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Child and Adolescent Mental and Behavioral Health Principles
Endorsed by:

American Academy of Pediatrics
American Association of Child and Adolescent Psychiatry
American Foundation for Suicide Prevention
American Muslim Health Professionals
American Psychiatric Association
American Psychological Association
Association of Maternal & Child Health Programs
Children's Defense Fund
Children's Hospital of Philadelphia
Children's Hospital Association
CLASP
Eating Disorders Coalition for Research, Policy & Action
Family Voices
First Focus on Children
Georgetown University Center for Children and Families
Mental Health America
NAMI, National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Pediatric Nurse Practitioners
National Association of School Psychologists
National Health Law Program
Nemours Children's Health System
REDC Consortium
Sandy Hook Promise
School-Based Health Alliance
Society for Adolescent Health and Medicine
The Jed Foundation
The National Alliance to Advance Adolescent Health
United Way Worldwide
ZERO TO THREE

Mental and behavioral health concerns in children and teens have been on the rise for many years. Suicide is the second leading cause of death for youth ages 10-18 in the United States.[1] The COVID-19 pandemic has worsened the ongoing children's mental health crisis and increased the fragility of the mental health safety net system for children and adolescents. The prevalence and severity of mental health conditions among children have sharply increased since March 2020.[2]

Risk factors associated with childhood mental health conditions have also grown precipitously, including family mental health and substance use issues, adverse childhood experiences, racial disparities, social isolation, trauma, food and housing insecurity, economic stress, and poverty.[3] [4] [5] The impact of racism on child and adolescent mental health demands acknowledgment. Racism operates at the level of individual experiences of discrimination by youth of color as well as the ways in which youth of color have differential access to mental health services and diagnosis and treatment for mental and behavioral health conditions.[6] These factors combined with the closure of school mental health services, early intervention and home-based programs, and

[1] https://www.cdc.gov/injury/wisqars/index.html
[2] Patrick SW, Henkhaus LE, Zickafoose JS, et al. Well-being of parents and children during the COVID-19 pandemic: a national survey. *Pediatrics.* 2020;146(4).
[3] Henderson MD, Schmus CJ, McDonald C, Irving SY. The COVID-19 pandemic and the impact on child mental health: a socio-ecological perspective. *Pediatric Nursing.*2020; 46(6).
[4] Shen J. *Impact of the COVID-19 Pandemic on Children, Youth and Families.* Boston: Judge Baker Children's Center, September 2020.
[5] National Academies of Sciences, Engineering, and Medicine 2019. A Roadmap to Reducing Child Poverty. Washington, DC: The National Academies Press. https://doi.org/10.17226/25246.
[6] Trent, M, Dooley, DG, Dougé, D. The impact of racism on child and adolescent health. *Pediatrics.* 2019;144(2).

the reduction in access to primary care as well as community-based outpatient and inpatient mental and behavioral health services is having a profound impact on children.

Now more than ever, families and children from infancy through adolescence need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services to appropriately address their mental and behavioral health needs. Prior to the pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that in 2019, 22.2% of adolescents had a severe mental health impairment. Further, SAMHSA reported the lifetime prevalence of any mental disorder among adolescents was 49.5%. Despite these alarming findings, only a small proportion of those in need received any mental health service in 2019: 16.7% in a specialty mental health inpatient or outpatient setting, 15.4% in an education setting, 3.7% in a general medical setting, 0.4% in a child welfare setting, and 0.2% in a juvenile justice setting.[7]

The human and economic toll of inadequately addressing childhood mental and behavioral health problems is significant. Untreated and undiagnosed mental and behavioral health disorders are associated with family dysfunction, school expulsion, poor school performance and disconnection from school, juvenile incarceration, substance use disorder, unemployment, and suicide.[8]

The child and adolescent mental and behavioral health crisis necessitates a coordinated approach from all federal agencies that addresses the opportunities and funds the essential programs outlined below. Interagency collaboration is essential to ensure that existing opportunities are leveraged, and funding-related gaps are identified and addressed. Collaboration across federal agencies is key to developing a comprehensive system of care across the continuum to address mental and behavioral health needs for infants, children, and adolescents.

