Addressing the Mental Health Needs for Girls from Low-Income Communities

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Applied Policy Project

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girls inc.

Acknowledgments

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Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

On my honor as a student, I have neither given nor received unauthorized aid on this assignment.

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Acronyms and Key Terms

CCBHC – Certified Community Behavioral Health Clinic

HHS – U.S. Department of Health and Human Services

Mental illness – A condition that affects someone's thinking, mood, or behavior which impacts their overall wellbeing

Project AWARE-SEA – Project Advancing Wellness and Resiliency in Education State Educational Agency

SAMHSA – Substance Abuse and Mental Health Administration

SBHC – School-Based Health Center

SOC Expansion and Sustainability Grant – This is the short title for the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Expansion and Sustainability Grant

Executive Summary

The mental health crisis in the United States is what some are calling a "silent epidemic" (Anderson, 2016). About 20% of children and teens in the U.S. suffer from a mental illness that disrupts their moods, thoughts, or behaviors (O'Connell et al., 2009). But this average statistic masks heterogeneity by gender: **girls are about three times as likely to be diagnosed with a mental illness compared to boys** (Breslau et al., 2017). Even worse, many of these children are not getting the treatment they need, especially if they come from a family with low income. Only about 15% of children from low-income families will receive mental health services and even fewer will complete treatment (Hodgkinson et al., 2017). When children do not get treated for their mental illness, they are more likely to drop out of high school, have poor adjustment skills at work and in the home, and they could even commit suicide. As a voice for girls from low-income communities, Girls Inc. has the unique opportunity to advocate for changes to the way mental health care is delivered to the girls that are most affected by this problem.

From the literature, it is clear that systems of care approaches and school-based interventions are the most effective ways to increase the accessibility and usage of mental health treatment services. Based on these findings, this report proposed three alternatives that Girls Inc. can pursue:

1. Advocate to sustain federal funding for Certified Community Behavioral Health Clinics over the next 5 years
2. Advocate for the passage of the Mental Health Services for Students Act
3. Return the budget allocation for Systems of Care Grants to 2019 and 2020 levels.

After conducting a cost-effectiveness analysis, evaluating political feasibility, and assessing the racial equity of each alternative, I recommend Girls Inc. implement the second option. Passing the Mental Health Services for Students Act is the most cost-effective and racially equitable option, and it is possible it will pass in the current Congress. The other options were not as cost-effective which impacted their political feasibility. Ultimately, the Mental Health Services for Students Act offers a feasible pathway to increase access to school-based services to children across the country. Implementation of this option should focus on working with key Republican offices in the Senate to ensure bipartisan support and passage of this bill. By increasing the collaboration between educational and mental health agencies, children will have more opportunities to get the support they so desperately need.

Client Overview

Girls Inc. delivers research-based programming to girls across the country to help them create a healthy lifestyle, succeed in school, and solve real-world problems. In order for girls to truly succeed in these goals, they must have stable and sound mental health. Mental illness is rising in girls, and Girls Inc. must be prepared to address this issue in their programming and their advocacy work.

Right now, one of Girls Inc.'s advocacy priorities is to "support girls' mental health" (*Advocacy Platform*, n.d.). My hope is that this report can serve as a resource to the advocacy staff to help them become a leader in mental health advocacy. As a champion for low-income girls, Girls Inc. is well positioned to advocate for changes to address disparities in access to and usage of mental health services and ensure girls across the country get the treatment they need to succeed in the years to come.

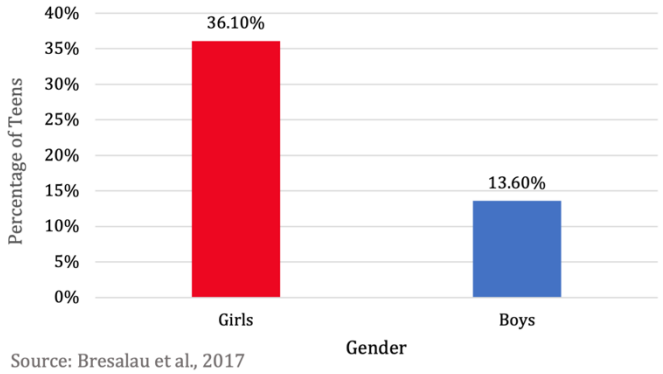
The Problem

Only about 15 percent of children from low-income communities will receive the mental health services they need and even fewer will complete treatment (Hodgkinson et al., 2017). Children that do not learn to manage their mental illness can have poorer educational achievements, lower productivity, and reduced social wellbeing (Breslau et al., 2017). The consequences of not receiving treatment can be particularly dire for girls since they are about three times as likely as boys to experience mental illness (Breslau et al., 2017). **The combination inadequate treatment and heightened diagnoses make girls from low-income communities at the greatest risk of suffering the negative consequences associated with mental illness.**

Background

Adolescence, ages 10-19 years, is one of the most critical stages of human development because the health and wellbeing cultivated during those ages can have lifelong consequences and influence long-term health trajectories (Blum et al., 2017). A mental illness is defined as a condition that affects someone's mood, thinking, or behavior that impacts their overall wellbeing. During these critical ages, girls are being diagnosed with mental illness at a higher rate than boys. About 36 percent of girls will experience a mental illness during adolescence compared to only about 14 percent of boys (Breslau et al., 2017). Even worse, the number of teenagers reporting they experienced depression has increased in the past 10 years; and the rate of growth is faster for girls (66%) than for boys (44%) (Geiger & Davis, 2019).

Figure 1. Share of Teens Who Will Experience Depression

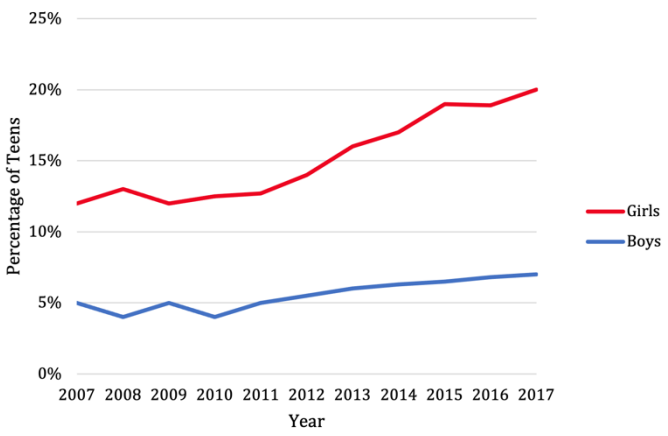


Source: Bresalau et al., 2017

It is not clear what specifically caused this sharp spike in rates of mental illness among teenagers, but researchers have a few explanations for why girls might be experiencing higher rates of mental illness than boys. First, brain scans show that girls' brains develop and mature faster than boys' brains, in terms of their emotional recognition (Steingard, n.d.). The emotional sensitivity that comes with this maturation could make girls in adolescence more vulnerable to mental health problems if they cannot properly understand the situation around them (Steingard, n.d.). Secondly, several researchers point

