State of Mind
Child Mental Health in Georgia – 0 to 25
Georgia Grantmakers Alliance · 2017 Annual Meeting
September 8, 2017 · Cox Enterprises, Central Park Campus · Atlanta, GA

Georgia Grantmakers Alliance
in partnership with the Southeastern Council of Foundations
2017 GGA Annual Meeting Planning Committee:

Jackie Stradley, Betty and Davis Fitzgerald Foundation (Chair)

Eve Byrd, The Carter Center

Bobbi Cleveland, Tull Charitable Foundation

Erica Fener Sitkoff, Voices for Georgia's Children

Bonnie Hardage, Jesse Parker Williams Foundation

Anne Sterchi, J.B. Fuqua Foundation
We are grateful to the following organizations for providing support to the Georgia Grantmakers Alliance:

- Callaway Foundation, Inc.
- Fuller E. Callaway Foundation
- J. Bulow Campbell Foundation
- Community Foundation for Greater Atlanta
- Cox Enterprises
- The James M. Cox Foundation
- The Wilbur and Hilda Glenn Family Foundation
- Healthcare Georgia Foundation
- Jesse Parker Williams Foundation
- Kaiser Permanente
- Pittulloch Foundation
- Sartain Lanier Family Foundation, Inc.
- SunTrust
- Tull Charitable Foundation
- William Josef Foundation
- Williams Family Foundation of Georgia
- The Zeist Foundation, Inc.
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LOCATED IN ATLANTA, nationally recognized nonprofit mental health treatment organization serving adults ages 18+ with a primary psychiatric diagnosis

www.skylandtrail.org
Mental Health 101:

What emerging science is telling us about mental illnesses, Ages 0 (or minus 40 weeks) to 25

Raymond J. Kotwicki, MD, MPH, FAPA
Chief Medical Officer & George C. West Endowed Chair, Skyland Trail
President, Georgia Psychiatric Physicians Association
Adjunct Associate Professor, Emory University & University of Miami

Georgia Grantmakers Alliance Annual Meeting; September 8th, 2017
Disclosures

Raymond J. Kotwicki, MD, MPH

Dr. Kotwicki has no relevant financial or research disclosures that bias or influence this discussion.
Upon completion of this hour, participants should be able to:

1. Apply their new understanding of the roles of *Nature and Nurture* in the development of mental illnesses to identify those individuals potentially at high risk for the development of a mental illness.

2. Discriminate between prodromal symptoms and common developmental milestones and misbehaviors in children.

3. Appreciate that all untreated mental illness produces cognitive decline/dysfunction and that cognition is a major predictor of functionality.

4. Formulate possible interventions designed to prevent the progression of psychiatric illnesses throughout individuals’ lifetimes.
Part One: Origins of Mental Illnesses
• **Diathesis** = genetic predisposition
  – BPAD, schizophrenia, MDD, OCD, alcohol dependence, completed suicides, some personality disorders
  – Not 100% heritable
  – Environmental impacts

• **Stressors**
  – Childhood abuse, neglect
  – Early substance misuse
  – Major losses, life transitions
  – Bullying
The Stress – Diathesis Model

Mental Illness known to have genetic predispositions

- Bipolar illness (heritability of 0.8)
  - RR 6.4 children of bipolar patients
  - RR 7.9 siblings of bipolar patients
- Schizophrenia
  - RR children of patients with schizophrenia 15-20 times greater than general population
  - Half of affected people start to become ill during childhood/adolescence

(Maziede, NEJM 376(10); March 2017)

Genetics are not autosomal, dominant

- Approximately 98 loci for schizophrenia
- Presence of genes does not guarantee development of symptoms, illness
- Developmental risk factors extremely important
Biology of Psyche

Epigenes

Genes
“Stress Diathesis Model”

Transcription / Translation

Proteins

Cell growth, change, death

Anatomy

Neurotransmitter modulation

Functionality

Thoughts

Behaviors

Feelings
Thoughts, feelings, behaviors
Potential Points of Intervention

- Stabilize / Change epigenes ($-CH_3$ groups)
- Promote / Squelch genes (vectors)
- Interrupt transcription / Translation
- Change anatomy (DBS)
- Modulate symptoms; thinking, feelings, behaviors
- Decrease Inflammation
Local Effects
- Increased vascular permeability
- Vasodilation
- Chemokine production
- Expression of adhesion molecules
- Pain

Effects on Brain
- Fever
- Fatigue
- Anorexia
- Anhedonia
- Altered sleep

Conservation of energy resources to promote increased metabolic demands of fighting infection and mounting a fever

SOURCE: MILLER AH 2013
## Top 10 Inflammatory Triggers

1. Sedentary lifestyle
2. Obesity
3. Smoking
4. Lack of resilience
5. Other sources of inflammation *(gingivitis etc.)*
6. Poor sleep
7. Poor diet *(transgenerational effect)*
8. Changes in gut permeability
9. Allergies
10. Vitamin D deficiency
Possible Physiological Mechanisms

- Child Maltreatment
  - Suicide
  - Age of onset
  - Inter-episode functioning

- Global, Uncontrolled inflammation
  - Other physical illnesses
  - Sleep deprivation
  - Chronic Anxiety, stress

Activation of HPA Axis

- TNF-alpha, IL-6, IL-8
Part Two: The Prodromes
Prodrome

- Prodrome synonymous with Psychosis-Risk Syndrome or Attenuated Psychosis
- Early “soft sign” harbingers for full-blown illness
- Lag between prodrome, full illness may be years
- Potential opportunities for prevention, early intervention
I. Positive Symptoms
   A. Delusions
   B. Hallucinations

