Increasing Access to Child and Adolescent Psychiatry for Children Involved with Child Welfare : The North Carolina Psychiatry Access Line (NC-PAL) Child Welfare Collaborative

Courtney L. McMickens, MD, MPH, MHS
Assistant Professor of Psychiatry
Lead Physician, NC-PAL DSS
Division of Child/Family Mental Health & Community Psychiatry
Duke Department of Psychiatry and Behavioral Sciences
Faculty, National Center for Child Traumatic Stress

Disclosures

- No Conflicts to Disclose

- NC-PAL DSS Collaboration is funded by NC Department of Health and Human Services

- Duke University Department of Psychiatry and Behavioral Sciences
- The National Center for Child Traumatic Stress

NC-PAL Child Welfare TEAM

Objectives

- Define roles of child and adolescent psychiatrists when working with children and families in foster care.
- Understand the current state of mental health needs and services for children involved with child welfare.
- Identify opportunities for trauma-informed assessments and mental health services to improve the quality of treatment received by children within child welfare.

Outline

- Overview of mental health needs of children and families involved in child welfare
- Discuss role of child and adolescent psychiatrists working with and within child welfare agencies
- Describe NC-PAL Child Welfare (DSS) Collaboration
- Lessons learned and broader implications

Mental Health and Child Welfare

- Children involved with child welfare are disproportionately affected by unmet mental health needs
- Up to 80% of children in foster care have a mental health diagnosis (Pecora et al. 2009)
- Common diagnoses are PTSD, ADHD, ODD, depression, and anxiety.
  - Higher rates of Bipolar Disorder and Schizophrenia/other psychotic disorders (Putnam-Hornstein et al, 2023)
- Youth in foster care are prescribed psychotropic medication at rate 4-10 times higher than general population(GAO Report 2014)
- Youth in foster care are 5 times (7.4% v. 1.4%) more likely to be prescribed an antipsychotic (Vanderwerker et al 2014)

Federal Policies and Initiatives

- Fostering Connections to Success and Increasing Adoptions Act of 2008
- Child and Family Services Improvement and Innovation Act
- Children's Bureau – Administration for Children and Families
- National Child Traumatic Stress Network
  - Created by Congress in 2000 as part of the Children's Health Act.
  - Administered by SAMHSA
  - Two million professionals, 43 states, and estimated 120,000 served yearly

North Carolina Policies and Initiatives to Improve Mental Health Services within Child Welfare

- Expansion of High-Fidelity Wraparound Services
- Expansion of Mobile Crisis Intervention Teams
- Strengthened Care Coordination between DSS and MCO/LME
- Establish Crisis, Inpatient and Residential Bed Tracking System
- Establish Placement First Pilots
- Expansion of NC-PAL Program Statewide – Key Populations

Transforming Child Welfare and Family Well-Being Together:
A Coordinated Action Plan for Better Outcomes, NCDHHS

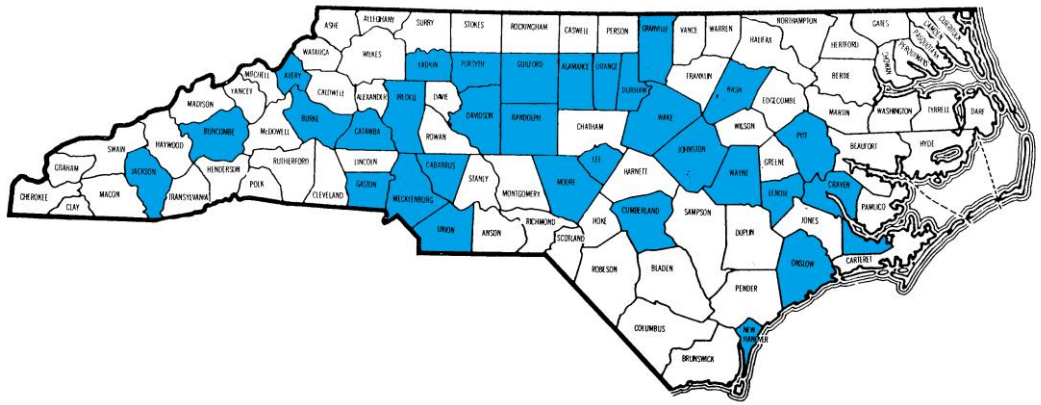
Children's Mental Health in North Carolina

Of the 2.3 million youth in NC, 364K or **1:6** have a behavioral health disorder [1]

66% of pediatricians report a *lack of training in counseling or medication* of children with mental health problems [16]

There are **only 200** Child and Adolescent Psychiatrists in all of NC [2]