to puberty as a reason girls tend to suffer more than boys from mental illness, especially during adolescence (Emamzadeh, 2019; Rudolph et al., 2014; Albert, 2015). During puberty, hormonal changes affect the brain's structure and function involved in emotional regulation (Rudolph et al., 2014). The imbalance between emotional regulation and heightened reactivity creates a scenario ripe for discomfort, low self-esteem, and defensiveness which can result in higher levels of anxiety and depression (Rudolph et al., 2014). Further, girls who go through puberty earlier than their peers are at an even greater risk of being diagnosed with a mental illness (Rudolph et al., 2014). As the first in their peer group to experience changes during puberty, early maturing girls may feel particularly self-conscious, isolated, and insecure (Rudolph et al., 2014). Research shows that early maturation in boys does not have the same harmful effects as it does for girls, which could be the reason we see such higher incidences of mental illness in girls rather than boys (Albert, 2015; Rudolph et al., 2014).

Figure 2. Percentage of teenagers reporting they experienced depression in the past year



Source: 2017 National Sruevy on Drug Use and Health

Not only are girls more likely to suffer from mental illness, but they are also less likely to receive the treatment they need if they are from low-income communities (Howell & McFeeters, 2008). Children of color who grow up in low-income families often receive lower quality mental health treatment and are more likely to terminate their treatment early, even though they have similar mental health needs as white, wealthy children (Howell & McFeeters 2008; Alegria et al., 2010). The problem with a lack of treatment persists because mental health treatment options have not evolved to meet the unique needs of patients from low-income communities; several studies point to the inaccessibility of traditional mental health services for people from minority communities (Alegria et al., 2010; Atkins et al., 2003; Howell & McFeeters 2008). In a study to detect the effectiveness of different mental health treatment options, researchers found that traditional clinical services were not effective at retaining young patients (M. S. Atkins et al., 2003). Elements like one's perception of mental illness, attitude toward health care providers, and prioritization of health can cause families to become disinterested or disengaged from seeking treatment (Alegria et al., 2010). Families from low-income communities need new approaches to treatment that are more accessible to them if girls are going to get the treatment they need.

Finally, the lack of access or underutilization of available mental health resources could not only be a function of cultural acceptability, but also an effect of the cost of treatment. In a study where a little more than half of the families lived below the poverty line, nearly a quarter of parents reported that their child did not receive the services they needed because it cost too much (DeRigne, 2010). The number of parents who cited cost as a barrier to treatment was even higher for families without insurance; uninsured parents were about 4 times more likely to not get treatment because of the cost (DeRigne, 2010). But even privately insured families struggle to afford mental health treatment. A large study conducted in Oregon found that children from low-income families were more likely to get their needs met with public insurance than families with private insurance (DeVoe et al., 2011). Across studies, public insurance helped the most families afford treatment compared to private or uninsured families (DeRigne, 2010; DeVoe et al., 2011; Georgetown Law Center on Poverty and Inequality, 2019). The cost of treatment along with stability and type of insurance coverage can explain why some people might be able to take advantage of mental health treatment options more than others

In all, girls from low-income communities have a greater risk of suffering from mental illness because of early hormonal changes in adolescence, yet they are not likely to get the treatment they need because of the inaccessibility and cost of traditional mental health services. Without the proper tools to manage mental illness, girls will face many obstacles to achieving proper mental, physical, and emotional wellbeing later in life (Steingard, n.d.).

Consequences of Inaction

There are a number of poor life outcomes associated with untreated mental illness. The consequences range from poor academic performance, to low self-confidence, to withdrawal from society, and sometimes suicide (Quiroga et al., 2013; Steingard, n.d.). While the consequences of untreated mental illness are far-reaching, this section will focus on three major outcomes: 1) the higher likelihood of dropping out of high school, 2) future problems in the workplace and the family, and 3) suicide.

1. Dropping Out of High School

Struggles with mental illness can affect girls' academic performance and ultimately lead them to drop out of high school (Quiroga et al., 2013). Because mental illness causes people to have a poor understanding of their self-worth, they often view their progress in school pessimistically (Quiroga et al., 2013). This misunderstanding of their progress and success in school can cause many students to disengage from the learning environment and

underachieve in school activities (Quiroga et al., 2013). In a study of teenage children in Quebec's schools, self-reported academic competence and achievement were positively associated with depression, and **adolescents with higher symptoms of depression were 23% more likely to become high school dropouts** (Quiroga et al., 2013). If girls are able to get the mental health treatment they need to cope with their problems, they might be able to avoid the staggering effects of dropping out of high school.

The costs of dropping out of high school are well documented and can be quite detrimental to both the individual who dropped out and the government. First, the U.S. Bureau of Labor Statistics reported that high school dropouts are nearly three times more likely to be unemployed than college graduates (U.S. Bureau of Labor Statistics, 2020). And even when high school dropouts are employed, they earn about $8,000 a year less than high school graduates (Alliance for Excellent Education, 2020). Secondly, the Department of Education reported that dropouts were about 10 percentage points more likely than high school graduates to live in poverty for the ages of 18 to 24 years old (National Center for Education Statistics, 2011). When people live below the poverty line, they often rely on federal assistance to make ends meet which increases the financial burden on the U.S. government. If the number of high school dropouts was cut in half, the federal government would save about $7.3 billion in annual Medicaid spending (Alliance for Excellent Education, 2020). Finally, incarceration rates were *63 times higher* for high school dropouts than among college graduates aged 16 to 24 (Breslow, 2012). Importantly, these data are not specific to girls from low-income communities, but the sheer volume of documentation on the consequences of dropping out of high school explains how detrimental an incomplete high school education can be for someone. If mental illness makes girls more likely to drop out of high school, they are at a greater risk of falling into poverty, earning less than their peers, and potentially falling into the prison system.

