



## **Children's Health Fund**

Mental Health Care in New York State:  
Prescriptions for Policy Change

The Children's Health Fund  
March 2008

## **Introduction**

The Children's Health Fund seeks to provide a medical home to medically underserved children in New York and across the country. More than just a family doctor, the medical home model encompasses all dimensions; it is care that is accessible, coordinated, and complete. Mental health is just as important as physical health for children, and seamless access to mental health services for children is essential. Unfortunately it is rarely accessible in a timely fashion if at all. According to the National Institute for Mental Health (NIMH), fewer than 20 percent of children who need mental health services actually receive treatment for such major mental illnesses as anxiety and depression. The situation is worse for medically underserved children, who face even greater barriers to access to mental health services.

The CHF has long advocated for policies and initiatives that improve access to mental health services. Indeed, mental health care has long been a major component of our policy and advocacy agenda. Our policy vision is motivated by a simple goal: we seek to identify the barriers that prevent children and their families from addressing mental illness and pursuing treatment, and promote policies that prevent mental illness from impairing the successful attainment of each child's potential.

This white paper focuses on current challenges facing children and families experiencing mental illness and accessing care. Changes taking place in New York State, including the implementation of Timothy's Law, will be discussed within the context of insurance as a financial barrier to access. Capacity issues will be highlighted, focusing on the high

demand and shortage of child mental health professionals. We will also discuss ways to enhance early identification and intervention for psychiatric disorders, and address the enormous problem of crisis mental health care and psychiatric hospital-emergency room diversion.

### **Background: Mental Health in Children**

Mental health problems are more prevalent among children than commonly thought. Between five and nine percent of children have psychiatric disorders sufficiently serious to affect their functioning at home and in school.<sup>1</sup> According to New York State's Commissioner of Mental Health, this translates to roughly 1 in 15 children, more than one child in every classroom in New York State, experiencing functional limitations due to a psychiatric disorder.<sup>2</sup> Yet, fewer than 20% of children who need mental health services actually receive the treatment they need, including for depression and anxiety disorders.<sup>3</sup>

There are significant disparities in child mental health needs and services. National Health Interview Survey (NHIS) data for 2001-2005 show an 80% higher rate of activity limitations due to mental health and developmental problems among poor children compared to non-poor children.<sup>4</sup> These disparities begin early, with low-income

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<sup>1</sup> New Freedom Commission on Mental Health. (2003). [\*Achieving the promise: Transforming mental health care in America. Final report\*](#) (DHHS Pub. No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>2</sup> Hogan, M. Presentation to The Children's Health Fund, New York City, December 7, 2007.

<sup>3</sup> National Institute of Mental Health

<sup>4</sup> Currie J, Wanchuan L. Chipping Away at Health: More On the Relationship Between Income and Child Health. *Health Affairs*. 2007;26:331-344.

preschool children showing a higher rate of behavioral problems than their more affluent peers.<sup>5</sup>

Finally, many children with mental illness end up as wards of the state as a result of financial and policy barriers. Of children and youth in juvenile detention, 65 percent of boys and 75 percent of girls have one or more psychiatric disorders.<sup>6</sup> Suicide is the third leading cause of death among people from ages 15-24.<sup>7</sup>

When mental health needs are present, treatment is often lacking. Without treatment, young children may experience developmental delays, older children and youth face school problems, and all children ultimately confront a lifetime of missed opportunities. As Surgeon General David Satcher stated in 2001, fostering the social and emotional health of children is part of healthy child development and must be a national priority.<sup>8</sup>

## **Barriers and Solutions to Mental Health Care**

### Access

Access to care is perhaps the first and most important barrier to improvement in mental health care for children. While pediatric mental health care has come a long way in recent years, thanks to hard work by advocates and recognition by policymakers in

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<sup>5</sup> Qi CH, Kaiser HP. Behavior Problems of Preschool Children From Low-Income Families: Review of the Literature. *Topics in Early Childhood Special Education*. 2003;23:188-216.

<sup>6</sup> Linda AT, Abram KM, McClelland GM, Dulcan MK, Mericle AA. Psychiatric Disorders in Youth in Juvenile Detention. *Archives of General Psychiatry*. 2002;59:1133-1143.

