Policy Brief
Mental Health Screening and Beyond: Recommendation for Expansion

TEAM UP™ FOR CHILDREN

Recommendation: TEAM UP for Children recommends that policymakers expand preventive behavioral health coverage to all children whose providers identify a need rather than defining eligibility based solely on a positive screening result.

The role of screening in access to care

Developmental and behavioral screening has long been recommended as an effective means to identify children with mental health care needs. However, connecting children to appropriate services has historically required a documented mental health diagnosis. Recognizing that the need for a diagnosis can serve as a barrier to preventive care, groundbreaking policy innovations have begun to require only a positive screening result to reimburse for treatment. This Policy Brief considers the potential benefits of this policy innovation and also how it might unnecessarily limit care and potentially exacerbate health disparities. Instead of relying solely on a screening result, TEAM UP for Children™, an initiative that builds the capacity of pediatric primary care to deliver high-quality, evidence-based integrated behavioral health services, recommends that service eligibility should be expanded to include medical providers' identification of need.

Children's mental health crisis

Children and adolescents are in desperate need of mental health services. We are in the midst of a National State of Emergency in Children's Mental Health. Suicide is the 2nd leading cause of death among people aged 10-34. Nearly 1 in 5 children suffers from mental health issues; however, only 20% receive treatment from a mental health provider. The average delay from the onset of symptoms to treatment is 11 years.

In 2021, MassHealth, the health insurance provider to the Commonwealth's structurally marginalized residents, made a policy change to extend coverage for behavioral health services to children under 21 without requiring that children be formally diagnosed with a mental health disorder; instead, only a positive screening result (which reflects an elevated risk of a mental health problem) is currently required. This change allows children beginning to experience serious symptoms to receive treatment before they experience the effects of a full mental health disorder. We applaud this effort to support early and preventive intervention before children experience the impairment that mental health disorders so often entail.

However, coverage for preventive behavioral health services still requires a positive result on a screening tool. Using screening tools as the sole gateway for preventive services may have unanticipated effects that run counter to the intention behind the policy change. Using data collected from TEAM UP health centers and an illustrative case study, we demonstrate that reliance on screening tools to access preventive services can inadvertently exclude children who would benefit from care.

KEY TAKEAWAYS

- Screeners help providers identify children who need services. They flag children with nearly three times the chance of having a mental health need than other children.
- Conservative estimates suggest that at least 1 in 5 children (20%) has a mental health concern. Yet, in the TEAM UP project, only 8.3% of children score positive on a validated screener (see Figure).
- Many children who would benefit from early, preventive behavioral health services do not screen positive. Thus, reliance on screeners alone to identify children at risk will miss many children in need.
- When providers identify mental health concerns, families accept additional services at a high rate— regardless of whether their children initially screened positive or negative.

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Case study

During a routine check-up at DotHouse Health in Dorchester, Lena, a 13-year-old Vietnamese teen, completed a standard screening questionnaire for depressive, anxiety, and attentional issues. She reported some depressive and anxiety symptoms, but her score did not meet the threshold for clinical concern. During her visit, Lena's nurse practitioner (NP) reviewed her responses and asked if her feelings affected her functioning at school and her relationships with friends. As a safety assessment, Lena's NP asked Lena if she had ever tried to harm herself, and Lena responded that she had been cutting herself to deal with her anxiety.

Lena and her family were fortunate to have a medical home that prioritizes integrated behavioral health care. That same day, Lena's NP introduced her to a behavioral health clinician (BHC) and community health worker (CHW) located on-site who worked to understand Lena's situation and put a supportive care plan in place for Lena and her family. The CHW, a Vietnamese woman who could speak with Lena's father in his native language with the knowledge of a shared cultural perspective, was critical. She spent time talking with him about adolescent development and mental health concerns. By the end of their discussion, he agreed to allow the BHC to follow up with Lena the next week, and he was open to her interfacing with Lena's school to find additional support for her.

(Read the complete case study here, *Emily Feinberg, ScD, CPNP; primary care provider at DotHouse Health & TEAM UP Implementation Director*).

The data

As the case study above illustrates, many children have significant mental health concerns that require treatment yet screen negative. Universal screening is a core element of TEAM UP, a project designed to integrate high-quality behavioral health care into pediatrics at Federally Qualified Health Centers (FQHCs). Participating pediatric practices successfully include screening at over 90% of pediatric well-child visits. Nevertheless, the TEAM UP model recognizes that screening is only one element in a care system: identification of mental health problems also depends on providers' conversations with patients and their caregivers, eliciting their concerns through discussion and direct observation. For this reason, TEAM UP sites do not just document screening scores; they also document providers' reports of whether a developmental or mental health problem was identified at each visit and whether families need and accept additional services.

