



Mental Health Assessments for Young Children

An Examination of Assessment Trends Following 2022 Policy Changes

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MENTAL, BEHAVIORAL, AND DEVELOPMENTAL DISORDERS affect approximately one in five young children (Vasileva et al., 2021). Although young children often experience disparities in access to mental health care (Mercer, 2025; HCA, 2024), evidence-based treatment models for infant-early childhood mental health (IECMH) show a strong return on investment (Oppenheim and Bartlett, nd). Timely and developmentally appropriate mental health assessment and diagnosis are key to ensuring young children and their families get care when and how they need it. The IECMH community in Washington worked together¹ for several years to advance policies that would support developmentally appropriate mental health assessment and diagnosis for young children, particularly for those enrolled in Apple Health (HCA, 2022). These efforts led to legislation passed by Washington State in 2021 to align Apple Health policies with best clinical practices for mental health assessments for young children ages 0 to 5 (RCW 74.09.520).²

The legislation resulted in a set of Apple Health policy changes that went into effect in January 2022, collectively referred to as Mental Health Assessment for Young Children (MHAYC).³ For mental health assessments for young children, these policy changes included reimbursement for multi-session assessments and for provider travel costs to home and community settings, as well as a requirement for providers to use the DC:0-5™, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. This report presents an overview of trends in mental health assessment characteristics in the 3 years before and 2 years after MHAYC policy changes, covering calendar years (CY) 2019 to 2023.

Key Findings

- 1. Very few young children received mental health assessments, even in the years following MHAYC policy changes.** About 1 percent of young children ages 0 to 5 received mental health assessments during the study period, compared to about 5 percent of older children ages 6 to 17.
- 2. Multi-session assessments became more common for young children after MHAYC went into effect.** The multi-session assessment rate for young children ages 0 to 5 increased from 4 percent of mental health assessments in 2019 to 13 percent in 2023. For children ages 6 to 17 years, there was a decline in the multi-session assessment rate over the same period.
- 3. The impact of the COVID-19 pandemic made it challenging to determine if MHAYC had any influence on where assessments for young children took place.** Sessions conducted in

¹ <https://www.hca.wa.gov/assets/program/timeline-of-advocacy-mental-health-assessment-for-young-children.pdf>

² <https://app.leg.wa.gov/rcw/default.aspx?cite=74.09.520>

³ <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/mental-health-assessment-young-children>

home/community settings and via telehealth increased markedly for children of all ages during the height of the COVID pandemic, which immediately preceded MHAYC implementation. The first 2 years of MHAYC implementation then coincided with the easing of stay-at-home orders, when health care delivery began to return to in-office settings.

- 4. Some changes were seen in diagnostic patterns for young children during the study period, including a decrease in diagnoses of Disruptive Behavior Disorders.** The decrease in diagnoses of Disruptive Behavior Disorders aligns with the lack of this diagnostic classification for young children in the DC:0-5™. There were also increases in diagnoses of Developmental Disorders, as well as increases in use of a diagnostic code used to indicate when a mental health disorder is suspected but not yet determined (Mental Health Disorder, Not Otherwise Specified or F99), for young children over the same time period.

Study Design

This study aimed to describe trends in select characteristics of mental health assessments for children ages 0 to 5, before and after MHAYC policies went into effect in 2022. We focused on measuring characteristics of assessments that were specifically targeted by MHAYC policy changes. MHAYC policy changes included:

1. Allowing reimbursement for multi-session assessments,
2. Allowing reimbursement for provider travel to home and community settings, and
3. Requiring the use of the DC:0-5™ diagnostic manual.

We selected a study population of young children, ages 0 to 5, who were enrolled in Apple Health (Medicaid and related programs) in each year from 2019 to 2023. Since MHAYC policy changes were specific to the 0 to 5 age range, we also reported trends for older children, ages 6 to 17, as a comparison group whose care was not subject to the policy changes.

The focus of the study was (1) identifying whether children in each age range received mental health assessments and (2) among those who received assessments, describing characteristics of the mental health assessment encounters, including identifying the following:

- Whether assessments took place over multiple sessions (related to MHAYC policy change #1),
- Where assessment sessions took place (related to MHAYC policy change #2),
- The final diagnosis from assessments (related to MHAYC policy change #3).

Data for this analysis came primarily from ProviderOne claims and encounter data, supplemented by demographic information from DSHS' Integrated Data Bases (ICDB; Mancuso and Huber, 2021). Code sets that defined each measure were developed through consultations with the IECMH clinical and program staff at the Health Care Authority (HCA), as well as review of both clinical and technical literature. Definitions for each measure are available in the technical notes.

How Many Children Received Mental Health Assessments?

A comprehensive mental health assessment is the first step in access to mental health care. In each year of the study, approximately 3,000 young children ages 0 to 5 received mental health assessments, except for 2019, during which about 4,300 young children received mental health assessments. The rate of mental health assessments for young children remained relatively stable during the study period, at about 1 percent of all young children enrolled in Apple Health in a given year (Figure 1).

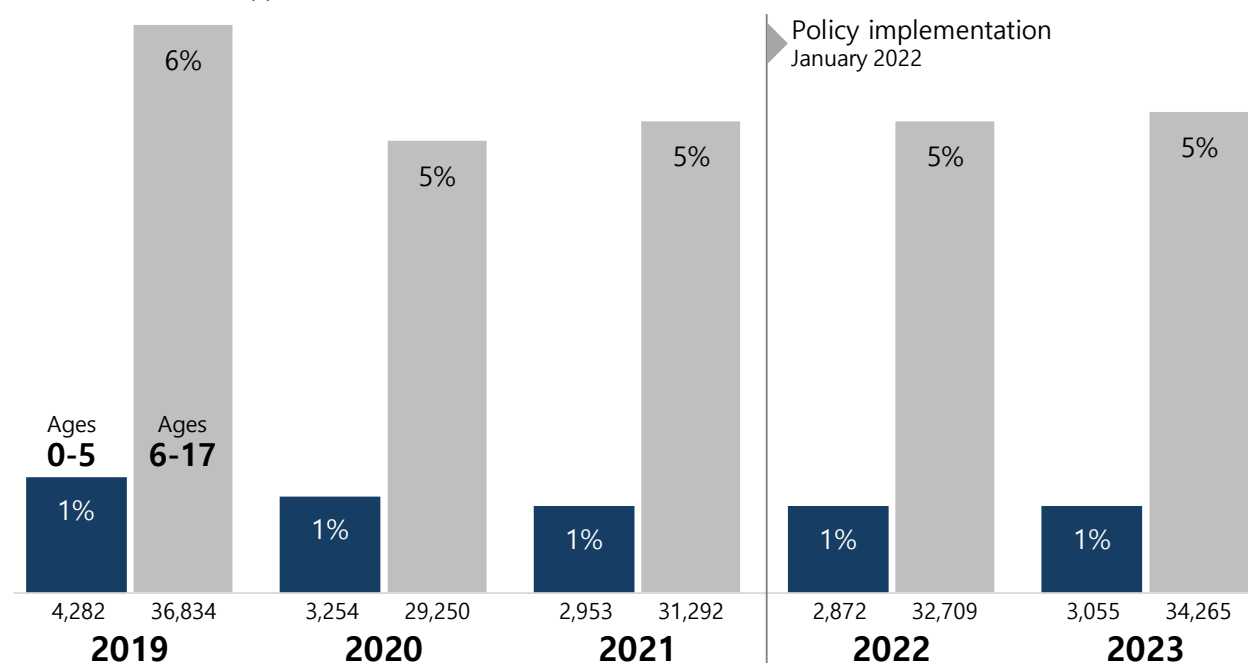
In all years, a higher number and greater percentage of older children ages 6 to 17 received mental health assessments than younger children. The number of older children who received a mental health

assessment per year hovered around 30,000, representing around 5 percent of children in the age group across the years of the study. Of note, the parallel decreases in children of all ages who received mental health assessments from 2019 to 2020 may be the result of the COVID-19 pandemic, as similar patterns were seen in outpatient mental health services more broadly during this time period (Patton et al. 2023).

