NAVIGATING THE MAZE

An Assessment of Mental Health Resources
For Children and Adolescents
In Charlotte-Mecklenburg

"See? If we just stick together, then we'll all be safe."

ABOUT THIS REPORT

In an endeavor to impact improvements to the local systems of mental health services and support for adolescents and children, Children's Medical Fund, Foundation For The Carolinas, and Mitchell's Fund commissioned a study of the issues and opportunities. The three foundations hired an independent consultant to lead the project and produce this report. The project is a response to growing concern among early educators, physicians, service providers, parents and other community members about the state of mental healthcare for Charlotte-Mecklenburg children ages 0 to 18. The objective of this needs assessment is to shine a light on the situation in hopes of serving as a catalyst for change.

This project is an early outcome of the Charlotte-Mecklenburg Opportunity Task Force report—leadingonopportunity.org—which highlights research on early brain development and how it lays the foundation for emotional, physical, intellectual and social development. Among the task force's key recommendations are to "deepen our understanding of the childhood mental health system and develop tangible strategies to address identified needs and gaps." (Strategy R) Therefore, this report includes a description of the ecosystem of services, providers and funding sources; identifies gaps in and barriers to treatment; and provides three "big picture" strategies for improving the system. This document is a culmination of nine months of research, including 83 in-person interviews with mental health professionals, government officials, parents, and philanthropic leaders, as well as dozens of telephone and email interviews with statewide experts.

This is a "living document" designed to give readers a snapshot of children's mental healthcare as of November 2017. Unfortunately, not every organization involved in serving the behavioral health needs of our community's children could be included due to limitations of space and time. It is the sincere hope of the author and funders that the community will embrace and expand upon this project, so the next phase will be to broaden the scope by including more professionals, families and organizations willing to take bold action to affect positive change.

Mental health, also referred to as "behavioral health," is defined as the general condition of one's mental and emotional state. It is characterized by the absence of mental illness. The term also refers to healthcare services and support dealing with the promotion and improvement of mental health and the treatment of mental illness.

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Executive Summary

Hubert Humphrey's admonition that the moral test of government is how it treats its weakest members holds true for communities as well. There may be no greater test of a community's will to provide for a reasonable standard of living for all its citizens than how it handles the crisis facing our children's mental healthcare system.

Our community is not alone in this challenge. Nationally, one in five children at some point during their lives has had a mental disorder considered to be debilitating. Many others are affected by social and emotional challenges that are less severe or persistent.

Because intergenerational poverty and prevalence of mental health disorders are interlinked, much of this report revolves around Medicaid; however, behavioral health is an issue that impacts every socioeconomic group, including families with private insurance.

Experts in the mental health field say that everywhere in the nation, the system is in crisis. They use words like "fragmented" and "siloed" to describe the ecosystem, noting that lack of access and stigma are the biggest issues.

The sheer complexity of the bureaucracy, coupled with the profusion of community agencies and other healthcare organizations whose services are reimbursed by Medicaid, make navigating the system extremely difficult for families and even professionals. A host of case managers, care coordinators and non-licensed professionals supplement the work of licensed clinicians (psychiatrists, psychologists, social workers and licensed professional counselors) who provide direct mental health services to children and adolescents.

Although Medicaid is a federal entitlement for low-income people, the North Carolina General Assembly decides how the state participates in the insurance program. The state Department of Health and Human Services (DHHS) has carved North Carolina into a handful of "catchment areas" and established a system of managed care organizations (MCOs) to administer Medicaid funds.

In 2016, in Mecklenburg County...

12,616 adults used their Medicaid benefits for mental healthcare

10,294 children and adolescents ages 3 to 17 used Medicaid for mental healthcare

34% of Medicaid recipients were white

5% were Hispanic or Latino

57% were African American

Source: Cardinal Innovations

1,973,084
Number of North Carolinians who were enrolled in Medicaid as of February 2017
Source: N.C. Health News

1,054,835
Mecklenburg County's general population
Source: U.S. Census estimate, July 2016

MEDICAID BY THE NUMBERS

Managed Care Organization

Mecklenburg County's MCO is **Cardinal Innovations Healthcare**. Cardinal's service area includes 20 counties served by a private-sector workforce of 800 employees, making it the state's largest Medicaid plan. Cardinal took control of Medicaid funds for Charlotte-Mecklenburg when the state forced the county to close MeckLINK.

Before MeckLINK was the Area Mental Health Authority. In those days, the county was in the business of delivering mental health services and managing Medicaid reimbursement. The state ended counties' ability to both

deliver and manage services in an attempt to rein in costs. North Carolina is now in the era of managed care, whereby Cardinal is perceived by some providers as a mechanism for delaying and denying treatment to save the state money. However, Cardinal says it approves 98 percent of the services requested; 92 percent of the $680 million it collects annually from Medicaid is spent on providing care; and only 8 percent is used for administrative costs, including salaries and real estate.

In addition to Cardinal, some of the major stakeholders in children's mental health are:

Mecklenburg County Government

- The **Behavioral Health Division** (BHD) manages a network of 16 mental health providers (separate from Cardinal's network) and supports the other county entities involved in mental health through its clinical consulting team.
- The **Health Department**'s main programs for children's behavioral and developmental health are Child Development-Community Policing (CD-CP) and the Children's Developmental Services Agency (CDSA).
- **Youth and Family Services** (YFS), a division of the Department of Social Services (DSS), takes children into custody in cases of abuse and neglect, and works with the courts system and Cardinal to find residential placement and treatment as deemed medically necessary.
- **Community Support Services** (CSS) provides training to public-school-system staff on issues such as teen-dating violence and cultural competence.
- The **Forensic Evaluations Unit** acts as a liaison to the juvenile and family courts system and provides psychological and parenting-capacity evaluations to the courts.

The Public School System

Charlotte-Mecklenburg Schools (CMS) has the equivalent of one full-time psychologist for every 2.74 schools, as well as a total of 42 social

workers and six substance use counselors to serve 150,725 students. Assistance is available to any student through CMS Student Services, including individual, group, family and community-based support ranging from counseling and intervention plans to home visits, family assessments and training for parents.

However, the ratio of psychologists to students makes it challenging for many schools to do much more than evaluations for exceptional children. So CMS partnered with Mecklenburg County to launch a school-based mental health (SBMH) program three years ago. Available to students at 101 of 170 schools, SBMH is a program whereby six community agencies provide clinical counseling within schools that elect to utilize the service.

The Two Hospital Systems

- In June 2017, **Novant Health** began implementation of an integrative care model, which joins mental health with medical care, in its primary care offices. For children and adolescents, Novant provides inpatient, outpatient and recreational therapy, as well as partial hospitalization and emergency mental health services. And Novant is teaming with Carolinas HealthCare System (CHS) to find ways to improve medical and behavioral health services in Charlotte's lower-income, underserved neighborhoods.
- **Carolinas HealthCare System**'s mental health facility, Behavioral Health-Charlotte (BH-C), contains the only dedicated psychiatric emergency department in the region. In 2015, about 50 percent of those patients were Medicaid recipients. CHS has integrated mental health with pediatric services, placed mental health telemedicine technology in its regular emergency departments, and in July 2017 began a psychiatric residency program.

N.C. Juvenile and Family Courts System

A common pathway for children and adolescents to come into the mental health system is through juvenile or family court. Children

Mental health service
A service that is paid for by an insurance company or Medicaid to address recovery from a diagnosis of an individual.

Mental health support
The care provided that is not strictly medical but is nonetheless considered to be necessary to the recovery and treatment process (supports to maintain independent housing, education, employment, or other activities associated with community integration).

Private Insurance	Health insurance policies tend to have high annual deductibles; for mental health, there are more limitations, fewer services and higher co-payments.
Medicaid	Eligible recipients may be denied services on technical grounds or for being "noncompliant." And the denial rate for certain services is too high, or Cardinal will approve lower levels of services than recommended by the service providers. (Cardinal disputes these allegations.)
Birth to Age 5	The same array of mental health services available for children covered by Medicaid who are over the age of 5 are available to children ages 3 to 5, but few clinicians statewide provide these services in an evidence-based, developmentally appropriate manner. And the services are not available to children under age 3.
Intellectual/ Developmental Disabilities	The waiting list for individuals with intellectual or developmental disabilities (I/DD) to receive an Innovations Waiver can be several years, and the Medicaid services available while they wait for a waiver are much more limited and don't include such services as personal care.
Bureaucratic Delays	Two barriers to treatment are bureaucratic delays and time-consuming paperwork. For certain Medicaid services, pre-authorization can take 14 days.
Child Psychiatrists	The American Academy of Child and Adolescent Psychiatry says Mecklenburg County has a "severe shortage" of practicing child and adolescent psychiatrists.
Trauma-Certified Clinicians	Treating trauma effectively requires training and specialized certification; Charlotte-Mecklenburg doesn't have enough credentialed clinicians, according to experts.
Charlotte-Mecklenburg Schools	Lack of parental consent was cited as the No. 1 barrier within the school system to children receiving clinical mental health services. A second barrier is a federal statute prohibiting undocumented individuals from receiving Medicaid. A third is the stipulation that students meet with a school counselor to be referred to a licensed therapist. A final barrier is only 59 percent of public schools have a SBMH intervention program.
Latino/Hispanic Children	Hurdles to providing mental health services include cultural stigma, the lack of Spanish-speaking counselors, a shortage of trauma-trained clinicians, the challenge of overcoming stereotypes and, in some families, the fear of deportation.
Residential Placements	While Cardinal maintains that the overall inventory of residential placements is "sufficient," there is common agreement among those interviewed for this report that Charlotte-Mecklenburg doesn't have adequate supply.
Adolescent Females	In Mecklenburg County, no group homes exist for girls in need of primary substance use treatment who require round-the-clock supervision. Part of the challenge is a reluctance to treat teenage girls, who may be viewed as difficult to work with.
Therapeutic Foster Homes	Cardinal maintains that the deficiency in therapeutic foster care (TFC) is not an overall shortage of licensed beds but rather the availability of specialized treatment for youth with highly complex mental health needs. Others say the issue is a shortage of effective therapeutic foster parents, especially parents who are willing to foster teens, and lack of support from providers.
LGBTQ Youth	The national rate of suicide attempts is four times greater for lesbian, gay and bisexual youth and two times greater for questioning youth than that of heterosexual youth. Yet many interviewees said the support available to local LGBTQ youth doesn't come close to meeting the demand.

involved in the courts system have either been accused of committing a crime or have been reported as victims of abuse or neglect. The latter may be taken into custody of the county and placed in a group living facility, foster home, or permanent placement through adoption. Virtually every child involved with the courts system receives a clinical assessment. The state Department of Juvenile Justice employs 30 juvenile court counselors (JCCs) who are responsible for the supervision of adjudicated, undisciplined and delinquent juveniles to assure their compliance with court-ordered dispositions. They also make referrals to community agencies for children who require mental health services.

Community Agencies/Service Providers

More than 250 not-for-profit agencies comprise Cardinal Innovations' provider network in Charlotte-Mecklenburg. Three of the largest are **Thompson Child and Family Focus**, **Alexander Youth Network**, and **Monarch**. Generally speaking, for an agency to receive reimbursement from Medicaid for providing a mental health service, authorization from Cardinal is required. Some experts interviewed for this report say this inherent conflict between managed care and "fee for service" creates an atmosphere of distrust between Cardinal and its own network.

Private Insurance Carriers

Insurance companies' "panels" of clinicians provide services to children whose families are covered through an employer or individual plan or who receive subsidies through the Affordable Care Act (ACA). **Blue Cross and Blue Shield of North Carolina** is by far the largest private insurance carrier in the state and the only one to participate in the ACA subsidies.

What Are Some of the Systemic Issues?

Just as lack of access is believed to be the biggest issue for children who need services, lack of resources is perhaps the biggest challenge for providers. While some community agencies are set up to bill both Medicaid and private insurance, nearly all rely on donations, fundraising events and grants to operate.

One of the most significant grants in recent years was for "system of care" (SOC)—a family-centered framework for coordinating mental health and child welfare services. When the federal grant expired in 2012, the county not only lost funding, but also a trove of data on outcomes. Today, the data collected varies widely, has no central repository, and may be difficult to obtain, making it impossible for policymakers to make fact-based decisions.

Another issue is the dilemma of hard-to-place youth who come into the system via YFS, the Juvenile Detention Center, or the psychiatric emergency departments. For a variety of reasons, children get stuck in limbo because there's no appropriate placement ready at the time of discharge.

Finally, to fully understand our community's mental health crisis, one must recognize the roles of socioeconomics, intergenerational racism and trauma. Research shows disproportionate prevalence of mental health incidence among children of color; this is true in Charlotte and across the country. According to U.S. Census estimates, Mecklenburg County's population in 2016 was 58 percent white, 33 percent African American, and 13 percent Hispanic or Latino. Yet, among Medicaid beneficiaries who received a mental health service in 2016, 34 percent were white, 57 percent were black, and 5 percent were Hispanic or Latino, according to Cardinal estimates.

The reasons for this imbalance can be traced back to intergenerational racism, Charlotte's history of segregation, and the concentration of lower-opportunity communities to the west and north of the center city. Children who experience trauma or are living with scarcity may not reach the early brain-development milestones necessary to avoid developing mental health issues later in life. This leads to a higher incidence of contact with the school disciplinary, juvenile justice, child welfare and mental health systems.

We simply cannot ignore the link between poverty and poor mental health.

strategies

The full report details three strategies and 16 tactics focused on prevention, access and quality, to more effectively serve children with mental health needs.

1. *Raise awareness and increase education on the importance of prevention and early intervention, as well as the impacts of trauma on early brain development*

Establish a live-time database for crisis placements

Create more adolescent treatment beds

Develop a provider clearinghouse

Provide more trauma training

PREVENTION | **ACCESS**

Raise awareness about the importance of early brain development

Facilitate more community-wide training

Expand school-based mental health to more schools

Adopt the Child First model

2. *Increase access to mental health services and support for children and families*

v

3. *Reward best practices and encourage collaboration and communication*

Create a data warehouse

Explore alternative approaches

Increase cultural competence

Adopt a common assessment

Transition to a whole-person model

QUALITY

Eliminate duplication of management and coordination

Include mental health-care in community resource centers

Evolve to an outcome-based model

Britney, Deon and Nicolás are fictional characters whose stories are based on realistic scenarios and compilations of anecdotes told by parents and professionals working in Charlotte's mental health, juvenile courts, child welfare and public school systems. Their stories are composites created to ensure client confidentiality. Throughout this report, we'll follow their journeys from diagnosis to treatment to illustrate the unique situations and common stumbling blocks along the path from illness to (hopefully) recovery.

Britney is a 17-year-old student at one of Charlotte's suburban high schools. When she feels overwhelmed or hopeless about getting into college, Britney cuts herself with a razor blade on her upper arms or abdomen where her parents won't notice. She has written about suicide in her journal and on her Tumbler page. Britney's high school doesn't have a school-based mental health program, so her increased absences, declining grades, and disengagement from other school activities largely go unnoticed. It takes an outburst—uncontrollable crying and threats to jump in front of a car—for Britney to be referred to a mental health specialist. Treatment is covered by her family's health insurance policy, although the annual deductible is so high and the waiting list so long that Britney's parents decide to forgo selecting a counselor from their insurance carrier's panel of in-network clinicians. Instead, they choose a licensed therapist who is out-of-network and doesn't accept insurance, thinking that her treatment costs will be less than their deductible. However, the initial assessment costs several hundred dollars, and Britney's parents worry about whether they can afford ongoing therapy. They had thought one or two sessions would fix the problem.

Deon begins selling marijuana soon after his 12th birthday. He thinks if he can earn enough money by convincing some of his classmates in middle school to smoke, his mother will stop prostituting herself to support him and his younger siblings. Deon is arrested for possession with intent to distribute, a felony charge, and is sent to the Juvenile Detention Center. At his disposition, the judge orders a comprehensive clinical assessment to include a substance use assessment and a psychological evaluation. The court psychologist diagnoses Deon as having attention-deficit hyperactivity disorder (ADHD). Cardinal Innovations authorizes him to receive intensive in-home services from an agency in its provider network since he's enrolled in Medicaid. The court professionals are unaware of his mother's prostitution and therefore determine she can provide adequate safety and supervision for him.

Six-year-old Nicolás' mother is killed in a car accident a few months after she and her husband and only child came into the U.S. without documentation. Although his father doesn't know the English word for it, Nicolás has autism, a neurodevelopmental disorder characterized by impaired social interaction, verbal and nonverbal communication, and restricted and repetitive behavior. Nicolás' parents first noticed his symptoms around the time he turned 2 but didn't seek a diagnosis, although they did have access to healthcare in their home country. His father knows Nicolás needs help to function, but without insurance he has no good options. Shortly after the accident, Nicolás' father leaves him in the lobby of the Department of Social Services (DSS), hoping someone will take him in and give him the services and support he deserves.

Introduction

Hubert Humphrey once said "the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped." *This report is dedicated to children who have mental health needs in the dawn of life in the hope that they won't be destined to live in the shadows.*

Research shows people who have behavioral disorders early in life—an incidence of mental health disturbance in childhood that rises to the level of clinical attention—are prone to have mental illness follow them into adulthood. Sadly, they may never fully recover. Similarly, focusing resources on the mental wellbeing of children and adolescents, in terms of prevention and intervention, can result in fewer hospitalizations, incarceration and other costs to society within the adult population.

"The issues of mental illness, developmental disabilities, and substance abuse do not discriminate," says Mebane Rash, director of law and policy for the North Carolina Center for Public Policy Research. "They touch the lives of the rich and poor, those living in urban and rural areas, all ages and races, and both genders."

Among children and adolescents, behavioral health disorders are common and can be particularly difficult for their families and caregivers, especially when the child suffers from a seriously debilitating mental illness. One in five children at some point during their lives have had a mental disorder considered to be debilitating.[1] Others are affected by social and emotional challenges that are less severe or persistent but can still create significant problems for themselves and their families.

People who have dedicated their careers to helping people with mental health challenges generally fall into two categories: licensed clinicians providing direct services—including psychiatrists, psychologists, social workers

and licensed professional counselors—and the case coordinators and school, court and peer counselors who provide support services but are not licensed to provide clinical treatment. And people who have been diagnosed as having a mental health or behavioral health need (these terms are synonymous) tend to be categorized as having an intellectual or developmental disability, a substance abuse diagnosis, or some other mental health need.

Because poverty and the prevalence of mental health disorders tend to go hand-in-hand, much of the following discussion is about Medicaid. However, the private system of commercial insurance is not immune to some of the same systemic issues.

"Everywhere in the country, the systems are broken in one way or another," says Dr. John Santopietro, a psychiatrist and former chief clinical officer of behavioral health for Carolinas HealthCare System (CHS) who now runs a mental hospital in Connecticut. "Lack of access and stigma are the biggest issues."

In 2016, among local children and adolescents ages 3 to 18 who received Medicaid services…

9,534 were mental health patients

803 were intellectually or developmentally disabled (I/DD)

328 were for substance use diagnoses

419 received an assessment without treatment

Source: Cardinal Innovations

MEDICAID BY THE NUMBERS

An Overview of the Ecosystem

Two analogies explain the jumbled patchwork of mental health services for children and adolescents in Mecklenburg County. First is the parable of the blind men and the elephant. In the oral traditions of several Eastern religions, a group of blind men use their sense of touch to try to understand what an elephant is. Each one feels a different part of the animal. The man who explores one of the massive legs declares the elephant to be like a pillar; the one who feels the trunk says it's like a tree branch; the one who touches the tail says the elephant is like a whip. It's not until a sighted man walks by and describes the entire animal that the blind men gain a complete picture of what an elephant truly is.

Like the blind men, the hundreds of organizations in Charlotte-Mecklenburg involved in mental health have little understanding of what their counterparts are doing. Practitioners in the private sector, who accept only out-of-pocket payment or whose clients are covered by insurance, often may not know how Medicaid works—and increasingly may not be interested in serving Medicaid patients. And, according to those interviewed, many of the agencies who utilize public funding sources largely are unaware of gaps in and barriers to services for consumers who have private insurance. Even among the major players, as well as community agencies operating in the same arena, at times it seems as if they, too, wear blinders. The majority are licensed experts in their respective fields and likely do very good work within their own domains but have little connection, collaboration or communication with their peers who work for other organizations. The word most commonly used to describe the system is "silos."

The reasons cited for this fragmentation are many. First is the sheer complexity of the bureaucracy. Another is the profusion of community agencies, governmental entities and private practitioners who have their hands around only one part of the elephant. Yet another is competition: No matter whether an organization is for-profit or not-for-profit, economics drive the system. "It's more accurate to call it a *non-system* than a *system* given the fragmentation," says Dr. Santopietro.

The second analogy that explains the overall ecosystem is a typical roadside construction crew. Imagine four workers in hard hats and safety vests laboring by the side of the road. One person is chest-deep in a hole wielding a shovel. The others are standing around the hole supervising the dig. In many ways, this scene depicts the infrastructure of the mental health system. For every clinician working directly with a family by counseling a child or teen, many more non-licensed professionals are providing an ancillary resource or support—or administering to the bureaucracy of compliance.

People who've been laboring in mental health for decades describe a system organized around Medicaid eligibility guidelines and reimbursement schedules for "service definitions." If a particular service comes with a higher reimbursement rate, anecdotal evidence suggests, that service is prescribed more often than one tied to a lower rate. Some critics of the system say it's not uncommon for psychiatric assessments calling for one mental health service to be changed to another if the service prescribed isn't offered by the agency, or if Cardinal Innovations deems the service too expensive.

These practices—and the larger issue of a system driven by financial incentives—come at the expense of the very families the system was designed to serve.

> *'It's more accurate to call it a non-system than a system given the fragmentation.'*
>
> **Dr. John Santopietro**
> *formerly of Carolinas HealthCare System*

A Brief History of National Reforms

The sorry state of children's mental healthcare begs the question, *how did we get here?* Before World War II, mental illness was viewed as incurable. Patients were housed in overcrowded state mental institutions. The war sparked the realization that post-traumatic stress disorder (PTSD) is indeed curable and can be treated successfully in outpatient settings. Soon after the war ended, the National Mental Health Act of 1946 made mental health funding and reform a national priority. It also established the National Institute of Mental Health (NIMH), which today is the world's largest research organization for mental illness.

In the 1950s and 1960s, funding for mental health research and services increased dramatically. In 1963, Congress passed the Community Mental Health Act to shift emphasis from institutionalization in psychiatric hospitals to community-based care. Community- and home-based services allow individuals to remain with family and in school, and to live in the community instead of mental institutions.

The 1960s also saw new federal funding for people with intellectual and developmental disabilities; NIMH research centers were founded for schizophrenia, child and family mental health, crime and delinquency, suicide, rape, urban problems, minority-group mental health disorders, and victims of natural disasters. With an increased awareness of substance abuse as a mental health issue, national centers for the study and prevention of alcoholism and drug abuse were established.

Arguably, the most significant healthcare legislation of the Sixties was the establishment of Medicaid. Congress created the entitlement program in 1965 by adding Title XIX to the Social Security Act, which was passed 30 years earlier during the Great Depression.