2. Future Problems in the Workplace and the Family

Adolescents who struggle with mental illness tend to have poorer outcomes in work and their family life, compared to their healthy peers (Essau et al., 2014; Bardone et al., 1998; Kuhl, n.d.). In a 16 year longitudinal study, researchers found that adolescent anxiety was significantly associated with a number of poor life outcomes (Essau et al., 2014). This study in particular found that adolescent anxiety predicted poor adjustment at work, poor family relationships, problems with the family unit, less life satisfaction, poor coping skills, and more chronic stress by age 30 (Essau et al., 2014). These findings are corroborated in another study that looked at long-term outcomes associated with depression. Researchers found that adolescent depression resulted in lower educational achievements, lower earning potential, and higher unemployment (Kessler, 2012). The poor management and adjustment skills caused by mental illness can lead to missing days of work or reduced

productivity when at work (Kuhl, n.d.). This might explain why people who suffer from mental illness have poorer workplace outcomes. In all, untreated mental illness during adolescence can lead to challenges in the workplace later and cause troubles in family life.

3. Risk of Suicide

The ultimate, most dire consequence of mental illness is suicide (Steingard, n.d.). Anxiety and depression are directly associated with suicidal thinking, and most kids who commit suicide suffer from a mental illness (Steingard, n.d.). Unfortunately, **suicides among teenage girls doubled from 2007 to 2015 and attempted suicides were higher among females (9.3%) than males (5.1%)** (*Girls and Mental Health*, n.d.). Further, a longitudinal study found that girls with persistent depression had a rate of attempted suicides almost two times that of boys with persistent depression (Breslau et al., 2017). Suicides stem from feelings of worthlessness or hopelessness, most often caused by mental illness (Steingard, n.d.).

Additionally, those in the LGBTQ community are also particularly vulnerable to suicide. More than 63% of gay, lesbian, and bisexual youth reported feeling persistently sad or hopeless in 2017, and 23% attempted suicide (*Girls and Mental Health*, n.d.). LGBT youth were 3 times more likely to attempt suicide compared to heterosexual teens (Mustanski & Espelage, 2020). The prevalence of mental illness among LGBTQ youth is higher than heterosexual teens which often leads to more serious consequences. For LGBT girls, the consequences of mental illness can be especially dire.

Key Findings from the Literature

In order to mitigate the harmful effects of untreated mental illness, legislators and communities must reform and rethink the ways they provide mental health care. This section will cover what is most important to consider when assessing policies that will be most beneficial for girls from low-income families. It will also explore the effectiveness of past interventions that aim to increase access to and usage of mental health services. The key takeaways from my analysis of the research are: 1) policies that promote early intervention can shorten the span and mitigate the harmful effects of mental illness (Steingard, n.d.; Breslau et al., 2017), 2) community systems of care are powerful models to increase treatment usage (Chenven, 2010; So et al., 2019), and 3) schools can serve as an easy site where children can access services (Juszczak et al., 2003; Bains & Diallo, 2016).

This section starts with an acknowledgement of the limitations of the research presented, then provides an overview of why early intervention is key when addressing

mental health problems. While the information on early intervention does not address specific policies that promote early detection, it provides context for why the subsequent policies in this report are included. My research concludes that the two methods that stand out the most among mental health interventions are systems of care models and school-based services. The subsequent section expands on the research used to come to this conclusion.

Limitations of the Research

Before discussing the literature in depth, it is worth noting that most studies in the mental health space do not address the unique situation of the problem at hand; there is a considerable gap in the research regarding how, specifically, girls from low-income communities respond to mental health treatments. There is research on how girls are affected by certain practices, and there is even more research on how low-income communities are affected by certain policies, but they are rarely considered together. The remaining sections combine the two circles of thought, but studies that explain the unique aspect of this research are scarce.

The Importance of Early Intervention

Detecting mental illness early on is important because adolescence is such a critical stage in human development. Mental health professionals note that early intervention can shorten the lifetime of the illness and increase social-emotional learning in a child (Steingard, n.d.). Especially for ethnic and racial minority children who are exposed to a number of societal obstacles such as racism and discrimination, early intervention can give these children mental health coping mechanisms that will be helpful throughout their lives (Alegria et al., 2010). These articles do not mention the magnitude of the impact on these children, but I have not found a single study that finds negative life outcomes from early intervention (Steingard, n.d.; Rudolph, et al., 2014; Alegria et al., 2010).

A study comparing persistent depression versus newly detected depression confirmed why a "wait and see" approach to providing mental healthcare can be detrimental compared to intervening right away (Breslau et al., 2017). In a nationally representative survey of children aged 12-17, those with persistent depression were about twice as likely as those with early signs of depression to have attempted suicide (28.7% versus 15.8%) (Breslau et al., 2017). This difference is particularly important for girls because *there was not a difference in suicide attempts between boys with early onset versus boys with persistent depression*. This means that girls could be particularly vulnerable to the negative effects of mental illness if they do not get treatment early. Also, girls with persistent cases of depression had higher levels of impairment than early cases, and this

difference was statistically significant (Breslau et al., 2017). These results indicate that depressive symptoms only get worse over time for girls who do not receive the proper treatment. This study, combined with other insights from researchers and experts in the field, demonstrates that policy solutions that can decrease wait times and get children connected with care quickly will help mitigate the effects of mental illness.

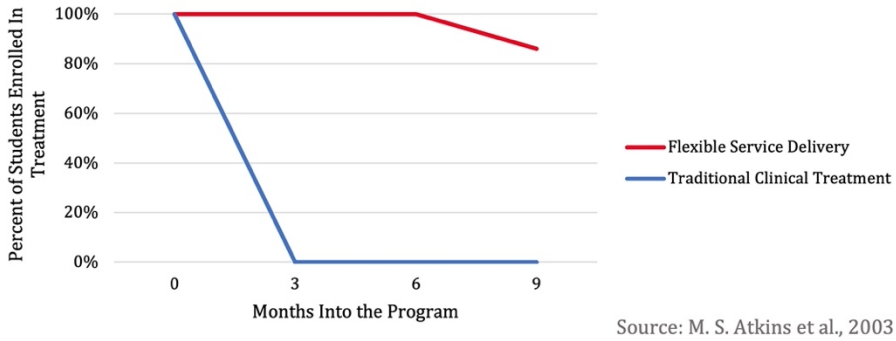
Systems of Care Offer Broad Support

Because low-income families face specific barriers to access mental health services, developing more flexible, comprehensive ways to access treatment can reduce the burden on families (*System of Care Definition and Philosophy*, n.d.). Community systems of care provide families with quality services in the settings that are most accessible to them, meaning there are several approaches to support the specific needs of the child (*Guiding Principles of Systems of Care: Community-Based Services*, n.d.). Community systems of care are designed to integrate not only one, but multiple services to support the child and family (Pumariega et al., 2003). In practice, this looks like providing services that range from school-based services to mentoring programs, to family support and educational programs (Chenven, 2010). Systems of care often connect different governmental agencies to create a circle of support around the child. This community design has been developing in the public health area for around 30 years and has gotten favorable reviews in federal assessments (Chenven, 2010). In a systematic review of policy approaches to mental health services, researchers found that community care models were associated with higher utilization and acceptability among patients (So et al., 2019). However, the studies covered in So's review do not make it clear how the utilization varied across racial, economic, or gendered lines.