FIGURE 1

Count and Percent of Children who Received a Mental Health Assessment by Year

Children enrolled in Apple Health, CY 2019 to 2023



How Common Were Multi-Session Mental Health Assessments?

For young children, both context and relationships are influential on behavior, and the variation in behavior across settings is highly informative for diagnosis of mental health conditions. Therefore, mental health assessments for young children should involve multiple sessions, with best practice recommending three to five sessions (Osofsky et al., 2025; Zero To Three, 2016). To align with best practices, MHAYC policy changes in 2022 allowed reimbursement for up to five sessions for mental health assessments for young children ages 0 to 5, without prior authorization.

Therefore, we examined whether this policy change was associated with a higher rate of multi-session assessments for young children ages 0 to 5, including a comparison to older children ages 6 to 17 (Figure 2). Mental health assessments were identified by procedure codes (90791, 90792, and H0031), and a measure of multi-session assessments was developed for this project (for more information, refer to the technical notes).

The percentage of young children who received a multi-session mental health assessment increased after MHAYC implementation in 2022. In the years before MHAYC implementation (2019, 2020, and 2021), between 3 and 4 percent of young children who were assessed received a multi-session assessment. In 2022, the first year of MHAYC implementation, this rate increased to 6 percent. In 2023, the second year of MHAYC implementation, the rate increased even further to 13 percent. This represents about a 4-fold increase in multi-session assessments for young children following MHAYC implementation.

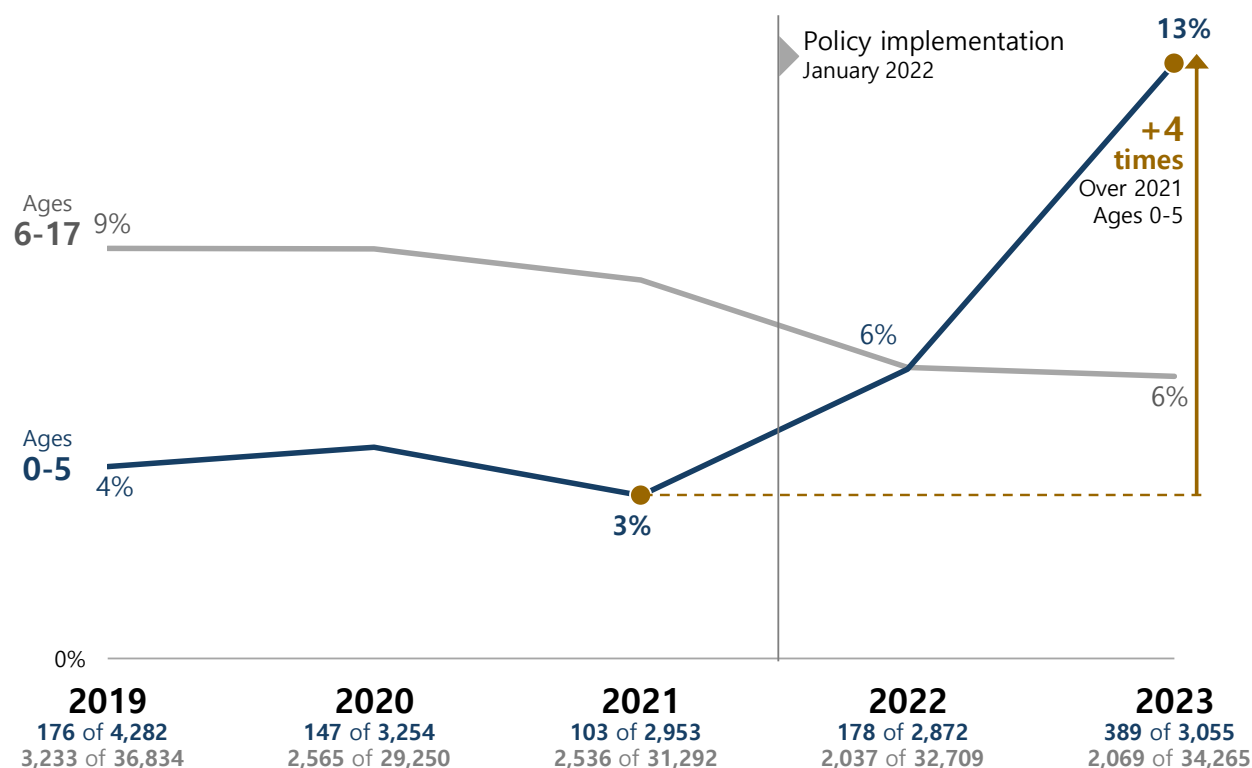
In comparison, the rate of multi-session assessments declined slightly over the same period for older children. In 2019, 9 percent of older children who received a mental health assessment received a multi-session assessment, and by 2023, that percentage had dropped to 6 percent.

The increase in multi-session assessments for young children coincides with the implementation of MHAYC policies, and since no similar increase was observed for older children, these results suggest that this increase for young children was due to MHAYC policy changes.

FIGURE 2

Multi-Session Mental Health Assessments by Year

Children enrolled in Apple Health with a mental health assessment, CY 2019 to 2023



Where Did Mental Health Assessments Take Place?

Because of the importance of evaluating behavior in different contexts, it is recommended that at least one session of a mental health assessment take place in the family's home or another community setting (Osofsky et al., 2025). To align with best practices, MHAYC policy changes in 2022 allowed reimbursement of provider travel to home and community settings for the purpose of mental health assessments for young children ages 0 to 5.

