Plan to Increase the Supply of Appropriate Treatment and Residential Settings for Minors in Need of Behavioral and Mental Health Services

Session Law 2021-132, Section 4.(b)

Report to the

Joint Legislative Oversight Committee on

Health and Human Services

By

North Carolina Department of Health and Human Services

April 20, 2023

Background

Session Law 2021-132 requires the North Carolina Department of Health and Human Services (NCDHHS) to develop a plan to increase the supply of appropriate treatment and residential settings for minors in need of behavioral and mental health services. NCDHHS worked in consultation with representatives across NCDHHS Divisions, other state Departments and external partners, including local management entities/managed care organizations (LME-MCOs), county departments of social services, people with lived experience, and provider groups to develop this plan that addresses minors that are in the custody of a county department of social services (DSS) and minors who are not in DSS custody and who need behavioral and mental health services.

Executive Summary

We all share a common vision for North Carolina's children
In North Carolina, we share a common vision that every child can grow up healthy in a safe, nurturing family and community. Families play the most important role in nurturing their children. Sometimes families need tools and resources to do that, especially when a family is in crisis. The right support at the right moment can help children overcome adversity, heal, and live productive lives—the kind of lives we all want for every child.

North Carolina has a child mental health crisis
Mental health for children was in crisis before the pandemic, and the COVID-19 pandemic made it worse. Close to one in four high school students seriously considered suicide in the last year, and the complexity of children's behavioral health needs is at an all-time high.[1] North Carolina's behavioral health system has been stretched and under-resourced for decades, making it hard for many children and families to access treatment for mental health issues.

In North Carolina, over half of children with mental illness receive no treatment.[2] We have ranked last in the country for children's access to mental health care.[3] We've also long underfunded our child welfare system, ranking last among peer states with decentralized systems in per-child funding.[4]

We are prioritizing increasing access to both behavioral health services AND appropriate placements
NCDHHS is working hard to increase the full range of mental health services for **all** North Carolina children who have behavioral health needs, in tandem with increasing the availability of appropriate placements. To make our behavioral health system work for children and families, we need to strengthen the continuum of care, from prevention to outpatient services, residential and inpatient psychiatric treatment.

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[1] Centers for Disease Control and Prevention, *Youth Risk Behavior Survey*. 2021.
[2] Whitney, D.G. and M.D. Peterson, *US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children.* JAMA Pediatr, 2019. **173**(4): p. 389-391.
[3] Whitney, D.G. and M.D. Peterson, *US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children.* JAMA Pediatr, 2019. **173**(4): p. 389-391.
[4] NCDHHS analysis using Child Trends data on "Child Welfare Financing Survey SFY 2018"

Each week in 2022-2023, NCDHHS is aware of at least 50 children statewide who are waiting in an emergency department (ED) or county DSS offices. The majority of these children are waiting to be admitted to a treatment setting that can address their complex behavioral health needs. Two settings can meet these needs 1) an inpatient or residential treatment facility or 2) a willing family, including foster caregivers, supported by behavioral health and other services in the community. Currently, there are not enough of either solution.

As a starting point, we have prioritized launching and seeking investment for services that can provide the evidence-based treatments and placements needed for children in child welfare who have acute and complex behavioral health needs. These strategies must be complemented by behavioral health and resilience supports that get upstream of crises so that fewer children ever get to the point where they are in crisis.

NCDHHS is undertaking significant efforts to support and provide for children with acute behavioral health needs. The following highlights just some of the items that we have implemented or have funding to begin implementing across the continuum of behavioral health supports:

- **Finding immediate solutions for children with complex needs living in EDs and DSS offices:** NCDHHS has convened a multi-disciplinary Rapid Response Team of child welfare and behavioral health experts and clinicians that meets daily to help County DSSs, LME-MCOs, and providers find immediate solutions for children in foster care with serious behavioral health needs who are being kept in EDs or county DSS offices.
- **Increasing the number of inpatient psychiatric beds for children:** NCDHHS recently partnered with UNC Hospitals to convert a state-run treatment center into a 54-bed inpatient psychiatric hospital for children and adolescents to provide acute psychiatric services to children who may otherwise be waiting for services in EDs. Repurposing this facility means that more children will receive the urgent high-quality treatment they need, with the goal of getting them back to their community with the right supports as quickly as possible. This approach creates a pediatric psychiatric treatment hospital much faster and at a lower cost than constructing a new facility. The goal is to operationalize hospital services in July 2023.
- **Increase access to community-based behavioral health services for children:** NCDHHS has launched and expanded multiple behavioral health services for children with more complex needs, such as high-fidelity wrap-around services that coordinate intensive behavioral health supports in the community, mobile crisis teams that specialize in working with children experiencing a behavioral health emergency, and stronger care coordination for all children in foster care with complex behavioral health needs.
- **Get more children in foster care living with foster families rather than in residential facilities:** NCDHHS invested in piloting a professional parenting program called Bridging Families. This program, offered by Crossnore Communities for Children, allows children with behavioral health needs to be placed in a family home with full time, trained foster parents devoted to providing for their care. With additional funding the program can be scaled across the state which may reduce the number of children living in residential facility settings.

We have a concrete plan and real solutions to transform child behavioral health in North Carolina
In this plan, NCDHHS has developed a road map which identifies strategies and concrete solutions to help children in North Carolina overcome adversity, heal, and live productive lives. The Department convened the Child Welfare and Family Well-Being Transformation Team, a collaboration with multiple

external stakeholders (hospitals, private agencies, LME/MCOs, county DSS, practitioners, attorneys and people with lived experience), to develop better coordination and increased resources for services that close gaps in care for all North Carolina children with behavioral health needs, especially those in foster care or at risk of entering into foster care.

As part of this effort, the Transformation Team developed the Transforming Child Welfare and Family Well-Being Together: A Coordinated Action Plan for Better Outcomes. The plan was submitted for funding by the NC General Assembly in the 2022 legislative session but was not funded.

Since the 2022 legislative session, the Transformation Team has continued to work together to build on the Coordinated Action Plan and prioritize solutions that will help address crises for children in foster care with complex behavioral health needs who lack adequate treatment and/or appropriate placements. The solutions have been prioritized to close critical care gaps so that we can offer the right treatments to each child in a place that is most appropriate for the child's needs at that time.

Real change requires smart new investments

The strategies in this report are organized in two categories: 1. Increasing access to behavioral health treatment for children and 2. Increasing timely access to appropriate placements for children with behavioral health needs.

Examples of solutions that close critical care gaps for these children and that require substantial investment to implement include:

- **Assessments for children.** Children are too often waiting days to weeks for an assessment to identify what treatments they need. We recommend launching community assessment teams so that children can be seen, wherever they are, by clinicians who specialize in working with children.
- **Specialty behavioral health treatments to divert children from inappropriate placements.** Some children need specialized behavioral health treatments that are currently unavailable to them in North Carolina. We recommend strengthening and expanding NC's specialized behavioral health treatment options for children, including:
    - Treatment to safely stabilize children who are experiencing a behavioral health crisis
    - Treatment programs for children with complex behavioral health needs, such as children with intellectual disabilities or challenging behaviors
- **Supports for families and caregivers.** Families also need intensive supports in their homes and communities so that children can be cared for and remain in a safe and stable home, such as teams that coordinate and wrap services around a family and family partners to support the caregivers of children with high behavioral health needs.
- **Support safe and stable homes.** More of North Carolina's children in foster care need to be cared for by extended family members, called kinship providers, or by foster parents. More kinship and foster parents will be able to care for children with behavioral health needs if they are provided with financial resources and behavioral health training and supports.
- **Critical infrastructure and workforce**. County DSS agencies need flexible funding for more staff and better pay for child protective services workers. Facilities and treatment providers need adequate staff to provide services.

In total, the investment needed to implement the full set of strategies is approximately $105 million in state share annually.

Progress is possible

Behavioral health is essential to health and well-being for children and families. By investing in the comprehensive needs of children and families, we can realize our vision that all children can develop to their full potential and thrive. Here are some examples:

- With substantial federal and state investment, the national 988 Suicide and Crisis Lifeline is able to respond to hundreds of calls in North Carolina per day, with the greatest growth in calls from young people looking for behavioral health support.
- Initial implementation of the Regional Support Model for child welfare has provided additional resources to counties through new positions funded last year by the general assembly. For child welfare services, these new staff have assisted counties in ensuring critical contacts on child safety were made.

In addition, North Carolina is taking the single most important step for improving access and affordability for behavioral health care: expanding Medicaid. Timely expansion will give North Carolina a $1.8 billion one-time "signing bonus" from the federal government. The highest priority for that bonus must be making smart investments in our mental health and substance use system across the entire continuum of care.

Needs Assessment and Service Adequacy of Treatment and Residential Settings for Minors in Need of Behavioral Health Services

The North Carolina Department of Health and Human Services collected, reviewed, and analyzed the access to many of the children's behavioral services available across North Carolina. Data sources included publicly available data and trends, state licensure reports, Medicaid claims, reports provided by LME-MCOs, and other sources. The review included an assessment of community-based services, facility-based services, and crisis services.

Prevalence of Youth Behavioral Health Needs

In December 2021, the US Surgeon General issued the Advisory on Protecting Youth Mental Health. The pandemic and other critical factors are resulting in increased behavioral health needs and crises for youth across the country. Emergency department (ED) visits for suicide attempts by adolescent girls were 51% higher nationally in early 2021 than in early 2019, worsening already concerning trends pre-pandemic.[5]

North Carolina has seen similar escalating trends in behavioral health needs of children and youth. The number of North Carolina youth with at least one major depressive episode increased nearly 50% during the pandemic from 2019-21. In 2021, nearly 1 in 4 adolescents in North Carolina seriously considered attempting suicide, and 1 in 10 attempted suicide.[6]

North Carolina ranks poorly compared to other states in rates of behavioral health needs and access to care for youth. In a national report, North Carolina had the highest proportion (72.2%) of any state for children with a mental health disorder who did not receive needed treatment.[7] North Carolina also ranked poorly for overall access to care and for children with private insurance that did not cover mental or emotional problems in 2022 according to data from Mental Health America.[8]

[5] Yard, E., et al., *Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021.* Centers for Disease Control and Prevention,, 2021.
[6] Centers for Disease Control and Prevention. *Youth Risk Behavior Survey*. 2021; Available from: www.cdc.gov/YRBSS.
[7] Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. *JAMA Pediatr.* 2019;173(4):389–391. doi:10.1001/jamapediatrics.2018.5399
[8] Reinert, M., T. Nguyen, and D. Fritze. *The State of Mental Health in America 2022*. 2022; Available from: https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf.

Children with co-occurring behavioral health diagnoses and Intellectual and Developmental Disabilities (IDD) who are Medicaid insured, aged 5-21, and at-risk of not being able to return to or maintain placement within the community are considered children with complex needs per a settlement agreement reached between the NCDHHS and Disability Rights North Carolina in 2016. Figure 1 shows the number of children meeting the Children with Complex Needs definition has been increasing each year, reflecting better and earlier identification of these children.

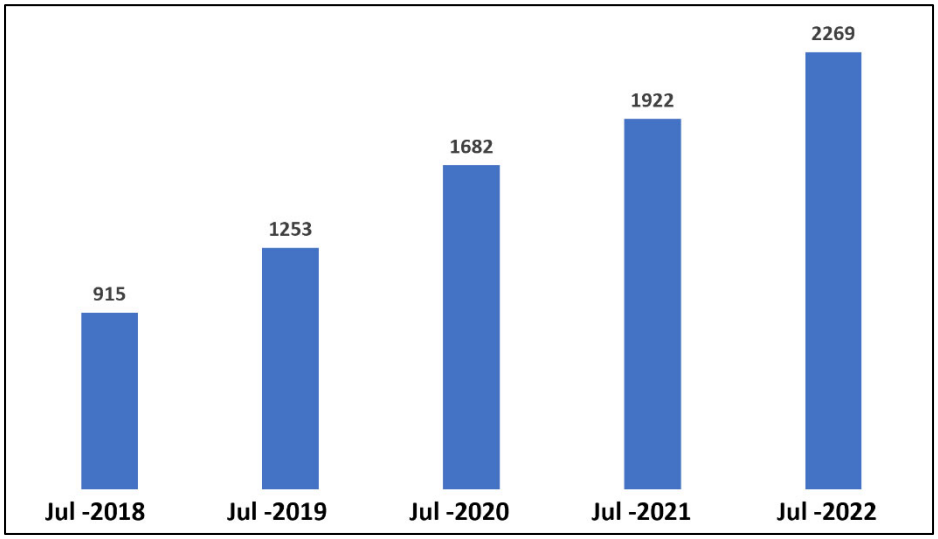


Figure 1. Children with Complex Needs by Year. *Defined as children with co-occurring behavioral health diagnoses and Intellectual and Developmental Disabilities who are Medicaid insured, aged 5-21, and at-risk of not being able to return to or maintain placement within the community.*

Children with complex needs are eligible for The NC Innovations Waiver, a Federally approved 1915 C Medicaid Home and Community-Based Services Waiver (HCBS Waiver) designed to meet the needs of Individuals with I/DD who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting. As of December 31, 2022, there are 6,776 children with IDD on the Innovations Registry of Unmet Needs.

NCDHHS continues to prioritize the needs of children with complex needs through increased access to training, consultation, and assessments. While stronger workforce training and consultation as well as improved identification of co-occurring needs exists, children with complex needs often have longer lengths of stays in EDs or in being housed in DSS offices because of lack of specialized treatment available in NC.

In 2022, children with IDD accounted for 33 of the 235 referrals to the NCDHHS Rapid Response Team (RRT), a multi-disciplinary team of child welfare, behavioral health experts and clinicians that meets daily to help child welfare and behavioral health payers and provider find solutions for children in foster care with serious behavioral health needs. Although only 14% of the total referrals to RRT, these children's

referrals remain open the longest; these children have the longest ED stays, and are most likely to go out of state for treatment.