II. Negative Symptoms
   A. Amotivation
   B. Anhedonia
   C. Affective flattening
   D. Alogia
   E. Avolition

Responsive to pharmacology; not predictive of recovery

Relatively unresponsive to pharmacology; better predictors of recovery
Risk Factors for Schizophrenia

STATISTICALLY SIGNIFICANT RISK FACTORS

Migration
  Urbanicity
  Advanced Paternal Age

Prodrome
  First-degree Relative

Winter Birth

Maternal Infections

Malnutrition

Childhood Trauma

Obstetric Complications

Cannabis Abuse
Schizophrenia Prodrome

- Develops weeks to years before frank psychosis
- Includes mood changes, perceptual changes, cognitive and social decline
  - Depressive symptoms, “negative” symptoms emerge on average 2 – 5 years before psychosis
  - “Sub threshold” positive symptoms develop on average 1 year before psychosis

(Tandon et. al. Neuropsychiatry, 2012)
### Description of Prodrome

<table>
<thead>
<tr>
<th>Affective</th>
<th>Cognitive</th>
<th>Social*</th>
<th>Perceptual</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anhedonia; especially social</td>
<td>• Verbal memory impairment</td>
<td>• Poor social cue processing</td>
<td>• Childhood onset of unusual or delusional ideas</td>
</tr>
<tr>
<td>• Depressed mood (not SIGECAPS criteria)</td>
<td>• Cognitive speed deficits</td>
<td>• Stressful events perceived more intensely</td>
<td>• Suspicious</td>
</tr>
<tr>
<td></td>
<td>• Increased rate of gray matter loss in right superior frontal, middle frontal, medial orbitofrontal cortices</td>
<td>• Disorganized communication</td>
<td>• Illusions</td>
</tr>
</tbody>
</table>

* Early adolescence social dysfunction strongest predictor (predictive power 59%; 92% specificity) Tarbox et. al. Dev Psychopathology 2013
Bipolar Illness

**PREVALENCE**

- 5% annual American prevalence  
  (for all types)

**IMPACT**

- 6th leading cause of disability worldwide
- $38 billion in indirect costs annually
- Link with heart disease

**SYMPTOMS**

- DIGFAST
- Major risk for substance abuse/dependence

Specific symptoms:
- Distractibility
- Irritability / Insomnia
- Grandiosity
- Flight of Ideas
- Activity increase
- Sleeplessness / Pressured Speech
- Thoughtlessness / Impulsivity
50% patients with BPAD misdiagnosed before concluding bipolar disorder (Martin, Smith, 2014)

90% initial presentations of patients with BPAD were depressive episodes

1 in 10 people with BPAD make suicide attempt within 1 year before affective episode
Patients identified before development of overt psychosis had milder deficits, better functionality compared to control groups in 10-year follow-up studies

(Hegelstad et.al. Am Jnl Psychiatry, 2012)
Bipolar Prodrome

Non-specific signs

► Irritability / aggression
► Anxiety
► Mood swings not meeting diagnostic criteria

More-specific “red flags”

► Sleep disturbance (differentiate from ADHD)
► Social disconnection
► Cognitive inefficiency / decline

Prodromal signs / symptoms emerge 1.8–7.3 years before overt BPAD
### Management Model for Early Bipolar Disorder

<table>
<thead>
<tr>
<th>Stage</th>
<th>Features</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Increased risk of severe mood disorder</td>
<td>Mental health literacy  &lt;br&gt; Self-help  &lt;br&gt; Substance abuse reduction</td>
</tr>
<tr>
<td>1a</td>
<td>Mild or nonspecific symptoms of mood disorder</td>
<td>Further, formal mental health literacy  &lt;br&gt; Substance abuse reduction  &lt;br&gt; Cognitive behavioral therapy  &lt;br&gt; Family psychoeducation</td>
</tr>
<tr>
<td>1b</td>
<td>Prodromal features of bipolar disorder</td>
<td>1a plus introduction of mood stabilizer such as quetiapine or lamotrigine  &lt;br&gt; Avoidance of unopposed antidepressant monotherapy</td>
</tr>
<tr>
<td>2</td>
<td>First episode threshold mood disorder</td>
<td>1b plus specialist case management</td>
</tr>
<tr>
<td>3a</td>
<td>Recurrence of subthreshold mood symptoms</td>
<td>2 plus maintenance medication and psychosocial strategies for full remission</td>
</tr>
<tr>
<td>3b</td>
<td>First threshold relapse</td>
<td>2a plus prevention strategies</td>
</tr>
</tbody>
</table>

(Martin & Smith, 2013)
1. Early onset of depression predicts BPAD diagnosis (sensitivity 71%; specificity 68%; ppv 0.69)

2. 100% people with schizophrenia report prodromal symptoms, often called something else

3. “Magical thinking” and perceptual abnormalities more common in BPAD prodrome than schizophrenia
An Ounce of Prevention

**Primary:** Efforts to reduce progression to mental illness in the general population:
- Reduce childhood abuse / neglect
- Improve maternal nutrition, obstetrical care

**Secondary:** Efforts to reduce progression to mental illness in high-risk groups:
- Cannabis education in families with diathesis
- Treat comorbid substance use, anxiety

**Tertiary:** Efforts to reduce functional decline and social disability in patients with illness:
- Psychotropic medications
- Bolster resiliency
- Recovery treatment
Identification of Prodromal Symptoms in Children

