partners forourchildren

CHILDREN'S MENTAL HEALTH

BRIEF | **JAN 2017**
Washington State

SUMMARY

Partners for Our Children supports improved access and accountability for children and their families who need behavioral and mental health services. Providing greater access, early identification, effective and appropriate treatment will help reduce the need for more expensive services, such as emergency rooms and juvenile detention, and better ensure success in school and life.

VULNERABLE CHILDREN & MENTAL HEALTH

It is estimated that 21% of low-income children and youth (ages 6-17) have a behavioral/mental health disorder, and more than half of these children (57%) are from households with incomes at or below the federal poverty level.[i] The rates are even higher for children and youth involved in the child welfare and juvenile justice systems. Approximately 50% of children and youth in the child welfare system, and nearly 70% of youth in the juvenile justice system, have a behavioral/mental health disorder.[ii] Data broken down by gender, age, race, and ethnicity is unavailable and/or difficult to access, but is essential to have.

IMPACT ON CHILDREN'S OUTCOMES

Educational Outcomes:

- Preschoolers now face a rate of expulsion that is 3.2 times higher than the national rate of expulsion for K-12 students, and this is primarily due to social-emotional needs.[iii]
- 37% of children aged 14 and older with a behavioral/mental health condition drop out of school—the highest dropout rate of any disability group.[iv] Additionally, children and youth with behavioral/mental health disorders are suspended or expulsed from school at a rate 3 times higher than their peers.[v]

Health & Well-Being:

- Substance abuse is linked to behavioral/mental disorders, where 43% of children who use mental health services also have a substance abuse disorder.[vi]
- Suicide is now the 3rd leading cause of death among youth and young adults (ages 10-24), and 90% of those who committed suicide had an underlying mental health disorder.[vii]

Child Welfare:

- Children with a behavioral/mental health illness are more likely to be removed from their home, and once in care are less likely to be placed in a permanent home.[viii]
- Young adults who exit care experience major mental health problems and drug and substance dependence at a significantly higher rate than the general population.[ix]

DISCONNECTED FROM SERVICES CURRENTLY

Of the children who have behavioral/mental health issues, nearly 80% do not receive the care they need.[x] The average delay between the onset of symptoms and an intervention is approximately 8-10 years.[xi] With nearly a decade passing by before necessary treatments are provided, there is an over-reliance on costly services such as juvenile detention, emergency rooms, and rehabilitations centers.[xii]

MORE COORDINATED & EFFECTIVE SERVICES

Care coordination through a child's primary care provider is an effective model that should be implemented to the greatest degree possible. Additionally, many of the Healthy Options plans identify an array of services available to their members; however, knowledge and use of the services by families, primary care providers, youth, and others appears to be limited. School-based interventions are also an effective model to ensure access and care for children and youth with behavioral and mental health disorders. Children and youth who have access to mental health services in school-based health centers are 10 times more likely to seek care for mental health or substance abuse than those who do not.[xiii]

CHILDREN'S MENTAL HEALTH WORKGROUP RECOMMENDATIONS

HB 2439, passed by the legislature in 2016, created a Children's Mental Health workgroup. The workgroup was established to identify barriers to accessing mental health services for children and families, and to advise the Legislature on statewide mental health services for this population. Their full report has been submitted to the Legislature for review.[xiv] The workgroup voted on and approved a total of 21 recommendations. The following recommendations were identified as the top five priorities that would improve outcomes for children and families (in order of priority):

Relating to Medicaid Rates:

The Legislature should provide funding to increase Medicaid rates to achieve equity with Medicare rates, in order to increase the number of providers who will serve children and families on Medicaid. After the rate increases have been implemented for two years, the Legislature should require an outcome-based study on providers, analyzing the impact on the workforce and the number of providers who serve children and families on Medicaid.

Relating to Screening and Assessment:

The Legislature should require the Health Care Authority (HCA) and the Division of Behavioral Health and Recovery (DBHR) to assemble a work group(s) to:

- Identify a standardized list of culturally- and developmentally-appropriate screening tools for children aged 0-20, for use by all primary care practitioners.
- Identify standardized mental health assessment, outcome, and diagnostic tools that are culturally- and developmentally-appropriate for children aged 0-5 that support access to Behavioral Health Organization (BHO) services.
- Identify billing options and propose coverage for a new or redefined code with an adequate reimbursement rate for the following services performed during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visit, or other primary care office visit for a child:
    - Maternal depression screening and behavioral health screening, including depression screening, for children aged 0-20.

Relating to Children's Mental Health Workforce Supports and Incentives:

The Legislature should provide a tuition loan repayment program targeted for child psychiatrists, therapists, and clinicians working for BHO- or MCO-funded agencies that serve a high percentage of children, youth, and families on Medicaid. The tuition loan repayment program should be directed at professionals in the above fields who make a commitment to work for 5 years in the public sector setting.

Relating to Mental Health Service Delivery and Care Coordination:

The Legislature should:

- Fund an FTE mental health lead at each of the nine Educational Services Districts (ESDs) and a coordinator in the Office of Superintendent of Public Instruction (OSPI) to help coordinate mental health services, and include funding for one "lighthouse" ESD, which has experience providing mental health services, to serve in an advisory role to other districts.
- Create 2-3 regional pilot projects to fund a provision of mental health services in school districts struggling to address mental/behavioral health needs in K-12.

The Legislature should require the HCA to incorporate care coordination into larger primary care provider practices. The care coordination model must: (1) use a psychiatric registered nurse or master's level mental health clinician with specified knowledge and training in mental health care and (2) provide advocacy and engagement services that foster warm hand-offs to mental health professionals, facilitate communication between health care providers, and provide education to children and families.

ENDNOTES

[i] Cooper, J., Masi, R. (2006). *Children's Mental Health: Facts for Policymakers*. National Center for Children in Poverty. Retrieved from http://www.nccp.org/publications/pub_687.html

[ii] Cooper, J., Masi, R. (2006)

[iii] Gilliam, W. S. (2005). *Prekindergartens left behind: Expulsion rates in state prekindergarten programs* (FCD Policy Brief Series 3). New York, NY: Foundation for Child Development. Retrieved fromhttp://ziglercenter.yale.edu/publications/National%20Prek%20Study_expulsion%20brief_34775_284_5379.pdf

[iv] National Alliance of Mental Illness. (n.d.) Retrieved from http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf

[v] Judge David L. Bazelon Center for Mental Health Law. *Facts on Children's Mental Health*. Retrieved from http://www.bazelon.org/LinkClick.aspx?fileticket=Nc7DS9D8EQE%3D&tabid=378

[vi] Bazelon Center for Mental Health Law (n.d.)

[vii] National Alliance of Mental Illness. (n.d.)

[viii] Bazelon Center for Mental Health Law (n.d.)

[ix] Bazelon Center for Mental Health Law (n.d.)

[x] Bazelon Center for Mental Health Law (n.d.)

[xi] National Alliance of Mental Illness. (n.d.)

[xii] Bazelon Center for Mental Health Law (n.d.)

[xiii] Child Mind Institute. (2016). *2016 Children's Mental Health Repor*t. Retrieved from http://childmind.org/report/2016-childrens-mental-health-report/introduction/

[xiv] The Children's Mental Health Workgroup (2016*). Final Report and Recommendations Submitted to the Governor and the Legislature*. Retrieved from http://leg.wa.gov/JointCommittees/CMH/Documents/CMH_FinalReport.pdf