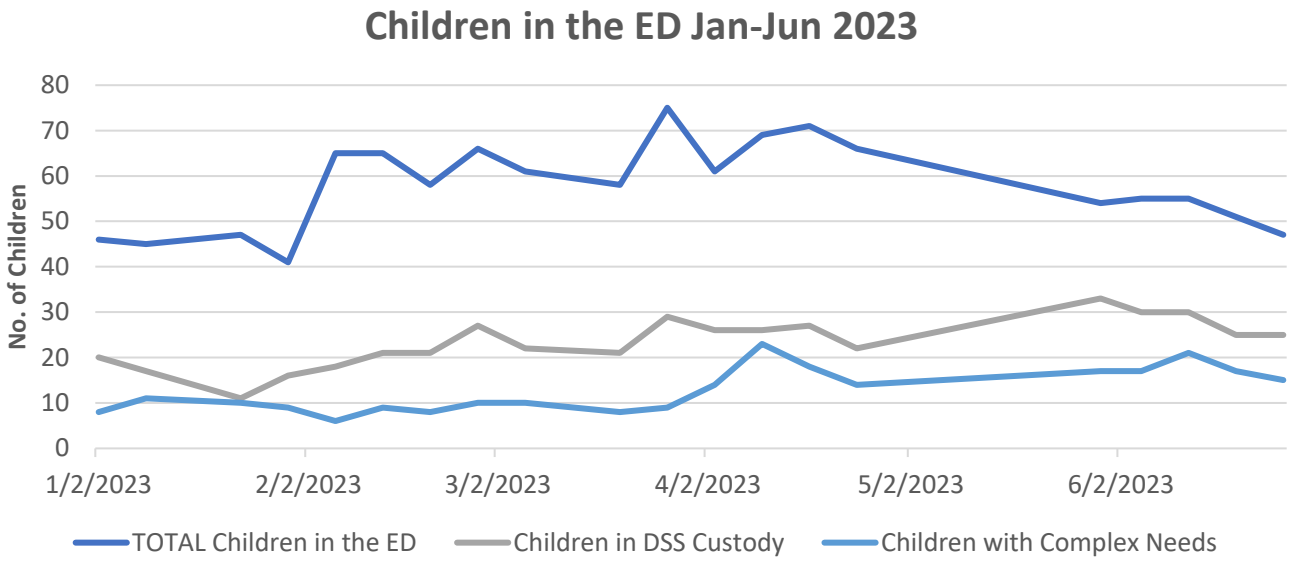
69/100 counties *don't* have a CAP

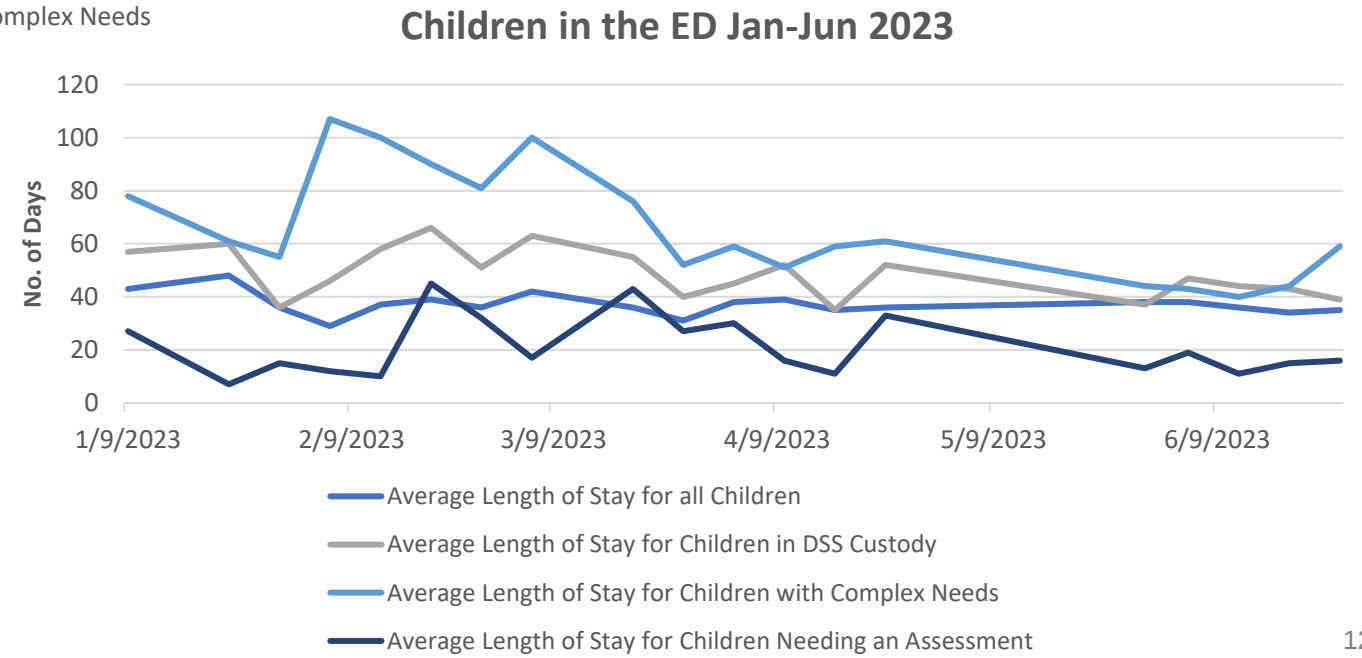


The New York Times Magazine

