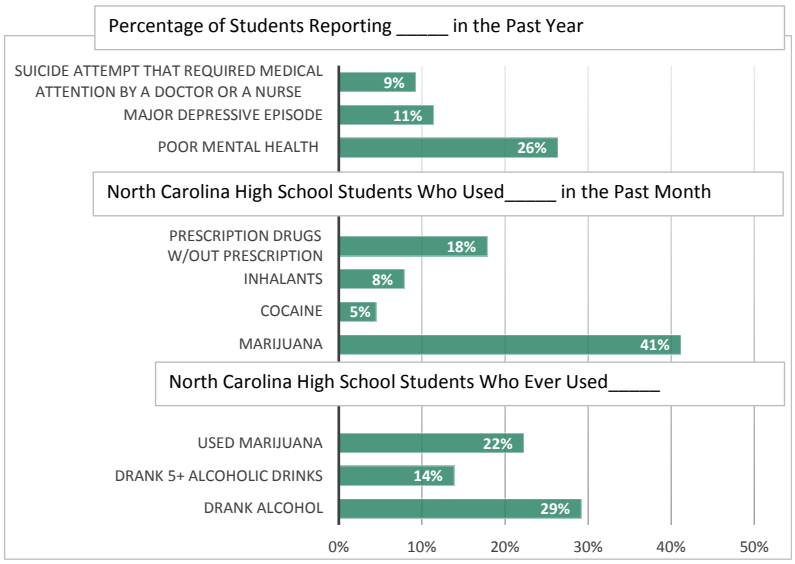
Chapter Four: Meeting The Needs of Adolescents

Mental health and substance use disorders are the most significant threat to the lifelong health and well-being of youth.[1] Approximately one in five adolescents has a diagnosable mental health or substance use disorder that, if left untreated, will likely persist into adulthood and contribute to poor lifelong education, employment, and health outcomes.[2] Adolescence, defined in this report as ages 12 to 18,[a] is an especially vulnerable time for the onset of mental health and substance use disorders. During this time, youth are maturing physically, cognitively, and sexually, while also developing social and intellectual skills in preparation for taking on adult roles. Although many adolescents experience some level of difficulty with emotional and behavioral regulation, these challenges are normal and most youth are able to develop positive mental health skills—including coping, resilience, and good judgement—that promote overall well-being. Similarly, during this time many youth experiment with drugs and alcohol, but most do not develop substance use disorders. However, as previously stated, approximately one in five adolescents does develop diagnosable mental health or substance use disorders.[2] Adverse experiences, in addition to biological factors and family history with mental health and substance use issues, can increase an adolescent's susceptibility to mental health and substance use disorders.[3] Youth with mental health and substance use disorders are often involved in more than one special service system, including mental health, special education, child welfare, juvenile justice, and health care.[1] However, the majority of mental health and substance use disorders among adolescents go unrecognized or untreated. Developing an improved system of mental health and substance use prevention, screening, and treatment, as well as improved coordination across youth-serving systems, are critical in order to create a more positive health trajectory into adulthood.

Figure 4.1: Poor Mental Health and Substance Use Are Common Among North Carolina's Adolescents



Source: NC Youth Risk Behavior Survey 2015 and National Survey on Drug Use and Health NC 2013-2014

Adolescents with mental health and substance use disorders are more likely to have academic or social problems, be expelled or suspended, become pregnant during adolescence, be convicted of a crime, and attempt suicide.[4] Furthermore, approximately half of adult mental health disorders start by age 14, and three in four start by the age of 24.[3] The majority of adults with substance use disorders started using substances during adolescence.[3] However, national data show that only 20% to 25% of eligible youth receive mental health services.[3] In North Carolina, the majority of adolescents with mental health and substance use needs do not receive treatment services.[5] Prevention and early intervention are particularly important among adolescents, as are follow-up care and recovery supports after treatment. Ensuring a full continuum of care for adolescents can result in substantially shorter and less disabling experiences with mental health and substance use disorders.[1]

Specific populations among young people are particularly at risk for mental health and substance use disorders, including youth involved with child welfare and juvenile justice systems, as well as disconnected youth. Disconnected youth are adolescents who are not connected to the skills, supports, resources, opportunities, and relationships needed to navigate their environment and succeed, such as those who have dropped out of school.[6] Mental health and substance use treatment is particularly challenging for youth not integrated within traditional systems. Nearly 1 in 14 North Carolina teenagers, aged 16 to 19, reported that they were not attending school and not working in 2014.[7] Furthermore, as youth age into being young adults, there is strong evidence that they face significant barriers to accessing care and treatment.[8]

a Adolescence is a period of development that does not begin or end at the same age for everyone. Adolescence is often considered to last until age 21, but for the purposes of this report we have elected to focus on youth ages 12-18.