Our organizations, representing a diverse array of perspectives, are dedicated to promoting the mental health and well-being of infants, children, adolescents, and young adults. In this document, we have identified nine concrete opportunities to improve and enhance mental health services for this population. As a coalition, we offer a set of specific and actionable opportunities that increase access to evidence-based prevention, early identification, and early intervention; expand mental health services in schools; integrate mental/behavioral health into pediatric primary care; strengthen the child and adolescent mental and behavioral health workforce; increase insurance coverage and payment; ensure mental health parity; extend access to telehealth; support children in crisis; and address the mental health needs of justice-involved youth.

Within each topic area, attention should be given to special populations, including youth of color and historically underserved youth, LGBTQ youth, children with chronic or complex conditions and disabilities, and youth involved in the juvenile justice and child welfare systems.

1. Prevention, Early Identification, and Early Intervention

Challenges: Roughly half of lifetime cases of mental illness begin by age 14 and nearly three quarters by age 24, making early identification and intervention a key child and adolescent health issue. Although the onset

[7] https://www.samhsa.gov/sites/default/files/behavioral-health-workforce-report.pdf

[8] National Research Council and Institute of Medicine. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2009.

of most mental disorders occurs during childhood, effective treatment is typically delayed despite the positive evidence of early intervention. This is due, in large part, to the fact that health care professionals, child care workers, and teachers often lack specialized knowledge and age-appropriate referral sources to identify and treat the early signs of mental and behavioral health conditions using evidence-based practices as well as the many barriers that exist to accessing services once a need has been identified. It is also due to underlying social and community factors, such as child poverty, racism, lack of health coverage, lack of safe, stable, and affordable housing, unemployment, and limited educational opportunities, many of which have been exacerbated by the COVID-19 pandemic, that make it difficult to obtain services.

Opportunities:

- Expand training of health care providers, child care workers, home visitors, early intervention providers, teachers, school personnel, school behavioral health providers, first responders, and others to increase awareness and use of the most developmentally-appropriate, research-based screening and diagnostic tools for children of all ages, including tools to assess social determinants of health, to reliably identify mental health conditions and suicide risk at an early age, and link children in need with developmentally-appropriate services.
- Incentivize screening for behavioral health needs at well-child visits, the provision of parental supports, and other early intervention services necessary to address needs early.
- Support Medicaid's Early and Periodic Screening, Diagnosis, and Treatment provisions and protections for children to ensure early identification and medically necessary treatment for those with or at risk of mental and behavioral health conditions.
- Address the growing prevalence of anxiety and depression in children.
- Strengthen linkages with social services to address the intersecting needs of children and families.
- Address and mitigate underlying factors that can contribute to mental health problems in children, including poverty, racism, housing needs, and gaps in health insurance coverage.
- Remove barriers that prevent children and caregivers from receiving services together.
- Support implementation of successful demonstration models for the prevention of psychosis and create similar models to prevent and treat other forms of serious emotional disturbance.
- Increase culturally and linguistically appropriate public awareness, screening, and treatment for maternal depression, infant mental health disorders, and trauma and toxic stress in children of all ages as part of routine preventive and primary care.
- Encourage implementation of evidence-informed suicide prevention and mental health programs in schools and on college campuses.
- Fund programs aimed at developing, maintaining, or enhancing culturally and linguistically appropriate infant and early childhood mental health promotion, intervention, and treatment.

2. School-Based Mental Health

Challenges: Across the nation, there is a shortage of mental health supports and professionals in schools. In fact, many students have no access to school counselors, psychologists, nurse practitioners, or social workers. Furthermore, 1 in 6 of school-aged children has a mental health diagnosis,[9] yet approximately 80% of this population did not receive care.[10] School-based mental health services represent an important mechanism to

[9] https://www.aafp.org/news/health-of-the-public/20190318childmentalillness.html
[10] https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.159.9.1548

ensure children and adolescents receive the health and mental health supports they need. In fact, youth are six times more likely to complete mental health treatment in schools than in other settings.[11] School-based mental health includes prevention, intervention, and treatment services provided in on-site clinics as well as efforts to strengthen the school climate and teachers/administrators' abilities to serve students with mental health concerns. When schools lack supportive mental health services, youth are more likely to receive punitive discipline, which can lead to an increase in pushouts and the school to prison pipeline.[12] Existing payment structures for school-based mental health services such as School-Based Health Centers limit the type of services many schools can offer including for culturally appropriate services.

