care. Think Of Us. 2021. Available at: https://www.thinkofus.org/case-studies/away-from-home. Accessed September 23, 2023.

Diffuse Accountability Complicates How States Address These Myriad Challenges

Few states are coordinating child and youth services across the multiple state agencies, payers, local authorities, providers, and multiple service settings responsible for mental health and SUD treatment. Involved systems include those responsible for behavioral health, public health, education, services for individuals with intellectual and developmental disabilities, child welfare, and juvenile justice. Service "siloes" and fractured lines of accountability contribute to piecemeal investments that may highlight solutions but often only reach limited populations with the highest need. Without a clear line of sight through these interconnected systems, it is difficult to establish a shared vision for how to address the root causes and improve access to quality care.

Upstream Prevention and Early Intervention Are Critical

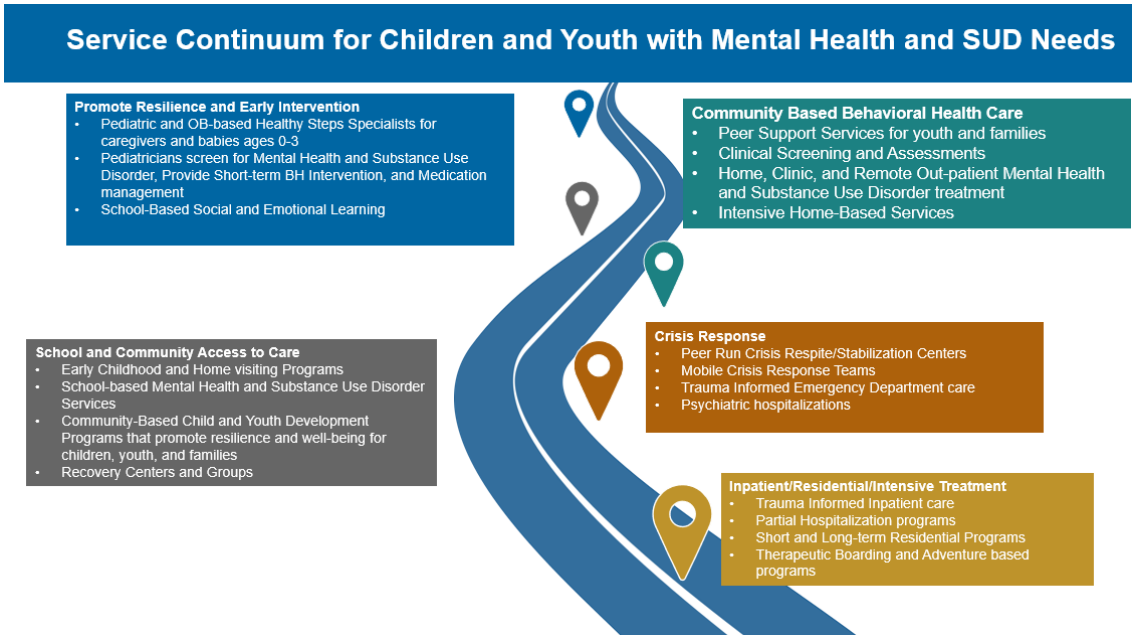
An effective response to the behavioral health and well-being of children and teens encompassed comprehensive systems of care that focus on prevention. Systems and strategies need to be in place to mitigate adverse childhood experiences (ACEs), promote emotional well-being within families, confront stigma, reduce socioeconomic stressors, and encourage resilience. Families and children often seek support from various sources, including social service agencies, domestic violence programs, housing supports, schools, community-based organizations (CBOs), and personal networks long before they engage with formal behavioral healthcare systems.

Collaborative strategies and care coordination models ideally harness the strengths of community supports. Complex needs often necessitate a responsive tiered system of care that prioritizes the least restrictive interventions while matching services to address specific needs. Culturally and linguistically responsive peer support or community health workers (CHWs) are an underused workforce resource for family support, mental health education, and access to care and services.

Building community resilience and establishing non-threatening access points, such as pediatric practices, schools, and other trusted community institutions, are essential to promoting mental well-being. Families and children require whole-person, holistic socioeconomic and socioemotional support and services to promote positive outcomes, strengthen protective factors, and enhance overall health and well-being.

Figure 1 represents an expanded service continuum for children and youth with needs ranging from mental health and substance use vulnerability to complex diagnosed disorders.

