Intervention

Chapter 5

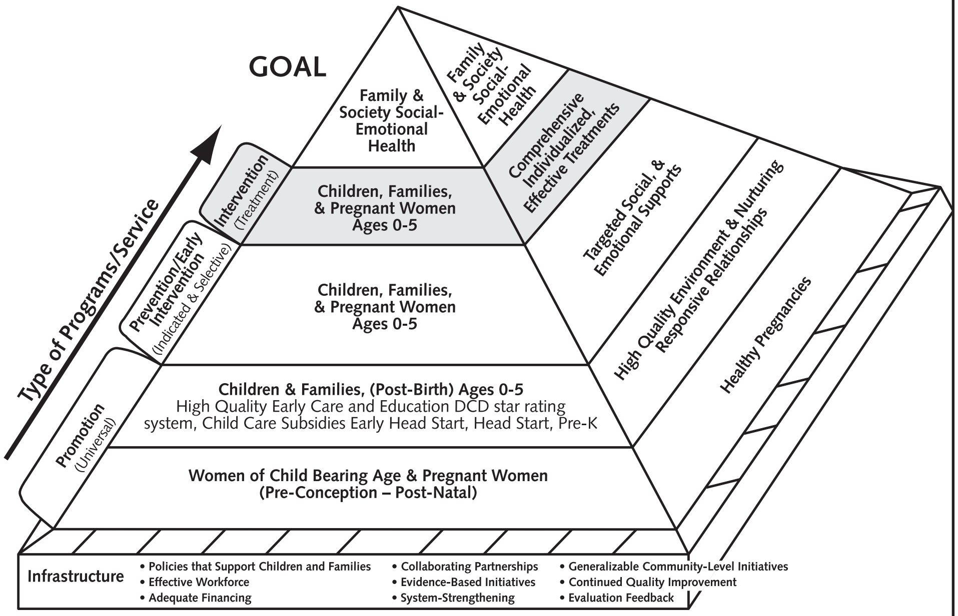
Within the framework for strengthening early childhood social-emotional development and mental health, intervention is about comprehensive, individualized, intensive treatment for the pregnant women, mothers, and young children with persistent social-emotional and mental health challenges. Interventions are aimed at resolving problem behaviors as well as supporting the development of new skills. It's essential that pregnant women and mothers of young children with persistent mental health and substance abuse disorders have access to this level of treatment. The goal of treating mothers is to improve the mother's well-being and health as well as the child's environment and relationship with his or her mother. A subset of young children with social-emotional and mental health needs also need access to this level of treatment. Research shows that intervening early can have a profound and positive effect on social-emotional problems as well as improve outcomes for children with serious disorders.[1]

Mental Health and Substance Use Treatment for Pregnant Women and Mothers of Young Children

Poor mental health and substance use during pregnancy and the early childhood years negatively impacts the health of the mother and child and impairs the

Intervention services provide comprehensive, individualized, intensive treatment for the pregnant women, mothers, and young children with persistent social-emotional and mental health challenges.

Figure 5.1
Pyramid for Strengthening Early Childhood Mental Health and Social Emotional Competence in Young Children



Note. This pyramid model conceptualizes the critical building blocks for achieving healthy mothers and healthy children. The front face of the pyramid explains the individuals and families who receive programs and services, which are divided up by the following categories: promotion, prevention, and intervention. The pyramid's side face lists the goals associated with the program/service recipients(s). these are further divided according to the socioecological model of health behavior. The foundation of the pyramid represents the necessary system-building blocks.

mother-infant relationship which is critical for social-emotional development and mental health. As discussed in the Chapter 4, pregnant women and mothers of young children should be screened for mental health and substance use problems. Screening is the first step in identifying mental health and substance use disorders. If the initial screening indicates there may be a problem, a more thorough assessment is needed. The purpose of assessment is to gather detailed information needed to define the problem, make a diagnosis, and develop a treatment plan that meets the needs of that individual.[2] While screenings and brief interventions for mental health and substance use disorders can be done by a range of health professionals, a thorough assessment should be performed by qualified and trained clinicians. Once the assessment is complete, a diagnosis and referral for treatment can be made and a treatment plan can be developed. In addition to a treatment plan for the mother, the needs of the child should also be considered. The children of mothers with mental health and substance use disorders often have impaired relationships with their mothers. Successfully treating the mother's mental health and substance use disorders does not usually solve the problems in the mother-child relationship—which is critical for healthy social-emotional development—unless there is an explicit therapeutic focus on the relationship.[3]

Poor mental health and substance use during pregnancy and the early childhood years negatively impacts the health of the mother and child and impairs the mother-infant relationship which is critical for social-emotional development and mental health.

Barriers to Treatment

Mental health disorders can disrupt the mother-child relationship. In particular, the Task Force focused on maternal depression due to prevalence and the documented impact of maternal depression on the mother-child relationship. Maternal depression is a medical disorder that can negatively affect a woman's ability to function as a mother, which can harm family functioning and young children's social-emotional, cognitive, and language development.[4] Women with maternal depression respond well to treatment. The most common forms of treatment for maternal depression are psychotherapy, pharmacotherapy, or a combination of both. However, mothers cite many barriers to treatment including the cost of treatment/lack of insurance coverage, lack of knowledge about the impact of depression and where to seek treatment, time constraints, and a reluctance to take medications.[5] Of those women who are screened and have a score indicating a need for treatment, most do not see a professional for treatment.[5]

Substance use impairs a mother's ability to provide a nurturing, responsive relationship and high quality environment, both of which are essential for young children's social-emotional development and mental health.[6] Furthermore, alcohol use during pregnancy is the cause of the leading preventable birth defect associated with mental and behavioral impairment.[7] Research shows that gender plays a role in the physical effects of substance use, patterns of use, barriers to treatment, access to treatment, and effectiveness of treatment. For example, women have more severe complications and health problems from substance use than men, women develop substance use disorders faster than men, women who have substance use disorders are more likely to have partners with substance use disorders which can then impact treatment engagement and outcomes, and women are more likely to be primary caregivers which is a barrier to receiving treatment.[2] Additionally, research has shown that women have unique needs when it comes to substance use treatment. Gender-specific factors which influence treatment and recovery include the importance of relationships, the influence of family, the role of substance abuse in sexuality, the prevalence and history of trauma and violence, and common patterns of co-occurring disorders.[2] Similarly, women often also need access to treatment which addresses pregnancy, child care, child services, and parenting skills.[2] Meeting these needs is critical to increasing treatment engagement and retention as well as improving outcomes for women and their children.[8]