In the 1970s, breakthroughs in drug research led to the now common practice of prescribing antidepressants, resulting in sharp drops in inpatient stays and suicides. Community-based care was greatly expanded in the Seventies to include ways of supporting pa-tients aside from clinical services. Components included housing, outreach and advocacy, crisis intervention, social and vocational rehabilitation, and family support and education. The community support program that NIMH initiated in 1977 placed heavy emphasis on case management: No longer was mental health the exclusive domain of licensed clinicians.

The Eighties were an era of sweeping federal budget cuts. Responsibility for mental health was delegated to the state level with passage of the Comprehensive Mental Health Service Act of 1986. In just four decades, the primary responsibility of caring for people with mental illness had shifted from the states to the federal government back to the states.

Yet the 1980s also saw scientific advances in understanding the functions of the human brain. In 1989, Congress passed a resolution designating the Nineties as the "Decade of the Brain." The emerging fields of neuroscience and neuropsychiatry held the promise of addressing clinical disorders of cognition and behavior caused by brain defects.

The Nineties were bookended by two landmark events: In 1990, Congress enacted the Americans with Disabilities Act (ADA) to prohibit discrimination against people with disabilities, including those with mental disorders and intellectual disabilities. And, in 1999, the U.S. Supreme Court ruled in Olmstead v. L.C. that people with mental disabilities have the right to live in community settings, if appropriate, rather than in institutions. The ruling paved the way for statewide reform legislation across the country.

Finally, three milestones in the first decade of the new century include a Surgeon General report in 2001 stating that the U.S. faces a public crisis in children's mental health, a NIMH report in 2002 showing that early intervention can reduce the harmful effects of exposure to violence, and a 2004 clinical trial of adolescents with severe depression that found a combination of medication and psychotherapy to be the most effective treatment.

FACTS ABOUT MEDICAID

✔ The objective of Medicaid is to provide states with matching federal funds to help people with low income obtain services deemed "medically necessary."

✔ States are not required to participate.

✔ North Carolina chose not to expand its program under the Affordable Care Act (ACA), commonly called Obamacare.

✔ Each state formulates its own program, including eligibility requirements, the scope and types of services covered, and the corresponding rate of payment.

✔ It's unclear what the future holds for Medicaid. Not only has the U.S. Congress failed to repeal and replace Obamacare, the N.C. General Assembly may dissolve the current system and replace it with capitated contracts with prepaid health plans. The new system may integrate mental health with the medical side of healthcare.

Recent Reforms in North Carolina and their Impact on Charlotte

Policy experts say North Carolina's journey along the highway to mental health reform has been a bumpy ride at best and, at worst, the state has driven the car into the ditch.[7] The Department of Health and Human Services (DHHS) and its Division of Mental Health, Developmental Disabilities and Substance Abuse Services are the state agencies that manage the delivery of medical and mental healthcare services, especially for children, low-income families, the elderly and people with disabilities. DHHS crafts policies to implement health-related bills ratified by the General Assembly.

In 2001, the state legislature passed the Mental Health System Reform Act in response to the 1999 Olmstead decision by the U.S. Supreme Court. The new law transferred responsibility for the vast majority of treatment of mental health from North Carolina's psychiatric hospitals to community-based care.[8]

"A large network of private providers was built up to increase service capacity in local communities across the state, but questions were raised about provider quality. However, the biggest problem with mental health reform in North Carolina has been the state's endless stream of changes in policy, funding levels, and leadership," according to Mebane Rash, director of law and policy for the North Carolina Center for Public Policy Research.

The 2001 law also required area mental health authorities to separate the management of mental health services from the delivery of those services. Created in the 1970s, regional authorities such as the Mecklenburg County Area Mental Health Authority had been in the business of providing direct mental health services utilizing public dollars. The new law did away with the area authorities and replaced them with local management entities (LMEs). Further, the law required the quasi-governmental LMEs to contract with private providers to deliver mental health services. Thus, the Mental Health System Reform Act was the first step towards privatization of the system.

As Rash writes in a 2012 article in *North Carolina Insight:*

In theory, North Carolina's approach was supposed to accomplish four things: to increase administrative efficiency by segregating management and oversight of mental health services from the actual provision of services; to promote innovation and utilize new technologies; to enhance provider quality; and to stimulate competition among providers. But the transition has not been easy. For consumers, the loss of a one-stop shop has been tough. ... This led to concerns that the private sector might not be sufficiently responsive to the needs of people with mental illness and that the profit motive could result in a reduction in the quality or quantity of services, particularly for those with severe and persistent mental illness.

Despite the transition to privatization, the state's Medicaid spending—the fastest growing program in the budget—continued to skyrocket. In fiscal year 2008-09, North Carolina spent $3.2 billion on Medicaid. The annual growth from 2001 to 2009 was 9.3 percent.[9] From 2008 to 2016, the state's Medicaid rolls swelled from 1.2 million to 1.9 million people, or nearly 20 percent of the population.

What about North Carolina's children? In 2008, nearly 800,000 children were covered by Medicaid or North Carolina Health Choice for Children, a state insurance program that covers children from families whose income is too high for Medicaid but can't afford private insurance. By 2015, more than 1 million chil-

Timeline of mental health reforms in N.C.	2001	2005
	General Assembly passes Mental Health System Reform Act	Piedmont Behavioral Health (now Cardinal) begins pilot program for managed care

dren were covered, for an annual growth rate of 3.7 percent. About a third of U.S. children are covered by Medicaid, but in North Carolina 41 percent are covered by Medicaid or N.C. Health Choice.[10]

Meanwhile, the federal government continued to tinker with Medicaid to allow states more flexibility in administering their programs. In 1991, the Medicaid Waiver Programs were created to give states the option to set up managed care systems in order to rein in costs. In North Carolina, DHHS devised a plan to roll out the waivers gradually, turning the LMEs into managed care organizations (MCOs) at a steady clip of one or two at a time. The initial pilot program for waivers was implemented in 2005 by Piedmont Behavioral Health (now called Cardinal Innovations Healthcare), which at the time was the LME for five rural counties in North Carolina. After several years of evaluating the pilot program, the state added two more sites. But, in 2011, the General Assembly hit the accelerator with a bill to expand the waivers statewide within two years.

Medicaid policy experts assert that North Carolina transitioned from area mental health authorities to LMEs to the LME-MCO model—which is in place today—far too quickly. And, they say, the road to managed care in Charlotte-Mecklenburg was full of potholes.

Mecklenburg County was scheduled to implement the waivers in 2011 but ran into delays. The county formed an agency called MeckLINK Behavioral Healthcare that initially employed 131 workers to oversee about $200 million in Medicaid payments to more than 500 community agencies providing mental health services to residents. MeckLINK was unique among the state's 23 LMEs in that it served only one county. North Carolina initially had 33 LMEs serving all 100 counties, but the General Assembly was intent on consolidating them. In a state where the norm was for an LME to manage multiple counties, MeckLINK stuck out like a sore thumb.

In late 2012, then County Manager Harry Jones announced to the County Commissioners that the state had pulled MeckLINK's contract over negative reports that it wasn't adequately prepared to implement managed care. The County Commission threatened to sue the state and won an extension to allow MeckLINK to continue to ramp up to become Mecklenburg's LME-MCO. In March 2013, MeckLINK began operations.

Then, three months later, the state voted to strip the county of control over Medicaid. The county was given the choice to join one of two LME-MCOs whose footprints were contiguous to Mecklenburg. By November, the commissioners had worked out an agreement with Cardinal to serve as the county's LME-MCO.

By this time, the county had poured at least $8 million into MeckLINK, which had grown to more than 200 employees. The agency had more debt than assets. When Cardinal took over on April 1, 2014, about 100 MeckLINK employees were hired by Cardinal, 55 were reassigned or retired, and about 40 lost their jobs. Four former MeckLINK employees were assigned the job of shutting down the agency and forming a new county department, the Behavioral Health Division (BHD), under the Consolidated Health and Human Services Agency.

The closing of MeckLINK and the rise of Cardinal represented the final step in what is now a fully privatized system of mental health.

> *'...the biggest problem with mental health reform has been the state's endless stream of changes in policy, funding levels and leadership.'*
> *Mebane Rash*
> *N.C. Center for Public Policy Research*

2011	2012	2013	2014
General Assembly passes bill to expand managed care statewide within two years	North Carolina pulls MeckLINK's contract; county commissioners threaten a lawsuit	MeckLINK begins operations as county's managed care organization	Cardinal becomes managed care organization for Mecklenburg County

An Overview of Key Stakeholders

While hundreds of public, private, not-for-profit and for-profit organizations constitute the ecosystem of mental health services and support for local children, a handful of key stakeholders form the backbone of the system. Some of them include:
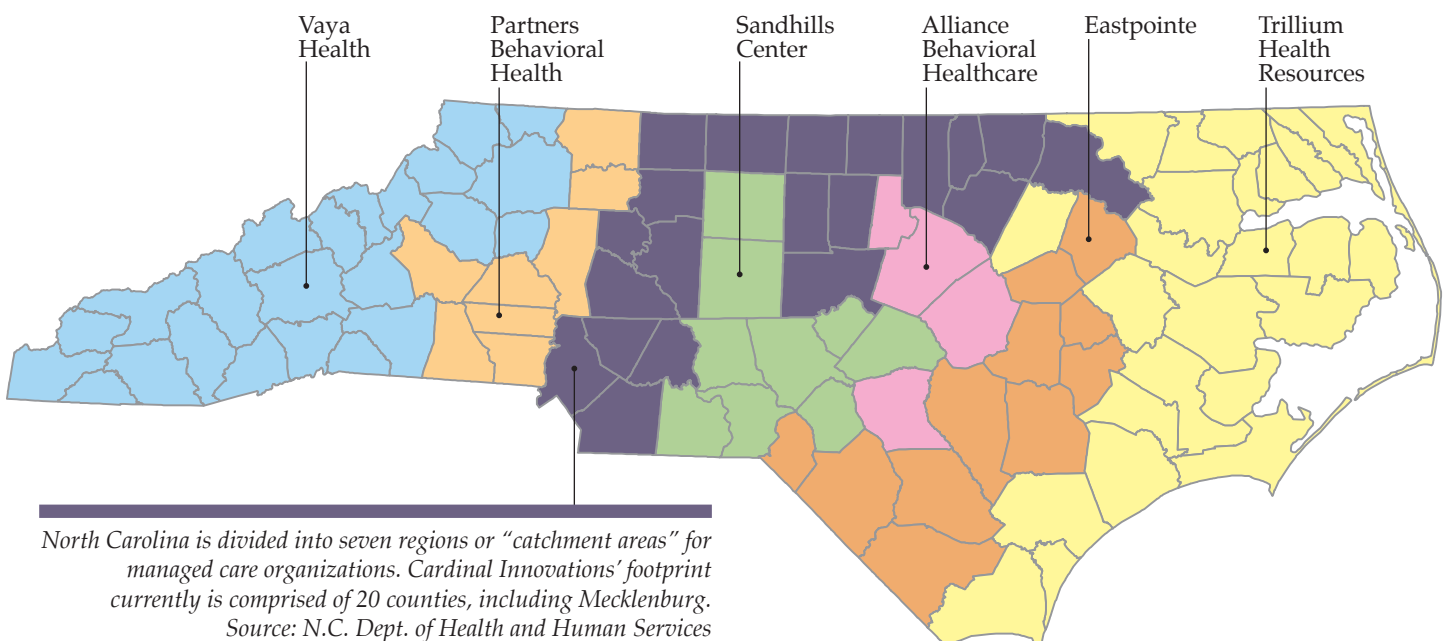
Cardinal Innovations Healthcare

Cardinal is the LME for IPRS, a state program for indigent people who don't qualify for Medicaid, and the MCO for administering Medicaid reimbursement for mental health services. Cardinal's "catchment area," or footprint, includes Mecklenburg and 19 other counties.[11]

Cardinal evolved from an area authority providing behavioral health services to residents of three rural counties of North Carolina in the mid-1970s. When it expanded into Mecklenburg in April 2014, its territory had grown to 15 counties. With the addition of Mecklenburg as the sixteenth county, its catchment area increased by nearly 75 percent.[12] Cardinal has continued to expand at a rapid pace. In July 2016, Cardinal absorbed the four counties that had constituted the CenterPoint Human Services catchment. Today the company manages benefits for about 850,000 Medicaid enrollees, who are served by Cardinal's private-sector workforce of 800 employees.

North Carolina currently has seven LME-MCOs, but DHHS has proposed an overhaul of managed care that would integrate medical and behavioral health into a "whole person" system. The new system, which would require legislative approval, would utilize capitated contracts with prepaid health plans. Medicaid members would choose between three commercial plans or from one of a dozen "provider-led entities."[13] While the long-term impact on the existing LME-MCOs is uncertain, experts say their role would be greatly reduced.

Meanwhile, Cardinal has moved its corporate offices from Kannapolis to leased space in the NASCAR Hall of Fame in uptown Charlotte, put its real estate holdings on the market, and transitioned much of its workforce

North Carolina is divided into seven regions or "catchment areas" for managed care organizations. Cardinal Innovations' footprint currently is comprised of 20 counties, including Mecklenburg. Source: N.C. Dept. of Health and Human Services

to a "mobile-based" model with employees working from home or on-site—all part of a corporate-wide effort to become more scalable and flexible.

In Charlotte-Mecklenburg, Cardinal contracts with 262 agencies or "service providers"—collectively referred to as the "provider network"—which represent the front lines of mental health treatment.[14]

"We consider ourselves as a specialty health plan," says Laurie Whitson, senior community executive for Cardinal's Mecklenburg Community Office. But for the clinicians who work directly with Medicaid patients, Cardinal has the final say in whether or not a particular mental health service is medically necessary. That means if Cardinal says "no," the service provider won't be reimbursed. And if there's no reimbursement, there's no treatment.

But Cardinal says it approves 98 percent of the services requested; 92 percent of the $680 million it collects annually from Medicaid is spent on providing care; and only 8 percent is used for administration costs, including salaries and real estate, even though federal rules allow up to 15 percent.[15]

Thompson Child and Family Focus
One of the largest agencies in Cardinal's provider network, Thompson Child and Family Focus was founded as an orphanage in 1886. Today it operates a family services center and a child development center, both in Charlotte; early childhood outreach programs in Mecklenburg, Cabarrus and Union counties; a psychiatric residential treatment facility (PRTF) in Matthews for children ages 5 to 13; and a community counseling center in Fort Mill, S.C. In the fiscal year 2015-16, Thompson impacted more than 12,000 individuals in the Carolinas.

Alexander Youth Network
Serving approximately 8,800 children a year in more than a dozen programs, Alexander Youth Network is also one of the largest service providers in Charlotte-Mecklenburg. Its focus is North Carolina children ages 5 to 18, providing them with outpatient, residential and community-based services. The not-for-profit organization was founded in 1888 as a women and children's rescue mission. In 1946, the agency began serving children with emotional and behavioral problems.

Monarch
Another of Charlotte's largest service providers, Monarch provides support statewide to 31,340 people, including 4,061 children. The not-for-profit agency began in 1958 with a focus on helping people with intellectual and developmental disabilities. Today it also serves individuals with mental illness and substance use disorder. Monarch has service locations in 45 counties across North Carolina and operates The Arc of Stanly County, which is a chapter of The Arc of North Carolina and The Arc of the United States.

Blue Cross and Blue Shield
By far the largest health insurance carrier in the state is Blue Cross and Blue Shield of North Carolina. In a 2016 ranking of top carriers by the number of policies written in the state, Blue Cross was nearly seven times larger than its closest competitors, UnitedHealthcare and Humana.[16]

Children who aren't eligible for Medicaid or N.C. Health Choice may be covered under their parents' health insurance policies or may not have any insurance. The state Department of Insurance regulates insurance companies and their agents and policies. The authority to regulate private insurance is delegated to the Commissioner of Insurance by the General Assembly. Prior to Obamacare, private health insurance policies didn't necessarily include coverage for behavioral health. Under Obamacare, a health insurance plan is required to cover at least some of the costs for mental health and substance abuse services.[17]

'We consider ourselves as a specialty health plan.'
Laurie Whitson
Cardinal Innovations Healthcare

**Assistant County Manager
Financial Services**

Financial Services Department
- *Central Finance*
- *Department of Financial Services*
- *Procurement*

Office of the Tax Collector

Information Technology

Risk Management

Mecklenburg County's Consolidated Health and Human Services Agency provides essential services designed to protect and enhance the health and well-being of its residents. Highlighted on the organizational chart, four of the five county entities involved in children's mental health are housed here; the fifth is part of Criminal Justice Services.

**Assistant County Manager
Health & Human Services**

**Consolidated Health &
Human Services Agency**
- *Behavioral Health Division*
- *Child Support Enforcement*
- *Community Support Services*
- *Health Department*
- *Department of Social Services*

**Deputy County Manager
Chief of Staff**

County Administration
- *County Manager's Office*
- *Business Process Management*
- *Project Management*

**Asset & Facility
Management**

Human Resources

Public Information

**Public Safety &
Criminal Justice**
- *Criminal Justice Services*
- *Medical Examiner*

Mecklenburg County Government

Although Mecklenburg County no longer is in the business of providing clinical mental health services to its residents, five separate governmental departments and divisions provide management, consultation and training in the behavioral health arena. This represents a sea change in the way mental health services are provided.

Four of the county governmental entities fall under the umbrella of the Consolidated Health and Human Services Agency. (A fifth county entity, the Forensic Evaluations Unit, is discussed under N.C. Juvenile and Family Courts System, on page 12.) They are:

ᵛ The **Behavioral Health Division** rose from the ashes of MeckLINK, which in turn evolved from the Mecklenburg County Area Mental Health Authority. BHD manages a network of 16 behavioral health providers (separate from Cardinal's network). BHD has five employees tasked with oversight of the providers' contracts with the county. Through this network of providers, BHD minimizes some of the gaps in services and support because county-funded programs and initiatives aren't subject to Medicaid guidelines. In addition, BHD supports the other county entities involved in mental health through its clinical consulting

team, which includes two psychologists and two clinicians. Another BHD staffer serves as project manager of Reid Park Initiative, which is discussed on pages 30-31.

ᵛ The **Health Department** is a key stakeholder in mental health through its Trauma and Justice Partnerships division. Although Crisis Intervention Teams, Carolina Alcohol and Drug Resources, and Officer Wellness and Resilience also are part of the division, the Child Development-Community Policing (CD-CP) program is the partnership in which children's mental health is the focus.

The CD-CP collaboration began in 1996 to increase officer awareness and identification of children at risk. Another goal was to increase clinical assessment of and intervention with children at risk. The program provides counseling to children ages 0 to 18 who are victims of violent crime or who have witnessed violent crime. On-call clinicians work in tandem with specially trained police officers to provide acute trauma services to children and their families. Police-clinician teams make multiple follow-up visits with families in their homes to provide additional support following an incident report. Roughly 10 percent of those cases are referred to outside service providers. During the 20 years that the program has been

**Assistant County Manager
Sustainable Communities**

**Land Use & Environmental
Services Agency**
- *Air Quality*
- *Code Enforcement*
- *Solid Waste & Recycling*
- *Water & Land Resources*
- *GIS*

Park & Recreation	**Legal**
Economic Development	**Budget Office**
Strategic Planning & Evaluation	**Internal Audit Department**
Workforce Development & Literacy	**Office of the Tax Assessor**

in place in Charlotte, nearly 40,000 cases have been referred to CD-CP, and more than 1,500 officers have been trained. In 2016, 7,658 children from 4,460 families were served. Eighty-eight percent of those cases also were referred to Child Protective Services (CPS) for suspicion of abuse or neglect. Forty percent of children referred last year were under the age of 6, and 39 percent of incidents involved intimate partner violence.

The local office of the statewide Children's Developmental Services Agency (CDSA) became part of the Health Department in 2015. CDSA is discussed on pages 19-20.

⌄ A division of DSS, **Youth and Family Services** (YFS) works with families whose children's health, welfare and safety are at risk. YFS receives mandatory reports of child abuse and neglect from the medical community, law enforcement, the school system, a relative or neighbor, or anyone within the community. YFS conducts family assessments and investigates these reports through CPS. When family interventions fail to reduce the risk to children, they may be taken into legal custody by judicial order.

As of Sept. 1, a total of 565 Mecklenburg County children were in custody of the county. YFS is their legal guardian and must ensure all

their needs are met, including mental health. If the child's mental health assessment determines a residential therapeutic service is medically necessary, YFS is responsible for finding a "therapeutic placement." Being placed in the county's custody automatically qualifies a child to receive Medicaid, so Cardinal must authorize the treatment of children whose families are no longer legally responsible for them.

YFS also works with children who are legally cleared for adoption to find permanent homes for them. In 2016, YFS found permanent homes for 60 children, a 20 percent increase from 2015.

⌄ While its primary emphases are homelessness, veterans, substance abuse, domestic violence and the prevention of violence, **Community Support Services** (CSS) also should be noted here. CSS provides training to Charlotte-Mecklenburg School (CMS) employees about teen violence to support lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. Through a community partnership with Time Out Youth, CMS teachers also receive training on cultural competence with LGBTQ youth. As part of the partnership, which is funded through a federal Department of Justice grant, Time Out Youth handles case management for teen dating violence targeting LGBTQ youth.

Another CSS initiative, the Healthy Relationships "Start Talking" curriculum, teaches teens and preteens about dating abuse and conflict resolution. And CSS provides direct mental health services for eligible children who have witnessed violence or who are victims of intimate partner abuse. For the transition-age group of 18 to 24, CSS provides victim counseling and substance abuse treatment for people who are in jail or homeless shelters.

As a non-state-mandated agency, CSS has more flexibility than those governed by the state; and although CSS contracts with Cardinal to provide mental health services for substance abuse counseling for adults, it does not bill Medicaid for the children it serves.

Novant Health

Headquartered in Winston-Salem, Novant Health is a not-for-profit healthcare system serving 4.4 million patients annually in Georgia, Virginia and the Carolinas. Novant was formed in 1997 when Presbyterian Health Services, in Charlotte, merged with Carolina Medicorp, in Winston-Salem. Novant operates two hospitals and three medical centers in Mecklenburg County, including Hemby Children's Hospital, which is located inside Presbyterian Medical Center. A fourth medical center is under construction in Mint Hill.

In June 2017, Novant began to implement an integrative care model, which joins mental health with medical care by screening patients for depression and other behavioral health concerns. A licensed clinical social worker is immediately available if a physician determines during a medical exam that a patient needs mental health services. A psychiatrist assigned to the primary care office consults with patients by telephone to make integrative care available throughout Mecklenburg County.

For local children and adolescents specifically, Novant's mental health services include:

✔ **Inpatient therapy**- Presbyterian Medical Center has a behavioral health center which includes 20 beds for patients ages 7 to 18. Staffed by one psychiatrist, one recreational therapist, one social worker and two nurses, 286 children received inpatient treatment in 2016. Nearly half (47.9 percent) were Medicaid recipients. "All inpatient team members are trained on trauma-informed care," said Judy Moore, director of Behavioral Health Services, Novant Health Presbyterian Medical Center. The inpatient unit also provides patients with a school teacher to keep them from falling behind on schoolwork and help them cope with stressors related to school.