In a study to detect the effectiveness of more flexible mental health treatment options, researchers found that traditional clinical services were not effective at retaining young patients (M. S. Atkins et al., 2003). The researchers enrolled some families in a community care/flexible service delivery model while other families were given access to traditional psychological services (M. S. Atkins et al., 2003). Flexible service delivery options, like at-school options, home visits, and phone conversations, were a lot more effective and were utilized more than traditional clinical services; **at 3 months into the program, all of the families enrolled in flexible treatment options were still participating and receiving treatment, whereas none of the families receiving traditional services were participating and were no longer receiving treatment after 3 months** (M. S. Atkins et al., 2003). At 9 months into the program, 86 percent of the families receiving flexible treatment were still enrolled, whereas the families in traditional models did not even stay enrolled through the first three months – as depicted in Figure 3

(M. S. Atkins et al., 2003). And those who dropped out of the flexible delivery only stopped because they changed schools (Atkins et al., 2003). It is not clear how generalizable these results are for different kinds of mental illnesses or whether the results are different for girls or boys. The idea behind a community system of care is to integrate several services for one child, but it is not clear which particular model of care, school-based services, mentoring programs, or family support programs, are the most effective for treating girls. The idea is that the coordination and integration of several agencies to oversee the child offer multiple pathways to access treatment and offer support.

Figure 3. Percent of Children Retained in Treatment Over Time



Source: M. S. Atkins et al., 2003

We also know that community models are effective for children of color and children in low-income communities (Alegria et al., 2010). One researcher explains that community systems of care emphasize strong family involvement in the life of the children while utilizing community resources first when dealing with an issue, which is consistent with some minority cultures' values (Pumariega et al., 2003). There is further evidence to support the effectiveness of community systems from a study that evaluated the role of key community leaders in mental health care usage (M. S. Atkins et al., 2003). When key leaders were involved in implementing broad health initiatives, those services were enhanced and better utilized (M. S. Atkins et al., 2003). Involving key leaders and expanding points of access to marginalized communities is imperative to increasing treatment for children and can be especially effective for African American, Latinx, and Native American children (Alegria et al., 2010).

The Accessibility of School-Based Services

Several studies point to school-based health centers (SBHCs) as a way to help increase access to and usage of mental health services for children. SBHCs are essentially clinics that operate within schools; they often provide primary care, vision, dental, and mental health services right in the school (School-Based Health Alliance, n.d.). School-based services provide care to students in a setting that feels comfortable and is accessible to them, and students are more likely to use mental health services at an SBHC than a traditional clinic (Juszczak et al., 2003; Bains & Diallo, 2016). SBHCs also cater particularly

to females and are effective at increasing access to treatment for racial minorities (Juszczak et al., 2003; Bains & Diallo, 2016).

In a systematic review of literature on SBHCs, researchers found that adolescents who had access to SBHCs were 3-10 times more likely to get mental health treatment than those who did not have access to one (Bains & Diallo, 2016). One study in particular showed that the number of mental health visits *quadrupled* in five years after the creation of the SBHC (Jepson et al., 1998). These two studies show that SBHCs increase mental health treatment access substantially. Further, 9 out of the 23 studies in Bains and Diallo's literature review concluded that female adolescents used SBHCs more often than male adolescents for mental health services (Bains & Diallo, 2016). One caveat to the assertion that girls use SBHCs more than boys is evident in one study that notes that boys from rural areas had a higher percentage of mental health-related visits than girls (Wade et al., 2008). But this one study should not overshadow the general body of research that suggests that girls use services at least at the same rate, if not more often, than boys at SBHCs. In general, studies show that SBHCs provide more sensitive care that is viewed more favorably by patients than the services provided at other traditional clinics, which might explain why the usage rates are higher (Knopf et al., 2016). Further, the visits to SBHCs are 21 times more likely to be for mental health reasons than the visits at community clinics, demonstrating the accessibility of SBHCs particularly for mental health (Juszczak et al., 2003).

School-based services also cater to racial minority youth. Hispanic children got treated more often in SBHCs than traditional health models (Bains & Diallo, 2016). A study of about 450 inner-city school children showed that minority youth had the highest visit rates at SBHCs; African American children on average visited the clinic at about twice the average rate, and Hispanic children visited the clinic at just over the average rate (Juszczak et al., 2003). Another study found a similar result; in a survey of about 300 Rhode Island students, researchers found that Hispanic students constituted the majority of users (about 88%) (Vaz et al., 1993). These findings indicate that SBHCs can be accessible for a diverse range of students.

One limitation of these studies is that a lot of the information presented is not always experimental, thus causation cannot always be established. In fact, none of the 23 studies included in Bains and Diallo's literature review were purely experimental. Some studies are simply descriptive or self-reported surveys which makes it hard to determine what the SBHC did to improve treatment versus the impacts of other unrelated factors.

Key Lessons Learned

The major takeaways from the literature on mental health treatment are that systems of care and school-based health centers offer promising avenues to provide services to children that usually do not get the care they need. Systems of care offer multiple points of access for children and coordinate care across agencies to provide a circle of support for a child. School-based health centers give children access to care in a space that is comfortable for them and easily accessible for all families since every child has access to a public school. Both of these interventions connect children with treatment faster, which can mitigate the harmful consequences of coping with a mental illness.

Evaluative Criteria

Each option will be evaluated on three criteria: cost-effectiveness, political feasibility, and racial equity. In the section below, I will describe how each of these criteria will be measured. I weigh each of these criteria equally, because each of these issues are important to my client. Using these three criteria will allow for consistent analysis across the alternatives I propose and inform my recommendation.

Cost-Effectiveness

This criterion will measure the cost to the federal government to fund the program against how effective the alternative is. The exact cost estimates of each alternative are provided in Appendix A. Below describes how I calculated the elements of cost and the effectiveness.

Cost: I measured the cost by calculating how much money the government will have to pay in order to institute the policy option. I was able to find this information from SAMHSA's past FOAs for each grant program. They published the amount of money they would allocate to each program for one year. I took the money allocated for 1 year of the grant and multiplied it by the number of years the grant program would be in place. Then, I discounted that total cost at a rate of 3%.

