

# CHILDREN'S MENTAL HEALTH CRISIS

US children's hospitals have declared a **national emergency** in child and adolescent mental health.

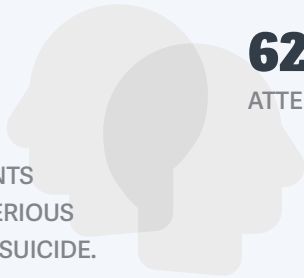
**1 in 5** youth ages 13 to 18 live with a **serious mental illness.**



Suicide was the **second-leading cause of death** among those ages 13 to 19 in 2019.

**12%**

OF ADOLESCENTS 12 TO 17 HAD SERIOUS THOUGHTS OF SUICIDE.



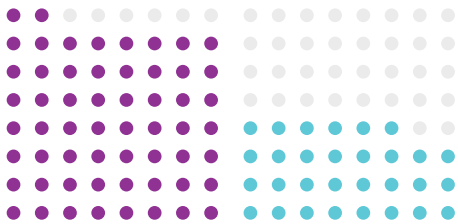
**629,000**  
ATTEMPTED SUICIDE.

There have been **double-digit increases** in mental health emergency visits in 2020.

AGES 5-11

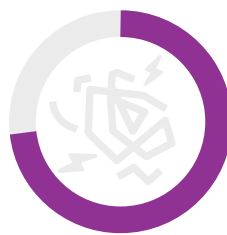


AGES 12-17

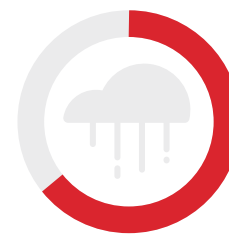


Black children are nearly **twice as likely** as White children to die by suicide.

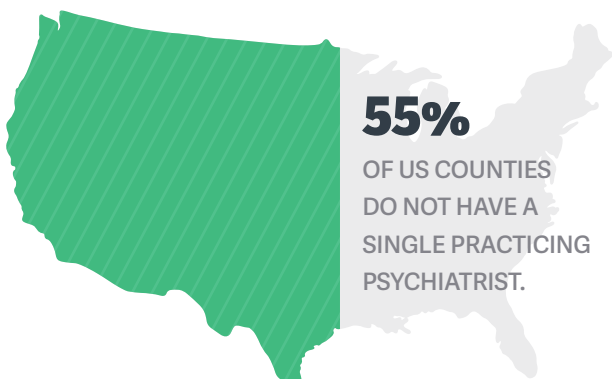
In a 2020 survey of **LGBTQ youth** (ages 13 to 17):



**73%**  
REPORTED SYMPTOMS OF ANXIETY.

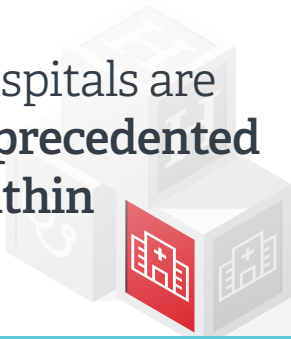


**67%**  
REPORTED SYMPTOMS OF DEPRESSION.



In 2016, **half of US children with a treatable mental health disorder did not receive needed treatment** from a mental health professional. Access issues have only been increasing since 2020.

# Children's hospitals are facing an **unprecedented pandemic within a pandemic.**



The child and adolescent mental health "COVID-19 surge" is breaking an historically inadequate delivery system, and federal, state, and local government agencies are looking to our nation's children's hospitals to repair the damage and solve the crisis. But how do you solve a crisis and achieve sustainability for an underfunded and underresourced service area? Plan, advocate, and redefine ROI.

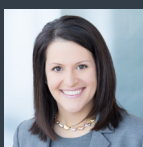
## INVESTING IN YOUR CHILD AND ADOLESCENT BEHAVIORAL HEALTH STRATEGY

### REACTIVE

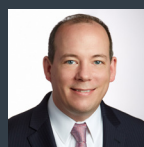
### SUSTAINABLE

<p>Addressing of immediate access pain points</p> <p>Existing community partnerships that support ongoing care</p>	 <p>ACCESS</p>	<p>Delivery continuum with BH access points across multiple levels of care</p> <p>New community partnerships for screening, transportation, and ongoing care</p>
<p>Leadership support based on community prevalence/crisis</p> <p>Management by a non-BH service line leader</p> <p>Targeting of diagnostic populations or age groups; limited focus on equity</p>	 <p>LEADERSHIP &amp; EQUITY</p>	<p>Pervasive leadership support; appetite for innovation and expansion</p> <p>Dedicated service line dyad leadership</p> <p>A focus on integrated care and at-risk, underserved populations</p>
<p>Augmentation of provider gaps with telehealth</p> <p>Limited recruitment</p> <p>Reliance on locum tenens</p>	 <p>STAFFING/RETENTION</p>	<p>Reach of services expanded by telehealth</p> <p>Appropriate use of APPs and training of PCPs</p> <p>A recruitment/retention pipeline and plan in place (e.g., residency/fellowship program)</p>
<p>Minimal planning</p> <p>Potential outsourced revenue cycle function</p> <p>Largely fee-for-service reimbursement</p> <p>Basic staff/provider training on documentation</p>	 <p>BUSINESS PLANNING</p>	<p>Complete planning (with demand forecasting)</p> <p>Managed care and revenue cycle coordination; enhanced reimbursement opportunities</p> <p>Dedicated training/auditing for clinical pathway and documentation adherence</p>
<p>Limited, if any, coordination</p> <p>Lack of clarity on targeted topics</p>	 <p>ADVOCACY</p>	<p>Coordination through government relations</p> <p>Reimbursement targeted for enhanced BH care coordination (for clinical and nonclinical staff)</p>
<p>No immediate or long-term return</p> <p>Minimized losses and decreased utilization of select services</p> <p>Partial/full funding through philanthropy</p>	 <p>ROI</p>	<p>Breakeven or potential for long-term return</p> <p>Reductions in the total cost of care</p> <p>Enhanced reimbursement/grant funding</p> <p>Philanthropy used for expansion</p>

## CONTACT US



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