✔ **Partial hospitalization**- Patients ages 13 to 18 receive treatment from two therapists at Presbyterian weekdays from 9 a.m. to 2 p.m. The therapists' combined caseload ranges from 10 to 12 teenagers at any given time; 97 pa-

tients were treated last year. The partial hospitalization program began in 2014 and currently has a waiting list.

✔ **Outpatient therapy**- Novant has three specialty clinics for mental health. Of the 1,637 children who received outpatient mental health services last year, 552 were on Medicaid and 78 were covered by N.C. Health Choice.

✔ **Emergency services**- Two staff psychiatrists in the pediatric emergency department at Presbyterian evaluate patients ages 0 to 18 and make referrals for mental health treatment. In 2016, the department saw 908 patients; 435 were on Medicaid. The emergency departments in Matthews and Huntersville are served by licensed clinical social workers; physician assistants and nurse practitioners trained in mental health provide services to community hospitals via telepsychiatry.

✔ **Recreational therapy**- Novant provides a gym staffed by a recreational therapist for children who are receiving inpatient mental health services.

In addition, Novant's Women's Center screens all new mothers for postpartum depression. If they screen positive, they're evaluated by a specialist who can treat their depression if needed. "Studies show women who suffer from postpartum depression have a harder time bonding with their infant, so early treatment is critical," Moore said. "We also get referrals from our pediatricians and OB/GYNs when they recognize these symptoms during follow-up care." And Novant is teaming with CHS to evaluate "resource deserts"—particularly in the zip code 28208—to find ways to improve services in neighborhoods that have few clinics and a disproportionately high incidence of medic calls to 911.[18]

Carolinas HealthCare System

CHS is one of the leading healthcare organizations in the Southeast and one of the most comprehensive public, not-for-profit systems in the nation. The 234-bed Levine Children's Hospital was recently named a Best Children's

Hospital in four specialties by *U.S. News & World Report.*

To a large extent, the responsibility for treating children with urgent behavioral health needs often falls to CHS, in particular the emergency departments of its eight hospitals and six freestanding emergency clinics in Mecklenburg County.

CHS highlighted five mental health initiatives the hospital system has implemented:

- Integrating mental health services with primary care, including pediatric services, which minimizes stigma and eliminates barriers to treatment;
- Opening a new, state-of-the-art facility in Davidson serving adults with mood disorders and co-occurring substance use disorders;
- Training 9,000 community members, including teachers, athletic trainers, emergency medical technicians, clergy and firefighters in Mental Health First Aid in conjunction with Novant Health;
- Using "virtual mental health" teams to reach out to 25 emergency departments, by using telemedicine technology to speak to patients about mental health and medication issues; and
- Extending the physician residency programs to include psychiatry.

CHS's 66-bed behavioral health hospital, Behavioral Health-Charlotte (BH-C), houses the only dedicated psychiatric emergency department in the region. In 2015, BH-C's emergency department served a total of 11,863 patients (adults and children); about 50 percent were Medicaid recipients. BH-C's mental health services include an inpatient psychiatric unit, outpatient medication management, substance abuse counseling, telepsychiatry, facility-based crisis programs and school-based mental health (SBMH).

For years, CHS benefited from a relationship with the county in which Area Mental Health reimbursed the hospital system for any financial losses from providing mental health treatment to residents. That relationship ended in 2013 with the termination of the $40-million, "no-cost" contract.[19] Whether the end of the contract resulted in a decrease in services is open to question.

Charlotte-Mecklenburg Schools

The public school system in Mecklenburg County is the 17th largest system in the nation by some estimates. CMS is comprised of 170 schools with 9,253 certified teachers serving 150,725 students enrolled in kindergarten through 12th grade. A host of professionals assist teachers and principals to address students' behavioral problems. They include behavior management technicians, social workers, school counselors and school resource officers, who are police officers employed by the school system or municipal police departments. CMS has the equivalent of 62 full-time school psychologists, a ratio of one psychologist for every 2.74 schools.

A distinction is made about the work school counselors, social workers and psychologists do as compared with the clinical services provided by licensed therapists. The counselors, social workers and psychologists who work for CMS technically do not provide mental health treatment; instead, they provide educational counseling and behavior and crisis interventions. Their focus is on factors that directly affect children in the school environment. Often this means teaching coping strategies and behavioral intervention rather than an emphasis on the underlying causes. While most high schools have multiple counselors, their work is primarily concerned with absenteeism, academic performance, credit accrual, and getting into college.

Recognizing the need for clinical counseling in the school setting, CMS implemented an SBMH intervention program beginning with the 2014-2015 school year. SBMH is a collaboration between CMS, Mecklenburg County, CHS and five community agencies.[20] The agencies—**Cano Family Services**, **Family First Community Services**, **Pride in North**

Carolina, **Thompson Child and Family Focus** and **Turning Point Family Services**—are part of Cardinal's provider network. The agencies also accept Blue Cross and Blue Shield and most accept other insurance as well. Now in its third year, SBMH is available in 59 percent of public schools. Students who participate in the intervention program showed positive trends for attendance, academics and behavior.

N.C. Juvenile and Family Courts System

A common pathway for children and adolescents to come into the mental health system is through the Department of Juvenile Justice section of the N.C. Department of Public Safety, Division of Adult Correction and Juvenile Justice. Children involved in the courts system have either been accused of committing a crime or have been reported as victims of abuse or neglect. Virtually every child involved with the courts system receives a clinical assessment from a licensed clinician.

The department also employs 30 juvenile court counselors (JCCs) to serve as mentors, advocates, case managers, and probation and compliance officers. During the intake process, the JCCs evaluate petitions and complaints against juveniles and determine whether to close the cases, initiate court action or divert juveniles to community programs.

They also are responsible for the supervision of adjudicated, undisciplined and delinquent juveniles to assure their compliance with court-ordered dispositions. JCCs don't provide direct mental health services, but rather make referrals to outside agencies. If the child receives Medicaid, the agency responsible for treatment is part of Cardinal's provider network.

Although the court system is a function of state government, Mecklenburg County plays a support role. The county's Forensic Evaluations Unit has two full-time psychologists who provide evaluations to the courts, and a liaison who adds another layer of accountability for
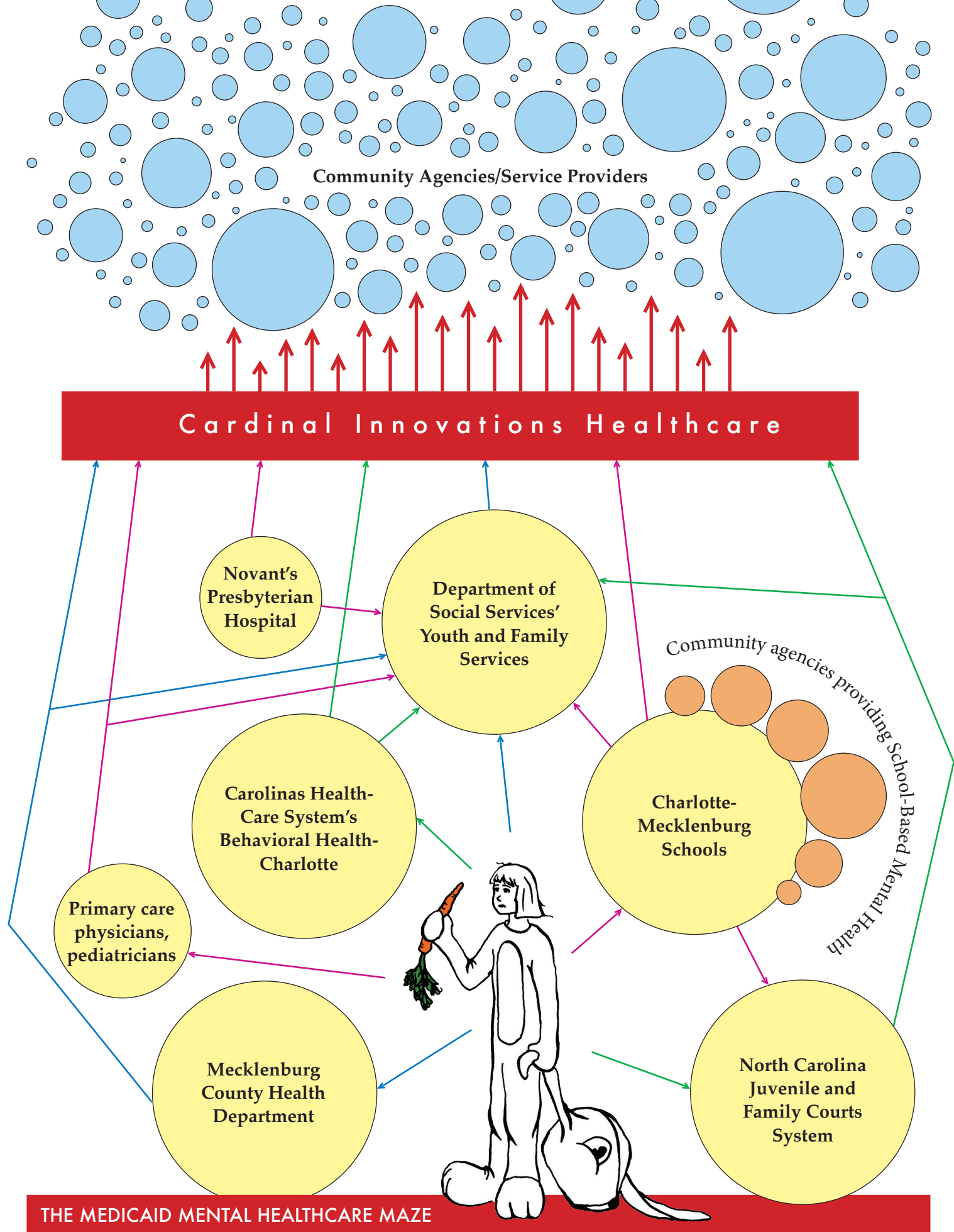
professionals and service providers involved in child and family matters. The unit also contracts with other local psychologists to complete specialized court-ordered evaluations.

In 2012, the Charlotte Mecklenburg Police Department arrested 5,717 children aged 15 or younger; 23 were incarcerated in a Youth Development Center. Under very strict circumstances, children who are accused of a crime and are waiting for their cases to be heard in court, or who've been adjudicated and are waiting to be sentenced, are detained in the Juvenile Detention Center. At the time of this writing, 13 children ages 12 and up were being detained. While in detention, juveniles don't receive mental health services because Medicaid rules prevent them from receiving services during the time of incarceration.

For children who have been reported as victims of abuse or neglect, their interests are represented by the attorney for YFS, which is mandated by law to protect children while attempting to preserve the family unit. Its role is to prevent further harm from intentional physical or mental injury, sexual abuse, exploitation or neglect. Child victims also are appointed guardians *ad litem* (GALs) whose role is to advocate for them in the courtroom.

The following types of cases are heard in juvenile or family court:

⌄ **Juvenile cases**, including abuse and neglect, dependency, termination of parental rights, delinquency, undisciplined, contempt, violations and emancipation;

⌄ **Mental health**, including voluntary admission and involuntary commitment;

⌄ **Domestic relations**, including child support, child custody, visitation, post-separation support, alimony, domestic violence, modification and contempt, divorce from bed and board, paternity, equitable distribution, uncontested and contested divorce; and

⌄ **Domestic violence**, including criminal and civil, child support, custody, visitation, spousal support and child sexual abuse.

Community Agencies/Service Providers

Cardinal Innovations Healthcare

Novant's Presbyterian Hospital

Department of Social Services' Youth and Family Services

Carolinas Health-Care System's Behavioral Health-Charlotte

Charlotte-Mecklenburg Schools

Community agencies providing School-Based Mental Health

Primary care physicians, pediatricians

Mecklenburg County Health Department

North Carolina Juvenile and Family Courts System

THE MEDICAID MENTAL HEALTHCARE MAZE

Medicaid recipients may also contact Cardinal directly by calling the 24-hour access/crisis line at (800) 939-5911 to receive a referral or assessment.

Funding Sources, Revenue Models

Nonprofit and for-profit organizations in the business of mental health generate revenue in a variety of ways; however, they may be broadly divided into public and private. Agencies that receive public funding rely on reimbursement from Medicaid and grants from federal, state and county government. Not-for-profit agencies also sustain themselves in part through donations, fundraising, and grants from private foundations.

In the private sector, mental healthcare professionals are credentialed by commercial health insurance companies and join the carriers' provider panels. Insurance companies set their own reimbursement rates, so private practices may choose to be part of some panels but not others. Increasingly, private providers are choosing to forgo the bureaucracy of insurance reimbursement by opting out of accepting insurance altogether. Their business models are based on serving clients who can afford to pay out of pocket.

For the community agencies that bill Medicaid, their business models must change annually to adapt to revisions to service definitions and reimbursement schedules. "You can't develop a strategic plan for more than a year at a time because the expectations change all the time," said Dr. Dawn O'Malley, a psychologist who has worked in the North Carolina public mental health sector for 20 years. And, since some service definitions are highly profitable while others are provided at a loss to the agency, the elimination of a Medicaid service or a reduction in pay means other services may face the chopping block, too. It may even spell the shuttering of an agency if its business model isn't diversified. For example, intensive in-home service is a money generator because it's an "enhanced service" and therefore has a higher reimbursement rate, so it subsidizes less-profitable services.

Staying afloat in a constantly changing funding climate is an exercise in creativity for providers. For example, Teen Health Connection shares infrastructure costs with CHS and receives community grants from the county, an Alcoholic Beverage Control grant from the state, direct donations from individuals, and funding from United Way of Central Carolinas. The outpatient medical and mental health clinic also holds annual fundraising events like "Stand Up and Get Down for Teens," which includes sponsorships and a silent action.

Although the agencies and institutions involved in children's mental health don't share a common business model, they do share the collective quandary of insufficient resources. The struggle to do more with less may be most evident in our public school system. Recognizing the need for more funds for mental health in public schools, the General Assembly is preparing a bill that would direct the Department of Public Instruction to study the issue and make recommendations. In April, the bill was passed by the house, and it also passed the first reading by the senate before apparently stalling out in committee.[21]
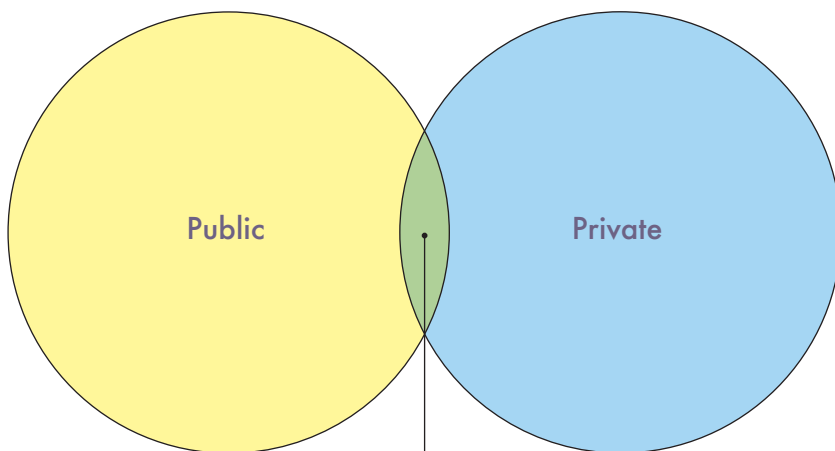
A minority of service providers accept both public and private funding. For example, they may be part of Cardinal's provider network for clients who have Medicaid, and Blue Cross and Blue Shield's panel to serve clients with private insurance. But the majority choose one business model or the other since having the ability to bill either system creates more overhead.

System of Care

The importance of grants in a system that lacks adequate resources can't be overstated. Grants plug some of the gaps left by the two primary funding sources—Medicaid and private insurance. So what happens when a grant goes away? As was the case with the system of care (SOC) grant that expired in 2012, "I would argue that we have no mental health system anymore," says Dr. Jim Cook, a psychology professor at the University of North Carolina-Charlotte.

Dr. Cook doesn't mean to imply that people no longer are receiving mental health services. His point is that Charlotte doesn't have a cohesive system of coordinated care that is family-centered. "And there are almost no efforts made to assess the degree to which services are implemented in a way that would likely lead to positive outcomes," Dr. Cook adds.

A nationally recognized expert in SOC, Dr. Cook wrote the SOC grant proposal for Mecklenburg County and served as its lead evaluator when the program was implemented. He's been involved in statewide SOC initiatives since 1997 and for 15 years has served as part of a national team of site visitors who evaluate SOC programs around the country.

To put Dr. Cook's rather gloomy evaluation of the state of children's mental health in Charlotte-Mecklenburg into context, some background is helpful. The federal SOC grant, which the county received directly from the Substance Abuse and Mental Health Services Administration (SAMHSA) from 2005 to 2012, was intended to transform the system. MeckCARES was the name given to the SOC program locally. MeckCARES provides training throughout the mental health community as a best practice approach to serving children and their families.[22]

At the heart of the SOC philosophy is a "family-centered" methodology, as opposed to "person-centered" modalities that may work well for adults but don't necessarily apply to children and adolescents. SOC recognizes that young people function within their families, schools, neighborhoods and peer groups; they're not "little adults." A pediatric mental healthcare system built on a holistic modus operandi considers mental health not in isolation but as part of a network of human services which provides a safety net for children and their families.

Research demonstrates that SOC is especially effective for youth who are at risk for committing crimes, using drugs or alcohol, getting pregnant, or being expelled from or dropping out of school. It recognizes the importance of a healthy home environment and gives parents the tools they need to work collaboratively with service providers.

Consider our fictional character Deon's home life: If his mom continues to work as a prostitute, with strangers coming and going at all hours… if he and his siblings are continually exposed to drug and alcohol abuse… if they're worried about their safety, about having enough food, about becoming homeless again… would an hour or two of counseling each week really do Deon much good? As one interviewee put it, "You can't polish an apple, put it back in the basket, and expect it not to rot when the rest of the basket is bruised."

Conversely, if the human services professionals charged with Deon's safety, housing, transportation, academic performance, mental health and so on were to collaborate as a Child and Family Team (CFT),[23] statistically speaking he would stand a much better chance of surviving his childhood and succeeding as an adult. CFTs are supposed to meet regularly with children and families to develop goals and plan for services—but, according to Dr. Cook, local CFTs often didn't do much planning and weren't much different from a case manager working with the parent and child.

Another big part of SOC is to help parents understand the complex system of human services available to them. A common theme expressed in interviews for this assessment is, if clinicians and case managers have a hard

System of care
A spectrum of effective, community-based services and supports for children and youth with, or at risk for mental or other challenges, and their families. SOC is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs to help them function better at home, in school, in the community and throughout life.

BRITNEY, DEON AND NICOLÁS*: THEIR STORIES CONTINUE

Britney sits in the waiting room of her therapist's office. Her face is flushed. She feels anxious. She's been working with this therapist for three months and feels shame and guilt that her parents are spending so much money on her treatment. Although her parents don't discuss finances in front of her, she worries that they'll have to dip into her college fund. Most of all, she's afraid the therapist will discover that last week she cut herself again. Even though it's unethical to discontinue services if a child is still harming herself, her therapist has said if Britney continues cutting she won't be allowed to continue therapy with her.

Deon is back in the Juvenile Detention Center, this time for a violent outburst at school. A second court-ordered evaluation recommends multisystemic therapy (MST). That means the intensive in-home treatment is terminated, and a new agency and team of professionals enter Deon's life, forcing him to undergo another circumstance where his life is on display. He has to tell his story again and trust another group of adults, while being careful not to reveal his mother's prostitution. The court counselor assigned to Deon warns his mom if he continues his disruptive behavior, CPS could hold a hearing to remove him from his home and place him in foster care—or even a locked facility. His mother pleads, "But Deon is only 12."

When DSS workers discover Nicolás wandering alone through their lobby, he's unable to communicate. He has nothing but the clothes he's wearing and no identification. He has a note stuffed in a pocket of his jeans saying his mom has passed away, he has no family in his home country who can care for him, and his dad must find work to survive. Written at the bottom of the crumpled note is a simply worded plea: "Please take care of little Nicolás. Thank you and god bless." Nicolás is placed temporarily in a foster home as a complicated legal process begins in juvenile court. Although he's no longer considered undocumented, he remains in the U.S. without permanent residency status, so no federal or state funds are available to pay for his foster care.

*Britney, Deon and Nicolás are fictional characters.

time steering families through the bureaucracy of mental health services, how are parents to navigate the maze?

Unfortunately, when the SOC grant from SAMHSA ended—about $9 million over seven years for training programs, child evaluations, counseling and case management for families, and MeckCARES salaries—the services provided through MeckCARES ended, too.[24] Without adequate Medicaid funding to pay for SOC services on an ongoing basis, the financial incentive to continue to utilize the model evaporated.

That's not to say the SOC philosophy isn't being incorporated into children's mental health services to this day, or that Medicaid offers no reimbursement for some SOC-based services. MeckCARES' ghost lives on in programs ranging from Reid Park Initiative, to the Thompson Wraparound program funded by a SAMHSA expansion grant, to CFTs in the juvenile justice system, to MeckCARES SOC Community Collaborative volunteers who continue to offer training.

But when the new, reduced SAMHSA funding began flowing into North Carolina counties again, it flowed through Raleigh first. With a state government intent on saving money, SOC became more of a buzzword than a way of doing business. Governments pick their priorities by choosing which programs to fund: Cardinal has one SOC coordinator for all of Mecklenburg County, and some of the other counties in its catchment area share a single SOC coordinator.

What the community lost when the SOC grant expired wasn't just money. It lost a trove of data on outcomes collected by the university. Dr. Cook and his colleagues lost a clearing house for obtaining information in order to analyze which approaches are working and which are a waste of taxpayers' money. In effect, Charlotte-Mecklenburg lost the ability to determine quantitatively whether children are getting healthier or getting worse.

Substance Use Disorder

Young people who are adversely affected by drugs and alcohol can be broadly divided into two camps: children growing up in households where abuse is present and adolescents who are substance users themselves. More than 7 million children in the U.S. live in a household where at least one parent is dependent on or has abused alcohol.[25]

In Mecklenburg County, between half and three-quarters of individuals under the age of 21 who were arrested between 2003 and 2011 tested positive for some type of drug other than alcohol.[26]

News media coverage of the dramatic escalation of overdose deaths since 2010 has brought increased attention to the national opioid epidemic. Overdose deaths are now the leading cause of accidental death in the U.S.[27] Between 2005 and 2015, North Carolina experienced a 73 percent spike in opioid-related deaths.[28]

Charlotte is not immune to the epidemic. In 2016, police arrested 368 people for heroin possession, including a 16-year-old. Last year, 203 nonfatal overdoses resulted from heroin use, up from 108 in 2015. Fatal overdoses declined in 2016, with 24 last year and 38 the previous year, including a 14-year-old.