Youth with substance use issues also have unmet needs. In North Carolina, the number of children (aged 0-18) presenting to the ED for opioid overdose was 225 in 2020 and 271 in 2021.[9] Children with substance use disorder accounted for 12% (n=28) of all referrals to the NCDHHS Rapid Response Team (RRT) in 2022. Many of these children were housed in DSS offices at the time of the RRT referral without access to needed substance use treatment, including those with opioid use disorder. As a result, DHHS supported county DSS agencies in accessing Naloxone/Narcan, a life-saving drug that can be administered to someone during an opioid overdose, to keep in their offices should a youth require this lifesaving treatment. DSS offices were also provided with information on treatment and harm reduction resources.

Indicators of Behavioral Health Service Adequacy

Each week in 2022-2023, NCDHHS is aware of at least 50 children statewide who are waiting in an emergency department (ED) or county DSS offices. The majority of these children are waiting to be admitted to a treatment setting that can address their complex behavioral health needs. Two settings can meet these needs 1) an inpatient or residential treatment facility or 2) a willing family, including foster caregivers, supported by behavioral health and other services in the community. Currently, there are not enough of either solution.

Here, we describe two key indicators of overall behavioral health service adequacy for children: (1) use of the ED for child behavioral health needs and (2) referrals to the NCDHHS Rapid Response Team (RRT).

Use of EDs for Child Behavioral Health Needs During the spring of 2020 at the beginning of the pandemic, North Carolina EDs began seeing a growing number of youth presenting for behavioral health needs. Use of the ED for behavioral health care is an indicator of service inadequacy because ideally (1) supports and treatments would be available in the community to prevent most ED visits, and (2) ED visits are brief to allow for assessment and determination of the treatment needs and setting for a patient.

Data source and considerations for Use of EDs for Child Behavioral Health Needs: This portion of the report includes data collected and analyzed by NCDHHS. For Figure 2, the Division of Mental Health, Developmental Disabilities, Substance Use Services (DMH/DD/SUS) began collecting data from LME-MCOs on the use of EDs by children for behavioral health needs in April 2020. The first quarter noted on the graph below (April 2020-June 2020) likely does not reflect typical patterns due to the onset of the pandemic. Data in Figure 3 are Medicaid and CHIP claims.

Standard Plans launched in July of 2021, resulting in changes to the children served by the LME-MCOs. Upon the launch of the Standard Plans, LME-MCO members included children with more complex needs including those receiving enhanced behavioral health services and those with more frequent use of

[9] NC DETECT Emergency Department Visit data, 2021-2022; 2022 data are provisional and subject to change. Analysis by the NCDHHS Division of Public Health Injury Epidemiology, Surveillance, and Informatics Unit

high-end crisis services, including EDs. Standard Plan implementation and the changes in the Medicaid population served by the LME-MCOs should be considered when reviewing the ED Data in Figure 2 and Figure 3.

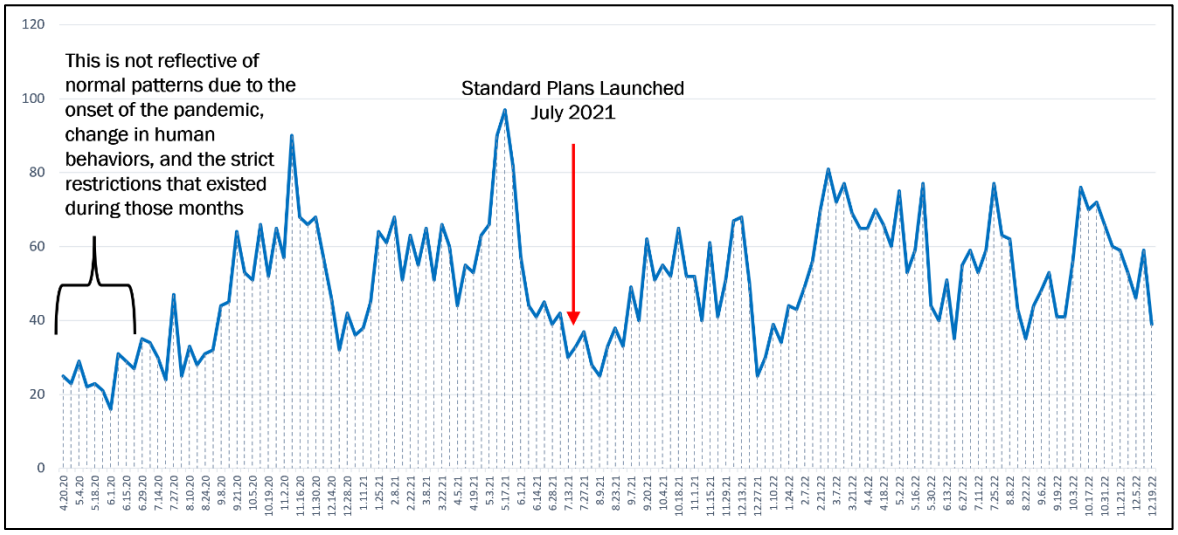


Figure 2. Children enrolled with LME/MCO in the emergency department for behavioral health needs by week

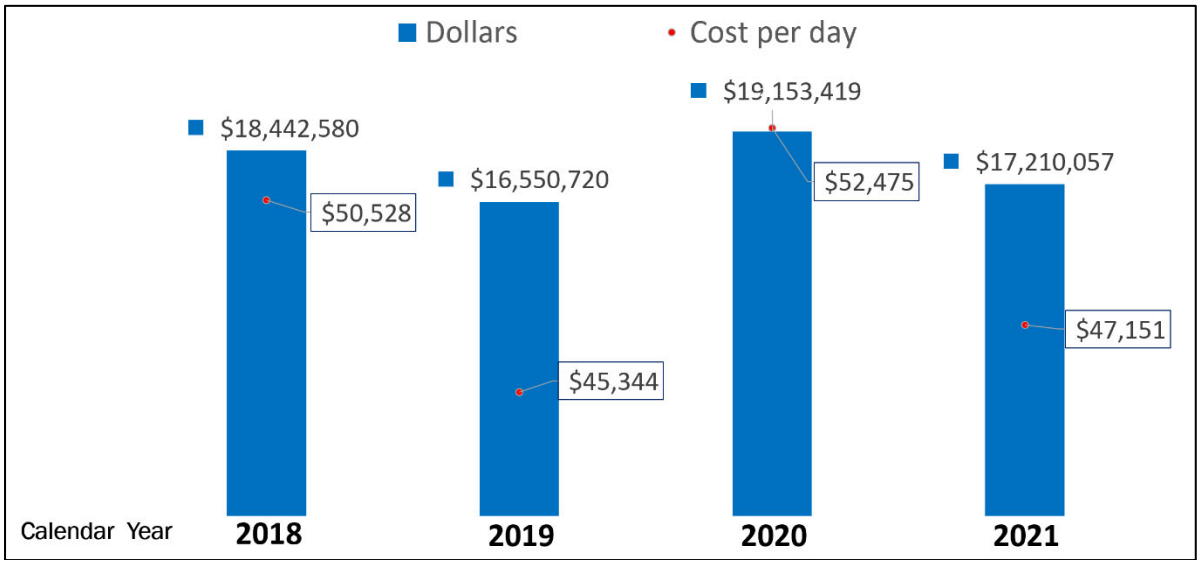


Figure 3. Total cost and cost per day to Medicaid for Emergency Department visits for behavioral health needs in NC

Data Trends: Each week, approximately 50 children and adolescents enrolled with the LME-MCOs access North Carolina EDs due to a behavioral health crisis. Some of these children are brought there by their families and many are also brought by a behavioral health provider who is unable to meet the child's psychiatric needs.

Of the children using the ED for a behavioral health crisis, 36% will remain there for 7 or more days, often after they have been medically cleared for discharge. During the last quarter of calendar year 2022 the median length of stay for LME-MCO enrolled children was 14 days. The median ED length of stay for children in DSS custody was 32 days. Among children in DSS custody, African American/Black youth are disproportionately represented in the ED for behavioral health needs; African American/Black children represent 46% of children in the ED while only 29% of children in DSS custody.

The proportion of children in the ED with a recommendation for inpatient psychiatric care has increased since 2020. In spring 2022, a weekly average of 60-80% of children involved with an LME-MCO in EDs for a behavioral health need were awaiting inpatient psychiatric care. Among children in DSS-custody, 87% of children in the ED for seven or more days need inpatient care or Psychiatric Residential Treatment Facility (PRTF) services. During state fiscal year 2022, each week 23% of children using the ED for behavioral health had an inpatient hospitalization or ED visit within the past 60 days for similar needs.

Children boarding in EDs for behavioral health issues is expensive. In 2021, the average cost of care per day was $47,151, which likely underestimates the actual cost of care for children in EDs.

Data Contextualization: The increasing number of children and longer lengths of stays in EDs for behavioral health crises is straining our health care systems; reflects an inadequacy of both upstream behavioral health supports for children to prevent escalation to a behavioral health crisis and more intensive treatment options, including child inpatient psychiatric beds and residential treatment programs; and is costly.

Rapid Response Team (RRT)

In December 2020, the Department launched the Rapid Response Team (RRT). RRT was established to address the immediate needs of children and youth in foster care who were residing in local DSS offices or boarding in EDs while awaiting placement. These were children whose complex behavioral health needs required behavioral health services available where they reside. The lack of availability of these services caused these children to board in DSS offices and EDs. A cross-divisional response team from NCDHHS (including NC Medicaid, Division of Mental Health/Developmental Disabilities/Substance Use Services, Division of Social Services, Division of State-Operated Health Facilities, and Division of Child and Family Well-Being) meets daily to respond to referrals from local DSS or LME-MCOs when crises exist and work with the local agencies to take action to address the child's immediate need.

These data from children served by RRT provide insights on some of the children who need high-intensity supports which are not easily identifiable or accessible in NC.

Data Source and Considerations (

Figure 4*)*: Child-level data are collected by the RRT team for each case referred to RRT

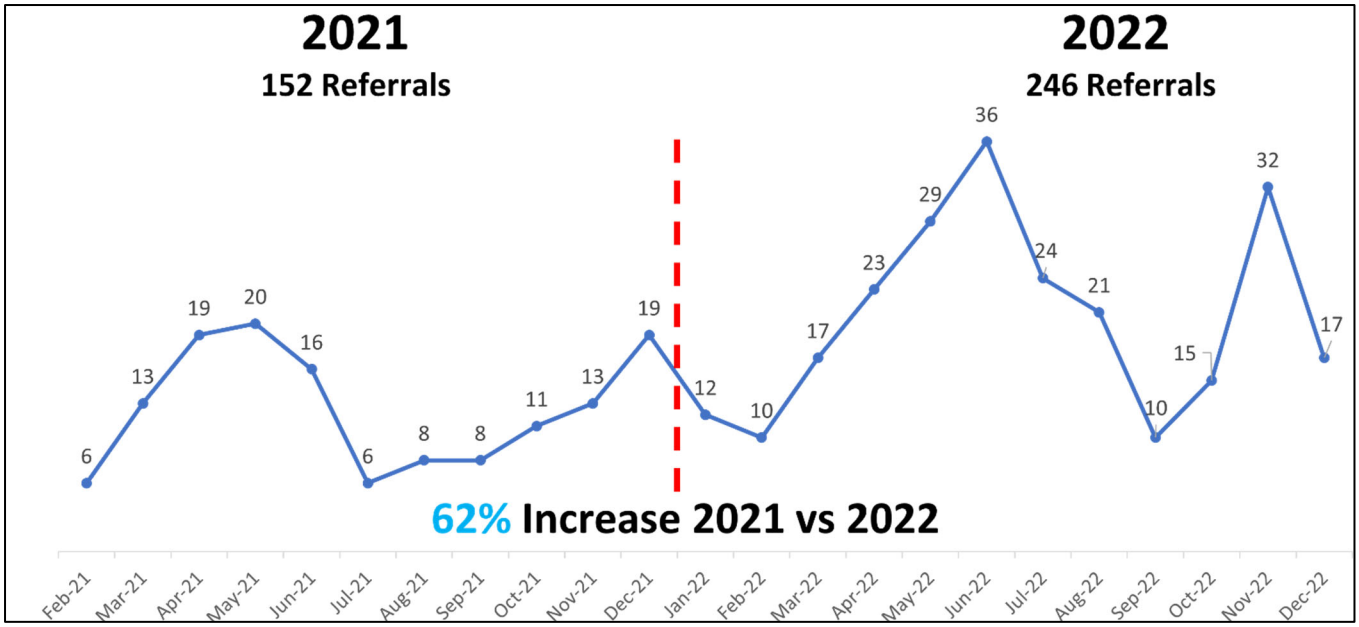


Figure 4. New Referrals to RRT by Month, 2021 – 2022

Data Trends: Since the implementation of Senate Bill 693 in October of 2021 requiring a referral to the Rapid Response Team when a child is in the ED or DSS office without access to the medically necessary treatment, response team referrals have increased, as shown in

Figure 4. New Referrals to RRT by Month, 2021 – 2022. The RRT often holds more than 7 meetings per week to address new referrals received each week and provide follow up meetings on open referrals.

Most children referred to RRT are in a hospital (44%) or housed in a DSS office (27%) at the time of referral. The other locations for children at the time of RRT referral include residential treatment facilities (i.e., facility-based crisis, level II/III, PRTF), respite provider, kinship or foster care provider or detention.

Children referred to RRT have often had multiple placements prior to their current treatment episode. Eighty percent of children experienced more than 10 distinct placements prior to RRT referral. The average number of placements was 34, while 25% of referred youth have been placed or moved across 50 or more placements. Nearly a third of children (32%) were residing in a setting that does not meet their medical needs because a program meeting their unique needs could not be located or appropriate settings lacked bed availability. Physical aggression was the most cited behavioral reason a placement could not be located (28%).

The recommended level of care for children referred to RRT is most often a PRTF (52%), followed by other level II/III behavioral health group homes (29%) (Figure 5).