Illustration by Ori Toor

RAPID RESPONSE TEAM: CHILDREN IN EMERGENCY DEPARTMENT





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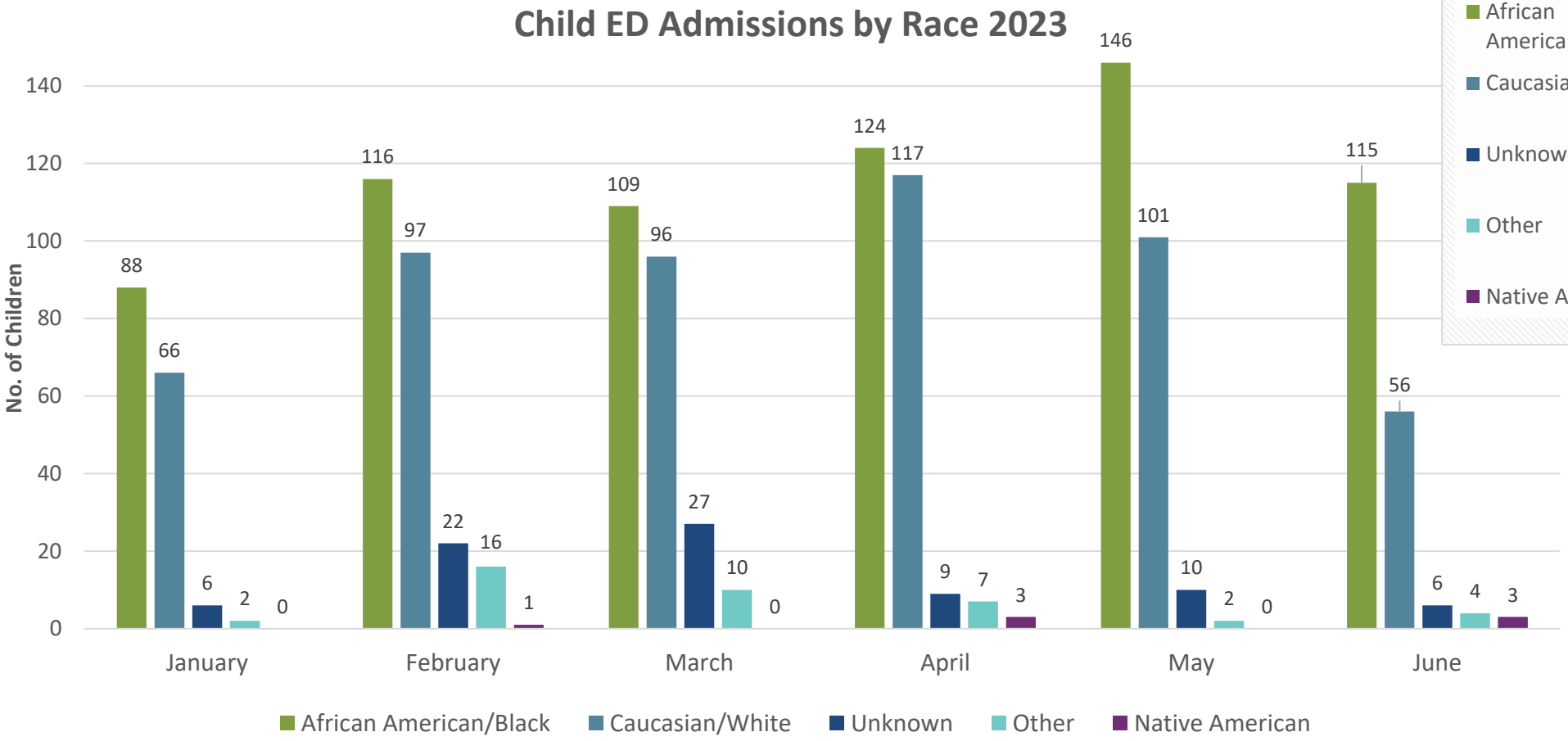
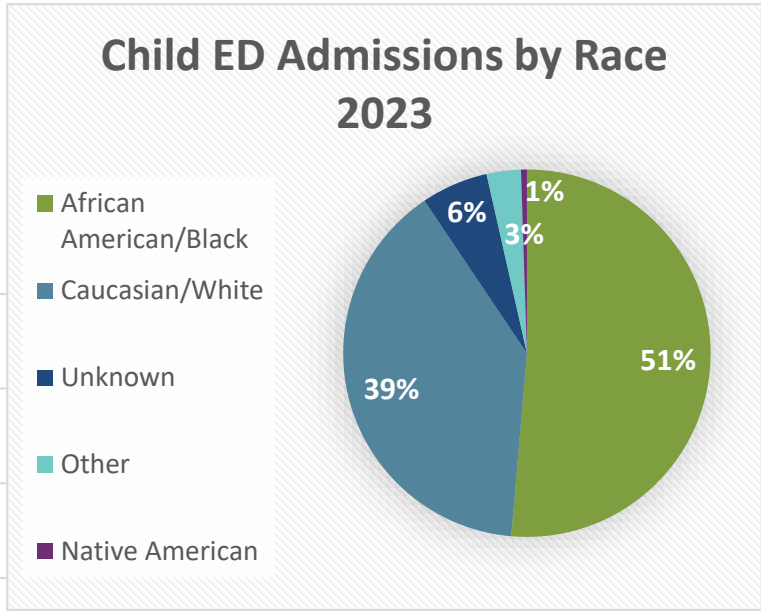
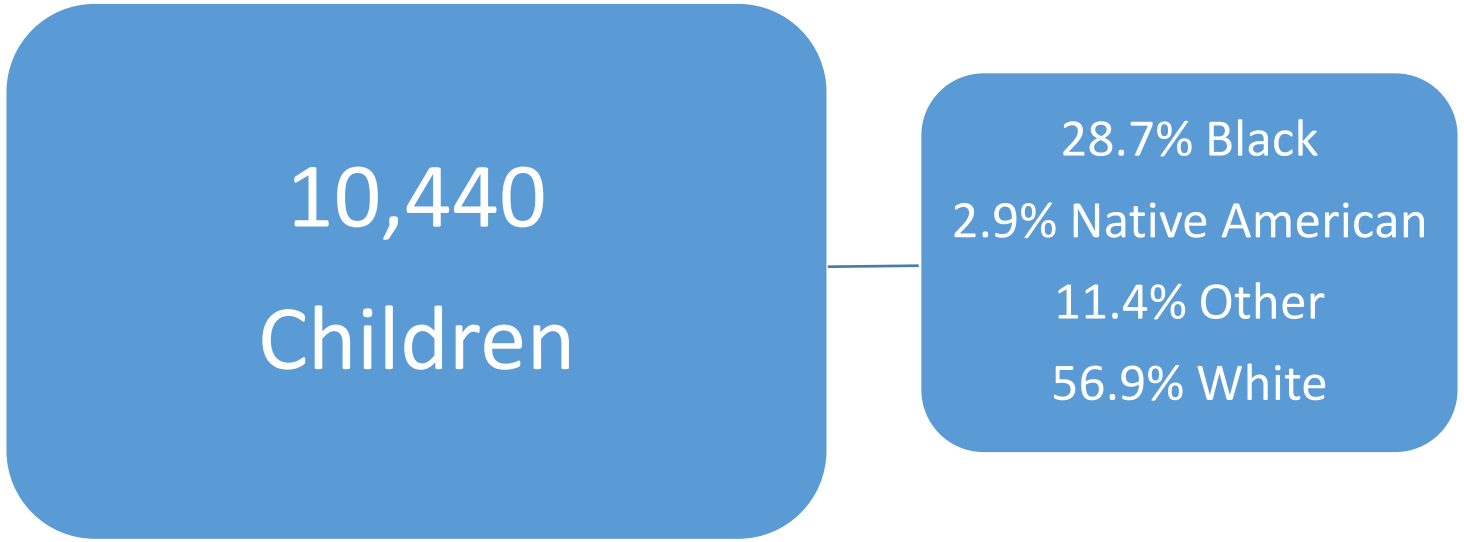