Young people ages 20 to 29 comprised the largest group of fatal overdoses from heroin, with 12 deaths in 2014, 11 in 2015 and eight in 2016. Whites overdosed from heroin at much higher rates than African Americans and were much more likely to be arrested for possessing it. In 2016, Charlotte police arrested 202 whites and 126 African Americans for possession of heroin.

As with alcohol and other drugs, children are affected by the opioid epidemic even if they don't use. Although a direct link to opioid use is not quantifiable, the number of children entering foster care statewide because of parental drug use has increased 41 percent from 2012 to 2016.[29]

In July, a new Substance Affected Infants plan was put in place by DHHS. The plan requires health care providers who deliver babies testing positive for alcohol or drugs to report it to their local DSS. The goal is to screen newborns for drug toxicity and withdrawal symptoms and determine if foster care is appropriate.[30]

While it's difficult to gauge how prevalent the use of drugs and alcohol is among our community's children, data from the Youth Drug Survey indicate the most commonly used drugs were alcohol and marijuana. The survey also shows a sharp increase in the abuse of prescription drugs.[31] Among the 10,294 local children ages 3 to 18 who received Medicaid services in 2016, 328 were for substance use.

Three of the largest local agencies for substance use treatment are:

✔ **Anuvia Prevention and Recovery Center** contracts with Mecklenburg County to operate a substance abuse service center for detoxification, residential, outpatient and chronic care programs. It is the primary recipient of the local grant from the Alcoholic Beverage Control Board. Last year, 80 young people ages 12 to 18 were served by Anuvia's adolescent outpatient treatment center—15 of them were in treatment for opioid use.

✔ **McLeod Addictive Disease Center** is the largest provider of alcohol and drug treatment in North Carolina. Last year, 83 adolescents received outpatient treatment (87 percent were male, 13 percent female) and 35 were in residential treatment (100 percent were male). The average length of stay for residential services was 102 days, and 91 percent were Medicaid recipients.

✔ **Dilworth Center** provides intensive outpatient treatment, including group, individual and family counseling on weekends and evenings. It also has programs specific to adolescents and young adults. And the Dilworth Kids Program for Children helps 6- to 11-year-olds understand chemical dependency as a disease and how it impacts the family. About 65 percent of clients have private insurance; 35 percent are self-pay.

FACTS ABOUT OPIOIDS

✔ Opioids are a class of drugs that include heroin as well as prescription pain relievers such as oxycodone, hydrocodone, codeine, morphine, fentanyl and others.

✔ Prescription opioid sales quadrupled between 1999 and 2010.[32]

✔ Heroin producers now add fentanyl and carfentanyl, drugs 50 to 100 times stronger than heroin, which dramatically increases the risk of overdose.

✔ 82 percent of fentanyl overdose deaths in 2013 involved illegally manufactured fentanyl, while only 4 percent were suspected to originate from a prescription.[33]

✔ As efforts to curb the abuse of prescription opioids began around 2010, heroin use skyrocketed. Four in five new heroin users started out misusing prescription painkillers,[34] which are far more expensive and harder to obtain.

Intellectual and Developmental Disabilities

Professionals in children's mental health often use the word "silos" to describe the fragmentation of the ecosystem. The word also is applicable to the three branches of the profession—mental health, substance abuse and intellectual/developmental disability (I/DD). What makes I/DD different from mental health and substance abuse is the fact that there is no cure for I/DD. Thus, the focus is not on recovery but on increasing individuals' ability to function in society.

In 2016, of the 10,294 Medicaid enrollees ages 3 through 17 who received a mental health service, 803 were children with I/DD. For these children and their families, it's a tale of "haves" and "have-nots"—those who have an N.C. Innovations Waiver and those on the waiting list, officially called the Registry of Unmet Needs.

The waivers provide services and support to children with I/DD so they may remain with their families and live in their communities rather than receive care in an institution or assisted living facility. The state Division of Medical Assistance (DMA) allocates waiver slots based on county population, and there aren't enough slots to meet the demand. Anecdotal evidence suggests the wait time for a slot can be as long as 10 years or more.

Meeting the guidelines for a waiver slot requires a psychological evaluation that consists of adaptive skills and cognitive testing to reach an accurate diagnosis. To be placed on the wait list, Cardinal Innovations also requires medical records and guardianship papers.

For families waiting for a waiver, some Medicaid services are available, such as assistance in locating community resources, in-home skill building, peer support, respite, psychiatric consultation, supported employment, transitional living and other supports. However, these services—called "(b)(3) services"—are very limited compared to the Innovations Waiver. Services such as personal care, community networking and case management are available only to families with waivers.

The division between the "haves" and "have-nots" doesn't mean families with waivers are living a life of ease. The waivers are capped at $135,000 per child per year. And I/DD support professionals cited many of the same gaps and barriers that apply to the system overall, including limited resources, difficulty navigating the system, and too much paperwork.

Gaps and barriers specific to I/DD include Cardinal not accepting school evaluations as evidence of an I/DD diagnosis, the requirement to show proof of a continuing diagnosis every three years (remember, there is no cure for I/DD), and a limited number of clinicians who are qualified to serve individuals with a dual-diagnosis, such as I/DD and substance use disorder, or I/DD and a mental health diagnosis.

Some of the state and local organizations serving children with I/DD are the **Autism Society**, **Easterseals**, **Disability Rights N.C.**, **UMAR**, **First in Families**, the **N.C. Council on Developmental Disabilities**, **InReach**, **Developmental Disabilities Resources**, **LIFESPAN**, and **The Arc of Mecklenburg County**.

I/DD

Mental health

Substance use disorder
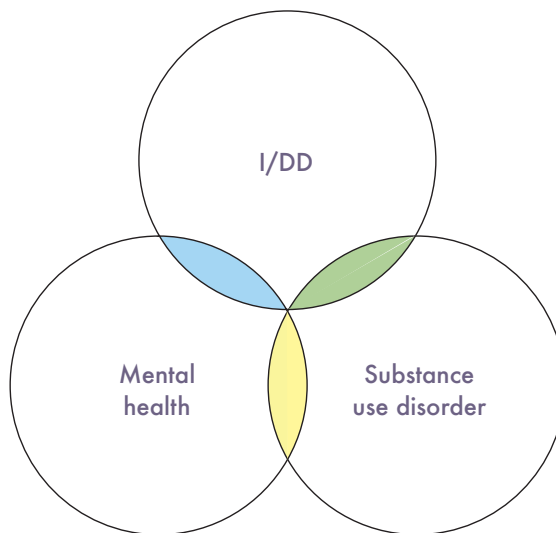
3 SILOS OF MENTAL HEALTH

Gaps in Services, Barriers to Treatment

True or false? Children covered by private health insurance have better access to mental health services than those who qualify for Medicaid. Answer: It depends on the insurance policy and family income, among other factors, but the answer is probably *false.* Why? Because health insurance policies have annual deductibles requiring families to pay up to thousands of dollars out of pocket before insurance kicks in.

For example, a family of three in Charlotte with annual household income of $80,650 would pay $2,140 in monthly premiums to get the lowest annual deductible of $1,500 from Blue Cross and Blue Shield. If they wanted to lower their premium by accepting the highest deductible available, their monthly payment would shrink to $1,396—and the annual deductible would swell to $7,150.[35]

For middle-class and upper-income families who have the ability to pay high premiums and deductibles, affordable access to mental health services may still be limited.

"Insurers historically have placed more limitations on mental health treatment, as well as higher co-payments for mental health care, than for other healthcare services," according to the Judge David L. Bazelon Center for Mental Health Law. Certain group plans, such as those offered by employers of 100 or more workers, are required by law to cover mental health services at the same level as medical care. However, private insurance typically has stricter limits and fewer services covered for mental health. "Many of the services needed by people who have the most serious disorders are not included… Those services are generally only covered under Medicaid," the center noted.

Medicaid

Families apply for Medicaid online through the DHHS website, in person at the local DSS office, or by phone or mail. The government-funded healthcare plan is available to low-income individuals who are under the age of 21, over the age of 65, blind or disabled, and are in need of long-term care. To be eligible, an individual must be a U.S. citizen or provide proof of eligible immigration status, provide proof of state residency, and have a Social Security number or have applied for one.

Each of the 31 service definitions and 19 enhanced services definitions[36] come with their own set of eligibility requirements, billing codes and reimbursement rates. Service definitions and reimbursements change annually.

"The service definitions from the state don't necessarily mesh with what kids need," said Sarah Greene, program administrator of Trauma and Justice Partnerships, Mecklenburg County Health Department.

Medicaid members may be denied services on technical grounds or for being "noncompliant." And many interviewees said the denial rate for certain services is too high, or Cardinal will approve lower levels of services than recommended by the service providers. (Cardinal disputes these allegations.)

Birth to Age 5

One of the most glaring gaps in mental health services is for infants and toddlers. While some services and supports designed to enhance the social/emotional development of infants and toddlers are available through CDSA, there is no single state agency fully charged with the responsibility of assuring mental health services to this age group. The behavioral health LME-MCOs in North Carolina have no statutorily defined responsibility to provide mental health services to children from birth to age 3.

Other factors that interfere with the provision of mental health services for children birth to age 3 include the shortage of qualified service providers, the difficulty inherent in applying prevailing diagnostic criteria to children under age 3, the reluctance to apply labels to very young children, and a "let's-wait-and-see-what-happens" attitude.

Medicaid *does* provide funding for pediatricians to do screenings, such as the Ages and

'The service definitions from the state don't necessarily mesh with what kids need.'

Sarah Greene
Mecklenburg
County Health
Department

Stages questionnaire for developmental delays, and for early developmental interventions—but not strictly for mental health. Zero to Three is a national organization working to change that, as is the North Carolina Infant Mental Health Association, ZFive of Mecklenburg County, the Whole Child Initiative, and other organizations.

This points to a common misunderstanding about Medicaid services available for ages birth to 3. Asked if *mental health* services are available for this age group, two county officials cited the CDSA as responsible. While the CDSA is the local provider for state-mandated infant/toddler services under the Individuals with Disabilities Education Act for children birth to age 3, it isn't responsible for providing a full array of mental health services to the children it serves, as is the case with the state's behavioral health LME-MCOs.

As Dr. John Ellis, a psychologist and early childhood consultant, pointed out, "trying to do traditional mental health out of this program is like trying to fit a square peg in a round hole."

That's not to say that CDSA's work isn't vital. As the Mecklenburg CDSA director, Joey Bishop-Manton, explained in an email:

The CDSA provides a wide variety of services focused on building parent competence and capacity in supporting child development. Family training and counseling are mandated services provided by licensed mental health clinicians and psychologists who address the social/emotional needs of young children and their families. As a specific method of family training and counseling, the Mecklenburg CDSA also provides attachment and biobehavioral catch-up (ABC) which is a parent-training intervention aimed primarily at children between 6 and 24 months of age and their caregivers. ABC targets young children who have experienced early adversity, such as maltreatment or disruptions in care, and addresses several issues that have been identified as problematic among children who have experienced early adversity, including behaving in ways that push caregivers away, and behavioral and biological

dysregulation. The program works with parents or other caregivers to help them learn how to 1) behave in nurturing ways when children are distressed; 2) follow their child's lead to behave in delighted ways when children are not distressed; and 3) avoid behaving in frightening or intrusive ways.

Children with developmental delays are at risk of having problems in adolescence and adulthood. Early intervention is essential. The connections infants and toddlers make with others are critical to their well-being and development. However, the lack of funding and a mandate for infants and toddlers with *mental health* needs is a not-so-obvious gap in services that should be addressed.

"Once a child turns 3, services through CDSA are no longer available. Charlotte-Mecklenburg Schools picks up the responsibility for developmental issues including mental health for children 3 years old and up," according to a 2008 report by The Lee Institute conducted on behalf of Smart Start of Mecklenburg County.

However, CMS picks up the tab only if the developmental or mental health concerns cause substantial delay in the child's academic, social or language skill development. The 2008 study, which was guided by the ZFive Infant Mental Health Working Group, estimated that only 5 percent of local children birth to age 5 with a diagnosable mental health disorder are receiving treatment.

"This indicates that approximately 95 percent of children with a diagnosable mental health disorder are not receiving the treatment they need," the report concluded.[37]

Dr. Cotrane Penn, the school system's mental health program specialist, clarified by email:

We do not 'pay' for any mental health services for children unless you count those delivered by CMS school counselors, school social workers, and school psychologists. In that case, the work is covered by these salaried positions. We have grant funds that pay for services for eligible students in grades 6 to 8 to receive mental health treatment from agency therapists, but those dollars do not

originate from within CMS or Mecklenburg County. We have a pro bono agreement with our SBMH partners that is available to any eligible CMS student ages 3 and up, but there is no exchange of funds for the rendering of those students' services. Children being served by CMS at age 3 typically have severe developmental disabilities and tend not to be candidates for mental health therapy.

In 2015, Smart Start commissioned another report on mental health services for children ages birth to 5 by some of the same researchers involved in the previous study.

The second study, which was prepared by Dr. Ellis and Dr. Natalie Conner, conservatively estimated that 9,177 children in Mecklenburg County under the age of 5 demonstrate problem behaviors that rise to the level of a diagnosable mental health issue.[38]

The study recommended replication of the Child First model in Mecklenburg County. Child First is a national, evidence-based, two-generation model that works with vulnerable young children and families by providing intensive, home-based services.

A statewide Child First office was established in 2016, and the program is being implemented by five affiliate agencies in 24 counties in eastern North Carolina, the catchment area for the Trillium Health Resources. However, the program hasn't been adopted in Mecklenburg County, although a Cardinal executive said the organization now is looking into the feasibility of implementing it.

Latino/Hispanic Children

Another population of underserved children is the Latino/Hispanic community. Hurdles to providing mental health services to this community include cultural stigma, lack of Spanish-speaking counselors, a shortage of trauma-trained clinicians, overcoming stereotypes and, in some families, fear of deportation.

For undocumented immigrant minors, the path to receiving public funding for mental health is a protracted, rigorous legal process. A federal statue prohibits undocumented immigrants from receiving Medicaid, so the first step is to become documented.

As with Nicolás, one of our three fictional characters, navigating the maze may require a team of professionals, including a DSS case manager, a YFS attorney to represent him in family court, and an immigration attorney to apply for special immigrant juvenile status.

"Unlike civil child protection courts, which are governed by a doctrine of ensuring 'the best interests of the child,' immigration courts treat children essentially as adults and provide no additional protections or representation," according to Dr. Kiara Alvarez and Dr. Margarita Alegría in an article for the American Psychological Association.

"In the absence of pro bono attorneys or a family's ability to afford one, children go without orientation to the court system, assistance in representing their case, or support in recounting traumatic experiences to strangers," they added.[40]

More than half of **Charlotte Community Health Clinic**'s patients are Hispanic or Latino. A free clinic offering primary care and behavioral health services to Medicaid recipients, and uninsured adults and children on a sliding fee scale, it's one of 20 free and low-cost clinics in the county. Until recently, the clinic had only one mental health counselor—and he's a part-time employee. His average caseload at any given time was about 100 patients, roughly half of them teenagers, allowing him time to see them only once every three or four weeks. (The clinic recently hired more counselors to try to keep up with demand.)

Bureaucratic Delays, Time-consuming Paperwork

According to interviewees, two of the most significant barriers to treatment are bureaucratic delays and time-consuming paperwork. For certain services, such as enhanced services for special populations, pre-authorization from Cardinal can take up to 14 days. And, if mistakes are made in the paperwork, pre-autho-

'We've created an administrative nightmare for families.'

Dr. Diana Moser-Burg Smith Family Wellness Center at Project 658

Although this re-
port focuses on ages
0 to 18, another vul-
nerable population
is transition-age
youth: people be-
tween the ages of 18
and 24, particularly
those in transition
from foster or cus-
todial care under
YFS supervision to
being fully indepen-
dent. Typically, once
they become adults
they can no longer
receive financial
assistance from
publicly funded
systems of care, but
a new law went into
effect in January
2017 extending fos-
ter care benefits for
individuals ages 18
to 21. Often, when
people "age out"
of YFS care they
wind up homeless.
During daytime
hours when shelters
are closed, many
find companion-
ship in unsafe
environments
where chronically
homeless people
gather. Although
some young adults
choose to remain in
foster care, many
try to make it on
their own.[39]

rization can drag out for months, according to
interviewees. That's because when an error is
made by a service provider, the 14-day approv-
al period could begin all over again.

The bureaucracy of compliance takes time
away from direct care; it increases agencies'
costs, so it's a disincentive to provide more ser-
vices; and evidence-based services have such
strict procedures that they don't allow enough
flexibility, interviewees said.

"We've created an administrative night-
mare for administrators and families," said
Dr. Diana Moser-Burg, integrated care clinical
manager of Smith Family Wellness Center at
Project 658.

Children with Dual-Diagnosis and Intellectual or Developmental Disabilities

Another barrier to treatment is for children
with I/DD. Medicaid funding for I/DD is
capitated, meaning a set amount of money is
provided each year through the North Caroli-
na Innovations Waiver.

The waiting list to receive such financial
assistance is several years long; one parent
interviewed for this assessment waited more
than five years to receive funding for her
adopted son. And an I/DD services provider
estimated the current wait list at 10 years.

In theory, children with I/DD can access
mental health and substance use treatment in
conjunction with I/DD services. "We know
these things go hand-in-hand," says Candace
Wilson, ParentVOICE program director for
Mental Health America of Central Carolinas.

However, the resources of providers who
can serve co-occurring or dual-diagnoses "are
slim to none," noted Dr. Moser-Burg. "There
are not enough clinicians who can serve both
needs. This is a gap both in the inpatient and
outpatient settings."

Charlotte-Mecklenburg Schools

As noted previously, CMS is one of the prima-
ry avenues to children receiving mental health
services and support. CMS is in its third year

of offering SBMH services to students enrolled
in 101 of its 170 schools.

But getting cooperation from parents can
be tricky, says CMS's Dr. Cotrane Penn, espe-
cially those with transportation or employ-
ment hurdles. Parents are required to provide
written consent for their children to receive
an intake assessment, which happens about
half of the time. The other parents either don't
return CMS's phone calls or don't show up for
their scheduled parent-clinician appointments.
Lack of parental consent was cited by Dr. Penn
as the No. 1 barrier within the school system.

A second barrier to students receiving
services through the school system is a federal
statute prohibiting undocumented individuals
from receiving Medicaid, so schools provide
pro bono mental health services to undocu-
mented students. The same goes for some stu-
dents who have private insurance since many
policies don't pay for long-term therapy.

A third barrier within CMS is the stipula-
tion that students must meet with their school
counselor to be referred to a licensed therapist.
While the requirement itself seems innocuous,
the result can be a lengthy delay in treatment:
A single school counselor is responsible for
hundreds of students, while a school-based
clinician's average case load typically is 25 to
30 students.

A final barrier within CMS may be obvious
but deserves emphasis here. Analysis by the
school system of data collected during the first
year of SBMH indicates positive outcomes for
participating students. Yet only 59 percent of
public schools are involved in the intervention
program.

Shortage of Residential Placements

When a mental health disorder becomes de-
bilitative or poses a safety threat to the child
or family, treatment in a residential setting
may be necessary. Residential placements are
expensive, and Medicaid has cut funding for
certain types of residential care in favor of
community-based treatment. According to

local mental healthcare experts, this has led to a gap in services: a shortage of residential placements. Exacerbating the situation is the issue of adolescents from outside the community taking Mecklenburg County's residential placements.

While Cardinal officials have asserted that the overall inventory of residential placements in Charlotte-Mecklenburg is "sufficient," there is common agreement among behavioral health professionals interviewed for this assessment that the community doesn't have adequate supply.

In 2014, the General Assembly allocated $2.2 million to the Crisis Solutions Initiative to enhance crisis service capacity across the state. In Charlotte, Cardinal has partnered with Monarch to apply for a grant from the initiative, which is a program of DHHS, to build a 16-bed crisis center. The new crisis center is scheduled to open later this year, yet many interviewees said 16 beds isn't nearly enough to meet the demand.

Adolescent Females

The shortage of residential placements is particularly dire for adolescent females: There are no group homes located in Mecklenburg County for girls in need of primary substance use treatment and around-the-clock supervision.

The clinical supervisor for Anuvia Prevention and Recovery Center, Jefforey Best, refers teenage girls in need of substance use treatment to Youth Villages in Knoxville, Tenn. For their children to receive treatment in a facility located more than 200 miles from Charlotte "places a tremendous burden on families," Best said. Part of the challenge is a reluctance on the part of providers to treat teenage girls, who are viewed by some providers as difficult to treat. So local residential providers focus on serving preadolescent girls instead.

"Where we really struggle as a community is specialized care for female teenagers," said Cardinal's Laurie Whitson.

Therapeutic Foster Homes

Another gap in mental health treatment placements is therapeutic foster care (TFC). The deficiency is not an overall shortage of licensed beds but rather "the availability of specialized treatment for youth with highly complex mental health needs," according to Cardinal Innovations.

However, "there is a shortage of *effective* therapeutic foster parents," noted one interviewee. "Foster parents have long complained about the lack of support they receive from their agencies to be able to manage the issues and behaviors that children and youth are dealing with, especially with teenagers. Having trained foster care coordinators who can provide adequate support and training to their foster parents is also an issue."

Shortage of Trauma-Certified Clinicians

Treatment methods such as trauma-focused cognitive behavioral therapy (TF-CBT) require trauma training and specialized certification to ensure the modality is provided to patients in an effective manner.

While the number of clinicians who have been certified in TF-CBT has slowly increased, Mecklenburg County doesn't have enough credentialed clinicians. Further, in other types of modalities where it's not specifically required that clinicians have special certification, best practices call for clinicians who have additional training and experience with treating children with a history of trauma.

This lack of experience can lead clinicians to misunderstand the origin of problems. A child who is noncompliant or frequently angry may be misdiagnosed with a conduct problem if the clinician doesn't know that these symptoms often are associated with trauma.

Charlotte AHEC, CHS, and the Mecklenburg County Trauma Informed Care Workgroup are working to change that outcome by offering trauma training to professionals in the school, courts, mental health and child welfare systems.

Out-of-town residential treatment 'places a tremendous burden on families.'

Jefforey Best
Anuvia Prevention and Recovery Center

Lack of Child Psychiatrists

According to the American Academy of Child and Adolescent Psychiatry, Mecklenburg County has 34 practicing child and adolescent psychiatrists for nearly 250,000 children, which the academy deems to be a "severe shortage."[40] North Carolina's shortage of child psychiatrists also is considered severe, just like every state in the country except for a handful for which the shortage is considered merely "high." No states were considered to have a "mostly sufficient supply."

LGBTQ Youth

The national rate of suicide attempts is four times greater for gay, lesbian and bisexual youth and two times greater for questioning youth than that of heterosexual youth, according to The Trevor Project. And 40 percent of transgender adults reported having made a suicide attempt; 92 percent reported having attempted suicide before the age of 25.[41] Yet many interviewees said the support available to lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth doesn't come close to meeting the demand.

The Time Out Youth Center is working to change that. Executive Director Rodney Tucker said the center has trained more than 3,000 public school personnel on issues facing LGBTQ students. The center's waiting list for support services swelled last year; however, the community responded and Time Out Youth received an influx of financial support for the purchase and renovation of an office building to be a hub for its programs, as well as a planned shelter for LGBTQ homeless youth.

