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SPECIAL REPORT

Child and Adolescent Behavioral Health: An Attractive but Overlooked Market for Investment

Contents

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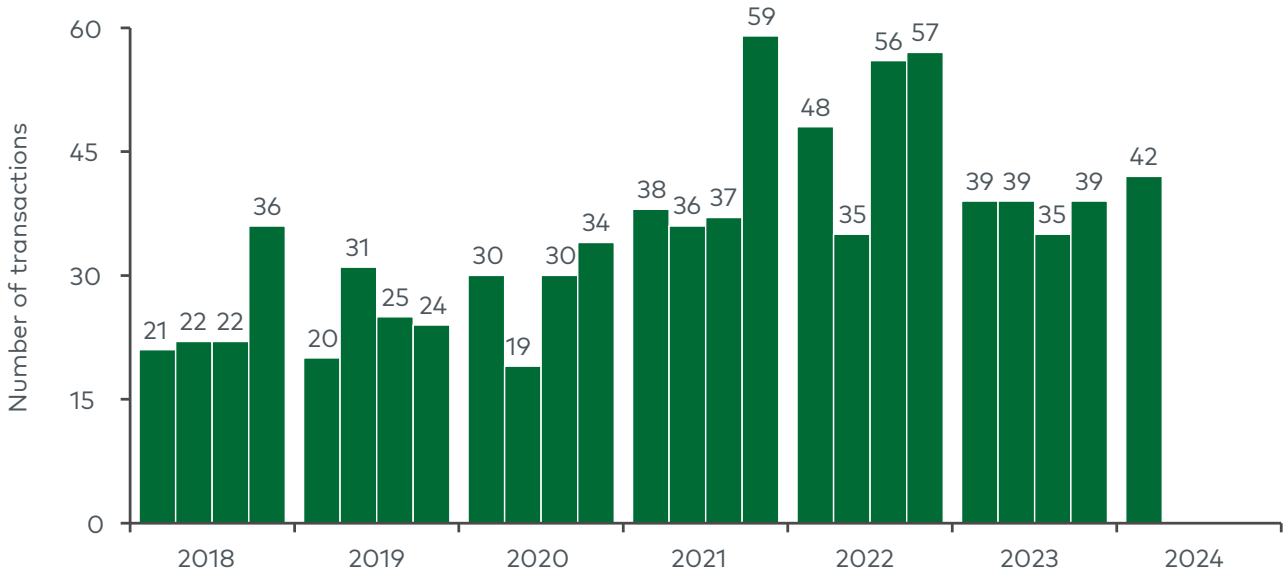
Introduction

The behavioral health market in the U.S. has seen significant deal activity since 2018 — investors have partnered with clinics, systems, payers and platforms to innovate, grow and better serve patient populations (see Figure 1). The behavioral health market covers therapeutic and pharmacological interventions for mental health disorders[1] (e.g., major depressive disorder, bipolar disorder, attention-deficit/hyperactivity disorder) and substance use disorders/SUD[2] (e.g., opioid use disorder, alcohol use disorder). Notable deals include LifeStance, which was acquired by TPG in 2020[3] and went public in 2021;[4] CARE Counseling, which was acquired by Optum in 2024 and builds on Optum's 2022 acquisition of Refresh Mental Health;[5] and the formation of PAX Health through the merger of Behavioral Medicine Associates, Workers Compensation Network and Reservoir Health by HCAP Partners and Hamilton Lane in 2024.[6]

Figure 1
US-based behavioral health M&A transactions, by quarter (2018-24)



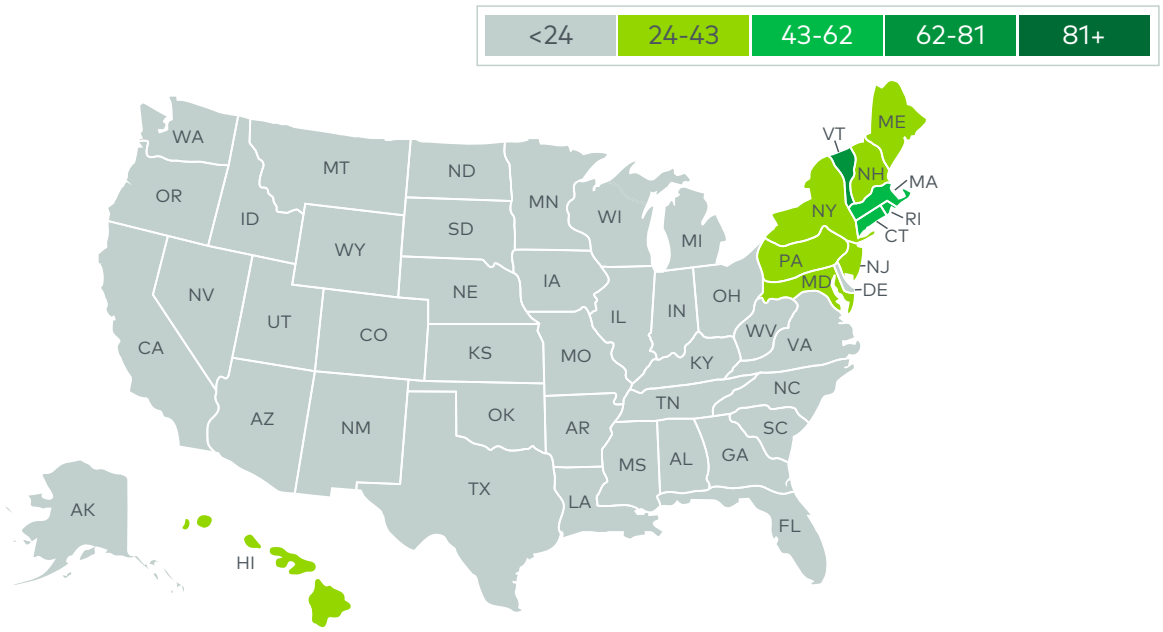
Source: Mertz Taggart (Behavioral Health M&A Report: Q1 2023); L.E.K. research and analysis

However, despite a flurry of deal activity, focus has only just begun to turn to the child and adolescent segment of the market, with Onex's 2021 acquisition of Newport Healthcare[7] and the acquisition of Embark Behavioral Health by Consonance Capital Partners in 2023.[8]

The supply of child/adolescent behavioral health providers in the U.S. remains insufficient to meet the rising demand for services. In 2023, there were approximately 11,400 practicing child/adolescent psychiatrists in the United States.[9] This represents a supply of around 21 child/adolescent psychiatrists per 100,000 5-to-17-year-olds nationwide.

Provider supply varies greatly by geography, from over 50 child/adolescent psychiatrists per 100,000 child/adolescent residents in northeastern states such as Vermont, Rhode Island, Connecticut and Massachusetts and the District of Columbia to under 10 providers per 100,000 in Wyoming, Idaho, Indiana and Mississippi (see Figure 2).