Being responsible for the care of dependent children is one of the biggest barriers for women receiving treatment.[2] Out-patient programs typically do not provide child care and very few residential programs offer dyadic treatment or allow mothers to have their children with them. Treatment for pregnant women is also difficult to find due to challenges around providing counseling, prenatal care, infant care, and services for older children within one program.[2] In addition to the lack of treatment programs designed for pregnant women and mothers of young children, many women fear the legal consequences of entering treatment, including losing custody of their children.[2] Other barriers to treatment include not being ready to stop using the substances, cost and health insurance barriers, social stigma, and not knowing where to go for treatment.[7,9]

Successfully treating the mother's mental health and substance use disorders does not usually solve the problems in the mother-child relationship unless there is an explicit therapeutic focus on the relationship.

Coverage for Treatment Services

As discussed in previous chapters, more than one in five women of childbearing age in North Carolina do not have health insurance and, therefore, do not have access to affordable mental health services.[10] About 51% of women receive Medicaid coverage during pregnancy.[a] Medicaid for Pregnant Women[b] covers services to treat conditions that may complicate pregnancy, including depression and substance use. Through North Carolina's Pregnancy Medical Home Model, pregnant women with mental illness including depression and substance abuse, receive additional care management services through a pregnancy care manager. Care managers work with individuals to determine needs, establish care plans, and connect individuals to needed care. However for most women, Medicaid coverage currently ends 60 days postpartum. Under the Affordable Care Act (ACA) states have the option to expand Medicaid coverage to cover more low-income adults (those will incomes up to 138% FPG, or $31,800 for a family of four in 2012). (At the time of writing, North Carolina had not made a decision on Medicaid expansion.)

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[a] Goldsmith, Catharine. Behavioral Health Section, Clinical Policy Programs, North Carolina Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication May 24, 2012.

[b] Eligibility periods ends on the last day of the month in which the 60th postpartum day occurs. (North Carolina Division of Medical Assistance, A Consumer's Guide to North Carolina Health Care Coverage Programs for Families and Children. North Carolina Department of Health and Human Services website. http://www.ncdhhs.gov/dma/medicaid/famchld.pdf. Accessed May 10, 2012.)

The majority of women who have private health insurance have mental health benefits. As of January 1, 2011, private employer based health insurance plans with more than 50 employees must provide mental health and substance use disorder benefits on parity with physical health benefits[c] (according to the federal Mental Health Parity and Addiction Equity Act of 2008).[11] This should increase women's access to mental health care and treatment for substance use problems. In addition, the ACA extends the same mental health and substance abuse parity to other small group and non-group plans beginning in 2014. Thus, most health plans will provide coverage for mental health and substance abuse disorder services.[12]

Women often need access to treatment which addresses pregnancy, child care, child services, and parenting skills. Meeting these needs is critical to improving outcomes for women and their children.

Individuals with mental health needs who have Medicaid coverage or who are uninsured are referred to the Local Management Entity-Managed Care Organization (LME/MCOs) serving their area.[d] As discussed in Chapter 2, LME/MCOs receive limited state funding to provide mental health services to target populations. North Carolina's target population includes pregnant women needing treatment for alcohol or drug use disorders, but does not include pregnant women with other mental health concerns.[13,14]

Current North Carolina Efforts to Provide Mental Health and Substance Use Treatment for Mothers

The University of North Carolina at Chapel Hill's Center for Women's Disorders in the Department of Psychiatry has clinical programs aimed at improving women's perinatal mental health. The Perinatal Mood and Anxiety Disorders Program targets women with mood and anxiety disorders during pregnancy and postpartum. The Perinatal Psychiatry Inpatient Unit is a five bed inpatient unit that provides inpatient care for women with serious mood conditions during pregnancy or postpartum. The Center also offers Interpersonal Psychotherapy, an evidence-based psychotherapy program to treat perinatal mood disorders; Partner-Assisted Therapy, which involves the spouse, partner, or a family member to continue treatment in the home; and Mindfulness-Based Cognitive Therapy, a group therapy for individuals with a history of depression.[15]

There are a number of programs and inititatives that provide substance abuse services, including treatment, to women and their families before and after the birth. The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Public Health (DPH) fund a substance use specialist position at the Alcohol/Drug Council of North Carolina. The substance use specialist provides technical assistance, training, and education regarding screening and referral for pregnant women and maintains a list of residential substance abuse services (including numbers of beds available for these women and their children). DMH/DD/SAS also funds the North Carolina Teratogen Information Service which provides prevention,

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[c] If they cover mental health benefits.

[d] By 2013, the current system of Local Management Entities will be replaced by a system of Local Management Entities-Managed Care Organizations.

education, and support activities, helps with patient evaluations and referrals, and operates the Pregnancy Exposure Riskline, which provides evidence-based, clinical information to patients and health care professionals about exposure to harmful substances during pregnancy and lactation. In addition, DMH/DD/SAS, through the LME/MCOs, provides support for qualified substance abuse professionals to be stationed in local Departments of Social Services (DSS), to provide screening, assessment, care coordination, and referral services to families involved with their local DSS.