Effectiveness: The unit of effectiveness is the ratio of the number of staff trained or hired to the number of girls served.

- *Number of staff trained or hired:* Each alternative either hired or trained staff to help girls. I used documents from a few states that reported how many staff they hired/trained and averaged them to get an estimate of how many staff would be hired/trained by the alternative. Once I had an average estimate of how many staff would be hired or trained, I multiplied it by the number of grantees the alternative guaranteed.

- *Girls reached:* I used the same documents that reported on the number of staff trained to calculate the number of girls reached. I used reports from several states and averaged the number of people they were able to reach. I then multiplied that number by the years of the grant program to estimate the number of girls reached per grantee.

Ratio: The cost-effective ratio measures the average number of staff hired/trained over the course of the grant against the number of people the program would be able to reach. In this case, the more girls one staff member could help received a higher cost-effectiveness score. Because the goal of these alternatives is to reach as many children as possible, the more children one staff member can help, the better. Below is a scale of how I evaluated each alternative:

Staff Trained to Girl Served Ratio Range	Cost-Effectiveness
1:1 – 1:2	Low
1:3 – 1:5	Medium
1:6+	High

Political Feasibility

This criterion will measure whether an alternative has bipartisan support. I measured this first by counting the number of votes from Republicans and Democrats in the House and Senate on previous appropriations packages that increase funding for mental health initiatives and previous votes for the alternative in the past. I also considered other comparable legislation in the case that there weren't specific votes for the alternative. I then created a "percentage of party" measure to show what percentage of each party supported the bill. The estimates of bipartisan support are evaluated according to this scale:

Percentage of Republican Party Support	Percentage of Democratic Party Support	Political Feasibility
0%-25%	75%-100%	Low
26%-75%	26%-75%	Medium
75%-100%	75%-100%	High

Racial Equity

This criterion will address whether a certain option increases mental health treatment for Black and Latinx people. There are several racial categories that could be considered in this section, but I am focusing on Black people and Latinx people because they often do not receive the treatment they need (Alegria et al., 2010). For each alternative, I used studies and reports to inform how an option will increase the usage of treatment services for Black and Latinx people. The studies used specifically evaluate how the alternative has performed in the past for racial minorities. If an option retains or increases the usage of services for Black and Latinx people, it is more racially equitable.

Based on these studies, I will evaluate each option on this scale:

Retains or Increases Treatment Usage by:	Racial Equity
0%-25%	Low
26%-74%	Medium
75%+	High

Policy Options

Option 1: Advocate for the Appropriations Committee to Sustain Federal Funding for Certified Community Behavioral Health Clinics (CCBHCs) Through 2026

Option 1 would have Girls. Inc. lobby Members of the Appropriations Committee to sustain funding for CCBHCs over the next 5 years. In 2019, SAMHSA allocated $150 million to fund CCBHCs; in 2020, they allocated $200 million, and in 2021, SAMHSA increased the allocation to $225 million (*HHS FY 2021 Budget in Brief*, n.d.). This option proposes sustaining the funding for CCBHCs at $225 million each year, increasing the allocation each year to adjust for inflation.

There are a few steps to ensure the implementation of this option. First, Girls Inc. would work with the Director of the Center for Mental Health Services at SAMHSA, Dr. Anita Everett, to ensure SAMHSA continues to allocate at least $225 million for CCBHCs each year. Then, Girls Inc. will lobby the Appropriations Committee to continue funding HHS at levels that will allow SAMHSA to allocate $225 million to CCBHCs. In 2021, the HHS budget totaled $1,370 billion (*HHS FY 2021 Budget in Brief*, n.d.). The Appropriations Committee would have to continue funding HHS at this rate in order to ensure the plausibility of this option. Currently, this option would not require HHS to cut funds from other programs in order to fund CCBHCs. If Congress continues the same level of appropriations, and HHS allocates the same budget levels to SAMSHA, the CCBHC grant program will be able to be sustained.

Currently, there are 340 CCBHCs, and SAMHSA is extending grants to 74 additional applicants in 2021(*Certified Community Behavioral Health Clinic Expansion Grants*, 2020). With this alternative, SAMHSA would be able to provide grants to an additional 370 clinics in the next five years. SAMHSA distributes funding to Behavioral Health Clinics in two-year increments, and each grantee can receive up to $2 million each year (*Certified Community Behavioral Health Clinic Expansion Grants*, 2020). Once the two-year grant is complete,

CCBHCs will sustain their funding through Medicaid payments or from other private insurance providers, depending on the client's coverage (*Getting Paid as a CCBHC*, n.d.). CCBHCs operate under a Prospective Payment System (PPS), which is a Medicaid payment methodology: the clinic calculates an average cost per patient and is then reimbursed through Medicaid based on the anticipated costs calculated. The PPS system ensures the sustainability of CCBHCs past the two-year grant period (*Getting Paid as a CCBHC*, n.d.).

Sustaining the appropriation levels for CCBHCs will increase the number of clinics across the U.S. and increase the number of patients receiving the mental health care they need. While sustainability can be difficult, CCBHCs are particularly good for adolescent girls because they can increase the availability of care, reduce wait times, and can increase the recruitment of youth psychiatrists (David et al., 2020).

Evaluation:

Criteria	Score	Evaluation
Cost-Effectiveness	1:4 staff to girl ratio	Medium
Political Feasibility	88.67% Democrat & 35.5% Republican Support	Medium
Racial Equity	Inconclusive	Low

Cost-Effectiveness

This alternative scored a medium cost-effectiveness. The total cost of this measure would be just over $1 trillion over the next 5 years. This total comes from the assumption that SAMHSA will continue to fund CCBHCs at $225 million over the next five years. Each year, SAMHSA can administer a grant of up to $2 million to each applicant. In 2021 SAMHSA is extending grants to 74 applicants. If SAMHSA continues to fund grants to 74 applicants in each of the 5 years, there will be 370 additional clinics created/sustained. This could be an overestimate of the number of clinics created because this assumes that each grantee is new. However, the same grantee can reapply for additional funding, so there could be fewer clinics created or sustained.

To measure the effectiveness, I used information on the performance of the first few CCBHCs established and applied it to the expansion proposal. The National Council on Behavioral Health reported that 66 CCBHCs hired 3,000 new staff (David et al., 2020). This means that, on average, each clinic hired about 45 people. If there will be 370 new clinics,

and they each hire about 45 new people, this will increase the number of staff by 16,650 people.

