CaroNova

THE STATE OF YOUTH MENTAL HEALTH IN THE CAROLINAS

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Acknowledging a Hard Truth

Mental healthcare services in the Carolinas fall far short of serving the growing numbers of youth who need them, a longstanding challenge that was worsened by the coronavirus pandemic.[1] As the demand for services outstrips available supports, too many youth are suffering needlessly through untreated mental illness, putting them at risk as they grow and mature. When youth mental illness is not addressed in timely and appropriate ways, there are tragic impacts on individuals, families, care providers, and communities.

The crisis is complex, exacerbated by fragmented efforts, inadequate funding, and concerned stakeholders' differing opinions about how problems should be addressed. The growing tide of underserved youth will only increase without urgent action to align sectors across the full continuum of care. Both North and South Carolina need to improve efforts to address upstream needs before mental health issues become emergencies.

The following report – the result of a six-month discovery and cultivation process by the CaroNova team – details trends in youth mental health (MH) in the Carolinas, and the policy realities that stymie access to early, easy-to-navigate care. In addition to providing an overview of the crisis, the report outlines several opportunities for CaroNova to identify and accelerate current promising efforts to improve the state of youth mental health in the Carolinas.

A Clear and Present Crisis in the Carolinas

Alarming new data from both North and South Carolina confirms the urgency of the situation.

Youth in North and South Carolina frequently do not receive the care they need for their mental health. Almost 1 in 5 North Carolinians ages 3 to 17[1] are unable to access needed MH care; in South Carolina, the figure is closer to 1 in 3 not obtaining care.[2] **This ranks the Carolinas nearly last, nationwide, at meeting mental healthcare needs in youth.**[3] This failure during the critical developmental periods of childhood, adolescence, and young adulthood, has lifelong implications for those whose problems are not properly addressed.

One in two mental illnesses appear by the age of 14.[4] Nationally, youth most commonly face anxiety and attention deficit hyperactivity disorders. The next most common mental illness in youth is depression, which also is a risk factor for dropping out of high school.[5] [6] Young people may face overlapping mental health conditions; for example, anxiety is known to be a precursor to other conditions such as eating disorders and depression.[7] [8]

In 2020, school closures highlighted the pandemic's emotional toll on students of all ages – but the youth mental health crisis had been developing for years. Of those visiting emergency departments for psychiatric conditions in 2015, only 16% saw a mental health provider during their visit.[9] Inadequate treatment can have tragic consequences. From 2007 to 2018, the rate of youth suicides increased by nearly 50%.[10] By 2020, the share of youth ages 12 to 17 visiting emergency departments for mental illness increased by more than 30% from 2019.[11] Such outcomes led experts to declare a national emergency in youth mental illness.[12]

[1] Youth is variously defined in this report but can include individuals as old as 25.

Regionally, the pandemic also accelerated existing trends. The rate of high school students reporting hopelessness in the Carolinas has increased over the past two decades to more than 1 in 3.[13] Compared to 47% nationwide, South Carolina saw a 56% increase in youth suicide rates between 2007 and 2018.[14] With the advent of the pandemic, North Carolina emergency departments faced an influx of youth MH cases. By 2020, for every 1,000 discharges, emergency rooms were seeing 20 more pediatric MH discharges than the year before.[15]

While the pandemic helped to expose painfully fractured and misaligned efforts around youth mental health support, it is equally important to note the persistent effects of stigma, which remains widespread and hinders intervention and treatment. Parents and family may downplay mental illness symptoms, attributing them to a passing phase. Subject matter experts interviewed reported that when mental illness emerges, stigma is overwhelmingly to blame for delays or failures in seeking treatment. By coalescing partners and programs around stronger, more visible systems of support, it may be possible to overcome stigma within some communities so that youths or families feel more comfortable and empowered to seek help.

Red Flags in Every Area of Measurement

Examining potential outcome metrics will help us identify opportunities for action.

Throughout the early cultivation process, CaroNova evaluated the potential to make an impact in the youth mental health crisis against our four pre-determined areas of outcomes: improved patient and provider satisfaction, meaningful health improvement, reduction in health disparities, and a positive return on investment. Our marker for success is to achieve significant, population level impact in each of the four outcome quadrants of innovation. The following is a review of the four quadrants as they relate to the state of youth mental health in North and South Carolina, and a potential roadmap for where CaroNova has opportunities to focus.

Patient and provider satisfaction

Youth, families, and providers have all experienced the strain of a fragmented system of care. Providers' feelings of stress and burnout lead to decreased quality of care, as youth and their families feel frustrated and lost.