Opportunities:

- Increase resources available to schools, including colleges, for child, adolescent, and young adult mental health services. Increasing the availability of resources and access to mental and behavioral health providers in school settings meet children, adolescents, and young adults at a critical care access point.
- Build infrastructure for schools through national, state, and local resources to include on-site clinics and an array of in school services that are accessible to students, families, and communities during the day as well as during evening, weekend, and summer hours.
- Support financing for school-based health centers and other school mental health programs through a combination of federal and state funding, private grants, Medicaid, private health insurers, and direct payment. Services must be available to all, regardless of insurance coverage.
- Provide mechanisms through Medicaid for payment for school-based mental and behavioral health services, including providing additional CMS guidance to state Medicaid programs.
- Incentivize school mental health programs to build strong partnerships with School-Based Health Centers, Federally Qualified Health Centers (FQHCs), Behavioral Health Organizations (BHOs), and community-based mental health providers to ensure timely access to needed care.
- Provide incentives to ensure school-based health providers are adequately trained to recognize the mental and behavioral health needs of students and to offer culturally sensitive and responsive evidence-based services. In addition, incentives should be available to provide basic training for all school staff on indicators of mental and behavior health concerns and who to notify within schools to connect children to needed supports.

3. Integration of Mental and Behavioral Health into Pediatric Primary Care

Challenges: Pediatric primary care is the setting where families regularly access care for their children and where identification, initial assessment, and care of medical, mental, and behavioral health conditions occur. Most integrated care efforts are funded through a patchwork of short-term public and private grants, limiting their reach and sustainability. Important research shows that the integration of mental health and primary care makes a difference for infants, children, and adolescents in terms of expanded access to mental health care, improved health and functional outcomes, increased satisfaction with care, cost savings, and improved coordination among primary and behavioral providers in clinics and school-based settings. Increasing support for primary care and subspecialist training in behavioral health and suicide risk and integrated, team-based care is needed to ensure that behavioral health services can be delivered in the pediatric primary care

[11] https://www.clasp.org/sites/default/files/publications/2020/06/2020.06.15%20Unlocking%20Transformation%20and%20Healing%20-%20CBC.pdf

[12] https://www.aclu.org/sites/default/files/field_document/030419-acluschooldisciplinereport.pdf

setting. Ensuring linkages to primary care as part of routine and specialty mental health care is also critically important.

Opportunities:

- Expand the Health Resources and Services Administration's (HRSA) Pediatric Mental Health Care Access Program nationwide. HRSA currently funds 21 state programs that increase access to mental health care for children. Federal investments to substantially expand child psychiatric telephone consultation programs could significantly increase the number of children receiving mental health services.
- Establish and promote behavioral health integration in the pediatric medical home, through training of primary care providers and behavioral health professionals, to ensure that prevention, early identification, and intervention can be delivered in the primary care setting.
- Foster the development of new, and support existing, sustainable models of co-location or integration of mental health providers in all pediatric primary care settings.

4. Child and Adolescent Mental and Behavioral Health Workforce

Challenges: Across the United States, there is a dire shortage of practitioners specializing in mental and behavioral health to care for infants, children, adolescents, and young adults. Prior to the pandemic, in 2020, SAMHSA estimated that 4.5 million additional behavioral health practitioners are needed to address the needs of children with serious emotional disturbances and adults with serious mental illness, including an additional 49,000 child and adolescent psychiatrists. The gap between currently available child and adolescent providers and what is needed to provide evidence-based mental and behavioral health care for this population is stark. New incentives and opportunities are needed to quickly expand a diverse child and adolescent mental and behavioral health workforce. The shortage of providers with specialized training to treat mental health conditions in infants and toddlers is even more extreme. Today, 50% of children with mental health conditions receive no treatment at all. Expanding the child and adolescent mental and behavioral health workforce, as well as increasing cultural and linguistic competence, is critical for addressing the enormous unmet mental and behavioral health needs of infants, children, adolescents, and young adults.

Opportunities:

- Develop a nationwide strategy with public and private partners to expand the supply, diversity, and distribution of the behavioral health workforce to address infant, child, adolescent, and young adult mental and behavioral health needs.
- Expand opportunities for practicing clinicians to increase competency and capacity in identifying and providing treatment for mental and behavioral health needs.
- Fund and implement the Pediatric Subspecialty Loan Repayment Program to address high student loan debt among child mental health professionals that serves as a barrier to expanding the behavioral health workforce.
- Expand loan repayment assistance programs for clinicians such as pediatric subspecialists, child psychiatrists, advanced practice nurses licensed or certified to provide pediatric behavioral health services, psychologists, social workers, and other behavioral health clinicians with expertise in child and adolescent health.

