Children with Special Health Needs Comprehensive Mental Health Services and Systems

Size of the Problem

"Children with special health needs" by definition, includes children whose conditions are mental or behavioral in nature. In addition, children with chronic physical conditions, physical disabilities and developmental disabilities are at increased risk for developing mental health disorders.

An estimated 45,050 children and youth with special health care needs in Minnesota required mental health care or counseling in 2001.T[i] According to federal estimates approximately 54,000 (9%) of children ages 9 to 17 in Minnesota have a serious emotional disturbance.[ii]

It is essential that a comprehensive mental health service system be in place for children with special health needs. This system includes screening and ongoing surveillance, evaluation when concerns are detected and treatment when disorders are diagnosed.

Mental Health Screening: Research has found that physicians, regardless of specialty, infrequently discuss common behavioral issues with adolescents with specific chronic illnesses.[iii] In reviewing primary care medical records of children seen in the MCSHN Development and Behavior Clinics, few children's records show documentation that the provider asked about behavior, emotional health, academic or social relationship concerns.

Evaluation: Once a mental health concern has been identified through screening, due to the shortage of pediatric mental health professionals, evaluation is delayed. It can take from six to months to eight for a child's condition to be evaluated depending on the suspected condition and the geographic region of the state.[iv]

Access to Mental Health Treatment: Over 14% of children and adolescents with special health care needs who need mental health care couldn't get it.[v] The ratio of child and adolescent psychiatrists per 100,000 children for the U.S. is 6.73 compared to Minnesota's ratio of 4.6 per 100,000. Providers from culturally diverse backgrounds and out in the rural areas are even less available.[vi] The average waiting time to see mental health professionals is 3 to 4 months.

Seriousness

Disparities: 1-3% of adolescents in the general population are diagnosed with depression compared to 15% of teenagers with asthma and 25% of children and teenagers with inflammatory bowel disease.[vii]

More than half (54%) of the children with special health needs receiving special education services were reported as needing mental health care, compared to 19% of the children with special health care needs who were not receiving special education services.[viii] Students with special health care needs are at higher risk for suicidal thoughts and attempts than their same aged peers.[ix]

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Non-white students with special health care needs have attempted suicide at a higher rate than either their same-aged non-white peers or their white peers with special health needs.[x]
In 2001, Minnesota's county-based, publicly funded mental health system served over 20,000 children.[xi] While American Indian, African American, Asian and Latino children make up 16 percent of the state's general child population, they comprise 22.4 percent of children in the publicly funded children's mental health system.[xii] Work still needs to be done to assure that services are appropriate and timely. Nationally, racial and ethnic minority populations are less likely to have access to available mental health services, to receive needed mental health care and often receive poor quality care.

People in rural or remote areas have inadequate access to care, limited availability of skilled care providers, lower family incomes, and greater social stigma for seeking mental health treatment than their urban counterparts.

Costs: Children within the juvenile justice system have a high prevalence of mental disorders. In one study, 66% of boys and nearly 75% of girls in juvenile detention had a least one psychiatric disorder. About 50% of these youth were abused or addicted to drugs and more than 40% had either oppositional defiant or conduct disorders. High rates of depression and dysthymia were also identified in 17% in boys, 26% of detained girls.

In 2001, the leading cause of hospitalization in Minnesota for children aged 5 to 14 years were mental disorders – accounting for more than 15,000 hospital days and 25 million dollars in expenditures. Mental disorders were the second leading cause of hospitalization for youth aged 15 to 19 years old - accounting for 33,000 hospital days and 45 million dollars.[xiii]

Undetected or untreated mental health problems in children and youth with special health needs have an effect on the child, their families, their classmates and teachers, and the community.

Interventions

"Intervening Early to Prevent Mental Health Problems" provides nurse visits to the homes of high-risk women when their pregnancy begins and for the first year of the child's life. Visit by visit protocols are utilized to help mothers adopt healthy behaviors and to responsibly care for their children. Follow up 15 years later with the children demonstrated 54% to 69% reduction in arrests and convictions, less risky behavior and fewer school suspensions and destructive behaviors. The key feature is a trained nurse, rather than a paraprofessional who visits the home.

Families and professionals can be made aware of the risk for mental health disorders among children with special health needs through effective public health. The National Center on Birth Defects and Developmental Disabilities of the Centers for Disease Control and Prevention provides guidance in the area of health communication that will be useful in raising awareness of this issue and changing current practice.[xiv] Those same strategies can be implemented to improve outreach to culturally diverse families and families who are uninsured or underinsured.