<sup>7</sup> Hsiang-Ching Kung, Hoyert, Donna L., Xu, Jiaquan, Murphy, Sherry, Deaths, Final Data 2005, Table 11: Death Rates for 113 Selected Causes by Age: U.S. 2005, National Vital Statistics Reports, Centers for Disease Control, January 2008.

<sup>8</sup> Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, U.S. Department of Health and Human Services, January, 2001.

passing mental health parity, improving child access to mental health care services extends beyond insurance coverage for services. Systems of care at the state, local, hospital and community level are straining to meet the growing need for mental health care. The level of reimbursement under commercial and public insurance programs does not reflect the time and intensity of visits necessary to adequately treat children. Many child mental health professionals no longer accept third party payment for clinical services because the system of billing and tracking payment has become too complex and time consuming. This trend, which has especially been noted as the penetration of managed care into the insurance market has increased, further reduces the available mental health professional workforce for low and middle income families.<sup>9</sup> Often, the disparate service systems families must access are too arcane to navigate especially when experiencing a mental health crisis.

Until recently, parents facing these insurance barriers faced the unnatural decision of turning over custody of their child to the state in order to access expanded mental health care services under Medicaid that their private insurance would not cover, an issue Timothy's law was designed to address. The namesake of the law, Timothy O'Clair, killed himself after being treated and prematurely released from a state mental hospital. Timothy's parents had exhausted their health insurance coverage for Timothy's illness and eventually relinquished custody of Timothy to the state so that he could have full access to mental health services as a Medicaid patient. According to the United States General Accounting Office, in 2001 parents placed more than 12,700 children into the

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<sup>9</sup> Davidoff A, Hill I, Courot B, Adams E. Effects of Managed Care on Service Use and Access for Publicly Insured Children with Chronic Conditions. *Pediatrics*. 2007;119:956-964.

child welfare or juvenile justice systems in order for their children to receive mental health services.<sup>10</sup>

Timothy's Law is an important first step in addressing the insurance access barrier. Currently, Timothy's Law requires that major health plans cover mental health services to same extent as physical health conditions, but the law does not apply to public insurance programs, including Medicaid and Child Health Plus. This is a major limitation in the law that should be remedied. In addition, the law is scheduled to expire in 2009, posing a potential setback for progress in mental health care for children and families.

***Prescription: CHF supports the expansion of Timothy's Law to public insurance programs, oversight of its implementation, and legislation to make it permanent.***

### Capacity Barriers

One of the most challenging factors facing mental health care is the lack of capacity to deliver quality mental health services to all of the children who need services. The problem includes both the inadequate supply of psychiatric beds for children and adolescents and the dearth of community-based clinics and mental health professionals with expertise in treating children, which results in long waits for services. There is a continuing shortage of child psychiatrists relative to child and adolescent mental health need. The geographic distribution of child mental health professionals is not consistent with levels of need in diverse communities, and children in low-income and rural

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<sup>10</sup> United States General Accounting Office Report to Congressional Requesters. Child Welfare and Juvenile Justice: Federal Agencies could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Resources. April 2003. GAO-03\_397. Internet: <http://www.gao.gov/new.items/d03397.pdf>.

communities have the greatest access problems.<sup>11</sup> Still fewer services are available for preschool age children.<sup>12</sup>

The situation for children on Medicaid is especially dire. Reimbursement for mental health services has been so low as to discourage mental health professionals from participating in Medicaid, as does the complexity of billing behavioral health subcontractors of Medicaid managed care organizations. Often public insurance reimbursement does not approach operating costs for community-based mental health centers or hospital-based ambulatory mental health clinics. The effect on these key sources of care ranges from restricting access for new patients to clinic closings.<sup>13</sup> These clinics are the “safety net” mental health providers in low-income communities, and their loss exacerbates the already severe mental health professional shortages and maldistribution of limited resources. Reimbursement rates that recognize the time required to treat a child with mental illness need to be implemented to attract more providers to the Medicaid program and retain those who currently participate in the program.