- Expand workforce training programs like the HRSA Graduate Psychology Education Program, the Children's Hospitals Graduate Medical Education Program, and the Substance Abuse and the SAMHSA Minority Fellowship Program.
- Identify new and expanded opportunities for accelerated behavioral health training programs for pediatric residents, pediatricians, and pediatric nurse practitioners, including the Triple Board Program.
- Recognize peer supports and community health workers as integral behavioral health practitioners to increase the supply and address health disparities and barriers to access care.
- Support fellowship training and college programs to encourage diverse groups of students to pursue careers in behavioral health, and embed education about infant, child, and adolescent behavioral health into these programs.
- Support cultural and linguistic competency training for the mental and behavioral health and primary care workforce.

5. Insurance Coverage and Payment

Challenges: Medicaid and CHIP, which now cover more than 37 million children, are vital sources of insurance coverage for mental health and substance use disorder services. These programs, along with private insurance expansions, have resulted in historic levels of coverage for infants, children, and adolescents. However, beginning in 2017, the child uninsurance rate began to climb, jumping to 5.7% in 2019.[13] Since this data was collected prior to the pandemic, the number of uninsured children is likely considerably higher in 2020, as families have lost their jobs and employer-sponsored insurance.

To better optimize access to mental and behavioral health care, participation by mental and behavioral health clinicians in both private and public insurance plans should be given heightened attention. Adequate payment rates for mental and behavioral health services should be a greater priority. The use of behavioral health carve-outs, lack of payment for emerging childhood mental health conditions and non-face-to-face aspects of children's mental health care, and restrictions on same day billing of medical and mental health services create additional barriers to children's access to mental health services. Even though private insurance, CHIP, and Medicaid managed care are subject to mental health parity requirements, access to timely and qualified mental and behavioral health providers is often limited because cost-sharing requirements are too high, access to out-of-network providers is prohibited, and essential mental and behavioral health services are often not covered (eg, family counseling).[14] Public and private payers should work to remove barriers to implementing therapeutic approaches that are evidence-based, evidence-informed, or promising practices. Services must also be provided in a culturally and linguistically appropriate manner, including interpreters as needed for children and/or their parents/caregivers.

Opportunities:

- Preserve and extend public and private insurance coverage for infants, children, adolescents, and young adults so that the historic coverage gains for children are regained and sustained. Ensure all plans have comprehensive, affordable coverage for mental health and substance use disorder services so that

[13] https://ccf.georgetown.edu/2020/10/08/childrens-uninsured-rate-rises-by-largest-annual-jump-in-more-than-a-decade-2/

[14] National Alliance on Mental Illness. *The Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care*. Arlington, VA: NAMI; 2017. Available from: https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf.

infants, children, adolescents, and young adults can access the care that they need, including through a variety of home and community settings.

- Invest in payment models that support integrated, team-based care for children and families.
- Encourage private and public payers to allow same-day billing for medical and mental and behavioral health services; to recognize and adequately pay for codes pertaining to behavioral and developmental and postpartum screening and assessment (using validated instruments), behavioral health counseling, telehealth, family therapy, care management services, and consultation services; and to ensure sufficient support for team-based, interprofessional approaches to screening and preventive care, care management, and service coordination.
- Ensure payment to pediatric primary care providers for the provision of developmentally appropriate mental and behavioral health services, including prevention and care of children whose conditions have not risen to the level of a diagnosis.
- Ensure that all medically necessary mental and behavioral health services and interventions for infants, children, adolescents, and young adults can be delivered in adequate quality and quantity, including access to out-of-network providers as needed.
- Commission a national study of private and public insurance participation by child and adolescent mental and behavioral health specialists, including infant and early childhood mental health specialists. Included in this study should be a set of recommended payment policies that would be necessary to ensure the participation of child and adolescent psychiatrists, psychologists, social workers, certified substance use counselors, and other behavioral health professionals in private and public insurance networks.
- Increase support to schools, school districts, and education agencies to implement strategies to access and utilize payment to support provision of school-based mental and behavioral health services to children and adolescents, including performance incentives to managed care health plans for collaborating with schools and school-based health providers.
- Ensure any payment reform efforts fully integrate mental health needs of children and adolescents and acknowledge that cost savings should not be the primary goal for improving children's outcomes—savings are longer-term in nature. Also, address real or perceived barriers to treatment, including sharing of information.