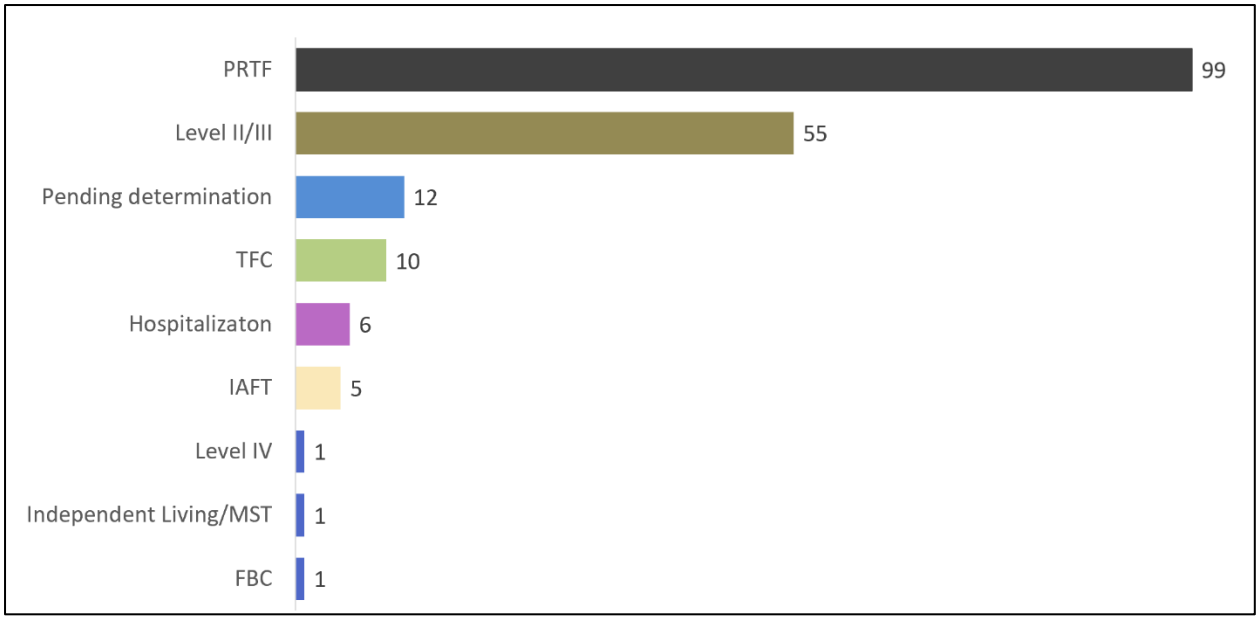


Figure 5. Placements needed at time of RRT referral – 2022.

Definitions: PRTF – Psychiatric Residential Treatment Facility; Level II/III and Level IV – Residential treatment programs with differing levels of structure, security and duration; TFC – Therapeutic Foster Care; IAFT – Intensive Alternative Family Treatment; MST – Multi Systemic Therapy; FBC – Facility-Based Crisis

Data Contextualization: These data on the children referred to RRT reflect the complexity of the behavioral health needs of some children in DSS custody, many of whom require specialty treatment and supports that are not currently available to them in North Carolina. The RRT process also highlights the critical coordination that is needed across systems for children with complex needs, including between DSS, behavioral health payers and behavioral health providers. During 2022, an average of 122 hours NCDHHS staff hours each week were spent on RRT activities despite having no staff fully dedicated to RRT. This workload is straining the ability of staff to complete other critical work for children and families of North Carolina. Analysis of the Rapid Response Team processes by the Department's Operational Excellence Team determined that RRT has capacity to support a case load of 25 open referals. Currently in March 2023 there are more than 120 cases open with the Rapid Response Team.

Behavioral Health Service Access and Utilization

This section highlights the availability and use of appropriate behavioral health services for children and adolescents in NC. In general, there is insufficient access to appropriate and specialized treatment options geographically dispersed across the state. Whether a child is in a community-based or residential treatment program, the preference is to keep a child near their family and community to provide connection and a sense of home to the child during their process to stabilize, recover, and heal from trauma.

1. **Child and Adolescent Psychiatrists**

Out of 6000 providers that prescribe medication to children and youth with Medicaid coverage, only 130 are trained as child and adolescent psychiatrists.[10] Over half of North Carolina's counties have no child psychiatrists (Figure 6).[11] Children with more complex behavioral health needs often require specialized assessments and treatments, particularly for medication management, by child and adolescent psychiatrists. In North Carolina, we do not have enough child and adolescent psychiatrists to treat the children who require their expertise.

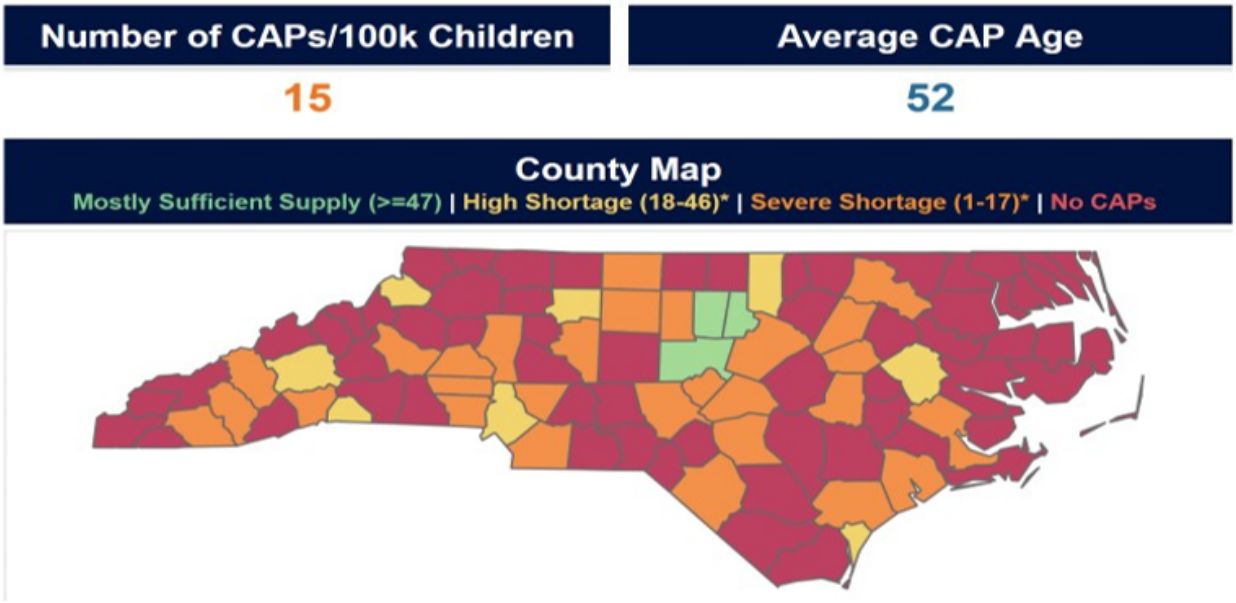


Figure 6. Practicing child and adolescent psychiatrist, Data Source: Workforce Maps by State (aacap.org) CAP = Child and Adolescent Psychiatrist

Due to the extreme shortage of child and adolescent psychiatrist expertise across the state, The NCDHHS has increased training and consultation to primary care providers through the statewide expansion of the North Carolina Psychiatric Access Line (NC-PAL), a free telephone consultation and education program to help health care providers address the behavioral health needs of pediatric and perinatal patients. This support focuses on reducing the inappropriate use of psychotropic medications, improving diagnostic evaluations, and providing alternative behavioral health interventions. Additionally, NC-PAL is piloting a program with select county DSS offices, providing consultation and education for children in custody at risk for a behavioral health emergency, and select school districts.

[10] French A, Jones KA, Bush C, Greiner MA, Copeland JN, Davis NO, Franklin MS, Heilbron N, Maslow GR. Racial and Ethnic Differences in Psychotropic Prescription Receipt Among Pediatric Patients Enrolled in North Carolina Medicaid. Psychiatr Serv. 2022 Dec 1;73(12):1401-1404. doi: 10.1176/appi.ps.202100473. Epub 2022 Aug 30. PMID: 36039550.

[11] American Academy of Child and Adolescent Psychiatry. *Workforce Maps by State*. 2022; Available from: https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

2. Community-Based Behavioral Health Treatment Services

In this section, we provide an overview of different types of behavioral health treatment services available in the community. Community-based services allow for children to stay in their home or their community-based setting while receiving the treatment needed to heal and recover. Access to community-based behavioral health treatments services for children and their families is insufficient and inconsistent across the state.

2.1. High Fidelity Wraparound

High-fidelity wraparound is an evidence-based care management program for children with behavioral health challenges. The program brings a team, including a facilitator and supports for the family and child, to help the family reach its goals. This intensive program has been shown to keep more children in their homes, preventing the need for facility-based or residential care, entry into the child protection or juvenile justice systems and use of the ED. North Carolina data demonstrate a savings of $33,000 for each child who received high-fidelity wraparound services.

High-fidelity wrap-around services are available in 69 counties (Figure 7). It is the goal of the Department to expand availability of the service statewide. Investment in start-up funding is needed to bring this service statewide.

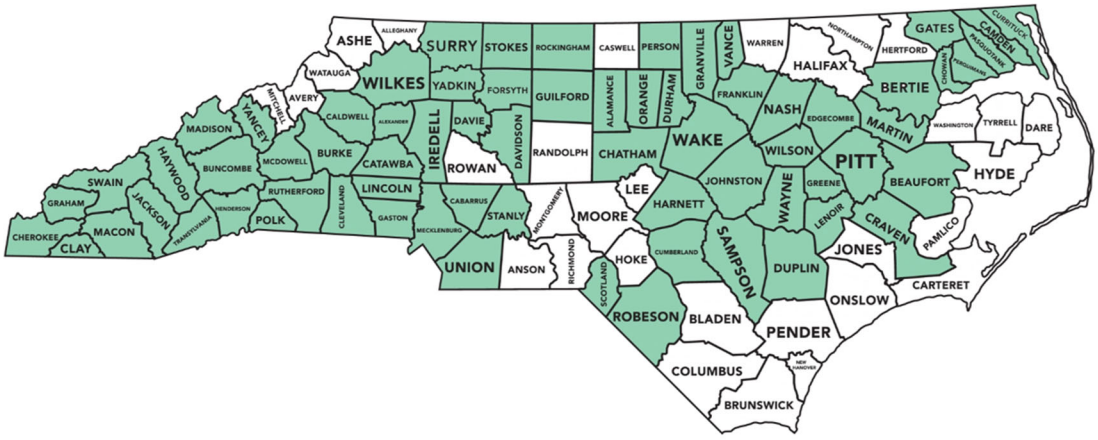


Figure 7. High Fidelity Wraparound Program Training

2.2 Intensive In Home

The Intensive In-Home service is a team approach designed to address the identified needs of children and adolescents who, due to serious and chronic symptoms of an emotional, behavioral, or substance use disorder, are unable to remain stable in the community without intensive interventions. In 2021, 20,856 children were served in intensive in-home settings at a cost of $111.8 million dollars.

2.3 North Carolina Child Treatment Program

The North Carolina Child Treatment Program (CTP) is a statewide effort to train mental health providers in evidence-based treatment models addressing childhood trauma, behavior, and

attachment. They train clinical professionals in a variety of evidence-based practices which are needed to treat the variety of needs children with complex behavioral health needs, including Trauma Focused Cognitive Behavioral Therapy, Parent Child Interaction Therapy, Problematic Sexual Behavior Cognitive Behavioral Therapy, and Structured Psychotherapy for Adolescents Responding to Chronic Stress. CTP maintains a roster of all clinicians credentialed to deliver each of these modalities and accepts Medicaid (Figure 8).

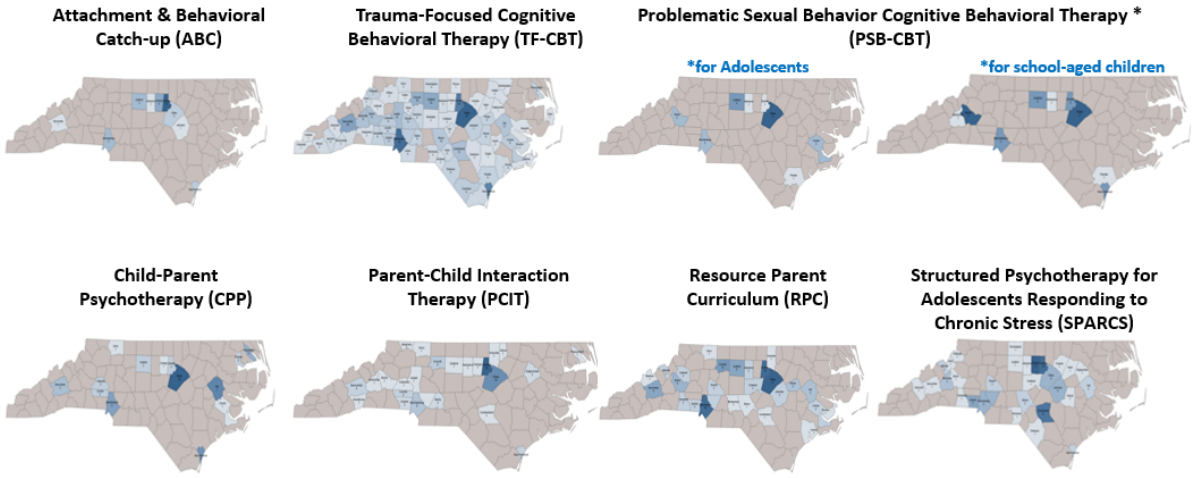


Figure 8. Rostered Evidence-Based Treatment Medicaid-Enrolled Providers. See Appendix for larger images and map legends.

Since 2013, The North Carolina Child Treatment Program has received $1.8 million per year in state funds to train clinicians in these evidence-based models for children that are involved in or at risk of involvement in the child welfare system. A top priority is to make these models more widely available to children with Medicaid. Potential providers have cited reimbursement rates being insufficient to support implementation of models to fidelity. The lack of providers willing to be trained and/or offer these services are a barrier to state-wide coverage. Medicaid rates cover between 20% to 75% of the actual cost of providing these models to fidelity.

2.4 Multi Systemic Therapy

MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to beneficiaries and their families. The services include assessment, therapy, peer supports/interventions, case management, and crisis stabilization. The Journal of Family Psychology found a return on investment of $23.59 for every $1.00 spent and an up to $200,000 net benefit per youth.[12]

Among NC counties, 89% have at least one MST provider. In 2021, 2,367 children paid by Medicaid and state funds received MST at a cost of $16.2 million.