Challenges to Meeting the Mental Health and Substance Use Prevention, Treatment, and Recovery Needs of Adolescents

In 2006, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DDMH/DD/SAS) and partners received a grant to identify challenges within the adolescent substance abuse system. While the adolescent substance abuse system was the focus, many of the same challenges exist in regards to mental health services for adolescents. This study found that coordination both within and across systems is a significant barrier to effective treatment; there is a need for better training of clinicians around screening and assessment for adolescents; and utilizing more evidence-based strategies to address adolescent mental health and/or substance use disorders would improve service delivery and health outcomes.[9] Because youth with mental health and substance use disorders are often involved in more than one special service system, the adolescent workgroup of the Task Force focused its recommendations on improving coordination within and across systems.

Systems Serving Children and Families Need Leadership and Support to Ensure Cross-System Collaboration

Youth with mental health and substance use disorders are often involved in more than one special service system, including mental health, special education, child welfare, juvenile justice, and health care.[1] These youth often have a variety of physical, mental, social, emotional, educational, and developmental needs. For example, in 2015, 21% of youth screened upon entering the juvenile justice system in North Carolina showed moderate or high risk for neededing substance use treatment. Youth and their families must navigate and then interact with multiple systems on a regular basis to meet these needs. These systems may include schools, medical and behavioral health care, social services, juvenile justice and the courts, local management entities/managed care organizations (LME/MCOs), and other community organizations working with youth and families. Coordination and cross-system collaboration between these various entities is crucial to best meet the needs of youth and families.

In North Carolina, as in the rest of the nation, no one agency is responsible for these youth.[1] However, meeting the mental health and substance use needs of youth involved in these systems is critical. If adolescents' mental health and substance use disorders are not identified and assessed, and then followed up with effective treatment and recovery supports, these disorders often continue into adulthood, and may lead to school failure, poor employment opportunities, and poverty.[1] In order to address this issue, there is a need for better coordination and collaboration at the systems level to meet the behavioral health needs of children and their families.

At the state and community level, North Carolina has been using a system of care (SOC) framework for the existing systems to come together to provide care to children with mental health needs (and their families) since the 1980s. At the heart of SOC is the value that systems must collaborate to meet the needs of children and families. In a SOC, services are family driven, youth guided, community-based, and culturally competent. SOC is a "spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life."[10] SOC has been shown to decrease the use of inpatient psychicatric and residential treatment, juvenile correction, other out-of-home placements, and health services, including emergency rooms.[11]

DMH/DD/SAS has supported the SOC framework as best practice for children with mental health and substance use needs. Beginning in 2001, the Departments of Public Instruction, Child Welfare, Juvenile Justice, and Public Health all commited to the SOC framework. In 2006, the North Carolina General Assembly awarded funding to DMH/DD/SAS to create a statewide staffing infrastructure (30 local SOC coordinators) to support cross-system networking and local service development. A primary responsibility of the SOC coordinators is to support the membership development and functioning of the local Community Collaboratives. These collaboratives are charged primarily with serving as the guardian for all local system of care development, and are intended to represent all the public child-serving systems in the community, family members of youth who rely on those systems, schools, private and community-based child-serving agencies (both non-profit and for profit agencies), and other community stakeholders concerned about the health, safety, and well-being of children and families in the community. The LMEs that have also become managed care organizations were given contractual responsibility for both the SOC coordinators and the Community Collaboratives.[b]

b Grant T. State System of Care Coordinator, North Carolina Department of Health and Human Services. Written (email) communication. August 14, 2016.