DMH/DD/SAS also supports the North Carolina Perinatal and Maternal Substance Abuse Initiative (PMSAI), which funds 21 specialized programs for women, before and after birth, with a substance related disorder. PMSAI includes residential services for pregnant and parenting women. Residential programs typically provide substance abuse treatment, life skills training, parenting education, child care, and transportation.[16] The PMSAI also supports transitional and outpatient programs for women. All of these programs are specifically designed to meet the needs of women who are using substances while they are pregnant and/or parenting and the needs of their children. Women can enter treatment with their children and receive comprehensive gender-specific substance abuse services as well as treatment for their children. The children served benefit from the services provided by the local health departments (pediatric care), early intervention programs, local child mental health providers, and child services coordination. Space in these programs is limited and many programs maintain waitlists.

More than one in five women of childbearing age in North Carolina do not have health insurance and, therefore, do not have access to affordable mental health services.

While North Carolina has a number of programs and services targeting pregnant women and mothers of young children who have substance abuse disorders, the number of residential programs that are able to accommodate women with children is limited. Additionally, there are few options available for women before and after birth who need comprehensive treatment for depression or other mental health concerns, or for treating the mother and infant/young child relationship. Therefore, the Task Force recommends:

Recommendation 5.1: Expand Treatment Services for Mothers with Substance Use and Mental Health Challenges

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), in collaboration with the North Carolina Division of Medical Assistance, the North Carolina Department of Health and Human Services housing specialists, the North Carolina Housing Finance Agency, and the North Carolina Division of Social Services should examine options to expand the array of treatment options for pregnant women and mothers with mental health and substance use disorders, including supports for women in their own home as well as residential treatment services. In particular, DMH/DD/SAS and partners

should explore options for women with young children who need to be in developmentally-appropriate environments to engage in mother-child treatment while their mother receives targeted treatment. DMH/DD/SAS should bring recommendations about resources needed to address these needs to the Joint Legislative Oversight Committee on Health and Human Services of the North Carolina General Assembly, no later than June 30, 2013.

Treatment for Young Children's Social-Emotional Development and Mental Health

It is estimated that between 9-14% of young children have serious and persistent emotional and behavioral health disorders (approximately 91,000 children ages 0-5 in North Carolina)[e] These children struggle to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn. They display repeated challenging behaviors that interfere with learning and positive engagement with caregivers and other children which jeopardizes care and preschool placements, disrupts family functioning, and affects growth and development in other domains. Challenging behaviors may include physical and verbal aggression, property destruction, severe tantrums, self-injury, noncompliance, and withdrawal. The intensity, frequency, and duration of such challenging behaviors is what distinguishes them from typical behavior during early childhood years.[17] Examples include:

- An infant with a substance abusing mother who is neglected and has delayed social development.
- An extremely fussy infant or very quiet infant who does not develop a secure relationship with her caregiver and has delayed social development.
- A toddler who responds to stressful situations by biting and kicking is avoided by other children and, therefore, does not develop the social skills needed to successfully interact with others.
- A 4-year old who does not respond to directions, is defiant and argumentative, and is expelled out of preschool.

Early identification and treatment can have profound and positive effects on social-emotional problems as well as improve outcomes for children with serious disorders.

Children who exhibit challenging behaviors at this level are vulnerable. In the short-term, challenging behaviors impact relationships with caregivers, peers, and teachers; in the long-run, persistent challenging behaviors can be the precursor to lifelong physical and mental health problems if left untreated.[17] North Carolina's Great Smoky Mountains Study indicates that these children are at substantially greater risk for: school dropout, childcare and school expulsion, drug or alcohol abuse, unplanned teen pregnancy, and conviction of crimes.[18] Early identification and treatment can have profound and positive effects on social-emotional problems

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[e] Based on 757,664 children ages 0-5 in 2010, 12%=90,920 children (0.12*757,664 = 90,920) (Office of State Budget and Management. July 1, 2010 County Total - Single Year Ages. http://www.osbm.state.nc.us/demog/countytotals_singleage_2010.html. Accessed June 20, 2012)

as well as improve outcomes for children with serious disorders.[1] The goal of treatment is to address and resolve problem behaviors before the behaviors become entrenched and seriously impact a child's current and future well-being.

As discussed in Chapter 4, there are many avenues for a child to be referred to a mental health provider including parents, pediatricians or other health care providers, early care and education providers, public health and other social service agencies, or the North Carolina Court System. Depending on the source of the referral, the child's age, the exact nature of the social-emotional and mental health needs, and the child's health insurance status, the young child could be referred to the Children's Developmental Services Agency (CDSA), LME/MCO, the Local Education Agency, or a private mental health professonal.

The goal of treatment is to address and resolve problem behaviors before the behaviors become entrenched and seriously impact a child's current and future well-being.

Coverage for Treatment Services

Federal Individuals with Disabilities Education Act

Young children ages 0-5 with significant social-emotional and mental health needs may qualify for treatment services under the federal Individuals with Disabilities Education Act (IDEA). In North Carolina, IDEA services are provided through the Infant-Toddler Program (ITP) for children ages 0-36 months and through the Preschool Program for children ages 3-5. (See Chapter 2.) The criteria for qualifying for the ITP are determined by the state, within the guidelines set by federal IDEA Part C.[19] To qualify for ITP in North Carolina, children with a social-emotional, cognitive, physical, communication, or adaptive developmental delay must meet a specific level of delay[f] or have an established condition.[19] Established conditions related to social-emotional and mental health development include fetal alcohol syndrome (FAS) and attachment disorder.[19] Children ages 3-5 with atypical social-emotional development that could interfere with their ability to learn may qualify for special education and other related services (such as speech therapy, occupational therapy, physical therapy, transportation, etc.) through the North Carolina Preschool Program. Children who qualify for services under IDEA receive evaluations and care coordination at no cost. Coverage and cost of intervention services varies based on the child's insurance status and income level. (See Table 5.1.)

Private Health Insurance

Parents of children ages 0-5 with social-emotional and mental health needs may seek help from local mental health providers directly, or be referred to treatment. Children with private health insurance coverage receive services according to their coverage plan. See "Coverage for Treatment Services" under "Mental Health and Substance Use Treatment for Pregnant Women and Mothers of Young Children" above for more information.

