

Meeting the Mental Health Needs of Children

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EXECUTIVE SUMMARY

Recent estimates suggest that 10 to 20 percent of children have a diagnosable mental health disorder^{1, 2} and 40 to 80 percent of children with mental health problems do not receive the services they need.^{1, 3, 4} Despite robust evidence indicating the benefits of timely prevention, detection, and intervention, physical and mental health systems continue to miss early opportunities to improve outcomes for these children.

Recent health reform legislation including the Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010 (PPACA, as modified by the Health Care and Education Reconciliation Act of 2010) have made important strides

in establishing mental health needs as equivalent with physical health needs. With the full implementation of these laws, all qualified health plans will be required to provide mental health services, including behavioral health treatment, at parity with medical benefits.⁵⁻⁷ In order to optimize the impact of these provisions on children's mental health, federal agencies, states, and private payers must establish care and reimbursement standards that promote a children's mental health environment more reflective of the evidence on best practices.

Through an examination of the evidence surrounding key issues in children's mental health, this brief proposes policy actions to improve outcomes for children and their families.

EVIDENCE

ACTION

Providing prevention-focused intervention for children who exhibit behaviors that are predictive of mental health disorders can improve outcomes.



Prevention-focused interventions in children's mental health should be included in the essential benefits package developed under PPACA.



States should make use of legislative and regulatory measures to require public and private insurance reimbursement for **prevention-focused** interventions in children's mental health.

Many children's mental health systems rely on unproven interventions.



States should make use of legislative and regulatory measures to require public and private payers to reimburse for **evidence-based** interventions in children's mental health.



States should take a more active role in managing the implementation and evaluation of children's mental health services.

Structural barriers limit the availability and accessibility of children's mental health services.



States should make use of legislative and regulatory measures to support the **integration** of mental health and primary care services.



State, city, and county health and mental health systems should promote the integration of mental health and primary care services by developing the flexibility to blend and braid funding streams.¹



Federal and state programs should fund the demonstration and evaluation of innovative mental health delivery models.

EVIDENCE TO ACTION FINDINGS

1 EVIDENCE: Providing prevention-focused intervention for children who exhibit behaviors that are predictive of mental health disorders can improve outcomes.

Most children's mental health problems are left untreated until they reach the severity of a diagnosable disorder.⁸ However, children usually exhibit behaviors that are predictive of the development of a disorder well before they receive a diagnosis.² Children exhibiting such predictive behaviors are up to five times more likely to develop full mental health disorders than their non-symptomatic peers.⁹⁻¹¹ If these children receive appropriate intervention at an early stage, it can prevent the onset of a diagnosable mental health disorder and improve emotional, behavioral, and cognitive outcomes.^{2, 2, 12-18} Additionally, in several studies, the academic, behavioral, and health benefits of prevention-focused interventions have lasted more than 10 years after the intervention.¹⁷ This evidence indicates the need for a shift towards prevention-focused intervention in children's mental health.

The current limited availability of prevention-focused intervention stems partly from the financing structure of children's mental health services. In most states, providers are required to submit diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* to be reimbursed for services provided. This results in some providers (up to 70 percent) using alternate diagnoses and often inflating the severity of a child's problems in order to provide or refer to services. When considering using alternate diagnoses, 65 percent of providers surveyed report doing so to obtain services for a patient, and 73 percent report doing so particularly for children with predictive behaviors that do not reach diagnostic severity.¹⁹ This practice is not without potential adverse effects, including the potential stigmatization that results from a child being labeled with a mental health disorder.²⁰ Furthermore, such labels often serve as pretext for the prescription of psychotropic medications. This includes the use of atypical antipsychotics, which have been prescribed off-label in children increasingly in recent

years despite emerging evidence of adverse effects.²¹ Alternately, a provider, knowing the unlikelihood of reimbursement or the dangers of stigmatization, may delay intervention for a child whose symptoms are not severe enough to warrant a diagnosis.¹⁹ This practice is equally problematic, as children with predictive behaviors are more likely to develop a diagnosable mental health disorder and because timely intervention is very effective among this group.^{9-13, 15, 17, 22} In either of these cases, the child with predictive behaviors is unlikely to receive appropriate prevention-focused intervention.

ACTION: Prevention-focused interventions in children's mental health should be included in the essential benefits package developed under PPACA.