***Prescription: CHF supports efforts to increase Medicaid reimbursement of mental health services and expand the pool of reimbursable mental health professionals to include clinical social workers and nurse practitioners.***

### Mental Health Workforce

Although New York is teeming with medical institutions, there are still mental health professional shortage areas across the state because of insufficient workforce. A related

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<sup>11</sup> Thomas CR, Holzer CE. The Continuing Shortage of Child and Adolescent Psychiatrists. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2006;45:1023-1031.

<sup>12</sup> Kataoka SH, Zhang L, Wells KB. Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status. *American Journal of Psychiatry*. 2002;159:1548-1555.

<sup>13</sup> Appelbaum PS. Commentary: The “Quiet” Crisis in Mental Health Services. *Health Affairs*. 2003; 22:110-116

issue is the paucity of outpatient treatment slots so that all children who need treatment can get it. There are simply too few child and adolescent psychiatrists to provide evaluation and treatment for mental health issues. The combination of inadequate capacity and a limited supply of child psychiatrists form a substantial barrier to getting mental health care to kids who need it.

It is not enough to identify a mental health problem early if a child cannot receive treatment. In Central Harlem, for example, there are more than three times as many children estimated to have a significant mental health impairment as there are treatment slots in the community.<sup>14</sup> According to a 2003 report done by the New York City Department of Health and Mental Hygiene, more than half, 57%, of children referred for mental health services in the borough never get any treatment at all, and 38% of those referred never even have an initial intake appointment.<sup>15</sup>

***Prescription: CHF supports increased funding to public mental health agencies, community health centers and hospitals to increase mental health service capacity.***

### Early Identification

Many mental disorders begin in early childhood while others often start in early adolescence. The average age of onset for mental illness in the United States is age 14 years.<sup>16</sup> Unfortunately, most mental health conditions are not diagnosed until much later in life. This gap may have unfortunate consequences for persons with mental disorders

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<sup>14</sup> Havens, J. Presentation to CHF Child Health Forum, New York City, December 7, 2007.

<sup>15</sup> New York City Department of Health and Mental Hygiene in Collaboration with Mailman School of Public Health at Columbia University. Children's Mental Health Needs Assessment in the Bronx. August 2003. Internet: <http://www.nyc.gov/html/doh/downloads/pdf/pub/na-cmh0803-bx.pdf>.

<sup>16</sup> Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime Prevalence and Age-of-Onset Distributions of *DSM-IV* Disorders in the National Comorbidity Survey Replication, *Archives of General Psychiatry*. 2005;62:593-602.

who might have responded well to early diagnosis and treatment. Virtually all mental health problems are entirely treatable,<sup>17</sup> and early detection and treatment are associated with better clinical outcomes and cost savings.<sup>18</sup> While mental health professionals and policymakers are well aware of this, the opportunity for early identification, diagnosis and treatment is often lacking.

With timely identification and treatment, mental health problems that would otherwise compromise school performance and academic achievement may be ameliorated, helping children to succeed academically. One goal of the President's 2003 New Freedom Commission on Mental Health is early identification, assessment, and intervention for children's emotional problems. A specific recommendation to meet this goal is to "improve and expand school mental health programs."<sup>19</sup> A study of clinical outcomes from 36 inner city schools found that the treatment success of school-based mental health services is comparable to that of psychiatric outpatient clinics, and these gains were achieved in less time than was needed in more traditional clinical settings.<sup>20</sup> Providing mental health screening and treatment at the location where children spend much of their days – schools – can help identify children with symptoms and may complement outpatient mental health care.

***Prescription: CHF supports efforts to expand mental health services in schools, specifically the availability of licensed clinical social workers who can provide mental health care for children and coordinate care with a child's doctor and parents.***

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<sup>17</sup> Havens, J. Presentation to CHF Child Health Forum, New York City, December 7, 2007.

<sup>18</sup> Glascoe FP. Early Detection of Developmental and Behavioral Problems. *Pediatrics in Review*. 2000. 21:272-280.

<sup>19</sup> Weist, MD. Fulfilling the Promise of School-Based Mental Health: Moving Toward a Public Mental Health Promotion Approach. *Journal of Abnormal Child Psychology*. 2007;33:735-741.