CaroNova's team recently held a patient journey mapping session to explore the experiences that youth, their parents, and caregivers have while navigating mental health in North and South Carolina. The live session involved 10 participants from the two states. They included young adults who had been diagnosed with mental illness when they were younger, and parents/caregivers of youth who have been diagnosed with a mental illness. A rich dialogue with participants led to insights including:

Journey mapping *visualizes a narrative timeline of a patient's experience receiving a service. The purpose is to understand the various dimensions of the relationship between the patient and the system providing their care.*

- The current system requires parents, caregivers, and youth to be "superheroes." These youth are facing challenging illnesses, usually a combination of illnesses. They may have to wait months to see providers and travel long distances to find treatment. Many arrived for appointments only to find out they had been canceled. Due to a shortage of providers, youth and families then had to wait another month or more for an appointment – which for the parents and caregivers,

meant having to take off another day of work (if they were able to do so). Youth with both private and public insurance reported similar experiences.

- Due to the difficulty of trying to navigate a broken system that does not prioritize youth's needs, parents and caregivers said that they ended up facing their own mental health challenges. This makes it even more difficult for parents to be fully there for their children: "You can't pour from an empty cup."
- There is need for more cultural competency and intersectionality when treating youth with mental health concerns. Many felt that providers treated their situation as a one-size-fits-all case, without looking at or understanding the full person. A comment: "Look at every individual as an individual and don't rush a diagnosis."
- Families acknowledged shortages in the healthcare workforce, and that overworked providers are less able to deliver high-quality care. But participants felt that improvements are needed, and effective mental health supports are inadequately resourced.
- Finally, there was a consensus that mental healthcare should not be the exception, but as available and normalized as physical healthcare. With a lack of systemic support, youth with mental health challenges are made to feel like a burden to their families and society.

In addition to youth and their families, providers are struggling with the burden of youth MH. Many patients turn toward primary care providers who typically are not adequately trained or supported to diagnose and provide treatment for youth mental health.[16] [17] Due to the lack of training and support, these providers may experience interpersonal stress that could lead to the mismanagement of mental health issues in the care setting. Thus, care networks are not sufficient to offer the most evidence-based treatment. Inadequate networks create longer wait times, increasing the risk of youth and their families giving up on seeking care and potentially exacerbating a mental health crisis.[18]

As noted, mental health clinicians are facing their own burdens when it comes to providing adequate care for youth, with many working in under-resourced clinical settings. Even before the pandemic, mental health clinicians were experiencing burnout. As increasing numbers of young people need help, clinicians' workload leads them to neglect their own self-care. A study of over 2,000 psychiatrists across North America found that 78% were experiencing burnout – with women, young psychiatrists, and those working in non-academic settings being at the highest risk.[19]

Health outcomes

Inadequate access increases wait times, which in turn increases the risk for poor outcomes. If youth need mental healthcare in the community and do not receive it, the need can escalate into a crisis for which they end up in the emergency room. From 2005 to 2015, youth waiting more than 12 hours in emergency departments for care increased from 1 in 20 to more than 1 in 10, a change only seen for mental health conditions.[20] As the pandemic consumed hospital resources in 2020, youth in North Carolina have waited almost twice as long if in an emergency room[2] for a mental health condition, as opposed to any other condition. [21] Wait times indicate inadequate treatment options, which continue to plague youth seeking MH treatment even beyond emergency care and hospitalization. When youth experience wait times of more than seven days for follow-up care after a psychiatric hospitalization, their risk of suicide is increases.[22]

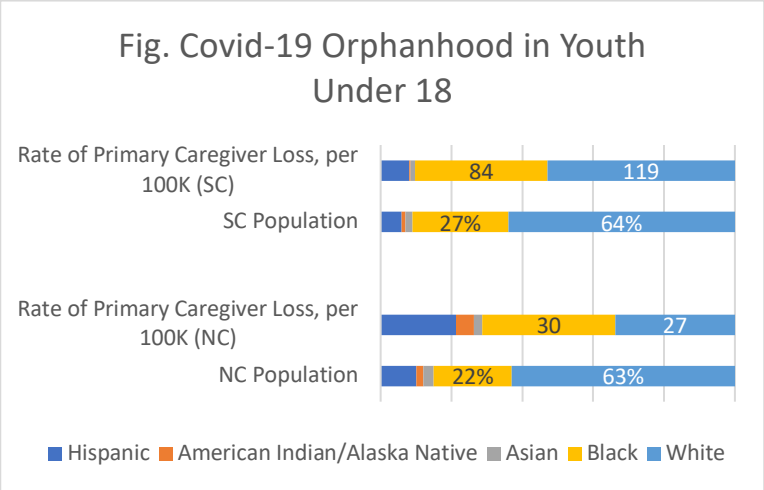
[2] Analysis of NCHA Patient Data System. Only includes ED patients not admitted for inpatient care.