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[f] The delay must be documented at a minimum of two standard deviations from the norm on a standardized test in one area of development or one and a half standard deviations from the norm in two or more areas. (North Carolina Infant and Toddler Program. New Eligibility Definition for the NC Infant Toddler Program. North Carolina Department of Health and Human Services website. http://www.beearly.nc.gov/data/files/pdf/EligibilityDefn.pdf. Accessed May 9, 2012.

Table 5.1
Eligibility for Treatment and Care Coordination Services, by Age and Insurance Status

	Treatment	Care Coordination
Private Insurance		
All Ages	Private providers (may or may not need prior approval depending on insurance plan)	May or may not get care coodination, depends on insurance plan.
Ages 0-36 Months, ITP Eligible	If qualify for Infant-Toddler Program (ITP), Children's Developmental Services Agency (CDSA) would cover treatment services not covered by private insurance plan based on a sliding fee scale.	CDSA
Ages 3-5, Preschool Program eligible	No coverage for mental health services.	No care coordination
Medicaid		
Ages 0-36 Months	6 mental health visits per year without a diagnosis 16 unmanaged mental health visits per year Additional mental health visits require prior approval from Value Options"	Medicaid-enrolled children with high-risk, high-costs, high-acuity health needs (e.g., asthma, congestive heart failure, chronic obstructive pulmonary disease, and diabetes) may receive care coordination through Community Care of North Carolina (CCNC). Children ages 0-5 who have been exposed to toxic stress and children with persistent social-emotional or behavioral health conditions may qualify for care coordination through Care Coordination for Children (CC4C).
ITP eligible	If qualify for ITP, CDSA would cover treatments not covered by Medicaid based on a sliding fee scale.	CDSA
Ages 3-5	6 mental health visits per year without a diagnosis 16 unmanaged mental health visits per year. Additional mental health visits require prior approval from Value Options."	Medicaid-enrolled children with high-risk, high-costs, high-acuity health needs (e.g., asthma, congestive heart failure, chronic obstructive pulmonary disease, and diabetes) may receive care coordination through CCNC. Children ages 0-5 who have been exposed to toxic stress and children with persistent social-emotional or behavioral health conditions may qualify for care coordination through CC4C.
Preschool Program eligible	No coverage for mental health services.	
Medicaid for Pregnant Women	Medicaid covers services to treat conditions that may complicate the pregnancy, including depression and substance use. Coverage ends 60 days postpartum.	Pregnant and postpartum women who are screened and found to have mental health conditions that may complicate their pregnancy or ability to bond with the infant, including depression and substance abuse, receive additional care management services through a CCNC pregnancy care manager.
Other Adults	8 unmanaged mental health visits (with a diagnosis) per year. Parents can receive 6 mental health visits under their child's Medicaid coverage. Additional mental health visits require prior approval from Value Options.	CCNC provides care coordination for the adult Medicaid population with high physical health needs and low behavioral health needs. LME/MCOs provide care coordination for the adult Medicaid population that has high behavioral health needs and low physical health needs.
Uninsured		
Ages 0-36 Months	No coverage for treatment, must pay out-of-pocket.	No care coordination
ITP eligible	If qualify for ITP, CDSA would cover treatment services based on a sliding fee scale.	CDSA

	Treatment	Care Coordination
Ages 3-5	LME/MCO Target Population: young children ages 3-6 with atypical social-emotional and behavioral development, exposure to physical or sexual abuse or other environmental situations that could significantly delay social-emotional development, or a parent with substance use or mental health disorder. Children in this population who seek treatment through the LME/MCO should get treatment through state funding to the LME/MCO. Children receiving state-unded services must pay out-of-pocket expenses according to a state-designed sliding scale related to family income.	Unlikely to qualify for care coordination. However, LME/MCOs provide care coordination for the population with high behavioral health needs and high costs.
Preschool Program eligible	No coverage for mental health services.	
Prenatal and Postpartum Women	LME/MCO Target Population: pregnant women needing treatment for an alcohol or drug use disorder. Women in this population who seek treatment through the LME/MCO should get treatment through state funding to the LME/MCO. Women receiving state-funded services must pay out-of-pocket expenses according to a state-designed sliding scale related to family income. Prenatal and postpartum women with other mental health concerns are not part of the LME/MCO target population. They must pay for treatment services out-of-pocket.	Unlikely to qualify for care coordination. However, LME/MCOs provide care coordination for the population with high behavioral health needs and high costs.
Other Individuals	Individuals who meet the LME/MCO target population definitions should get treatment through state funding to the LME/MCO. Individuals receiving state-funded services must pay out-of-pocket expenses according to a state-designed sliding scale related to family income.	Unlikely to qualify for care coordination. However, LME/MCOs provide care coordination for the population with high behavioral health needs and high costs.

Medicaid

Children receiving Medicaid may be referred to a local mental health provider by their primary care provider or, for children ages 3-5, they may be referred to the LME/MCO for further assessment and referral to treatment. Children receiving Medicaid can receive up to 6 mental health visits without a diagnosis and up to 16 visits without prior authorization. If more than 16 visits are needed, the services must be approved by Value Options (or the LME/MCO, if the LME has converted into a Managed Care Organization), the managed care mental health and substance abuse services operator for Medicaid, regardless of whether the child went through Value Options to first obtain treatment.[g]

Uninsured Children

As discussed earlier in this chapter, limited state funding for mental health services for the uninsured is allocated for target populations. Young children ages 3-5 who exhibit atypical social-emotional and behavioral development, have been exposed to physical or sexual abuse or other environmental situations that could significantly delay social-emotional development, or parents with substance use or mental health disorder are included in the target population.[20]

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[g] Currently Value Options must approve mental health and substance abuse services for most Medicaid recipients. In the Durham, Eastpointe, and Piedmont LME catchment areas, the LME approves services. (ValueOptions. North Carolina Medicaid. ValueOptions websites. http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm. Accessed May 11, 2012.) Under the new LME/MCO structure, the LME/MCO will approve services for the population ages three and older. Value Options will continue to approve services for children 0-36 months.

