Child Health and Development Institute

ISSUE BRIEF

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Improving Behavioral Health for All: Ensuring Every Child Benefits from Quality Improvement Initiatives

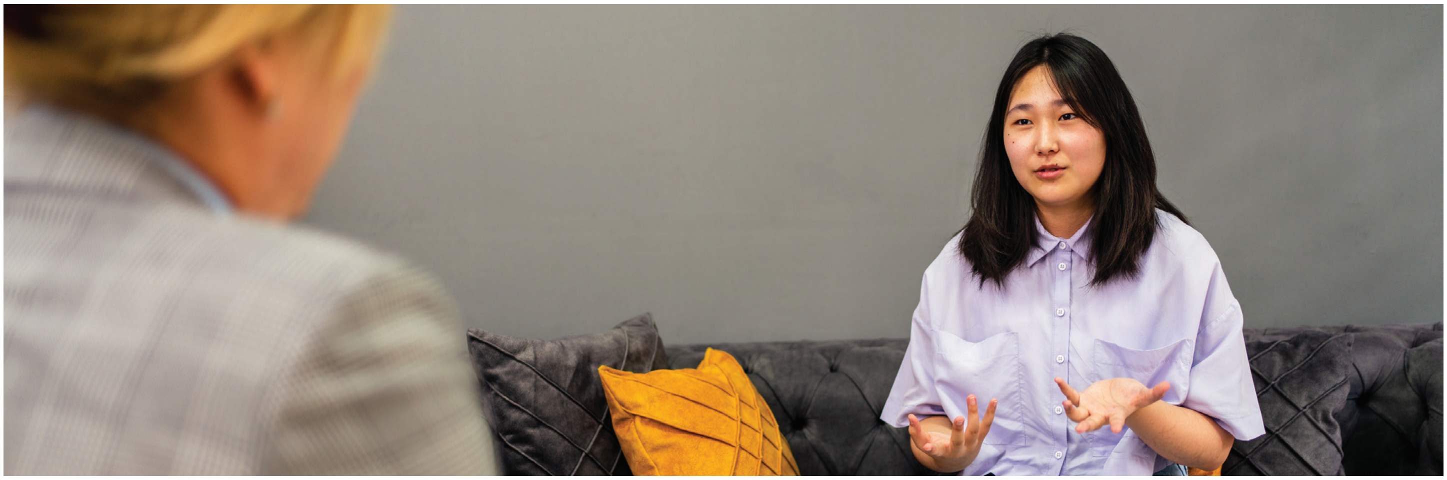
The need for children's behavioral health services has never been more urgent. In 2023, 40% of high school students in the U.S. reported persistent feelings of sadness and hopelessness, a 33% increase compared to 2013.[i] One in five students said they had seriously considered suicide. Despite these trends, less than half of children with behavioral health needs receive treatment,[ii] with even lower rates among Black and Hispanic youth. A clear quality improvement (QI) framework can increase access and enhance service delivery, but if it is not intentionally designed to identify and address racial, ethnic, gender, and other disparities, it can inadvertently worsen them. **An explicit and intentional focus on health equity from the beginning of any QI effort is needed to ensure that all children receive the effective care they deserve.**

This issue brief outlines common challenges and strategies for using QI to promote equity in children's behavioral health services. Illustrated with examples from efforts to address racial and ethnic disparities, the recommendations included here are broadly applicable to reducing inequities across a wide range of populations and circumstances.

Disparities and Data Issues Hinder Quality

Longstanding unaddressed disparities in social determinants of health combined with racism, discrimination, lack of trust in the children's behavioral health system, and limited reliable data impede efforts to achieve equity.[iii] Despite higher prevalence of certain common conditions, Black and Hispanic youth are less likely to see a behavioral health specialist and the disparity between Black and White youth has increased over time.[iv] Black and Hispanic youth are the recipients of lower overall mental health care expenditures than White youth, with Black youth especially experiencing lower outpatient expenditures.[v] Lower levels of access to outpatient services can lead to the use of more intensive and costly interventions such as use of the Emergency Department (ED) for behavioral health reasons; indeed, while such visits have increased for all youth, they have done so at a faster rate among Hispanic children and Black children, who are the most likely to utilize EDs.[vi] There continue to be significant disparities in access and utilization, making these crucial considerations in behavioral health care.