Figure 2
Child/adolescent psychiatrists per 100,000 child/adolescent US residents (ages 5-17), by state (2022)



Source: American Academy of Child and Adolescent Psychiatry; Health Resources and Services Administration; L.E.K. research and analysis

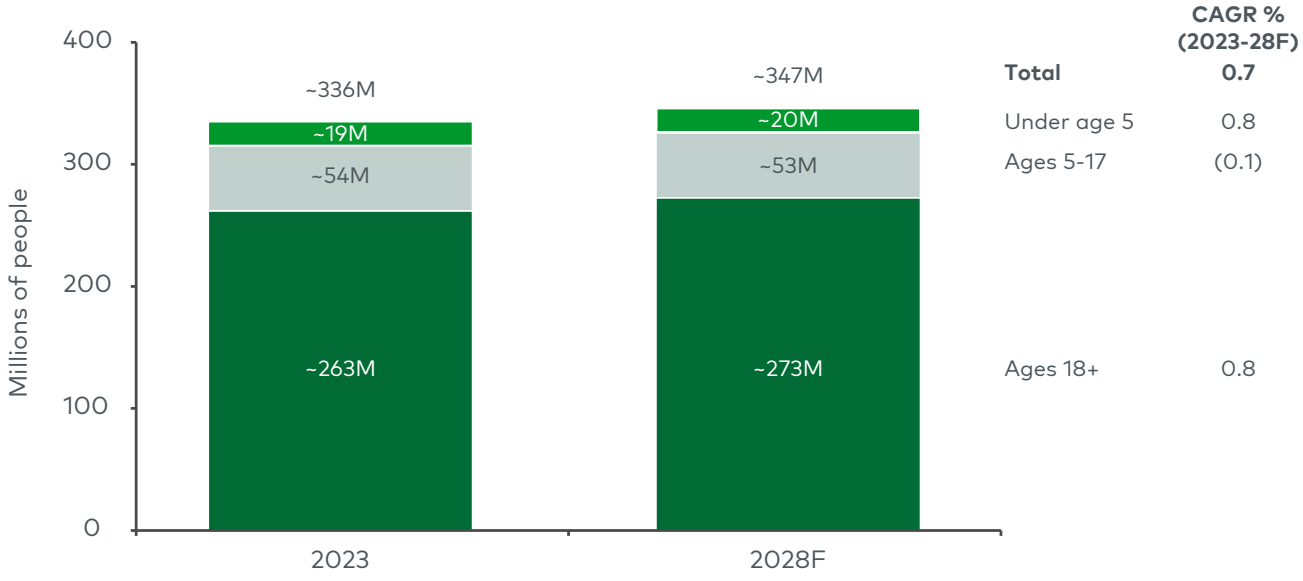
The demand for child/adolescent behavioral health services is large. Of the roughly 54 million children and adolescents (ages 5 to 17)[10] in the U.S. in 2023, about 11 million have at least one behavioral health condition, including approximately 9.1 million (17%) who have a mental illness and around 1.4 million (2.6%) who have a substance use disorder (SUD). These groups include roughly 700,000 children/adolescents with co-occurring mental illness and SUD.[11]

Overview of market dynamics

The market for child/adolescent behavioral health continues to expand, with growth supported by several key underlying demand drivers, including population demographics, a rise in societal awareness and acceptance, improvements in access to care, a shift toward in-network utilization, and the COVID-19-accelerated adoption of telehealth.

Population demographics: The child/adolescent population is not expected to grow significantly (see Figure 3). Still, the prevalence of behavioral health conditions among 5-to-17-year-olds has continued to climb over time (see Figure 4).[12]

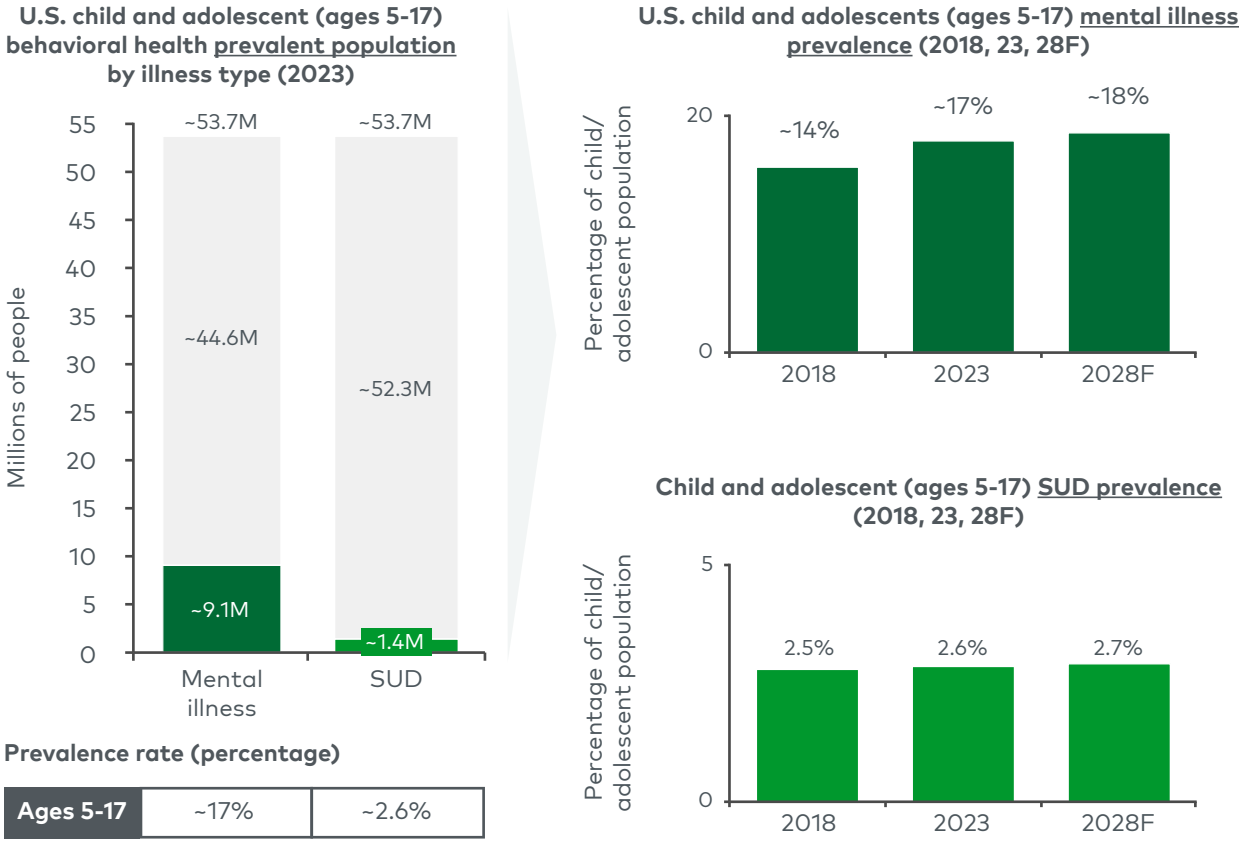
Figure 3
US population growth, by age group (2023, 28F)