There is a statewide coordinator in the North Carolina System of Care who is financially supported by DMH/DD/SAS. The system is supported at the local level by Community Collaboratives. Community Collaboratives bring together community agencies, families, service providers, organizations, and advocates who are concerned about and committed to children with mental health, substance abuse, and intellectual or developmental needs and their families to provide local leadership within the SOC. Community Collaboratives at the local level serve as a forum at the local county/regional level for child-serving systems to design protocols and coordinate policy to improve service coordination for special populations including multi-agency involved children with behavioral health needs. There are 87 Community Collaboratives across the state. The LME/MCOs typically have staff (usually called SOC coordinators or community care coordinators) who help coordinate the meetings. While SOC has been the framework for providing services to youth with mental health, intellectual, developmental, and substance use needs for a long time, changes in personnel, funding, and systems have limited statewide application of this important framework for serving children and families.

Additionally, no formal authority requires the child-serving systems to utilize a common philosophical and operational framework to ensure that public resources are maximized to support the needs of all children dependent upon public child-serving systems. The many systems serving children and families all have their own processes for identifying the mental health and substance use needs of the children and families they work with, as well as their own strategies for meeting those needs. There is a need for better collaboration at the local systems level (e.g., LME/MCOs, the court system, child welfare, juvenile justice) to ensure that information, policies, procedures, and funding are better coordinated to meet the needs of youth and families. LME/MCOs are well-positioned to lead local cross-systems collaboration efforts, as they are often the front door for mental health and substance use services for youth enrolled in Medicaid and those who are uninsured, which, when taken together, account for 56% of children.[12] Therefore, the Task Force recommends:

Recommendation 4.1: LME/MCOs should act as a lead player in cross-system collaboration.

DDMH/DD/SAS contracts with LME/MCOs should require commitment to the System of Care (SOC) model as well as participation in local Community Collaboratives. As part of this commitment, LME/MCOs should:

1) Ensure that LME/MCO leadership (not just SOC coordinators, but also appropriate LME/MCO decision-makers) meet quarterly with leadership from the Department of Social Services, local departments of health, school districts, juvenile courts, primary care provders, and juvenile justice groups (i.e., Reclaiming Futures, Juvenile Crime Prevention Councils, Juvenile Justice Substance Abuse Mental Health Partnerships, and Juvenile Justice Treatment Continuum groups) within their catchment areas.

2) Include at least one youth and one youth family member in all Community Collaboratives.

3) In counties where there is not a functioning Community Collaborative, partner with a similar collaborative organization (e.g., Juvenile Crime Prevention Councils, Juvenile Justice Mental Health Substance Abuse Partnerships, Reclaiming Futures) and encourage the group to consider acting as a SOC Community Collaborative.

4) In partnership with Community Collaboratives, LME/MCOs should establish guidelines for screening youth for mental health and substance use when they encounter any system and develop pathways for youth with positive screens to access assessment and treatment services as indicated.

5) In partnership with Community Collaboratives, LME/MCOs should establish guidelines for consolidating case plans when children and families are served by more than one system.

6) Lead efforts to enhance coordination of care within and across systems for youth and families and identify pathways for access to care and ongoing case/care management when needed.

Recommendation 4.2: Support and further develop local System of Care (SOC) Community Collaboratives.

1) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DDMH/DD/SAS) should:

a) Develop outcome measures to indicate whether or not System of Care (SOC) is working.

b) Provide training and technical assistance for SOC coordinators to conduct Community Collaborative assessments, strengthen Collaborative membership, use data in creation of priorities, and develop local agreements to increase collaboration for the youth with the most complex needs.

c) Work with other key public child-serving agencies to inventory existing training and technical resources across public agencies that can be utilized to support the development of local systems of care and Community Collaboratives.

2) LME/MCO SOC/Community Collaborative coordinators should work to:

a) Strengthen and diversify Community Collaborative membership including increasing family and youth representation.

b) Develop and monitor progress on data-supported priorities, including disparities in access and treatment by age, gender, race/ethnicity, or other factors.

c) Develop local agreements to increase coordination of care across public agencies.

Assure that, as LME/MCO consolidation proceeds, SOC coordinator funding and staffing is adequate to meet the needs of a growing number of communities in the catchment area of the LME/MCO.