Starting in 2014, PPACA will require all qualified health plans²³ and individual and small group plans²⁴ to provide a package of essential benefits including mental and behavioral health services.²⁵ Additionally, PPACA requires that all qualified plans²⁶ and individual plans²⁷ provide these services at parity with medical benefits. The ongoing process of defining the benefits that will be included in these packages provides great opportunity to reshape the children's mental health system to better reflect the known benefit of timely prevention-focused intervention. In defining the mental health services included in the essential benefits packages, prevention-focused interventions should be prioritized.

ACTION: States should make use of legislative and regulatory measures to require public and private insurance reimbursement for **prevention-focused** interventions in children's mental health.

In the interim—before the full implementation of PPACA—states should mandate reimbursement for prevention-focused interventions to support availability of and access to such services for children. Although Medicaid policy does not generally support intervention for children without a diagnosis, many states have worked within the framework of the current system

¹ In both blending and braiding of funds, the provision of services is supported by multiple systems; however, blending funds combines funds into a single pool while braided funds remain separately linked to the supplying administrative system.

² Effect sizes of 0.24 to 0.93

to expand services to children exhibiting predictive behaviors.²⁸ As of 2000, North Carolina Medicaid allows six visits annually for mental health services without a diagnosis for children under 21 years of age. These visits can include evaluation and individual or group therapy sessions.²⁹ Similarly, Washington state passed legislation in 2007 providing up to 20 mental health visits through a fee-for-service network for children who do not meet criteria for a diagnosable disorder.²⁸ While increased access to these types of clinic treatment is an important step in prevention, states should require public and private insurers to empower mental health professionals to extend a variety of clinic and non-clinic preventive services to children who meet a well-defined set of risk factors.

Though such change could increase the upfront burden on the children's mental health system, unnecessary treatment might be prevented by ensuring that fewer children receive more serious mental health diagnoses. As long as regulations are in place to ensure that treatment is given only when appropriately indicated, this could lead to cost savings over time.^{1, 30} This could also result in children receiving more appropriate treatment, and, most importantly for both child outcomes and cost-effectiveness, lead to fewer children with diagnosable mental health disorders as they age.

Given the paucity of evidence in this area, efforts to implement prevention-focused interventions should be tracked and evaluated to determine with certainty whether these modifications result in better outcomes for children and are more cost-effective over time.

2 EVIDENCE: Many children's mental health systems rely on unproven interventions.

Ensuring best outcomes for children with mental health problems requires not only timely intervention but also the use of interventions that have proven effective. Despite the existence of evidence-based interventions for the treatment and prevention of a variety of children's mental health problems, many states, cities, and counties continue to use unevaluated interventions and even use interventions that have been proven ineffective.^{17, 31-34} The most promising behavioral health interventions focus

on addressing behaviors exhibited by children as well as caregiver responses to these behaviors. A review of 130 prevention-focused studies demonstrated that children receiving behavioral or cognitive-behavioral interventions had better outcomes than 70 percent of those receiving other types of interventions or no interventions.¹³ Furthermore, several studies have found that usual care approaches to children's mental health have little to no benefit to children.^{17, 35, 36}

The limited dissemination and implementation of many of the most promising evidence-based interventions is partly due to current reimbursement practices that inadequately fund core characteristics of these programs. For instance, although children's mental health research strongly indicates the benefit of treating both caregiver and child as "patient,"^{15, 28, 32, 37} private and public insurance plans often do not reimburse for such "family-focused" treatment. Defining the child as the sole patient, "individual therapy" is usually reimbursed, while "family therapy" is covered less often. This issue is further complicated when seeking reimbursement for caregiver-only sessions as part of a child's treatment.³⁸ Additionally, many insurance plans limit the number of mental health sessions that are reimbursable in any given year, which is sometimes fewer than the number indicated for evidence-based programs.³⁹⁻⁴¹ Providers are therefore forced to seek repeated reauthorization in order to follow treatment protocols that have proven most beneficial for child outcomes. These strict reimbursement requirements may interrupt the treatment course or even discourage some providers from offering or referring to evidence-based programs despite their proven efficacy.

ACTION: States should make use of legislative and regulatory measures to require public and private payers to reimburse for **evidence-based** interventions in children's mental health.

