Child Health and Development Institute of Connecticut, Inc.

ISSUE BRIEF

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Ensuring Young Children Receive Mental Health Services:

Barriers to Billing and Proposed Solutions

The foundation for mental health is laid in infancy and early childhood, but getting help when needed can be difficult for children under five. Between 7 and 10 percent of children under five experience clinically significant emotional, relational, or behavioral problems.[1] Additionally, one in four children will witness or experience a potentially traumatic event by age four.[2] Fortunately, awareness of the importance of infant and early childhood mental health is growing and the number of interventions to support young children at risk is expanding. **Unfortunately, access to these services is often limited by current reimbursement regulations that require a diagnosis of a disorder, making it difficult to deliver mental health interventions to very young children who may not meet criteria.** The result is that when parents indicate a need for mental health services, children ages 3-5 are less likely to receive them than their older peers.[3]

Young Children have Mental Health Needs

The events young children experience shape their ability to form relationships, regulate emotions, and explore their environments, which are the key domains of infant and early childhood mental health (IECMH).[4]

Even normative stressors such as adapting to new environments or changes in routine can be challenging for young children, particularly when they occur during vulnerable developmental periods or without sufficient caregiver support. Young children also face more significant adverse events such as trauma exposure or household dysfunction (e.g., poverty, caregiver substance abuse, and caregiver mental illness)[5] which can contribute to mental health concerns. Understanding the potential effects of adverse events in the context of IECMH domains - relationships, emotions, explorations - makes it clear young children do have mental health needs.

Donald Winnicott, a pioneer in the field of developmental psychology, famously said, **"There is no such thing as a baby; there is a baby and someone."**[6] Young children are wholly dependent on caregivers. A caregiver's own mental health and the quality of the caregiver-child relationship are inextricably linked to an infant's or young child's mental health. Stressors that affect the caregiver or quality of the relationship are an important focus of intervention for the child, even if the child may not meet criteria for a mental health disorder.

Exposure to early adversity does not necessarily result in a mental health disorder, but it can alter the trajectory of development in such a way that undermines later mental health. Fortunately, the reverse is also true. Even small adjustments and brief interventions, especially when delivered early, can ensure children remain on a healthy developmental trajectory and prevent more serious and costly problems from developing later in life.

Young Children who are At-Risk Have Unique Service Needs

Early childhood is a critical window for prevention and intervention for at-risk children. Recent efforts to increase awareness and invest in workforce development (led by organizations such as the Alliance for the Advancement of Infant Mental Health and the Connecticut Association for Infant Mental Health) have improved identification of at-risk children. When young children are identified with concerns about their mental health, outpatient mental health agencies offer an inexpensive, widely available resource to provide services. Unfortunately, providers are currently limited by reimbursement regulations that do not allow them to bill for services unless the child has a mental health diagnosis. As a result, few young children are served because they usually do not meet the criteria for a mental health diagnosis despite having a clear need.

In addition to outpatient care, IECMH-focused in-home services work with at-risk caregivers and children to offer support and promote well-being. Home visiting is an effective service delivery model, but programs are often challenging to fund. They are typically not reimbursable through health insurance and rely on grants and other funding sources, which limits the number of families they can serve.

Preventive services that support the child and family and address risk early can ensure conditions do not worsen to the point at which a mental health disorder can be diagnosed. This preventive approach decreases suffering and future costs that are incurred when problems have become more intractable and interventions more intensive. **Tying treatment to a diagnosis forfeits advantages that prevention offers.**

At-Risk Codes in Oregon

Health care providers in Oregon can now bill Medicaid for preventive mental health services using a code (ICD-10 code, Z63.8) that indicates the presence of family or environmental factors that put a child at-risk. Additionally, Oregon expanded use of other codes to provide mental health services for children experiencing abuse and neglect. **Oregon's use of these at-risk codes allows for the flexibility needed to address children's mental health needs early.**

Diagnostic Criteria are Different for Very Young Children

The severity of a mental health concern can rise to the level of a diagnosable disorder for young children. When a diagnosis is necessary, it should be assigned using a developmentally appropriate classification system such as the DC: 0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5).[7] Mental health disorders can present in very different ways for young children in comparison to their older counterparts. Additionally, there are disorders that are unique to infancy and early childhood. Other classification systems, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM),[8] are intended for use with adults, adolescents, and older children and do not typically incorporate the best available evidence for diagnosing infants, toddlers, and preschoolers.