Parents of children receiving state-funded services must pay out-of-pocket expenses according to a state-designed sliding scale based on family income. Uninsured children ages 0-2 who do not qualify for treatment services through the CDSA must pay the full cost of mental health services out-of-pocket.

Improving the Quality of Women and Young Children's Social-Emotional and Mental Health Care

Currently many variables affect an individual's chance of receiving the kind of high quality mental health treatment services that have been shown to make a positive difference in the lives of women and young children. Health insurance coverage is critical to helping people pay for needed health care services. However, simply having health insurance does not guarantee identification or treatment of social-emotional and mental health needs. Whether or not a provider screens for depression, substance use, and atypical social-emotional development; the quality of the tool used; whether or not the provider is trained in providing brief intervention services; the availability of providers to provide more intensive treatment services; the knowledge of and ability to refer to local mental health providers; and the types of treatment available through local providers all play a role in determining whose needs are identified, whether or not appropriate treatment is received, and the quality of treatment.

There is a need to establish standard protocols for the tools and methods used for screening, triage, assessment, referrals, and clinical treatment.

There is a need to establish standard protocols for the tools and methods used for screening, triage, assessment, referrals, and clinical treatment to address the social-emotional and mental health needs of pregnant women, young children ages 0-5, and their families. As discussed in Chapter 2, evidence-based programs and interventions are those that have been proven, through evaluation, to achieve positive health outcomes. Whenever possible, the state should encourage the use of evidence-based, or evidence-informed, strategies to provide screening, triage, assessment, referrals, and treatment. In addition to improving the quality of care women and young children receive, clearly defined protocols could help both providers and families better navigate the system.

In addition, the state can do more to encourage and reward behavioral health providers to use evidence-based screening and assessment tools, to obtain training in evidence-based treatment methods, and to deliver evidence-based treatment with fidelity via the state's adopted System of Care (SOC) framework. (See Chapter 3 for more information on SOC.) However, the current Medicaid and DMH/DD/SAS payment system is largely based on a fee-for-service model. Health care and behavioral health professionals are paid for each procedure or treatment provided, regardless of whether evidence-based treatments, shown to achieve positive outcomes, were used. In the context of the waiver, the state should begin to move to a value-based payment system that pays providers, in part, based on the outcomes achieved. In order to accomplish this goal, DMA, CCNC, DMH/DD/SAS, LME/MCOs, and other appropriate partners should define age-appropriate, validated behavioral health process and outcome measures to tie to performance-based payments. In addition, the state should maintain a list of health care professionals who have received training and are rostered in evidence-based treatment methods.

This is a particularly opportune time to transition to a performance-based payment system. As discussed, LME/MCOs are responsible for managing, coordinating, facilitating, and monitoring mental health, developmental disability and substance abuse services and funding at the local level. In addition to providing screening, triage, and referral to treatment services for the population ages 3 through adult, under the state's 1915(b)/(c) Medicaid waiver, the Division of Medical Assistance (DMA) contracts with the LME/MCO to provide mental health, developmental disability, and substance abuse services for the counties they serve. LME/MCOs receive a capitated payment to provide services for their area. Under the waiver, LME/MCOs will be able to pay providers differential rates, limit the provider network,[h] and provide some care management services. These new options provide opportunities to incentivize providers and improve the quality of services provided. In a waiver context, getting the right services and supports to the individual in need at the right time is crucial to the broader success of the waiver. For effective child outcomes, a Child and Family Team, with membership specific to each child's strengths and needs and comprised of those who the family identifies as service providers and supports, work together to plan appropriate services and supports for each child and family. The Child and Family Team develop, implement, monitor, and revise the Person-Centered Plan based on team review of the ongoing comprehensive clinical and developmental assessments. When services and supports are implemented in a System of Care framework , positive outcomes and savings will accrue, not only in the public mental health sector, but in other health and human services as well.[21] It should be noted as part of North Carolina's system change via the 1915 (b)(c) waiver, all of North Carolina should be implementing or should have implemented SOC as outlined above in order to ensure the efficacy of the system, both fiscally and, more importantly, qualitatively for the child and family.

The state should begin to move to a value-based payment system that pays providers, in part, based on the outcomes achieved.

There is an identified need to improve current systems for screening, triage, assessment, referral, and treatment for both women and young children. Doing so could increase the number of individuals whose needs are identified and referred to treatment and, ultimately, improve the quality of care delivered and the outcomes for women and children served. Therefore, the Task Force recommends:

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[h] After the first year.

Recommendation 5.2: Establish Care and Reimbursement Standards to Promote Women and Children's Mental Health (PRIORITY RECOMMENDATION)

a) The North Carolina Division of Medical Assistance (DMA), in collaboration with Community Care of North Carolina (CCNC), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Public Health (DPH), and the North Carolina Infant and Young Child Mental Health Association (NCIMHA) should identify evidence-based or evidence-informed prevention programs, screening tools, triage, assessment, referral protocols, and clinical guidelines, for:

  1) **Pregnant women using or abusing alcohol or other harmful substances.**

  2) **Women with prenatal or postpartum depression or other mental health disorders.**

  3) **Infants and young children with social-emotional and mental health needs.**

  4) **Women and children who have experienced family violence or other trauma.**

b) DMA, CCNC, DMH/DD/SAS, Local Management Entity/Managed Care Organizations (LME/MCOs), DPH, and NCIMHA should define age-appropriate, validated behavioral health and social-emotional and mental health process and outcome measures on which to tie performance-based incentive payments.

c) DMA, CCNC, DMH/DD/SAS, DPH, LME/MCOs, and NCIMHA should develop value-based Medicaid payments that provide additional reimbursement to professionals who are in the roster and provide evidence-based or evidence-informed protocol in clinical settings and natural environments (e.g. home, primary care, early care and education), and report process and outcome measures for the following populations:

  1) **Pregnant women using or abusing alcohol or other harmful substances.**

  2) **Women with prenatal, perinatal or postpartum depression or other mental health disorders.**

  3) **Infants and young children with social-emotional and mental health needs and their families.**

4) Women and young children who have experienced family violence.

d) Private insurers should also implement changes to incentivize health care professionals to use evidence-based screening, assessment, referral, and clinical treatment protocol for similar populations.