To estimate the number of girls reached by these CCBHCs, I used reports from Michigan, Oregon, Missouri, and Texas. The average number of children reached in these clinics was 16,250 annually (Foney et al., 2019). However, these estimates could be skewed by the large number of children reached in a state as big as Texas. By excluding Texas in these estimates, the average number of children reached annually was about 12,300. So, over the next 5 years, a clinic would be able to reach about 61,600 children (again, this could be an overestimate given the variability of clinic capacities).

With about 12,000 staff reaching about 61,000 children, this means there are about 3 or 4 girls to one staff person in the clinic. Because the goal of these alternatives is to increase the number of girls treated, and 1 staff person could reach 4 girls, this option receives a medium cost-effectiveness.

Political Feasibility

This option would have a medium political feasibility. CCBHCs were first approved by Congress in 2014 with the "Protecting Access to Medicare Act." When Congress initially voted on this measure, there was some bipartisan support for the bill. In the House, it was agreed to on a voice vote, so there are no records on the positions of individual Members (*Actions - H.R.4302 - 113th Congress (2013-2014)*, 2014). However, in the Senate, the bill passed 64-35 (with one person not voting) (*U.S. Senate Roll Call Votes 113th Congress - 2nd Session*, n.d.). In the Democratic Party, 88.67% of Senators voted for the bill with 35.5% of Republicans also voting for the bill. This vote demonstrates that there was some bipartisan support for measures like this in the past.

In the 2021 Budget Reconciliation Process, Congress approved $4 billion for SAMHSA to increase funding for mental health services (*New CCBHCs Announced, Budget Resolution Passed*, n.d.). In the House, the Budget Resolution passed with support from 218 Democrats and was opposed by 2 Democrats and 210 Republicans (Clerk for the US House of Representatives, 2021). This Budget Resolution was tied in the Senate with a 50-50 vote, and Vice President Harris was the tie-breaking vote in favor of the Resolution (*U.S. Senate Roll Call Votes 117th Congress - 1st Session*, 2021). Based on this data, this option would have low political feasibility in the current Congress. However, there are extenuating circumstances of this bill that are not captured in these numbers; there were several other measures in this Resolution that were unrelated to the funding for SAMHSA. If we took a more historic view of Congress and consider the original vote count for CCBHCs, this option scores a medium political feasibility. But, given that expanding access to mental health

treatment is on the Democratic Agenda but not the Republican Agenda, it's hard to say how likely the two parties are to come together to support this option. As such, this option receives a medium on political feasibility.

Racial Equity

This option scored a low on racial equity. The data outlining how CCBHCs affect racial minorities is very limited, which makes it difficult to give an accurate representation of how this option scores on this alternative. I was able to find one report that found that 94.4% of CCBHCs served racial minorities (Foney et al., 2019). There were 18 states that participated in this report, each with varying degrees of racial demographics. This finding is actually a bit concerning considering that about 6% of clinics reported that they *do not* serve racial minorities. While most CCBHCs clearly serve Black and Latinx people, it's unclear whether this service delivery model particularly caters to these demographics. As such, this alternative has a low score on racial equity.

Option 2: Advocate for the Passage of the Mental Health Services for Students Act

This option would have Girls Inc. work with Rep. Napolitano (D-CA) to pass the Mental Health Services for Students Act. This Act was first introduced by Rep. Napolitano in 2013, and it has been reintroduced in every Congress since, and it was just reintroduced in the 117th Congress in February. It actually passed the House in 2020 but did not make it out of the Senate. This option would have Girls Inc. partner with Rep. Napolitano's office as well as the other Senate Cosponsors' offices to reintroduce the bill and advocate for its passage within the 117th Congress.

The Mental Health Services for Students Act authorizes $200 million for SAMHSA's Project Advancing Wellness and Resiliency in Education State Educational Agency (AWARE-SEA) Grant Program. Project AWARE-SEA is designed to connect State Educational Agencies with State Mental Health Agencies to oversee Local Education Agencies' expansion of school-based mental health services (*Project AWARE State Education Agency Grants*, n.d.). The goals of Project AWARE-SEA are threefold: 1) to increase awareness of mental health issues among school children; 2) to provide training to school faculty to detect and respond to markers of mental health issues; and 3) to connect children who show signs of behavioral issues and their families to needed services (*Project AWARE State Education Agency Grants*, n.d.). This grant will help schools enhance mental health service delivery in their school. Ideally, local schools would provide in-house mental health treatment and train staff to positively intervene and promote resilience in school

children (*FY 2020 Project AWARE FOA*, n.d.). By increasing the connection between behavioral health specialists and students along with providing training to school staff, children have more opportunities for early intervention.

In 2021, SAMHSA budgeted $62.4 million for Project AWARE-SEA grants and intends to award 34 Educational Agencies funding (*Project AWARE State Education Agency Grants*, n.d.). Each grantee would be eligible to receive up to $1.8 million per year for up to 5 years (*Project AWARE State Education Agency Grants*, n.d.). The Mental Health Services for Students Act would increase this budget allocation to $200 million and effectively increase funding available to 100 school systems.

Evaluation:

Criteria	Score	Evaluation
Cost-Effectiveness	1:6 staff to girl ratio	High
Political Feasibility	74 Democrat & 4 Republican Cosponsors	Medium
Racial Equity	Retains 100% of Black and Latinx children	High

Cost-Effectiveness

This option has a high cost-effectiveness. The bill allocates $200 million for fiscal years 2022-2025, so the total cost ends up being around $800 million. Grantees have not reported the number of staff they *hired* due to Project AWARE funding, but some have reported the number of staff they *trained* because of the grant. I used the numbers reported from a few states to estimate how many staff would be trained to detect mental illness in students and suggest care. To do this, I used numbers from reports from South Dakota, Washington, D.C., and Connecticut. South Dakota reported that they trained 1,579 people due to Project AWARE funding (Pacific Institute for Research and Evaluation, 2019); Washington D.C.'s goal was to reach at least 1,500 educators and administrators (Barrow Consulting Services, n.d.); and Connecticut trained 650 staff members over the course of the grant period (LoCurto, n.d.). Each of these numbers represents the total number of staff trained over the course of the grant period, which is up to 5 years. To create an effectiveness measure, I averaged the number of staff trained to be 1,243 over the course of 5 years. If each grantee can receive up to $1.8 million, then SAMHSA could administer about

413 grants, who would each train about 1,243 staff. So, the total number of staff trained would be about 513,372.