Race Data for Child ED Admissions from January-June 2023

North Carolina Foster Care



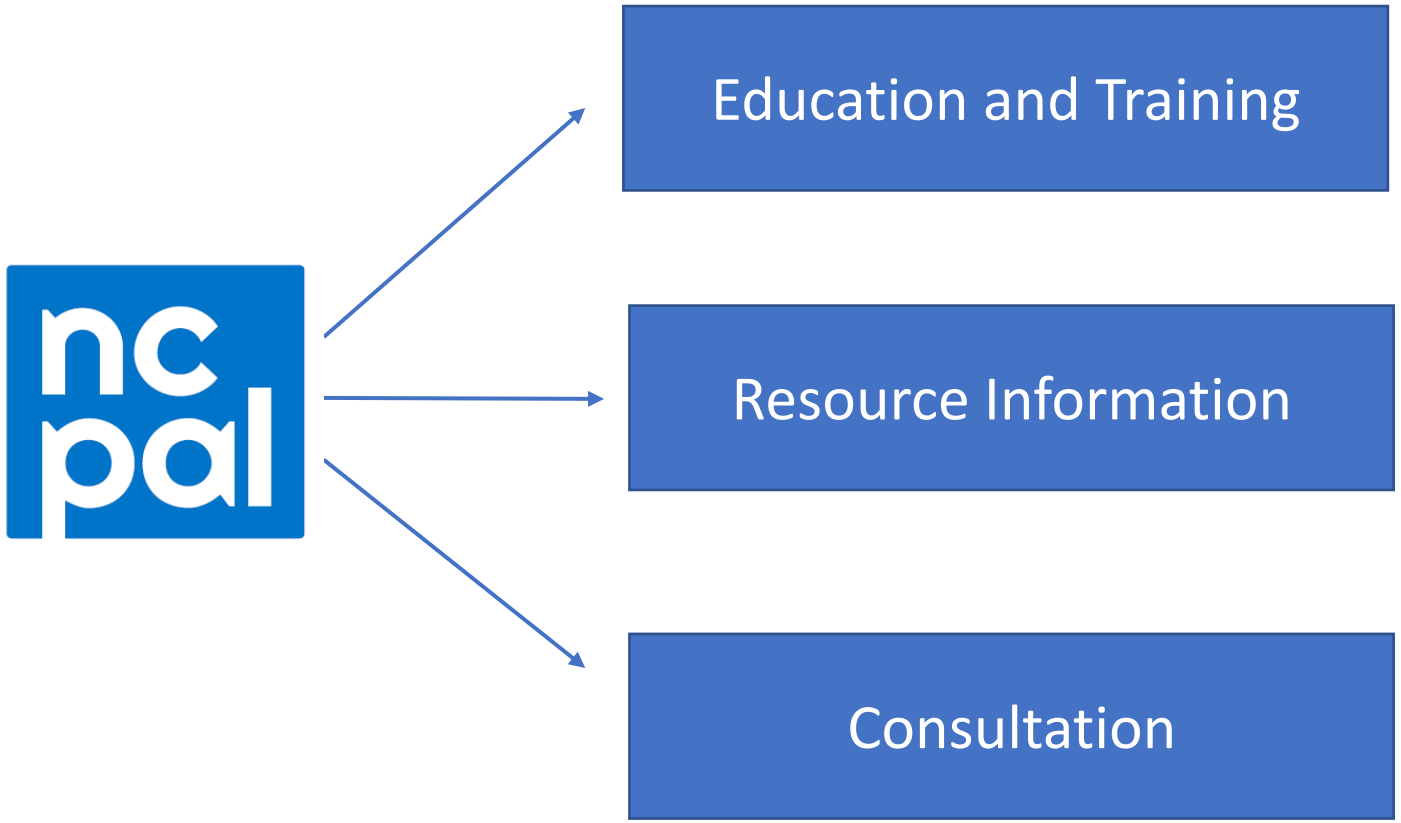
January 2023

NC-PAL Child Welfare Collaborative

Rapid Response Team (RRT) March 2022

- ❑ Psychologist and Psychiatry team members join multidisciplinary team
- ❑ Provide education and recommendations
- ❑ Conduct case reviews and provide consultation

Pediatric Psychiatry Collaborative for Child Welfare (PPC-CW County Pilots) February 2023