The Time Out Youth Center's client visits doubled in 2016 with 357 youth visiting the center for the first time, compared to 162 in 2015. The drop-in space was used 4,683 times in 2016, compared with 2,370 in 2015, and discussion group participants numbered 3,419, compared with 1,930 in 2015.

WHAT ARE THE MEDICAID SERVICE DEFINITIONS FOR RESIDENTIAL PLACEMENT AND TREATMENT?

When a young person who is enrolled in Medicaid can no longer be safely managed in their own home, behavioral health professionals turn to residential placement and treatment options. Varying levels of treatment are provided in different residential settings, ranging from foster care to locked facilities.

Some of them include:

✔ **Psychiatric residential treatment facilities** (PRTFs) provide non-acute inpatient facility care for individuals who have a mental illness or a substance use disorder and need 24-hour supervision and specialized interventions.

✔ **Residential treatment** provides a structured, therapeutic, and supervised environment. The LME-MCO is the established portal of entry and completes an assessment and determines the appropriate level of care. There are four levels of residential treatment; none include reimbursement for room and board. **Level I** provides a low to moderate structured and supervised environment in a family setting (foster home); **Level II** provides a moderate to highly structured and supervised environment in a family setting (therapeutic foster home) or program setting (group home); **Level III** has a highly structured and supervised environment in a program setting only; and **Level IV** has a physically secure, locked environment in a program setting only.

✔ **Facility-based crisis service** for children and adolescents provides an alternative to hospitalization for an eligible beneficiary who has escalated behavior due to a mental health or I/DD need, or a substance use disorder, and who requires treatment in a 24-hour residential facility with 16 beds or less. It's an intensive short-term, medically supervised service provided in a physically secure setting. And it's available 24 hours a day, seven days a week, 365 days a year. The only facility-based crisis service in Charlotte will be operated by Monarch. (See page 23).

✔ **Inpatient psychiatric treatment** services provide treatment in a hospital setting 24 hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or physician. This service is designed to provide continuous treatment for individuals with acute psychiatric or substance use problems.

✔ An **intermediate care facility** is an institution that functions primarily for the diagnosis, treatment or rehabilitation of individuals with I/DD. It provides ongoing evaluation, planning, 24-hour supervision, coordination and integration of services in a residential setting.

The Dilemma of Hard-to-Place Youth

One of the most complex and troubling findings of this report is the dilemma of hard-to-place youth who come into the system via the Juvenile Detention Center, YFS, or the psychiatric emergency departments of Novant or BH-C.

Whether this represents a gap in services is debatable: Cardinal officials maintain that the network of therapeutic residential placement and treatment facilities is adequate, but others disagree. The problem is so vexing that a stakeholders' group, lately called the "Community Transition for Youth Collaborative," was formed more than a year ago to try to find solutions.

Hard-to-place youth enter YFS custody because a juvenile court has ruled they can't be discharged to their homes due to abuse or neglect, or because they've been abandoned by family members who can't be reached or refuse to pick them up from one of the two hospitals.

Finding appropriate placement and treatment for them isn't easy because they require intensive care—often due to violent or self-destructive behavior. Convincing foster families to take them in is a tough sell: Even if a foster family is willing, the foster parents may lack special training to provide the intensive therapeutic care the child needs. Securing appropriate placement is only half the battle, as they usually require treatment from counselors who are trained in trauma-informed care.

Compounding the issue is the limited capacity of residential facilities such as Level III group homes and PRTFs. These placement facilities often are filled with adolescents from other counties. If the facilities already are at capacity, local youth in the secure custody of juvenile justice may get stuck in the detention center; others may be stranded at one of the psychiatric emergency departments of the two hospitals. And, occasionally, they would spend one or more nights in an office at YFS. Since YFS began tracking the problem nearly four years ago, 18 children have slept there.

However, that situation hasn't occurred in over a year, according to YFS Director Charles Bradley.

The challenge of hard-to-place youth also was lessened when the county approved a waiver to allow YFS to place children in Level III residential facilities in the Cardinal network. Prior to the waiver, which was implemented in January 2017, differences between YFS's network and Cardinal's network resulted in Cardinal having placements available but YFS being unable to place the child. Providers who contract with Mecklenburg County were subject to special auditing requirements that surpassed Cardinal's requirements.

Despite the progress that's been made, problems remain. One of the most troublesome is the issue of YFS sending young people across the state line to New Hope Carolinas, a PRTF in Rock Hill. New Hope is a "placement of last resort" because it's a locked facility: Sometimes children whose clinical recommendations don't support being placed in a locked facility are sent there anyway because no other beds are available. Mecklenburg County has a contract with New Hope to use its beds on an emergency basis, which costs the county over $400 per day per child. Last fiscal year, the county spent over $594,000 for emergency-placement beds at New Hope for children in custody who had no other placement option. Although children in custody automatically qualify for Medicaid, New Hope isn't part of Cardinal's network, so the county pays the bill. Children have stayed at this facility for up to two months before transitioning to a facility in North Carolina. Because New Hope is located in South Carolina, where children don't have the same rights as in North Carolina, they aren't entitled to judicial hearings to determine if they meet the medical criteria to remain in a locked facility.

Asked about New Hope, Bradley responded, "YFS has been diligently working to significantly reduce or eliminate placements" there. He added that the responsibility of con-

> *'...these matters continue to put larger and larger strains on the juvenile court system, not to mention the Constitutional issues they raise.'*
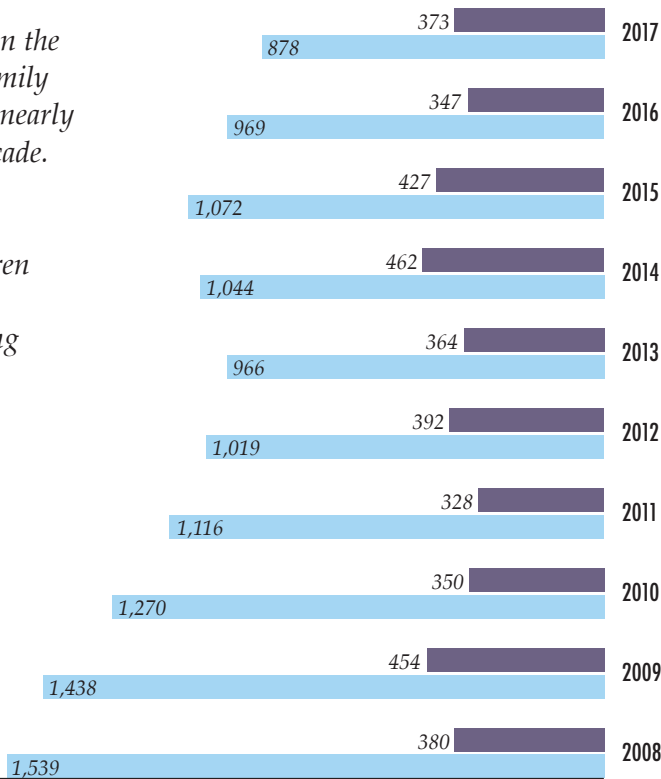>
> *Judge Louis Trosch, Jr.*
> *North Carolina*
> *26th Judical District*

NUMBER OF CHILDREN IN YFS CUSTODY

The number of children in the custody of Youth and Family Services has declined by nearly 60 percent in the last decade.

Overall number of children in custody at some time during the year, including new children entering custody

New children entering custody

Year	Overall number	New children
2017	878	373
2016	969	347
2015	1,072	427
2014	1,044	462
2013	966	364
2012	1,019	392
2011	1,116	328
2010	1,270	350
2009	1,438	454
2008	1,539	380

Source: Youth and Family Services

tract solicitation and management of out-of-home placement recently was transferred from YFS to BHD, resulting in "increased oversight, care coordination and discharge planning for all children placed at New Hope."

In addition to cutting its contract with New Hope in half, in 2016 YFS added With Friends in Gaston County to its network of emergency placement facilities.[42]

After months of meetings between members of the stakeholders' group, in December 2016 Judge Louis Trosch, Jr. subpoenaed officials from YFS, Novant, BH-C and Cardinal after three youth were discharged to New Hope before the holidays—even though none met the criteria to be placed in a locked facility.

In an email to the collaborative group explaining his rationale, Judge Trosch wrote "these matters continue to put larger and larg-er strains on the juvenile court system, not to mention the Constitutional issues they raise."

During an interview for this report, Judge Trosch described New Hope as a "lawsuit waiting to happen." He said that as a district court judge involved in the Child Victims Project Model Court, he's obligated to use his judicial position to advocate for change.

In Charlotte, the Model Court was established in 1998 to improve the juvenile courts' handling of child neglect and abuse cases. The "one judge-one family" system ensures that cases involving the same child or family are assigned to the same judge. Juvenile court judges strive to reduce unnecessary, prolonged out-of-home placement; expedite adoptions when parental rights are terminated; and keep juveniles out of the custody of the county whenever possible by diverting them to community-based programs.

DSS Director Peggy Eagan summed it up:

All members of the stakeholders' collaborative acknowledge that this is a significant problem, and we have committed countless hours to developing a community response that meets the needs of the youth, their families, and our community. While the perfect solution has not yet been found, it appears that responsible parties have moved toward better understanding and a willingness to work together. It should be noted that this same problem has been identified in other North Carolina communities, and Mecklenburg County was invited to present the collaborative process that is currently underway at a statewide conference earlier this year. The conclusion of that work will hopefully move our community toward a long-term solution for this population.

The Roles of Socioeconomics, Trauma and Intergenerational Racism

Although Charlotte-Mecklenburg lacks a central database of statistics on behavioral health incidence, data collected by Cardinal Innovations (and previously by the county Area Mental Health Authority) suggest disproportionate prevalence among African Americans.

According to the U.S. Census, in 2016 the county's population was 58 percent white and 32 percent African American. Yet, in the same year, among Medicaid beneficiaries who received a mental health service, Cardinal's preliminary numbers indicate 34 percent were white and 57 percent were black. (Five percent were Latino or Hispanic.)[43]

Why do African Americans appear to experience disproportionate contact with the mental health system? "Certain ethnic and racial groups suffer from high rates of mental illness because they are disproportionately affected by the deleterious effects of poverty, including stigma, lack of access to healthcare, and limited education," said Dr. Richard McAnulty, associate professor of psychology, University of North Carolina-Charlotte.

This phenomenon is not unique to our community and is particularly noticeable in the juvenile justice system. In 2010, across the U.S., "African American youth were almost five times as likely (than whites) to be incarcerated, while Latino and American Indian youth were two to three times as likely to be placed in a juvenile residential placement," Shantel Crosby wrote in the March 2016 issue of *Juvenile & Family Court Journal.*

Since the majority of youth involved with Charlotte's courts are identified as having behavioral health needs and receive court-ordered treatment, the juvenile justice and mental health systems are intrinsically linked.

In 2013, Race Matters for Juvenile Justice (RMJJ) convened law enforcement officers, school leaders, judges, county officials, GALs, child advocates, DSS officials, and other community leaders. They looked at data from the Area Mental Health Authority from 2009.

In that year, the authority served 8,395 people under the age of 18. The data indicated African Americans disproportionately were affected by mental health incidence: 63 percent of the authority's clients were African American. Among African American children, the most common diagnosis was ADHD, followed by oppositional defiant disorder (ODD) and conduct disorder (CD).[44]

RMJJ is a local collaborative leadership group working to reduce disproportionality and disparate outcomes for children and families of color through institutional organizing, education, and workforce development. The group has developed five modules in its speakers' bureau series aimed at increasing the community's understanding of issues related to racial justice. One of the presentations, the School to Prison Pipeline, examines the over-representation of children of color in school disciplinary actions.

Critics of the school system allege that CMS treats children of color with mental health challenges differently from other school children.

"CMS responds to children of color who have disabilities from a punishment standpoint as opposed to treating the mental health needs," said one interviewee. "The punishment often leads to a child missing school, dropping out, and becoming part of the prison system."
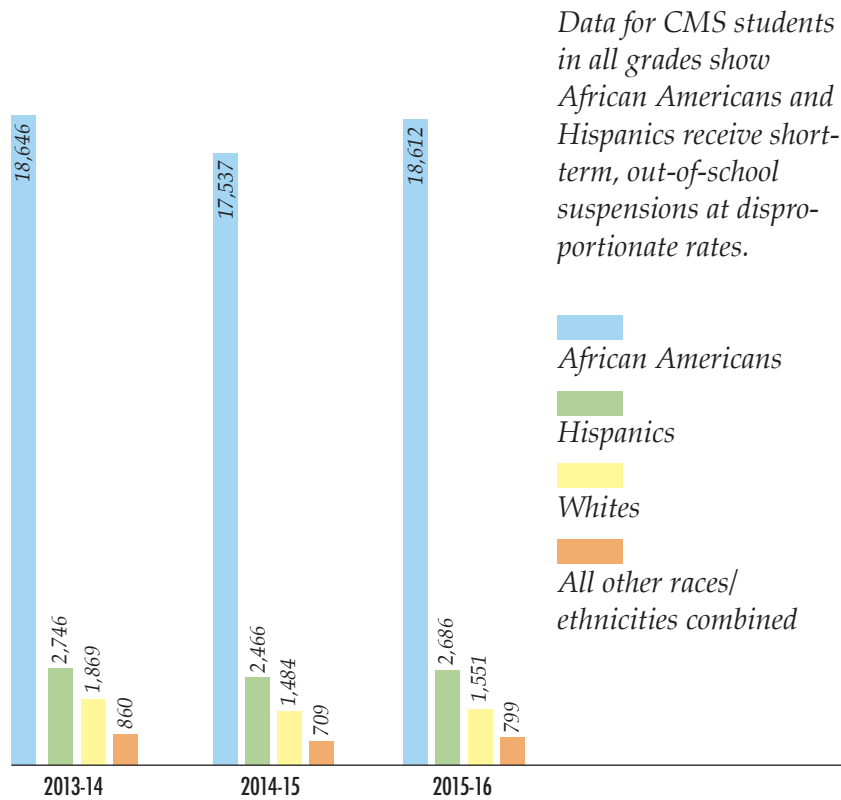
Another critic faulted the school system for not recognizing the symptoms of PTSD and how it affects classroom behavior, resulting in punishment, misdiagnoses and over-medication. Whether or not these criticisms apply to isolated situations or are systemic, they point to the fact that racialization not only is a factor in the juvenile justice system but also in public schools.

Since mental illness doesn't discriminate on the basis of race or ethnicity (nor by gender or sexual orientation), what factors contribute to involvement in the mental health system by disproportionate numbers of African American

'We create mental health issues through socioeconomic issues.'

Amber Pierce
Assuring Better Child Health and Development

CMS SUSPENSIONS BY RACE/ETHNICITY

Data for CMS students in all grades show African Americans and Hispanics receive short-term, out-of-school suspensions at disproportionate rates.

■ *African Americans*

■ *Hispanics*

■ *Whites*

■ *All other races/ ethnicities combined*

Source: N.C. Dept. of Public Instruction

2013-14: 18,646 / 2,746 / 1,869 / 860
2014-15: 17,537 / 2,466 / 1,484 / 709
2015-16: 18,612 / 2,686 / 1,551 / 799

youth? Dissecting the myriad causes of racial disproportion begins with a brief discussion of intergenerational racism.

The fact is, we live in a segregated society and a segregated community. In Charlotte-Mecklenburg, concentrations of low-income families of color lie to the west and north of the center city, forming a "crescent" of lower-op-portunity neighborhoods. This didn't happen overnight but rather is the legacy of intergen-erational poverty resulting from centuries of racism.

The impacts of poverty on early childhood development and family stability directly cor-relate to a greater prevalence of mental health disorders.

"We create mental health issues through socioeconomic issues," says Amber Pierce,

coordinator of Assuring Better Child Health and Development for the greater Meck-lenburg region.

Early brain development, which begins before a child is born and is most critical up to age 5, is a key determinant to mental health. Early childhood is a time of extraor-dinary cognitive, emotional and social develop-ment. Too often in low-income households, parents are confronting the urgent demands of employment, transportation, food, shelter and safety, which can impact their ability to provide the care and supervision children need to optimize their development. Basic parenting capacity may be limited because people experiencing intergenerational poverty may lack the ability or opportunity to transfer parenting skills from one generation to the next.

"What happens to children who do not form secure attachments?" asks Kendra Cherry, a psychosocial rehabilitation specialist. "Research suggests that failure to form secure attachments early in life can have a negative impact on behavior in later childhood and throughout life. Children diagnosed with an ODD, CD or PTSD frequently display attach-ment problems, possibly due to early abuse, neglect or trauma."[45]

According to Shantel Crosby, author of the *Juvenile & Family Court Journal* article cited previously, 90 percent of youth in detention have experienced previous trauma, which is linked to an increased likelihood of further delinquency. Young people who are victims of or witness to violence tend to perpetuate violence.

"In general, African American youth are more than twice as likely as white youth to be raised in poverty-stricken areas, increasing their overall exposure to crime, community violence, stress and trauma," Crosby writes. Even for children who don't grow up with violence in their households, living with scarcity can cause toxic stress, which can affect their developmental trajectory and lead to self-defeating behavior.

A groundbreaking study conducted by the Centers for Disease Control (CDC) demonstrated the relationship between exposure to childhood emotional, physical or sexual abuse, and household dysfunction during childhood, and risky health behavior and disease in adulthood. The Adverse Childhood Experiences (ACE) study found that adults who had experienced significant trauma as children were more likely to suffer from alcoholism, drug abuse, depression, and suicide attempt. The study also found that childhood trauma increased the risk of chronic disease, including asthma, heart disease and diabetes.

To stem the adverse effects of socio-economics on mental health, "we need to place more emphasis on trauma," suggests Sarah Greene, head of Trauma and Justice Partnerships. Greene distinguishes between trauma treatment—which refers to clinical intervention for individuals diagnosed with a trauma disorder—and trauma-informed care, an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma. To help survivors rebuild a sense of control and empowerment, trauma-informed care emphasizes physical, psychological and emotional safety for both individuals in treatment as well as mental health providers who are subject to secondary trauma.

Secondary traumatic stress (STS), also known as "compassion fatigue," can result from counseling people who've been directly traumatized; it can lead to burnout or a gradual lessening of compassion over time.

The need for service providers in Charlotte-Mecklenburg to routinely address STS in the workplace is explored in the Trauma Informed Systems training sessions led by Dr. George Ake and Dr. Angela Tunno of the Center for Child & Family Health, in Durham. A program of Charlotte Area Health Education Center (AHEC), CHS, and the Mecklenburg County Trauma Informed Care Workgroup, the training is for professionals in the school, juvenile justice, mental health and child welfare systems who want to learn about the prevention of burnout from STS.

Although trauma is harmful to clinicians and clients alike, to children and their families, and to people of all races, intergenerational trauma places children from poor neighborhoods at the greatest risk.

Clearly, if Charlotte-Mecklenburg is to reduce the disproportionate incidence of mental health needs among low-income children of color, clinicians, case managers, law enforcement and educators should be trained to recognize the impacts of trauma and chronic stress in early brain development.

According to local mental health experts, treatment interventions shouldn't focus exclusively on maladaptive behaviors, but on increasing capacity to cope with the stress of scarcity and violence. And, because poverty and poor mental health are intertwined, our community should work to eliminate inequities among families in low-opportunity neighborhoods to break the cycle of trauma.

Trauma-specific treatment
A clinical intervention following a specific, evidence-based model to facilitate healing in individuals diagnosed with a trauma disorder.

Trauma-informed care
An organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma.

Secondary traumatic stress
A condition characterized by a gradual lessening of compassion over time, common among individuals that work directly with trauma victims.

Mental Health in Public Schools

In the absence of a safe and nurturing home environment, meeting the social/emotional needs of children and adolescents often falls to the public school system. Today's students face threats from cyber bullying, opioid use and gun violence that didn't exist for prior generations. Now more than ever, educators must be aware of the risk factors, early warning signs and treatment options available to students with behavioral health needs.

Safeguarding the well-being of 150,725 CMS students from pre-kindergarten through high school requires an enormous commitment of time, energy and resources. The public school system employs the equivalent of 62 full-time school psychologists, plus 42 social workers and six substance use counselors. Assistance is available to school children through CMS Student Services, including individual, group, family and community-based support ranging from counseling and intervention plans to home visits, family assessments and training for parents. However, critics say the assistance is limited and is related to CMS's legal obligations, such as truancy or special education.

In addition, school-based clinicians from CHS and five community agencies work in 101 of the public school system's 170 elementary, middle and high schools. The SBMH intervention program is funded by Mecklenburg County and is available in most Title I elementary schools. (Title I is a federally funded program for schools that serve at-risk students in low-income areas.)

SBMH services may include individual, group and family therapy, medication evaluation and monitoring, intensive in-home services, and referral to day treatment or inpatient facilities. Agencies that provide SBMH services are evaluated annually by the school system to measure outcomes related to academics, attendance and behaviors. An annual report compares students who participated in the program to a comparison group. Students in the comparison group had behavioral and emo-

tional needs similar to those in the intervention group but didn't receive SBMH services.

In the 2014-15 school year, the first year of SBMH and the only year for which data was available,

✔ More male than female students were in both groups;

✔ The vast majority of students in both groups were African American, followed by Hispanic and then white;

✔ About 25 percent of participants in the intervention group and 18 percent of students in the comparison group were exceptional children (children with I/DD diagnoses) and about 11 percent were limited English proficient;

✔ The agencies provided an average of 14 hour-long counseling sessions per student;

✔ Both intervention and comparison group students' academic performance significantly increased compared to the prior school year, with the exception of end-of-course scores (state-required tests for some high school classes);

✔ Comparison group students experienced a significant decrease in school attendance compared to the prior year, whereas the intervention group experienced an increase in attendance, though not significant;

✔ Students who completed the SBMH program showed positive trends for both attendance and behavior-related indicators from pre- to post-treatment; and

✔ Students who began but didn't complete the SBMH program experienced a significant decrease in attendance and a significant increase in unexcused absences and out-of-school suspensions.

A pilot project that shows signs of promise is **Reid Park Initiative**, located next to Reid Park Academy, a K-8 school in one of Charlotte's oldest crescent communities. Six independent agencies provide SOC coordinators to Reid Park Initiative, helping families harness public assistance resources as well as mental health services. The initiative focuses

on children who require help with reading and math, have three or more unexcused absences or suspensions, change schools frequently, or pose an immediate threat to themselves or others. The initiative is designed to attend to the physical and mental health and economic challenges of the family and the academic needs of their children. The model focuses on the whole family through comprehensive case management.

The project began in 2011 as a collaboration between the Junior League of Charlotte and the Council for Children's Rights. When the original grant expired in 2016, the county stepped in to fund it.

Reid Park Initiative currently serves 126 children from 46 families, or nearly 15 percent of the school's enrollment. The six coordinators from **A Child's Place**, **Pride in North Carolina**, **Communities in Schools**, **Catholic Charities Diocese of Charlotte**, **Charlotte Housing Authority** and DSS have the capacity to serve 150 students.

