



Adolescent Health Task Force Minutes  
Mental Health  
March 6, 2009

In attendance: Barb Bowsher, Donna Breitenstien, Jane Brown, Mimi Chapman, Steve Cline, Tamera Coyne-Beasley, Representative Susan Fisher, Carol Ford, Laura Gerald, Sharon Mangun, Steve North, Connie Parker, Kay Phillips, Marcus Plescia, Krista Rager, Joel Rosch, Carol Tant

Interested Persons and Staff: Phyllis Blackwell, Kimberly Alexander-Bratcher, Kelly Crowley, Regina Dickens, Jane Foy, Tracie Hazelett, Mark Holmes, Jim Martin, Ruth Petersen, Sharon Rhyne, Romaine Riddle, Michael Sanderson, Pam Silberman, Tara Strigo, Tony Troop, Carol Tyson, Courtney Woo, Berkeley Yorkery

**OVERVIEW OF AVAILABLE DATA AND THE MENTAL HEALTH SYSTEM**

*Kelly Crowley, LCSW, System of Care Coordinator, Community Policy Management  
NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services*

Based on national data sources, approximately 204,000 children and youth (ages 0-18) in North Carolina are estimated to have a serious emotional disturbance that disrupts their daily life. Only 47% (or 95,696 children) with MH diagnoses were served by North Carolina's public mental health system in SFY 2008. The number of children being served by the public mental health system has increased 33.2% since SFY 2006. Three-quarters of those served in 2008 were ages 10-17. Of those children served by the public mental health system, 53% have a primary diagnosis of attention deficit disorder, adjustment or conduct problems, or anxiety.

The North Carolina public mental health system provides comprehensive clinical assessment, diagnostic assessments, and basic benefits to eligible children and youth. Children who are eligible for benefits can receive an array of services including: outpatient support, community support, intensive in-home, multisystemic therapy, day treatment, mobile crisis management, partial hospitalization, inpatient hospitalization, residential levels I-IV (therapeutic foster care), and psychiatric residential treatment facility. The vast majority of youth receiving services get outpatient support or community services. In 2008, fewer than 15% received more intensive services; 7% received residential treatment.

There are a number of ways to improve public mental health services for children and youth, including implementing the use of an evidence-based assessment tool, hiring additional System of Care Coordinators, utilizing more evidence-based practices, and serving more youth through community-based services rather than residential services.

An evidence-based functional assessment tool would help guide clinical conversations and matching of services; take some stigma away when working with families through the use of an objective tool; and help in measuring outcomes and needs. A primary-care friendly assessment tool could help in diagnosis and referral to increase the percentage of children with mental health

needs who receive services. Currently the Department of Juvenile Justice and Delinquency Prevention is using a universal screening tool (GAINS) to assess whether youth need to be referred to mental health services.

System of Care Coordinators work with families to ensure that their children have access to appropriate services. More coordinators would increase the number of children and families that could be served and should increase number of children receiving appropriate services and supports. The public mental health system currently uses a number of evidence-based practices, but more could be implemented if there was funding for infrastructure (including supervision and monitoring fidelity) and training. Community-based services are the most cost-effective services available through the public mental health system. In one quarter in 2008, \$62 million was spent to serve 4,700 children receiving residential services while \$89 million served 31,000 children receiving community support services. The outcomes for children receiving residential services are not any better than those being served in the community, therefore shifting to serving more children in the community should allow the public mental health system to serve more children for less money while achieving similar outcomes.

#### **SUICIDE PREVENTION**

*Romaine Riddle, Director of Community Outreach and Education  
NC Mental Health Association*

Suicide is the 3<sup>rd</sup> leading cause of death for youth ages 10-24 in North Carolina. Suicide is underreported due to questions of intent and differences in the training of medical examiners and the definition of suicide. In 2004 and 2005 combined, there were 52 suicides among 10-17 year-olds in North Carolina. While females are more likely to attempt suicide, males are more likely to be successful in their attempts. Firearms are the most common means of death among males and hanging is the most common mean among females. The most common suicide circumstances among youth include depression, mental health problems, crisis in the past two weeks, and relationship problems. Risk factors for attempting suicide include mental disorders, substance abuse, a history of trauma, relationship loss, economic hardship, impulsiveness, genetics, and having a firearm in the home.