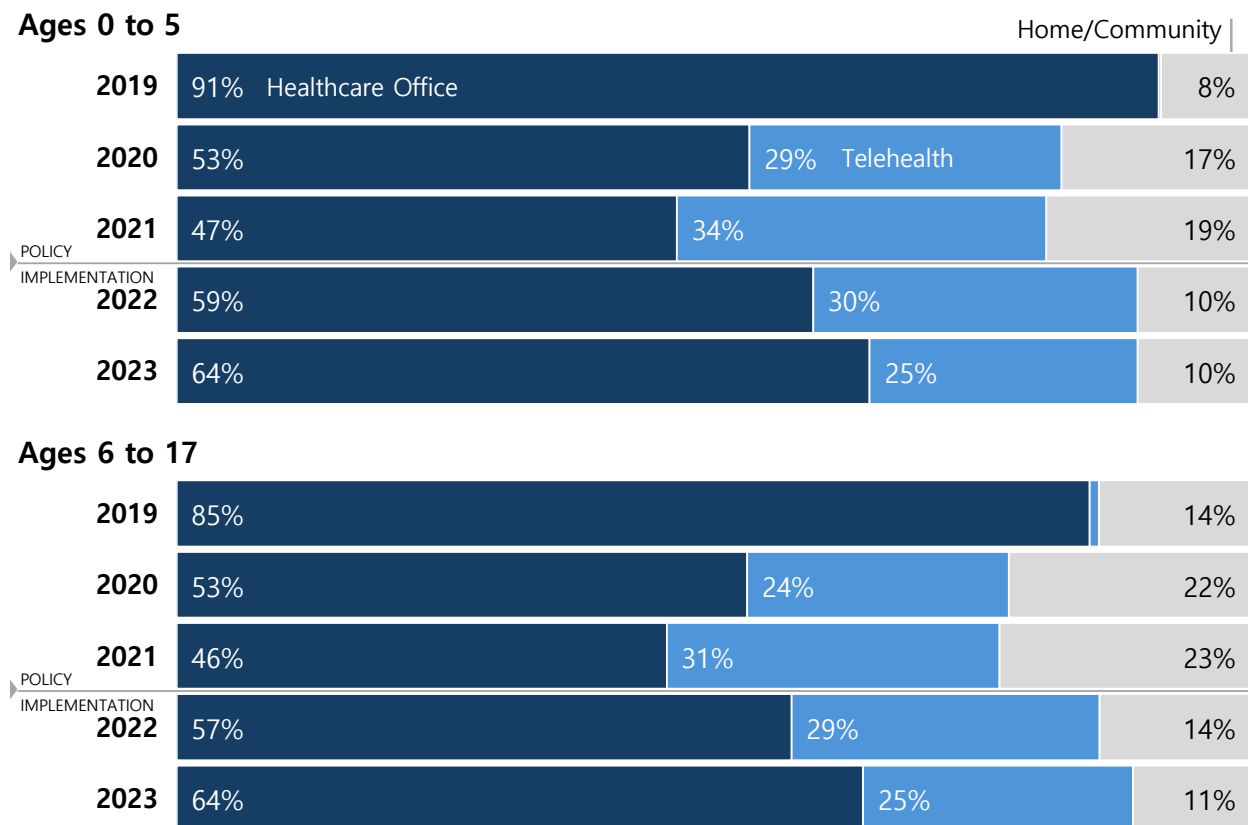
Therefore, we examined whether this policy change was associated with a higher rate of assessment sessions that took place in home or community settings for young children ages 0 to 5, including a comparison to older children ages 6 to 17 (Figure 3). We analyzed trends in assessment session locations, grouped into three broad categories: 1) healthcare settings, 2) home/community settings, or 3) via telehealth. For more information about classification of these codes, refer to the technical notes.

In 2019, the majority of mental health assessment sessions took place in healthcare settings, both for young children ages 0 to 5 (91 percent) and for older children ages 6 to 17 (85 percent). The remaining assessment sessions in 2019 were conducted in home/community settings, and less than 1 percent of assessments were conducted via telehealth.

FIGURE 3

Place of Service for Mental Health Assessment Sessions

Encounters for mental health assessment sessions among children enrolled in Apple Health, CY 2019 to 2023



NOTES: Small numbers of claims for mental health assessment (one-half of a percent or less) are missing the place of service code. Totals may not sum to 100 due to missing codes and due to rounding. Detailed counts are available in Appendix Table 2.

In 2020, delivery of all health care services changed with the onset of the COVID-19 pandemic and stay-at-home orders. In 2020, the proportion of mental health assessments delivered in health care settings decreased to approximately half for both age groups. The proportion of assessment sessions conducted via telehealth increased rapidly, from less than 1 percent in 2019 to about one quarter of all assessment sessions in 2020, and the proportion of assessment sessions conducted in home/community settings also increased. In 2021, the proportion of assessments delivered via telehealth grew again to about one-third, and the proportion delivered in the home/community increased slightly.

In 2022 and 2023, as the pandemic eased, the proportion of assessment sessions delivered in healthcare settings began to increase, though the rate had not returned to its pre-COVID level. The proportion delivered in home/community settings simultaneously decreased, returning to close to pre-COVID levels, and while the proportion delivered via telehealth also decreased, the rate of telehealth sessions remained much higher than pre-COVID levels.

Amidst these changes, however, the percentage of sessions conducted in home or community for young children was 2 percentage points higher in 2023 than in 2019 (from 8 to 10 percent), while the same pattern did not emerge for older children. This may suggest some MHAYC-related impacts, but ultimately, the substantial influence of COVID-19 on location of services makes comparison over time on this metric difficult.

What Diagnoses were Made on Mental Health Assessments?

Comprehensive and developmentally appropriate assessment, diagnosis, and clinical formulation are crucial to informing high quality mental health care for young children and their families. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood or DC:0-5™ is an internationally accepted diagnostic classification system for developmentally appropriate assessment of young children's mental health. The DC: 0-5™ uses developmentally specific diagnostic criteria reflecting mental health disorders that are typically diagnosed in infancy and early childhood. It is recommended by both CMS and SAMHSA. To align with best practices, MHAYC policy changes in 2022 required that mental health professionals utilize the DC:0-5™ for mental health assessments for young children ages 0 to 5.

While not a direct measure of DC:0-5™ utilization, we examined whether MHAYC policy changes were associated with changes in diagnostic patterns for young children ages 0 to 5, including a comparison to older children ages 6 to 17. For each child in the study population, we report the primary, final diagnosis from their mental health assessment.⁴

We first conducted analyses to report on final diagnoses by two broad categories of ICD-10 diagnostic codes that represent specific disorders:

- Specific Mental Health Disorder diagnoses,
- Specific Developmental Disorder diagnoses.

We broke down these categories into further diagnostic subtypes, such as Adjustment Disorders or Autism Spectrum Disorders.

We also specifically analyzed the prevalence of two diagnostic codes used in Apple Health billing practices to indicate unknown or ruled out conditions.

- Mental Disorder, Not Otherwise Specified (NOS) (ICD-10 code F99), used when a mental health disorder is suspected but has not yet been made.
- Mental Disorder, Ruled Out (ICD-10 code Z03.89, or '*encounter for observation for other suspected diseases and conditions ruled out*'), used when a mental health assessment concludes that a mental health disorder has been ruled out.

Diagnostic codes that did not fall into any of the above four categories were grouped together under Other Diagnoses (Not Yet Categorized). Code sets for each diagnostic category and subtype were developed through consultation with the IECMH clinical and program staff at HCA, as well as review of both clinical and technical literature.

Mental Health and Developmental Disorder Diagnoses on Mental Health Assessments

For children of all ages, the majority of mental health assessments led to final diagnoses of Specific Mental Health Disorders (see Figure 4). For young children ages 0 to 5, about three quarters of those assessed received a Specific Mental Health Disorder diagnosis. However, this prevalence did decrease during the study period, from 81 percent in 2019 to 72 percent in 2023. The decrease in Specific Mental Health Disorder diagnoses for young children was primarily driven by increases in diagnoses of Development Disorders and diagnoses of Mental Disorder, NOS, as described below. For older children ages 6 to 17, the percentage diagnosed with Specific Mental Health Disorders was higher, between 88 and 91 percent and showed only a small decrease over time.