Care Coordination and Care Management

Effective social-emotional and mental health interventions often involve more than one provider and more than one system of care.[22] Therefore, linkages between providers and systems (e.g. public health, mental health, early care and education) are critical to ensuring children and families receive the services and support that they need (such as medical care, family support, and transportation). Even if the resources are available and linkages exist, families may need assistance understanding and navigating multiple providers and systems. (Table 5.1 on pages 94-95 provides an illustration of the various systems and policies that providers and families must navigate when trying to obtain treatment and care coordination services.) Care coordination (also referred to as service coordination or case management) includes efforts to assure young children and their families are connected with needed services and supports. Care coordinators also help improve communication between families and providers. Care coordination has the potential to reduce some of the barriers to treatment that families face.[22]

Linkages between providers and systems are critical to ensuring children and families receive the services and support that they need.

Care coordinators can help families understand the types of services their child needs as well as connect them with providers, monitor treatment, and provide follow up to ensure that services are received and are adequate to meet the child's needs. Additionally, care coordinators may help identify services and supports to meet other family needs which affect children's development (e.g. nutrition services and parent skills training). Care coordination is a benefit that is provided to some children and families through private health insurance, Medicaid, or other programs. Who is eligible and what types of support are offered through care cordination vary widely. Care coordination is available to some participants receiving services through North Carolina's public systems, including the Infant and Toddler Program, the Preschool Program, CCNC, CC4C, and the LME/MCOs.

Care management programs assist high-risk or high-cost populations, or populations with specific diseaeses. Care managers may provide individuals with educational materials, in-person or telephonic consultations from nurse care managers or social service specialists, a personalized plan of care, transition care after hospitalizations, and identification and coordination of other community resources. Most often, if individuals do not fall into the high-risk categories that the case managers screen for, the individuals do not receive case management services.

Infant and Toddler Program

Children ages 0-36 months with delayed social-emotional development or established conditions that qualify for North Carolina's Infant andToddler Program (ITP), may receive care coordination services (service coordination) through Children's Developmental Services Agencies (CDSA). As discussed in Chapter 2, eligible children receive a thorough assessment and then work with a service coordinator to develop an Individualized Family Service Plan (IFSP), which outlines the needs of the child and family. Service coordinators organize services and supports to meet those needs and provide monitoring and follow-up to ensure that services are received and are adequately meeting needs. If services are not meeting the needs of the child and family, the service coordinator is responsible for making adjustments to the IFSP and services. The job of the service coordinator is to ensure that the needs identified in the IFSP are met which, depending on the child and family being served, may require intensive support. Service coordination is provided at no cost to families. (See Chapter 2 for more information on ITP.)

Care coordination includes efforts to assure young children and their families are connected with needed services and supports.

ITP service coordinators have training to work with infants and toddlers with specific developmental needs. They are trained to identify those needs and have extensive knowledge of the various services and supports available to meet the specific developmental needs of eligible children and their families. (See Chapter 2 for more on the types of services and supports.) ITP service coordinators generally do not have training or experience in meeting the medical needs of children. Children enrolled in ITP who have extensive medical needs may receive care management or care coordination through CCNC, CC4C, or private health insurance.[i]

CCNC

Community Care of North Carolina (CCNC) serves all of North Carolina's Medicaid population and provides care management, through a CCNC network care coordinator, for the high-risk, high-cost, and high-acuity Medicaid populations. CCNC screens their claims records to identify individuals and providers who fall in these populations. High-cost diseases targeted by CCNC include asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes. If the children covered by CCNC do not have the high-cost diseases, they are not targeted at all for care management. CCNC care management does not specifically target children with mental health needs. The number of young children with social-emotional and mental health needs receiving care management through the current CCNC system or referred to CC4C for care coordination from CCNC is not well defined but probably low. (See Chapter 2 for more information on CCNC.)

CCNC care managers do not have specific training on meeting the needs of children, they have general training on how to work with patients with high

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[i] Earls, Marian, MD, FAAP. Lead Pediatric Consultant, Community Care of North Carolina. Written (email) communication June 20, 2012.

medical needs, regardless of age. CCNC care managers do not have training on early childhood development or on community resources to meet the needs of young children. A CCNC network care manager's caseload may include children who have been identified as priority patients because of high cost (or costs not consistent with their risk group), overuse of the emergency department, or hospitalizations. Children getting care management through CCNC are more likely to have a chronic medical condition such as asthma, diabetes, or anemia. However, primary care providers can refer patients to a CCNC care manager for reasons other than chronic medical conditions. If a child is working with a CCNC network care coordinator, the care manager may provide some assistance in managing psychosocial issues affecting the child.[j]

Care coordination has the potential to help ensure young children with social-emotional and mental health needs are connected to and receive the types of services and supports that they need.

Care Coordination for Children

Children ages 0-5 who have been exposed to toxic stress, including but not limited to physical or emotional abuse, neglect, extreme poverty with family chaos, persistent parental substance use and severe and enduring maternal depression, and children with persistent social-emotional or mental health conditions may qualify for care coordination through Care Coordination for Children (CC4C).[k] CC4C care coordinators can work with children who are not eligible for services through the ITP but still have social-emotional problems or have known risks for social-emotional developmental problems.[l] CC4C care managers focus on the healthy development of young children within the context of the family. Eligible young children who have social-emotional and mental health needs work with a CC4C care manager to address identified needs that impact the child's health. CC4C is family-focused—care managers can meet with families in their home, in their community, and over the phone. CC4C is provided at no cost to the family. (See Chapter 2 for more information on CC4C.)

