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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
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.
- 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
• Review of claims data, pharmacy claims data, and/or electronic medical record systems to identify providers who prescribe above established thresholds
• Prior authorization/hard edit processes requiring review of certain prescriptions and/or drug combinations.
• Second opinions/specialist consultation
• Provider feedback, training & corrective action
• Enhancement of psychosocial services
North Carolina Policies and Initiatives to Improve Mental Health Services within Child Welfare

- Expansion of High-Fidelity Wrapparound 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

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
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

- Education and Training
- Resource Information
- Consultation
RAPID RESPONSE TEAM: CHILDREN IN EMERGENCY DEPARTMENT

Children in the ED Jan-Jun 2023

- TOTAL Children in the ED
- Children in DSS Custody
- Children with Complex Needs

Children in the ED Jan-Jun 2023

- Average Length of Stay for all Children
- Average Length of Stay for Children in DSS Custody
- Average Length of Stay for Children with Complex Needs
- Average Length of Stay for Children Needing an Assessment
North Carolina Foster Care

10,440 Children

- 28.7% Black
- 2.9% Native American
- 11.4% Other
- 56.9% White
RAPID RESPONSE TEAM: CHILDREN IN EMERGENCY DEPARTMENT

Race Data for Child ED Admissions from January-June 2023

Child ED Admissions by Race 2023

Race Data for Child ED Admissions from January-June 2023
Senate Bill 693

1 BUSINESS DAY
- All children in the ED, a DSS office, or other setting that does not meet the medically necessary level of care at the time referral is received.

2 BUSINESS DAYS
- All children at risk of placement disruption and at risk of being in an ED, a DSS office, or other setting that does not meet the medically necessary level of care.

3 BUSINESS DAYS
- All other accepted referrals.

“This legislation takes important steps to help protect children from abuse and neglect and to help them grow up successfully in a safe environment.”

- Gov. Roy Cooper
# Rapid Response Team (RRT)

<table>
<thead>
<tr>
<th>DHHS</th>
<th>Local Partners</th>
<th>Additional Supports</th>
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<tbody>
<tr>
<td>• Division of Child and Family Well-Being (DCFW)</td>
<td>• LME-MCO</td>
<td>• NC Psychiatric Access Line (NC PAL)</td>
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<tr>
<td>• Division of Social Services (NCDSS)</td>
<td>• County Department of Social Services</td>
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<tr>
<td>• Division of Mental Health (DMH/DD/SAS)</td>
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<td>• Division of Health Benefits (DHB)</td>
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<tr>
<td>• Division of State Operated Health Facilities (DSO HF)</td>
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The NCDHHS Rapid Response Team receives referrals for children in DSS custody who are lacking appropriate treatment placement.

<table>
<thead>
<tr>
<th>Year</th>
<th>Referrals</th>
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<tbody>
<tr>
<td>2021</td>
<td>152</td>
</tr>
<tr>
<td>2022</td>
<td>246</td>
</tr>
<tr>
<td>2023</td>
<td>110</td>
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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

- 110 referrals received between January – June 2023
- 45 Counties, Average age at time of referral 11.3 years
RAPID RESPONSE TEAM: CHILDREN REFERRED

Diagnostic information for children referred to RRT from January-June 2023
High-Risk Prescribing
Common Recommendations

- Assessment of IDD and ASD
- Diagnostic Clarity: Clinical Support for Diagnosis
- Assessment of Trauma
- Medication Monitoring and Indication
- Concern Medication Combinations
- Appropriate Care Setting
- Management of medical comorbidity
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 up, 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.
Need For Upstream Interventions
• 80% of children have experienced >10 distinct placements prior to RRT referral.
• Average number of placements is 34.
• Over 25% of these children have been placed and moved across 50 or more placements.
# Targeted Timeframes for RRT Meetings

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<tr>
<th></th>
<th>Business Day</th>
<th>Description</th>
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<tr>
<td>1</td>
<td></td>
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<td>2</td>
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<td>3</td>
<td>Business Days</td>
<td>All other accepted referrals.</td>
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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 Components

Engagement
- Site Visits

Education
- Learning Community
- Educational Materials

Consultation
- Weekly Case Discussion
- Case Review Option

Evaluation
- Focus Groups
- Evaluation Surveys
### Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
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<tbody>
<tr>
<td>Focus Group/Site Visit</td>
<td>2-hour first month</td>
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<tr>
<td>Learning Community (designated staff – foster care and BH coordination)</td>
<td>1.5 hour webinar each quarter</td>
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<tr>
<td>Drop-in Clinical Hour – open to all staff</td>
<td>1 hour once a week with each DSS office</td>
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<tr>
<td>Complex Case Consultation – Foster Care youth</td>
<td>As requested/needed</td>
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Staff Perceptions of Support Children with Mental Health Concerns

- **Barriers to mental health service**: social barriers (transportation), lack of service availability and wait lists, turnover in providers, treatment quality, access to acute services, and placement instability

- **DSS staff challenges**: time, staff shortages, not addressing concerns early on, lack of support from EDs, inconsistent treatment/diagnosis, difficulties with consistent med management, lack of access to clinical documents, children in DSS office

- **Opportunities to create better collaboration**: improving information sharing, collaborative relationship with other agencies, common understanding of privacy and state statutes, case management

- **Helpful supports**: system changes (single access to care), parenting and early intervention, more training for placements, increased access to psych evals and assessments, fewer barriers with MCOs (care management), and DSS team collaboration
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 change.