On top of inadequate access to needed treatment, many youth are lacking the social and emotional supports[3] needed to live healthy lives which increases their risk of developing a MH condition or could put them at risk of experiencing a MH crisis. Youth who have low social support are at higher risk of feeling hopelessness and developing anxiety, while youth who have low to no family social supports suffer higher rates of posttraumatic stress disorder and depression symptoms.[23]

The dearth of accessible, effective prevention and treatment options and the need for increased social supports are only a few of the factors threatening the health outcomes of youth with mental illness.

Disparities

Poverty, orphanhood, ethnicity, race, and sexual orientation impact a youth's risk for poor MH outcomes – all disparities further amplified by the pandemic. Poverty and living with grandparents instead of parents are each associated with more mental health problems in youth.[24] [25] While an estimated 1 in 753 white children lost a parent or caregiver due to the pandemic, 1 in 168 American Indian or Alaska Native children experienced that same loss, representing a 20% increase for all youth.[26] Similar trends appear in the Carolinas (see figure 1).[27] [28]



Youth not in poverty and who have not experienced the trauma of orphanhood may still find that their racial, ethnic, or sexual identity poses added risk to their health. The trauma of estrangement from family for sexual or gender identity, for example, significantly impacts MH outcomes. A survey of 35,000 LGBTQ[4] youth found twice the rate of suicide attempts among those whose families rejected their preferred gender pronouns.[29] Racial and ethnic minority youth are particularly susceptible to poor mental health outcomes. Among those with mental illness, white youth receive needed depression treatment at higher rates and, in North Carolina, attempt suicide at lower rates than Black and Hispanic youth.[30] [31] This points to early treatment being even less accessible for minority youth than for the general population of youth with mental illness. In an emergency department, the odds of a more than a 12-hour wait is three times higher for a Hispanic youth than non-Hispanic youth.[32]

Return on investment

The emergency room often functions, inappropriately, as a safety net for mental health disorders,[33] leaving public and private insurers, as well as care providers, paying a premium for MH care. A study of Medicaid across 11 states found the annual average cost for the top 1% of

[3] Social and emotional support are social relationships and the perceived support of those relationships. They can include family, friends, teachers, classmates, community.
[4] Lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ)

youth with mental illness was $160,000 per member.[34] Meanwhile, a private insurer in Massachusetts found that 6 in 10 of youth responsible for the top 1% of spending had a mental illness. The top 1% of spenders cost a median $52,000 annually, compared to about $1,000 for all covered youth.[35] Some MH conditions do require extensive, hospital-based care. However, growing evidence supports alternative approaches to care that yield better access and better outcomes at lower cost for youth mental health.[36] [37] [38]

The same care that prevents youth from developing MH emergencies can reduce the costs associated with long-term morbidity from mental illness. Aside from the real human costs, the long-term morbidity of untreated mental illness shapes the health of the population to be insured and treated. The suffering of untreated mental illness in youth often resurfaces decades later in greater risk of further chronic illnesses such as diabetes and cardiovascular disease.[39] Treatment for chronic illness makes up a disproportionate share of healthcare spending; while those with three or more chronic conditions make up a quarter of the US population, they account for two-thirds of healthcare spending.[40] Early intervention in youth MH not only helps keep them out of the ED in the short term but equips youth to stay productive, safe, and healthy in the long term.

Negative Downstream Effects Compounding Across Sectors

The youth mental health crisis impacts an entire ecosystem and spans lifetimes.