[12] Klietz SJ, Borduin CM, Schaeffer CM. Cost-benefit analysis of multisystemic therapy with serious and violent juvenile offenders. J Fam Psychol. 2010 Oct;24(5):657-66. doi: 10.1037/a0020838. PMID: 20954776.

2.5 Day Treatment

Day Treatment is a structured treatment service in a licensed facility, for children or adolescents and their families, that builds on strengths and addresses identified needs. This service is designed to serve children who, as a result of their mental health or substance use disorder treatment needs, are unable to benefit from participation in academic or vocational services at a developmentally appropriate level in a traditional school or work setting.

The map below (Figure 9Figure 5) shows the distribution of licensed Day Treatment programs across the state. As of January 2023, 35 counties lack a Day Treatment site, and 17 counties have fewer than one site per 11,000 or more kids.

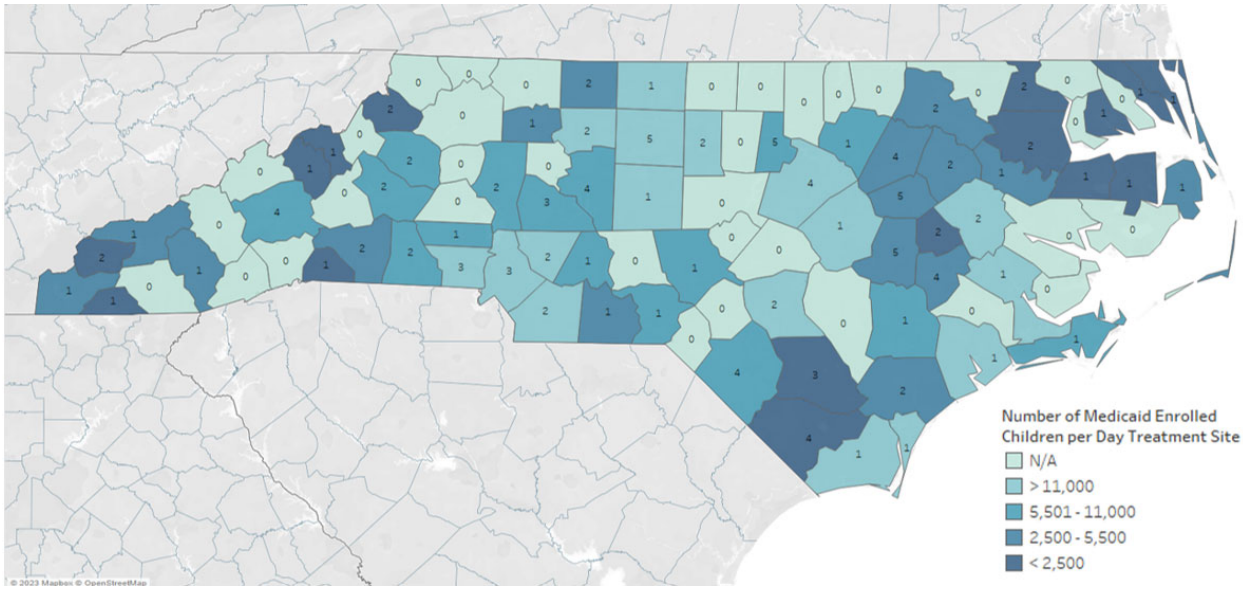


Figure 9. Distribution of Day Treatment Providers

3. Residential Treatment Services

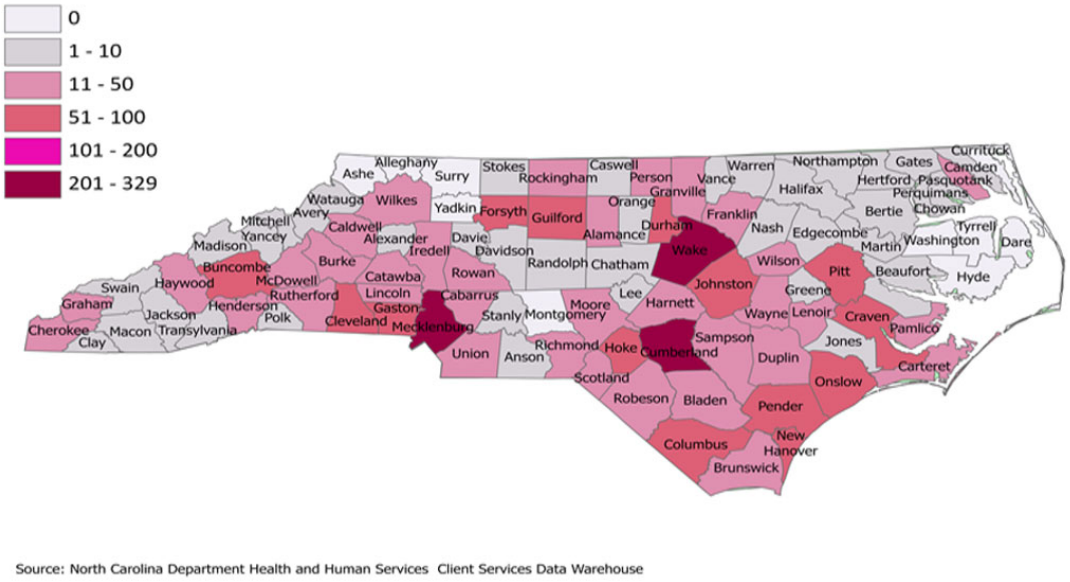
3.1 Therapeutic Foster Care

Therapeutic foster care homes provide a community-based alternative and a more family like environment for children in need of out of home behavioral health treatment. Therapeutic foster parents have specialized training to care for children with complex medical and behavioral needs.

Therapeutic Foster Care services are licensed by the Division of Social Services and reimbursed by North Carolina Medicaid. Therapeutic foster care homes serve children in the custody of the Departments of Social Services and children in the custody of their parents. Therapeutic homes provide a community-based alternative and a more family like environment for children in need of out of home behavioral health treatment.

A map of licensed therapeutic foster homes (Figure 1011) shows that there are no homes in 10 counties and another 40 counties have less than 10 homes. Not only do the data show that

therapeutic foster care capacity is limited in more than half of North Carolina counties, the map also shows which NC regions have the most inadequate access to Therapeutic Foster Care (e.g., northeast). The inadequate network of therapeutic foster care providers means that children will not be able to be served in their home county; may have to travel multiple counties away to access the service, creating barriers to family participation; or may be placed in a more restrictive setting, such as a residential facility.



Source: North Carolina Department Health and Human Services Client Services Data Warehouse

Figure 10. Number of Licensed Therapeutic Foster Care Homes on August 31, 2021

In addition to the inadequate number of licensed therapeutic foster care providers, Figure 1112 below shows that the majority of the beds licensed for Therapeutic Foster Care are not serving children. There are several reasons for therapeutic foster care providers not operating at full capacity:

- Homes reducing the number of children served at one time due to the treatment needs of the child already placed in the home.
- Licensed homes choosing to no longer provide foster care.
- Training is not adequate to develop the skills required to meet the needs of children placed.
- Licensed homes not receiving adequate services or support to maintain placement.
- Homes may be serving family foster care children instead of or in addition to therapeutic children.
- IAFT homes may be licensed as therapeutic with a capacity of 2 but can only serve 1 IAFT client.

There are several factors that impact the ability to attract and retain qualified therapeutic foster homes. Barriers include but are not limited to insufficient reimbursement rate for families, lack of training and support to licensed homes, and lack of incentives for licensed homes to serve children with complex behavioral and medical care needs.

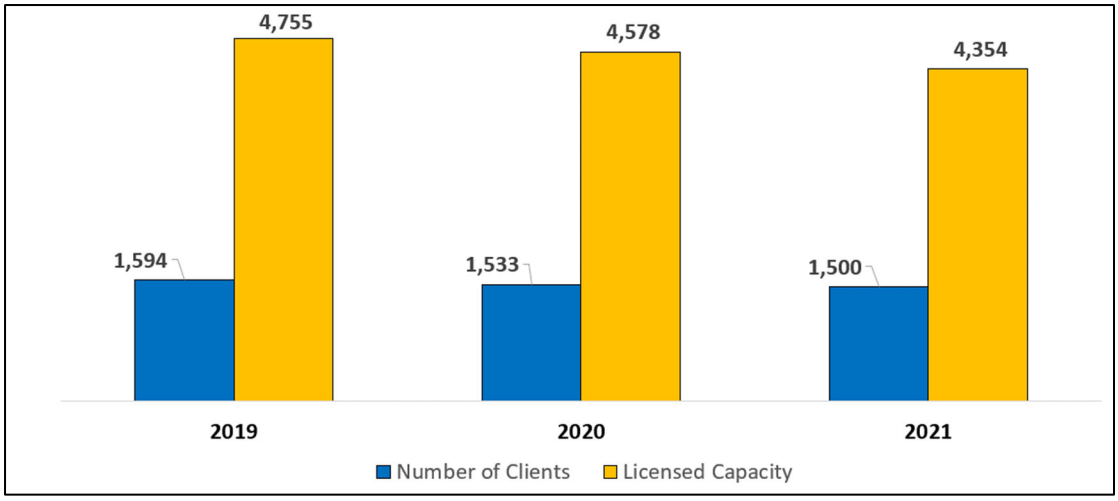


Figure 11. Therapeutic Foster Homes Caring for Children

3.2 Intensive Alternative Family Treatment (IAFT)

Within the Therapeutic Foster Care service continuum, North Carolina has several promising programs that would allow more children to be served in a community based and family centered intervention. Intensive Alternative Family Treatment (IAFT)®, developed by North Carolina providers, is a specialized, in-home, family-based foster care option. IAFT® supports difficult-to-place children/teens by providing a more intense level of care than therapeutic foster care. IAFT® also serves children/teens as they step down from a more restrictive level of care. The individualized approach, the increased focus on quality, the use of evidence-based treatments, and the family focused approach, provide better support and has been shown to result in improved outcomes for children. The University of North Carolina at Chapel Hill has led several evaluations and has ongoing research of IAFT® with the following initial findings: (1) improvements in child functioning over time (e.g., daily behaviors); (2) a 20% reduction in risk for both first time PRTF entry and PRTF recidivism;[13, 14] and (3) bending of the Medicaid cost curve among a population of beneficiaries with previously escalating behavioral health costs.[15] Future research has been funded and will include a randomized-controlled trial of IAFT® to assess the efficacy of the program and further examine Medicaid costs.

[13] Lanier, P., Chung, G., & Rose, R. (2021). A quasi-experimental study of Intensive Alternative Family Treatment to prevent entry to psychiatric residential treatment. Child and Adolescent Social Work Journal, 39, 303-311.
[14] Rose, R., Chung, G., & Lanier, P. (2020). Effectiveness of Intensive Alternative Family Treatment on reducing re-admissions to psychiatric residential treatment facilities. *Journal of Emotional and Behavioral Disorders, 29*(2), 113-124.
[15] Lanier, P., Rose, R., & Domino, M. (in preparation). Cost analysis of Intensive Alternative Family Treatment on Medicaid expenditures.

The map below (Figure 12) shows the IAFT® coverage across North Carolina.

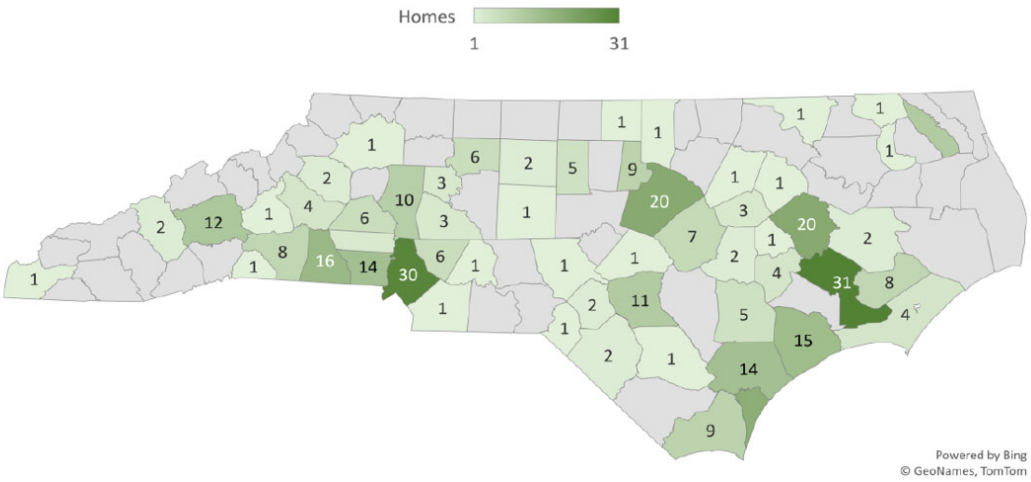


Figure 12. Location of IAFT® home 2019 – 2022

3.3 Behavioral Health Residential Treatment Settings

Some children with complex behavioral health needs require more intensive levels of treatment and supports, which can be provided in a residential treatment setting. North Carolina licenses four types of congregate residential treatment settings. These four congregate settings provide children with a short-term place to live while receiving behavioral health treatment. The lowest level of care in this category of services is a Level II group home. The highest residential treatment setting is PRTF. The acuity of the child's needs help to determine the level of care needed. Staffing patterns, staffing ratios, and supervision requirements are some of the differences found in these settings. The goal is to provide the treatment a child needs in a residential program and to return a child to a community, home-based setting with the right supports as quickly as possible. Table 1 indicates the number of facilities and beds available in North Carolina by year.