But the complexity of the kids’ mental health needs, their behaviors and these substance abuse issues, we really need some long-term inpatient 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.

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.

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.
<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>I am able to recognize children's mental health symptoms</td>
<td>82%</td>
</tr>
<tr>
<td>I understand the role that trauma plays in children's mental health concerns</td>
<td>92%</td>
</tr>
<tr>
<td>I feel comfortable participating in the shared decision-making and consent process when it comes to foster care children being prescribed psychiatric medication</td>
<td>65%</td>
</tr>
<tr>
<td>I feel prepared to provide appropriate oversight of psychiatric medication use, including analysis of the risks and benefits of psychiatric medications</td>
<td>43%</td>
</tr>
<tr>
<td>I am able to meet the needs of children with mental health concerns</td>
<td>51%</td>
</tr>
<tr>
<td>I feel that my DSS office takes a proactive rather than reactive approach to addressing children's mental health concerns</td>
<td>43%</td>
</tr>
<tr>
<td>It is clear what my role is when addressing children's mental health needs</td>
<td>59%</td>
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Clinical Drop-In Discussion

- Management of behaviors in the office
- Talking with providers in ED or outpatient setting
- Diagnosis of Autism Spectrum Disorder
- Navigating interactions with other systems
NC-PAL Tip Sheet

Hallucinations in Children and Adolescents

Children and adolescents commonly experience hallucinations or altered perceptions that are not psychotic in nature. It is important to understand what is causing hallucinations in children – treatment and outcomes for psychotic hallucinations are very different than for non-psychotic hallucinations.

If a child in your care is experiencing hallucinations, it's important to get a medical evaluation and referral to a child psychiatrist if indicated. Sometimes, in the case of uncharacteristic or unsafe behavior, a visit to the emergency department (ED) will be necessary.

It is important to urgently get the child an evaluation. If the child’s hallucinations are psychotic, the longer they go without appropriate treatment, the worse they are likely to do in the long term. If the hallucinations are not psychotic, they still may be disruptive to the child, and most causes are responsive to treatment. Whatever the underlying condition, the information on this sheet will be helpful for you to consider and communicate to the child's provider.

NC-PAL Child Welfare Tip Sheet

Crisis Management & Safety Planning

What is a crisis?
A crisis is when a youth is at risk of harming themselves or others, or if their emotions and/or behaviors are highly intense, dangerous, debilitating, and/or unmanageable. This can include:

- Expressing suicidal thoughts or engaging in suicidal behaviors
- Engaging in self-injurious behavior, such as cutting or burning
- Physical and/or verbal aggression or making threats to harm others
- Damaging property
- Intense emotion dysregulation (e.g., severe agitation or panic)
- Significant intoxication or substance use related crises

How to Prevent Crises

Assessment
To prevent a crisis, knowing what situations have led to a crisis in the past and what behaviors or early warning signs occurred before the crisis is critical. Proactively assessing risk factors, such as suicidality, is one major way to prevent crises.

Things to assess:

Safety Planning
A safety plan is a brief intervention to help those experiencing self-harm and suicidal ideation (SI) with a concrete way to mitigate risk and increase safety by identifying a prioritized list of coping strategies and sources of support that youth can use before or during a crisis.

Safety plans include:
Learning Community

Mental Health Assessments and Introduction to Treatment

Managing a Behavioral Health Crisis

Mental Health Treatment

Juvenile Justice and Diagnosing Disruptive Behaviors
"...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 I don’t think anybody revisits to figure out what’s going on. They just say, “This is what it is, maybe they just need a higher dosage of this or higher dosage of that.”

"So kind of by the time we get involved in a lot of cases, but this one specifically, is that... the parents are pretty much done with this child’s behaviors, they’re exhausted by the mental health system and by their child’s behaviors escalating. They probably are misresponding to their child’s behaviors which is causing more trauma and more behaviors. And they’ve reached the end of their rope and they’re like, “Take this kid.”

"Or even getting them to call us back sometimes. 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.
Future Directions

Connect
• Connect with local primary care providers and mental health providers to provide consultation services.

Identify
• Identify ways of better engaging an already overextended workforce

Integrate
• Integrate the NC PAL workstreams to meet the needs of children in foster care

Increase
• Increase collaboration with community organizations and resources and other state child welfare programs – NC Child Treatment Program, Center for Children and Family Health, NCTSN, Missouri, Washington, Tennessee, Utah

Encourage
• Encourage utilization of in-depth consultation services and engagement of NC PAL in the CPS and investigative stage
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?

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NCPALDSS@duke.edu
Additional Resources