Schools Can Play a Significant Role in Meeting the Mental Health and Substance Use Prevention, Treatment, and Recovery Needs of Youth

Youth with mental health and substance use disorders are most likely to access services through schools and health care settings.[13] Adolescents spend a significant amount of their time in school, and teachers and other school personnel are important partners in efforts to identify youth with mental health and substance use needs and route them to appropriate services. In fact, many students in North Carolina receive mental health services at their school through school counselors, social workers, and mental health therapists.[14] North Carolina schools have implemented Positive Behavior Intervention and Support, a schoolwide proactive system of behavior support that defines and teaches appropriate student behaviors and positive school environment; as well as other discipline strategies to ensure that schools are caring and safe places for all children. However, the level of understanding of adolescent mental health and substance use disorders varies greatly across school personnel.

School personnel are in a key position to identify youth with mental health and substance use problems, as the vast majority of youth ages 12-18 are enrolled in school and interact with their teachers daily.[15] School personnel play a large role in whether an adolescent is identified as needing mental health and substance use services or is identified as having behavioral problems that should be handled through discipline and juvenile justice involvement. Raising awareness of youth mental health and substance use and teaching skills to handle various behaviors can increase school personnels' ability to identify and respond in constructive ways. Therefore, the Task Force recommends:

Recommendation 4.3: Educate school personnel on the behavioral health needs of adolescents.

To increase the knowledge and skills of school personnel,

1) The North Carolina Department of Public Instruction should:

a) Work with local superintendents and schools to publicize the online credits for current professional modules related to student behavioral health.

b) Work with the public and private institutions of higher education and with educator and school counselor preparation programs to ensure that elective courses on adolescent development and behavioral health qualify towards degree credit.

c) Work with the North Carolina Sheriffs' Education and Training Standards Commission to make Youth Mental Health First Aid a credit-earning course for student resource officers and explore making Youth Mental Health First Aid a requirement for student resource officers. The Department of Public Instruction should work with the Commission to make crisis intervention trainings and courses on adolescent development credit-earning electives as well.

2) Local boards of education should encourage school staff and others who work with youth to receive Youth Mental Health First Aid training and Trauma-Informed Care training. (see Recommendation 3.3 Increase Number of North Carolinians Trained in Mental Health First Aid).

3) Each school district should ensure that at least two staff are trained in Youth Mental Health First Aid, ideally as instructors. These staff serve as the point persons to assist in the event of a crisis and coordinate staff training.

Schools in North Carolina work to meet the mental health and substance use prevention, treatment, and recovery services and supports needs of students in a variety of ways. Many schools have processes in place to assess risk and refer students and families to community-based mental health and substance use supports.[16] Others have resources like a school-based health center that can assist in meeting the mental health and substance use needs of students. However, schools have also identified challenges that prevent them from fully meeting the needs of students, including lack of services (particularly in rural counties), difficulty obtaining services for students with private or no insurance, need for parent training, and more prevention services at all levels of schooling.[16]

A handful of school districts across the state have increased access to services for students with mental health and substance use service needs through partnering with local LME/MCO and provider communities to bring services into schools. For example, Buncombe County schools have collaborated with their local provider community to bring services into schools for more than 20 years.[14] The most common service provided is outpatient therapy provided in the school setting.[17] By teaming with local providers to bring services into their schools, schools can increase access to, coordination of, and family engagement in mental health and substance use treatment services.[14,17] In some cases, providers working in the school also provide training for staff around youth mental health and substance use disorders.[17] School systems that have participated in such partnerships emphasize the importance of this process of being collaborative with the local LME/MCO and provider community and the need for clarity of purpose, services, and structure for providing services in schools. Because of the benefits to students, families, and schools, the Task Force recommends:

Recommendation 4.4: Encourage partnerships between schools and LME/MCOs.

1) The Department of Public Instruction and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should develop models for effective, coordinated efforts between LME/MCOs and schools, school-based health centers, service providers, and school systems. Model memoranda of agreement should be developed and shared with the North Carolina School Boards Association, superintendents, and principals. Memoranda of agreement should not exclude service types, particularly evidence-based programs delivered to fidelity. The agreements should include:

a) Model memorandum of agreement between a school district and their LME/MCO that outlines how these entities can partner to meet the mental health and substance use needs of students and their families.

b) Model memorandum of agreement between a school, LME/MCO, and service providers that outlines how these entities can work together to meet the mental health and substance use needs of students and their families.