Table 1. Residential treatment settings 2019 - 2022

	2019		2020		2021		2022	
	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds
27G.1300 (Level II Group)	44	336	37	305	36	303	31	273
27G.1700 (Level III)	168	694	168	693	192	782	190	760
27G.1800 (Level IV)	2	24	2	24	4	42	5	51
27G.1900 (PRTF)	33	453	33	454	29	417	27	339

There are several identified challenges resulting in difficulties finding appropriate residential treatment for children. Most notable are the following:

- **Rules** regulating residential settings need to be updated to reflect changing standards of staff competency, the use of evidence-based models, and the use of alternative methods to de-escalate crises other than restraint and seclusion.
- **Medicaid residential reimbursement** rates have not increased in a significant period of time. This results in a lack of improvement in systems, staff competencies, and staff hires.
- **Staffing Crisis**: Ongoing challenge to find a sufficient number of staff with appropriate competencies.
- **Lack of specialization among residential programs**: A lack of appropriate training by staff at a facility to address a child/youth's problem sexual behavior, aggression, and elopement are among the most common reasons a child/youth will be denied for a residential program. The state also lacks programs designed to treat children with co-occurring behavioral health and IDD or co-occurring substance use disorders. North Carolina does not have adequate specialty programs to accommodate these needs.
- **Provider denials**: LME-MCOs contract with providers directly and often those contracts lack requirements for providers to accept youth that meet a specialized population (e.g., children or youth with problem sexual behaviors, children with co-occurring health and IDD). Providers cite the liability risk for serving children with increasingly complex needs and also inadequate training supports and resources.

Psychiatric Residential Treatment Facilities (PRTFs) provide care for children or adolescents who have serious mental health or substance use needs. PRTFs provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, and require supervision and specialized interventions on a 24-hour basis. PRTFs are located in hospital and non-hospital settings.

In state fiscal year 2021, a total of 1,234 unduplicated children were served in PRTFs at a Medicaid cost of $119,450,200. The number of PRTF facilities and beds in North Carolina has decreased since 2021 (Table 2).

Table 2. PRTF capacity by year 2018-2023 in North Carolina

Year	PRTF Facilities	PRTF Beds
2022 – 2023	27	339
2021 – 2022	29	417
2020 – 2021	33	454
2019 – 2020	33	453
2018 – 2019	33	450

Based on data submitted by the LME/MCOs to NCDHHS regarding the use of PRTFs, the number of children accessing this level of care dropped significantly during the third and fourth quarter of SFY 2019-20, coinciding with the first quarters of the COVID-19 pandemic. Otherwise, the number of children accessing PRTF services has been relatively stable since 2018 (Figure 13).

The number of NC children accessing PRTF services outside of NC is rising. In the first quarter of SFY 2021-22, 703 children with Medicaid received PRTF treatment with 42% of them receiving this care in another state (Figure 13). Placements out of state often occur because of limited specialized bed capacity within North Carolina. Specialized care that is needed and often unavailable within the state includes treatment for problematic sexual behavior, autism spectrum disorder, co-occurring IDD, complex medical needs, and substance use disorders. In addition to lack of specialized capacity in North Carolina, the overall general PRTF capacity has decreased by more than 100 beds since the start of the pandemic.

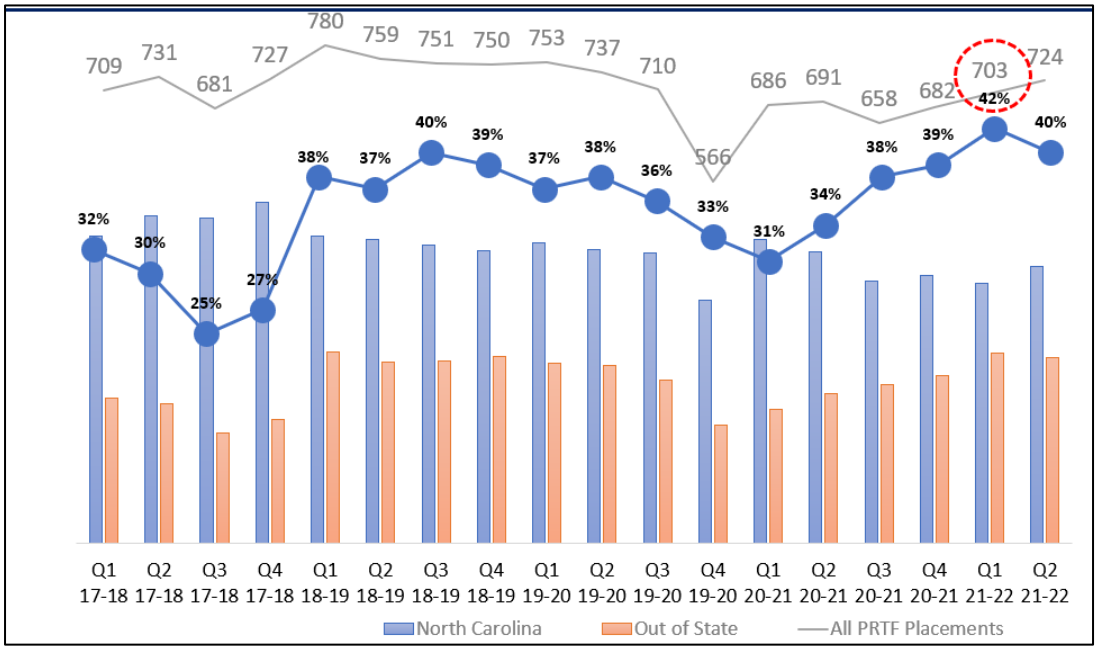


Figure 13. PRTF In State / Out of State Trends. Data source: Medicaid claims. Note: Some children may be counted in more than one quarter if their length of stay includes dates in both.

There are many concerns and challenges when children are served in out of state PRTFs. These include but are not limited to:

- **Lack of oversight and monitoring of the out of state facility:** Facilities located in North Carolina are monitored by Division of Health Service Regulation (DHSR), however, DHSR does not have legal authority or resources to monitor treatment facilities out of state. Monitoring by LME-MCOs is generally specific to the individual child's treatment while at the facility and varies by LME-MCO. County DSS maintain contact with children in their custody, however, this does not include monitoring of the facility.
- **Inconsistent educational services:** All PRTF providers are expected to provide for the education of children placed in their facility. However, North Carolina does not pay for educational services provided in out of state facilities, resulting in inconsistent access to educational services and denials for care because of lack of educational funding.

- **Limited access to information on investigations in out of state facilities:** An Interstate Compact on the Placement of Children (ICPC) request is required for children placed out of state for behavioral health treatment, but on some occasions that process is not completed prior to placement. When an approved ICPC request and notification of placement is made, North Carolina may be able to access information about investigations or actions taken against out of state facilities even if there are not in the public record. However, when a placement is made without going through ICPC that information is not available, further limiting any oversight of facilities serving North Carolina's children and adolescents.
-
- **Decreased opportunities for family engagement in treatment:** For some children, placement out of state may mean that they are able to stay closer to their family and local community. However, often, an out of state placement means children are much further from their families or other supports, limiting family involvement. Family engagement in treatment is critical to successful transitions back home and overall treatment outcomes.

Barriers to keeping children out of PRTFs or reducing their length of stay is also multifactorial, including the following:

- **Lack of community-based behavioral health services to prevent condition escalation or allow children to be supported in the community upon discharge,** especially for children with specialized behavioral health needs, such as aggression or co-occurring mental health and IDD.
- **Lack of step-down behavioral health treatment programs**, including level 2-4 residential treatment settings, for children who require continued intensive supports in a setting less restrictive than a PRTF.

4. Inpatient Services

Inpatient psychiatric services provide acute treatment where children can be closely monitored, stabilized and kept safe.

From 2018-2022, there has been a steady decline in youth receiving behavioral health treatment in North Carolina's state psychiatric hospitals (Figure 14). This is attributed to a combination of workforce challenges and longer lengths of stay due to decreased residential and other community treatment options. Consequently, youth are waiting longer periods of time for a state child and adolescent psychiatric hospital bed, growing from approximately 4 days in 2018-2019 to 11 days in 2021 and 16 days in 2022. The unmet need for children who require inpatient psychiatric care is growing in our state facilities.

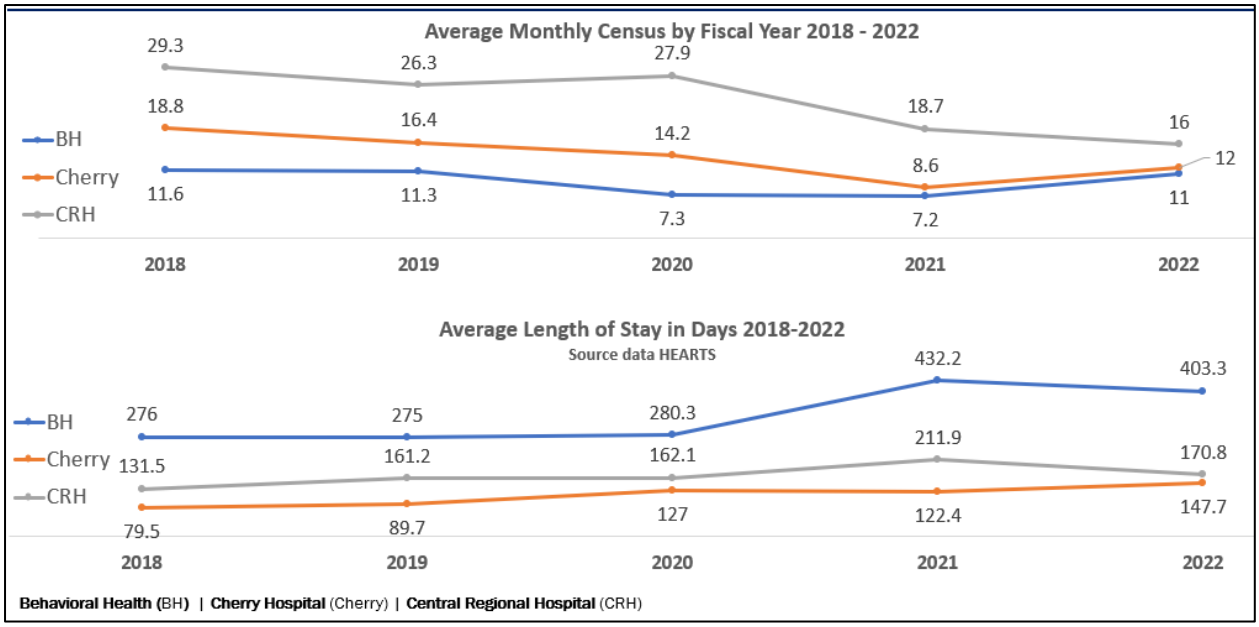


Figure 14. State Psychiatric Hospital Child/Adolescent Services

These trends are not unique to our state psychiatric hospital facilities (Table 3). In North Carolina, other hospitals are operating fewer inpatient psychiatric beds for youth as evidenced by the percent utilization of licensed psychiatric beds in Table 3. The end result is a pressing need for access to inpatient psychiatric care by NC youth.

Table 3. Psychiatric in Bed Patient Utilization

Psychiatric Care in Acute Care Hospitals	Child /Adolescent (0-17)			Total
	FY 2018	FY2019	FY 2020	
Licensed Beds	162	162	162	486
Days of Care	34,937	35,773	35,032	105,742
% Utilization of Licensed Psychiatric Beds	59.1%	60.5%	59.2%	59.6%

Psychiatric Care in Psychiatric Hospitals	Child /Adolescent (0-17)			Total
	FY 2018	FY2019	FY 2020	
Licensed Beds	224	224	235	683
Days of Care	86,568	70,120	68,231	224,919
% Utilization of Licensed Psychiatric Beds *	105.9%	85.8%	79.5%	90.2%

Psychiatric Care in Acute Care Hospitals and Psychiatric Hospitals	Child /Adolescent (0-17)			Total
	FY 2018	FY2019	FY 2020	
Licensed Beds	386	386	397	1,169
Days of Care	121505	105893	103,263	330,661
% Utilization of Licensed Psychiatric Beds **	86.2%	75.2%	71.3%	77.5%

* Does not include Psychiatric beds in State Psychiatric hospitals
** For fiscal year 2018, Strategic Behavioral Center – Gartner appears to have reported psychiatric days of care provided in beds that were not psychiatric inpatient beds i.e. it was licensed for 56 psychiatric inpatient beds and 60 PRTF beds.

Together, these data on decreasing availability of beds and the increasing need for services clearly indicate the need for additional availability for inpatient psychiatric treatment for youth. As part of a shared commitment to behavioral health and the well-being of children and families, the NCDHHS and UNC Health are partnering to convert the R.J. Blackley Alcohol and Drug Abuse Treatment Center in Butner, N.C., into a 54-bed inpatient psychiatric hospital for children and adolescents.

5. Crisis Services

The crisis services available for mental health, substance abuse, intellectual and developmental disabilities issues vary across NC.

Mobile crisis management services are available to meet children and families in a safe location, including their home, school or workplace. In FY 2021, mobile crisis was provided to consumers under the age of 21 approximately 7,050 times (NC Tracks Data FY21; this does not include crises that resulted in ED admissions).

Our current mobile crisis system does not have the ability to appropriately serve children and youth that require specialized interventions and supports. Further, our EDs are not equipped to best support children most in need. To address this gap, NCDHHS has advanced several reform initiatives to improve child crisis services. These include:

- Implementation of the NC Psychiatric Access Line (NC-PAL) with a strategy to expand the program statewide
- Implementation of Mobile Outreach Response Engagement Stabilization Service (MORES) Pilot, a child focused mobile crisis pilot, with a plan for statewide implementation based on funding.
- NC 988 Suicide and Crisis Lifeline went live July 16, 2022

Behavioral Health Facility-Based Crisis Centers and Behavioral Health Urgent Care sites provide immediate care to adults, adolescents or families in crisis.

Figure 6 and **Error! Reference source not found.**7 illustrate the locations of these Centers and the youth served and costs to Medicaid. Longer lengths of stays and increased reimbursement contribute to rising costs seen in Figure 19.