Data from a sample of 17,121 school-aged children and adolescents screened with the Pediatric Symptom Checklist (PSC) at TEAM UP sites is presented in the Figure below. As shown, about 1 in 12 children (8.3%) screens positive—a result that reflects an elevated risk. Among these children, their providers identify nearly 60% with a developmental or mental health concern that would benefit from treatment. In contrast, the overwhelming majority of children (91.7%) screen negative—a result that typically allays concerns. While far less common among these children, their providers still identify almost 20% with a developmental or mental health concern.

Notably, the PSC screener depicted in the Figure is well-validated and approved by MassHealth. Yet, not even validated screening questionnaires are perfectly accurate. Thus, restricting coverage to children who screen positive may make it difficult for children with mental health concerns who would benefit from services to access them.

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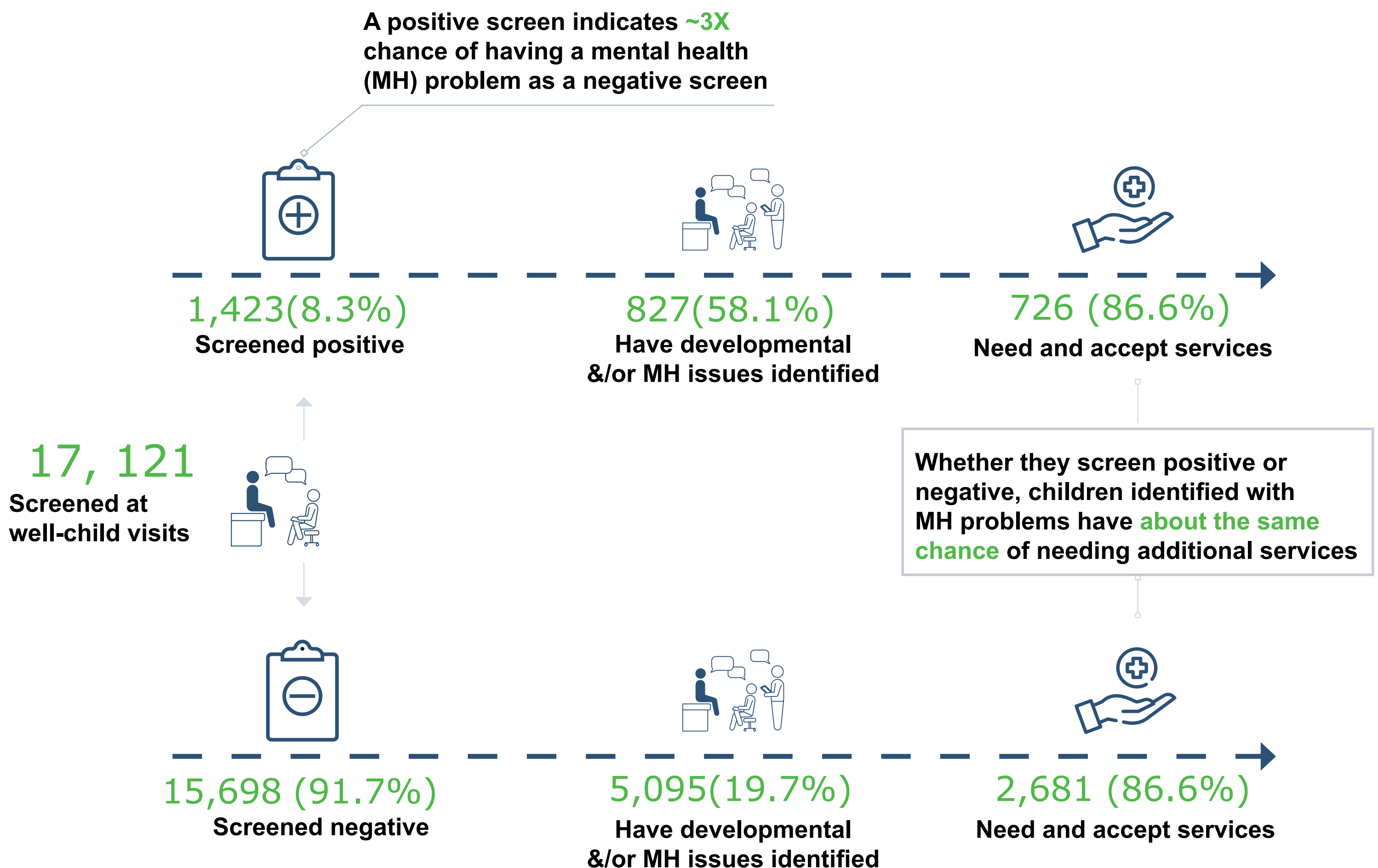