Note: CAGR=compound annual growth rate
Source: Woods & Poole; L.E.K. research and analysis

This is due in part to academic pressures, digital device-driven sleep disruptions, social media-enabled cyberbullying[13] and pandemic-driven stressors (e.g., decreased social interactions) (see Figure 4).[14] These pressures are expected to continue to drive a rise in depression, anxiety and substance abuse.[15]

Figure 4
Overview of US child and adolescent prevalence rates in behavioral health, mental illness and SUD

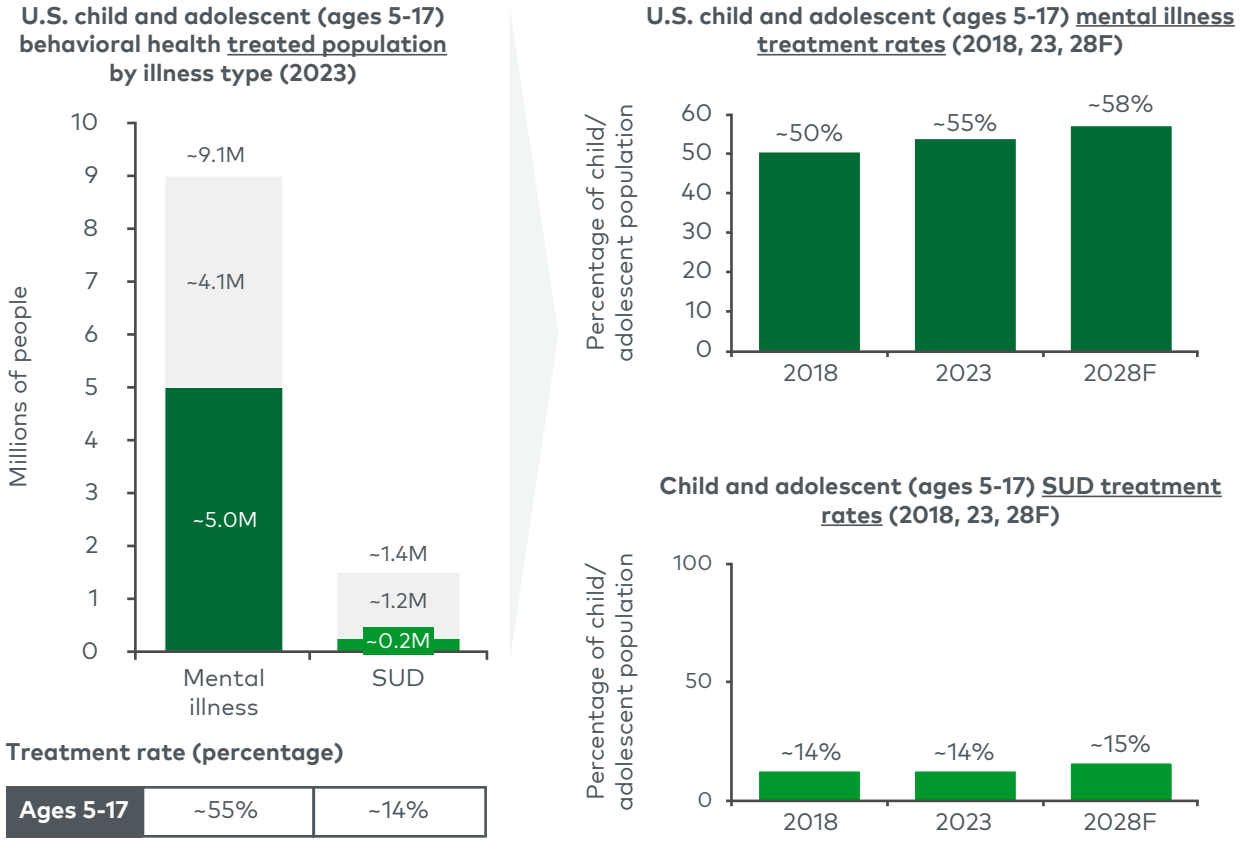


Note: SUD=substance use disorder
Source: National Center for Biotechnology Information; Child and Adolescent Health Measurement Initiative; Substance Abuse and Mental Health Services Administration; Woods & Poole; L.E.K. research and analysis

Rise in awareness: Treatment rates for child/adolescent behavioral health have increased over time, a trend that is expected to continue as awareness and acceptance increase and societal stigma declines (see Figure 5).[16]

Wider awareness and acceptance of behavioral health is being driven by primary care physicians conducting more behavioral health screenings,[17] employers offering services through employee assistance programs,[18] mass marketing efforts,[19] and advocacy groups[20]/legislative committees[21] pushing for policy reform.

Figure 5
Overview of US child and adolescent treatment rates in behavioral health, mental illness and SUD



Note: SUD=substance use disorder
Source: National Center for Biotechnology Information; Child and Adolescent Health Measurement Initiative; Substance Abuse and Mental Health Services Administration; Woods & Poole; L.E.K. research and analysis

Improvements in access to care: While the number of child/adolescent covered lives has remained stable (see Figure 6), the child/adolescent behavioral health market has been buoyed by favorable regulatory changes and new public initiatives to promote access.

For example, in June 2022, the House of Representatives passed the Hope for Mental Health and Well-Being Act,[22] a bill that would eliminate the X-waiver[23] and reduce barriers to medication-based SUD treatments. Additionally, in July 2022, the 988 Suicide and Crisis Lifeline[24] was launched; the hotline provides those experiencing a behavioral health crisis with access to counselors and resources to find care.