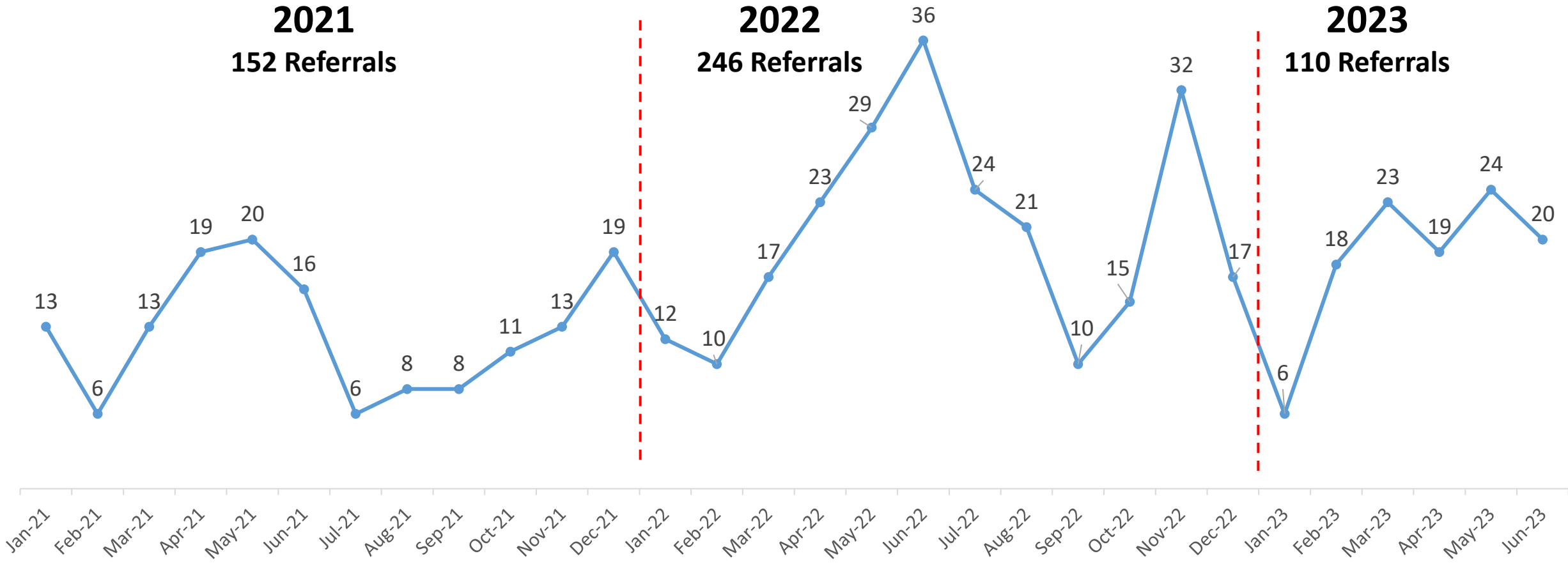


RAPID RESPONSE TEAM (RRT)

DHHS	Local Partners	Additional Supports
• Division of Child and Family Well-Being (DCFW) • Division of Social Services (NCDSS) • Division of Mental Health (DMH/DD/SAS) • Division of Health Benefits (DHB) • Division of State Operated Health Facilities (DSOHF)	• LME-MCO • County Department of Social Services	• NC Psychiatric Access Line (NCPAL) • Community Care of North Carolina (CCNC)

RAPID RESPONSE TEAM: REFERRAL TRENDS

The NCDHHS Rapid Response Team receives referrals for children in DSS custody who are lacking appropriate treatment placement.



Source: DHHS Rapid Response Team

RAPID RESPONSE TEAM: DATA

- **110 referrals received between January – June 2023**
- 45 Counties, Average age at time of referral 11.3 years