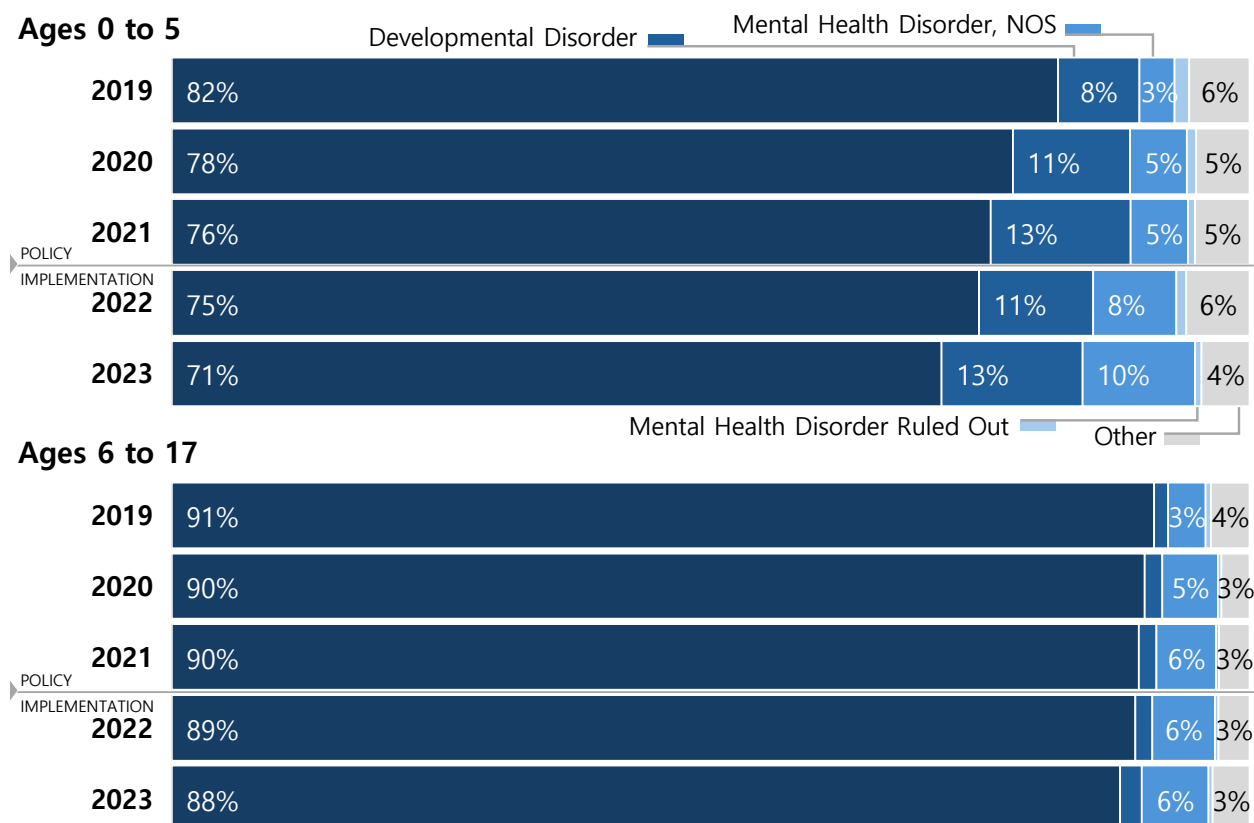
⁴ For children with single-session assessments, the final primary diagnosis corresponds to the primary diagnosis on the single assessment claim. For children with multi-session assessments, the final primary diagnosis corresponds to the primary diagnosis on the last assessment claim in the multi-session assessment. For more information about construction of this measure, please refer to the technical notes.

For young children, the second most common final diagnoses were Developmental Disorders, and the prevalence of these diagnoses also increased slightly over time, from 8 percent in 2019 to 13 percent in 2023. For older children, diagnoses of Developmental Disorders were relatively uncommon on mental health assessments, received by 2 percent or less of children assessed, and the prevalence remained relatively stable over time.

FIGURE 4

Final Diagnosis on Mental Health Assessments

Children enrolled in Apple Health with a mental health assessment, CY 2019 to 2023



Most Common Specific Mental Health Disorder Diagnoses on Mental Health Assessments

For young children ages 0 to 5 who received mental health disorder diagnoses on mental health assessments, the most common final diagnoses were Adjustment Disorders (see Figure 5). While diagnoses of Adjustment Disorders on assessments in this age range declined over the study period, they remained the most common diagnoses during the entire period.

The next most common diagnoses for young children were Post-Traumatic Stress and Other Stress Disorders (PTSD). While Disruptive Behavior Disorder (DBD) diagnoses were more common on assessments in 2019, PTSD diagnoses surpassed DBD diagnoses in 2020 and remained the second most common diagnostic type during the rest of the study period. Conversely, final diagnoses of DBDs declined over the study period from 16 percent in 2019 to 10 percent in 2023.

FIGURE 5

Prevalence of Specific Mental Health Disorder Diagnosis Subgroups on Mental Health Assessments

Children enrolled in Apple Health with a mental health assessment, CY 2019 to 2023

Specific Mental Health Disorders: Breakdown

| Ages 0 to 5 | | Adjustment Disorders | Post-Traumatic Stress Disorders | Disruptive Behavior Disorders | Anxiety Disorders | ADHD | Depressive Disorders | Other Mental Health Disorders |
|-----------------------|-----|----------------------|---------------------------------|-------------------------------|-------------------|------|----------------------|-------------------------------|
| TOTAL | | | | | | | | |
| 2019 | 82% | 33% | 14% | 16% | 10% | 6% | 3% | 1% |
| 2020 | 78% | 30% | 16% | 14% | 8% | 7% | 2% | 2% |
| 2021 | 76% | 32% | 14% | 13% | 7% | 6% | 1% | 2% |
| POLICY IMPLEMENTATION | | | | | | | | |
| 2022 | 75% | 31% | 14% | 13% | 7% | 6% | 2% | 2% |
| 2023 | 71% | 28% | 15% | 10% | 7% | 6% | 3% | 2% |

| Ages 6 to 17 | | Adjustment Disorders | Post-Traumatic Stress Disorders | Disruptive Behavior Disorders | Anxiety Disorders | ADHD | Depressive Disorders | Other Mental Health Disorders |
|-----------------------|-----|----------------------|---------------------------------|-------------------------------|-------------------|------|----------------------|-------------------------------|
| TOTAL | | | | | | | | |
| 2019 | 91% | 20% | 14% | 7% | 17% | 8% | 23% | 2% |
| 2020 | 90% | 20% | 15% | 5% | 17% | 8% | 23% | 2% |
| 2021 | 90% | 19% | 15% | 5% | 18% | 7% | 23% | 3% |
| POLICY IMPLEMENTATION | | | | | | | | |
| 2022 | 89% | 19% | 15% | 5% | 19% | 7% | 22% | 2% |
| 2023 | 88% | 18% | 16% | 5% | 19% | 8% | 20% | 2% |

NOTE: Percentages in this chart represent the proportion of all mental health assessments with the indicated (column labels) subcategory of Specific Mental Health Disorder Diagnoses in the year. Therefore, the percentages of the subcategories sum (roughly, there may be slight differences due to rounding) to the percentages shown in Figure 4 for Specific Mental Health Disorder diagnoses. Other Mental Health Disorders is a roll-up group consisting of several subgroups, which are outlined further in the Appendix Table 3.

Comparing both overall diagnostic rates and trends over time revealed similarities and differences between young children ages 0 to 5 and older children ages 6 to 17. Adjustment Disorders were more commonly diagnosed in younger children than in older children: approximately a third of young children were diagnosed with Adjustment Disorders, compared to about a fifth of older children. However, both age groups experienced decreases in diagnoses of Adjustment Disorders during the study period. Disruptive Behavior Disorders (e.g., Oppositional Defiant Disorder, Conduct Disorder) were also more commonly diagnosed in younger children than older children: over 10 percent of young children were diagnosed with Disruptive Behavior Disorders (DBDs) each year of the study, compared to around 5 percent of older children.

Young children experienced a marked decrease in DBDs during the study period (from 16 percent to 10 percent). While the decline in diagnosis of DBD for younger children began before MHAYC implementation, it continued to decline between 2022 and 2023 (after MHAYC implementation), while DBD diagnoses for older children remained relatively stable during this period.