6. Mental Health Parity

Challenges: Despite enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its subsequent expansions to Medicaid managed care, CHIP, and the insurance marketplaces, there has been a persistent need to improve oversight and compliance with the requirements of MHPAEA. In late 2020, Congress passed new legislation aimed at improving parity compliance by granting the Department of Labor new powers to audit health plans to determine whether they comply with MHPAEA, recommend changes the plan should make to gain compliance, and require plans to notify beneficiaries of their noncompliant status if corrections are not made. While these new measures are promising, many children and adolescents still face barriers in access to mental health and substance use disorder treatment due to insurance discrimination that singles out these services. In addition, consumer and provider awareness about mental health parity protections and remedies are not well understood.

Opportunities:

- Maintain applicability of MHPAEA in the current public and private insurance markets, including individual and small group markets, and enact more robust enforcement requirements.
- Expand MHPAEA to children and adolescents enrolled in Medicaid fee-for-service arrangements and encourage more robust enforcement of the parity requirement in Medicaid MCOs and CHIP, eliminating the more restrictive limits and barriers that are placed on mental health and substance use disorder services as compared with medical and surgical services, including burdensome prior authorization requirements.
- Partner with state agencies, such as Attorneys General, insurance commissioners, and Medicaid agencies, to ensure compliance with existing MHPAEA protections for children and adolescents in the private *and* public insurance markets, including Medicaid and CHIP.

7. Telehealth

Challenges: Changes in telehealth policy in Medicaid, the Children's Health Insurance Program, and commercial insurance in response to the COVID-19 pandemic greatly expanded access to and continuity of care for children and families across the country. These changes proved to be a critical lifeline for the rising numbers of children and adolescents struggling with mental and emotional problems,[15] offering an efficient way to support their mental health needs, especially those in rural, underserved, and low-income communities who continue to face the most barriers to care. The tremendous surge in telehealth utilization during these challenging times demonstrated as never before the significant promise continued access to telehealth offers for reducing barriers to care even beyond the current emergency. Moreover, emerging data is demonstrating that telehealth -- particularly telehealth for mental health and substance use care – can maintain and even improve the quality and comprehensiveness of patient care while expanding access to evidence-based care for children with mental and behavioral health needs. However, while quality telehealth care promises to increase access and mitigate barriers to care for patients, this must be done in support of and integrated with the medical home, not in place of it.

Opportunities:

- Make certain that beyond the pandemic, telehealth, particularly for mental health and substance use treatment, continues to be part of a comprehensive set of care options available to provide the right care in the right place at the right time. Use of telehealth should be based on the health condition, preferences of the patients, families, and provider, resources available, integrated with the medical home, and available through both video-enabled and audio-only devices as appropriate and in accordance with patients' preferences and needs.
- Ensure that providers who deliver health care services through telehealth, as well as referring clinicians and participating facilities, should receive equitable payment for their services to increase the availability of health care services for all children and families. Providers should receive payment for services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with

[15] The CDC recently reported dramatic increases in the numbers of children and adolescents seeking mental health treatment in emergency rooms: https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm; see also https://childmind.org/our-impact/childrens-mental-health-report/2020-childrens-mental-health-report/.

accepted standards of medical or clinical practice; payment should not be determined by the technology used to deliver these services. Patients should have access to telehealth services regardless of their geographic location.

- Expand telehealth and teleconsultation mechanisms to expand access to mental and behavioral health services to child and adolescent populations, including through bidirectional training of providers to foster telehealth use and expanded internet connectivity. Broadband access will be critical to ensure equitable access to telehealth.

8. Infants, Children, and Adolescents in Crisis

Challenges: Providers are witnessing an alarming number of children and adolescents in behavioral health crisis, with emergency departments seeing increases in suicidal ideation and self-harm. From April to October 2020, hospitals across the U.S. saw a 24% increase in the proportion of mental health emergency department visits for children ages 5 to 11, and a 31% increase for children and adolescents ages 12 to 17.[16] Behavioral health clinicians have reported over the last several years that children and adolescents are increasingly "boarding" in emergency departments for days because they do not have sufficient supports and services.