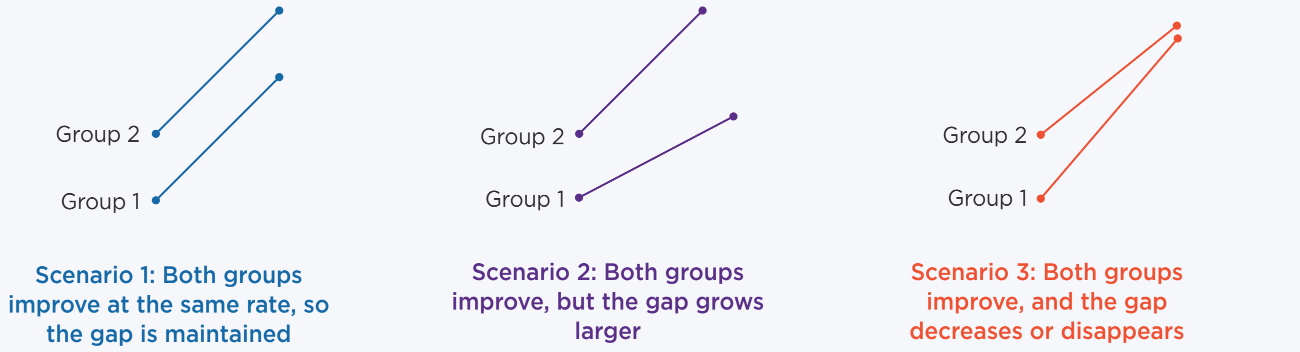
When children do access behavioral health treatment, little is known about the quality and effectiveness of the care they receive. Because a comprehensive service array includes a variety of services across multiple levels of care, there is wide variability in the services children and families receive as well as in the accountability mechanisms used to monitor performance. Some studies suggest that most who receive community-based "usual care" – as opposed to specific evidence-based treatment models - do not show clinical improvement[vii] or only experience moderate change.[viii] However, for most behavioral health services, there simply are no data collected and reported, making it impossible to know if children are improving, let alone whether there are differences across groups. The lack of transparent data available about services makes it difficult for families, communities, and stakeholders to know what works and for whom, which negatively impacts all children. Attempts to improve the delivery of behavioral health services must be based on meaningful data that are consistently collected, analyzed, and reported, to determine overall effectiveness and potential disparities.



The Role of Quality Improvement

Quality improvement (QI) is the systematic approach to using data to guide actions that result in better outcomes. QI is a powerful tool for improving services and addressing disparities, even when all groups experience improvement. Figure 1 illustrates scenarios where there is an initial disparity between two groups on an outcome measure. In the first scenario, the QI strategy works equally well for both groups, but the disparity is maintained. The intervention in Scenario 2 leads to improvement in both groups, but greater improvement for the group already at an advantage; the disparity actually grows larger. These scenarios highlight why, when there is an established disparity between groups, improvement strategies must intentionally take it into consideration and measure the differential impact on groups. Scenario 3 depicts improvement in disparity: both groups improve and the gap between them shrinks. Because any QI intervention can potentially improve, maintain, or worsen disparities, every QI effort needs to integrate equity from the start.