CC4C care managers have more expertise around children's development, including toxic stress and social-emotional development, than CCNC care managers but less than ITP service coordinators. CC4C care managers also have training on meeting the medical needs of young children as well as on the services and supports targeting young children such as early care and education resources, immunizations, and the Women, Infants, and Children (WIC) program.[m] CC4C care managers may make referrals to the CDSA or Preschool Program, home visiting programs, or parenting skills programs. Care managers may also coordinate with the LME/MCO (see below) and community-based mental health providers to address domestic violence, parental substance use, an unsafe or unstable home, parental depression or other mental health issues.

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[j] Earls, Marian. Lead Pediatric Consultant, Community Care of North Carolina. Written (email) communication, June 20, 2012.

[k] Sexton, Carolyn. Project Manager, Care Coordination for Children. Written communication, June 4, 2012.

[l] Earls, Marian. Lead Pediatric Consultant, Community Care of North Carolina. Written (email) communication, June 20, 2012.

[m] Earls, Marian. Lead Pediatric Consultant, Community Care of North Carolina. Written (email) communication, June 20, 2012.

Local Management Entity/Managed Care Organization
LME/MCOs provide care coordination services for consumers with high risks or who incur high costs. Under the LME/MCO, a "high-risk" consumer is one who has "been assessed as needing emergent crisis services 3 or more times in the previous 12 months" and a "high-cost" consumer is one "whose treatment plan is expected to incur costs in the top 20% of expenditures for all consumers in a disability group."[23] While very young children are unlikely to be "high-risk" consumers, they may be "high-cost" consumers, because high cost consumers are designated separately for each of six age/disability groups.[23] LME/MCO staff work with individuals receiving care coordination through the LME/MCO to develop a Person Centered Plan of care and facilitate connections to primary health providers. The number of young children receiving care coordination through the current LME system is unknown but is not likely very high.

LME/MCOs, with approval, can invest some of their savings in prevention and early intervention—especially if these services can help reduce more costly interventions.

Developing Protocols for Care Coordination
As described above, there is potential overlap between individuals eligible to receive care coordination services through the CDSAs, CCNC, CC4C, and LME/MCOs. To address this, DMA and DMH/DD/SAS developed a "four quadrant model" to determine which agency has responsibility for providing care coordination services. Under this model, an individual's physical and mental health needs are classified as high or low and care coordination is determined by the combination of type of need, level of need, and age. Because CCNC care coordination, CC4C, and the LME/MCOs are all in a state of transition right now, they are still working out which children receive which type of care coordination.

Care coordination has the potential to help ensure young children with social-emotional and mental health needs are connected to and receive the types of services and supports that they need. Thus, the Task Force recommends that DMH/DD/SAS, DMA, DPH, DPI, LEA, CCNC, CC4C, CDSAs, and LME/MCOs develop integrated protocols outlining which children receive care coordination from each program, how to coordinate care as children transition from one program to another, and how to strengthen collaboration and co-management in the care of the child by providers within the different systems. (See Recommendation 5.3.)

Addressing Gaps in the System

LME/MCO Role in Meeting Young Children's Social-Emotional and Mental Health Needs
One of the benefits of the new LME/MCO system is LME/MCOs, with approval from the state and the Center for Medicare and Medicaid Services, can invest some of their savings in prevention and early intervention—especially if these services can help reduce more costly interventions. As discussed previously, research shows that promoting young children's social-emotional development can change the trajectory of children's lives and generate savings and societal benefits.[24-26] Programs and services that promote young children's positive

social-emotional development can help reduce the need for more costly interventions.[1] Therefore, the Task Force recommends that LME/MCOs invest in social-emotional and mental health promotion and prevention programs for young children at risk of social, emotional, and mental health needs. (See Recommendation 5.3.)

While LME/MCOs are supposed to meet the needs of young children ages 3-5 who have social-emotional and mental health needs, it is unclear how many children receive basic services and care coordination through the current LME system. Under the new LME/MCO arrangement, LME/MCOs are also responsible for doing a community needs assessment and crafting a plan for meeting the mental health needs of the communities they serve. As part of the community needs assessment, the LME/MCO must assess the "population in the catchment area, identified gaps in the service array, including gaps for underserved populations, perceived barriers to service access, and the number and variety of age-disability providers for each service...[in addition] the LME/MCO shall assess community need and provider capacity for children's services within the LME/MCO catchment area"[23] As part of their plan to address community needs, LME/MCOs must ensure there are providers available to meet the needs of the community. If providers are not available, LME/MCOs must submit "a plan for developing a local provider community."[23] Because the needs of young children are different from older children and adults, the Task Force recommends that each LME/MCO retain a staff person trained on young children's social-emotional development and mental health who is responsible for ensuring that the needs of this population are met. Furthermore, these staff members should understand and be able to interact with the various systems that play a role in meeting the social-emotional and mental health needs of young children in their community. (See Recommendation 5.3.)

Few children with significant social-emotional delays and established conditions, related to social-emotional development and mental health, are qualifying for and enrolling in ITP.

Identifying and Treating Young Children Ages 0-36 Months

It is likely that more children meet the North Carolina ITP eligibility criteria due to a developmental delay in social-emotional development or related established conditions than are being identified and served, primarily due to the inherent difficulties in identifying and assessing infant/toddler mental health and social-emotional delays.

A child who qualifies for ITP due to significant social-emotional developmental delays or established conditions related to social-emotional development and mental health has, under the program, a service plan with specific outcomes. Based on the outcomes, services are available for the child and family such as community-based rehabilitative services, psychological, social work and family counseling services. (See Chapter 2 for more information on the ITP program including the types of services and supports they provide and how they are provided.) While data are not available to say how many of the children who are currently enrolled qualify on these grounds, data show that few children are receiving these types of services. Data based on headcount and services on October 31, 2011, revealed that 9,960 children were enrolled in ITP. Of the children enrolled on this date, 49 children (<1%) were receiving psychological services, 25 children (<1%) were receiving social work services, and 89 children (<1%) were receiving family counseling services.[n] These data indicate that few children with significant social-emotional delays and established conditions, related to social-emotional development and mental health, are qualifying for and enrolling in ITP.