The increasing need for behavioral health services due to the traumatic impacts of the pandemic on infants, children and adolescents has highlighted the existing gaps in access to services across the continuum of care, challenged in part by shortages of mental and behavioral health providers and alternatives to inpatient hospital care, such as intensive community-based supports and services, mobile crisis intervention, therapeutic foster care, and intensive case management services. These access challenges are a barrier to early intervention services that minimize or prevent the need for crisis care interventions and to other community alternatives for children who need more support. Hospitals have been able to stabilize children during a crisis situation; however, they have identified gaps in their ability to counsel patients, identify the best referral care option, or follow up with families to make sure they found necessary, ongoing care.

Opportunities:

- Designate funding specifically intended to target the behavioral health needs of infants, children, and adolescents with flexibility to fund a range of activities across the continuum of care, including crisis care needs e.g., pediatric training for crisis response and initiatives to relieve the stress on emergency departments and inpatient units, including mobile crisis intervention, intensive community-based supports, and intensive case management services, and therapeutic foster care.
- Support access to step-down programs (e.g., partial hospitalization and intensive outpatient programs) that support infants, children, and adolescents that may be necessary following crisis stabilization before safely returning to their communities.
- Support effective implementation of the 9-8-8 universal telephone number as the national suicide prevention and mental health crisis hotline.
- Increase federal funding for the National Suicide Prevention Lifeline.
- Support federal legislation to enhance the promotion and accessibility of crisis response services, including current congressional efforts to enhance public education regarding crisis services and help-

[16] 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. Available at: http://dx.doi.org/10.15585/mmwr.mm6945a3

seeking, reinforce quality assurance provisions and standardized services, and provide Medicaid and Medicare coverage for the crisis care continuum.

9. Justice-Involved Youth

Challenges: Although estimates vary, the prevalence of mental health disorders among justice-involved youth ranges from 50% to 80%. Common mental and behavioral health disorders include depressive disorders, anxiety disorders, disruptive behavior, attention-deficit/hyperactivity disorder, posttraumatic stress disorder, and substance use disorders. The high prevalence of mental health disorders among juvenile-justice involved youth is interconnected with the high prevalence of trauma and adverse childhood experiences (ACEs) they experience. Most justice-involved youth experience trauma and polyvictimization from a young age. These experiences and resulting toxic stress response often result in maladaptive behaviors, such as increased stress reactivity, impulsivity, hyperarousal, and decreased ability to self-regulate. Youth who have experienced multiple traumatic events are at increased risk of delinquency, contact with law enforcement, involvement with the juvenile justice system, school suspension, disconnection from school, volatile relationships, and substance use. Polyvictimized youth are also more likely to receive diagnoses of externalizing disorders such as conduct disorders, oppositional defiant disorder, and antisocial behaviors. There is increasing recognition that for many youth, these diagnoses may be rooted in complex trauma and polyvictimization.

Opportunities:

- Recognize incarceration as a last resort only for youth who have committed serious crimes and cannot be safely placed in a community-based programs.
- Invest in funding for diversion programs as an alternative to incarceration for justice-involved youth, including programs specializing in addressing mental health and substance use care needs.
- Ensure confined youth receive the same level and standards of care, including mental health and substance use care, as nonconfined youth accessing care in their communities, including initial mental health screenings for all youth confined for more than 1 week.
- Provide robust funding for the Juvenile Justice and Delinquency Prevention Act (JJDPA) and its core protections which include improving conditions for detained youth, reducing detention of status offenders, and reducing racial disparities to ensure conditions of confinement are developmentally appropriate.
- Ensure that states fully implement the statutory changes to Medicaid included in the SUPPORT Act to ensure that youths' Medicaid eligibility is not terminated upon incarceration, and that youth are enrolled and benefits are fully reinstated upon release.
- Support funding for juvenile facilities to implement a comprehensive suicide prevention program that includes ongoing suicide risk assessment.
- Support detention facilities and juvenile justice systems in implementing a trauma-informed approach that responds to the needs of justice-involved youth and their families.
- End the use of isolation and solitary confinement for children and adolescents.