1. *Social disability best predictor; not academic performance
2. *Sleep disturbances without tiredness
3. Disparities in cognitive processing speeds
4. **Structured Interview for Prodromal Syndromes (SIPS)**
   - High rates of false positives
   - Use in family members with genetic diathesis
5. Smelling tests, eye movements, blinking rate, startle responses under rigorous investigation
Interventions

- Antipsychotic initiation before symptoms develop is controversial
- Treat underlying anxiety / mood / substance misuse problems to mitigate disabilities
- Omega-3 fatty acids
- Glycine
- Decrease global inflammation
- Cognitive Behavioral Therapy
- Family therapy
- Close monitoring
- Social skills monitoring / training
- Cognitive Training
Mental illnesses develop from a multifactorial model, including genetic, social, environmental, secular variables; trans-generational

Cognitive and social disabilities precede overt symptoms and are extremely disabling

Genetics is hard!

Prodromal signs / symptoms emerge quite early in life and confer an opportunity to prevent frank illness

Teachers, counselors, coaches, parents, caregivers, have unique opportunities to initiate early interventions


References


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Video Presentation: What does Mental Illness Look Like?
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Children’s Mental Health

Data and Beyond

When people are emotionally invested, they want to contribute.

Garry McGiboney, Ph.D.
Georgia Department of Education
Between 9.5 and 14.2 percent of birth to 5 year-old children experience significant mental health problems that negatively impact their functioning, development, and school-readiness (Brauner).
Almost 50 percent of all long-term mental health problems start by the age 14 (Kessler, Amminger, Augilar-Gaxiola, Alonso, and Ustun).

The onset of major mental illness problems may occur as early as 7 to 11 years of age (Kessler, Beglund, Demler, Jin, and Walters).
15.4 percent of children (1 in 7) ages 2-8 have at least one diagnosed mental health, behavioral health, or developmental disability (Bitsko, et al).
14 percent of children with mental health problems receive mostly Ds and Fs on school work (Blackorby, Cohorst, Garza, and Guzman).

44 percent of children with mental health problems drop out of high school (Wagner).
In the course of a school year, many children with mental health problems miss as many as 18 to 22 days of school (Blackorby).
Students’ unmet mental health needs can be a significant obstacle to student academic, social and emotional development, and can compromise school safety (Froeschle and Meyers).

[many times attributed to trauma]
Only 45 percent of children who were hospitalized for a suicide attempt received mental health services in the prior month (Freedenthal).

Only 29 percent of children expressing suicide ideation in the prior year received mental health services (Freedenthal).
Up to 80 percent of children in need of mental health services do not receive them (Kataoka, Zhang, and Wells)
Schools are often one of the first places where mental health crises and mental health needs of students are recognized and initially addressed (Froeschle and Meyers).

If not addressed, the student’s mental health deteriorates (Froeschle and Meyers).
In a survey of school social workers, only 11 percent of respondents reported all or most students on their caseloads with mental health issues received mental health services outside of school (Kelly, Berzin, et al.).

Mental illness is one of the top five health conditions for children in the United States (Zupp).

26% of children in the United States will witness or experience a traumatic event before they turn age four (National Center for Mental Health Promotion and Youth Violence Prevention).
The Untold Story

Children’s Mental Health and...
Adult Outcomes
Children and teenagers with an untreated psychiatric disorder have six times higher odds of having health, legal, financial and social problems as adults (Copeland, et al).

Studies show mental health problems during childhood that are left untreated make it more likely that the child later as an adult will be arrested (Copeland, et al).
Early identification of mental health problems and early treatment significantly reduces the risk of negative qualify of life issues due to prolonged mental illness (National Institutes of Mental Health).
73 percent of female state prison inmates and 55 percent of male state prison inmates have a serious mental illness (Varney). Many of them do not leave prison (Varney).
Mental, emotional, and behavioral disorders that are untreated in childhood and adolescence are significantly more likely to manifest in alcohol and drug abuse, incarceration, and/or homelessness (Mental Health Policy Forum).
Early treatment may be the difference for some children between a lifelong disability with possible incarceration or dependence, or a healthy measure of economic and personal self-sufficiency (Kopel and Cramer).
The effect of untreated children’s mental illness is a steady decline in mental health and physical health into adulthood (Young).

Mental illness will not go away on its own, and the longer it persists, the harder it is to treat and the more serious the outcomes become into adulthood (Young).
Ben Lahey, a professor of epidemiology at the University of Chicago:

“We don’t invest enough in children’s mental health treatment to reduce the negative outcomes in adulthood.”
You cannot change things by fighting the existing reality. To change things you must build a new system to make the existing system obsolete.

-Buckminster Fuller
Dependency

• Focus on the behavior of the adults and its impact on meeting the needs of the child or children

• Identify stressors of parental substance abuse, mental illness, domestic violence, parental inability, and poverty that underlie neglect and abuse

• Implement a plan for safety, permanency and well being
Delinquency

• Focus on the child’s behavior
• Provide treatment and rehabilitation
• Serve in the community
• Support education
• Screen for substance abuse and mental illness
• Devise a plan to meet the needs of the child with a focus of resiliency of the child and family
Seeds for Mental Health

• Having a nurturing, appropriate adult as a caretaker
• Strengthening the bond between the child and caregiver
• Having basic needs met in a safe environment
• Having routine, structure and consistency
• Having the same faces and same places
• Having quality early education experiences
Seeds for Mental Illness

• Begins with lack of nurturing, safety and consistency which leads to impairment of language development