One of the advantages of the collaboration between independent agencies working within the SOC framework is the ability to share data.[46] Each CFT has access to the family's records on academics, employment, housing, mental health and any involvement with social services or the courts system, providing a complete picture of family stability.

Even for stable families whose children feel safe and secure, who have two involved parents with financial resources and access to private health insurance, the challenges of being a teenager can become overwhelming. Common teenage struggles include depression, social anxiety, eating disorders, body negativity, self-injury and suicide.

In the last school year, CMS Student Services conducted 1,760 suicide risk assessments. According to Mental Health America, as many as one-third to one-half of adolescents in the U.S. have engaged in some type of non-suicidal self-injury, often beginning around the ages of 12 to 14.

BRITNEY, DEON AND NICOLÁS* SHOW SIGNS OF PROGRESS

Britney tries to use the tools her therapist has suggested in order to stop cutting her skin when she's upset, like listening to music or calling a friend, but nothing else seems to help. She feels like a failure and is too embarrassed to tell her therapist the truth. During a visit to her pediatrician's office for a sports physical, the doctor notices fresh incisions on her arm and asks about them. Britney tells the pediatrician about how stressed she feels over her grades, how cutting herself with a razor blade makes her feel better. Her pediatrician tells her about a colleague to whom she has referred many girls with similar stressors, and how the girls really seem to trust her and feel much better after working with her. Britney and the pediatrician tell her mother about her continued struggles, and about the therapist who specializes in working with girls with similar problems. The pediatrician makes a referral to the new therapist, who is covered by the family's insurance and is available to meet with Britney within a few days.

After having multiple professionals and multiple teams enter his life, Deon is able to identify one male clinician who helps guide him through the process of juvenile court and the mental health system. Cardinal Innovations provides the mental health service requested by his male clinician. Slowly, Deon's clinician builds trust and rapport. Deon begins to confide about how his traumatic past and present troubles are affecting his life.

Two weeks after Nicolás begins living with a foster family, a family court judge officially places him in the custody of the county. YFS contacts an immigration attorney to seek help applying for special immigrant juvenile status, the first step toward granting Nicolás legal residency so he can gain access to permanent placement and care, including mental health treatment. YFS can't make any promises about how long the process will take. His foster care providers, who have received no compensation or reimbursement, are exhausted. But they agree to keep Nicolás for a few more weeks.

*Britney, Deon and Nicolás are fictional characters.

For Britney, a composite character, self-injury is a way to cope with distressing emotions. She's been told many times that this behavior isn't healthy, but it doesn't seem all that abnormal to her. She knows girls at school who starve themselves, girls who make themselves vomit, girls who obsessively pull their hair and pick at their skin. She doesn't realize all of these behaviors are warning signs for mental disorders that disproportionately affect girls: anorexia, bulimia, body dysmorphia, trichotillomania and dermatillomania.

A collaborative survey conducted every two years by CMS and the Health Department assesses health risk behaviors that contribute to some of the leading causes of morbidity and mortality in youth. The Youth Risk Behavior Survey, produced by CDC, measures behaviors such as unintentional injuries and violence; tobacco, alcohol and other drug use; sexual behaviors that result in HIV infection, other sexually transmitted diseases and unintended pregnancies; nutrition and physical activity.

The 2015 survey was administered to 2,078 students in 29 CMS high schools. It identified five areas for improvement:

✔ Almost half of the students surveyed think bullying is a problem at their school, even as reports of bullying have decreased;

✔ Students reporting symptoms of depression increased to 32 percent in 2015 from 28 percent in 2007;

✔ Approximately one-third of students reported having at least one alcoholic drink in the past 30 days;

✔ Over 25 percent of students had sexual intercourse with one or more people in the past three months; and

✔ About 42 percent of students played a video or computer game or used a computer for something that was non-school-related three or more hours a day during an average school day, up from 26 percent in 2007.

Recognizing that no public education system should be solely responsible for the physical and mental health of school children,

a variety of community organizations and the two hospital systems have created programs to serve young adults.

Two examples include:

✔ **Teen Health Connection** provides behavioral and medical healthcare to young people ages 11 to 22 regardless of whether they have Medicaid, private insurance or no insurance. The outpatient clinic employs seven clinicians who provide same-day services if patients are identified during medical exams as having behavioral health needs.

Patients are screened for potential issues and receive immediate counseling if a need for mental health services is established. This "triage model" eliminates any delay between diagnosis and treatment. Clinicians may also recommend other services. Another advantage to the outpatient clinic's business model: By integrating medical and mental health services, the stigma of psychological counseling is reduced.

✔ **Time Out Youth** runs a school outreach program in partnership with Equality NC and the HRC Foundation. The Welcoming Schools program works to create respectful, supportive elementary schools for embracing diversity, creating LGBTQ-inclusive schools, preventing bias-based bullying and gender stereotyping, and supporting transgender students.

In middle schools and high schools, Time Out Youth supports Gay-Straight Alliances, which are student-led clubs for LGBTQ youth and students who support LGBTQ causes. Time Out Youth offers workshops on topics such as healthy relationships, advocating for safe schools and how to be an ally. The center also works to eliminate bias, homophobia and transphobia.

For K-12 teachers, staff and administration, Safe Zone Training is offered to help identify issues facing LGBTQ students, articulate appropriate terminology, and tap additional resources. And Transgender 101 Workshops focus on topics related specifically to gender identity and expression.

Privatization vs. Government-Run Mental Health

Whether the topic is education, retirement savings or mail delivery, conservatives and liberals have long debated who can best fulfill the function—government or the private sector.

Champions of the private sector argue that competition in a free market produces the best service at the lowest cost. They point to examples of fraud and wasteful spending by governmental bureaucracies.

Liberals maintain that the essential duties of society are best left to government because the profit motive of the private sector will trump altruism every time. "You cannot make money on human services," says Robert Evans, president of the Charlotte chapter of the National Alliance on Mental Illness (NAMI-Charlotte). "It's just not profitable."

Three years have passed since Medicaid's mental healthcare system was fully privatized in Charlotte-Mecklenburg. Perhaps that's not enough time to evaluate whether managed care is working. And now the state is considering yet another overhaul. Yet Cardinal asserts privatization *is* working—at least from the standpoint of cost containment. Cardinal has managed the state's Medicaid and IPRS dollars so well that it has "continued to provide a full array of services while state-funded mental health budgets were cut," according to Ashley Conger, Cardinal's vice president of corporate communications and public relations. She said the company charges the state slightly more than 8 percent for administrative costs and salaries, even though federal rules allow LME-MCOs to keep 15 percent of the public funds they receive.

However, critics of the state's privatization of mental health point to four chief problems:

✔ It created a fragmented system. "In the old days, there used to be a community mental health center. Everybody in the community knew where it was. That changed since we privatized mental health. It's not readily visible," Debra Dihoff, former director of NAMI-North Carolina, said in a 2014 TV interview.

✔ It allowed service providers to "cherry pick" their clients. "No one wants to work with a kid when things get really nasty," one interviewee confided.

✔ It produced a system that revolves around reimbursement rates for services rather than children and families. The most profitable services are the ones with the highest reimbursement rates that can be performed by unlicensed, low-wage employees.

✔ It stifled collaboration. The more than 250 community agencies that comprise Cardinal's provider network in Charlotte-Mecklenburg have little interaction with each other because they're all competing for the same 10,294 kids.

Did anything good come from privatization? Many interviewees credit Cardinal with "cleaning up" the Medicaid provider network, citing lack of accountability, poor quality and rampant fraud under the previous systems of government-run mental health. In the process of switching providers from MeckLINK's network to its own network, Cardinal consolidated the pool from 557 to about 420 agencies. Agencies that scored too low on Cardinal's "sanction grid" were given the opportunity to improve. Many made the transition, but hundreds chose to forgo Medicaid reimbursement or go out of business altogether. Further consolidation has decreased the network to fewer than 300 agencies. "We're trying to shape the network and move to value-based care," said Laurie Whitson, senior community executive for Cardinal's Mecklenburg office.

Proponents of privatization argue Mecklenburg County had its chance to implement managed care during the MeckLINK era and failed.

But for those who think government is best able to care for the poorest among us, Cardinal will be the antagonist in this saga no matter what. Bridging the divide between the two viewpoints may be moot: No matter what happens to Medicaid and the LME-MCO model in the near future, managed care is probably not going to fade away anytime soon.

'You cannot make money on human services. It's just not profitable.'

Robert Evans
National Alliance on Mental Illness

Fee-for-Service vs. Value-Based Care

If you put two youngsters in a canoe and gave one a single-bladed paddle and the other a paddle with two blades, they'd probably go around the lake in circles. That's because they'd be trying to accomplish the same thing—paddle in a straight line—with considerably different tools. A similar scenario is playing out in Mecklenburg County with Cardinal Innovations and its provider network.

If it's true that the profit motive drives the system, then all you have to do is follow the money to see the inherent conflict between the LME-MCO model and the agencies that provide mental health services to Medicaid recipients. LME-MCOs were established to save the state money. Critics say they're incentivized to limit, delay and deny services.

Conversely, Cardinal's provider network is incentivized by the fee-for-service model: The more services they provide… and the more clients they serve… and the longer they keep them as clients, the more fees they collect.

By design, managed care and fee-for-service are in direct opposition. Managed care was put in place to control runaway costs, giving the state more predictability in budgeting for mental health. At the far ends of the spectrum, an LME-MCO would deny more services than it approved… and service providers would manipulate assessments so clients would be prescribed the most expensive services at the lowest cost to the provider, for as many times as they could be approved.

With either hypothetical extreme, there'd be no financial incentive for patients to recover.

Since Cardinal and its provider network employ two vastly different business models, it's no wonder they often go around in circles. How can the system change so the LME-MCO and its provider network can learn to paddle in tandem? The answer may lie in a value-based care model. First, some definitions:

Managed care is a cost containment system whereby a third-party (Cardinal) mediates between service providers (Cardinal's provider network) and patients (Medicaid enrollees), negotiates fees for services, and authorizes treatment and payment.

Capitated reimbursement is a lump-sum payment to a service provider based on a set (or "capped") amount for each patient placed in its care. The amount of remuneration is based on the average expected services required by the patient for a set amount of time.

Fee-for-service is a system in which a provider performs a service and collects a fee. It's the old business model of health care, and the one nearly every non-healthcare company has always used: You take your car to the mechanic, she replaces the master cylinder and charges you for parts and labor.

Now imagine if you offered your mechanic a lump sum to take care of your car for an entire year. If she could keep your car working for less than the agreed price, she'd make a profit. But, if the car broke down more often than she estimated, she'd lose money.

Under a capitated payment arrangement, a smart mechanic would spend more time on maintenance to avoid costly breakdowns. She'd know the more time she spent preventing mechanical failures, the less time she'd spend diagnosing and repairing them.

Value-based care goes a step further by rewarding providers who produce positive patient outcomes. It encourages providers to use "evidence-based modalities," that is, methods that have been proven effective through the measurement of outcomes. Thus, "value"

refers to services and supports having the greatest potential to produce positive results.

Cardinal's Ashley Conger wrote about the potential to transition to a value-based model:

To this day, capitated health plans largely utilize fee-for-service provider payment methodologies to reimburse providers for services rendered to members. It is well known that fee for service provides a financial incentive for providers to provide a higher volume of services in order to receive higher total reimbursement. Further, there is no relationship between the fee for service payment and the value, or outcomes, derived from that service. Recognizing the volume vs. value dilemma, Cardinal Innovations, like other health plans, is focusing on value-based contracting, which ties provider payments to the clinical outcomes achieved, in part. Where outcomes are not easily measured, provider payments are tied to the prevalence of nationally accepted processes or training deployed by the provider that have been correlated to improved outcomes generally. Regardless, the benefit of value-based contracting is that the payment methodology, whether fee-for-service, capitated, or something else altogether, is irrelevant, thus removing the issue of whether the provider was incentivized to provide more or less care. Instead, providers are incentivized to focus on the quality of care they provide, leading to better outcomes for all of our members. Value-based contracting is in its infancy and to date represents a small minority of total provider payments. As the ability to measure and collect outcome data and the ability to analyze large data sets improves, Cardinal Innovations will continue to expand the use of value based contracting.

Value-based care likely would require providers to gather and report more data on their patients, adding another layer of paperwork. But, if it has the potential to transform the system from one that revolves around Medicaid service definitions to a system focused on recovery, value-based care might be the next, best wave of mental healthcare reform. It may have the potential to transition providers from treating disorders to preventing them from happening in the first place.

HAS ANYTHING GOOD COME FROM MANAGED CARE?

As the state government considers another major overhaul of its Medicaid and N.C. Health Choice programs, mental health professionals continue to bemoan the transition to privatization. The latest DHHS proposal would consolidate medical and mental healthcare and expand Medicaid coverage. Yet experts predict that managed care, in some form or fashion, is here to stay.

In Mecklenburg County alone, the behavioral health LME-MCO, Cardinal Innovations Healthcare, employs 24 care coordinators for mental health and substance abuse and 53 for I/DD; five network engagement specialists who work with the provider network; and a senior community executive who acts as a liaison with county commissioners, social services and other stakeholders. That's in addition to its community operations staff.

Because so many interviewees were critical of Cardinal specifically and the LME-MCO model generally, it prompted the question, *has anything good come from managed care?*

Cardinal provided the following information about four accomplishments it says it has achieved locally in the three years it has served Mecklenburg County:

✔ In 2015, Cardinal introduced a TFC "value based contracting initiative," which includes a quarterly measurement and scoring of all TFC providers. Designed to reward high-performing providers with enhanced payment and the opportunity to add more homes in the network, the initiative promotes access to increasingly higher-quality treatment services. "Since inception, this initiative has increased TFC provider performance by 71 percent," said Cardinal spokesperson Ashley Conger. "The result is better assessment by psychiatrists early in treatment, greater therapy for childhood trauma, and greater child and family team performance."

✔ In 2014, Cardinal implemented "transitional living services," a community-based service specifically for youth with mental health needs who are "aging out" of the foster care setting, or transitioning to independent living. Outcomes in Mecklenburg County, and across Cardinal's service area, include reducing legal involvement and crisis episodes, securing employment and following through with schooling.

✔ In late 2015, Cardinal introduced "family-centered treatment." "This intensive family-based service diverts children from residential treatment and reduces lengths of stays in residential. This is an evidenced-based model that focuses on the entire family system and the development of supports in the community," Conger said.

✔ Cardinal is working with Monarch to build a 16-bed crisis facility, which is scheduled to open later this year. It will be the only facility-based crisis service in Charlotte.

BRITNEY, DEON AND NICOLÁS*
RECEIVE THE HELP THEY NEED

After several months of working with her new therapist, Britney feels significantly less distressed and more hopeful about her future. Her new therapist has training and expertise in the development of specific emotional regulation skills, and Britney trusts her enough to be completely honest during their sessions together. She and her parents are grateful their pediatrician connected them with the right therapist, but they also wish they'd known what to do to avoid wasting time and money on the wrong services.

Deon's new clinician adheres to best treatment practices and teaches him coping skills to deal with the symptoms of the trauma he has experienced in his life. Deon is included in the development of a person-centered plan which establishes treatment and life goals for him to achieve with help from his clinician. These goals are reviewed monthly to ensure there is progress and that Deon has input into the goals. Deon embraces the coping skills he has been taught, begins achieving his goals, and is able to refrain from illegal activities. It takes many years, several mental healthcare providers, and significant resources to get him to this outcome.

It's been a four-year journey for Nicolás to obtain a visa. He's now 10 years old, and after bouncing from foster home to foster home, YFS finally was able to place him in a residential treatment facility specializing in I/DD. The special immigrant juvenile status he was granted as a result of being abandoned by his father makes him eligible for Medicaid; without that, he wouldn't have been able to live in the group home. For the last four years, he's been receiving mental health services—but not for his autism. Because autism is classified as an I/DD disorder, Nicolás had to apply for an Innovations Waiver from Medicaid. Funding for the waivers is capitated, so the wait list is several years long. But Nicolás is safe and well-cared for and, if he's lucky, by the time he enters middle school he'll be able to receive treatment for his autism. By that time, he will have been in the country for almost half of his life.

Nicolás, Britney and Deon's stories illustrate the complexity and magnitude of some of the systemic issues—and how decisions at the macro-level have a very real impact on specific situations facing real families.

Their stories beg the question, *what can we as a community do to improve the lives of children and adolescents with mental health needs?* In August 2017, the funders who supported this project convened leaders from the key stakeholders identified on pages 6-12 to review the three "big picture" strategies and 16 implementation tactics discussed in the conclusion to this report. The collaborative problem-solving sessions were simply a first step. The final plan should be incorporated into the implementation plans for the Economic Opportunity Task Force since poverty and mental health incidence are interlinked. Only through honest conversations about causation and the roles of trauma, socioeconomics and intergenerational poverty can we as a community come to realistic conclusions about how to ensure all of our children grow up healthy—in mind, body and spirit.

*Britney, Deon and Nicolás are fictional characters.

P roviding children and their families with the behavioral healthcare they deserve is a complex and multi-dimensional problem— there is no magic wand we can wave to create equal access for everyone. As a community, we must realize the issue goes far beyond mental health: We need to resolve the socioeconomic disparities that contribute to disproportionality in the courts, in our schools, and in the child welfare and mental health systems. Having a comprehensive report on children's mental

viewed, a different priority for improving the system was emphasized. Thus, there is no clear consensus on a single path forward.

Rather than attempt to provide a "set in stone" action plan, this final section of the assessment is an invitation to think more broadly about the mental health system overall, the various roles being fulfilled by some of the major stakeholders, and a few critical ways they could impact positive changes in the future. A preliminary draft of this portion of the report

1. *Raise awareness and increase education on the importance of prevention and early intervention, as well as the impacts of trauma on early brain development*

3. *Reward best practices and encourage collaboration and communication*

PREVENTION   **ACCESS**   **QUALITY**

2. *Increase access to mental health services and support for children and families*

health and an understanding of how the major stakeholders are responding to the crisis are important first steps to setting an agenda for the future.

The following key strategies and implementation tactics are works in progress. They emerged during nine months of research, which included face-to-face interviews with 83 local mental health professionals, public policymakers and parents, as well as dozens of telephone conversations with experts from across the state. For nearly every person inter-

was presented to 21 stakeholders[47] in advance of two brainstorming sessions. Their input, advice and constructive criticism were a valuable part of the process and will be even more important during the next phase of the project: deciding which suggestions to implement and who will spearhead the work. The author and project funders hope the stakeholders and community-at-large will expand upon it so the next phase will include more people willing to collaborate in a broad-based endeavor to improve the system for the benefit of all.

Raise awareness and increase education on the importance of prevention and early intervention, as well as the impacts of trauma on early brain development

Provide more
trauma
training

PREVENTION

Raise awareness about
the importance of early
brain development

Adopt the
Child First
model

Perhaps the most critical void in Medicaid-funded mental healthcare is services for infants and toddlers.

Although Medicaid does reimburse pediatricians to screen for developmental delays and intellectual disability, it doesn't include mental health service definitions specific to children under the age of 5.

Instead, Medicaid funding for infants and toddlers is more focused on developmental issues from birth to age 3. According to a study by The Lee Institute, only 5 percent of Charlotte-Mecklenburg children ages 0 to 5 with a diagnosable mental health disorder are receiving treatment.

A more recent study by Drs. John Ellis and Natalie Conner estimated that more than 9,000 local children under age 5 demonstrate problem behaviors that rise to the level of a diagnosable mental health issue.

Research shows a child's earliest years have a profound impact on the rest of their lives. Early brain development is essential for children's health and welfare: Safe, stable and nurturing relationships with caregivers are fundamental to healthy maturation during these critical first few years of life.

Conversely, neglect and abuse, chronic stress, scarcity, trauma, and exposure to violence are detrimental to children of all ages.

To fully understand our community's mental health crisis, one must acknowledge the impact of intergenerational racism and poverty on these adverse childhood circumstances. We simply cannot turn a blind eye to the link between poverty and poor mental health. Tactics to be considered to raise awareness about trauma, early brain development, prevention and intervention include:

✔ Early Brain Development
Raise awareness among parents and other caregivers about the critical importance of positive early brain development on the social and emotional impacts of children's growth.

A key recommendation from the Opportunity Task Force report is echoed here: "Educate parents, early educators, and other caregivers on the importance of positive early brain development, social/emotional development, and early literacy, and provide training on how to best support and interact with their children from an early age." (Strategy E-1)

Feedback from the stakeholders indicated that multiple, evidence-based models should be used and suggests "the LME-MCO needs to recognize there's not just one." The model must be a good fit for the clinician and the patient. Psycho-education for the family should help them understand the process of treatment, including the family's role and what the diagnosis means for the child and caregiver.

✔ Trauma
Reduce the shortage of trauma-certified clinicians and raise awareness of trauma's impact on children; determine what additional resources are required to support Charlotte AHEC, CHS and the Mecklenburg County Trauma Informed Care Workgroup in their ongoing effort to provide trauma training for professionals in schools, juvenile and family courts, and continuing education for clinicians in the mental health and child welfare systems; and increase the number of licensed clinicians who receive trauma training and certification

to accurately diagnose and treat children exposed to scarcity, trauma and toxic stress.

✔ Child First
Adopt and implement the Child First model in Mecklenburg County to promote the healthy development of children from birth to age 5. In 2015, a study commissioned by Smart Start of Mecklenburg County recommended the adoption and implementation of Child First, a national, evidence-based, two-generation model that works with vulnerable young children and families by providing intensive, home-based services. A statewide Child First office was established in 2016 and the program is now being implemented in eastern North Carolina.

However, the Child First model has yet to be implemented in Charlotte-Mecklenburg. Representatives from the ZFive Infant Mental Health Working Group, CMS, CDSA, Smart Start of Mecklenburg County, Assuring Better Child Health and Development, Intensive Home Visitation programs, Mecklenburg County Consolidated Health and Human Services, Cardinal Innovations, local pediatricians and other relevant early childhood partners should collaborate to develop an early-childhood SOC.

This working group, or its designated leaders, should then integrate the Child First model into a wider early-childhood SOC, which would be responsible for promoting the healthy development of young children and strengthening family capacity throughout Mecklenburg County.

Next, these organizations should work with the Child First National Program Office in Bridgeport, Conn., and the regional clinical director in Wilmington to identify a lead organization. Finally, the lead organization should identify affiliate agencies with the necessary qualifications to implement the model, and develop a financing plan for start-up and sustainability so Mecklenburg County can become an official replication site.

I f lack of access is the greatest barrier to children and adolescents receiving treatment for behavioral health problems, increasing their ability to receive help is where reform should begin. Ideally those resources should be located in the neighborhoods where they live.

Given the current political climate in Washington and in Raleigh, funding for Medicaid may very well be reduced over the next decade. And, because parity is unlikely to be achieved in the commercial insurance market, middle class families increasingly will have to pay out of pocket or forgo mental healthcare altogether.

The burden on community agencies and service providers—who already are trying to do more with less—will rise dramatically in the future.