One issue is that the assessment of social-emotional development is more difficult to quantify using a standard of delay, and may require the use of specialized tools. Children's functioning in this area of development is particularly variable across days and settings, especially compared to other developmental domains. Additionally, diagnosing mental health disorders in infants and toddlers is complex, partly due to the need to include an assessment of the relationship between the child and primary caregiver in the diagnostic process. Obtaining a diagnosis of attachment disorder in children ages 0-36 months, whether due to reluctance on the part of the family or diagnosing clinician can be difficult, and questions remain regarding the diagnostic criteria. Identification of children with FASDs is dependent on accurate reporting of maternal alcohol use during pregnancy, and diagnosis of FAS requires identification of physical signs by healthcare professionals, as well as identification of developmental delays which can be subtle. The North Carolina Early Intervention Branch, within the Division of Public Health, has identified these issues and has developed an Early Intervention Task Force on Assessment of Social-Emotional Development. This group is working on developing strategies for better identification of social-emotional delays within the current ITP eligibility criteria. The Task Force is reviewing evaluation tools that may be used to identify children with delays in this area and is developing guidance regarding practices that will enhance the program's ability to identify and serve these children. The Task Force is also considering what training for staff and intervention providers would be helpful in achieving the program's goals in this area. Recommendations from the Early Intervention Task Force are due to the state program office in August 2012.

There is a need to identify a health home for children ages 0-36 months who have social-emotional and mental health needs that do not meet the eligibility criteria for ITP.

The Task Force supports the work of the Early Intervention Task Force to improve identification of social-emotional delays and established conditions related to social-emotional development and mental health. There is also a need to identify a health home for children ages 0-36 months who have social-emotional and mental health needs that do not meet the eligibility criteria for ITP. A child's health home should have the capacity to address physical health needs, as well as the social-emotional development and mental health needs of the child. CCNC primary care health homes can provide some of these services, but may not be able to address the child's social, emotional and mental health

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[n] Carroll, D.E., Early Intervention Branch Head, Women's & Children's Health Section, Division of Public Health, North Carolina Department of Health & Human Services. Written (email) communication. May 15, 2012.

needs if the needs are significant. Based on the four-quadrant model, discussed earlier, the LME/MCO would have primary responsibility for serving as the health home if the person has low physical health needs, but high mental health needs. However, the LME/MCOs can only serve as health homes for children once they reach age three. Therefore, the Task Force recommends further exploration of which system or program is best suited to provide a health home that addresses the physical, social-emotional, and mental health needs of young children under the age of three. (See Recommendation 5.3.)

As discussed throughout this report, too many young children with social-emotional and mental health needs fall through the cracks between primary health care providers and providers of mental health, early intervention, child welfare, and early care and education services. The state can play an important role in removing barriers, and providing support and guidance on how to move toward more integrated services. In taking such steps, the state can lead the way towards developing a more comprehensive, coherent, and integrated system of care for this population. Therefore, the Task Force recommends:

Recommendation 5.3: Enhance Prevention, Promotion, Treatment, and Care Management for Young Children with Mental Health Needs (PRIORITY RECOMMENDATION)

a) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should work with the Division of Medical Assistance (DMA) to amend the 1915(b)/(c) waiver to include integrated comprehensive social-emotional and mental health promotion and prevention programs for young children at risk for social-emotional and mental health problems and their families who could be supported through 1915(b)/(c) savings.**

b) **DMH/DD/SAS and DMA should require every Local Management Entity/Managed Care Organization (LME/MCO) to have at least one staff member trained on young children's social-emotional development and mental health (e.g., the System of Care (SOC) coordinator, access, utilization review; or other clinical staff) who, with support from LME/MCO management, is responsible for ensuring that the needs of this population are being met and that the state's adopted SOC philosophy is adhered to.**

c) **DMH/DD/SAS and DMA should require every LME/MCO to have, as a part of their provider network, appropriately qualified and trained providers who can adequately address the service and support needs of young children's social-emotional development and mental health, who participate with the LME/MCO in ensuring that the needs of this**

population are being met for those living in the catchment area, and work to ensure that the state's adopted SOC framework is adhered to.

d) DMH/DD/SAS, DMA, Division of Public Health (DPH) including the North Carolina Infant and Toddler Program (ITP) Children's Developmental Services Agencies (CDSAs), Department of Public Instruction (DPI), local education agencies (LEAs), Community Care of North Carolina (CCNC), Care Coordination for Children (CC4C), and LME/MCOs should develop integrated protocols outlining which children (prenatal through age 5) receive care coordination, the process for authorizing and paying for services, how to apply the SOC framework to this population, and how to strengthen collaboration and coordination in the care of the children and their family by providers within the different systems. In addition, the groups should:

   1) Ensure that children and their families at risk for social-emotional and mental health problems receive appropriate care coordination services per SOC guidelines. The groups should create eligibility criteria for at-risk children that recognize the linkages between different domains of development (e.g. cognitive, language, and social-emotional). The eligibility criteria should also include, but not be limited to, eligibility based on problems within the parent-child dyad.

   2) Examine the process for transitioning children at age 3 from the early intervention system through the CDSAs and into other appropriate systems of care providers.

e) DMH/DD/SAS, DMA, DPH, ITP, CDSAs, CCNC, CC4C, and LME/MCOs should examine the current application of SOC framework for children ages 0-36 months to ensure that children at risk of social-emotional and mental health problems have a health home that addresses the physical, social-emotional and mental health needs of the child. Specifically, the group should determine whether children at risk of, or identified with, social-emotional or mental health needs should be served within the CDSA system, CCNC, or LME/MCOs (or combination thereof), the costs of these services, and how these services should be funded and coordinated. As part of this effort, the group should consider how to expand eligibility within the CDSA for certain high priority at-risk individuals, such as children who display developmental delays and have other environmental risk factors.

f) DMH/DD/SAS, DMA, DPH, DPI, LEA, CCNC, CC4C, CDSA, and the LME/MCOs should educate providers, care coordinators, and the public on what the System of Care for young children with social-emotional and mental health needs and their families is and how to navigate, participate in, and build capacity from it.

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