• Emerges as behavior demonstrating the absence of the ability to self regulate at home, in daycare and at school that is sanctioned and inadvertently reinforced

• Escalates as children fall further and further behind their peers in social and academic skills
Serving Children

• Break down barriers to insurance
• Promote opportunities to enroll children
• Develop methods of updating information without mailing forms to last known addresses as our families are mobile
• Address workforce issues that compound the problems of the family with enrolling and keeping insurance
Serving Children

• Intervene to assure normal physical, social and emotional development

• Use well checks to better monitor and provide services

• Utilize early education opportunities with Part C Public Health services, quality certified child care, Early Head Start, Head Start, Part B Early Special Education Services through local school systems
Challenges

• Work force development in child welfare, eligibility, juvenile justice, psychiatry, psychotherapy
• Service silos
• Access to services without public transportation
• Consistency with providers
• Use of methodologies that are proven effective
Promising Practices

• Family preservation services
• Family treatment courts
• Infant plan of safe care
• Child parent psychotherapy
• Parent-child interaction therapy

• Brief family therapy
• Home visitation programs
• Telemedicine
• Child in need of services
University Students and Mental Health

MAHLET ENDALE, PHD
Trends in University Mental Health
<table>
<thead>
<tr>
<th>Presenting Concern</th>
<th>Mean %</th>
<th>Median %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>47.34</td>
<td>47.00</td>
</tr>
<tr>
<td>Depression</td>
<td>40.13</td>
<td>40.00</td>
</tr>
<tr>
<td>Relationship issues</td>
<td>32.48</td>
<td>30.00</td>
</tr>
<tr>
<td>Taking psychotropic medication</td>
<td>26.08</td>
<td>25.00</td>
</tr>
<tr>
<td>Suicidal thoughts/behaviors</td>
<td>20.19</td>
<td>18.00</td>
</tr>
<tr>
<td>Had extensive or significant prior treatment histories</td>
<td>14.72</td>
<td>10.00</td>
</tr>
<tr>
<td>Engaging in self-injury</td>
<td>12.80</td>
<td>10.00</td>
</tr>
<tr>
<td>Alcohol abuse/dependence</td>
<td>10.58</td>
<td>8.00</td>
</tr>
<tr>
<td>Learning disability</td>
<td>8.77</td>
<td>5.00</td>
</tr>
<tr>
<td>ADD or ADHD</td>
<td>8.78</td>
<td>6.00</td>
</tr>
<tr>
<td>Sexual/physical assault/acquaintance rape</td>
<td>8.30</td>
<td>5.00</td>
</tr>
<tr>
<td>Substance abuse/dependence other than alcohol</td>
<td>7.66</td>
<td>5.00</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>7.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Issues of oppression (racism, sexism, homophobia, etc.)</td>
<td>8.70</td>
<td>3.00</td>
</tr>
<tr>
<td>Being &quot;stalked&quot;</td>
<td>2.33</td>
<td>1.00</td>
</tr>
</tbody>
</table>
According to the American College Health Association 2015 Survey

A survey of 33,512 students at 51 institutions across the United States

Includes undergraduate, graduate, and professional students

At some point in the past 12 months:
- 50.1% of university students report feeling hopeless
- 86% of university students report feeling overwhelmed by all they had to do
- 60.6% of university students reported feeling very lonely
- 38.2% felt so depressed it was difficult to function
- 60.8% felt overwhelming anxiety
- 6.9% engaged in intentional self injurious behavior
- 10.4% seriously considered suicide
- 1.9% attempted suicide

However, two-thirds of students who are struggling do not seek treatment
Undergraduate Student Mental Health

According to the Jed Foundation:

- 75% of lifetime cases of mental health conditions begin by age 24
- One in four young adults between the ages of 18 and 24 have a diagnosable mental illness
- More than 25% of college students have been diagnosed or treated by a professional for a mental health condition within the past year
- More than 40% of college students have felt more than an average amount of stress within the past 12 months
- Almost 73% of students living with a mental health condition experienced a mental health crisis on campus
  - Yet, 34.2% reported that their college did not know about their crisis
- Suicide is the 2nd leading cause of death among college students
Graduate Student Mental Health

A 2008 survey at the University of California–Irvine found:
- 17% of graduate students across disciplines reported having a serious mental disorder
- Nearly 30% reported having a mental health concern that affected their well-being or academic performance

2014 Academy of Psychiatry article found:
- 2.3% of surveyed graduate students reported having plans to attempt suicide

2017 Belgian Study found:
- 32% percent of Ph.D. students are at risk of having or developing a psychiatric disorder such as depression
Medical & Law Student Mental Health

According to a 2012 Annals of Internal Medicine Study:
- 50% of 2200 medical students across 7 medical schools reported burnout and 11% said they considered suicide in the past year

According to the Dave Nee Foundation:
- Depression among law students is 8-9% prior to matriculation, 27% after one semester, 34% after 2 semesters, and 40% after 3 years.
- Stress among law students is 96%, compared to 70% in med students and 43% in graduate students.
- Psychological distress, dissatisfaction and substance abuse that begin in law school follow many graduates into practice.
Communities with Higher Levels of Completed Suicides

The communities on campuses generally have less adequate services available to them than the general population of college students (Russell, Van Campen, Hoefle, & Boor, 2011; SPRC, 2004):

- Commuter students
- Non-traditional/older students
- LGBTQIA+ identified students
- International students
Video Presentation: Story Corps Interview
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Connecticut’s Children’s Behavioral Health Plan

