

A Marshall Plan for Children's Mental Health after COVID-19

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Background

There is no doubt that COVID-19 will have a long-term impact on every individual and every service sector. This is clear, even as we are in the midst of this acute pandemic. Attention is largely focused on public health and economic impacts. Fortifying the country's health system, restoring the population's health, and stabilizing the economy will take years, and will require a collective effort from all citizens and sectors. Taking a longer view, however, the recovery of the country will ultimately rest on having healthy, productive, and engaged citizens who can contribute to a flourishing society and economy. This requires attention to the present generation of children living through this pandemic because they instantiate the future of the country. In addition to infecting children, the pandemic has completely disrupted their family life, including school and community closures, and relationships that reinforced their health and wellness. The pandemic's economic impacts will also increase poverty, homelessness and hunger for many children and families. A concerted, collective, and robust social and economic rescue plan is needed to support these families and children. Because the U.S. had a less-than-enviable record of ensuring the mental health of children and adolescents prior to COVID-19, this rescue plan will require a fundamental societal shift in American priorities, services, and the systems that actually support families and children, with best practices implemented and sustained, rather than hollow statements.

At this juncture when children's health, mental health, and the basic safety net of systems and supports for them and their families are in great jeopardy, we propose a Marshall Plan for Children's Mental Health after COVID-19. Modeled after the economic and social reconstruction effort to restore post-war Europe, this renewal and rejuvenation plan for children's mental health rests on two cornerstones.

Children First Ethics. For decades, there has been agreement among most citizens and sectors that it is valuable to take care of children, provide them free and equal access to education, and, more recently, to healthcare services of varying quality. We are calling for something more profound: a unilateral commitment to a societal

obligation that puts the needs of children first. Like the “health-in-all-policies” enacted over the last decade, *children-in-all-policies* should be adopted to encourage children’s social-emotional development—in all policy deliberations. This commitment would privilege a societal ethics that puts children first. It would translate into a principle for action by citizens throughout communities—from coaches, investors, bus drivers, teachers, etc.—across all strata in society. For example, ensuring that child socio-emotional development is a priority for all sports coaches, rather than just athletic development, would alter societal perceptions of the importance of children’s mental health.

Building Back Better: Building Back Better (BBB), pioneered by the United Nations, is a post-disaster recovery approach to encourage resilience after localized traumas and multi-level short and long-term actions that improve the well-being of populations (1). This pandemic presents an opportunity to build back better: to provide a continuum of services that are personalized to meet families’ needs, whenever and wherever they occur, along with an infrastructure to support and monitor services and outcomes.

Four key propositions from BBB apply to our Marshall Plan proposal. They include: (a) families and local communities driving their own recovery; (b) recovery that promotes fairness and equity; (c) valid and reliable data collection on access and outcomes to monitor improvement; and (d) financial flexibility to spark innovative solutions.

The current composite of services funded by States was fragmented before the pandemic, and is now in even more extreme disarray. Most behavioral health services are at a standstill, except for those that were prepared for digital delivery. We suggest that BBB requires a shift away from the current system of bricks-and mortar, or at least away from the exclusive emphasis on them. Instead, we propose categories of supports and services that map onto the four features of BBB.

First, locally-driven services should provide skills training and supports to families, whenever and wherever they are needed. This means making available child and family support services to any parent or caregiver who requests them, and in locations convenient to the family, not to the provider entity. This should be implemented immediately. Prevention is possible, and will have long-term benefits if families and children are provided supports now. In some communities, this would mean delivering services in Women, Infant and Children (WIC) programs, churches, schools, shopping malls, community centers or, as is likely to be increasingly the case, virtually. The range of services should be wide, from pre and postnatal services for mothers and infants, to childcare and other early childhood services, as well as vocational training and technical skills training for older youth. Expansion of the workforce will be needed, building upon the availability of community-level navigators, paraprofessionals, and certified parent support specialists, all of whom could deliver most of these services without the nearly-exclusive prior focus on high-cost specialists. In many communities, training and certification exists to enable community members to provide screening, psychoeducation, diagnostic assessments, facilitated referrals, and group support (2).

For example, parent support specialists or other support professionals could be made available for any family that requests them. Families and communities drive their own recovery when they are empowered to identify community needs, priorities, and the means for accessing services.

Second, promoting fairness and equity as a feature of BBB means meeting parent's basic *mental health* and *economic security* needs as they arise, and where delivery is driven not by zip code of residence but by severity of need. This may include provision of *mental health services* for family therapy, for prenatal and postnatal services, or for economic or housing supports. This may also entail *economic supports*, such as job skills training, paid sick leave, extension of family leave policies, and restoration of a minimum wage that is livable. Both the Supplemental Nutrition Assistance Program (SNAP) and the Earned Income Tax Credit (EITC) support economic security, which in turn, assists children's sense of stability, an important ingredient in healthy development (3).

Third, BBB depends on the availability of good data to guide access to and outcomes associated with services. This includes real-time tracking, through integrated data systems, as well as population-level indicators, at national, state, and community levels. A rejuvenated service system will also capitalize on the use of digitalized technologies, including web-based support and services and telephone and text-based services, to enable families to have easy and affordable access to all providers (e.g. pediatricians, nurse practitioners, employment counselors, and parent support specialists), care personalized to fit *individual* family needs.

Fourth, in our conceptualization BBB entails a new financial infrastructure model built on an alternative payment system that follows children's social-emotional-developmental needs, not insurance protocols. It means financing children's mental health outcomes themselves, not volume. This new system will be driven by family choice, preference, and service needs, not insurance reimbursement schedules, and it will follow children's well-being by tracking need, use and outcomes. While no single payment system can respond to every situation or to the varying severity of children's mental health needs, it is clear that value-based payments, like capitation, encourage a broader population approach and a greater focus on prevention and health-promotion (4). Some combination of capitation and incentives for outcomes or pay-for-performance will be important. Even more so, coordination-enhancing agreements, crafted locally and embedded into regulations or policies, will allow mental health care to be linked to other sectors, such as special education, foster care, and juvenile justice. Aspects of these innovations have been proposed and are being tested in the Integrated Care for Kids (InCK) federal demonstration program (5) and will be critical to BBB for children's mental health.

Conclusion

In the chaos that will emerge as society gradually recovers from this pandemic, child mental health issues are at risk of being ignored as the spotlight focuses on the larger political and economic gamesmanship that so often consumes the headlines. To alter that, a coordinated and collaborative commitment, something like a Marshall Plan for

Children's Mental Health after COVID-19, will be essential to ensure that the next generation is not the longest living victims of the COVID-19 pandemic, with higher rates of anxiety, poverty, depression, suicide and other negative consequences. Such a plan might be coordinated by a national children's oversight committee, or as recent successes with Children's Cabinets in some states have shown, with local adaptation and implementation regionally. Implementing such a plan will take both a re-allocation of existing dollars, as well as an influx of new dollars tied to outcomes, to make sure that children are getting what they need to thrive.

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