To support the use of evidence-based interventions, states should require public and private insurance plans to reimburse for key characteristics of these interventions. Primarily, insurers must expand their definition of "patient" to cover caregivers of children when appropriate. "Family therapy" and "multifamily group therapy" should be reimbursed comparable to "individual therapy." Insurance plans should also reimburse for services to

caregivers without the child present when the services are geared towards improving child outcomes. Some states have already taken the lead on this issue. Hawaii, Vermont, California, Colorado, and Arizona provide models for the billing of evidence-based ‘family-focused’ interventions.⁴² Additionally, provisions must be built into public and private insurance plans to ensure that reimbursement for evidence-based interventions can be authorized for the duration of treatment. Removing these reimbursement-related barriers is a crucial step in increasing the dissemination and implementation of

evidence-based interventions. [See Table 1 for examples of evidence-based interventions]

ACTION: States should take a more active role in managing the implementation and evaluation of children’s mental health services.

To ensure the quality of care children receive, states should be more active in managing the implementation and evaluation of children’s mental health services. Coordinated management at the state level could

TABLE 1. SELECTED EVIDENCE-BASED INTERVENTIONS IN CHILDREN’S MENTAL HEALTH

Intervention	Treatment Focus & Aims	Outcomes
Parent-Child Interaction Therapy (PCIT) www.pcit.org	Age: 2-7 years and their caregivers; recent adaptations for ages 8-12 Treatment Focus: Externalizing behavior problems	Reduced: • Re-reports of physical abuse Improved: • Parenting skills and attitudes • Child behaviors
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) tfcbt.musc.edu	Age: 3-18 years and their caregivers Treatment Focus: Emotional/behavioral problems resulting from child sexual abuse; adaptations for use with other traumatic experiences	Reduced: • PTSD symptoms • Self-reported fear and anxiety • Symptoms of depression Improved: • General functioning • Positive parenting skills • Parent and child coping skills
CBT for Depression: Coping with Depression for Adolescents (CWDA) www.kpchr.org/public/acwd/acwd.html	Age: 12-18 years and their caregivers Treatment Focus: Depression and/or dysthymia	Reduced: • Symptoms of depression • Development of diagnosable depressive disorders
CBT for Anxiety: Coping Cat	Age: 6-17 years and their caregivers Treatment Focus: Anxiety	Reduced: • Symptoms of anxiety • Symptoms of associated depression Improved: • Coping skills
The Incredible Years (IY) www.incredibleyears.com	Age: Birth-12 years and their caregivers or teachers Treatment Focus: Externalizing behavior problems	Reduced: • Parental depression • Child behavior problems Improved: • Parental positive affect • Effective parenting techniques • Child social and emotional competence

*This table highlights some promising evidence-based interventions in the field of child and adolescent mental health. It is not an exhaustive list of all interventions with a strong evidence base. The following resources offer more information:

- The California Evidence-Based Clearinghouse for Child Welfare: www.cebc4cw.org
- Blueprints for Violence Prevention: www.colorado.edu/cspv/infhouse/index.html
- SAMHSA’s National Registry of Evidence-Based Programs and Practices: www.nrepp.samhsa.gov
- The Office of Juvenile Justice and Delinquency Prevention’s Model Programs Guide: www2.dsgonline.com/mpg

strengthen the evidence base surrounding new and existing interventions and ensure continued efficacy once interventions are implemented. This charge is not simply for the identification of evidence-based practice, but a larger commitment to understanding how to adapt interventions for the populations they serve. Such an approach appreciates the full ecology (e.g. political, social, familial) that influences the success or failure of a mental health intervention, not just the intervention and outcomes in isolation.⁴³

The complexities of state mental health systems resist a one-size-fits-all approach to reform. However, states that have undertaken efforts to implement evidence-based interventions have developed various strategies involving regulation, training, evaluation, and financing that could serve as models for other states. For instance, New York has established year-long training on evidence-based interventions, altered the clinic rate structure to incentivize the use of evidence-based interventions, and incorporated federal dollars into program evaluation. Hawaii has implemented statewide training programs, convened best practice conferences, and published practice guidelines. Oregon took a regulatory approach and passed legislation requiring 75 percent of its public mental health services to be evidence-based by 2008, while Michigan developed systems for outcome data and evaluation to allow the data to drive the reform.^{44, 45} These state-level reform efforts should be evaluated to inform best practices in future large scale evidence-based implementation efforts.