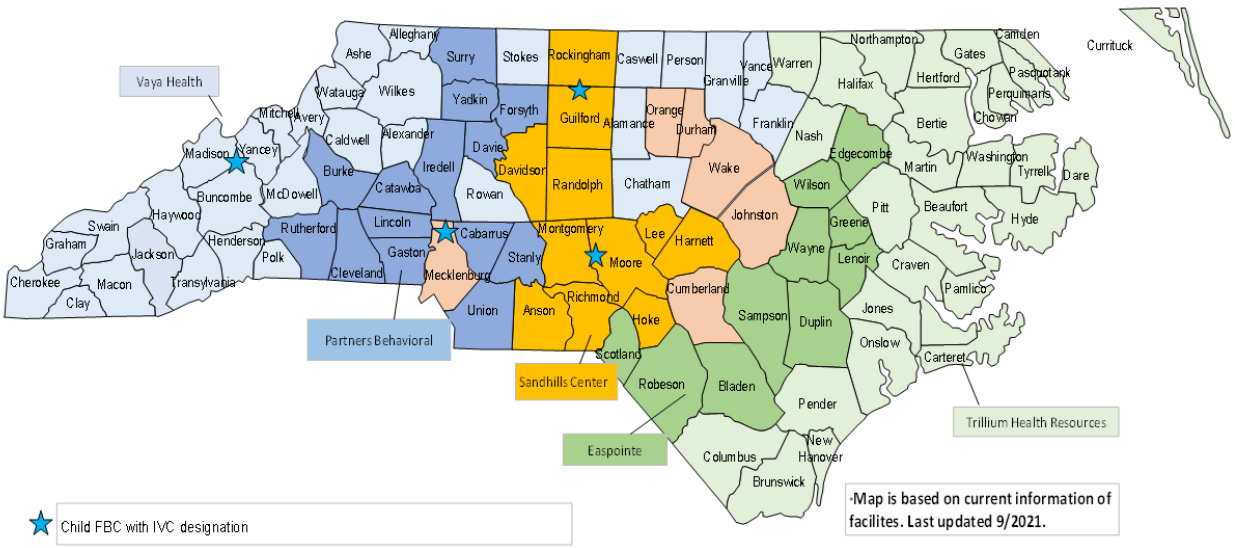


Figure 16. NC Behavioral Health Facility-based Crisis & Behavioral Health Urgent Care Locations

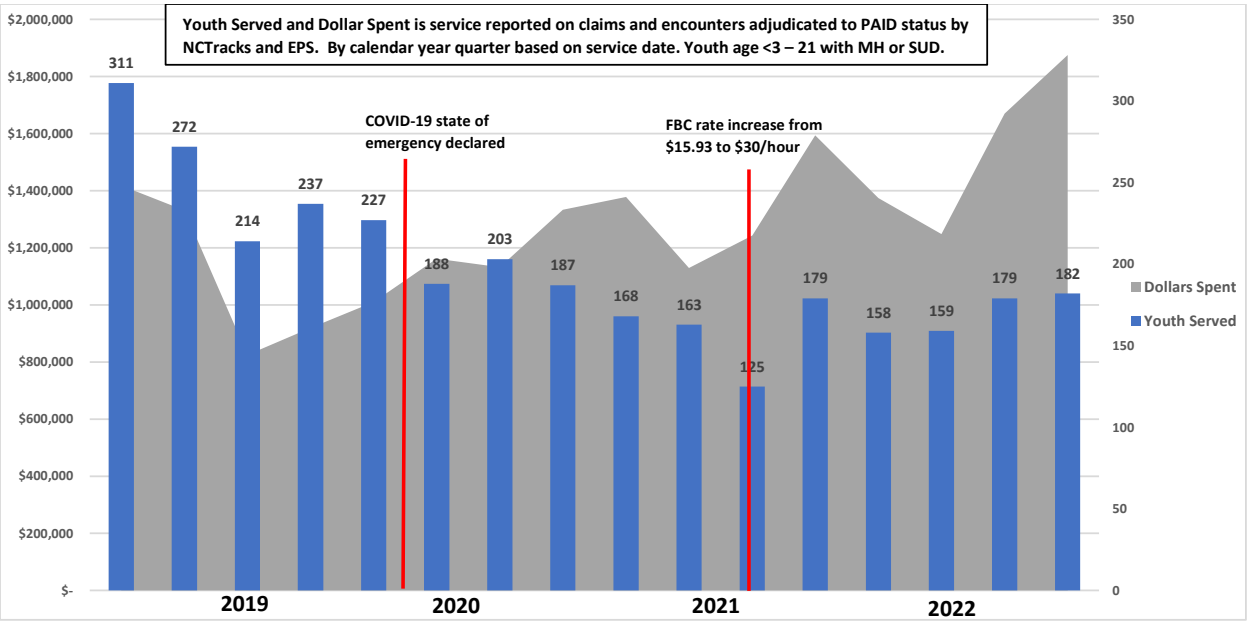


Figure 17. Services Paid by NC Medicaid for Facility Based Crisis Services

Recommendations, Timeline, and Estimated Costs/Staffing

Recognizing that we can and should do better to work together across sectors, NCDHHS has repeatedly stated that the current situation is not satisfactory, and agency leadership and officials have been working hard to increase the full range of mental health services for **all** North Carolina children who have behavioral health needs, in tandem with increasing the availability of appropriate placements for those who are in the custody of county DSS.

The strategies are organized in two categories: 1. Increasing access to behavioral health treatment for children (Table 4), and 2. Increasing timely access to appropriate placements for children with behavioral health needs (Table 5). Several of the strategies are also described in the previously published NCDHHS Coordinated Action Plan https://www.ncdhhs.gov/media/14828/download?attachment.

In Table 4 and Table 5, the description of each strategy includes the anticipated impact for children and families, including which children and families are anticipated to benefit, and cost, if any, for strategy implementation. Of note, nearly all children in foster care and approximately half of all children in North Carolina receive their health insurance through Medicaid; therefore, several strategies impact children insured by Medicaid. Strategies with an asterisk (*) in the Tables indicate that the service has been launched in at least some parts of the state; some strategies that have launched may require additional investment for increased access and/or quality.

In total, the state share investment needed to implement the full set of strategies is approximately $105 million of state share annually.

Increasing Access to Behavioral Health Treatment for Children (Error! Reference source not found.)

Ensuring that children have the behavioral health treatments and supports they need requires a multipronged approach. We have prioritized launching and seeking funding for services that fill critical care gaps in NC, as detailed in the beginning of this report, and that have strong evidence of their ability to help children with behavioral health needs. We focus on the urgent behavioral health needs of dozens of children involved with the child welfare system who are boarding in EDs or staying in county DSS offices. Many of the selected strategies set the groundwork for driving transformative long-term change.

We describe how to increase access to behavioral health treatment for children in the following categories: improving clinical assessments to identify the treatments that children need; increasing availability of specialty behavioral health treatments to divert children from inappropriate placements; supporting families and caregivers so that children can be cared for and remain in a safe and stable home; maximizing the impact of health care payers; and reinforcing the critical infrastructure and workforce needed to execute this work.

Increase Timely Access to Appropriate Placements for Children with Behavioral Health Needs (Table 5)

NCDHHS and our partners believe that children should live in safe, stable placements where they have the best opportunity to thrive. NCDHHS is working to expand our supply of appropriate and least restrictive placements. We know that one way to improve the adequacy of our supply is to prevent the service from being needed in the first place; the discussion on prevention is limited in this report since the legislatively mandated report does not address prevention. Our Family First Services Prevention Act plan focuses on preventing children from entering foster care. The plan established our path to implementing prevention services like Homebuilders which teaches critical skills of parenting and child development and Sobriety Treatment and Recovery Teams (START) which support parents in safe parenting while they are recovering from substance use disorder.

When children cannot safely live in the home, relatives are the first choice for placement. Supports to kinship care families allow children to remain with their families. When children's behavioral health needs require them to live in residential settings or in foster homes these should be in the community, when possible. We have prioritized launching and seeking funding for services that establish new and more safe placement options for children with behavioral health needs in community, provide more supports for caregivers, and reinforce our workforce.

Staffing Needs

Implementing the strategies detailed in Table 4 and**Error! Not a valid bookmark self-reference.Error! Not a valid bookmark self-reference.** Table 5 would require 16 additional staffing in the following Divisions: Division of Child and Family Well-Being (5), Division of Social Services (5), Division of Mental Health (2), Division of Health Services Regulation (2), Division of Health Benefits (2). In the context of high vacancies and turn-over in our NCDHHS and local partner teams, these additional state NCDHHS staff would be critical for launching or expanding the strategies in this plan. Prioritized approaches to strengthening the child behavioral health (in Table 4) and child welfare workforce (in Table 5) are included in the plan.

Conclusion

Progress is possible. Behavioral health is essential to health and well-being for children and families. By investing in the comprehensive needs of children and families, we can realize our vision that all children can develop to their full potential and thrive. Here are some examples:

With substantial federal and state investment, the national 988 Suicide and Crisis Lifeline is able to respond to hundreds of calls in North Carolina per day, with the greatest growth in calls from young people looking for behavioral health support.

Initial implementation of the Regional Support Model for child welfare has provided additional resources to counties through new positions funded last year by the general assembly. For child welfare services, these new staff have assisted counties in ensuring critical contacts on child safety were made.

In addition, North Carolina should take the single most important step for improving access and affordability for behavioral health care: expanding Medicaid. Timely expansion will give North Carolina a $1.8 billion one-time “signing bonus” from the federal government. The highest priority for that bonus must be making smart investments in our mental health and substance use system across the entire continuum of care.

Table 4. Prioritized Strategies to Increase Access to Behavioral Health Treatment for Children

Strategy	Description	Impact	Cost[1]
Improving Community Assessments to Identify the Treatments that Children Need			
Community assessment teams	New community assessment teams would conduct assessments and determine individualized needs for youth who have or are at risk of losing their placement. The team would include behavioral health clinicians and collaborate with the child's Child and Family Team to make holistic and individualized recommendations for level of care, services and supports, and other considerations for treatment and disposition planning.	Available to all children: Preventing unnecessary family separations and ensuring beds in higher levels of care are reserved for youth who most need them	$10 million in State share annually, and the service is eligible for federal match.
Specialty Behavioral Health Treatments to Divert Children from Inappropriate Placements			
Specialty residential treatment programs with technical assistance	New specialized residential treatment programs will serve children and youth who have complex, challenging behavioral health needs but who have long lacked access to the treatments. This strategy includes new specialized residential treatment options at multiple levels as well as professional foster parents trained in intensive support services, skill development, and keeping a child in a safe and stable home. In addition, staff will have 24/7 access to specially trained technical assistance providers and clinical resources to care for the most complex behavioral issues.	Available to all children: Preventing inappropriate or prolonged in-state placements and costly out-of-state placements	$5.5-6.5 million in State share annually, and the service is eligible for federal match.
Crisis stabilization facilities	Specialized crisis stabilization facilities will provide emergency, short-term shelter and therapeutic services, including rapid assessments, for up to 50 children and youth at a time, which equates to 400 to 600 youth per year. These children would otherwise be placed in hospital EDs, hotels, and even local DSS offices for extended periods of time, compounding the trauma they experience. The new or expanded crisis facilities will include a small number of reserved beds to ensure beds and staff are available to youth when needed, at any time.	Available to all children: Reducing inappropriate placements in EDs and DSS offices	$4 million in State share annually, and the service is eligible for federal match.
Increase family-type placements and	Expand the Intensive Alternative Family Treatment model (IAFT) through recruitment of new foster homes and training of existing homes and	Medicaid-insured children: Reducing	$2.1 million in State share

Strategy	Description	Impact	Cost[1]
community-based residential treatment settings*	fidelity monitoring of new homes. IAFT—a model developed in North Carolina—is designed specifically for youth who exhibit severe emotional or behavioral difficulties; are at risk for hospitalization or institutionalization; may have experienced multiple failed placements; or may have additional functional development diagnoses. This strategy will increase the number of placements by a total of 60 placements.	inappropriate placements in EDs and DSS offices and increasing children cared for in the community	annually, and the service is eligible for federal match.
Expand Mobile Outreach Response Engagement Stabilization (MORES)*	Evidence based, MORES Crisis Intervention Teams provide in-person and virtual mobile crisis services for children and adolescents resulting in fewer children unnecessarily going to the ED for a behavioral health crisis. Clinicians trained in working with children experiencing a behavioral health emergency respond within an hour of being called, assess, and connect the child with clinical and social services, avoiding unnecessary ED visits and providing better person-centered care. The MORES team also provides ongoing stabilization support for two to four weeks after the crisis. With funding from The Duke Endowment, the program is launching with four providers covering 7 counties and should begin serving patients Spring of 2023.	Available to all children: MORES teams in other states have kept more than 90% of the children they served out of the hospital and stabilized in their current living situation. Statewide expansion will serve an estimated 2,830 children annually.	$28M annually to expand this program statewide
UNC hospital partnership*	As part of a shared commitment to behavioral health and the well-being of children and families, NCDHHS and UNC Health are partnering to convert the R.J. Blackley Alcohol and Drug Abuse Treatment Center in Butner, N.C., into a 54-bed inpatient psychiatric hospital for children and adolescents. This approach creates a pediatric psychiatric treatment hospital much faster and at a lower cost than constructing a new facility. Services will begin in 2023.	Available to all children: More children can access high-quality treatment and return to their community as quickly as possible.	No additional funding is required

Strategy	Description	Impact	Cost[1]
Intensive Supports For Families and Caregivers So Children Can Be Cared For and Remain In a Safe and Stable Home			
Expand access to Family Peer Support*	Family Peer Support services is a community-based service provided to the parent or caregiver of a youth that has a mental illness, substance use or IDD diagnosis. The service that will be expanded statewide enables certified family peer support specialists, also called Family Partners, to provide structured, one-to-one interventions that promote self-determination, self-advocacy and focus on recovery and resiliency. One Family Partner can serve up to 12 families at a time.	Medicaid-insured children: Improves outcomes, increases family capacity to manage their own services while promoting recovery and preventing out-of-home placement	$170,000 for the 2023-2025 Biennium and is eligible for the federal match.
Expand access to High Fidelity Wraparound (HFW)*	HFW is an evidence-based, intensive care coordination service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious behavioral difficulties, have complex needs, are at risk of placement in residential settings, or have experienced multiple crisis events. Statewide expansion of HFW will lead to increased access for at least 2,600 children and families.	Medicaid-insured children: Keep more children in their homes; reduce emergency, inpatient and residential care. ~$33,000 savings per child.	$2.8 million in State share annually, and the service is eligible for federal match.
Implement 988*	In July 2022, 988 became the three digit number to call or text that connects North Carolinians to the Suicide and Crisis Lifeline. All individuals regardless of insurance experiencing a behavioral health crisis are connected to a trained crisis counselor to assess the crisis and link individuals to immediate resources when needed, such as a mobile crisis team, including those that specialize in the care of children like MORES mobile crisis teams. Investment is needed to ensure adequate availability of crisis services (e.g., mobile crisis teams, emergency respite providers and facility-based crisis services) for people who reach out to 988. In NC, 988 has seen a 22% increase in call volume and added chat/text in July, responding to an average of 657 chats/texts each month, a number that is increasing.	Available to all children: Increase the quality of behavioral crisis care for children and reduce the involvement of law enforcement in these crises	$1.3 million annually is needed to maintain the NC 988 call center