Figure. The role of screening and provider identification in the pathway to services

Health disparities in screenings

The unintended effect of requiring a positive behavioral screen to access services is potentially compounded at Federally Qualified Health Centers (FQHCs), which serve diverse, multilingual families. There are at least two challenges to consider. The first has to do with the screening tools themselves. Translations of validated screening tools are rarely studied and may not be as accurate as the English-language versions. Moreover, literal translations may not capture cultural nuances, and cultural representations of behavioral health concerns may not align with traditional euro-centric views.

The second challenge has to do with trust. Families from marginalized communities often have a well-founded distrust of the medical system due to the institutional racism historically perpetrated by this system. As a result, children and their caregivers may be less likely to disclose mental health symptoms on an otherwise validated screening tool. In addition, adolescents may worry about confidentiality and whether medical staff will inform their family. Thus, restricting coverage to children who screen positive may exacerbate health disparities in accessing services.

Recommendation

We applaud efforts to extend high-quality mental health care coverage to children without formal diagnoses. We strongly recommend that policymakers expand preventive behavioral health coverage to all children whose providers identify a need rather than defining eligibility based solely on a positive screening result. This change would advance our shared goal of increasing early and equitable access to mental health services for all children covered by MassHealth.

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Case study

Working as a nurse practitioner at a community health center, I have known Lena, a 13-year-old Vietnamese teen, since she was a baby. Lena is an only child and lives with her parents, who are devoted to her well- being. Her father usually brings her for care as he is more comfortable speaking English than Lena's mother.

At one routine check-up, I saw Lena alone, without her father, as I typically do with teenagers. As a routine part of her check-up, Lena completed a standard screening questionnaire for depressive, anxiety, and attentional issues. She reported some depressive and anxiety symptoms, but her score did not meet the threshold for clinical concern.

As part of her visit, we reviewed Lena's responses to the questions. I asked if her feelings affected her functioning at school and her relationship with friends. As a safety assessment, I asked if she had ever tried to harm herself. At that point, Lena told me she had been cutting herself to deal with her anxiety. I expressed my concern and asked if she would be willing to speak with our behavioral health team. Lena agreed.

Lena and I were fortunate to have had her check-up at a community health center that prioritizes integrated behavioral health care. As a result, I could connect with the onsite behavioral health team immediately. I met with the behavioral health clinician (BHC) and the community health worker (CHW) to inform them of my concerns and introduced them to Lena. We call this a "warm handoff" – a transfer of care between health care team members that occurs in real-time with the patient and family. This type of handoff is a key component of integrated behavioral health care. It provides an immediate opportunity to meet care providers, share information, ask questions, set goals, and make care plans. In TEAM UP, we have found that families who experience a warm handoff are more likely to engage in ongoing care.

The BHC and CHW met with Lena, further assessed her safety, and discussed her feelings about follow-up services. Lena talked about stressors at school. The BHC introduced alternative strategies to deal with the emotions that led Lena to cut, strategized what to do if the feeling became overwhelming, and discussed school accommodations that might help Lena deal with her stress.

The more challenging work was explaining our concerns about Lena to her father, who joined us in the exam room. As someone who had known his daughter and his family for Lena's entire life, I played a crucial role as we explained our concerns. I could also introduce him to the people – in person – who would be following Lena. Having these discussions in a primary care setting, rather than an emergency room or a mental health clinic, made it far less stigmatizing.

His first reaction was disbelief and then denial. He could not understand why his daughter would cut herself and how she could be experiencing such distress when he and his wife provided a good life for her. He was hesitant about school accommodations as he did not want the teachers to feel his daughter had a problem. At least, at first, he did not think that Lena needed additional care.

The presence of the CHW, a Vietnamese woman who could speak with the father in his native language with the knowledge of a shared cultural perspective, was critical. She spent time talking with him about adolescent development and mental health concerns. By the end of their discussion, he agreed to allow the BHC to follow up with Lena by phone in a week. He was also open to her interfacing with the school to find support for Lena.

While I was very concerned about Lena, we had done an amazing job. Working together as a team, we provided Lena care during the visit and collaboratively set goals in a way that was respectful of her family's culture and values. At that point, Lena did not have a diagnosis—she did not even have a positive screening result. What she did have was a team of providers who identified a behavioral health problem and worked with her family to plan for her care.

~Emily Feinberg, ScD, CPNP; primary care provider at DotHouse Health & Implementation Director, TEAM UP

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