Jeffrey J. Vanderploeg, Ph.D.
Vice President for Mental Health
Child Health and Development Institute

Tim Marshall, L.C.S.W.
Director, Office of Community Mental Health
CT Department of Children and Families
Background/Context

- PA 13-178 was one of the CT legislature’s responses to the shootings in Newtown

- History of fragmentation in CT’s behavioral health system
  - Access based on insurance type, system involvement, geographic location, race/ethnicity, language
    - Multiple public and private systems involved in the delivery and financing of mental health care
    - Approximately 40% Medicaid; 28% commercially insured; 28% employee-sponsored plans

- Growing recognition of the impact of trauma

- Importance of promotion, prevention, and full service array
Areas of Concern in Connecticut

- Ensure access for all children
- Reduce fragmentation
  - Insurance type, system involvement, geography
- Address concerns with commercial insurance coverage
  - Coverage for services; coverage for conditions; medical necessity criteria and utilization management; adequacy of provider networks; perceived cost shifting to state
- Meaningful family engagement
- Full continuum of care
- Wellness promotion, prevention activities
- Sufficient administrative infrastructure and support
- Fully supported provider network
- Address ED crisis
- Promote community-based treatment as service mix changes
- Expand the workforce
Fragmentation

Children and Families with Behavioral Health Needs
- DCF
- Schools
- SDE
- OEC

DSS
DMHAS
CSSD
DDS

Commercial Insurers
Employee-Sponsored Health Plans
Federal and Philanthropic Funders

Provider Network
Community-based clinics, school-based practitioners, hospitals, private practitioners
What do we want in a Children’s Behavioral Health System?

- Youth with behavioral health needs are identified early and have access to appropriate care
- A full service array is available and youth and families are matched to the appropriate treatment based on their needs (not insurance type, geography, system involvement, race, ethnicity, language)
- Services promote equity and work to reduce behavioral health disparities that impact disadvantaged populations
- Providers are trained and supported to provide services backed by the best available science for effectiveness
- Service delivery is supported by robust data collection, reporting and quality improvement
- Children and families achieve the best possible outcomes and expenditures are closely tracked and monitored to ensure cost effectiveness
Overarching Framework

The Plan will be:

- **Comprehensive** in scope
- **Integrated** across public and private systems
- **Inclusive** of system-involved and non-system-involved youth
- Built on existing system **strengths**
- Will focus on **key principles** identified in PA 13-178 that support an effective system of mental health care
Summary of Information Gathering Process

- PA 13-178 directed Department of Children and Families (DCF) to lead the development and implementation of the Plan:
  - DCF would lead the process, but do so in close collaboration with other state agencies/systems
  - Systematically implement Plan recommendations
  - Limited internal capacity

- DCF contracted with CHDI to facilitate input gathering process and Plan development
  - 9 months from initial charge to Plan delivery (Jan - Sep 2014)
  - Balancing time/resources with work plan

- Later, PA 15-27 provided additional accountability to other state agencies for implementing the plan and reporting progress; and established an Implementation Advisory Board
Plan was guided by values and principles of a “system of care” approach

- A framework for implementing the full array of services and supports that comprise a comprehensive system. A system of care is defined as:

- A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

- Strong emphases emerged in:
  - Data-informed implementation, pooled funding across public and private payers, mechanisms for care coordination, families and youth as full participants in governance and oversight
The Role of Philanthropy

- Major funding provided by CT Health Foundation (Patricia Baker, President & CEO)
  - Smaller contributions from The Children’s Fund of Connecticut and Grossman Family Foundation
- CT Health Foundation had invested in mental health for many years with some significant successes as well as some investments that were not sustained
- The investment of private philanthropy (along with DCF funds) provided necessary capacity for the work:
  - Infrastructure capacity that allowed CHDI to provide project management and lead plan development
  - Capacity for ensuring meaningful partnership with the communities affected by the issue (Reciprocity: “nothing about us, without us.”)
    - (e.g., Community conversations, open forums, public input via Plan website)
- Very interested in ensuring prominent roles for health promotion, early identification and intervention, health equity and disparity, reducing fragmentation, data/outcomes
- Very interested in blended funding across state agencies, Medicaid, commercial sources
- “Access, but access to what?” Clinical services are not the only part of the solution; public health, social determinants, community-driven models complement medical model approaches
The Role of Philanthropy

- Ongoing implementation
  - Focus on the transformative work
  - Don’t get lost in a heavy, laborious plan
  - Continue focus on various systems working in true partnership
  - Put money into expertise, supporting adaptive leadership, convening to improve process and product
  - Promote efficiencies, ask critical questions, ensure accountability, push the envelope, don’t be afraid to ask “so what?”
  - “Philanthropy can help people not lose their way in complex environments”
  - “Be persistent, even if you’re frustrated. Stay in it for the long haul. Change is rarely, voila”
  - Philanthropy adds value by addressing an issue on a long term basis versus an election cycle
  - Philanthropy looking to step in again to support infrastructure in the form of project management
Summary of Information Gathering Process

- Twelve Facilitated Discussions (220 participants)
- Six Open Forums (232 participants)
- 26 Community Conversations (339 adults, 94 youth)
  - Public input was co-facilitated by Michael Hoge (Yale University) & Beresford Wilson (family advocate)
- Public Input through website (www.plan4children.org)
  - 60 input forms (from individuals and large groups)
  - 115 report draft review forms
- Key Document/Data Review
- Advisory Committee Meetings
- All input notes and summaries posted publicly to website
Seven Themes Emerged