The same states reported how many children they were able to reach over the course of the grant. South Dakota was able to reach 55 children in one year (Pacific Institute for Research and Evaluation, 2019). Assuming they would continue to serve this many children over the next five years, South Dakota would serve 275 children. Washington D.C. reported they would reach 11,000 children (Barrow Consulting Services, n.d.), and Connecticut reported they would reach 12,000 students over the course of the grant (LoCurto, n.d.). So, the average number of children served is about 7,758 over five years. If there are 413 grantees, 3,204,276 children will be served.

According to these estimates, this option would increase funding for about 413 grantees that would train about 513,000 staff members and serve about 3.2 million kids. This means that 1 staff person could take on about 6 girls. These estimates yield a high cost-effectiveness since the staff is able to reach more girls.

Political Feasibility

This option has medium political feasibility. In 2020, the Mental Health Services for Students Act passed the House on a voice vote, so there is no record of the breakdown of votes across party lines (*Actions - H.R.1109 - 116th Congress (2019-2020)*, 2020). However, the bill had 135 Cosponsors, of whom 130 were Democrats and 5 were Republicans. While the bill never made it out of the HELP Committee in the Senate, there were 11 Cosponsors on the bill – 10 Democrats and 1 Independent (*Cosponsors - S.1122 - 116th Congress (2019-2020)*, 2019).

Currently, the reintroduced House bill has 78 Cosponsors – 74 Democrats and 4 Republicans (*Cosponsors - H.R.721 - 117th Congress (2021-2022)*, 2021). It is unclear whether the Senate will support this bill. Senator Smith (D-MN) introduced the companion bill in the Senate in 2019, but she has not reintroduced the bill in this new Congress.

It is hard to tell whether Republicans and Democrats will come together to support this bill, but there is evidence that the Mental Health Services for Students Act is more bipartisan than other similar bills. The Pursuing Equity in Mental Health Act of 2019 had similar aims to the Mental Health Services for Students Act, but it only gained 35 Democratic Cosponsors and no Republican Cosponsors (*H.R.5469 - 116th Congress (2019-2020)*, 2020). It seems as though the Mental Health Services for Students Act has a greater possibility of gaining bipartisan support based on these numbers and has a medium political feasibility.

Racial Equity

This option scored a high in racial equity. In a study where all of the children were Black or Latinx, school-based mental health services retained 100% of the children enrolled in the program, whereas in the same study, all of the children assigned to traditional clinical services dropped out of the program after 3 months. (M. Atkins et al., 2006). Assuming that the passage of this Act increases the usage of school-based services at a similar rate as this, Black and Latinx children will use school-based services at a much higher rate than other clinical services. Because of the large increase in the use of services, this option scores a high in racial equity.

Option 3: Return Budget Allocation for Systems of Care to 2019 & 2020 Levels

In this option, Girls Inc. would advocate for SAMHSA to increase the budget allocation by $10 million in 2022 for the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (short title: Systems of Care (SOC)) Expansion and Sustainability Grant. In 2016, SAMHSA allocated over $52 million for SOC Expansion and Sustainability Grants. However, recently the amount allocated for these grants has decreased by a substantial amount. In 2019, SAMHSA allocated $25.6 million to the SOC Expansion Grants, and in 2020, they allocated $28.3 million. In 2021, SAMHSA only allocated about $15 million for the SOC Expansion and Sustainability Grants, cutting the number of eligible grantees in half. This option would have Girls Inc. work with the Center for Mental Health Services in SAMHSA to increase the budget allocation for these grants back to $26 million.

The goal of this grant program is to improve the mental health outcomes for children by creating sustainable funding streams for local Systems of Care models. In this case, grantees of the SOC program work to integrate primary care, education, child welfare, and juvenile justice systems to ensure that children are receiving comprehensive care from multiple streams (*The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program*, 2015). In the past, grantees have transformed their care delivery model to more effectively meet the needs of children, and 86.3% of youth treated reported overall satisfaction with their care (*The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program*, 2015). By maintaining the budget levels at $26 million, SAMHSA will be able to continue to expand access to Systems of Care for children across the country.

However, expanding this budget allocation would require SAMHSA to cut funding from other programs, otherwise Congress would have to increase HHS's overall budget

appropriation. Because HHS delivers such comprehensive and important services, I propose that Girls Inc. work with the Appropriations Committee and SAMHSA to increase the funding for HHS that is then directed towards SOC Expansion and Sustainability grants.

Evaluation:

Criteria	Score	Evaluation
Cost-Effectiveness	5:1 staff to girl ratio	Low
Political Feasibility	88% of Democrats & 77% of Republicans Support	High
Racial Equity	Black children use at 2 times the rate, Latinx children use at same rate as white children	High

Cost-Effectiveness

This alternative scored a low cost-effectiveness. This alternative would return the budget allocation for SOC grants to $26 million in 2022. The maximum award a grantee could get is $3 million, so there would be about 10 grantees in 2022 if this budget allocation is put in place. There could be more grantees if they each got less than $3 million, so this is a conservative estimate of the number of grantees in this alternative, potentially meaning it could have a greater cost-effectiveness.

According to a report on North Carolina Systems of Care, they were able to train 2,912 staff over the life of the SOC grant (Lawrence & Snyder, 2009). Texas reported that they were able to train 799 staff (Texas Institute for Excellence in Mental Health, 2020). This means that on average, grantees were able to train about 1,855 people. Assuming all grantees are able to train this many people, and assuming SAMHSA awards about 10 grants, this alternative would train a total of 20,296 people.

Texas also reported that they were able to reach about 444 children (Texas Institute for Excellence in Mental Health, 2020), while North Carolina reported that they were able to reach 352 children in their System of Care model (Lawrence & Snyder, 2009). On average, these models were able to reach about 398 children. Assuming all grantees could serve this many children and SAMHSA awards about 10 grants, this alternative would serve about 4,353 children in total. With these estimates, this alternative would create a ratio of

about 5 staff to 1 girl. Because the goal is to increase the capacity of staff members to reach multiple children, and this option estimated 5 staff to 1 girl, this option has a low cost-effectiveness.

Political Feasibility

This option has a high political feasibility. When Congress first established the System of Care Program under SAMHSA, there was widespread bipartisan support for the initiative. When Congress passed the bill that established the SOC Grant Program, 88% of Democrats and 77% of Republicans supported the bill (*U.S. Senate Roll Call Votes 102nd Congress – 2nd Session,* n.d.; Clerk for the US House of Representatives, 1992). While this data is from 1992, these numbers indicate that there is a high likelihood of bipartisan support for this initiative. To bring this information up to date, I considered how cost might affect legislators' decision-making on this alternative. Because there is a high likelihood that Members of Congress from both the Republican and Democratic Party will continue to fund HHS at consistent levels, this option scores a high political feasibility.