Figure 1

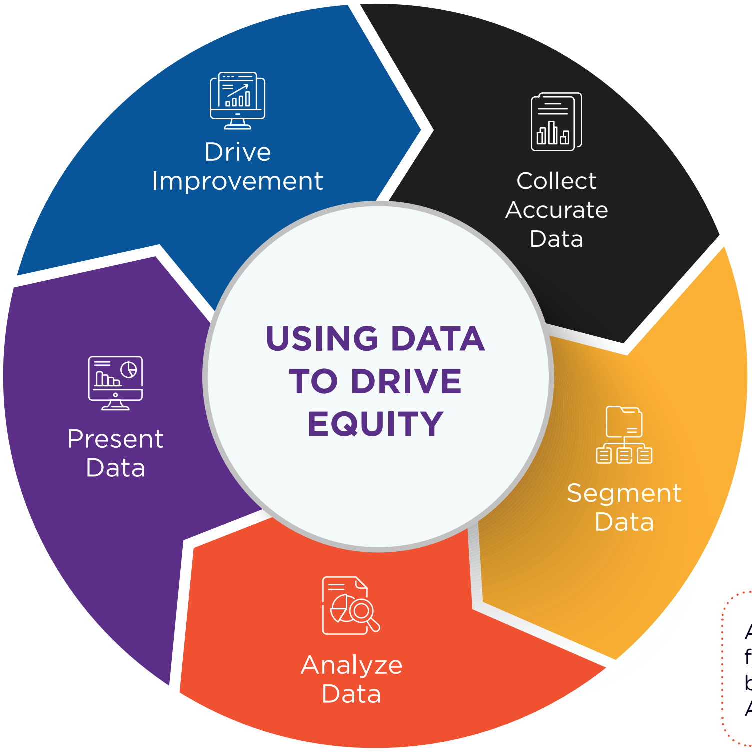


Scenario 1: Both groups improve at the same rate, so the gap is maintained

Scenario 2: Both groups improve, but the gap grows larger

Scenario 3: Both groups improve, and the gap decreases or disappears

Data is the cornerstone of QI. Therefore, ensuring QI improves health equity begins with having a framework for approaching data from an equity perspective. The National Academy of Medicine laid out five steps to do this, as illustrated in Figure 2. First, accurate data must be collected. Second, these data should be disaggregated by relevant subgroups, as the overall trends often differ from trends within subgroups. Differences can be related to many factors; race, ethnicity, geographic location, socioeconomic status, preferred language, age, and gender identity are all potential dimensions to examine, as is the way these factors intersect. Third, appropriate analytic strategies need to be implemented. Fourth, the data should be shared; accessible data fosters transparency and accountability. Finally, the data must be actively used to drive improvement. It is not sufficient to merely document disparities; they must be actively addressed. To do so, QI results can lead to engagement with impacted communities to understand potential underlying causes and test interventions to improve outcomes and reduce disparities.



Adapted from framework developed by the National Academy of Medicine

Figure 2

Addressing Disparities in Mobile Crisis Services: An Example from Connecticut

Connecticut's Mobile Crisis Intervention Service (MCIS) provides a rapid, in-person response to any child experiencing a behavioral health crisis. Funded by DCF and available free of charge to all families in the state, MCIS diverts children from more intensive and restrictive levels of care and instead provides de-escalation and stabilization supports in the home, school, and community. Access to the service is available through both 988 and United Way's 211, the centralized call center that connects callers to one of 14 local community providers. CHDI has served as Connecticut's MCIS Performance Improvement Center (PIC) since 2009, helping the state gain national recognition as a model for crisis services for children. Our continuous QI work has facilitated dramatic improvements in mobility rates and response times that have been sustained for nearly 15 years. Connecticut and CHDI were central in developing the national MRSS Best Practices and the [Data Best Practices Guide]() provides a data and QI model for other states to adopt.

MCIS episode volume decreased during COVID and has yet to return to pre-pandemic levels. Before adopting QI strategies to improve MCIS utilization, it was important to understand how youth and families entered the program. In partnership with DCF, 211, and providers, CHDI developed a list of every decision point in the model (e.g. presenting problem, reason for discharge) and examined each for racial or ethnic disproportionalities using the past four years of data. Not all indicators showed differences, but several disparities were identified. For example, compared to all other youth served by Mobile Crisis, Black youth were:

- 8% more likely to have been referred by a school
- 22% less likely to be referred by families, and
- 40% more likely to have a primary presenting problem of "disruptive behavior."