A. System Organization, Financing and Accountability
B. Health Promotion, Prevention and Early Identification
C. Access to a Comprehensive Array of Services and Supports
D. Pediatric Primary Care and Behavioral Health Care Integration
E. Disparities in Access to Culturally Appropriate Care
F. Family and Youth Engagement
G. Workforce Development integrated through out plan
A. System Organization, Financing and Accountability-Sample

- **Goal A.1.** Redesign the publicly financed system of behavioral health care for children to direct the allocation of existing and new resources.
  - A core finding from all input sources is that the *children’s behavioral health services are fragmented, inefficient and difficult to access for children and families.* Those issues would be substantially improved by integration of public funding that brings together multiple payers and streamlines eligibility, enrollment, service arrays, documentation, and reimbursement mechanisms.
  - Strategies in this area include the following:
    - Identify existing spending on children’s behavioral health services and supports across all state agencies.
      - Determine if those existing funds can be re-aligned or used more efficiently to fund the full array of services and supports.
      - Identify mechanisms for pooling funding across all state agencies.
      - Identify a full array of services and supports that will constitute the children’s behavioral health system of care.
      - Conduct a cost analysis to identify cost savings associated with implementation of the system of care approach and a focus on prevention.
      - Identify and address workforce development needs in the children’s behavioral health system of care.

- **Goal A.2.** Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.
Completed Same for other six areas

Goals and Strategies

B. Health Promotion, Prevention and Early Identification
C. Access to a Comprehensive Continuum of Care
D. Pediatric Primary Care and Behavioral Health Care Integration
E. Disparities in Access to Culturally Appropriate Care
F. Family and Youth Engagement
G. Workforce Development
Associated Activities

- CONNECT System of Care Transformation Grant
  - Focused on regionalized implementation of BH Plan, System of Care approach, family and youth engagement
  - Implementation of National Culturally and Linguistically Appropriate Services (CLAS) standards
- Social Marketing
- Joint/Coordinated Workgroups between CONNECT and BH Plan
  - Network Analysis
  - Fiscal mapping/integration
  - Data integration
  - Early Childhood (Help Me Grow)
  - School Mental Health (multiple partners)
Progress to Date

- **Education and Awareness**
  - Workforce Development, educational and outreach materials including thousands of folders, wallet cards, notebooks, pens, highlighters, water bottles, jump drives)

- **System Organization and Financing**
  - Partial implementation of Care Management Entity (CME)
  - Two populations: 1) Youth in DCF custody stepping down from Congregate Care; 2) frequent utilizers of emergency departments, regardless of system involvement

- **Data Integration**
  - Partnership between FAVOR, OPM, Beacon Health Options, CHDI
  - Data Work Plan; Data 101 training, dashboards, Open Portal

- **Access to Comprehensive Service Array**
  - EMPS Expansion- (Increase in Mobile hours, added facility liaison)
  - EBP Expansion - TFCBT, MATCH-ADTC, CFTSI, CBITS, Circle of Security
Progress to Date (continued)

- **Pediatric Primary Care Integration**
  - Network of Care integration study examines strength of connections between and among:
    - Behavioral Health Providers
    - Pediatric Primary Care Providers
    - Families and Children
    - Schools
  - ACCESS Mental Health: Psychiatric consultation accessed in pediatric primary care

- **School Mental Health**
  - May 2017 School Mental Health Symposium; early stages of partnership to expand school mental health (i.e., family-school-community partnerships, professional development, screening and assessment, evidence-based practices)
Workgroup Structure

- Each workgroup is developing the following:
  - Vision:
  - Goal:
  - Identification of System Outcomes:
    - How will we know that the children’s behavioral health system is better off?
    - Infusion of RBA language
  - Key strategies:
  - Evaluations strategies:
  - Current work plan:
Additionally

- Additional legislation (PA 15-27) added other state departments who share the role of children's behavioral health:
  - DDS, DSS, DPH, DMHAS, SDE, CID, OEC, Judicial-CSSD and The Commission on Children, Office of Health Advocate, and the Office of Child Advocate were all added as additional responsible parties to the annual updates to the Children’s Behavioral Health Plan

- Last year’s annual update from 12 state departments and supporting agencies had over 100 activities aimed at improving the behavioral health system for children and their families.

- Currently finalizing the annual update
Lessons Learned in Connecticut

- Tips from CT’s experience that may be worth considering now, or further along in implementation:
  - KidCare Experience 2000 to Public Act 13-178 2013
  - Bring Family and Youth Partners in from the very beginning and maintain the partnership throughout the process
  - Role of Philanthropy
  - Gather and Collect system data as soon as possible
    - Highlight what is still needed to collect (e.g. fiscal map)
    - Prioritize the data needs
    - Develop a plan to collect that data
    - Develop system level outcomes (how will you know if you made progress a year from now)
  - Workforce Development is important
    - Parents, caregivers and youth are as important as the provider community
    - Center of Excellence CHDI and University project
Questions & Discussion
OVERVIEW OF GEORGIA CHILDREN’S BEHAVIORAL HEALTH SYSTEM

Presentation to the Georgia Grantmakers Alliance
Friday, September 8, 2017
System of Care Approach (SOC)

Core Value: SOC should be **community-based**, with the locus of services as well as management and decision-making responsibility resting at the community level.

Core Value: SOC should be **child, family, person-centered** and family and community focused, with the needs of the child or individual and family dictating the types and mix of services provided.

Core Value: SOC should be **culturally competent**, with the agencies, programs, and services that are responsive to the cultural, linguistic, racial, and ethical differences of the populations they serve.