Figure 1. Service Continuum for Children, Youth with Behavioral Health Needs



Whole Society Response to Child and Youth Mental Wellness and Care Delivery

A robust behavioral health ecosystem offers children and families:

- Early education about mental health
- Regular screening and assessment for a range of mental health issues
- Access to customized services based on each person's unique needs
- Natural access points to a comprehensive continuum of evidence-based care, trauma-informed services focused on minimizing disruptions to normal growth and development
- Support for caregivers and families as vital partners and their children's most essential resource

As Table 1 on the following pages indicates, enhancements within each delivery setting on and across the continuum requires committed leadership, interagency alignment, funding, and significant cross-agency collaboration.

Table 1. Cross-Sector Approaches to Addressing Behavioral Health Issues in Pediatric Population

Service Provider	Involved Sectors	Solutions and Models to Explore	Outcomes	Challenges
Primary care	• Medicaid • Physical and behavioral health	• Collaborative care • Dyad benefit • Healthy Steps Model for infants and toddlers	• Expanded screening and assessment for child and family behavioral health needs • Improved attention to medical screening for underlying health issues • Early family/caregiver support and intervention to address parent mental health challenges • Early identification of infant/child developmental and behavioral health needs • Improved behavioral healthcare access and use	• Knowledge and skills acquisition • Practice transformation • Integration of new workforce • Culture shift
Community activation	• Medicaid • Public health • CBOs • Physical and behavioral health • Child welfare	• Workforce expansion (CHWs, peer support) • CBO capacity building • Community hubs for contracting, billing, claims, and quality management (e.g., Pathways Community HUB model)	• Home and community-based family/caregiver supports • Optimized family first prevention services • Facilitated referrals to local services and care • Improved CBO inclusion in system of care • Coordinated care across the clinical and non-clinical service system	• Practice transformation • Integration of new workforce • Culture shift • Backbone organizations able to support CBO resource sharing and collective contracting • Infrastructure development for data integration • Support for workforce expansion
School-based services	• Medicaid • Education • Behavioral health	• Early screening for learning disabilities that contribute to mental health issues • Attention to emotional disorders in individual education plans • Multi-tiered system of supports (MTSS) • Universal school-based mental health training (e.g.., Dialectical Behavioral Therapy Skills Training for Emotional Problem-Solving - Adolescents • Medicaid funding to enhance onsite services (e.g., Dialectical Behavioral Therapy Skills Groups and Adherent Skills Groups and Adherent DBT-A)	• Stigma reduction • Early identification • Expanded access to care • Access to family/caregiver support • Improved outcomes	• Knowledge acquisition • Practice transformation • Integration of new workforce • Culture shift

Service Provider	Involved Sectors	Solutions and Models to Explore	Outcomes	Challenges
Targeted supports for children and youth with behavioral health needs	• Medicaid • Behavioral health • Physical health • Child welfare	• Certified community behavioral health clinics • High-fidelity Wraparound • HCBS waiver services • Crisis respite and stabilization centers • Access to evidence-based interventions • Family/caregiver support • Access to specialized programs when needed (e.g., programs for eating disorders, outdoor/adventure therapy) • Trauma training for staff in residential and inpatient facilities (e.g., Risking Connections)	• Improved integration within community settings • Expanded access to care • Expanded access to the right care • Access to family/caregiver support • Improved outcomes	• Workforce Training • Practice transformation • Integration of new workforce • Culture shift
Person-centered planning and enhanced coordination across the care continuum	• Medicaid • Behavioral health • Education • Physical healthcare • Child welfare	• Special needs managed care programs for youth with complex care needs/foster youth • Systems of care and wrap-around • Children's health home care management • Workforce expansion (CHWs/peers)	• Child and family-centered care planning and service delivery • Timely access to needed services • Child and youth voice and choice • Support for families and caregivers	• Workforce Training • Practice transformation • Integration of new workforce • Culture shift

Coordination and Financing Strategies Are Critical

Several states have assessed their child and youth behavioral healthcare systems, aligned efforts across state agencies and sectors, and begun to optimize the state and federal resources available for prevention, identification, early intervention, and treatment of children and youth with behavioral health conditions. Often the deepest investments focus on system integration, navigation, and improved care coordination, recognizing that widescale improvement is a "ground game" at the local level. Coordination, however, requires service/provider availability, which, in turn, depends on adequate financing.

Beyond agreeing that the need is great and identifying the optimal course of action, financing large-scale transformation is critical. Frequently, Medicaid reimbursement rates must be increased to adequately fund the necessary workforce. State plan amendments often are necessary to finance waiver services or include new benefits, such as CHWs, youth and adult peer support specialists, and peer family advocates. This expanded workforce can support wellness, prevent crises, combat stigma, reach populations facing the most severe disparities, and optimize the clinical workforce.