Racial Equity

This option scored a high on racial equity. Studies show that the Systems of Care approach makes Black children two times as likely to use mental health services than white children in their area, and Latinx children use System of Care services at about the same rate as white children. (Alegria et al., 2010; Miech et al., 2008). Because Systems of Care reduce the gap in treatment and particularly help children from Black and Latinx families, this option scores high on racial equity.

Outcomes Matrix

Criteria	Option 1: Increase Funding for CCBHCs	Option 2: Pass the Mental Health Services for Students Act	Option 3: Expand Systems of Care
Cost-Effectiveness	Medium 1:4 staff to girl ratio	High 1:6 staff to girl ratio	Low 5:1 staff to girl ratio
Political Feasibility	Medium 88.7% of Democrats & 35% of Republicans Support	Medium 74 Democrats and 4 Republican Cosponsors	High 88% of Democrats and 77% of Republicans Support
Racial Equity	Low Inconclusive data	High Retains 100% of Black and Latinx children in treatment	High Black children use SOCs at 2x times the rate, and Latinx children use SOCs at the same rate as white children

Recommendation

I recommend Girls Inc. implement Option 2 and advocate for the passage of the Mental Health Services for Students Act. This option has the highest cost-effectiveness, scored high on racial equity, and has the potential for bipartisan support. The goal of this project is to increase access to mental health services for girls from low-income communities, and Option 2 is the most likely alternative to achieve that goal. Option 2 will institute programs in schools that will train faculty to detect early warning signs of mental illness and increase the presence of mental health professionals in schools, which will increase the number of supports available for girls at the most cost-effective rate.

The downside of this option is that it might not be as politically feasible as some of the other alternatives. Because this option will require about $800 million over Fiscal Years 2022-2025, Members of Congress who oppose increases in federal spending might not support this bill. Option 3 is more politically feasible than Option 2 precisely because it does not require an increase in federal spending. Option 1 would also have a medium political feasibility, but Option 1 does not score as high on cost-effectiveness or racial equity. There are significant tradeoffs between each of these options, but ultimately Option 2 offers the most promise for girls. The biggest obstacle to implementing this option will be finding enough bipartisan support in the Senate to overcome a potential filibuster. In the last Congress this bill passed the House, so efforts should be focused on increased Republican support for the bill in the Senate.

Implementation

Since this Act passed the House in the last Congress, I think it is likely that it will pass again in this Congress as the Democrats retained their majority. There are currently 81 Cosponsors (77 Democrats and 4 Republicans), which indicates similar levels of support in this Congress as the last Congress. Representative Napolitano (D-CA) is the most vocal champion in the House, and it would be smart to partner with her office to receive updated information and leads on where to target advocacy work. The Mental Health Caucus within the House also offers a list of key Members who would likely support this bill (*Congressional Mental Health Caucus Members*, n.d.).

I foresee the biggest barriers to passage in the Senate. This bill was introduced in the last Congress with 11 Cosponsors, all of whom were Democrats (and one Independent, Sen. Sanders). Gaining Republican support for this bill is possible, it just might be difficult. In the past, Republicans have talked about the need for mental health services, but it has traditionally been done in the context of gun violence and opioid use (Kennedy, 2018). The

party's position on mental health services is further complicated by their stance to cut Medicaid and Medicare funding, which traditionally helps people access mental health services (Kennedy, 2018). To overcome the potential Republican resistance, I suggest working with offices of key Republican Senators who might consider supporting this bill.

Key Republican Senators:

- Senator Capito (R-WV)
    - Sen. Capito comes from a state that has been deeply affected by the opioid epidemic. The Mental Health Services for Students Act could be framed as a way to ensure that children in her state do not turn to substance abuse or self-harm in the midst of the crisis in their state. Sen. Capito has also partnered with Girl Scouts of the USA in the past, indicating her support for girls' initiatives. Also, as a member of the Health and Human Services, Labor, and Education Appropriations Subcommittee, she will be a key player in ensuring appropriations for this bill (*Health Care | U.S. Senator Shelley Moore Capito of West Virginia*, n.d.).
- Senator Romney (R-UT)
    - Sen. Romney sits on the Senate HELP Committee and also has a history of working across the aisle. While he has not explicitly supported this initiative, he does support federal-state partnerships on healthcare which aligns with this bill (*Health Care | Senator Mitt Romney*, n.d.).

Other Key Senators:

- Cosponsors of the Mental Health Services for Students Act in the 116th Congress:
    - Sen. Smith (D-MN)* – original Sponsor
    - Sen. Hassan (D-NH)*
    - Sen. Murphy (D-CT)*
    - Sen. Whitehouse (D-RI)
    - Sen. Wyden (D-OR)
    - Sen. Blumenthal (D-CT)
    - Sen. Stabenow (D-MI)
    - Sen. Udall (D-NM)
    - Sen. Van Hollen (D-MD)
    - Sen. Hirono (D-HI)
    - Sen. Sanders (I-VT)*
    - Sen. Rosen (D-NV)*

*Members of the Senate HELP Committee

I also suggest working with other nonprofits to support the passage of this bill. The

Mental Health Liaison Group organized a sign-on letter of almost 50 national organizations in support of the bill in the last Congress (*MHLG Mental Health Services for Students Act Senator Smith*, 2018). This sign-on letter provides a broad overview of national organizations working in the mental health space who could be potential partners. I also suggest working with the American Association of Child and Adolescent Psychiatry as they were a big proponent of the bill when it was last introduced.

The immediate next steps to ensure the passage of this bill will revolve around gaining Republican support. Once the bill gets to the Senate, or if you are able to convince Sen. Smith (D-MN) to reintroduce the bill, efforts should be made to partner with key Members on the Senate HELP Committee. Convincing the Committee to hold a hearing would be a great step in the right direction. Leveraging the support from the numerous nonprofit associations will be crucial in persuading Senators to support this bill. In the event there does not seem to be enough support for this bill on its own, there could be potential to include the increase in funding for Project AWARE in the Budget Reconciliation process next year. While there are several potential roadblocks to passing the Mental Health Services for Students Act, there are also immense opportunities to increase support and incentivize passage of the bill that will help children across the country.

Appendix A

Cost-Effectiveness Analysis

	Option 1	Option 2	Option 3
Total Cost	$1,030,434,117.12	$743,419,681	$25,242,718.45
Average Staff Trained or Hired	16,818.18	513,372.59	20296.40777
Average Number of Children Reached	61,666.67	3,204,276.49	4353.527508
Girl to Staff Ratio	3.67	6.24	0.21

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