Accurately identifying a disorder often requires an extended assessment period. Young children may not be able to verbalize their needs the way older children and adults can. Assessment relies on caregiver reports as well as observations and careful consideration of other contextual factors. Further, evaluation of the caregiver's own needs and capacities is critical, as these factors are so closely

tied to the child's experience and functioning. Additional time ensures a comprehensive assessment can be completed that takes into consideration many of the factors unique to working with young children, which in turn leads to a more accurate diagnosis and treatment plan.

Connecticut's Outpatient Agencies Have Made Progress in Serving Young Children

Connecticut is currently benefitting from a five-year SAMHSA grant as part of the National Child Traumatic Stress Network. The Early Childhood Trauma Collaborative (ECTC) is disseminating trauma-informed, evidence-based treatments for young children. To date, over 150 outpatient clinicians in Connecticut have been trained in one of two interventions: Attachment, Self-Regulation, and Competency (ARC) and Child-Parent Psychotherapy (CPP). These services require a billing code for reimbursement, which can limit their use with very young children. Additionally, there are effective in-home services available for young children. Two examples are Child First and Minding the Baby®. Both programs are evidence-based and are available in Connecticut. However, the capacity of home visiting programs is often limited by insufficient reimbursement options. As the availability of these services for young children expands in Connecticut, mental health reimbursement rules must be modified to ensure that all families of young children have access to effective and supportive services.

Recommendations

1. **Create "at risk" reimbursement codes.** Public and private insurance should allow reimbursement for mental health services that are preventive and available for children who do not meet diagnostic criteria for a mental health disorder. This can be accomplished by the introduction of "at risk" codes, similar to what was developed in Oregon.

2. **Recognize young children have unique diagnostic considerations.** Public and private insurance can formally recognize age-appropriate diagnoses by accepting DC: 0-5 for billing purposes or through the endorsement of a crosswalk of DC: 0-5 to DSM-5 and ICD-10 codes.

3. **Allow for longer assessment times.** Public and private insurance should allow for an extended assessment period for young children, increasing the number of sessions a provider can have with the child and family before they determine a diagnosis and course of treatment.

4. **Strengthen the service array.** Early childhood advocates and stakeholders should continue to work with Connecticut policymakers, payers, and providers to build and support a continuum of effective IECMH services, including preventative home visiting programs and evidence-based outpatient treatments. This should include an exploration of current Medicaid billing options to help augment and pay for expanded services.

REFERENCES

1. Gleason, M. M., Goldson, E., Yogman, M. W., & Com-mittee on Psychosocial Aspects of Child and Family Health. (2016). Addressing early childhood emotional and behavioral problems. Pediatrics, 138(6).
2. Briggs-Gowan, M. J., Ford, J. D., Fraleigh, L., McCarthy, K., & Carter, A. S. (2010). Prevalence of exposure to potentially traumatic events in a healthy birth cohort of very young children in the northeastern United States. Journal of traumatic stress, 23(6), 725-733.
3. Child and Adolescent Health Measurement Initiative.(2016). 2016 National Survey of Children's Health data query.
4. ZERO TO THREE. Retrieved from https://www.zero-to-three.org/resources/110-infantearly-childhood-mental-health January 3, 2020.
5. Kerker, B. D., Storfer-Isser, A., Szilagyi, M., Stein, R. E., Garner, A. S., O'Connor, K. G., Hoagwood, K. E., & Horwitz, S. M. (2016). Do pediatricians ask about adverse childhood experiences in pediatric primary care? Academic pediatrics, 16(2), 154-160.
6. Winnicott, D. W. (1964). Further thoughts on babies as persons. In D. W. Winnicott (Ed.), The child, the family, and the outside world (pp. 85–92). Harmondsworth, UK: Penguin Books.
7. ZERO TO THREE. (2016). DC:0-5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood. Washington, DC: Author.
8. American Psychiatric Association (2013). Diagnostic and statistical manual of mental health disorders (5th ed.). Washington, DC: American Psychiatric Publishing.

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