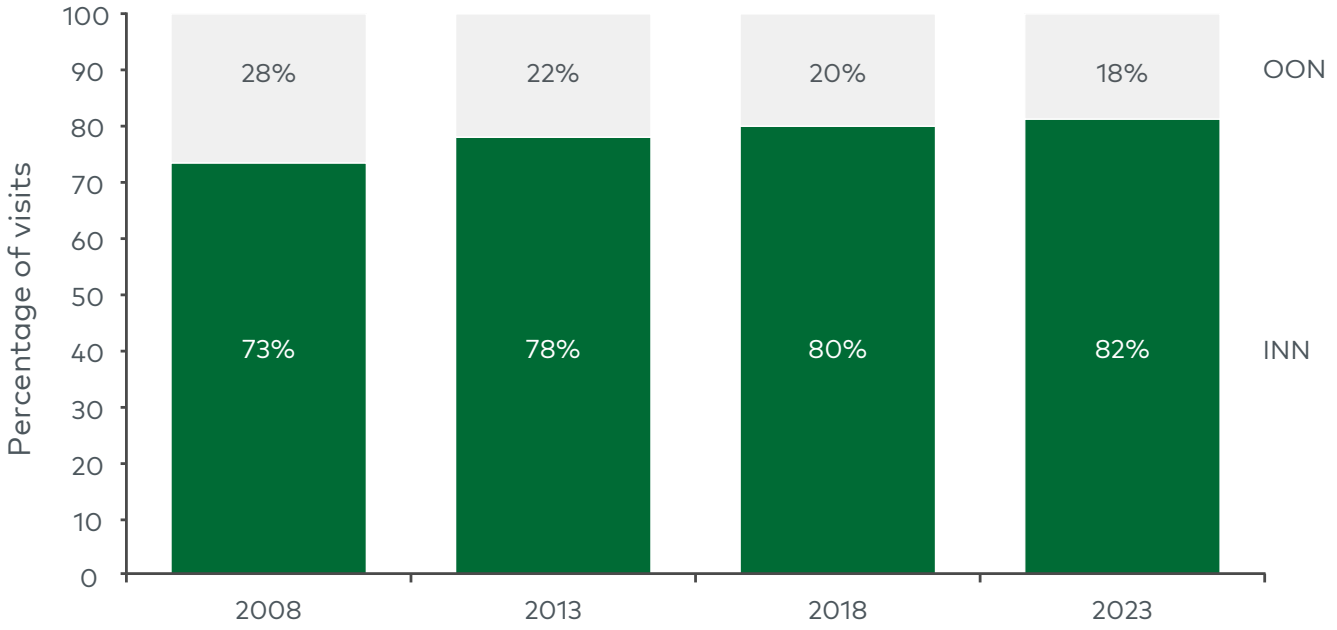
Figure 6
US child and adolescent (ages 5-17) population, by health insurance coverage (2018-23)

Source: Census Small Area Health Insurance Estimates program; Mark Farrah; L.E.K. research and analysis

Shift toward in-network providers: In-network (INN) utilization for child/adolescent behavioral health has trended upward, driven by healthcare consumerism trends, greater provider consolidation and the shift of child/adolescent clinician mix toward midlevel providers (e.g., therapists, social workers).

As demand for behavioral health services increases and out-of-network (OON) rates outpace growth of INN rates,[25] families are expected to continue to seek out INN providers (Figure 7 shows commercial utilization by utilization mix). Meanwhile, provider consolidation in the broader behavioral health space is expected to continue as organizations look to standardize across providers and achieve higher patient volumes by bringing providers in network. These trends will be enabled by the shift of clinician mix toward midlevel providers who are willing to trade off lower INN rates for the steady patient volumes afforded by INN participation.

Figure 7
US psychotherapy utilization mix, by child and adolescent commercial group enrollees (ages 0-18) (2008-2023)

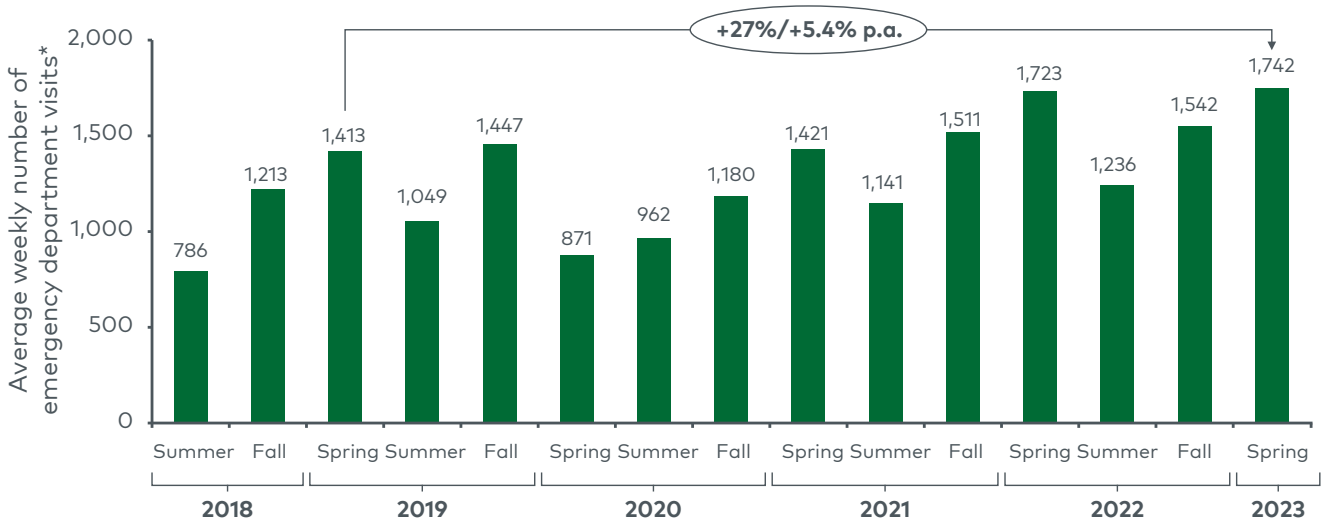


Note: OON=out-of-network; INN=in-network
Source: Song and Benson, "Prices And Cost Sharing For Psychotherapy In Network Versus Out Of Network In The United States," Health Affairs (2020); L.E.K. research and analysis

COVID-19 impact: The COVID-19 pandemic brought with it stressors that induced an increase in child/adolescent behavioral health episodes as well as innovations in care access via expanded telehealth solutionsfor certain mental health conditions (e.g., major depressive disorder, anxiety disorders).

In the seven to eight months following the U.S. COVID-19 emergency declaration on March 13, 2020, there was an approximately 30% increase in the proportion of child/adolescent emergency department visits attributed to mental health and SUD emergencies, relative to the same period in 2019. The Centers for Disease Control and Prevention reported that the visits might have been attributed to "disruptions to daily life associated with mitigation efforts, including anxiety about illness, social isolation and interrupted connectedness to school."[26] Child/adolescent behavioral health-related emergency department visits have continued to climb, with the weekly average number of visits in the spring of 2023 sitting about 27% higher than at the same time in 2019, representing around 5.4% growth per year[27] (see Figure 8A).[28]

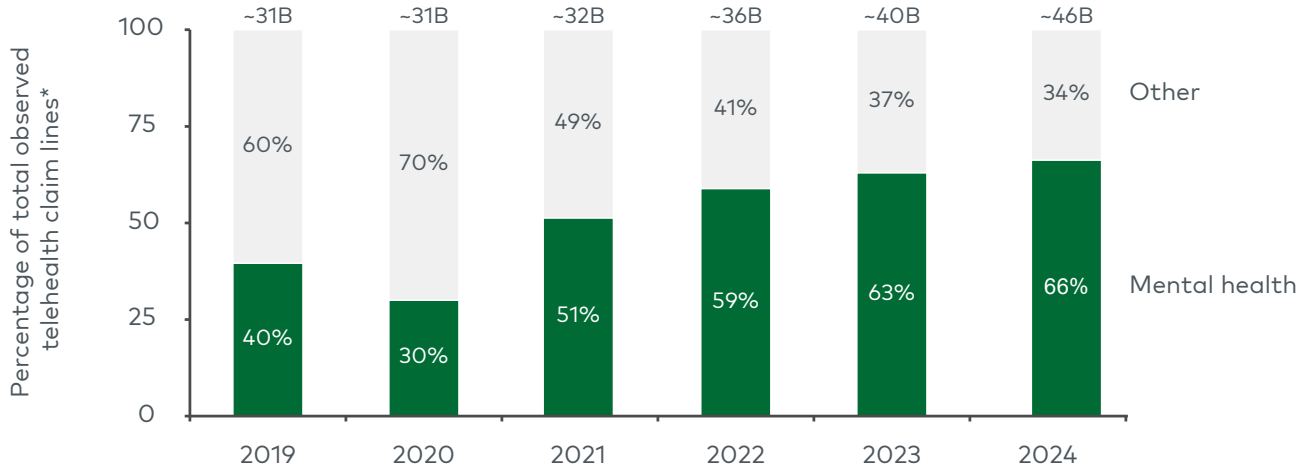
Figure 8A
US average weekly number of emergency department visits for mental health and substance abuse conditions in children and adolescents (ages 5-17) (2018-23)