Location at Referral

- 54% Emergency Department
- 23% DSS Office
- Other: PRTF and Inpatient

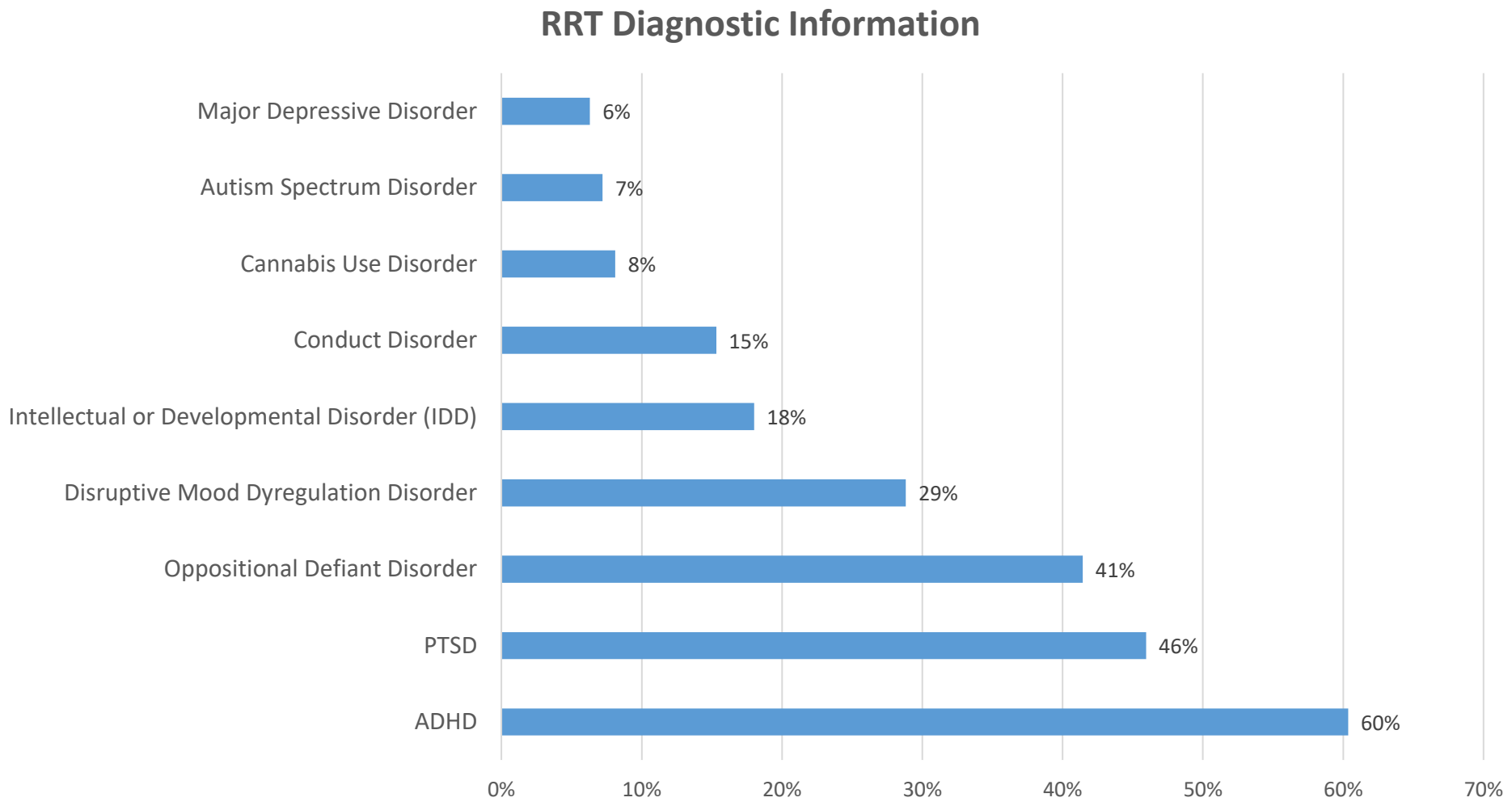
Service Needed

- 48% PRTF
- 28% Level II/Level III
- Other: Inpatient, TFC, IAFT

Barriers to Placement

- 80% Aggression Behavior
- 3% Bed Availability
- Other: IDD/ASD, Medical Needs, PSB

RAPID RESPONSE TEAM: CHILDREN REFERRED



Diagnostic information for children referred to RRT from January-June 2023

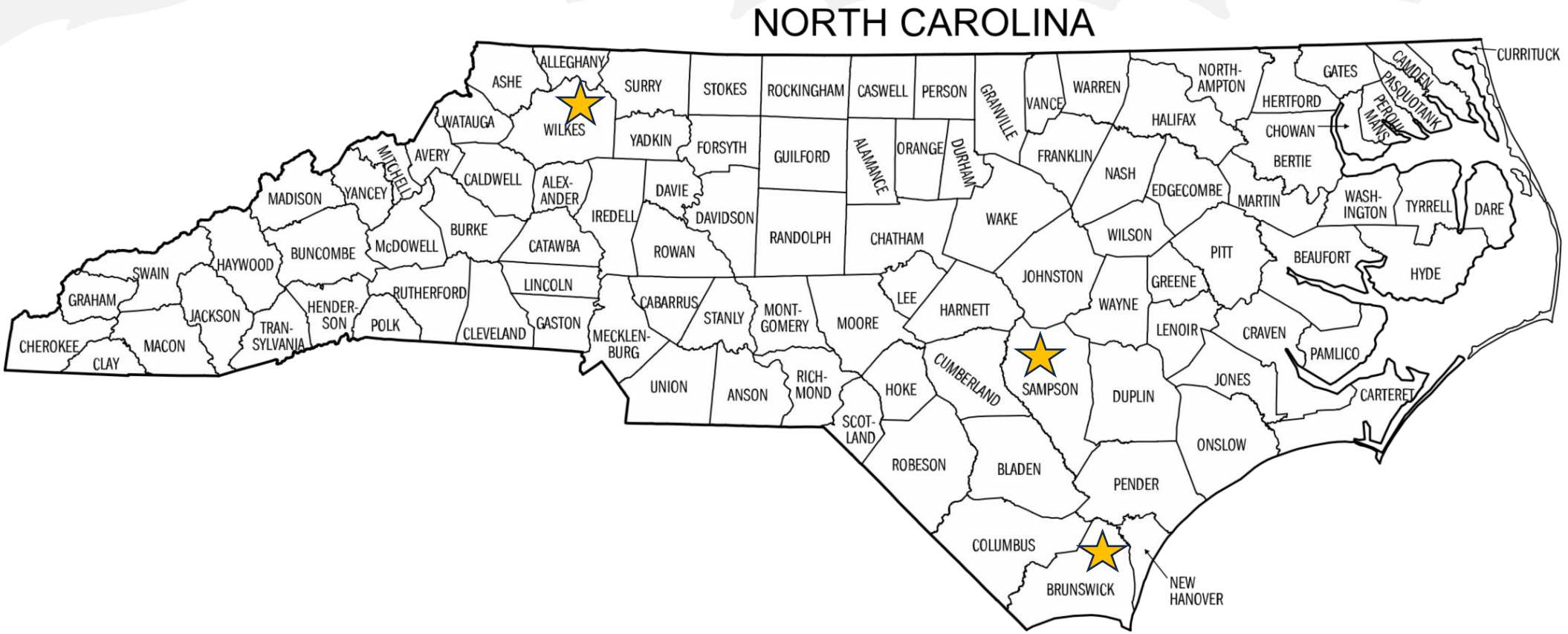
Lessons Learned

- Mental health and child welfare professionals have different goals, work in different systems, and speak different languages while caring for the same children (and families).
- Due to the demands of child welfare work and competing goals, reflection on how trauma and mental health symptoms have influenced a child's behavior and consideration of long term medical, social, and educational planning can be challenging.
- Lack of metabolic monitoring, consistent follow uo, and communication for child's medication management is common.
- Aggression, intellectual disability, and problematic sexual behavior pose service challenges and illustrate gaps in specialized treatments.