That said, the gaps in services and barriers to treatment identified in this report must be addressed if we as a community are serious about doing a better job of helping our most vulnerable youth. We cannot rely on Medicaid and private insurance alone to fund gaps in services.

The Mecklenburg County BHD manages a network of 16 providers separate from the Medicaid provider network. Could the county find more funding in its annual budget to expand BHD's ability to identify and minimize (or even eliminate) gaps in services and support? Could Mecklenburg County's Consolidated Health and Human Services Agency lead the charge in aggressively pursuing federal grants to eliminate gaps in services?

And could philanthropic organizations "adopt" specific components of this assessment to expand access to care?

Acknowledging that additional funding sources will need to be identified and discussed in order to implement this key strategy, some specific ways to increase access include:

⌄ Adolescent treatment beds

Create more 30- to 90-day adolescent treatment beds, especially for hard-to-place children and adolescent females with substance use disorder, where they can receive a quality assessment.

Among the stakeholders who convened in August 2017 to brainstorm these tactics, disagreement arose about whether Charlotte-Mecklenburg has a shortage of residential placements or whether the issue is that some residential placement facilities refuse to take certain adolescents. If there is indeed a shortage, it appears to be exacerbated by children from outside the county taking up beds in Mecklenburg County, as well as the high cost of such placements coupled with cuts to Medicaid for this service definition.

Opening later this year, Monarch's 16-bed crisis center certainly will help alleviate the problem, but some service providers say Charlotte-Mecklenburg could fill many times that number.

Also, teenage girls in need of round-the-clock supervision and substance use treatment currently are being referred to group homes outside the state.

Since different levels of residential placement require specific licensure from the state—and there are significant differences of opinion over the mental health services most needed—a feasibility study should be undertaken to determine the best type of facility to meet the highest demand.

For example, could a first-of-its-kind "hybrid" facility be funded outside the restraints of Medicaid guidelines to allow flexibility in placement options?

Certainly, the priorities for the potential new beds should be adolescent females with substance use disorder and hard-to-place youth in custody of YFS. At a minimum, any new residential placements should eliminate these two glaring gaps.
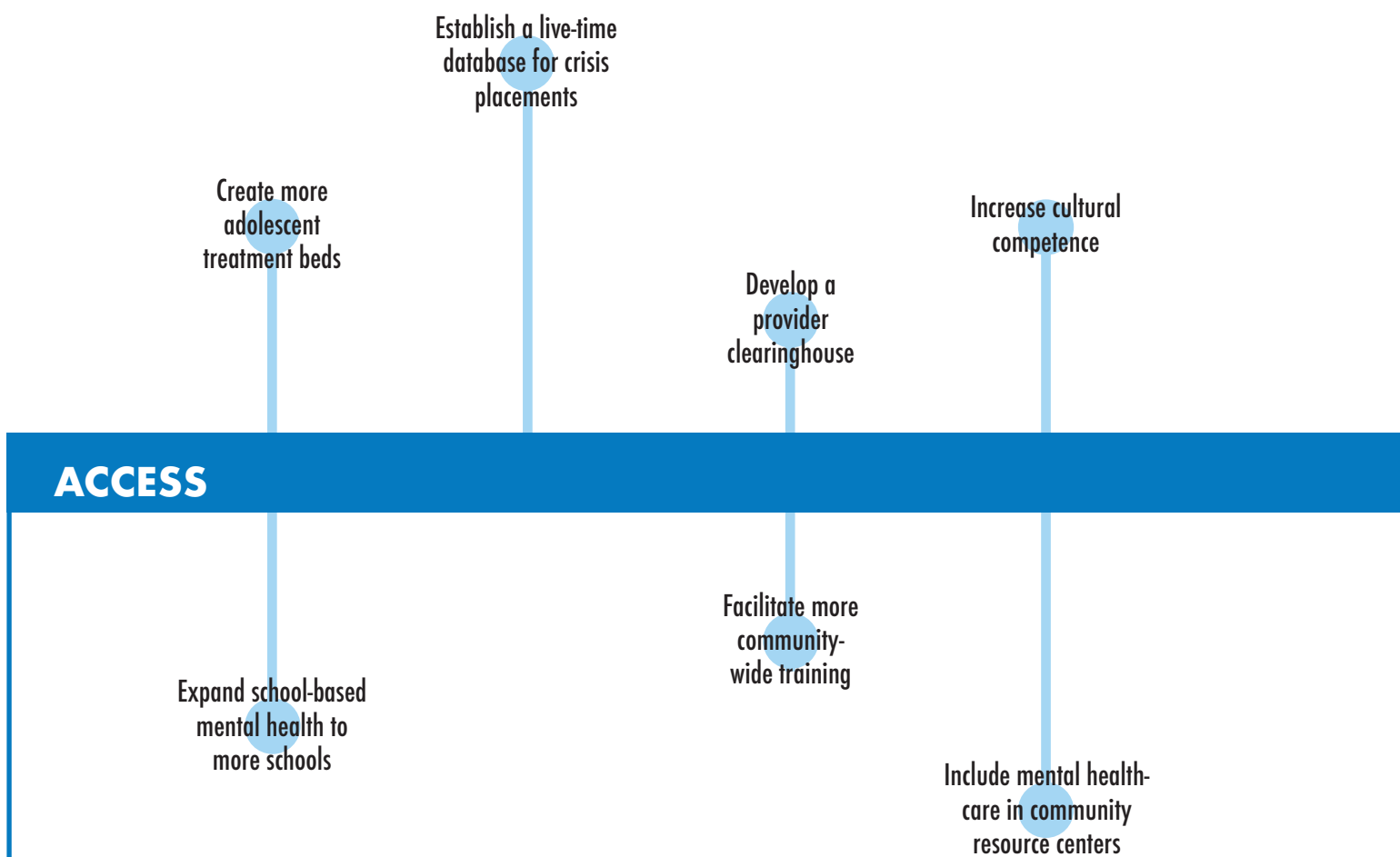
Establish a live-time
database for crisis
placements

Create more
adolescent
treatment beds

Increase cultural
competence

Develop a
provider
clearinghouse

ACCESS

Facilitate more
community-
wide training

Expand school-based
mental health to
more schools

Include mental health-
care in community
resource centers

2. *Increase access to mental health services and support for children and families*

✓ School-based mental health

Expand SBMH services to more schools in the CMS system and consider making the program available to pre-K and charter schools.

Our public school system has the equivalent of one psychologist for every 2.74 schools. The school psychologists and other student services professionals (social workers and school counselors) don't provide clinical counseling per se but rather focus on factors that directly affect children in the school environment. While their work is vitally important,

CMS recognized the need for behavioral health treatment in the school setting and implemented a SBMH intervention program in 2014-15. The program has grown to include nearly 60 percent of schools, and participating students have shown positive trends for attendance, academics and behavior.

However, a barrier to expanding the program to more schools is buy-in from school principals. (As one SBMH agency staffer put it, "CMS should have SBMH in every school, and don't leave the decision to the principal.")

Other barriers include written consent from parents for their children to receive an intake assessment, and consent from the school counselor and CMS administration for students to be placed in the program, creating delays to receiving treatment.

Could all three barriers be mitigated through a streamlined process of consent? Would more school principals sign up for SBMH if they understood the benefits to their students and the promising, early successes of the program?

A survey of parents, students, principals, teachers, SBMH providers, and student services professionals should be conducted to better understand the underlying issues so these barriers may be removed. The survey of SBMH providers should address the challenge of sustaining the program and whether the schools' expectations of clinicians are too high, placing undo time constraints on counselors in proportion to their billable time.

✓ Crisis placements

Establish a live-time database for available crisis placements for children in the custody of YFS.

The availability of residential placements within the facilities that provide housing and treatment to children in YFS custody changes from day to day, hour to hour. The status of the providers also changes frequently, making it difficult to know which are in good standing (and therefore authorized to accept placements), which are being investigated, and which are no longer part of Cardinal's provider network or the YFS placement network. Even if the two provider networks were to remain static, the only way to determine if a bed is available would be to call the providers.

A further complication is the providers offer different levels of care, serve different populations, and provide different types of clinical services. Therefore, a live-time database should be created to manage placement availability. The database would provide care coordinators at YFS and Cardinal with information about each provider, the level of care they provide, and whether any beds are available right now. Thus, to be effective it must be in real time to eliminate the potential problem of a placement being available in the morning and finding out it's gone by the time the child has a court hearing in the afternoon. While such a database wouldn't eliminate the problem of facilities rejecting certain individuals, it would go a long way toward improving the current system.

✓ Provider clearinghouse

Develop a web portal to serve families and professionals by providing a "clearinghouse" of direct service providers, support organizations, and their eligibility requirements, qualifications and services.

As a community, we need to do more to help families stay intact by wrapping services around the entire family. A web portal should be developed to help navigate the system of services and support. It would provide up-to-date information on direct service providers and support organizations. It would give families a comprehensive directory of resources, both public and private, for children's mental healthcare. And it would allow community agencies to see how other providers fit into the overall ecosystem so they can make timely referrals.

✓ Community-wide training

Train more community members to recognize the signs of potential behavioral health incidence so they may connect them with the appropriate resources.

When people who work with children and adolescents are aware of the mental health challenges they face, as well as the resources available to help them, early intervention is more likely. Identifying and resolving a mental health issue before it becomes a crisis is less traumatic for the child and less expensive for society as a whole.

The two hospital systems, Novant and CHS, together have trained about 9,000 teachers, athletic trainers, emergency medical technicians, clergy, firefighters and other non-mental health professionals in Mental Health First Aid. Since 2012, Mental Health America of Central Carolinas has trained more than 5,700 people in Mental Health First Aid. And the Health Department has facilitated training for more than 1,500 police officers in CD-CP. These and other training programs should be expanded to ensure greater numbers of non-mental healthcare professionals, such as bus drivers and cafeteria workers, receive education about children's mental health and how to put families in touch with appropriate resources.

✔ Cultural competence
Address cultural competence and language barriers that limit immigrant populations from accessing mental health services and support for their children.

Due to a federal statute prohibiting undocumented individuals from receiving Medicaid, CMS provides pro bono mental health services to undocumented students, but community agencies are said to lack sufficient numbers of bilingual clinicians to adequately serve this population.

CMS should consider providing training to teachers about the effects of trauma on children who have immigrated to the U.S., especially those who may have been abused by human traffickers or were separated from their parents in detention centers. Children born to immigrants and the trauma they face should be considered, too. And community agencies could make bilingualism a bigger priority in their hiring practices.

✔ County Resource Centers
Finally, **behavioral health services and support should be included as a component of the County Resource Centers** being built in our crescent communities.

WHAT'S THE MENTAL HEALTH TASK FORCE?

Many of the tactics suggested in this report overlap with those of the Mental Health Task Force. Every four years, the Health Department conducts an extensive examination of community health indicators through a state-developed Community Health Assessment (CHA). The department uses findings from the CHA to develop or support collaborative community action addressing issues identified as priorities.

In 2013, the CHA advisory committee reviewed the nine priorities from the 2010 assessment, and county residents were surveyed to re-prioritize the focus areas. More than 100 community agencies participated in a priority-setting meeting and ranked mental health as the No. 2 priority, second to chronic disease and disability. (No. 3 was access to care.) Participants also developed specific recommendations for the top four priority areas.

The second phase of the CHA was to develop a community action plan to address mental health issues. Chaired by Connie Mele, assistant director of the Health Department, the Mental Health Task Force was formed in 2014.[48] The task force determined these steps to be taken:
✔ Increase funding for mental health services, numbers of beds for acute and residential care, and number of providers;
✔ Increase the number of providers representing varied ethnic and cultural backgrounds through scholarships and incentives;
✔ Promote school-based programs;
✔ Make available free or low-cost counseling;
✔ Increase education and prevention services;
✔ Ensure comprehensive care, including physical and mental health;
✔ Work to decrease the stigma of seeking mental healthcare;
✔ Promote Mental Health First Aid training for mental health professionals;
✔ Promote communication and collaboration among mental health providers and other disciplines, such as substance abuse, the criminal justice and education systems, hospitals and social services;
✔ Raise awareness of infant mental health, dual-diagnosis, and the idea that with appropriate treatment people can get better;
✔ Develop a central repository/hub for mental health resources, including more materials in languages other than English;
✔ Extend mental health training to non-mental health professionals and workplaces including law enforcement, the school system, hospitals and social services, and consider non-traditional partners such as frontline workers and transit staff; and
✔ Limit access to firearms.

Whether the task force will continue after the 2017 CHA is completed hasn't been decided. "Unfortunately," one county official lamented, "the task force didn't receive the backing and support it needed to accomplish much."

B ecause the publicly funded mental healthcare system revolves around Medicaid's reimbursement schedules for specific service definitions, the most significant way to reform the system itself is to redesign the financial incentives.

Is there a means and a will to evolve beyond the traditional fee-for-service model? And is there a better way to incentivize LME-MCOs so they're not tempted to deny and delay services merely to avoid spending the state's Medicaid dollars?

Value-based care may hold the potential to transform the system to align the profit motive with what's best for children, by focusing on prevention and intervention rather than treatment after a crisis.

3. *Reward best practices and encourage collaboration and communication*

Create a data warehouse

Adopt a common assessment

Transition to a whole-person model

QUALITY

Eliminate duplication of management and coordination

Explore alternative approaches

Evolve to an outcome-based model

Further, what can be done to minimize the "silo effect" in order to join back together a fragmented mental healthcare system? And how can medical and mental health services be integrated into a "whole person" approach?

Medical and psychological healthcare shouldn't be treated apart from one another. Likewise, mental health, substance abuse and I/DD shouldn't be treated in isolation with separate funding streams for each; that cre-ates hardships for families with children who have dual-diagnoses. Breaking down the silos would involve communication and collabo-ration between the community agencies that comprise Cardinal's provider network.

Mental health professionals should be encouraged to learn best practices from each other, and the agencies' financial incentives should be restructured to reward accurate diagnoses and evidence-based treatments.
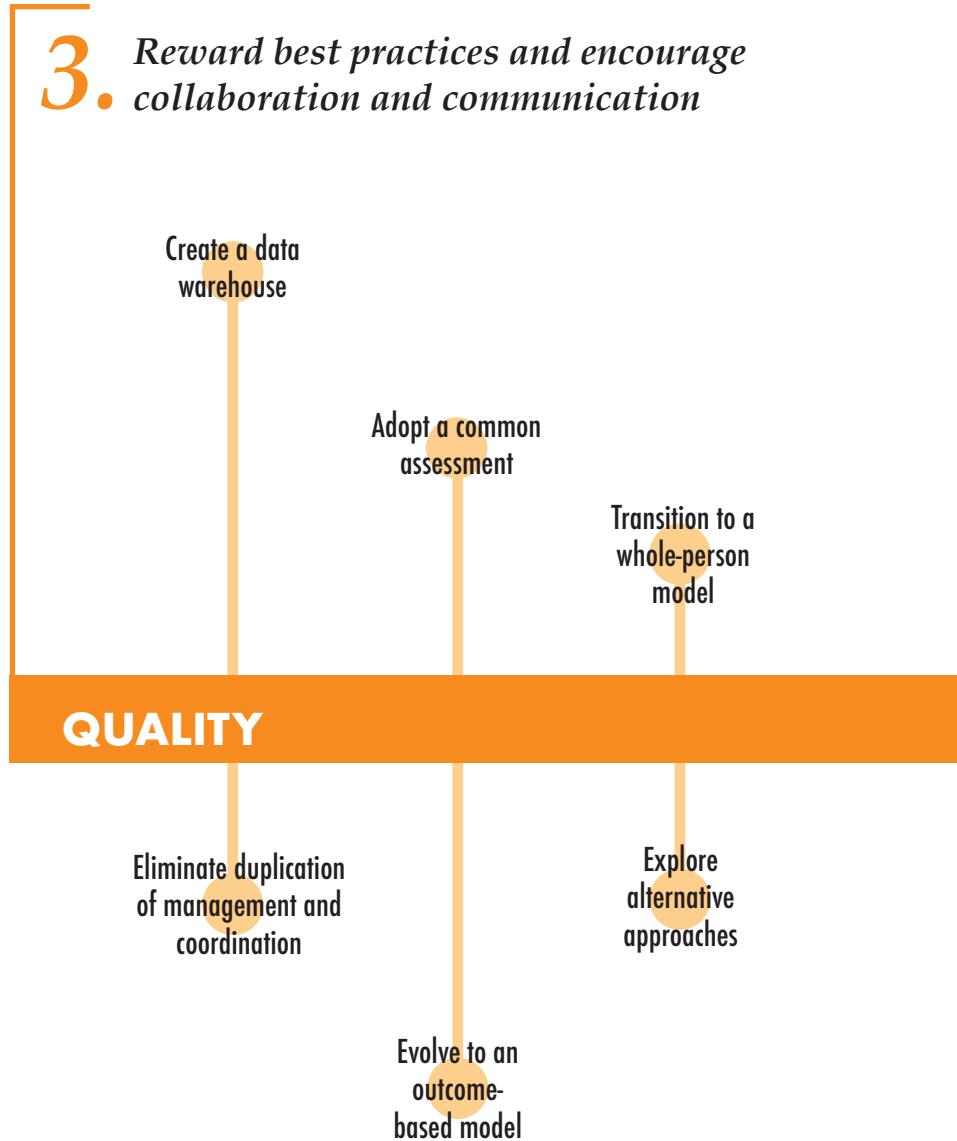
✔ Data warehouse

Create an electronic mental health record and data warehouse accessible to all providers in good standing in the Cardinal network as well as policymakers.

Much of the data collection that took place during the era of the Area Mental Health Authority, and in the years Charlotte-Mecklenburg received a federal SOC grant from SAMHSA, is no longer taking place. And the data that *is* being collected is hard to obtain.

Although patients' privacy must be protected, a mental health system where information, including statistical data, is freely shared would help to eliminate the silo effect and provide a "single view of the citizen."

Without data we cannot see how children from low-income neighborhoods are disproportionately affected, how needs and gaps in children's services can be identified, how financial resources can be directed to services which have the most impact, how strategies can be developed for treatment, how peer networks can be formed to enable parents, teachers and others to collaborate and seek support.

An electronic mental health record, similar to the idea of a "universal healthcare card," would help both families, providers and policymakers. It would allow clinicians to see assessments, evaluations and records of mental health, school, juvenile justice, detention and child welfare contact so they could obtain a complete picture of a child and family's mental health history and socioeconomic circumstances.

It would reduce or eliminate multiple (and expensive) assessments and the risk of further traumatizing children through having to repeat their stories again and again. And it would enable policymakers to make decisions based on facts gathered from analysis of robust data and predictive analytics, including evidence-based modalities, academic performance, graduation rates, college entry rates, and other key measures.

✔ Elimination of duplication

Determine the specific situations and scenarios in which the duplication of case management or care coordination commonly occurs. While too many cooks in the kitchen is better than none, if the system overall must continue to make do with fewer and fewer resources, then it can't afford to pay for duplicate services from separate agencies.

✔ Common assessment

Streamline comprehensive clinical assessments and evaluations where possible by adopting a common, unbiased, independent psychological assessment. This would eliminate wasting resources on duplication, and it would minimize the potential for further traumatizing children through multiple assessments and evaluations by multiple agencies.

✔ Outcome-based model

Evaluate the feasibility of transitioning the LME-MCO provider network away from the fee-for-service model towards an outcome-based reimbursement model that would incentivize treatment plans utilizing evidence-based modalities. According to Cardinal, "as the ability to measure and collect outcome data and the ability to analyze large data sets improves, (we) will continue to expand the use of value based contracting." Are there ways to bring private providers into an evidence-based model as well?

✔ Whole-person model

Determine the systemic changes needed to move towards a whole-person model, a holistic approach to medical and mental health that can reduce barriers and eliminate stigma.

✔ Alternative approaches

Explore ways the community can increase the use of alternative approaches to mental health care, including self-help, diet and nutrition, expressive therapies such as play therapy, yoga and relaxation and stress reduction techniques.

SUGGESTIONS FOR MOVING TO ACTION

This assessment has provided an overall description of the ecosystem of services and support for children and adolescents with mental health needs, the underlying issues and reforms that created the system as it is today, and some of the major gaps in services and barriers to treatment.

In addition, it has suggested three key strategies and 16 implementation tactics to:

✔ Raise awareness about the importance of prevention and early intervention;

✔ Increase families' access to services and support; and

✔ Reward best practices while breaking down the silos that may exist among service providers and other organizations involved in children's mental healthcare.

The overarching goal of this project is to jump-start the implementation of Strategy R of the Charlotte-Mecklenburg Opportunity Task Force report by augmenting the community's understanding of the pediatric mental health system and by developing tangible strategies to address needs and gaps. The strategies discussed on the preceding pages are intended to provide an overall context and general framework for taking decisive action as a community.

During our meetings with nearly two dozen stakeholders, one of the main topics of discussion was the various roles each type of organization should fulfill in the next phase of this work. The stakeholders' input about which organizations should be involved and what roles they should play is illustrated in the chart below.

So where do we go from here? The next phase of this project will be for the funders to convene the stakeholders again, in addition to others who are committed to improving the system. The funders will designate a neutral facilitator to engage the group in discussions about how to address the issues and perceptions raised in this report. The group also will study the recommendations contained in this report to help determine priorities, roles and responsibilities moving forward.

An important point made by many of the stakeholders time and again is that no single organization is in a position to oversee or implement all of the suggested strategies and tactics. Transforming the system will require collective action from everyone involved in children's mental health, as well as the business and academic communities, faith-based organizations, and philanthropy.

As stated in the Opportunity Task Force report, "Our hope is that everyone can find a place to connect with this work and help make a difference."

POTENTIAL IMPLEMENTATION ROLES

	Supply Funding	Raise Awareness	Provide Leadership	Improve Access	Facilitate Training	Reduce Stigma	Collect Data
Business Community		✔	✔		✔	✔	
Charlotte-Mecklenburg Schools	✔	✔	✔	✔	✔	✔	✔
Faith-based Organizations		✔	✔		✔	✔	
Managed Care Organization	✔		✔	✔		✔	✔
Mecklenburg County Government	✔	✔	✔	✔			
Philanthropic Organizations	✔	✔	✔	✔		✔	
Service Providers		✔	✔	✔	✔	✔	✔
Two Hospital Systems		✔	✔		✔	✔	✔
UNC-Charlotte			✔		✔		✔

Note: All groups can impact each role above; however, the checks indicate where groups could have the greatest potential impact.

ENDNOTES

[1] http://tinyurl.com/z5ogrdc

[2] http://tinyurl.com/y94ejb9d

[3] http://tinyurl.com/y8nsax9y

[4, 5, 6] Preliminary numbers are from Cardinal Innovations Healthcare's 2017 Community Mental Health, Substance Use and Developmental Disabilities Services Needs and Gaps Analysis, which had not been finalized at press time.

[7] http://tinyurl.com/zjnyd94

[8] From 2001 to 2011, the number of persons served at the state's psychiatric hospitals declined from more than 17,000 people to fewer than 6,000 people, according to the N.C. Center for Public Policy Research.