While each state must tailor its approach to its particular needs and the structure of its children's mental health system, states should consider the following approaches for using regulation, training, evaluation, and financing to move towards evidence-based intervention in children's mental health:

1. Prioritize and standardize evidence-based programs for funding except where programs are in demonstration as a pilot phase.
2. Provide funds for ongoing personnel training and evaluation to increase capacity and ensure that interventions are delivered with fidelity to protocol, whether in the public or private sector. This could involve embedding training in evidence-based interventions into licensing requirements for mental

health professionals or requiring professionals to be certified in specific interventions in order to receive reimbursement for services rendered.

3. Seek federal demonstration dollars for development and evaluation in areas where interventions are lacking and to ensure the continued efficacy of programs once widely implemented. (Notably, the recent health reform legislation establishes a federal grant program designed specifically to fund the delivery of evidence-based prevention services.)

3 EVIDENCE: Structural barriers limit the availability and accessibility of children's mental health services.

A successful shift to a prevention-focused and evidence-based approach in children's mental health is also contingent on addressing barriers to availability and access. The dissemination and implementation of evidence-based interventions will improve outcomes only if the programs reach the children who need them. As mental health needs have risen over recent decades, there has been no parallel increase in services.¹⁸ Shortages in resources, including a lack of professionals trained in children's mental health, have left many communities without access to quality mental health services.^{15, 46-49}

While the data surrounding shortfalls in mental health services are limited, reports consistently identify a disparity between need and availability. Between 40 to 80 percent of children are reported to not receive the services they need.^{1, 3, 4} Even after being accepted for a mental health evaluation, 30 to 60 percent never attend an appointment.^{2, 50, 51} Additionally, 29.3 percent of caregivers who reported their child had a need for special therapeutic or educational services, equipment, or counseling had difficulty in accessing the needed services.⁵² Notably, rates of unmet mental health needs are highest among Latino, African-American, economically disadvantaged, and uninsured children^{3, 53} and up to 75 percent of children in the child welfare system have been reported not to receive the mental health services they need.⁵⁴

The factors contributing to underutilization of services are complex. Families most commonly attribute the limited use of mental health services to a lack of knowledge

about available services, lack of availability, lack of transportation, lack of understanding about the purpose and mechanism of treatment, financial constraints, children’s mental health professional shortages, stigma related to mental health disorders, and concerns about the use of psychotropic medications.^{48, 55, 56} Additionally, 40 to 60 percent of families that begin treatment terminate it prematurely, with many of them reporting similar barriers as a reason for termination.^{1, 57}

Creative solutions are needed to increase the availability of children’s mental health services as well as to address access barriers for children and families. While there are many possible approaches to these issues, including increased training in mental health for medical and non-medical personnel working with children and families or co-locating mental health services in non-traditional settings such as community centers, more evaluation and evidence is needed to establish the potential impact of these approaches.

One innovation targeting these issues with promising results is the integration of mental health and primary care services. Early studies with adults have shown integrated services to treat mental health problems more effectively than standard care.⁵⁸ Integration of mental health and primary care services for children has been reported to be especially effective at “capturing” children with mental health problems because these children are more frequent users of primary care and are more likely to have numerous medical conditions than children without mental health problems.⁵⁹ In one study, when referred to a mental health provider located outside of a primary care office, only 60 percent of families sought these services within six months, while more than 80 percent of these families had returned to the primary care pediatrician’s office for medical reasons during this time.⁶⁰ Providers also report increased provider satisfaction and decreased stigmatization and access barriers for families when mental health and primary care services are integrated.⁶¹

Some existing models for the integration of services include co-locating mental health professionals in existing pediatric primary care settings and establishing telemedicine mental health consultation. Massachusetts has used telephone consultations to expand access to approximately 95 percent of children in the state. After an initial phone consultation, the child receives appropriate intervention or connection to community resources.⁶²

When mental health and primary care services are integrated in these ways, providers report greater frequency of consultations and referrals for mental health services and increased satisfaction with the process.^{62, 63}

Despite the potential benefit of integrating mental health and primary care services for children, current reimbursement practices largely do not support this approach.^{18, 64} Under many insurance plans, the provision of multiple services by different practitioners within the same provider organization on the same day is not allowed.⁶⁵ Outpatient consultation to a primary care provider is also often not reimbursed. Similarly, there is often minimal or no reimbursement for services that are not face-to-face with the patient (the child), even though billing codes exist to categorize many of these services.^{31, 66} Accordingly, efforts to coordinate and integrate services such as appointments between clinicians and caregivers to discuss a child’s mental health, discussions of care with teachers and schools, and conferencing between interdisciplinary mental health teams are often not financially supported.^{65, 66}

ACTION: States should make use of legislative and regulatory measures to support the **integration** of mental health and primary care services.