Aligning other federally supported efforts also is important. Examples include: the Certified Community Behavioral Health Clinic Demonstration and grants from the SAMHSA and Title IV-E funds for new services available through the Family First Prevention Services Act. Both initiatives fund services that offer significant opportunities to expand publicly supported behavioral healthcare access within schools, shelters, and other community settings.

States often seek to optimize managed care for children and youth with serious behavioral health needs and young people in foster care. Special needs plans (SNPs) for these populations can speed efforts to transform practice, improve care coordination, and promote implementation of new services. Other challenges that require attention include holding commercial plans accountable for mental health parity goals and commercial and public plans responsible for equitable coverage for both mental health and SUD treatment.

Several states offer valuable blueprints for optimizing Medicaid and other state and federal resources to support expanded care coordination and improved access to new services.

California

California has invested $4.7 billion to improve access to mental health services for all Californians ages 0−25 by reimagining service delivery and adding 40,000 new workers. California's Master Plan for Kids' Mental Health includes establishment of a Children's Mental Health Resource Hub to centralize access to resources and hotlines, a platform to improve access to mental health assessment and intervention, support to expand school-based services, crisis response, and improve services for children and youth with the most significant needs.

New Jersey

New Jersey has supported children and youth who have complex care needs by combining state funds with expanded Medicaid services. It leverages a single vendor to provide statewide access to regional systems of care (originally funded through SAMHSA grants) for service planning, care coordination, and evidence-based assessment and intervention. Initially the state targeted children and youth involved in the child welfare system and those with Medicaid coverage living in a few counties. It has gradually rolled out statewide to all children and youth who need specialized care. To ensure that commercial plans pay for the services they have agreed to provide to children and youth with private coverage, the state's Division of Banking and Insurance, which issues provider licenses, is enforcing federal Mental Health Parity Act requirements.

Virginia

Virginia's Children's Services Act (CSA), established in 1993, blends funding across state agencies—social services, juvenile justice, education, and behavioral health—and allocates these funds to municipalities to support at-risk youth through case management. Local authorities contribute matching funds and report on pool expenditures as a whole rather than by funding stream. State officials have described this model as "state supervised; locally operated and administered."[30] The Virginia Medicaid office, the Department of Medical Assistance Services, also braids Medicaid funds into the CSA pool of funds to support specific case management services. With improved coordination of services, funding, and reporting, case managers have more flexibility and time to tailor services to youths' needs.[30]

West Virginia

West Virginia funds socially needed services (SNS) that can be provided either formally and informally alone or in bundles to support children and families through its expanded 1915© waiver. The waiver expansion added services for children with serious emotional disturbances (SED). West Virginia also implemented a SNP to develop the continuum of home and community-based services (HCBS) necessary to support foster care prevention and avoid residential placements for children. The Children with SED Waiver (CSEDW) is

[30] The State and Local Advisory Team, State of Virginia. A Guide to the Children's Services Act for Children and Families – Virginia. September 2021. Available at: csa.virginia.gov/content/doc/CSA_Family_Guide_2022.pdf. Accessed October 12, 2023.

available to children who are in or at risk of placement in foster care because of SED. Screening is accessible to providers and caregivers via an accessible call center that offers support while children are being assessed for waiver services.

CSEDW expands HCBS beyond what the state's Medicaid plan covers for children and young adults (ages 3−20) who have a mental, behavioral, or emotional disorder.[31] Services provided to children and adolescents include case management, in-home family therapy, independent living/skill building, job development, respite care, in-home services, supported employment, assistive equipment, and community transition. Family supports include mobile response, non-medical transportation, peer support, respite care, out-of-home services, and specialized therapy.

Conclusion

The data presented in this brief raises significant concerns about the youth of our nation. Behind every statistic are hundreds of thousands of vulnerable children and families with urgent needs who require cross-system reforms, including policies that drive integrated financing to optimize care coordination, improve provider collaboration, and enhance upstream prevention. No agency can tackle these issues alone. Enhancing and expanding child and family centered practice and supporting local collaboration within each community's system of care requires adequate funding and strong collaborations at all levels. This paper outlines both the problem statement and provides examples of successful collaborations around the country to provide a path forward as states look to build more seamless systems of care for children and youth experiencing behavioral health needs.

[31] State of West Virginia. Application for a §1915(c) Home and Community-Based Services Waiver 1915(c). February 1, 2020. Available at: https://dhhr.wv.gov/bms/CMS/Documents/CSEDW%20CMS%20Approved%20Initial%20Application_Approved%2012_19_19.pdf. Accessed September 23, 2023.