*Data is split between spring (weeks 1-23), summer (weeks 24-36) and fall (weeks 37-53) to align to academic school years
Source: Centers for Disease Control and Prevention; L.E.K. research and analysis

In response to the COVID-19 crisis, many states modified licensure requirements for telehealth services.[29] These policies, combined with the ongoing public health crisis, opened the floodgates for behavioral health telemedicine (see Figure 8B). Coupled with rising awareness and social acceptance of mental health conditions, provider usage of telehealth solutions has persisted.[30]

Figure 8B
Top telehealth diagnoses (2019-24) (U.S.)



*Based on January of each year
Source: FairHealth; L.E.K. research and analysis

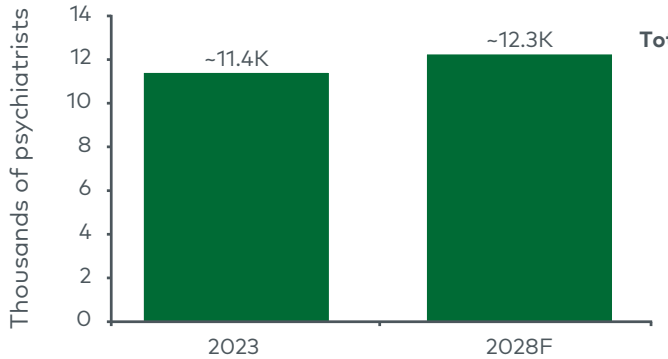
However, investment activity remains low

Despite these attractive market dynamics, investment in the child/adolescent behavioral health market remains limited today. Three key market challenges are at play.

Low clinician supply: Projections based on the Substance Abuse and Mental Health Services Administration's 2019 Behavioral Workforce Report,[31] which estimates provider demand based on the prevalence of conditions, suggest roughly 47,000 additional child/adolescent psychiatrists are currently needed to meet patient needs. For comparison, the Health Resources and Services Administration estimates there is a 2024 primary care workforce shortage of about 28,000 providers nationwide.[32]

The severe shortage of child/adolescent psychiatrists is expected to persist, assuming provider supply and underlying child/adolescent population growth rates continue to follow historical trends (see Figure 9). The small accessible labor force of child/adolescent psychiatrists represents a challenge for scaled investment. Furthermore, this labor force is geographically concentrated, further narrowing the field of investment opportunities. For example, in 2022 approximately 72% of all U.S. counties were without any child/adolescent psychiatrists.[33]

Figure 9
Total child and adolescent psychiatrists (2023, 28F) (U.S.)



	CAGR % (2023-28F)
Total	~1.4

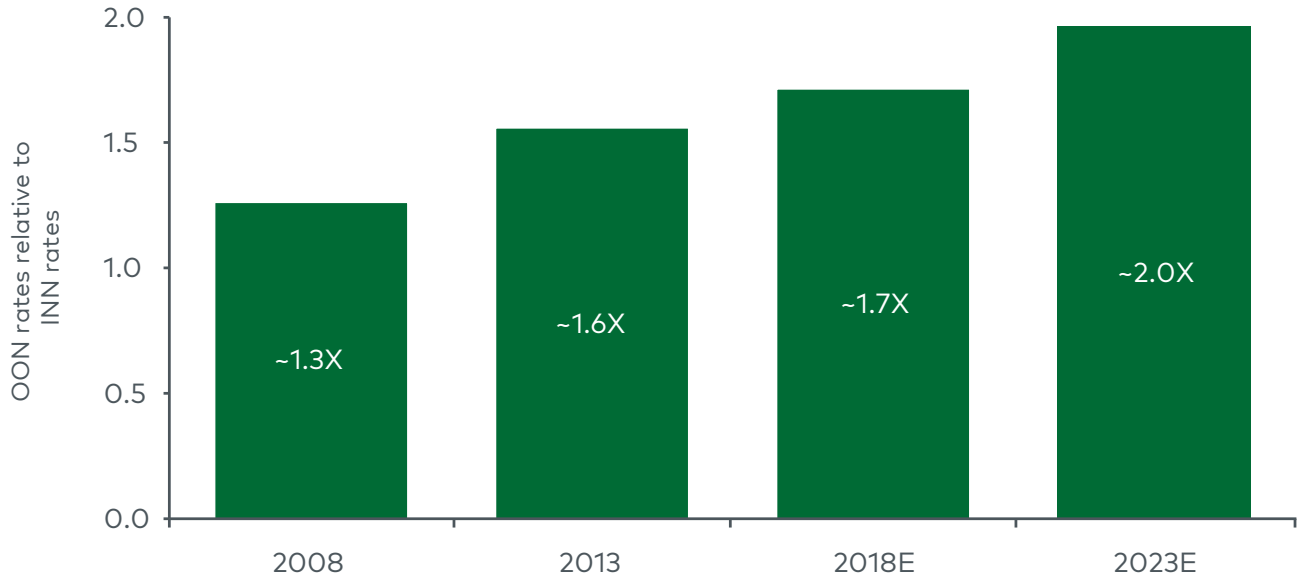
	2023	2028F
Required supply of child/adolescent psychiatrists*	58.5K	59.4K
Unmet demand for child/adolescent psychiatrists	47.1K	47.2K

*Growth in required supply based on underlying growth of child/adolescent population (~0.3% p.a.)
Note: CAGR=compound annual growth rate
Source: Health Resources and Services Administration; American Academy of Child and Adolescent Psychiatry; Substance Abuse and Mental Health Services Administration; Census; L.E.K. research and analysis

Attractive OON dynamics: For many child/adolescent behavioral health providers, attractive OON dynamics are likely to impact willingness to participate in an investment strategy that would bring them in network.

Compared with other types of office visits (e.g., medical/surgical care), the existing disparity between OON and INN rates in the child/adolescent behavioral health space is large.[34] For example, OON commercial group psychotherapy visits for a child/adolescent patient command an approximately 2X premium over INN rates (see Figure 10). In addition to receiving higher rates, providers remaining out of network face less administrative burden in the form of payer negotiations and claims processing, including potential claim denials.