Pediatric Psychiatry Collaborative for Child Welfare (PPC-CW)

- Improve mental health outcomes for children involved with child welfare by increasing timely access to appropriate mental health services by:
  - Increasing knowledge, skills, and confidence of DSS staff in the areas of mental health conditions and mental health services
  - Providing clinical consultation to DSS staff, primary care providers, and clinicians working with families with child welfare involvement
  - Increasing provider network and offering mental health support to clinicians in the local area

PPC-CW Pilots Counties



PPC-CW Components

Engagement

Site Visits

Education

Learning Community

Educational Materials

Consultation

Weekly Case Discussion

Case Review Option

Evaluation

Focus Groups

Evaluation Survey

PPC-CW

Activities

Schedule	Time/frequency
Focus Group/Site Visit	2-hour first month
Learning Community (designated staff – foster care and BH coordination)	1.5 hour webinar each quarter
Drop-in Clinical Hour – open to all staff	1 hour once a week with each DSS office
Complex Case Consultation – Foster Care youth	As requested/needed

Staff Perceptions of Mental Health Concerns

- **Barriers to obtaining care**: social barriers, MCO/insurance issues, lack of a desire to engage in treatment, lack of availability and wait lists, and distance to services
- **Challenges to achieving good care**: turnover in providers, treatment setting, placement instability, and finding quality or effective providers
- **DSS staff challenges**: time, staff shortages, not addressing concerns early on, lack of support from EDs, inconsistent treatment, implications of diagnosis, difficulties with med management, lack of access to clinical documents, children in DSS office
- **Creating better collaboration**: sharing information, collaborative relationship with other agencies, common understanding of privacy and state statues, continuity of care, case management

Focus Group Responses

"Something that's a concern for me is I think we have one person in the area that can do psychologicals on children. And sometimes you need just a psychological, and sometimes you need something that's really in depth, that's really diagnostic, and trying to figure out what is wrong with the child..

"...they get diagnosed with ADHD or ADD or whatever it is and then that diagnosis just carries with them. But nobody re-evaluates… because things change. Circumstances change, and based off of the trauma, that's why it changes."

"But the complexity of the kids' mental health needs, their behaviors and these substance abuse issues, we really need some long-term in-patient facilities to rehabilitate these kids, for these children to actually have some sort of life in the future. You cannot get better in four to five days in the IVC."

"Sending records, sometimes we have to physically go to the agency to get the record. Those little things that don't seem like a lot, as they add up over time, they're time consuming for the workers who are trying to get what they need to make decisions and move on."

"Yeah, a lot of times we find services that we know would be appropriate or a good fit for the family and sometimes we run into the barrier this had to wait three or four months before it can even be put in place. So, then you're trying to promote stability and keep everything at a good place but having to wait several months and trying to keep a child to behave who's under control or whatever the situation is, I mean that can kind of put the situation at risk"

Lesson Learned

- Resources, quality of care, and access to mental health services vary by county.
- Relationships with LME/MCO are critical for obtaining appropriate care for youth engaged with the child welfare system.
- As mental health professionals, it is important to understand the complete history and obtain as much information as possible because clinical documentation can have long term consequences
- Child welfare staff are eager to gain more information on child mental health and trauma but feel their role if often unclear and outside the scope of their responsibilities.
- It may be helpful for mental health professionals to educate or provide guidance for their local judges, schools, and other professionals working with children involved in child welfare.

Child Psychiatry and Child Welfare

- Principle 1. Clinicians should understand the child welfare process and how youth and family may interface with the child welfare system
- Principle 2. Clinicians should be familiar with child welfare system core values and principles
- Principle 5. Clinicians should communicate with the referral source and the child welfare worker to obtain the information needed to proceed with the evaluation
- Principle 9. Clinicians should be familiar with common problems presenting in youth involved with the child welfare system
- Principle 10. Clinicians should be knowledgeable about evidence-based psychosocial interventions for youth involved with the child welfare system
- Principle 11. Clinicians should be familiar with regulations and procedures for prescribing psychiatric medications to youth involved with the child welfare system and should follow evidence-based and best prescribing practices

AACAP Practice Parameter for the Assessment and Management of Youth Involved With the Child Welfare System, 2015

Thank You!!

Any Questions?

(or save for the panel)

Email:

courtney.mcmickens@duke.edu or NCPALDSS@duke.edu

Additional Resources

- Pecora, P. J., Jensen, P. S., Romanelli, L. H., Jackson, L. J., & Ortiz, A. (2009). Mental health services for children placed in foster care: an overview of current challenges. *Child welfare*, *88*(1), 5–26.