2) Local school boards should encourage schools in their district to explore ways to partner with providers to meet the mental health and substance use needs of children and their families.

Creating Trauma-Informed Systems

Adverse childhood experiences (ACEs), including child maltreatment, family dysfunction such as violence in the home, mental illness, substance abuse, and incarceration of a family member, affect children throughout their lives. In North Carolina, more than half of adults reported having experienced at least one ACE, with 20% reporting three or more.[18] Although many children experience traumatic events without lasting negative effects, others will have more difficulty and long-lasting impacts. Unaddressed trauma increases an individual's risk of developing mental health and substance use disorders, as well as heart disease, obesity, lung disease, diabetes, and other conditions in adulthood.[19] Research has shown that with appropriate supports and interventions, people can overcome the negative effects of trauma. In order to address the needs of youth who have experienced trauma, our child- and family-serving systems need to understand the impact of trauma and how service systems can help alleviate or exacerbate trauma-related issues.[13]

Among the many systems that serve youth and their families, North Carolina's juvenile justice and child welfare systems are leading the way in implementing trauma-informed policies and practices. Trauma-informed systems realize the widespread impact of trauma on children and families, recognize the signs and symptoms of trauma among those involved in the system, respond by integrating knowledge about trauma into policies, procedures, and practices, and work to not re-traumatize those within the system.[20] The main principles of the trauma-informed approach are safety, trustworthiness, transparency, peer support, collaboration, mutuality, empowerment, and cultural competency.[20] Project Broadcast is a five-year federal grant (2011-2016), from the U.S. Department of Health and Human Services Administration for Children and Families, awarded to the North Carolina Division of Social Services with the goal of developing a trauma-informed child welfare system in 12 demonstration counties. The results reported from these counties will be used to inform the best strategies to implement trauma-informed practices and then incorporate these practices statewide. Implementing trauma-informed practices and policies come at a cost: the North Carolina Division of Social Services estimates an allocation of $800,000 per year in recurring funding in FY 2017-2025 would be needed to support implementation of Project Broadcast in all 100 counties. However, evidence is emerging that such investments reduce both direct and indirect costs substantially.[21] Identifying and addressing trauma can help improve outcomes for children and youth, including minimizing the likelihood of developing mental health and substance use disorders. Therefore, the Task Force recommends:

Recommendation 4.5: Support the implementation of trauma-informed child and family serving systems across North Carolina counties.

The North Carolina Department of Health and Human Services should:

1) Promote the integration of trauma-informed practices and policies across human service and public safety agencies serving youth.

2) Introduce trauma-infromed services into the core education and training for child and family serving human service and public safety agencies.

3) Emphasize interdisciplinary collaboration and relationship-building across child and family serving human service and public safety agencies.

4) Develop a Trauma Advisory Council to help oversee efforts to develop trauma-informed systems.

Improving Medicaid for Youth with Serious Emotional Disturbance

The adolescent workgroup of the Task Force also examined potential changes to Medicaid that would help improve services for youth with serious emotional disturbance. Youth with serious emotional disturbance includes those "who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities."[22] These are youth with high cost, high intensity mental health and substance use treatment needs.

In 2015, the North Carolina General Assembly asked the Division of Medical Assistance to study the feasibility of implementing a 1915(c) waiver for children and adolescents with serious emotional disturbance who meet the psychiatric inpatient level of care.[23] This waiver would allow children who meet the level of care for placement in a psychiatric residential treatment facility (PRTF) and their families to have a choice of receiving home and community-based services in their home or foster home in the community rather than being placed in a restrictive institutional setting. The Division of Medical Assistance found that an average savings of at least 35% could be achieved by implementing a 1915(c) waiver for serious emotional disturbance.[23] Nine other states have implemented similar waivers and found cost savings of up to 68% over the cost of PRTF admissions, improved school attendance and performance, improved clinical and behavioral outcomes, decreased contact with law enforcement, and other positive outcomes.[23] Therefore, the Task Force recommends:

Recommendation 4.6: Submit a Medicaid waiver to best serve youth with serious emotional disturbance.

The North Carolina General Assembly should instruct the North Carolina Division of Medical Assistance/ Division of Health Benefits to submit a 1915(c) Medicaid waiver to serve children with serious emotional disturbance in home and community-based settings.

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