Figure 10
US psychotherapy rates, by child and adolescent group enrollees (ages 0-18) (2008-2023E)



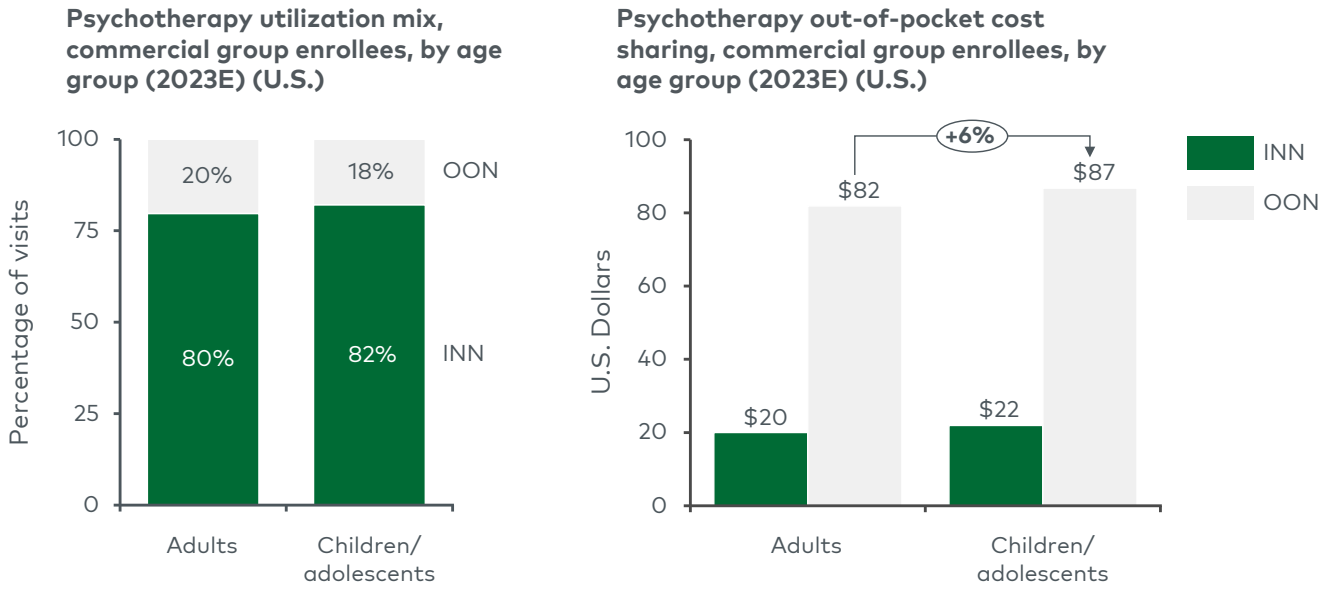
	2008	2013	2018E	2023E
OON	$118.85	$128.73	$141.22	$151.90
INN	$94.18	$82.60	$82.39	$77.41

Note: OON=out-of-network; INN=in-network
Source: Song and Benson, "Prices And Cost Sharing For Psychotherapy In Network Versus Out Of Network In The United States," Health Affairs (2020); L.E.K. research and analysis

Furthermore, while psychotherapy utilization mix across commercial group adults and children is similar, there is often an increased willingness of parents to pay out of pocket versus adults paying for their own care. OON out-of-pocket costs for children/adolescents are around 6% higher than costs for adults in this setting (see Figure 11).

These dynamics have the effect of amplifying localized shortages of INN clinicians, presenting a further challenge for investment opportunities in the space.

Figure 11
Overview of US psychotherapy utilization mix and cost sharing

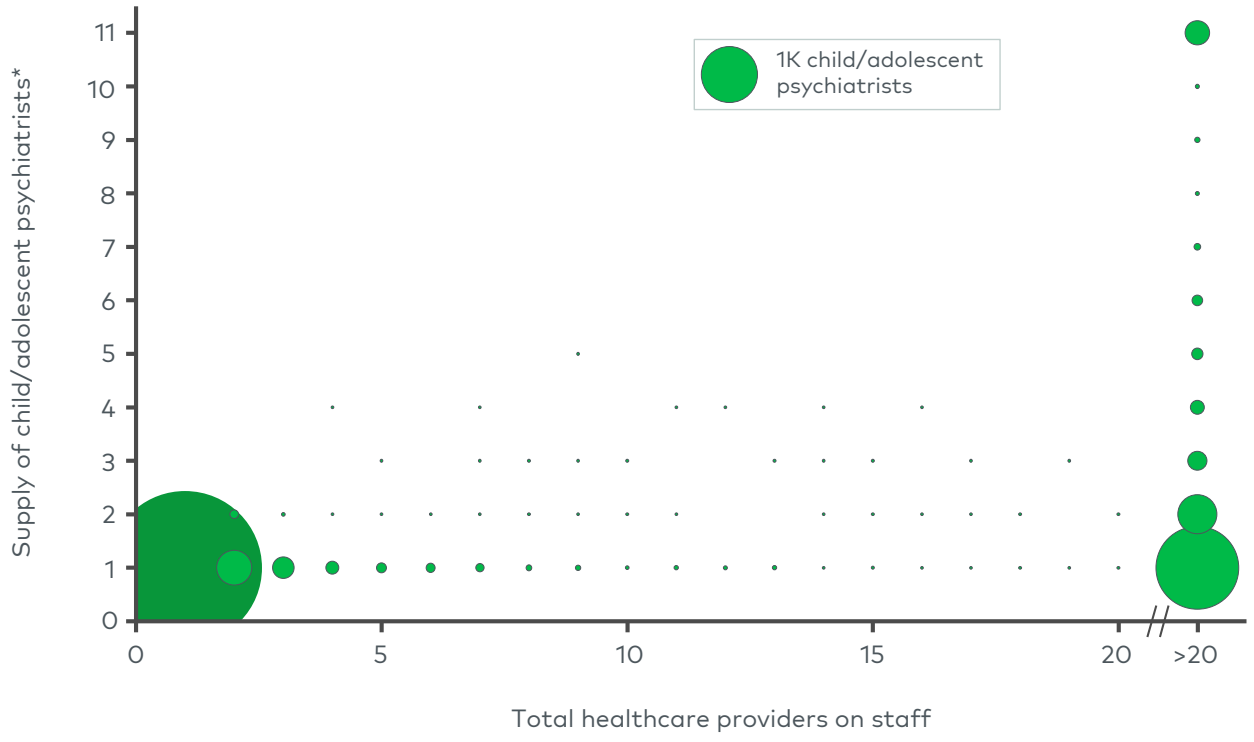


Note: OON=out-of-network; INN=in-network
Source: Song and Benson, "Prices And Cost Sharing For Psychotherapy In Network Versus Out Of Network In The United States," Health Affairs (2020); L.E.K. research and analysis