Even with these decreases, however, DBDs were still the third most commonly diagnosed type of mental health disorder for young children at the end of the study period, and they were still more

commonly diagnosed among young children than older children. Other differences in diagnoses between young children and older children were seen for Anxiety and Depressive Disorders, as well as Attention Deficit and Hyperactivity Disorders (ADHD). Depressive Disorders were the most common type of mental health disorder for older children, while they were rarely diagnosed for young children. Anxiety Disorders were also about twice as common for older children (17 to 19 percent of children) than for younger children (7 to 10 percent of children). ADHD diagnoses were slightly more common for older children (about 8 percent each year) than for young children (about 6 percent).

The remaining Mental Health Disorder types with small numbers were included in a 'Other Mental Health Disorders' roll-up subgroup for this report. These included Other Childhood Emotional, Behavioral, and Social Disorders, Eating Disorders, Obsessive-Compulsive Disorders, Relational Disorders, Behavioral Sleep Disorders, Somatoform Disorders, and other types of mental health disorders. Combined, these types of disorders were diagnosed in about 2 percent of both young children and older children. Complete counts and percentages for all Mental Health Disorder diagnostic subgroups are available in Appendix Table 3.

Most Common Specific Developmental Disorder Diagnoses on Mental Health Assessments

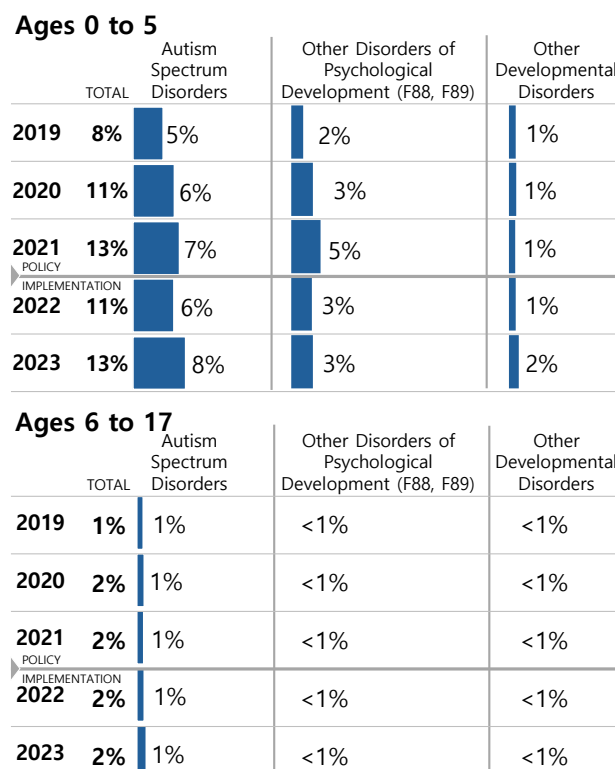
As noted previously, Developmental Disorders were diagnosed on mental health assessments more frequently for young children ages 0 to 5 than for older children ages 6 to 17, and their prevalence among young children also increased during the study period, from 8 percent in 2019 to 13 percent in 2023. The most common Developmental Disorders diagnosed on mental health assessments for young children were Autism Spectrum Disorders (6 to 8 percent). Autism Spectrum Disorders were also the most commonly diagnosed Developmental Disorder for older children, but were diagnosed less frequently (1 to 2 percent).

The second most commonly diagnosed type of Developmental Disorder among young children was Other Disorders of Psychological Development. This disorder includes two ICD-10 diagnostic codes, F88 and F89, which are relatively generic in description and may be used to represent various developmental conditions, including Global Developmental Delays and Sensory Disorders, as well as Other Specified or Unspecified Neurodevelopmental Disorders. Prevalence of these disorders for young children ranged from 2 to 5 percent across 2019 to 2023. For older children, prevalence was less than 1 percent, remaining stable over the study period.

FIGURE 6

Prevalence of Developmental Disorder Diagnosis Subgroups on Mental Health Assessments

Children enrolled in Apple Health with a mental health assessment, CY 2019 to 2023



NOTE: Percentages in the chart above/right represent the proportion of all mental health assessments with the indicated (column labels) subcategory of Developmental Disorder diagnoses in the year. Other Developmental Disorders is a roll-up group consisting of several subgroups of Developmental Disorders, including Language Disorders, Chromosomal or Congenital Conditions, Fetal Alcohol Syndrome, Intellectual Disabilities, Learning Disabilities, and Motor Disorders; these smaller subgroups are shown in Appendix Table 3.

Other Diagnoses on Mental Health Assessments

Two diagnostic codes are also used in Apple Health billing practices to indicate unknown or ruled out conditions, and these codes were specifically analyzed for this study.

Apple Health billing guidance instructs providers to use Mental Disorder, Not Otherwise Specified (NOS), or ICD-10 diagnostic code F99, when a mental health diagnosis is suspected, but has not yet been made. This was reinforced as part of MHAYC billing guidance, as providers were instructed to use Mental Disorder, NOS (F99) for the initial sessions of multi-session assessments. The percentage of young children who received Mental Disorder, NOS as their final diagnosis increased over time, from 3 percent in 2019 to 10 percent in 2023. In comparison, the prevalence of Mental Disorder, NOS diagnoses for older children ages 6 to 17 remained relatively stable over time, at approximately 5 percent.

During the study period, some Apple Health billing guidance⁵ also instructed providers to use Mental Disorder Ruled Out⁵ (ICD-10 diagnosis code Z03.89; '*encounter for observation for other suspected diseases and conditions ruled out*') for assessments that determine that a mental health disorder can be ruled out. This diagnosis was relatively uncommon for both young children and older children during the study period, representing 1 percent and less than 1 percent of all children assessed, respectively.

Lastly, a small percentage of final diagnoses did not fall into any of the diagnostic categories defined for this study, (labeled as 'Other' in Figure 4). Approximately 5 percent of young children and 3 percent of older children received a final diagnosis that did not fall into any of the previously defined diagnostic categories, and this prevalence was relatively stable for both age groups over time.

Discussion

This report presents an overview of trends in mental health assessments for young children ages 0 to 5 from 2019 to 2023 and compares trends for older children ages 6 to 17, in order to understand the impact of MHAYC policy changes that went into effect in 2022. MHAYC policy changes, which were applicable only to young children ages 0 to 5, included reimbursement for multi-session assessments and for provider travel costs to home and community settings, as well as a requirement to use the DC:0-5™. While this analysis is not a formal evaluation of MHAYC policy impacts, it offers insights into potential impacts, which could be investigated in future studies. Our results suggest that MHAYC policy may have led to an increase in multi-session assessments for young children, while the potential impacts of MHAYC implementation on assessment location and the types of diagnoses received were less clear.

Very few young children received mental health assessments, even in the years following MHAYC policy changes.

Epidemiological studies suggest that rates of mental health conditions among young children are similar to those of older children (Vasileva et al., 2021), but young children typically experience less access to mental health care (Mercer, 2025; HCA, 2024). While MHAYC policies were primarily focused on improving the quality of mental health care for young children, they are also part of larger efforts to ensure equitable and expanded access to care for all young children who need it.