Strategy	Description	Impact	Cost[1]
Maximizing The Impact of Payers			
NC Medicaid Health Plan: Stronger care management, oversight & accountability*	NCDHHS in conjunction with Prepaid Inpatient Health Plans (PIHPs), LME/MCOs, and Community Care of North Carolina (CCNC) have been consistently improving care management for children in foster care. The Medicaid PIHP and Behavioral Health and IDD Tailored Plan (TP) contracts are scheduled to go into effect on April 1, 2023. These contracts include requirements that strengthen accountability and oversight for meeting the needs of children and youth in foster care who are insured by NC Medicaid. First, enhanced care management requirements will ensure these children are prioritized and that there is close coordination with County Child Welfare Workers. Second, our new contracts will strengthen oversight and accountability, including close monitoring of operational reports that detail care management interactions and care needs screening completion. Third, we added new reporting requirements on the services and supports provided to children in foster care, including ED utilization and discharge planning efforts. The implementation of new PIHP and TP requirements addresses issues within the existing LME/MCO system and enables consistency across managed care plans while promoting increased accountability and oversight for meeting the needs of children and youth enrolled in NC Medicaid who require timely access to mental health, I/DD, and substance use disorder services.	Medicaid-insured children involved with DSS: More timely access to care and more upstream healthcare for children resulting in better health outcomes and more stable placements	No additional funding is requested
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit strengthening & education*	The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. EPSDT is particularly beneficial for children with specialized behavioral health needs, whose treatment needs may not be covered by traditional Medicaid. NC Medicaid is offering additional education and technical assistance to health plans, health care providers and child welfare to increase awareness and utilization of EPSDT benefits for children and youth.	Medicaid-insured children: More timely access to necessary treatments to reduce ED, inpatient, and residential care utilization	No additional funding is requested

Strategy	Description	Impact	Cost[1]
Critical Infrastructure & Workforce			
Crisis, inpatient, residential bed tracking*	A new statewide crisis, inpatient and residential bed tracking and crisis referral system that launched in 2023 monitors daily bed availability so that children can receive the care that they need more quickly. Over the next phases of work, additional levels of care beyond inpatient psychiatric treatment will be added, such as, PRTF's and residential levels of care. In future phases, referrals in the system will be electronic to streamline how providers can use the system; additional functionality will be needed to dispatch mobile crisis teams as quickly as possible.	Available to all children: Reduce the number of children being housed in EDs or county DSS offices	$10 million annually for a fully optimized system
Expand NC Psychiatric Access Line (NC-PAL)*	NC-PAL is a provider-to-provider psychiatric telephone consultation service for children's mental health diagnosis and treatment recommendations as well as a training service for primary care providers. Through consultation and training, NC-PAL will expand the expertise and capacity of North Carolina's primary care workforce to address the needs of more publicly and privately insured children with mental health symptoms. In addition to expanding NC-PAL for primary care providers statewide, NC-PAL will also offer consultation in pilots with select county DSS offices, residential providers, schools, and the NCDHHS Rapid Response Team (RRT).	Available to all children: 34% fewer children requiring visits with specialists and 10% fewer children going to EDs	$2 million annually
Strengthening the child behavioral health workforce*	Our work to strengthen our child behavioral health workforce is focused in three areas. First, we are growing training opportunities in specialty child behavioral health treatments where we have critical care gaps, such as in trauma-informed care for children and treating children with challenging behaviors. Second, we are multiplying the impact and reach of our child behavioral health workforce into primary care through statewide child psychiatry consultation with NC-PAL, in rural areas with expanded telehealth programs, and in schools with increased support staffing. Third, we want to help providers be financially sustainable in the public behavioral health system through policies including Medicaid expansion and clinical loan forgiveness programs.	Available to all children to increase timely access to needed behavioral health treatments	$10 million annually

[1] Footnote: Cost data includes only the state share of investments. Many of the proposed strategies will receive federal investment from Centers for Medicare & Medicaid Services and Administration for Children and Families.

* Indicate that the service has been launched in at least some parts of the state; some strategies that have launched may require additional investment for increased access and/or quality

Table 5. Prioritized Strategies to Increase Timely Access to Appropriate Placements for Children with Behavioral Health Needs

Strategy	Description	Impact	Cost[1]
Establish New Safe and Stable placement Options for Children in the Community			
Establish "Placement First" pilots	Youth in foster care with a history of complex trauma who are at risk for sleeping in inappropriate settings (e.g., EDs, county DSS offices) and who can be cared for in the community will be stabilized in Placement First settings. Placement First settings are foster, kinship, or small group homes where children can live for up to 90 days with high caregiver-to-youth ratios and intensive support services that include crisis response, respite, and care coordination. A comprehensive, trauma-informed assessment and planning for longer-term placement will begin when a child enters a Placement First placement. As children transition from their Placement First placement to a more permanent setting, they will receive on-going support for 18-24 months. An estimated 60 to 150 children per year will be served by two or three provider organizations who work with foster, kinship or small group homes and who will have statewide coverage in these pilots.	Children in foster care: Reduce the number of children sleeping in inappropriate settings and increase the timeliness to permanency for children.	$4.6 million annual non-recurring funding for two years is needed for the pilot. Additional funds will be needed to expand beyond the pilot.
Establish Professional Foster Parents*	Professional Foster Parenting is a strategy that fills the gap between residential-based services and existing foster care options. Professional Foster Parents receive additional training and resources to support children with higher behavioral or physical health needs. Professional Foster Parents receive a living wage, wraparound support services, trauma-based training, and targeted skill development. NCDHHS invested in piloting a professional parenting program, Bridging Families, beginning in 2022. This program is offered by Crossnore Communities for Children. It allows children with behavioral health needs to be placed in a family home with full time, trained foster parents devoted to providing for their care. With additional funding, a statewide pilot with 10 to 12 Professional Foster Parent families will serve 25 to 35 children at a time with a focus on siblings in DSS custody.	Children in foster care: Keep more children in community-based settings, reduce the number of children in institutional settings, and increase rates of permanency and stable placements	$2 million in annual recurring funding is needed for the pilot. Additional funds will be needed to expand beyond the pilot.
Use administrative flexibilities and enforcement to create	Multiple administrative flexibilities and enforcements have been identified to increase the number of children receiving the supports and treatments that they need and to reduce the number of children in	Beneficial to all children: Reduce the number of children in	$200,000 annually

Strategy	Description	Impact	Cost[1]
new placement and service options for children	inappropriate settings. These include implementing flexibilities to allow new providers to serve children more quickly through faster and more efficient licensure processes without compromising health and safety and verifying that any new proposed residential capacity for children is needed. In addition, priority requests for licensure of child residential settings can be expedited and processed for operation in a reduced time frame. Increased staffing in the Mental Health Licensure and Certification Section of the Division of Health Service Regulation is needed to implement identified flexibilities and enforcements and to process, monitor, and report on new program applications more efficiently so that children can get the supports and services they need more quickly.	unsafe and inappropriate settings and increase the number of children receiving the needed supports and treatments	
Supports for Caregivers of Children in Foster Care			
Kinship provider subsidies	NC places fewer children in foster care with extended family, called kinship providers, than other states. Yet, NC children who are placed with kin are twice as likely to achieve permanency within a year than kids who are not placed with kin. Kinship providers in NC currently receive no financial support which makes it financially difficult for some people to take in a child. A subsidy would be provided to kinship care providers caring for children in DSS. Payment will be monthly disbursements equal to half the foster care board rate per child in DSS custody residing in their home. The subsidy will be time limited up to 12 months with a possible 6 month extension.	Children in foster care: Increase in permanency for children	$10.2 million annually
Establish emergency respite pilots for caregivers	North Carolina will establish 10 licensed emergency respite programs that give foster, kinship, adoptive and birth families temporary relief from their intensive parenting responsibilities. Respite requested by caregivers will be provided in a child's home or in a respite care home in the community. Respite care can be time that caregivers schedule in advance or that is available immediately at a time of crisis. Ten new emergency respite programs will serve up to 500 children across the state.	Available to all children: Keep more children in their homes and reduce the risk of abuse or neglect by providing the relief needed for their caregivers	$3.6 million in State share annually, and the service is eligible for federal match.

Strategy	Description	Impact	Cost[1]
Critical Infrastructure & Workforce			
Fund the legislative requirement for the NCDHHS Rapid Response Team (RRT), required in Session Law 2021-132	NCDHHS's RRT is a multi-disciplinary team of child welfare and behavioral health experts and clinicians that meets daily to help county DSS, LME/MCOs and providers find solutions for children being inappropriately housed in EDs or county DSS offices. Additional staffing of three staff across NCDHHS Divisions is needed to respond to increased referrals. A new data system is needed so that the RRT can efficiently follow up on children served and monitor outcomes for children.	Children in foster care: Reduces the number of children being held in inappropriate settings and provides more timely access to services and supports	$500,000 annually
Strengthening the child welfare workforce	North Carolina has long underfunded its Child Welfare System. NC has the lowest per child spending in child welfare among peer states with decentralized systems and ranks 36th among 49 states overall. NC also has a turnover rate of more than 30% and rising among its child welfare staff. Having more child welfare staff will allow for manageable workloads for foster care, and preventive services to provide sufficient time for each worker to meet all requirements and comprehensive assessment of services for children and families. County agencies need additional flexible funds to address staffing shortages through competitive salaries and other strategies to both recruit and retain sufficient child welfare staff.	Children in foster care: Increased permanency for children with a consistent case worker. A child who has one case worker is 74% likely to be in a permanent home within a year of coming into foster care compared to just a 17% chance with two or more workers.	$5 million annually
Child Welfare Information System (CWIS)*	Achieving a Statewide Child Welfare Information System (CWIS) is a critical goal of NC DHHS to support child welfare operations in NC. The CWIS will provide vital decision support to child welfare social workers by giving them electronic tools, dynamic data dashboards, automated case insights, and mobile-friendly capabilities that enable decision to be made and information to be more easily captured in the field. Our CWIS will enable the efficient collection and retrieval of information necessary for both local and state monitoring of families' experiences with the child welfare system, across all counties in NC. Children, especially children with complex behavioral health needs, who are engaged with	Children in foster care: Increase the visibility of risk factors, family needs, and available services	At this time, we do not anticipate needing any additional one-time funding to implement. Funding will be needed

Strategy	Description	Impact	Cost[1]
	child welfare will benefit from the completion of a statewide CWIS because the statewide system will enable automated interfaces with other systems (such as courts, schools, Medicaid, and placement provider systems) which will increase the visibility of risk factors, family needs, and available services. The system will also provide a child's placement and treatment history to ensure optimal decision making by those who provide services. Additionally, it allows for better monitoring of staffing resource needs and the automated production of federally mandated reports. The development of this system has been funded by the NCGA and should be available to all 100 counties in 2025.		to maintain the system over time.

[1] Footnote: Cost data includes only the state share of investments. Many of the proposed strategies will receive federal investment from Centers for Medicare & Medicaid Services and Administration for Children and Families.

Appendix

The following maps are larger reproductions of the images found in Figure 8. Rostered Evidence-Based Treatment Medicaid-Enrolled Providers. See Appendix for larger images and map legends.

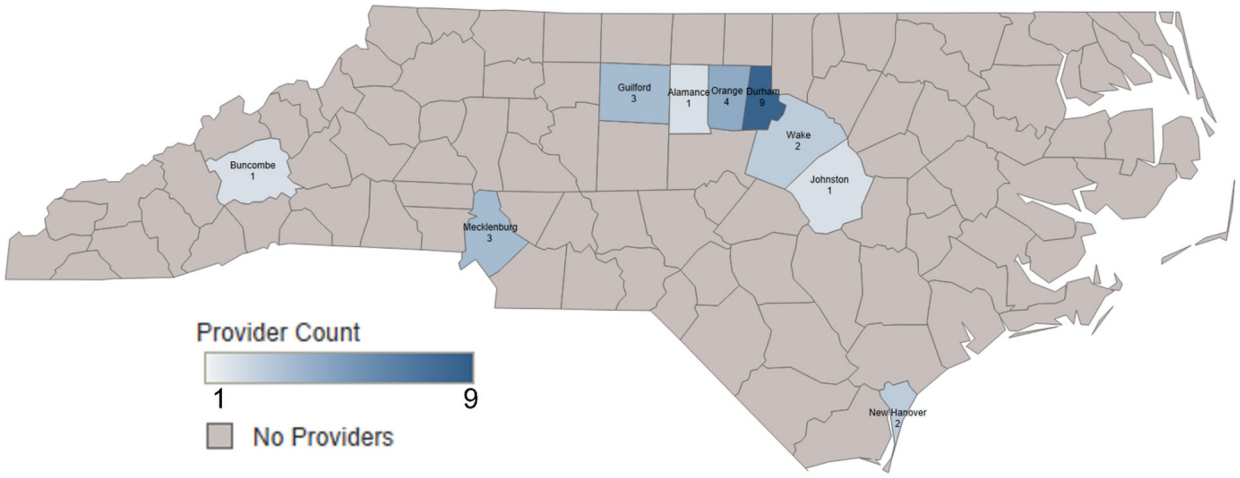


Figure 15. Rostered Medicaid-Enrolled Providers of Attachment & Behavioral Catch-up (ABC) Therapy, an Evidence-Based Treatment.