- Community based
- Supports functioning in all parts of life (school, home, etc.)
- Family-driven, youth-guided
- Culturally competent
- Coordinated (between providers & agencies)
Introduction

• Georgia has made significant investments in child and adolescent (C&A) behavioral health over the past few decades
  – 2015; four (4) study committees of the GA General Assembly focused on C&A issues
  – SAMHSA awarded initiatives (e.g., Project Launch, Project AWARE, and several SOC grants)
  – Flexible use of Block Grant Funding
  – Development of the Interagency Directors’ Team (IDT)
  – Development of the GA Center of Excellence for Children's Behavioral Health
  – Infusion of non-traditional supports and services into the system
Opportunities for the SOC

• Improve coordination across child serving systems
• Maximize existing resources
• Invest in system of care infrastructure
• Enhance crisis coordination and continuum of care
• Invest in development of the workforce
BH Supports/Services By Age
DBHDD Provider Network

Behavioral Health Services and Supports for Children and Young Adults By Age

DBHDD OCYF
4 years to 26 years

The Department of Public Health (DPH) promotes screening, early intervention services and mental health promotion for young children 0-3 years. The Project LAUNCH pilot in Muscogee County coordinates services and supports up to age 8 years.

DBHDD OCYF underwrites behavioral health services and supports for ages 4-26 years.

DBHDD Community Behavioral Health Provider Network Structure

Serving Georgia’s uninsured and SSI Medicaid

TIER 1
Comprehensive community providers (CCPs) function as the safety net, serve the most vulnerable and respond to critical access needs.

TIER 2
Community medicaid providers (CMPs) provide behavioral health services and supports identified in the Medicaid State Plan for children and young adults covered by Medicaid.

TIER 3
Specialty providers offer an array of specialty services including Intensive Family Intervention (IFI), emerging adult support services, school-based mental health services, supported employment and youth clubhouses.

CENTER OF EXCELLENCE FOR CHILDREN’S BEHAVIORAL HEALTH
integrating research, policy, and practice
Public System Service Array
Services Supported by DBHDD & DCH
Areas of Focus for GA’s SOC

SOC Plan Development: Areas of Influence / Goals

**ACCESS**
Provide access to a family-driven, youth-guided, culturally competent, and trauma-informed comprehensive SOC.

**COORDINATION**
Facilitate effective communication, coordination, education, and training within the larger SOC and among local, regional, and state child serving systems.

**EVALUATION**
Utilize a framework of measuring and monitoring data on key SOC outcomes to demonstrate and communicate the value of a SOC approach for improving children’s behavioral health and support ongoing quality improvement.

**Funding / Financing**
Utilize financing strategies to support and sustain a comprehensive, community-based, family-driven, youth-guided, culturally competent, and trauma-informed SOC, anchored in cross-agency commitment to effective and efficient spending.

**Workforce Development**
Develop, maintain, and support a culturally competent, trauma-informed workforce to meet the needs of children, youth, and young adults and their families.
Public System Service Array
(Glossary)

- Care Management Entity (CME) – High fidelity Wraparound approach providing intensive care coordination.
- Center of Excellence for Children’s Behavioral Health (COE) – Part of the Georgia Health Policy Center housed within the Georgia State University Andrew Young School of Policy.
- Certified Peer Support–Parent & Youth (CPS-P & -Y) – System of Care informed recovery-oriented peer certification, continued education training, and workforce development, for parents and youth with lived experience.
- Community Based Alternatives for Youth (CBAY) – Community-based alternatives for ages 5-21 years to help avert Psychiatric Residential Treatment Facility (PRTF) admission. Provided by DBHDD and Department of Community Health (DCH).
- Community Innovation Pilots (CIP) – Supports existing or new behavioral healthcare services, programs or projects, that assist OCYF with accomplishing its mission and add value to Georgia’s public mental health system.
- Core Benefit Package – Evaluation/assessment, diagnosis, counseling and medication, therapy (individual, group, and family), community support services, crisis assessments and physician services.
- Crisis Stabilization Unit (CSU) – Short-term acute stabilization. Provided by DBHDD and DCH.
- Emerging Adult Support Services (EASS) – Includes several initiatives focused on improving the lives of emerging adults ages 16-26 years, including supported employment, and first episode psychosis early treatment programming.
- Georgia Apex Program – School-based mental health program.
- Local Interagency Planning Team (LIPT) – Multiagency teams that support youth and families through collaborative planning and coordination of services and supports.
- Mobile Crisis - Community-based, face-to-face crisis response 24 hours a day, seven days a week to individuals in an active state of crisis.
- Project LAUNCH – Federal grant to the Department of Public Health (DPH) to increase the quality and availability of evidence-based programs for children and families; improve collaboration among child-serving organizations, and integrate physical and behavioral health services and supports for ages 0-8 years in Muscogee County. DBHDD serves as the behavioral health collaborating partner.
- Psychiatric Residential Treatment Facility (PRTF) – In-patient treatment for patients ages 5-21 years. Provided by DBHDD and DCH.
- State Contracted Beds – OCYF contracts for private, in-patient hospital beds when CSU beds are unavailable.
- System of Care Funds – Seek to ingrain and further the System of Care philosophy, framework and processes in child-serving agencies across Georgia.
- Youth Clubhouses – Nontraditional services and supports for mental health, prevention and substance use for ages 6-21 years.
State of Mind
Child Mental Health in Georgia – 0 to 25

Georgia Grantmakers Alliance · 2017 Annual Meeting
September 8, 2017 · Cox Enterprises, Central Park Campus · Atlanta, GA

Georgia Grantmakers Alliance
in partnership with the
Southeastern Council of Foundations
Let’s Talk About Suicide

Erin Harlow-Parker, APRN,PMHCNS-BC
Consult Psychiatry, Children’s Healthcare of Atlanta
Suicide Facts
Suicide Facts

FACT Suicide is the second leading cause of death in youth ages 15-19. Third leading cause of death ages 10-14.
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**FACT** Suicide admissions to Children’s Hospitals doubled over the last decade
The state of Georgia sends out an annual self-report student health survey to all students in grade 6-12.