We found that only 1 percent of young children ages 0 to 5 enrolled in Apple Health received mental health assessments during the study period, compared to about 5 percent of older children ages 6 to 17. We did not see any increases in the number or percentage of young children who received mental

⁵ During the study period, guidance to use Z03.89 was included in MHAYC-specific billing guidance and in Apple Health Mental Health Billing Guide Part 1. Guidance to use Z03.89 is anticipated to be added to all Apple Health behavioral health billing guides effective January 1, 2026.

health assessments after MHAYC implementation. This suggests that there is still work to be done to increase access to mental health care, including assessments, for young children. HCA's work with multiple partners on mapping and improving referral pathways may prove valuable in these efforts (HCA, 2025).

Multi-session assessments became more common for young children after MHAYC went into effect.

Multi-session assessments are considered a best practice for young children (Zero To Three, 2016; Osofsky et al. 2025), though they may also be beneficial for children of all ages (Srinath et al., 2019). Our results showed a 4-fold increase in rates of multi-session assessments for young children ages 0 to 5 following MHAYC implementation, while there was a slight decrease for older children over the same time period, suggesting that MHAYC policies may have contributed to the growth in this best practice.

The impact of the COVID-19 pandemic made it challenging to determine if MHAYC had any influence on where assessments for young children took place

Conducting assessments in natural settings such as families' homes or other community locations is considered a best practice for young children (Osofsky et al., 2025), though it may also benefit children of all ages (De Los Reyes et al 2015). We found that while there were striking changes in assessment locations during the study period, the influence of the COVID-19 pandemic made it challenging to determine if there were any MHAYC-related impacts. Sessions conducted in home/community settings and via telehealth increased markedly for children of all ages during the height of the COVID pandemic, which immediately preceded MHAYC implementation. The first 2 years of MHAYC implementation then coincided with the easing of stay-at-home orders, where health care delivery began to return to in-office settings. Marked expansion of telehealth during and after the pandemic (Pavelle et al., 2024; McBain et al., 2024), as well as parallel declines in services provided in home/community settings (Milliman, 2025) have been observed in other studies.

Some changes were seen in diagnostic patterns among young children during the study period, including a decrease in diagnoses of Disruptive Behavior Disorders

Accurate diagnosis of mental health and developmental disorders is crucial to inform appropriate treatment planning and evidence-based care, especially for young children. While all three MHAYC policy changes were designed to support more accurate and developmentally appropriate assessment and diagnosis, the requirement to utilize the DC:0-5™, the developmentally appropriate diagnostic manual for young children, may be most closely associated with any changes in the diagnoses that young children receive on assessments.

Specific Mental Health Disorders

Both young children and older children experienced decreases in Disruptive Behavior Disorders (DBD) diagnoses during the study period. The decrease in DBD diagnoses was greater for younger children than for older children, though half of the decrease for young children occurred prior to MHAYC implementation.

The decrease in DBD diagnoses during the study period may reflect shifting understandings of psychopathology and diagnostic etiology among children, especially young children. Recent research and clinical literature has highlighted concerns about the validity and appropriateness for DBDs, especially given the evidence of significant racial disparities in DBD diagnoses (Olivia Rivera, 2025; Savage et al., 2024). The DC:0-5™ does not include DBDs within its diagnostic classification system, as emerging research suggests that the underlying etiology of symptoms like irritability, aggression, and 'non-compliance' in early childhood are related to emotional dysregulation, rather than behavioral dysregulation (Zero To Three, 2016). Since MHAYC implementation began in 2022, over 750 mental

health providers have received clinical training in the DC:0-5™, and participants have shared that the training has helped them to better understand appropriate mental health diagnoses for young children (Fabian & Cole, 2023; Cole & Fabian, 2024; CERH, 2025), which may suggest that MHAYC implementation and DC:0-5 training could have contributed to this shift.

Even with these shifts, DBDs were still the third most commonly diagnosed mental health disorders for young children at the end of the study period, and they were also more commonly diagnosed among young children than older children. In comparison, Depressive and Mood Disorders, which can share symptoms with DBDs in early childhood, were rarely diagnosed for young children. Further analysis to track ongoing trends in diagnostic patterns as MHAYC implementation continues may prove helpful in understanding both the needs of children and families, as well as diagnostic mental models used by providers.

Developmental Disorders

About 10 percent of young children ages 0 to 5 who were assessed during the study period received a final diagnosis of a Developmental Disorder, and this rate increased over time, from 8 percent in 2019 to 13 percent in 2023. In comparison, Developmental Disorders were rarely diagnosed on mental health assessments of older children, and the prevalence remained relatively stable over time. It is possible that the increases in Developmental Disorder diagnoses among young children were related to MHAYC implementation and widespread DC:0-5™ training. However, MHAYC implementation and DC:0-5™ training have been primarily targeted at mental health professionals, not all of whom have the diagnosis of developmental disorders within their scope of practice. Further analysis to understand the types of mental health providers who are conducting mental health assessments and diagnosing different disorders in young children may reveal helpful insights about these trends.

Other Diagnoses

Not all mental health assessments resulted in final diagnoses of Specific Mental Health or Developmental Disorders. One diagnostic category that was specifically analyzed as part of this study was Mental Disorder, Not Otherwise Specified (NOS) (ICD-10 code F99). Guidance around the use of this code was clarified and reinforced through MHAYC implementation

The percentage of young children who received Mental Disorder, NOS as the final diagnosis on an assessment increased after MHAYC implementation, from 5 percent in 2021, to 8 percent in 2022 and 10 percent in 2023. In comparison, the prevalence of Mental Disorder, NOS diagnoses for older children did not increase after MHAYC implementation, remaining at roughly 6 percent from 2021 to 2023. Further study to track the use of Mental Disorder, Not Otherwise Specified (NOS) diagnoses, including interplay with multi-session assessments, could prove helpful in understanding this trend.

Lastly, a small percentage of final diagnoses on assessments did not fall into any of the diagnostic categories defined for this study. The majority of these diagnoses were '*Symptoms, signs and abnormal clinical and laboratory findings*' (ICD-10 R codes) and '*Factors influencing health status and contact with health services*' (ICD-10 Z codes). Both families of diagnostic codes span broad ranges of symptoms and factors, some of which may be related to or influence mental and developmental health. Further work to categorize these codes into meaningful groups for study could be beneficial in understanding the conditions affecting young children and their families.

Future directions for expanded study

This study's focus was on monitoring trends in select characteristics of mental health assessments that were the focus of MHAYC policy changes. While the discussion sections above outline suggested approaches for further study on these characteristics, there are also opportunities to expand areas of interest. For example, future studies could examine the characteristics of the children and families who received mental health assessments, including demographics like gender, race/ethnicity, and

geography, as well as other health factors and connections to other health and social services. Such studies could help to identify if there are existing disparities in access to care and if specific populations should be the focus of additional IECMH support.

Future studies could also expand from the current focus on mental health assessments to a broader understanding of conditions affecting young children's mental and developmental health. Further studies could examine the prevalence of mental health and developmental disorders among young children overall, not just among those who received mental health assessments. A longitudinal approach could also examine when a child was first diagnosed with a mental health disorder, if that first diagnosis was part of a mental health assessment, and whether diagnosed conditions are stable or shift over time as a child ages. Further research could also identify other factors available in administrative claims or other health and human services data that could indicate a need for mental health services among infants and young children. To date, research on the prevalence of mental health and developmental disorders among young children utilizing administrative claims data is limited but expanding (Cummings et al., 2025; OCID, 2025), and it represents a valuable area for exploration.