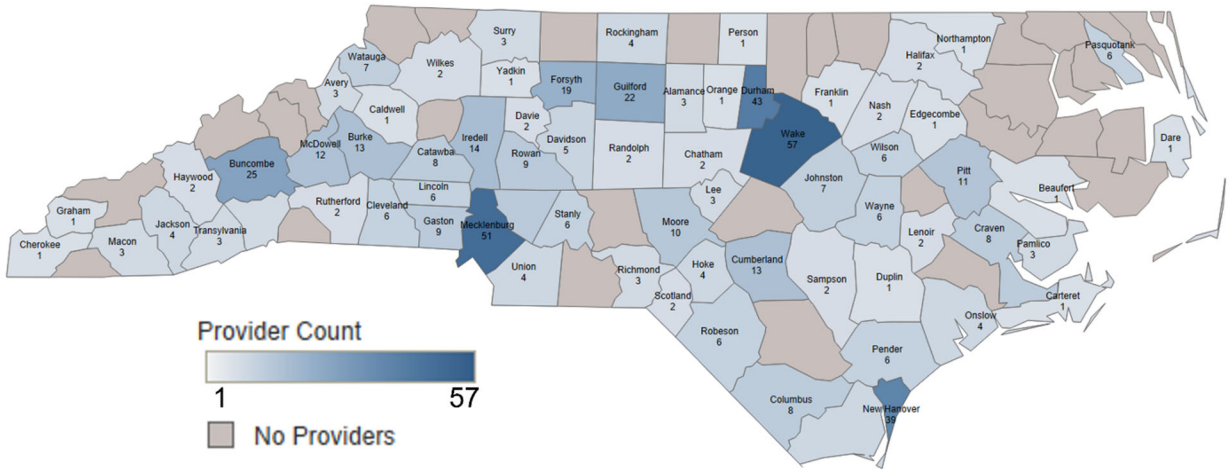


Figure 16. Rostered Medicaid-Enrolled Providers of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an Evidence-Based Treatment.

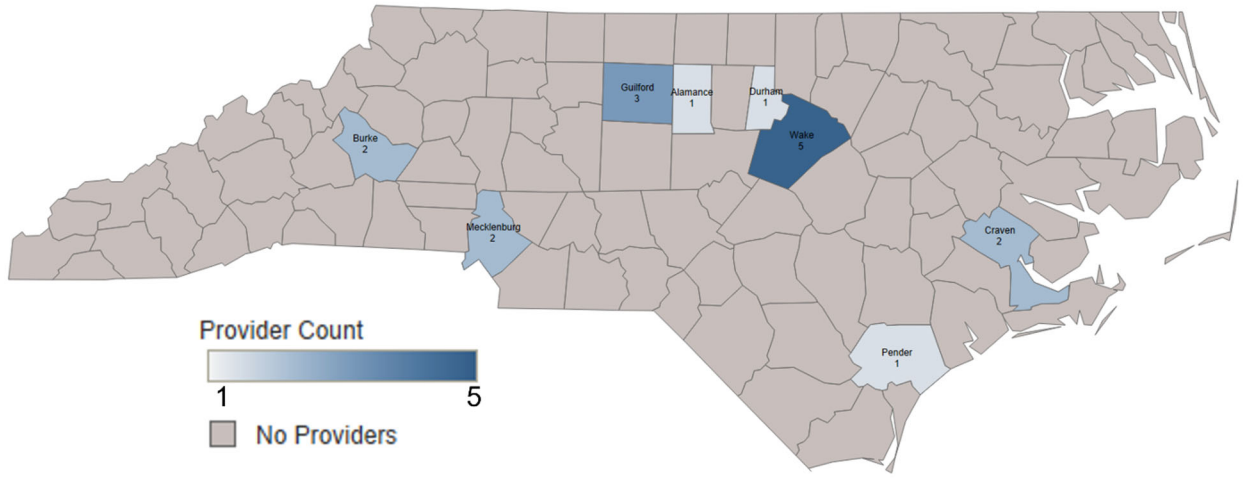


Figure 17. Rostered Medicaid-Enrolled Providers of Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT) for Adolescents, an Evidence-Based Treatment.

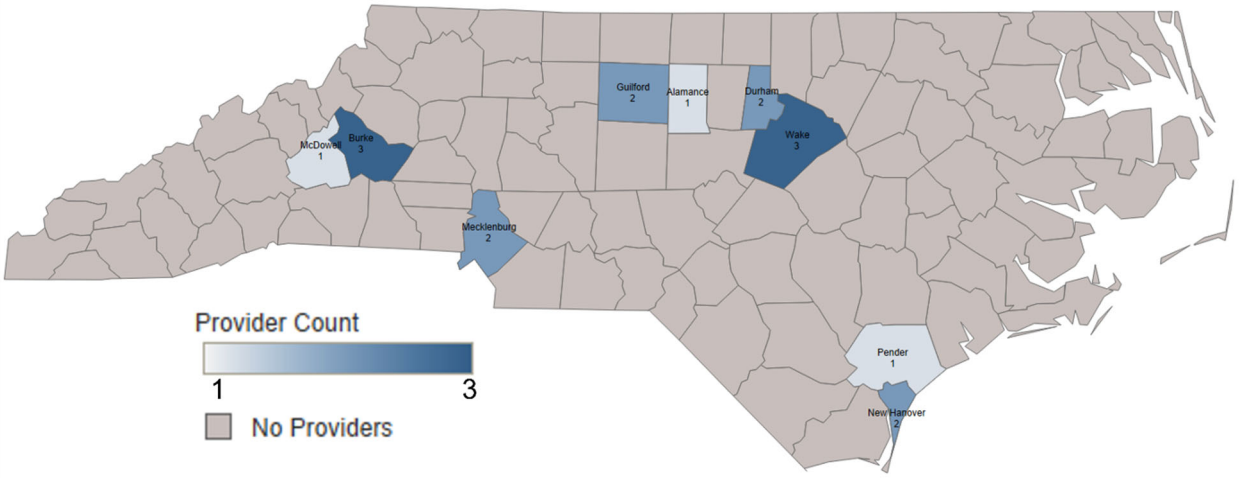


Figure 18. Rostered Medicaid-Enrolled Providers of Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT) for School Aged Children, an Evidence-Based Treatment.

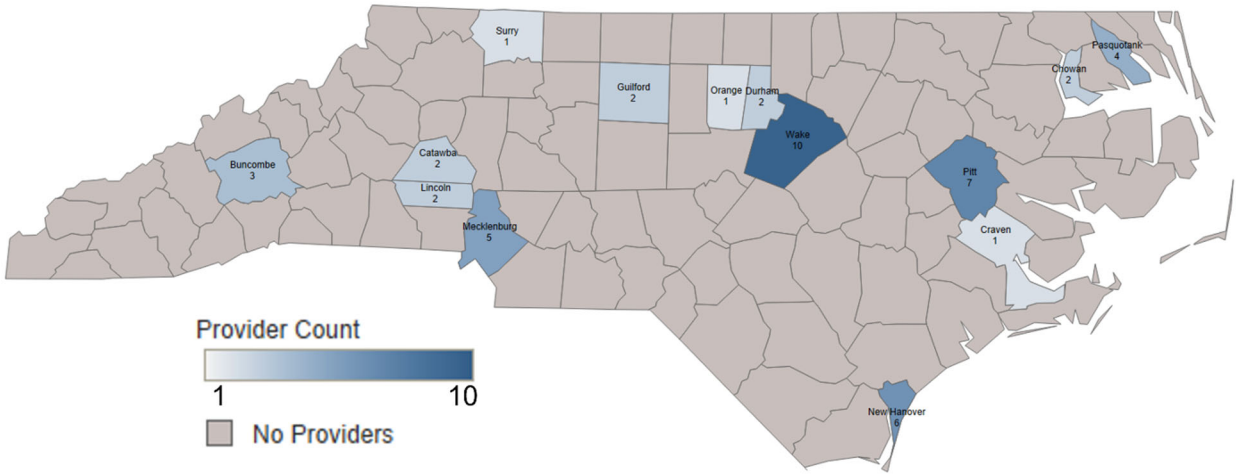


Figure 19. Rostered Medicaid-Enrolled Providers of Child-Parent Psychotherapy (CPP), an Evidence-Based Treatment.

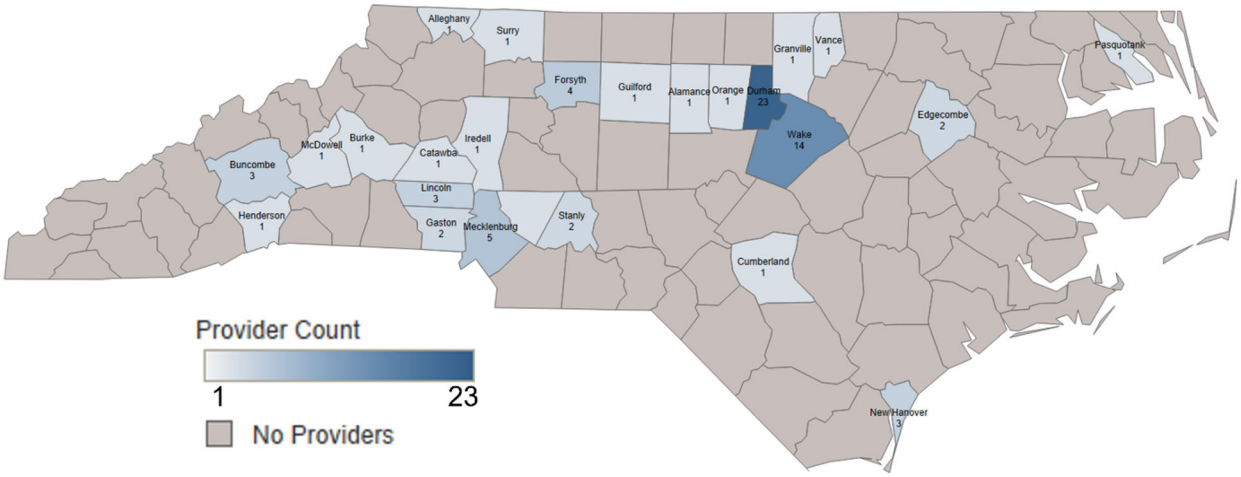


Figure 20. Rostered Medicaid-Enrolled Providers of Parent-Child Interaction Therapy, an Evidence-Based Treatment.

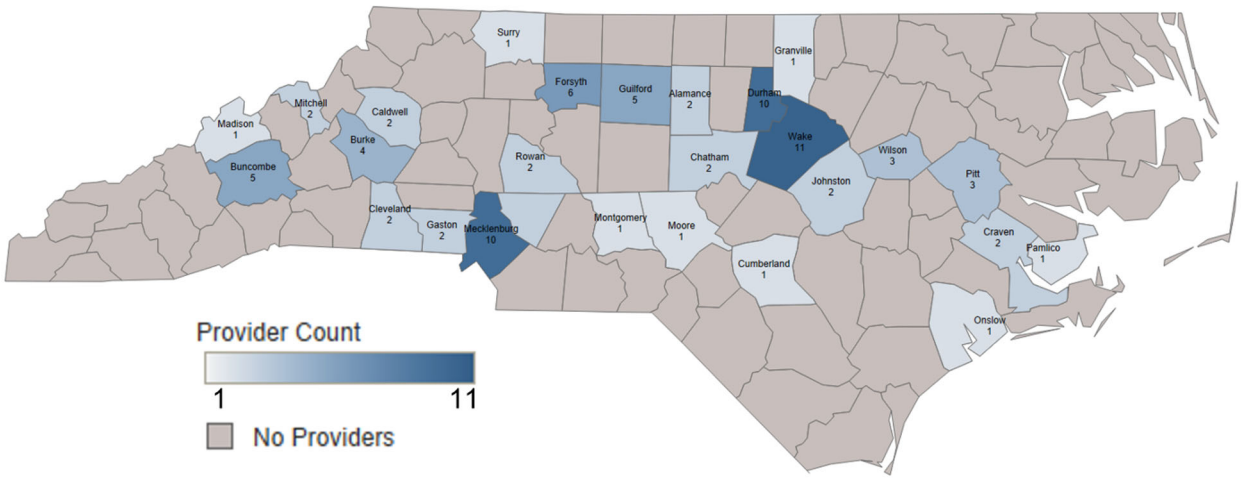


Figure 21. Rostered Medicaid-Enrolled Providers of Resource Parent Curriculum (RPC), an Evidence-Based Treatment.

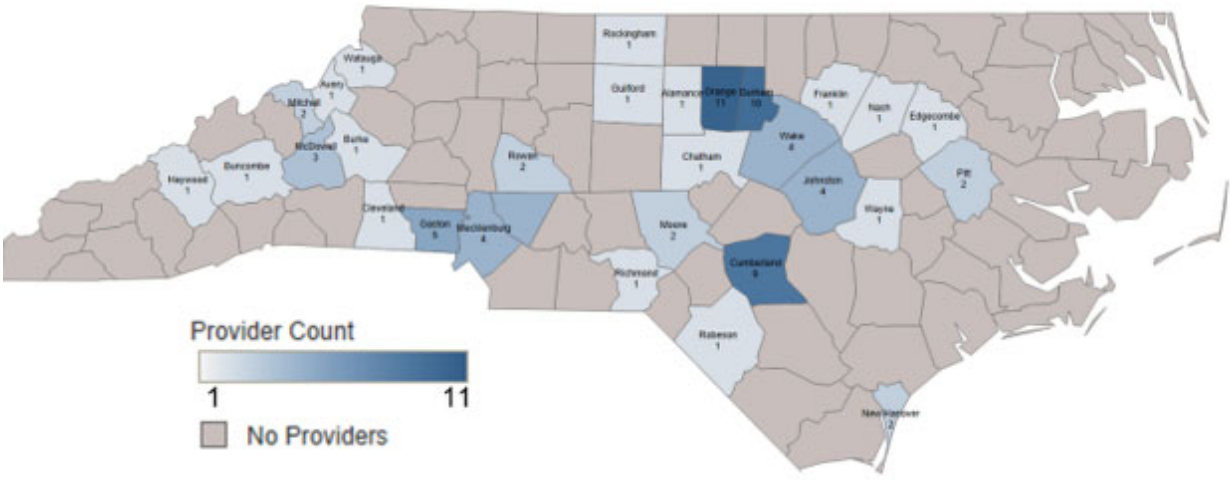


Figure 22. Rostered Medicaid-Enrolled Providers of Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), an Evidence-Based Treatment.