A highly fragmented set of providers: Many child/adolescent psychiatrists work in small, independently operated practices. For example, of the roughly 6,500 psychiatrists who reported child/adolescent psychiatry as their primary specialty to the Centers for Medicare & Medicaid Services in 2022, about 36% were employed by practices with only one or two providers (see Figure 12). Several factors have driven a high degree of fragmentation in the child/adolescent segment, including the following:

- Private equity has traditionally focused on consolidating practices with higher INN reimbursement rates (e.g., orthopedics, dermatology), leaving many behavioral health practices to remain independent.[35]
- There are many types of clinicians within behavioral health (e.g., psychiatrists, psychologists, social workers, therapists), meaning that practices can have varying treatment philosophies, areas of clinical focus and manners of operation, which can make consolidation challenging.
- Child/adolescent treatments are often bespoke and require treating/interacting with both the individual and factors in their environment (e.g., parents, schools); this presents a challenge for larger organizations looking to standardize treatments across practices.
- Start-up costs associated with setting up a practice can be low relative to other specialties; starting an outpatient behavioral therapy practice requires low levels of capital beyond obtaining necessary degrees/licensures, renting and furnishing an office, and setting up some basic administrative infrastructure.

Figure 12
US practices with child/adolescent psychiatrists, by practice size and staff composition (2024)



*Providers must have a National Provider Identifier (NPI) number to be included in the CMS NPPES/NPI database; child/adolescent psychiatrists include only those who report child/adolescent psychiatry as their primary specialty
Source: Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System/NPI; L.E.K. research and analysis

But these challenges can be addressed

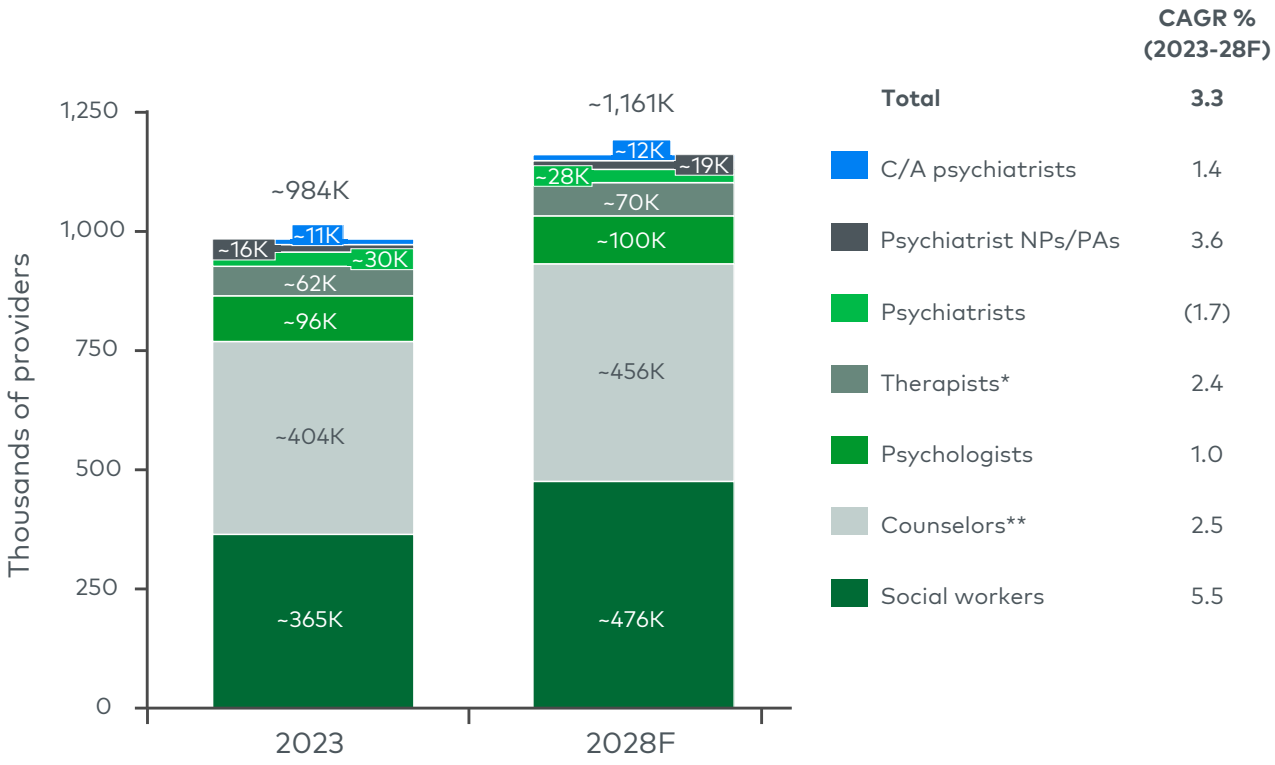
Despite difficulties, there is a path to addressing these challenges and forming a successful investment strategy in the child/adolescent behavioral health space.

Low clinician supply: Though the supply of child/adolescent specialized psychiatrists is low, clinician supply is not low across all behavioral health clinician types. As in many other specialties with supply constraints, midlevel providers with the ability to prescribe medications — such as nurse practitioners (NPs) and physician assistants (PAs) — can play a critical role in child/adolescent behavioral health practices. This is enabled by growth in the midlevel workforce, which is expected to outpace the broader behavioral health workforce through 2027 (3.6% p.a. versus 3.3% p.a. 2023-28F) (see Figure 13).

Midlevel practice support is further enabled by states' gradual loosening of requirements allowing more NPs to work at the top of their licensure. Many states temporarily expanded prescriptive authority to NPs in the wake of COVID-19-driven physician shortages,[36] and some states, such as California, have made these privileges permanent.[37]

There is an opportunity for other licensures (e.g., therapists, counselors and social workers) to play a role in the space. The inclusion of both midlevel providers and other licensures likely improves practice-level unit economics and increases profitability.

Figure 13
US total behavioral health providers, by type (2023, 28F)



*Therapists category includes marriage and family therapists
**Counselors category includes addiction, mental health and school counselors
Note: C/A=child/adolescent; NPs=nurse practitioners; PAs=physician assistants; CAGR=compound annual growth rate
Source: Health Resources and Services Administration; American Academy of Child and Adolescent Psychiatry; L.E.K. research and analysis

Attractive OON dynamics: The attractive OON dynamics in the child/adolescent behavioral health space are generally the result of the low rates negotiated by payers. Efforts to consolidate child/adolescent providers have the potential to overcome this challenge. As practices gain scale, they can invest in the infrastructure to support value-based care arrangements and drive further profitability.

A highly fragmented set of providers: The fragmentation of providers (e.g., practices with one or two clinicians) is a challenge that can be overcome by demonstrating the value of a roll-up or tuck-in platform play to independent clinicians.

Beyond benefiting payer negotiations, a consolidation of independents is likely to create a path to increased profitability. Aggregating practices will require a degree of legwork but will have the benefits of reducing administrative burdens in the form of centralized back-office operations and making it economical to implement strategies that drive increased patient volumes (e.g., telehealth platforms, partnerships with health systems).