Future studies could also expand from a focus on assessment and diagnosis to understanding access to high quality, developmentally appropriate mental health treatment. Further research could examine the relationship between receiving a mental health disorder diagnosis on an assessment and accessing mental health treatment services, as well as the types of mental health treatment services that young children receive. Information about young children's access to mental health care is limited, especially since nationally standardized administrative metrics of children's mental health usually only apply to children older than age 6 and often do not capture the full breadth of developmentally appropriate care (CMS, 2025b). Following the example of states like Oregon (OHA, 2025), Washington has the opportunity to contribute to this growing field of study and lay the foundation for advanced work on understanding mental health outcomes for young children.

Broader Policy Implications

While the focus of this study was on specific characteristics of mental health assessments, findings have broader policy implications.

Usefulness of administrative claims data

To our knowledge, these results represent the first time that administrative claims data have been used to study the key aspects of assessment for young children, including multi-session assessments and assessments in home/community setting. Results discussed here align with findings from other data sources, including surveys and focus groups with Apple Health infant-early childhood mental health (IECMH) providers. The increase in multi-session assessments seen here aligns with other data sources indicating that multi-session assessments have been implemented by some providers, and, when implemented, they have been beneficial to both providers and families (Fabian & Cole, 2023; Cole & Fabian, 2024).

These results may also align with findings from other data that conducting assessments in home/community settings can be resource intensive to implement, and current MHAYC policies do not fully address key barriers to implementation (Fabian & Cole, 2023; Cole & Fabian, 2024). Further study to continue analyzing this trend over time could provide insights into whether additional policy changes are needed to support IECMH providers in moving towards this best practice.

Research using administrative claims data is a powerful companion to survey or focus group data and can help to triangulate impacts of policy changes.

Limits to administrative claims data

It is important to note that while examining ICD-10 diagnostic patterns can provide some insight into implementation of MHAYC policies, including the use of the DC:0-5™, Apple Health administrative claims data do not specifically indicate whether the DC:0-5™ was used. Additional reports have looked at utilization of the DC:0-5™ in small or select samples of providers and have found that, while DC:0-5™ use appears to be increasing in Washington, there are still barriers to implementation (Fabian et al., 2022; Fabian & Cole, 2023; Cole & Fabian, 2024; CERH, 2025). Currently, no comprehensive data about use of the DC:0-5™ among Apple Health providers are available. Clinical record review studies or changes to standard behavioral health administrative data collection, such as the utilization of specific modifier codes or the addition of a specific field within the [Behavioral Health Data System](#) (BHDS) for the DC:0-5™ could help provide more comprehensive information about its use.

The impact of clear clinical policy and billing guidance

This report also highlights the importance of clear clinical policies and billing guidance in the adoption of developmentally appropriate practices. For example, while MHAYC legislation codified the allowance of multi-session assessments into state law, multi-session assessments were already allowable under federal Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, which mandate that states cover all medically necessary services for children and youth. However, prior to MHAYC implementation, Apple Health billing guidance on this topic was not uniform across provider types, nor was it framed, or communicated specifically for IECMH providers. Unclear billing guidance can lead to administrative burden, which is a known challenge in health care (CMS, 2025a; Zhu & Eisenberg, 2024), and previous reports have found that IECMH providers face particular challenges in this area, which adds strain to an already limited specialty provider network (Oxford & Lecheile, 2022; Perigee Fund, 2021; Cole & Fabian, 2024).

MHAYC implementation efforts focused heavily on clarifying and aligning billing guidance, especially for multi-session assessments, and on communicating this guidance to IECMH providers in accessible ways (Fabian & Cole, 2023). The results of this study show that when multi-session assessments were technically allowed but guidance and processes were unclear, multi-session assessments rates were low. After MHAYC implementation, when clearer billing guidance was developed and disseminated, multi-session assessment rates more than tripled. This aligns with qualitative and survey data collected from IECMH providers, who highlighted HCA's communication as key to implementing the new practices (Fabian & Cole, 2023). These combined results demonstrate the impact of not only policy change, but of policy implementation, particularly billing guidance and provider communication, on supporting high quality care.

Understanding implementation over time

These results align with key principles of implementation science, which suggest that full implementation of new practices may take 4 to 5 years (Chamberlain et al., 2011). For example, small increases in multi-session assessment rates were seen in the first year of implementation, and slightly larger increases were seen in the second year of implementation. In addition, while rates of multi-session assessments for young children are increasing, they remain relatively low. Lastly, IECMH best practices suggest that assessments of young children should take three to five sessions (Zero To Three, 2016; Osofsky et al., 2025), but during this study period, almost all multi-session assessments took only two sessions. These findings align with provider feedback that implementing multi-session assessments is complicated, and takes time and resources (Fabian & Cole, 2023; Cole & Fabian, 2024), and they suggest while initial implementation is underway, full installation may take place over multiple years. Further study to continue analyzing trends over time could provide insights into how widespread implementation of both practice and billing changes occur within the field of behavioral health.

SUPPORTING TABLES

APPENDIX TABLE 1

Prevalence of Mental Health Assessment, Multi-session Assessments, and Primary Diagnosis Categories for Children Ages 0 to 5

CY 2019 to 2023

| | CALENDAR YEAR | | | | | | | | | |
|---|----------------|-------|----------------|-------|----------------|-------|----------------|-------|----------------|-------|
| | 2019 | | 2020 | | 2021 | | 2022 | | 2023 | |
| TOTAL Children with Apple Health | 344,622 | | 333,783 | | 333,741 | | 335,187 | | 335,545 | |
| Of Total Apple Health | # | % | # | % | # | % | # | % | # | % |
| Mental Health (MH) Assessment | 4,282 | 1.2% | 3,254 | 1.0% | 2,953 | 0.9% | 2,872 | 0.9% | 3,055 | 0.9% |
| Of Children with MH Assessment | # | % | # | % | # | % | # | % | # | % |
| Multi-Session MH Assessment | 176 | 4.1% | 147 | 4.5% | 103 | 3.5% | 178 | 6.2% | 389 | 12.7% |
| MH Diagnosis on MH Assessment | 3,521 | 82.2% | 2,539 | 78.0% | 2,243 | 76.0% | 2,151 | 74.9% | 2,182 | 71.4% |
| DD Diagnosis on MH Assessment | 324 | 7.6% | 354 | 10.9% | 384 | 13.0% | 304 | 10.6% | 399 | 13.1% |
| Mental disorder, NOS (F99) on MH Assessment | 138 | 3.2% | 172 | 5.3% | 158 | 5.4% | 221 | 7.7% | 319 | 10.4% |
| Mental disorder ruled out (Z03.89) on MH Assessment | 60 | 1.4% | 27 | 0.8% | 18 | 0.6% | 27 | 0.9% | 18 | 0.6% |
| Other Diagnosis on MH Assessment | 239 | 5.6% | 162 | 5.0% | 150 | 5.1% | 169 | 5.9% | 137 | 4.5% |

DD=Developmental Disorder

APPENDIX TABLE 2

Place of Service Trends for Mental Health Assessments for Children Ages 0 to 5

CY 2019 to 2023

| | CALENDAR YEAR | | | | | | | | | |
|--|---------------|-------|--------------|-------|--------------|-------|--------------|-------|--------------|-------|
| | 2019 | | 2020 | | 2021 | | 2022 | | 2023 | |
| TOTAL Mental Health Assessment Sessions | 5,033 | | 3,823 | | 3,358 | | 3,449 | | 4,024 | |
| | # | % | # | % | # | % | # | % | # | % |
| In healthcare settings | 4,601 | 91.4% | 2,038 | 53.3% | 1,563 | 46.5% | 2,036 | 59.0% | 2,586 | 64.3% |
| In home or community settings | 415 | 8.2% | 669 | 17.5% | 635 | 18.9% | 359 | 10.4% | 417 | 10.4% |
| In telehealth settings | 11 | 0.2% | 1,111 | 29.1% | 1,154 | 34.4% | 1,037 | 30.1% | 1,001 | 24.9% |

NOTE: Assessment sessions with missing settings were not included in the total count or in a separate category in the table because of small numbers. This table includes all assessment sessions within all assessment episodes, including multi-session assessments. Therefore, total counts of assessment sessions are higher than total children with mental health assessments, as children may have had more than one assessment episode, and may have experienced multiple assessment sessions within a single episode of assessment.