<sup>20</sup> Armbruster P, Lichtman J. Are School Based Mental Health Services Effective? Evidence From 36 Inner City Schools. *Community Mental Health Journal*. 1999; 35(6):493-504.

## Policy Barriers

A consistent barrier to increasing mental health services in New York State has been “Medicaid Neutrality.”<sup>21</sup> Medicaid Neutrality is a mechanism, only applied to mental health care capacity that has prevented the expansion of services regardless of need in a community if the result might be increased state expenditures for Medicaid. Hospitals and community-based mental health centers wishing to expand mental health services were required to prove that expansion would cost the state no additional funds or take away services from another area of the agency’s budget. The result has been a virtual moratorium against the establishment of new Medicaid-reimbursed mental health treatment resources.<sup>22</sup> New York State also has restrictions on Medicaid reimbursement for licensed clinical social workers providing mental health services in health care settings. These restrictions make it financially difficult to co-locate mental health services in primary health care settings in keeping with the goals of a comprehensive medical home. New York State has recognized this issue and is working to remedy the consequences of years of misguided policy, but more needs to be done to ensure that future expansion of critical services is not stymied.

***Prescription: CHF supports eliminating Medicaid Neutrality in New York State for pediatric mental health services.***

## Emergency Care

Innovative models of community-based treatment are important for their potential to address long-standing issues in mental health care for kids. One review of mental health treatment in New York State during the 1990s found that over half the children receiving

<sup>21</sup> Title 14 NYCRR Part 551.13

<sup>22</sup> The Coalition of Voluntary Mental Health Agencies, Inc. Community Mental Health Services. New York State Budget Fiscal Year 2005-2006: A Briefing Book. February 2005. Internet; <http://www.coalitionny.org/policy/2005/BudgetBook2006.pdf>

high-intensity services – in state hospitals, residential treatment, or psychiatric hospitals, had never received any kind of outpatient care before their admission to these very intensive and very costly treatment models.<sup>23</sup> All too often, kids go from no treatment to the highest intensity services. Early treatment through outpatient services is much less expensive (and likely more effective in the long run) than inpatient hospitalization or residential treatment for mental health conditions.

When all systems break down and the child's atypical behavior escalates to a level that is potentially dangerous to himself or others, the service system does not have adequate resources to respond in a timely fashion. In too many cases, children are seen for a superficial evaluation at a hospital emergency room and referred for community-based treatment at a clinic with a long waiting list – if a clinic is available at all. Innovative programs have emerged to deal with children and adolescents in crisis in New York City. One particularly successful emergency intervention/hospital prevention model has been developed and implemented at New York Presbyterian Medical Center that incorporates a home-based crisis intervention, case management, and mobile community based care, bridging barriers to access.<sup>24</sup>

***Prescription: CHF supports the mental health delivery model, Home-Based Crisis Intervention, based on social work intervention in the home, to reduce the hospitalization of psychiatric children in crisis.***

### Case Management

<sup>23</sup> Havens, J. Presentation to CHF Child Health Forum, New York City, December 7, 2007

<sup>24</sup> Havens, J. Presentation to CHF Child Health Forum, New York City, December 7, 2007.

Families of children with significant psychiatric problems often face multiple problems and require assistance navigating multiple service systems. When they receive care from different agencies – assuming they are able to access such care at all – these diverse resources must be coordinated. Case management should be viewed as an integral part of child mental health services, one which is essential to providing a comprehensive and consistent treatment plan in the diverse settings in which a child participates – home, school, community settings, health care.

Despite the fact that it is recognized as an important element of community-based child mental health care in former Surgeon General Satcher’s landmark mental health report,<sup>25</sup> case management is only reimbursed by Medicaid under specific and restrictive circumstances. It should instead be recognized and reimbursed as an important clinical service for children and families with complex psychosocial needs. Similarly, restrictions on reimbursement for collateral contacts (the therapist’s necessary meetings with parents, teachers, and others involved in the life of their child patient) undermine the fiscal viability of providing mental health services and may be a disincentive to maintaining this important level of communication and care coordination.