Conclusion

The market for child/adolescent behavioral health has several fundamental dynamics that make it an attractive space for investment, including population demographics, a rise in societal awareness and acceptance, improvements in access to care, a shift toward in-network utilization and the COVID-19-accelerated adoption of telehealth. Despite these attractive market dynamics, investment in the space remains limited due to structural challenges, including a shortage of specialized psychiatrists, attractive OON dynamics and a fragmented landscape that includes few scaled assets. However, with a degree of commitment and investment of resources, each of these challenges can be overcome to not only drive improvements in care while reducing total cost of care but also drive practice economics.

To the question of how one goes about identifying attractive markets and potential assets, L.E.K. Consulting has identified several frameworks and analytic tools to assess geographic markets attractive for the broader behavioral health space as well as the child/adolescent subsegment. Common prioritization criteria are supply-demand imbalance, payer dynamics and competitive intensity, to name a few.

For more information, please **contact us**.

Endnotes

[1]Pediatric behavioral health includes mental illness, the prevalence of which follows National Survey of Children's Health definition of any clinician-diagnosed finding of depression, anxiety, or AD/HD and SUD prevalence based on the Substance Abuse and Mental Health Services Administration definition of any substance use disorder behavior in the past year (e.g., alcohol, opioid, stimulants, cannabis)

[2]Common substance use disorder diagnoses include alcohol use disorder (AUD), opioid use disorder (OUD, including prescription and illicit opioids), cannabis use disorder (CUD), stimulant use disorder (StUD, including prescription and illicit stimulants)

[3]PEHub.com, "TPG steps up with $1.2bn deal for LifeStance Health." https://www.pehub.com/tpg-steps-up-with-1-2bn-deal-for-lifestance-health/

[4]Reuters.com, "TPG-backed mental health firm LifeStance raises $590.4 million in U.S. IPO." https://www.reuters.com/article/us-lifestance-health-ipo/tpg-backed-mental-health-firm-lifestance-raises-590-4-million-in-u-s-ipo-idUSKCN2DM04M

[5]BHbusiness.com, "Optum-Backed Refresh Mental Health Acquires CARE Counseling." https://bhbusiness.com/2024/04/11/optum-backed-refresh-mental-health-acquires-care-counseling/

[6]BHbusiness.com, "PE Firms HCAP Partners, Hamilton Lane Fuse Three Companies to Make PAX Health." https://bhbusiness.com/2024/03/12/pe-firms-hcap-partners-hamilton-lane-fuse-three-companies-to-make-pax-health/

[7]PEHub.com, "Onex completes Newport Healthcare buy at $1.3bn value." https://www.pehub.com/onex-completes-newport-healthcare-buy-at-1-3bn-value/

[8]BHbusiness.com, "Consonance Capital Partners Acquires Majority Stake in Youth-Focused Embark Behavioral Health." https://bhbusiness.com/2023/02/09/consonance-capital-partners-acquires-majority-stake-in-youth-focused-embark-behavioral-health/

[9]Based on L.E.K. analysis of American Academy of Child and Adolescent Psychiatry and Health Resources and Services Administration data: AACAP.com, "Workforce Maps by State." https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx, data.HRSA.gov, "Workforce Projections." https://data.hrsa.gov/topics/health-workforce/workforce-projections

[10]This article focuses primarily on 5-to-17-year-olds; children under 5 years old also experience behavioral health conditions, including autism. L.E.K. Consulting has covered this market for many applied behavior analysis providers, tech platforms and investors.

[11]SAMHSA.gov, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health." https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

[12]Pediatric behavioral health includes mental illness, the prevalence of which follows National Survey of Children's Health definition of any clinician-diagnosed finding of depression, anxiety, or AD/HD and SUD prevalence based on the Substance Abuse and Mental Health Services Administration definition of any substance use disorder behavior in the past year (e.g., alcohol, opioid, stimulants, cannabis)

[13]OECD.org, "The future of health systems." https://www.oecd.org/els/health-systems/Children-and-Young-People-Mental-Health-in-the-Digital-Age.pdf

[14]HHS.gov, "New HHS Study in JAMA Pediatrics Shows Significant Increases in Children Diagnosed with Mental Health Conditions from 2016 to 2020." https://www.hhs.gov/about/news/2022/03/14/new-hhs-study-jama-pediatrics-shows-significant-increases-children-diagnosed-mental-health-conditions-2016-2020.html

[15]NCBI.nlm.nih.gov, "The impact of the COVID-19 pandemic on child and adolescent development around the world." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8652930/

[16]Pediatric behavioral health includes mental illness, the prevalence of which follows National Survey of Children's Health definition of any clinician-diagnosed finding of depression, anxiety, or AD/HD and SUD prevalence based on the Substance Abuse and Mental Health Services Administration definition of any substance use disorder behavior in the past year (e.g., alcohol, opioid, stimulants, cannabis)

[17]CDN.YMAWS.com, "Where is Behavioral Health Integration Occurring? Mapping National Co-location Trends Using National Provider Identifier Data." https://cdn.ymaws.com/members.cfha.net/resource/resmgr/website_redesign/npi-full-report_final.pdf

[18]MHAnational.com, "Improving Mental Health through EAP Usage." https://mhanational.org/blog/improving-workplace-mental-health-through-eap-usage

[19]NYTimes.com, "Therapy on Aisle 7: Retailers Are Entering the Mental Health Market." https://www.nytimes.com/2021/05/07/well/therapy-pharmacy.html

[20]CCHA.org, "Improving Behavioral Health Care for Children in California." https://www.ccha.org/sites/main/files/file-attachments/ccha_behavioral_health_white_paper_final.pdf?1575927706

[21]Finance.senate.com, "Mental Health Care in the United States: The Case for Federal Action." https://www.finance.senate.gov/imo/media/doc/SFC%20Mental%20Health%20Report%20March%202022.pdf

[22]Congress.com, "H.R.7666 - Restoring Hope for Mental Health and Well-Being Act of 2022." https://www.congress.gov/bill/117th-congress/house-bill/7666

[23]The X-waiver requirement stems from the Drug Addiction Treatment Act of 2000, which requires clinicians to complete an X-waiver in order to treat opioid use disorder with buprenorphine in clinic offices.

[24]NPR.com, "The new 988 mental health hotline is live. Here's what to know." https://www.npr.org/sections/health-shots/2022/07/15/1111316589/988-suicide-hotline-number

[25]EuropePMC.org, "Prices And Cost Sharing For Psychotherapy In Network Versus Out Of Network In The United States." https://europepmc.org/article/med/32634359

[26]CDC.gov, "Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020." https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm

[27]Mental health related emergency department utilization includes visits with one or more ICD-10 codes for depressive disorders, suicidal ideation or self-harm, trauma and stressor-related disorders, cannabis-related disorders, lifestyle or life management factors, mood disorders, poisoning by drugs, and symptoms of mental or substance use conditions

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