In 2004, the North Carolina Youth Suicide Prevention Task Force (YSPTF) published *Saving Tomorrows Today: The North Carolina Plan to Prevent Youth Suicide*. In the report, the (YSPTF) provided recommendations to achieve the following six goals:

- Promote awareness that suicide is a public health problem that is preventable.
- Develop and implement community-based suicide prevention programs.
- Promote efforts to reduce access to lethal means of self harm.
- Implement training for recognition of at-risk behavior and delivery of effective treatment.
- Improve access to and community linkages with mental and substance abuse services.
- Improve and expand surveillance systems.

In 2008, the YSPTF was awarded a three year Garrett Lee Smith Suicide Prevention grant. The grant is funding a communications campaign, suicide prevention training programs (ASIST

Training for Trainers and safeTALK Training for Trainers), suicide prevention training and implementation of suicide prevention curriculum in 10 schools, and an evaluation of these activities.

The YSPTF's efforts would benefit from recognition and support from the larger community. Furthermore, if the evaluation of programs funded by the Garrett Lee Smith Suicide Prevention grant shows them to be effective, funding for maintaining and expanding those activities will be needed. Additionally, North Carolina would benefit from having more than one certified crisis center in state to handle calls to the national suicide prevention hotline.

Increasing the knowledge of medical practitioners may also help reduce youth suicide. It is important for primary care physicians to be able to recognize the risk factors for suicide and trained in how to interface with patients at risk of suicide. Additionally, there is a need for more psychiatrists around the state.

#### **EFFECTIVE TREATMENT FOR ADOLESCENT MENTAL HEALTH**

*Jane Meschan Foy, MD, Professor of Pediatrics, Wake Forest University School of Medicine  
Medical Director, School Health Alliance for Forsyth County*

Although only 12% of youth ages 10-17 are diagnosed with severe emotional disturbance, an additional 16% of youth do not have a mental health diagnosis but do have significant impairment in daily functioning. Further, 9% of youth have a mental health diagnosis but no impairment. Using this data, more than 1-in-3 youth have mild to severe mental health problems. These problems may include: depression, anxiety suicide attempts, drinking and driving, alcohol consumption, physical fights, carry weapon at school, STD

There are good, evidence-based psychosocial interventions for youth with mild to severe mental health needs. Many primary care providers and others turn to psychopharmacology because of a lack of knowledge about good psychosocial interventions. However, there are interventions that can be easily learned by primary care clinicians that can improve child and parent functioning as well as help families overcome barriers to seeking additional help if needed.

While there are barriers to care for youth with mental health needs, there are evidence-based approaches to prevention, early intervention, and treatment that could be implemented in a variety of settings (primary care, schools, juvenile justice, and child welfare. Some policies that could help improve the delivery of mental health care to adolescents include:

- Establish standard of care requiring MH specialists to request consent for exchange of information with primary care clinician (PCC)
- Require DSS and juvenile justice to collect social and MH history, perform psychosocial screen, and communicate with PCC
- Support development of community protocols for treating traumatized children and managing psychiatric emergencies
- Fund “key services initiative” through LMEs

- Establish DPI standards for school personnel to follow in collecting information and behavioral scales needed by PCCs
- Expand funding for school-based MH services
- Fund trainings for school nurses, guidance counselors, and PCCs in psychosocial screening, common factors techniques, and use of community MH resources
- Establish state-wide child psychiatry consultation network for PCCs and other pediatric MH providers (such as Massachusetts model, MCPAP)
- Supplement / incentivize PCCs who co-locate a MH provider

## **NEW MODELS OF CARE: ICARE, CO-LOCATION, AND CHILD AND FAMILY SUPPORT TEAMS**

### **ICARE**

*Tracie L. Hazelett, ICARE Provider Training Specialist*

*North Carolina Academy of Family Physicians*

*and*

*Regina Dickens, EdD, LCSW, Local Model Development Coordinator*

*RSD Consulting*

ICARE is working to create a healthy system across North Carolina that is integrated, collaborative, accessible, respectful and evidence-based. The ICARE Partnership is a collaborative group of agencies dedicated to both the physical and mental health well-being of North Carolinians. The ICARE Partnership works to improve patient outcomes by

- increasing the collaboration and communication between primary care providers and providers of mental health, developmental disabilities, and substance abuse services; and
- increasing the capacity of primary care providers to provide basic mental health services and for mental health providers to refer for physical illness.