The use of developmentally appropriate mental health screening protocols in multiple settings should be mandated. Locations include primary care clinics (including Child and Teen Check-Ups), public health home visiting, the Follow-Along Program, WIC Clinics, child care and preschool programs (including Headstart), Early Childhood Special Education and Preschool Screening. There are a number of screening tools (ASQ-SE, PECFAS Screener, TeenScreen, Pediatric Symptom Checklist, etc.,) with high validity and reliability.

Resource kits for health care providers have been utilized effectively. "First Signs", a

project to raise awareness and encourage primary care physicians to screen for autism, is a model for physician outreach related to screening. "Bright Futures in Practice: Mental Health Practice Guide, Vols.1&2" contain resources and tools to aid in mental health screening, education, direct management and improving access to community resources in the primary care setting.

Co-locating mental health providers in primary care clinics and educational settings could improve access to screening, diagnosis and treatment. Some communities have utilized collaborative funding to hire school-based social workers or Family Support Workers who are able to provide some community based mental health services. A Southwestern Minnesota Medical Center has 2 child psychologists in their office. A Central Minnesota primary care clinic utilizes a consultative model whereby a staff pediatric psychiatrist is available to consult with primary care physicians caring for children with mental health needs.

Minnesota Children with Special Health Needs offers multidisciplinary team assessments in rural Minnesota for children with multiple concerns in the areas of development, academic progress, health, mental health, behavior and functioning at home, school and in the community.

Engaging professional organizations in educating new frontline providers in various systems in child development and training them to recognize early symptoms of emotional or behavioral problems could enhance identification.[xv]

The range of mental health services provided to rural consumers over a telemental health network is virtually limitless and includes all of the same services that can be provided in person. Telemental health also has broad application as an education and training tool for mental health staff, and as a way to bring special interest groups, including consumers and family members, together for information and support. Practitioner experience and findings from program evaluations suggest that telemental health improves continuity of care for rural consumers, increases family and consumer involvement in treatment, and reduces lengths of stays and re-admission rates to state psychiatric facilities. Participant satisfaction surveys reveal that consumers perceive telemental health services as worthwhile, of high quality, and worth continuing.[xvi]

Status

The vast majority of local public health agencies in Minnesota have identified mental health and well being as a priority as part of the needs assessment process.

The Minnesota Department of Human Services has implemented mental health screening for children found to be at the greatest risk such as: developmental assessment of children 0-3 who have been abused/neglected, homeless children, delinquent children, children in need of protection, and youth in chemical treatment.[xvii] The Minnesota Medical Assistance Mental Health Benefit Set for children is very comprehensive, offering many types of community based services in many locations.

School districts are implementing the procedure of meeting with parents of children who have been removed from school for 10 cumulative school days in a school year to discuss a mental health screening (for the child) with parent permission.[xviii]

There are some "evidence-based practices" (EBP's) for children and their families: preventative interventions for children at risk for serious emotional disturbances, parent-child interaction therapy and family psycho-education. The mental health field also has developed promising but less thoroughly documented "emerging best practices" for school mental health services, wraparound

services and systems of care for children with serious emotional disturbances and their families. However, little has been done to develop and test interventions that would prevent or treat emotional problems among children with chronic health conditions.

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[i] Source:Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001
[ii] Children with Serious Emotional Disturbance: Estimation Methodology, 63 Fed. Reg. 38661 (1998).
[iii] Britto, M. et al. "Preventive Services Received by Adolescents With Cystic Fibrosis and Sickle Cell Disease". Arch Pediatr Adolesc Med. 1999;153:27-32.
[iv] Source: Minnesota Children with Special Health Needs Information and Referral Service (unpublished data).
[v] ibid
[vi] Minnesota Children's Mental Health Task Force. (August 2002)."Blueprint for a Children's Mental Health System of Care".
[vii] "Depressioin in Children and Adolescents with a Chronic Disease", www.aboutourkids.org Posted 6/24/03
[viii] Source:Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.
[ix]Source: Minnesota Student Survey 2001.
[x] ibid
[xi] Minnesota Department of Human Services' Community Mental Health Reporting System, Calendar Year 2001.
[xii] ibid
[xiii] "Five Leading Causes of Hospitalization in Minnesota 2001". Minnesota Hospital Association.
[xiv] Lyon-Daniel, KL., "Health Communication Research: How To Get Your Message Across." Power Point Presentation. www.cdc.gov/ncbddd. Accessed 6/19/2004.
[xv] Report of the Surgeon Generals's Conference on Children's Mental Health: A National Action Agenda, December, 1999
[xvi] Smith, H., Allison, R., (2001). Telemental health: Delivering Mental Health Care at a Distance. US Department of Health and Human Services. http://telehealth.hrsa.gov/pubs/mental/home.htm. Accessed 7/25/04
[xvii] DHS Bulletin
[xviii] Minnesota Department of Education: Summary of Chapter 294 2004 Omnibus K-12 Education Policy Act