***Prescription: CHF supports efforts to reimburse case management services for pediatric mental health.***

## **Conclusion**

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<sup>25</sup> U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Internet: <http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec7.html#newer>

While pediatric mental health care has come a long way in recent years, thanks to hard work by advocates and recognition by policymakers that changes were needed to successfully treat children and assist them in returning to their daily lives, there is still a ways to go. Fortunately, New York State has begun to shift away from a reactive approach to child mental illness to one that emphasizes screening and identification of children early in the process – and developing a greater capacity for treating them. Further progress in addressing children’s mental health issues can be accomplished through an emphasis on early identification, community based treatment programs, and critical policy changes. Considerably more work remains to address the barriers that many children and families face accessing mental health services.

Support for improved access to child mental health services is improving but is still inadequate, and so advocacy is essential. Advocacy can play an especially significant role in educating the public and policy makers about the profound impact that mental health disorders have on the lives of children. In the end, however, policy advocacy should be grounded in an informed understanding of the realities of children’s lives, in how they grow and develop, and in a realistic understanding of the approaches that have proved most useful in helping them and their families.

## **Prescriptions**

### **Access - Insurance**

***Prescription: CHF supports mental health parity and the expansion of Timothy's Law to public insurance programs, oversight of its implementation, and legislation to make it permanent.***

CHF supports the expansion of Timothy's Law to apply to public insurance programs, Medicaid and Child Health Plus and expansion of the program so that it does not sunset in 2009, as the enacted legislation is set to do. CHF also calls on the Office of Mental Health and the Office of Insurance to provide oversight of mental health coverage within major health care plans in New York State. When the law "sunset" in 2009, it should be reauthorized and made permanent.

### **Capacity: Reimbursement**

***Prescription: CHF supports efforts to increase Medicaid reimbursement of mental health services and expand the pool of reimbursable mental health professionals to include clinical social workers and nurse practitioners.***

New York State's Executive Budget for 2008-2009 includes reimbursement for licensed clinical social workers, and nurse practitioners in shelters, providing mental health care. CHF applauds this effort and will support its passage through the legislature. Also, the budget removes burdensome regulations that previously prevented community based clinics from billing for more than one service in a single visit. If a patient was seen for a physical ailment and also had a mental health consultation, the clinic would only be reimbursed for a single treatment, not both.

### **Capacity: Funding**

***Prescription: CHF supports increased funding to public mental health agencies, community health centers and hospitals to increase mental health service capacity.***

As new mental health funding becomes available, the highest priority should be to use it to increase community-based child mental health service capacity in high-risk communities where the prevalence of child mental health problems is greatest.

### **Capacity: Medicaid Neutrality**

***Prescription: CHF supports eliminating Medicaid Neutrality in New York State for pediatric mental health services.***

Medicaid Neutrality has been a long-standing barrier to expanding community-based mental health service capacity. This attempt to control increases in Medicaid spending has only been applied to mental health services, which is inappropriate if not discriminatory against people with psychiatric disorders. Can anyone imagine government requiring that physicians place a cap on the number of children with asthma who may be treated? CHF advocates the immediate cessation of Medicaid Neutrality so that certificates of need – applications for additional Medicaid funded treatment facilities or treatment slots – can be approved based on their merits.

### **Early Diagnosis**

***Prescription: CHF supports efforts to expand mental health services in schools***

New York's health reform plans include plans to support licensed clinical social workers to provide mental health care for children in schools. This is a great first step, but measures need to be taken to coordinate care with the child's doctor and involve parents in treatment of the child.

### **Children in Crisis**

***Prescription: CHF supports the mental health delivery model, Home-Based Crisis Intervention, based on social work intervention in the home, to reduce the psychiatric hospitalization of children in crisis.***

### **Case Management**

***Prescription: CHF supports efforts to reimburse case management services for pediatric mental health.***

The Children's Health Fund calls for the state to recognize case management as an integral part of treatment. Mental health professionals spend valuable time with children and families to create a coordinated treatment plan and must be adequately reimbursed for the time taken during a mental health visit with a child.