The ICARE Partnership works to improve patient outcomes by providing trainings and opportunities for practice, and working to change policies and processes to lead to more integrated services.

ICARE provides training, technical assistance, and curriculum development for primary care and mental health providers. This work includes providing educational opportunities as well as on-site technical assistance and consultations with medical practices. ICARE's work on policy and process change focuses on identifying barriers that prevent integration of services and working to implement strategies to reduce or remove those barriers.

ICARE has launched a handful of pilots across the state to test and implement various strategies. These pilots have experienced various levels of success at providing integrated care. Things that pilot sites have worked on include implementing Screening, Brief Intervention and Referral to Treatment (SBIRT), an evidence-based model, co-location of mental health providers in primary care practices and vice versa, providing training for primary care and behavioral health providers, sharing best practices and evidence-based practices, and training on billing and coding practices.

### **Child and Family Support Teams**

*Tony Troop, Child and Family Support Teams Program Coordinator  
NC Department of Health and Human Services*

The Child and Family Support Teams (CFST) is a Department of Public Instruction/Department of Health and Human Services joint initiative developed to help at-risk children avoid failure in school and out-of-home placement by coordinating services among education, health, mental health, juvenile justice and social service agencies. CFST is mandated and guided by legislation.

Child and Family Support Teams are being piloted in 21 local education agencies (LEAs) across the state. LEAs selected schools to participate. For each participating district, CFST was established at designated schools; CFST Leaders (a school nurse and a school social worker), a Care Coordinator from the LME, and a Facilitator from DSS were appointed; and a Local Advisory Committee was developed. Each school participating provides data twice a year.

CFST social workers and nurses identify the students most at risk of academic failure or of out-of-home placement due to social, legal, mental health, physical health, academic, or developmental reasons; conduct strengths-based family centered holistic assessments; and collaborate with other agencies to provide in-depth case management services to assure the needs of students are adequately met. Services are planned through Child and Family Team meetings with the CFST, including those listed above, the child, parents, service providers, and others as identified by the family. The Care Coordinator helps provide on-going case management until the case is closed.

The implementation of CFST is being evaluated as part of the legislation. The evaluation is being done by Duke University. The evaluation results are just starting to come out, but just the 1<sup>st</sup> year survey data show that principals are pleased and nurses and social workers are having more success connecting kids with services.

CFST needs the continued support of the legislature to ensure pilot implementation and evaluation. If the evaluation shows improved outcomes, the program could be expanded statewide. Additionally, social workers in schools are critical for CFST to function as intended.

### **RECOMMENDATION DISCUSSION**

A number of areas were identified that should be addressed in recommendations:

#### **General**

- Need to get away from notion that the only kids who need mental health services are those that have diagnosable condition
- Need screening, global functioning assessment tools, comprehensive mental health and monitoring progress over time.
- Need to create the community networks of services, as well as provider training to identify and refer patients.
- Need to develop continuum of care in communities.

- Availability of trained providers (psychiatrists, psychologists, etc).

#### Mental Health System

- Want to get people into the “right level of service at the right time”—so need an appropriate assessment tool
- Medicaid program that incentivizes advanced training? Advanced payment for completing competency based training?
- Formalizing and funding the peer family partners initiative in DMHDDSAS;
- Benefit design issues—as long as we pay fee for service, can’t make this model sustainable.

#### Other Public Systems

- Support continued funding of CFST (and social workers);
- Information should be shared across agencies (look at assessment tools across systems to be coordinated and cross-walked)
- Should do global functioning assessment when kid shows up in a high-risk setting (eg foster care, DJJDP, domestic violence) OR eliminate screenings and provide services directly for some high-risk adolescents.
- Evidence-based training for PTSD in MAHEC

#### Military:

- Need to educate civilian mental health providers, primary care providers, and teachers about the mental health needs of children and youth whose parents are in the military, National Guard, and reserves.

#### Tools:

- Need to look at recommendation to promote technology to bring resources into communities where can’t reach the kids (e.g., telepsychiatry, telepsychology (counseling services), online screening tools, family health tool (Surgeon General), use technology teens use to reach teens)