[9] http://tinyurl.com/glq23kn

[10] http://tinyurl.com/gt2m78r

[11] http://tinyurl.com/ycrd4ryb

[12] The 20 counties in Cardinal's catchment area are organized into five geographic regions. Mecklenburg is the only county in its region, and that region has the largest general population. The county's Medicaid beneficiaries comprise 37.4 percent of Cardinal's total membership.

[13] http://tinyurl.com/ybu72ey6
http://tinyurl.com/y9yoe66b
http://tinyurl.com/ycm4n28x

[14] Included in the 262 figure are agencies serving adults only, and service providers located in Mecklenburg County that do not serve local residents. Asked how many agencies are in its local provider network for children's mental health, Cardinal did not provide the number of local agencies serving local children.

[15] Two state audits have called into question Cardinal's high salaries and overspending, resulting in its board passing a resolution on October 17, 2017, to cut CEO pay from $617,526 to $204,195. http://tinyurl.com/y7c3hu9y

[16] http://tinyurl.com/me7hpxq

[17] http://tinyurl.com/ksvb7hd

[18] http://tinyurl.com/mcz3b3q

[19] http://tinyurl.com/kbl3vva

[20] CMS receives $330,000 annually from Mecklenburg County to support SBMH.

[21] http://tinyurl.com/ycpbpb4n

[22] MeckCARES Community Training Institute is one of only three sites in North Carolina authorized to provide comprehensive SOC training, which is required in the first 90 days of employment with service providers such as the Department of Juvenile Justice, YFS, DSS, all comprehensive behavioral health service providers and various positions in the school system. Courses introduce participants to the concept of SOC. Skills are developed in CFT coordination through a strengths-based approach, which emphasizes cultural discovery and natural supports. Wrap-around facilitation, strengths assessments, effective child plan development and crisis planning are additional course topics.

[23] SOC team plans go by different names, including the "Child and Family Plan," "One Child One Plan" or "1 Family/1 Team/1 Plan."

[24] According to a top-ranking county official, Mecklenburg made significant efforts to sustain the grant. Asked why it was not sustained, Dr. Cook replied "...probably the majority of the SOC grants in the state didn't sustain well. ...The lack of sustainability in this state is not surprising, given the chaos and poor policymaking at a state level resulting in policies that were inconsistent with SOC implementation."

[25] http://tinyurl.com/zslxmza

[26] Statistic from Charlotte-Mecklenburg Drug Free Coalition as provided by the Dilworth Center

[27] http://tinyurl.com/677gtz8

[28] http://tinyurl.com/yccs95tg

[29] http://tinyurl.com/y82nt8pg

[30] http://tinyurl.com/y9668pyo

[31] The Youth Drug Survey is conducted every two to four years by the Center for Prevention Services in collaboration with CMS. The 2015 self-report survey was administered to 3,892 youth ages 12 to 18.

[32] http://tinyurl.com/yamf5buz

[33] Statistic from CDC as provided by the Charlotte-Mecklenburg Police Department

[34] http://tinyurl.com/y9bp4wjr

[35] With an annual household income of $80,650, a family of three would be just over the limit to qualify for an ACA subsidy. The same family earning $50 less per year would qualify for an estimated monthly subsidy of approximately $1,000 to offset private insurance premiums. Rate quotes are based on 2017 Blue Cross and Blue Shield plans and on hypotheticals such as family members' ages (51, 40 and 2) and applicants' zip code (28202).

[36] http://tinyurl.com/lsur8dw
http://tinyurl.com/lqgcnuv

[37] http://tinyurl.com/kk4l9x5

[38] The estimate of 9,177 is based on national averages of prevalence of mental health issues among infants, toddlers and preschoolers, applying the metric to 2010 U.S. Census data.

[39] Mecklenburg County provided funding in 2017 to hire two transition-age youth peer support staff. One has been outsourced to On

Ramp, the other to Youth Treatment Court and Reid Park Initiative.

[40] http://tinyurl.com/lpfy48l

[41] http://tinyurl.com/ojlkoa8

[42] With Friends is a youth shelter, not a specialized care facility.

[43] In 2016, Hispanics and Latinos represented 13 percent of the county's general population, the U.S. Census estimates.

[44] Children exposed to violence may exhibit the same behaviors and symptoms of ADHD and ODD, which can lead to misdiagnoses.

[45] http://tinyurl.com/lp8fwgq

[46] Asked if Reid Park Initiative has evidence to support its effectiveness, a BHD staffer replied, "...we have some data, but several aspects of this multi-faceted initiative have yet to grow and mature (e.g., housing, mentorship, etc.) to yield meaningful data."

[47] Attendees of the stakeholder brainstorming sessions included Victor Armstrong, BH-C; Adelaide Belk, United Way of Central Carolinas; Joey Bishop-Manton, CDSA; Charles Bradley, YFS; Annie Burton; Ashley Conrad, Alexander Youth Network; Matt Dillworth, Thompson Child and Family Focus; Peggy Eagan, DSS; Dr. John Ellis, psychologist and early childhood consultant; Penny Hawkins, Novant Health Foundation; Heather Johnson, Council for Children's Rights; Janelle Martin, Novant Health Foundation; Angie Meindl-Walker, Forensic Evaluations Unit; Connie Mele, Health Department; Dr. Diana Moser-Burg, Smith Family Wellness at Project 658; Wendy Pascual, Camino Community Center; Dr. Elizabeth Peterson-Vita, BHD; Judge Louis Trosch, Jr., N.C. 26th Judicial District; Laurie Whitson, Cardinal; Candace Wilson, Mental Health America of Central Carolinas/Parent VOICE program; and Will Woodell, Cardinal.

[48] Other members of the Mental Health Task Force include Victor Armstrong, BH-C; Nancy Brandon, Novant Health; Kerry Burch, Epidemiology; Cherene Caraco, Promise Resource Network; Dr. Ken Dunham, Novant Health; Bob Evans, NAMI-Charlotte; Ellis Fields, formerly of Mental Health America of Central Carolinas; Andrea Gardin, Novant Health; Keshia Ginn, Sante Group; Dr. Erica Herman, Novant Health; Teri Herrmann, The SPARC Network; Dennis Knasel, BHD; Melissa Neal, Criminal Justice Services; Dr. Cotrane Penn, CMS; Dr. Elizabeth Peterson-Vita, BHD; Libby Safrit, Teen Health Connection; Anita Schambach, CHS; Bob Simmons, Council for Children's Rights; and Laurie Whitson, Cardinal.

ALPHABET SOUP: ABBREVIATIONS USED IN THIS REPORT

ABC	Attachment and Biobehavioral Catch-Up
ACA	Affordable Care Act (commonly called Obamacare)
ACE	Adverse Childhood Experiences
ADA	Americans with Disabilities Act
ADHD	Attention-Deficit Hyperactivity Disorder
AHEC	Area Health Education Center (Charlotte AHEC)
AMHA	Area Mental Health Authority* (now extinct)
BH-C	Behavioral Health-Charlotte (a CHS facility)
BHD	Behavioral Health Division*
CD	Conduct Disorder
CDC	Centers for Disease Control
CD-CP	Child Development-Community Policing*
CDSA	Children's Developmental Services Agency*
CFT	Child and Family Team
CHA	Community Health Assessment
CHS	Carolinas HealthCare System
CMS	Charlotte-Mecklenburg Schools
CPS	Child Protective Services*
CSS	Community Support Services*
DHHS	Department of Health and Human Services**
DMA	Department of Medical Assistance**
DSS	Department of Social Services*
GAL	Guardian *ad litem*
I/DD	Intellectual and Developmental Disabilities
IPRS	Integrated Payment and Reimbursement System
JCC	Juvenile Court Counselor
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
LME	Local Management Entity
MCO	Managed Care Organization
MST	Multisystemic Therapy
NAMI	National Alliance on Mental Illness
NIMH	National Institute of Mental Health
OB/GYN	Obstetrics and Gynecology
ODD	Oppositional Defiant Disorder
PRTF	Psychiatric Residential Treatment Facility
PTSD	Post-Traumatic Stress Disorder
RMJJ	Race Matters for Juvenile Justice
SAMHSA	Substance Abuse and Mental Health Services Administration***
SBMH	School-Based Mental Health
SOC	System of Care
STS	Secondary Traumatic Stress
TFC	Therapuetic Foster Care
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
THC	Teen Health Connection
YFS	Youth and Family Services*

* A division or department of county government

** A department of state government

*** A branch of the U.S. Department of Health and Human Services

A common theme in many of the interviews conducted for this assessment was the heavy-handed bureaucracy of Cardinal Innovations Healthcare's administration of Medicaid funds. In Charlotte-Mecklenburg, more than 250 community agencies contract with the MCO to provide direct mental health services to children and families who receive Medicaid and state IPRS benefits. In interviews with many of these organizations, Cardinal's role in the authorization of and payment for those services was a dominant topic of conversation. Making sure the agencies comply with the rules is an important, thankless task—but, as one interviewee put it, "Cardinal has superimposed stricter standards than the state has set."

The interviewees' most common complaints were compiled and provided to Ashley Conger, Cardinal's vice president of corporate communications and public relations, in order to provide the MCO the opportunity to respond. The unedited responses are as follows:

1

The most common complaint, and this is nearly across the board, is Cardinal finds ways to delay, limit and deny treatment.

Cardinal Innovations' mission is to improve the health and wellness of our members*—individuals who often have complex needs. We accomplish this by ensuring our members have access to and engage in healthcare services unique to their clinical needs and thus have the greatest probability of clinical success.

As it relates to the complaint that Cardinal Innovations finds ways to delay treatment, the data requires a different conclusion. Cardinal Innovations processes 99.9 percent of all complete requests for routine services, and 99.6 percent of expedited requests within required timeframes. We approved 97.6 percent of all service requests in the last fiscal year.

Unfortunately, many times service requests for individuals with complex needs are incomplete, lacking a comprehensive clinical assessment or other key clinical information to support the service being requested. In these cases, Cardinal has little choice but to ask that an appropriate assessment be conducted or additional clinical information be obtained in order to support a conclusion that the services requested are medically necessary. Cardinal Innovations exercises care and caution when authorizing care for our members, particularly in situations where a child may be removed from his or her home.

Finally, Cardinal's historic clinical denial rate is the second lowest in the state. In fiscal year 2016 Cardinal denied 2.4 percent of requests, while the statewide average clinical denial rate was 4.0 percent. Importantly, every clinical denial of a particular service request issued by Cardinal Innovations includes at its core a recommendation for more evidenced based or clinically appropriate assessments and/or services based on the member's current clinical presentation and the history of prior clinical interventions. It is a recommendation for a more appropriate treatment based on the clinical information available.

2

A similar complaint is treatment is authorized at the lowest level so children have to fail their way up through the levels of service to obtain the treatment they need.

Clinical best practice is to provide services that are appropriate to the clinical presentation of the individual child and delivered in the least restrictive setting. That is good medicine, and it is Medicaid policy.

Children are not required to "fail their way up".

Clinical best practice is, whenever possible, to provide trauma informed, family preserving services to youth in their home, kinship setting, or community-based setting in order to provide the highest likelihood for long term success for the child. Cardinal Innovations recommends

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* "Members" refers to Medicaid enrollees in the Cardinal catchment who have behavioral health needs.

services to promote long term success for each child based upon the individual clinical situation, even if occasionally such recommendations are more challenging to arrange.

Cardinal Innovations regularly receives requests for services which would require a child be removed from their home and sent to a residential facility, sometimes a locked facility, for as long as 6 to 12 months at a time, without an assessment indicating such treatment is necessary, and without first attempting to provide trauma-focused outpatient therapy or family-centered therapy delivered directly in the home setting.

Additionally, a complex case or unique clinical situation often requires care at a specialized facility which may not always be immediately available. Cardinal does not equate "any care" with "the right care". In lieu of approving a request for a service by less appropriate providers who have immediate openings but are poorly equipped for therapeutic success for the child, Cardinal Innovations will approve care to a provider who can offer specialized services, which are much more appropriate for a specific child's situation. In each of these situations, we recommend relevant transitional services to support the member during the period until the most appropriate treatment becomes available.

Cardinal's high turnover and lack of experience among care coordinators means providers spend an inordinate amount of time getting care managers up-to-speed, only to have to do it all again when that care manager leaves Cardinal.

3

Cardinal Innovations prides itself on its ability to recruit and retain talented staff, as evidenced by a voluntary termination rate of 11 percent, a rate that is well below industry averages. Each Cardinal Innovations care coordinator has relevant experience in providing behavioral health services to youth, and for most care coordinators, that prior experience has been in Mecklenburg County. Cardinal is highly selective in its recruitment of care coordinators for children and youth.

We have made an intentional effort over the past 12 months throughout its 20-county service area to improve the clinical and management capabilities of the care coordination staff, in part, which has included addition of new staff, reorganization of management, and changes to work flows, supervision, and roles. Granted, that intentional work has meant more than usual changes over the past year. The current Mecklenburg care coordination team is the highest performing Mecklenburg care coordination team overall since Cardinal Innovations assumed management of behavioral health services in Mecklenburg in 2014.

Another complaint is the paperwork and proofs are too time-consuming and too rigid. As with No. 3, that takes time away from providing direct services.

4

Cardinal Innovations' requirements for care plans and service orders are those prescribed by NC Medicaid. No more or less.

Cardinal Innovations does require that clinical assessments performed are comprehensive, appropriate to the complexity of the case, and instructive to the treatment to be determined for each individual and are not to be provided as some fulfillment of a pro forma service request requirement. This is especially true for our most complex or clinically unique cases. We regularly require providers to obtain more complete or apt assessments so the most appropriate treatment can best be determined. Children with highly complex or unique clinical presentations require and deserve comprehensive, skilled assessments so one can fashion treatments that have a higher likelihood of success and provide these children with wellness, meaningful and healthy relationships, and opportunities to participate effectively in school or work.

5

One of the more serious allegations is Cardinal cut some services three days after the state mandated that Cardinal spend the money it had bankrolled. The mandate was to spend the surplus on providing services to members.

Cardinal Innovations' state-funded service array has remained unchanged despite the fact that State budgets for mental health services were cut significantly in fiscal year 2016 and again in 2017. During that same time, Cardinal Innovations has made up the difference, maintaining the same level of funding for services for the uninsured and underinsured as existed prior to the budget cuts, at a cost of approximately $12 million in fiscal year 2016, and $25 million in fiscal year 2017. In order to maintain that funding, and attempt to provide increased access to care for our non-Medicaid members*, Cardinal Innovations undertook significant efforts in the fall of 2015 to maximize the coverage of services under our Medicaid health plans.

In November 2015, Cardinal Innovations issued a series of communications to our provider network to encourage each provider to critically evaluate whether members currently receiving certain state-funded services** could receive the same or similar services, as clinically appropriate, through Medicaid. For example, we found that a small number of children receiving Intensive In-Home services paid by state funding could receive the exact same service by the same provider, but was funded instead by Medicaid, if Medicaid eligibility for the children was pursued more assertively.

By ensuring members were appropriately accessing public resources for which they were eligible, including identifying and assisting individuals with enrollment in Medicaid, we were able to maximize limited state funding available for the benefit of individuals who cannot access Medicaid.

6

Cardinal's power to interpret Medicaid regulations and to do "report cards" on providers gives it the ability to "play favorites." That favoritism translates into higher rates for the same services, and more referrals given to its favorites.

One of the key tenets of managed care is the closed network. Under fee-for-service Medicaid, Medicaid enrollees are allowed to receive services from, and the State Medicaid Agency is required to pay any qualified provider of those services. Under managed care, states give MCOs the right to contract with those providers who are willing to meet certain quality standards, ensuring Medicaid enrollees have access to quality healthcare that achieves their wellness goals. Cardinal Innovations uses various tools to ensure the quality of its closed network of providers, including training and incentive-based mechanisms to encourage its providers to meet certain quality criteria.

Over the last two years, Cardinal Innovations has implemented value-based contracting for Therapeutic Foster Care, Multi Systemic Therapy, and Family Centered Treatment. Provider payments are tied to provider performance. Explicit criteria are provided to each provider, training is provided on a group and individual provider basis, member specific performance under the criteria is reported to each provider, and providers are given the chance to provide additional information before scores are finalized. It is entirely open code. We want every provider to thrive under value-based contracting, resulting in more effective services and outcomes for our members and increased payment levels to providers.

The payment level for each provider under value-based contracting is determined expressly by each provider's performance. The only favoritism exercised by Cardinal Innovations has been the extra individual training and consultation provided to low-scoring providers in attempts to assist the providers to improve performance and enhance the effectiveness of care to members.

Cardinal Innovations implemented value-based contracting for Therapeutic Foster Care in late 2015. The performance criteria encourage TFC agencies to work with fostering families to

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* "Non-Medicaid members" refers to recipients of IPRS funds, which are available to certain individuals who don't qualify for Medicaid.
** "State-funded services" refers to IPRS funds

make sure that children are assessed by a psychiatrist early upon placement in the home and an effective treatment plan implemented, that children are regularly engaged in therapy, and that families are engaged in family therapy so that families are better able to be successful once children are restored to their natural home. There are 17 total measures. In a little over a year the providers' overall performance has improved by 43 percent. More therapy, more family engagement, better opportunities for better outcomes and healthier children and families.

Cardinal's denial rate for basic outpatient services is too high. 7

Outpatient therapy using clinical best practices is the most readily accessible, efficacious, and most cost effective generally available treatment modality. Cardinal Innovations was one of the first LME-MCOs to implement Comprehensive Care Clinics covering all of our 20 counties where members could receive same day walk in assessments and care. Effective, accessible outpatient therapy is a high priority for Cardinal Innovations and we work with providers to make outpatient assessment and therapy readily accessible.

For fiscal year 2016, almost 40,000 members covered by Medicaid received outpatient therapy. We issued 45 denials for outpatient therapy (0.1 percent). These denials typically were where the number of visits requested greatly exceeded 24 per year and the clinical presentation indicated that continuing with the same therapy was not going to provide the desired clinical outcome and alternate therapy was preferable.

Cardinal Innovations allows 24 visits each fiscal year before an authorization is required. 92 percent of members receiving outpatient therapy do not exceed the 24 visits and no authorization request needed to be submitted. The similar state requirement is 16 visits for children. Cardinal Innovations allows 24 visits without authorization required to promote the easy access and provision of appropriate outpatient services.

Two years ago, there were a handful of outpatient therapy providers in Mecklenburg which showed outlier utilization patterns. A systematic retrospective review of actual clinical records conducted by licensed therapists using consistently applied review criteria showed that in some cases the utilization pattern was justified, and the clinical record documented that clinically appropriate, evidence-based services were being provided. In other cases, there was no, or scant, support for the number or nature of services provided. Some of these latter providers were placed on a performance plan and improved, others are no longer participating in the Medicaid program.

Cardinal's denial rate for intensive in-home services is too low. 8

Intensive In-Home is a service that can be effective if utilized correctly, ineffectual if not. Cardinal Innovations has worked with providers and its utilization management program to promote the use of clinical best practice and more appropriate use within the delivery of IIH services. Through these efforts, the use of IIH in Mecklenburg today is 38 percent of what it was when Cardinal Innovations began managing services in Mecklenburg in Spring 2014. The clinical appropriateness of use of IIH in Mecklenburg is much greater now than previously.

Even at this more clinically appropriate level of utilization, currently one out of every 11 Mecklenburg IIH requests is denied and, upon clinical review by a PhD psychologist or child psychiatrist, other more clinically appropriate services for the specific clinical situation are recommended instead.

Cardinal Innovations recognized the limitations of IIH and innovated to obtain NC Medicaid exception approval for two new alternative services to increase the milieu of services available and allow more effective treatment for children. Family Centered Treatment, a nationally recognized, evidenced based treatment was implemented in Mecklenburg in late 2015 under a value based contract. Early results have been promising. FCT has been especially helpful in certain complex cases and in other cases that otherwise would have resulted in long term treatment in a residential program away from the child's home.

In mid-2015, Cardinal Innovations also rolled out In Home Therapy Service with a greater emphasis on outpatient therapy performed by a licensed professional in the youth's home. This service has a greater therapy intensity than IIH and is informed by the dynamics of the child's actual home environment. These two new services, together with outpatient therapy, IIH, Multisystemic Therapy, and Respite provide a richer milieu of community based services which can be better tailored to each child's clinical situation. Our goal is to promote access to the most clinically effective service with data that supports the best outcomes, much like what is done for heart disease or cancer. As such, these alternative services provide children and their families with the greatest opportunity for success. In fact MST was specifically designed for youth who are engaged with the court system who have complex family issues, educational difficulties and require coordination across all systems. There are specific rules that direct the treatment and providers must be certified and adhere to standards. We will often deny IIH and recommend MST for youth who meet the criteria as it is the most appropriate treatment. Cardinal Innovations plans to launch value based contracting for IIH in Summer 2017.

9

Cardinal is too quick to label a patient as noncompliant and cut off services.

Cardinal Innovations seeks to give every child every chance to be successful in treatment and have the greatest opportunity for recovery, resilience, symptom abatement, wellness, family preservation, and success at school or work.

Behavioral health rehabilitative services are provided with a child, not to a child. Rehabilitative services require the ability of a youth to participate in therapy. In rare cases, the record of a youth's repeated failure to engage or participate in therapy demonstrates convincingly that the youth will not be able to participate in the treatment requested. If one persists in the face of non-participation, the treatment will not prove effective, the child is at risk for further treatment failure and trauma, other alternative treatments that may prove more likely to be helpful are forgone and valuable time is squandered. And, in the case of congregate settings like residential or PRTF, other youth are at high risk for treatment disruption, treatment failure, or injury.

Such cases require a complex set of professional and clinical considerations. Recommendation for alternate therapy due to the demonstrated inability of a youth to participate successfully in the requested treatment is entered into soberly and with exhaustive consideration by a board-certified child psychiatrist and the treatment review team. Determinations about reductions or denials of services for all members can only be made, per Medicaid rules, by a doctorate level clinician. In Cardinal Innovations' case, we have 3 BC/BE Child and Adolescent Psychiatrists on staff (including our CMO) as well as 3 PhD Psychologists with expertise treating the under 21 population. In addition, we have methods of identifying and escalating complex cases to each of these doctors and cases are reviewed daily on a scheduled basis. Our team looks at all elements which impact the child and their family and as such consider the social, emotional, psychiatric, developmental and educational needs consistent with standards of practice when making decisions. When necessary our team pulls together all key stakeholders to address treatment needs.

10

The compensation paid to Cardinal's top-level management is far too high.*

Cardinal Innovations pays market compensation for all of our staff based on the healthcare industry and paid out of the administrative fee we charge the state. The federal rule allows us to charge up to 15 percent for our administrative fee. We charge only 8.05 percent and for the past two years, have continued to provide a full array of services while state-funded mental health budgets were cut. Importantly, market compensation of our staff in no way restricts or limits the amount of services we are able to provide to our members. Our pay for performance model ensures our employees are compensated based on how well they serve our members.

* http://tinyurl.com/ydxtnjor   http://tinyurl.com/y75btnza   http://tinyurl.com/yd7obla9
   http://tinyurl.com/y7ch2uq9   http://tinyurl.com/h8lpxsc   http://tinyurl.com/yb7osugb