- 672,307 responses from those students:
  - 9% (57,677) had seriously considered suicide
  - 4% (25,758) had attempted suicide
Suicide Death Trends
2010-2015, GA (GA OASIS)
5 Year Youth Suicide Deaths For Georgia: 2012-2016

Source: Child Fatality Review Unit

* 2016 data is not all inclusive
## Youth Suicide Data for Georgia: 2017

### Total Suicide Methods by Age and Gender

<table>
<thead>
<tr>
<th>Age Group</th>
<th>5 to 9</th>
<th>10 to 14</th>
<th>15 to 17</th>
<th>Total</th>
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<tbody>
<tr>
<td>White Male</td>
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<td>3</td>
<td>9</td>
<td>12</td>
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<tr>
<td>White Female</td>
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<td>African American Female</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hispanic Male</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hispanic Female</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asian Female</td>
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<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>6</td>
<td>18</td>
<td>25</td>
</tr>
</tbody>
</table>

### Total Suicide Methods by Race and Gender

<table>
<thead>
<tr>
<th>Method</th>
<th>5 to 9</th>
<th>10 to 14</th>
<th>15 to 17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gunshots</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>14</td>
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<tr>
<td>Hangings</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>7</td>
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<tr>
<td>Overdose</td>
<td>0</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>6</td>
<td>18</td>
<td>25</td>
</tr>
</tbody>
</table>

**Source:** GBI Child Fatality Review Unit

Children’s Healthcare of Atlanta
ED Suicidal Ideation or Attempt Diagnosis

Suicidal Ideation Or Attempt

Data Source: Population Disco
For discussion purposes only

Admitting Diagnosis:
- T14.91 Suicidal Attempt
- R45.851 Suicidal Ideations
- V62.84 Suicidal Ideation
Why the increase?
The answer is.....

• The reality is the answer is never simply one reason.
• School/social demands
• Bullying
• Family stressors
• Social media
• Lack of coping
• other
What Do you Need to Know?
Common Misconceptions

“People who talk about suicide won’t really do it.”
Common Misconceptions

“Anyone who tries to kill him/herself must be crazy.”

“People who talk about suicide won’t really do it.”

Misconceptions
Common Misconceptions

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“If a person is determined to kill him/herself, nothing is going to stop it.”
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“If a person is determined to kill him/herself, nothing is going to stop it.”

“People who talk about suicide won’t really do it.”

“People who commit suicide are people who are unwilling to seek help.”

“Talking about suicide may give someone the idea.”
Resources

- National Suicide Prevention Lifeline: 1-800-273-TALK
- National Hopeline Network: 1-800-SUICIDE
- Georgia Crisis and Access Line: 1-800-715-4225
- U.S. Department of Health and Human Services, National Strategy on Suicide Prevention, http://www.mentalhealth.samhsa.gov/suicideprevention
What are we doing to address this crisis?
Georgia State Government

• Jason Flatt Act - Georgia
Georgia State Government

- Jason Flatt Act - Georgia
- Requires local school systems to provide annual suicide prevention education training to all certificated school system personnel and to adopt a policy on student suicide prevention
Jason Flatt Act - Georgia

Requires local school systems to provide annual suicide prevention education training to all certificated school system personnel and to adopt a policy on student suicide prevention

www.gadoe.org, search “House Bill 198”
DBHDD

• Suicide Prevention team: 4 projects
  – Community and Agency Suicide Education & Training Project
  – Promotion and support of DBHDD’s policy 01-118
  – Maintaining the Georgia Suicide Prevention Information Network
  – Implementation of the Garrett Lee Smith Youth Suicide Prevention Grant

• Spot the Signs media campaign
Department of Education

• Suicide Prevention Task Force
• Suicide Prevention Summits
• Project Aware
Georgia Bureau of Investigation

- Spring/Summer 2017 Created a task force of community and state agencies to come together and collaborate on how to address the crisis.
- Will produce a PSA promoting peer to peer suicide prevention approach
- Multiple Press releases to various media outlets
Children’s Healthcare of Atlanta

• Member of the DOE suicide prevention task force
• Joined forces with the GBI and other agencies to address the crisis
• Created educational video for Georgia School Nurses
Dr. Dan Salinas, CMO, recent blog post to social media on the Georgia suicide crisis

- On the Children’s Facebook page, the post reached 127,099 people.
- More than 3,500 people joined the Facebook conversation through likes, comments and shares; these interactions took place on the Children’s page, as well as the pages of individuals and other organizations who shared the blog.
  - Of those interactions, more than 1,100 were shares.
- On Children’s Twitter account, the post earned additional 2,000 impressions.

- Here’s a link to the blog post: https://www.choa.org/blog/2017/august/suicide-prevention
What Can You Do?

• Talk about suicide!
• Talking about suicide brings it out of the shadows and helps reduce stigma
• Offer hope
• Look for opportunities to partner with your local schools, and community agencies