These findings have provided important context for subsequent QI efforts to increase the use of MCIS for children in crisis and do so in a way that addresses disparities. For example, there is a unique dynamic at play when a third party such as a school makes the referral rather than the family reaching out directly. The family is the ultimate decision maker in MCIS treatment. When a problem has been identified by someone outside the family, the MCIS clinician needs to engage the family to see if they view the current situation in the same way as the third-party caller. Additionally, higher rates of disruptive behavior referrals for Black youth in the context of national research indicating increasing rates of hopelessness, depression, and thoughts of suicide among Black youth suggest potential missed opportunities to identify youth who may be experiencing significant internal distress.

Understanding the various ways families connect with MCIS allows for more specific targets for improvement. Rather than simply increasing volume, QI efforts are also focusing on increasing self/family referrals for Black youth and increasing use of MCIS for reasons beyond disruptive behavior. Actions were taken at the statewide network level as well as within each agency, which allowed providers to establish QI goals that were specific to their community's circumstances. Examples included:

- One agency set specific targets for strengthening relationships with local family organizations and churches that are more likely to reach parents and caregivers, using data to select specific communities with lower call rates.
- Another agency started auditing episodes and providing outreach to ensure all families, regardless of racial or ethnic background, were receiving effective follow-up care.
- Multiple agencies are focusing on outreach and relationship building with schools to share data and underscore the full range of circumstances, beyond disruptive behavior, for which a call can be made to access Mobile Crisis.
- A new training specifically focused on suicide prevention with Black youth was offered to clinicians. This was motivated by troubling national trends showing rising rates of suicide attempts for Black youth. Yet, locally, Mobile Crisis is most often called to respond to disruptive behavior or conflict among Black youth, suggesting that underlying suicide risk may go undetected. The training was designed to ensure clinicians can identify and address suicide concerns even when they are not the presenting issue.
- Additional trainings on family engagement and the impact of racism on mental health were developed for an online platform, Kids Mental Health Training Portal, giving on-demand access to that content to all Mobile Crisis providers.

Recommendations

To achieve the best outcomes for all youth, behavioral health services must prioritize equity throughout the entire quality improvement process. Historically, the tools and frameworks used to improve these services have not focused explicitly on identifying and addressing disparities. Actively measuring disparities and the effectiveness of strategies to address them is essential for improving outcomes. Recommendations include:

1. **Invest in quality improvement work**. Many services have no data at all. Some services that collect data never have those data analyzed, reported, and used for QI. QI must be supported with sufficient resources to establish data infrastructure and support staff with the expertise to analyze, report, and use those data for QI. Providers need time to collect data and conduct internal QI processes. Often an independent and objective QI entity

can improve efficiencies and provide support to providers by analyzing data, offering consultation, sharing strategies across providers, and ensuring the entire system is making progress on performance and equity goals.

2. **Increase accountability to the public:** Transparency fuels trust and accountability. Publishing QI data—stratified by race, ethnicity, language, and other demographics—not only highlights disparities but also motivates stakeholders to act. Public reports and dashboards ensure communities, policymakers, and other partners can track progress and advocate for improvements.
3. **Involve families and those with lived experience.** Embedding individuals and families with lived experience into the QI process ensures interventions address real-world needs, build trust, and avoid unintended harm
4. **Train providers in QI approaches.** All partners in a system or initiative must have a common understanding of the goals and process for improvement. Shared trainings focused on QI tools and equity principles can increase staff buy-in, improve data integrity, and help ensure there is a consistent language and approach across a system.

Accurate data deployed within an equity-focused QI framework provides a roadmap for evaluating effectiveness and ensuring services work better and more equitably.

This issue brief was prepared by Kellie Randall, PhD, Associate Vice President of Quality Improvement (krandall@chdi.org).

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