
CHAPTER FOUR

Best Practices and Lessons Learned from North Carolina's Local Management Entities

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In the past several decades there has been increasing attention paid to children's mental health services in North Carolina. In many cases, this attention has arisen from inadequacies in the system and the services provided. Significant efforts have been made to develop and implement a new approach that is based on a System of Care (SOC), within which:

- Children and families are involved and valued;
- Individualized treatment plans meet the unique needs of each child and family; and
- Services are coordinated among multiple providers that coordinate services.

This approach, along with the adoption of best practices and innovative strategies, are becoming more widely available and accessible to children in North Carolina. Local Management Entities (LMEs) have made strides in meeting the needs of children with mental illness and their families but not without setbacks along the way. Mental health reform has been a challenge and opportunity for LMEs. From acclimating new service providers to a SOC philosophy to leveraging the new service definitions to allowing for new community-based treatment, all are striving to achieve excellence in children's mental health services.

Staff of the Center for Child and Family Policy at Duke University interviewed five LME leaders to learn about their experiences with new models for organizing services and treating children. Two of the participating LMEs serve a single county area and three serve a multi-county area. Collectively, they represent urban and rural areas, as well as communities in the east, west, and piedmont regions of North Carolina. This firsthand information illustrates the range of children's mental health needs, the challenges of serving this population, and concrete examples of promising strategies.

Meeting the Needs of Children

There are similarities across LMEs in terms of the average profile of the children they serve. Children served are likely to be between the ages of ten and 17, and more likely to be boys than girls. The most prevalent diagnoses are ADHD, conduct disorders, and detachment disorders.

Of particular concern to LMEs are the children they are not serving. There is unanimous agreement that Hispanic children are not well-served. In addition to the language barrier are cultural issues. A general distrust of government, issues of documentation, and the cultural stigma associated with mental illness present unique challenges. Cultural barriers also exist for other minority groups, including African-Americans, and cultural norms in certain areas of the state at times conflict with best recommended treatments whether in or out of the home.

Table 1. Overview of LMEs interviewed.

Characteristic	LME1	LME2	LME3	LME4	LME5
Catchment Area	4 counties	3 counties	1 county	8 counties	1 county
Estimated # of Active Child Cases	2,100	1,095 (<i>includes mental health and substance abuse</i>)	7,500	2,600	1,500
General Assessment of Prevalent Diagnoses	<ul style="list-style-type: none"> • ADHD • Conduct disorders • Children of abuse 	<ul style="list-style-type: none"> • ADHD • Mood disorders • Post traumatic stress 	<ul style="list-style-type: none"> • Conduct disorder • Detachment disorder 	<ul style="list-style-type: none"> • ADHD • Anxiety disorder • Depression 	<ul style="list-style-type: none"> • ADHD • Conduct disorder • Depression
General Characteristics of Children Served	<ul style="list-style-type: none"> • Tri-racial service area • Growing gangs are adding to conduct disorders 	<ul style="list-style-type: none"> • More boys than girls • More white than African-American 	<ul style="list-style-type: none"> • More boys than girls • More African-American than white 	<ul style="list-style-type: none"> • More boys than girls • American-Indian population largest minority 	<ul style="list-style-type: none"> • More boys than girls • More African-American than white • 90 percent on Medicaid

Other groups of children mentioned as needing additional attention include:

- Juvenile offenders;
- Older youth ages 16-18, in need of independent living skills and with mental health services;
- Substance abusers;
- Teenagers needing 24-hour monitoring; and
- Children needing immediate crisis intervention.

In some cases, reaching these children requires access to treatment facilities not available in the community. Teenagers with serious mental illnesses that require a restrictive environment outside the home are often forced to leave their community because locked residential facilities are not available.

Implementing Best Practices

System of Care (SOC) was the most common response by LMEs when asked about best practices being implemented in their communities. Several of the LMEs are recipients of a five-year federal grant to assist in implementing SOC to treat children and their families. Child and Family Teams (CFT), a critical component of the SOC approach, was cited as an essential part of increasing the quality of care for children in their community. The benefits achieved through properly implementing CFTs include:

- Involving families in their children’s treatment decisions and management;
- Providing formal and informal support for children and families to meet the unique needs of each child, including after school care, transportation, and summer camp;
- Engaging community partners in meeting the needs of severely ill children and encouraging efforts to develop individual plans with in-home treatment options when possible; and
- Creating an expectation of service for children and their families that can help benchmark and evaluate treatment outcomes.

Several evidence-based practices such as multi-systemic therapy, therapeutic foster care, and intensive in-home treatment are also being implemented in communities across the state. It is anticipated that the new service definitions will allow for an expansion and greater availability of these treatments for children in North Carolina.

Increasing Quality through Innovation

Because there will always be more children in need of mental health services than resources available to treat them, LMEs continue to assess the gaps in their service continuum and think creatively about how best to fill them. LMEs and providers are implementing innovative programs to address these needs. The results are an increase in the quality of treatment and a decrease in the number of children placed outside their homes. These strategies generally fall into three categories: working with schools, community collaborations, and decreasing out-of-home placement.

Working with Schools

- Creating school-based mental health service initiatives to offer an array of mental health services in the school setting, such as day treatment. Schools provide an effective way to reach children whose families may not be able to access treatment due to financial or other constraints.
- Developing and training crisis response teams for schools to respond internally to children who have a crisis while at school.
- Implementing a one-stop clinic at a county high school with high incidences of substance abuse and drop-outs. On-site services include medical, mental health, substance abuse, and women's health services, with substance abuse counselor and clinician available one day a week.
- Establishing school teams to work in collaboration with CFTs in developing informal support networks for children with mental illness and their families.
- Developing a training program for school nurses to identify mental health needs that will result in more children receiving early treatment.