APPENDIX TABLE 3

Final Diagnosis on Mental Health Assessments for Children Ages 0 to 5

CY 2019 to 2023

| | CALENDAR YEAR | | | | | | | | | |
|---|---------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| | 2019 | | 2020 | | 2021 | | 2022 | | 2023 | |
| | # | % | # | % | # | % | # | % | # | % |
| Children with MHD Diagnoses from MH Assessment | 3,521 | 82.2% | 2,539 | 78.0% | 2,243 | 76.0% | 2,151 | 74.9% | 2,182 | 71.4% |
| Adjustment Disorders | 1,397 | 32.6% | 991 | 30.5% | 941 | 31.9% | 889 | 31.0% | 866 | 28.3% |
| Posttraumatic Stress or Other Stress Disorders | 592 | 13.8% | 520 | 16.0% | 404 | 13.7% | 403 | 14.0% | 464 | 15.2% |
| Disruptive Behavior Disorders | 681 | 15.9% | 442 | 13.6% | 393 | 13.3% | 377 | 13.1% | 318 | 10.4% |
| Anxiety Disorders | 413 | 9.6% | 259 | 8.0% | 205 | 6.9% | 187 | 6.5% | 218 | 7.1% |
| Attention Deficit and Hyperactivity Disorders | 250 | 5.8% | 213 | 6.5% | 189 | 6.4% | 171 | 6.0% | 178 | 5.8% |
| Depressive and Other Mood Disorders | 124 | 2.9% | 55 | 1.7% | 41 | 1.4% | 61 | 2.1% | 78 | 2.6% |
| Other Childhood Emotional, Behavioral, Social Disorders | 44 | 1.0% | 38 | 1.2% | 35 | 1.2% | 38 | 1.3% | 40 | 1.3% |
| Eating Disorders | Suppressed | | Suppressed | | 17 | 0.6% | 15 | 0.5% | 16 | 0.5% |
| Obsessive-Compulsive Disorders | Suppressed | | Suppressed | | Suppressed | | Suppressed | | Suppressed | |
| Relational Disorders | Suppressed | | Suppressed | | Suppressed | | 0 | 0% | 0 | 0% |
| Behavioral Sleep Disorders | 0 | 0% | Suppressed | | Suppressed | | Suppressed | | Suppressed | |
| Other Mental Health Disorders | Suppressed | | Suppressed | | Suppressed | | Suppressed | | Suppressed | |
| Children with Developmental Disorder Diagnoses from MH Assessments | 324 | 7.6% | 354 | 10.9% | 384 | 13.0% | 304 | 10.6% | 399 | 13.1% |
| Autism Spectrum Disorders | 195 | 4.6% | 203 | 6.2% | 207 | 7.0% | 176 | 6.1% | 241 | 7.9% |
| Other Disorders of Psychological Development | 80 | 1.9% | 111 | 3.4% | 138 | 4.7% | 94 | 3.3% | 104 | 3.4% |
| Language Disorders | 47 | 1.1% | 37 | 1.1% | 30 | 1.0% | 30 | 1.0% | 48 | 1.6% |
| Chromosomal or Congenital Conditions | Suppressed | | Suppressed | | Suppressed | | Suppressed | | Suppressed | |
| Fetal Alcohol Syndrome | Suppressed | | 0 | 0% | 0 | 0% | 0 | 0% | Suppressed | |
| Intellectual Disabilities | 0 | 0% | Suppressed | | Suppressed | | Suppressed | | Suppressed | |
| Learning Disabilities | 0 | 0% | Suppressed | | Suppressed | | 0 | 0% | 0 | 0% |
| Motor Disorders | 0 | 0% | 0 | 0% | Suppressed | | Suppressed | | Suppressed | |

NOTES: Other Mental Health Disorders include dissociative/conversion disorders, factitious disorders, mania/bipolar disorders, personality disorders, psychotic disorders, and miscellaneous mental health disorders. Counts under 11 are suppressed to protect confidentiality.

ACRONYMS

| | |
|----------------|---|
| MHAYC | Mental Health Assessments for Young Children |
| HCA | Health Care Authority |
| ICD-10 | International Classification of Disease, 10 th revision |
| IECMH | Infant-Early Childhood Mental Health |
| DC:0-5™ | Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood |

POPULATION

The study population is comprised of children ages 0 to 5 years who were enrolled in Apple Health (Medicaid and related programs), referred to as 'young children'. Children ages 6 to 17 years enrolled in Apple Health (referred to as 'older children') are used as the comparison group.

DATA SOURCES

Data was utilized from ProviderOne administrative claims and encounter data supplemented by demographic information from DSHS' Integrated Data Bases (ICDB; Mancuso and Huber, 2021). The measurement period spans 2019, 2020, 2021, 2022, and 2023, as well as the final 90 days of 2018, in order to identify multi-session assessments that span the calendar year.

MEASURE DEFINITIONS

Mental health assessment. Mental health assessments were identified using ProviderOne claims and encounters where the procedure code is one of the following:

| | |
|--------------|---|
| 90791 | Psychiatric diagnostic evaluation |
| 90792 | Psychiatric diagnostic evaluation with medical services |
| H0031 | Mental health assessment, by non-physician |

Multi-session assessment. Within the population with at least one mental health assessment session, we identified clients who received at least one additional assessment session with the same billing provider within 90 days of the initial assessment. Assessments that span years were assigned to the year of the final session. Ninety days was chosen as the multi-session assessment window based on consultation with a clinical IECMH expert in HCA, as well as guidance within the [Behavioral Health Data Guide](#).⁶ Detailed documentation of this measure is available here: <https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-282-App1.pdf>.

Mental health and developmental disorders. The sets of ICD-10 codes indicating mental and developmental disorders and specific disorder types within each diagnostic category (e.g., anxiety disorders, language disorders) for the 0 to 5 age range were developed as part of this project. These code sets were derived from review of the DC:0-5™ manual, the Apple Health DC:0-5™ Crosswalk, and the mental health and developmental disorder diagnosis measures currently in use by the Department of Social and Health Services, Research and Data Analysis Division (RDA). We also received guidance and consultation from infant and early childhood mental health program and clinical staff at HCA, and reviewed both clinical and technical literature. Detailed documentation of this measure is available here: <https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-282-App2.pdf>.

Place of service refers to the location or setting in which a service takes place. Place of service codes are developed and defined by the Centers for Medicare and Medicaid Services (CMS), and they are reported in the facility type code field for professional claims in ProviderOne. Code sets for three primary place of service groups were developed as part of this project including 1) healthcare settings, 2) home/community settings, 3) telehealth settings. Detailed documentation of this measure is available here: <https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-282-App4.pdf>.

⁶ Appendix K: Closing Service Episode of Care Guidance in the [Behavioral Health Supplemental Transaction Data Guide](#) states that for Mental Health services, if an Enrollee (i.e., client) has not actively participated in treatment, HCA recommends closing the service episode after more than 90 days of no contact.

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