

**Task Force on the Mental Health, Social, and Emotional Needs of Young Children and
Their Families**

Thursday, September 22, 2011

North Carolina Institute of Medicine, Morrisville

10:00am-3:00pm

Meeting Summary

Attendees:

Task Force Members: Beth Melcher (co-chair), John Thorp (co-chair), Rosie Allen, John Ellis, Catharine Goldsmith, Jill Hinton, Judy McKay, Emma Miller, Robert Murphy, Laura Muse, Kevin Ryan, Marla Satterfield, Terri Shelton, Jean Smith, William Smith

Steering Committee Members: Melissa Johnson, Marcia Mandel, Deborah Nelson, Susan Robinson, Adele Spitz-Roth

NCIOM Staff: Thalia Fuller, Emily McClure, Sharon Schiro, Pam Silberman, Rachel Williams, Berkeley Yorkery

Other Interested Persons: Gary Ander, Alison Herndon, Rick Zechman

Welcome and Introductions

Beth Melcher, PhD, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, North Carolina Department of Health and Human Services

John Thorp, MD, Division Director and Distinguished Professor, Department of Obstetrics and Gynecology, UNC Health Care

Dr. Thorp welcomed everyone to the meeting.

Description of Mental Health Issues of Toddlers and Pre-Schoolers

*Melissa Johnson, PhD, Pediatric Psychologist,
WakeMed Health and Hospital*

Dr. Johnson gave a brief overview of common mental health diagnoses among children ages 0-5 years, including affective and relationship disorders, aggressive and oppositional disorders, and regulatory disorders. Specific diagnoses included attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and autism. Problems with diagnosing young children include the use of diagnostic systems designed for adults, a lack in understanding of mental health disorders in young children, and the interaction of psychology and development.

Dr. Johnson's presentation can be found here: [Mental Health Diagnoses for Children 0-5](#).

Selected questions and comments:

- Some children have symptoms of PTSD but have not been exposed to what we would consider trauma. However, children may consider something traumatic because they lack a way to handle the situation.
 - Experiences beyond the everyday, such as natural disasters, can trigger PTSD. For children (especially those with learning delays), events that are not routine, such as a doctor's visit, can trigger PTSD because it is seen as traumatic. Part of the problem in diagnosing children with PTSD is that sometimes the traumatic event cannot be identified.
- There are developmental stages in young children that can mimic mental health problems. Fussiness, for example, is a developmental change, especially the purple crying period. However, fussiness can also be a sign of mental health problems. It is sometimes difficult to determine what normal development is and what the symptom of a mental health problem is.
- Another issue is the way the parent handles a child's behavior. What if a child's behavior is not outside normal development and the parent cannot handle it well?
 - We don't want to label the child if the parent is the problem. We have to address the relationship between the child and parent.
- Misdiagnosis is a problem in this population. How many young children are misdiagnosed as ADHD and put on Ritalin when they have PTSD or something else?
 - There are some cases of sexually abused children on Ritalin. No one went the extra step to find out what the reason for the hyperactive behavior was; they just assumed it was ADHD.
- Practitioners that work with young children should know both the areas of mental health and neurological health in order to be able to tell the difference and correctly diagnose disorders (i.e., ADHD, a mental health disorder, versus autism, a neurological disorder).
 - Autism is a good example of the overlap in behavioral and developmental disorders.

Existing Systems and Services of Young Children and Their Families

Emily McClure and Rachel E. Williams, MPH

Research Assistants

North Carolina Institute of Medicine

Ms. McClure and Ms. Williams summarized the research they have conducted on what programs and services exist for young children with mental health problems in North Carolina. The project aims to show the range of programs and services offered in the state, show the variety of

fundings, and to provide data on the programs and services. A conceptual model was created to help categorize the programs listed in the Continuum of Services to identify gaps in evidence-based programs and services.

Their presentation can be found here: [Continuum of Services Summary](#).

[Conceptual Model Handout](#)

[Systems and Major Players Handout](#)

[Continuum of Services](#)

[Evidence-Based Programs Handout](#)

Selected questions and comments:

- Sometimes programs have over-arching program descriptions, but they do not include what treatments or services they are providing.
- It would be helpful to know what the wait lists for some of these programs look like.
- How can unmet need be measured? We might want to ask programs what they think the unmet needs are.
- The need for these programs is huge. There is a lot going on across the state, but the actual number of people being served is quite small.

Mental Health Systems for Toddlers and Pre-Schoolers

Laura E. Muse, MS, NCC, LPC, Clinical Services Coordinator, Alamance Alliance for Children and Families

Gary Ander, Project Director, Alamance County Department of Social Services

Ms. Muse and Mr. Ander gave a summary of the Alamance Alliance for Children and Families. A six-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) is funding the Alliance in order to make the current system of screening and referral for early childhood social-emotional health more efficient. The Alliance aims to improve outcomes for children and families as well as system outcomes by developing partnerships between local child serving agencies to increase coordination and reduce fragmentation, create awareness of early childhood behavioral health, and develop a sustainable infrastructure.

Their presentation can be found here: [Mental Health Systems for Toddlers and Pre-Schoolers](#).

Selected questions and comments:

- IDEA Part C has categories set by the federal government. States have flexibility to set the degree of delay and a list of conditions for eligibility, including a category for at-risk children. North Carolina did away with the at-risk category and the state has been losing appropriations since then.

- The reason the state got rid of the at-risk category is because the definition of at-risk was too broad. This Task Force could define a more narrow definition of at-risk in the recommendations to make these determinations more flexible while not opening up eligibility to everyone.
- There are a lot of ways the definitions can be expanded to make more children eligible without making it too broad as it was before. Currently, however, because fewer children are eligible, it makes it faster for children to receive services.
- Q: What kind of social marketing has the Alliance done and how has success been measured? A: Don't know how success is measured. So far we have done brochures, education, tag lines, etc., and interconnected education and social marketing.
- Q: What kind of evaluation will the Alliance have? A: The Center of Child and Family Policy at Duke University is doing the evaluation. Evaluation is done every six months with families over a course of two years.
- Q: The Alliance is only funded for six years. If family partners were to continue, where would they be funded under Medicaid? A: Not sure. We would like the partners to have their own foundation and be sustainable on their own.
 - A special waiver called the Innovation Waiver includes coverage for a set of alternative services including community guides. However, I am not sure how broad that definition is and who would qualify for that.

Discussion of Potential Recommendations

Public Comment Period

No further public comments were given.