Community Collaborations

- Hiring a full-time family advocate with blended funding from the LME and county Department of Social Services (DSS). Located in the county's family resource center, this position supports the families of children receiving treatment. In addition, this position is tasked with creating an advocacy network for families throughout the county.
- Hiring a SOC coordinator for a multi-county LME with blended funding from the LME and the county social services, juvenile justice, and school systems. One LME uses the county Smart Start Partnership to staff such a position. This staff person holds a seat on the community mental health collaborative board to assist with management of the effort.

- Hiring a juvenile justice/mental health liaison for a two-county area with funds from juvenile justice and social services to ensure that mentally ill children in the juvenile justice system receive care.
- Establishing a Child Taskforce to develop a strategic plan to meet the gaps in services in the continuum of care and increase the quality of existing care. The taskforce will consider how to allocate available resources based on a prioritization of needs.

Decreasing Out-of-Home Placements

- Establishing crisis intervention facilities that allow for stabilization, assessment, and development of a treatment plan in efforts to prevent hospitalization or out-of-home placement. Several models are being implemented across the state. However, crisis intervention is a service gap in many communities. It is a treatment option that several LMEs have not been able to get a private provider to undertake. They are looking at creative ways to fund such facilities in their community.
- Providing therapeutic foster care. LMEs use this treatment option for children at risk of being hospitalized and as a viable alternative to residential facility placement outside the community. Training for providers and foster parents is critical to the success of this treatment option. One challenge cited was that a change in the service definitions may decrease reimbursement for case management support, which is essential to this treatment option.
- Creating a day treatment program for young children and their families. Working in collaboration with local DSS and juvenile justice stakeholders to provide clinical and case management, this program allows most participating children to stay in their homes.
- Establishing a Care Review system. Several communities have implemented Care Review. This involves committees with representation across multiple agencies serving as a sounding board and accountability partner for CFTs. CFTs are required to come before the Care Review board and share the treatment plan for each child. If they are recommending out-of-home placement, they must show that every other option has been exhausted for that child. The rate of residential placement has decreased in the communities using a Care Review process.

Challenges to Providing High Quality Services

In spite of these positive achievements, there are still significant challenges to providing a continuum of care to children with mental illness. In some cases these challenges threaten the ability of LMEs to continue the innovative programs that are working to keep children in their homes and communities. Several challenges stem from reform and the changes in roles and responsibilities of LMEs. Others stem from geographic constraints and human resource limitations. Commonly voiced challenges include:

- Implementing a SOC model within a large private provider network. Many LMEs expressed concern about their ability to sustain the SOC model they have implemented and are committed to continuing. When LMEs were providing direct services under the previous system, the training, oversight, and service could be managed and quality could be ensured. Working with a large network of providers and limited authority to hold providers accountable,

makes it more difficult for LMEs to ensure that SOC values and principles are maintained, and that CFTs are being properly trained and used in treatment planning.

- Providing best practice programs in rural communities. LMEs in rural counties expressed difficulty in attracting providers and professionals trained in best practices and willing to implement those services in rural communities. In some cases, providers will offer services only in urban parts of the catchment area. Issues of cost and low population densities are cited as barriers to rural service availability.
- Offering prevention services. Little funding is available for prevention. In some cases, children are recommended for or seek treatment that might have been prevented with earlier intervention. Intervening early helps prevent serious illness and the need for more intensive treatment and out-of-home placement later.
- Changing the cultural mindset. Technical assistance, training, and mentoring for children's mental health service providers is needed to change how people think about treating children with mental illness and successfully implementing a SOC approach. Training and skill development is needed not only for new staff but existing staff, providers, and community partners. In many cases front line staff now provide services that require different skills and a deeper understanding of the complexity of mental illness. Stakeholders (DSS, DJJ, schools) must also begin thinking about a more holistic approach to serving children.
- Aligning incompatible policies. Inconsistencies among state philosophies, mandates, and organizational structure can impede the establishment of an array of community-based services that provide high quality care for children. Issues of local decision making, accountability, standards of care for providers, care coordination, and case management are all areas in which local autonomy plays a critical role in providing quality and cost-effective care.

Lessons Learned

Across LMEs there have been key lessons learned and insights gained in working to meet the needs of children with mental illness and their families. Two that were common among the LMEs who shared their stories are:

- **System of Care.** SOC has shown positive outcomes in the communities that have implemented it. LMEs cite SOC as an effective approach for children in danger of losing their home, failing in school, or in trouble with the law. To implement it well, providers need formal, hands-on training. A greater investment of time, information, and state resources to LMEs for is needed to support implementation of SOC. In addition, each community would benefit from a staff person dedicated to SOC who can bring people together, develop and work with the network of providers, and support front line staff. This would assist in making SOC the expectation for serving all children with mental illness.
- **Community Collaboration.** Community collaboration is critical to changing community culture and mindset. It takes time, leadership, and commitment from all stakeholders. This is hard work and communities need training and guidance to be successful. More importantly there must be a commitment from community stakeholders to come together to create a shared vision and prioritize needs and resources to be most effective in meeting the needs of mentally ill children and their families.