States should require public and private insurers to support the integration of children’s mental health and primary care services. Primarily, states must remove restrictions on services provided to a child on a single day at the same provider organization. These rules prevent a primary care pediatrician and a mental health professional working in the same provider organization from coordinating the care of a child in a timely and convenient way. This is an unnecessary barrier for families trying to access services for their child. States should also expand reimbursement for activities that coordinate care such as care plan oversight meetings and teleconferencing between providers. Removing these restrictions is an essential step to promoting integrated, prevention-focused intervention in children’s mental health and primary care. Notably, telehealth services for the treatment of behavioral health problems was highlighted as an example of the types of programs to be tested by the newly created Center for Medicare and Medicaid Innovation.⁶⁷

ACTION: State, city, and county health and mental health systems should promote the integration of mental health and primary care services by developing the flexibility to blend and braid funding streams.

Recognizing the limited financial resources available for mental health systems, states should be more proactive in blending and braiding funding streams across systems to support mental health efforts. In both blending and braiding of funds, the provision of services is supported by multiple systems; however, blending funds combines funds into a single pool while braided funds remain separately linked to the supplying administrative system. Blending allows for greater flexibility, as the funds can be distributed from a single source to cover a variety of children’s mental health expenses while braiding requires more maneuvering of funds from different streams to cover approved expenses but allows for greater tracking and accountability of monies.⁶⁸ Reflecting the far-reaching benefits of timely and effective interventions in children’s mental health, funds from children’s mental health, education, child welfare, delinquency and crime prevention, and substance abuse streams should be combined in these ways to maximize the resources available to provide children’s mental health services. States where these practices are already in place include Nebraska, Ohio, Wisconsin, Vermont, Michigan, and Indiana.⁴² A collaborative funding effort will also promote a multi-system, integrated approach to meeting the needs of children with mental health problems.

ACTION: Federal and state programs should fund the demonstration and evaluation of innovative mental health delivery models.

Currently, while it would seem that integrated models of service delivery, whether in primary care or other locations, could alleviate challenges around availability of and access to mental health services, such models are still in their infancy and are not widely disseminated, implemented, or evaluated. We need to better understand whether such models can significantly reduce disparities in access to and utilization of mental health services in underserved communities. Therefore, state and federal agencies should fund the demonstration and evaluation of innovative delivery models to improve availability and accessibility of mental health services while retaining a commitment to evidence-based approaches in children’s mental health.

CONCLUSION

Children’s mental health systems face the challenge of serving the diverse mental health needs of a growing number of children while capacity and funding do not keep pace. This brief presents evidence-driven actions to improve outcomes for children by moving towards a mental health system focused on prevention, evidence-based intervention, integrated mental health and primary care services, and ongoing evaluation.

PolicyLab’s Work On Children’s Mental Health

Enhanced Parenting For Depressed Caregivers

The intervention aims to reduce symptoms of depression in caregivers of young children through a primary care-based parental screening and intervention using the Incredible Years model.

CSAW: Pilot Intervention

The intervention works with families in the child welfare system to reduce behavioral problems, decrease placement moves, and mitigate caregiver stress. Two evidence-based interventions, Parent-Child Interaction Therapy and Child Adult Relationship Enhancement training, are co-located in foster care agencies through partnership with the City of Philadelphia’s Department of Human Services and Department of Behavioral Health.

Translating Evidence-Based Developmental Screening

This project aims to improve the appropriate identification and treatment of early developmental and behavioral problems in children by examining the feasibility, adaptability, and effectiveness of standardized developmental screening in pediatric practices.

Evaluating the Nurse Family Partnership Program

The Nurse Family Partnership is a prenatal home visitation program that has been found to positively impact a variety of maternal and child outcomes. PolicyLab’s evaluation of the program in Pennsylvania aims to assess the impact on five specific outcome measures to inform practice improvement initiatives and dissemination efforts.

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The mission of PolicyLab at The Children’s Hospital of Philadelphia is to achieve optimal child health and well-being by informing program and policy changes through interdisciplinary research.

PolicyLab develops evidence-based solutions for the most challenging health-related issues affecting children. We partner with numerous stakeholders in traditional healthcare and other community locations to identify the programs, practices, and policies that support the best outcomes for children and their families. PolicyLab disseminates its findings beyond research and academic communities as part of its commitment to transform “evidence to action.”

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