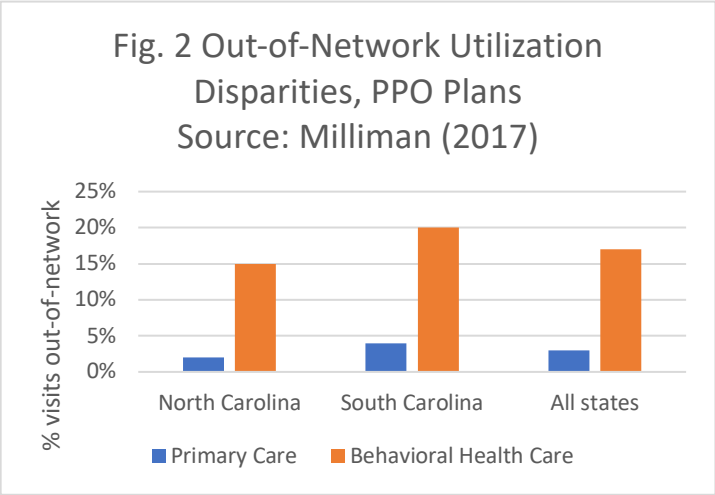
Youth and families

Persistent stigma prevents some youth from seeking treatment, and from obtaining parental permission to access that treatment. The concept of focusing on internal experiences and needs as part of MH treatment may be viewed as selfish and in conflict with the values of youth in more collectivist cultures.[41] Regardless of specific culture, the evidence points to stigma against mental illness remaining stable, despite an increase in people understanding the biological role of mental illness (i.e., that it is a “brain disease”).[42]

Youth whose caregivers are supportive of mental healthcare often still find the process of accessing mental healthcare confusing; it may be unclear what type of provider to visit, whether they are in-network, how much the visit will cost if out-of-network, and how to get to care that may not be nearby. Experts consulted in North and South Carolina repeatedly pointed to in-school MH care and telemedicine as crucial to improving access and outcomes. However, in South Carolina, school psychologists are expected to support almost three times the recommended student caseload.[43] While schools are understaffed, accessing care elsewhere also proves challenging. Although the telehealth-enabled mental healthcare business is booming, [44] the infrastructure to pay for providing MH care to all youth who need it is lagging in the Carolinas. High out-of-pocket costs limit the accessibility of treatment; poorly coordinated payment and practice among providers limits the quality of that care.[45]

Providers

Families and youth turning to primary care instead of schools to help address mental illness find that primary care structure and training are not up to the task.[46] [47] As many as 1 in 4 patients of pediatric primary care providers have mental illness.[48] [49] This has led the American Academy of Pediatrics to recommend annual depression screening for children and young adults. [50] However, factors including the time limits of a typical primary care visit hinder providers’ ability to meet the needs of patients who screen positive.[51]



For behavioral healthcare[5] providers, including psychologists, psychiatrists, and counselors, securing adequate payment proves to be one of the greatest challenges. The supply of in-network behavioral health providers offering office visits is substantially narrower than that for primary care,[52] leading to higher out-of-pocket costs for patients. This is evident in the percentage of office visits that are out of network for primary versus behavioral healthcare (see fig. 2). The mental health providers who are in-network are reimbursed at a lower rate than medical providers for services that are equally intensive and evidence-based.[53] One expert in South Carolina described how low contracting rates with mental health providers is an ongoing challenge. As limited incentives for providers specializing in mental health shrink the pool of providers, patients pay more out-of-pocket costs and insurers pay higher rates when delayed care necessitates a visit to the emergency room.

Businesses and governments

Untreated mental illness that persists into adulthood interferes with an individual's ability to secure employment and pay taxes, the backbone of the U.S. economy. The National Alliance on Mental Illness (NAMI) describes the effects of mental illness as rippling out from the individual to his or her family and community, with potentially dire economic consequences.[54] Youth experiencing mental illness have nine times the odds of multiple poor outcomes in adulthood, such as struggling to keep a job, stay housed, and avoid early parenthood.[55] Additionally, those with mental illness are at increased risk of developing a substance use disorder, further complicating their ability to contribute to society.

As youth with untreated mental illness grow into adolescence and adulthood, they too often interface with law enforcement at some point in their lives. One town in Virginia estimated that it used more than six months' worth of officer time in a year to assist with involuntary commitments.[56] Youth mental illness is also associated with greater risk of later incarceration, which in North Carolina costs $37,000 annually per inmate.[57] [58] Incarceration trends do not indicate that youth with mental illness grow up to be dangerous, however. Instead, those with severe mental illness are more likely to be the victims of sexual or domestic violence than those without mental illness.[59] Intervening early saves families, communities, and governments from the large costs in time and money required to assure the well-being of those who did not receive support early on for their mental health.

Growing recognition of the current state of youth MH and the importance of the well-being of today's youth for tomorrow's economy has prompted public action in both North and South Carolina. In 2021, South Carolina Governor Henry McMaster issued an executive order committing the state Department of Health and Human Services to a review of school mental health services.[60] Meanwhile, healthcare advocates in South Carolina continue to work with the

[5] Behavioral health encompasses traditional mental health and substance use disorders, as well as overall psychological well-being. (CDC/CMS)

legislature to promote both MH care and telehealth availability.[61] North Carolina's Medicaid Transformation is designed to pay for the health of a population instead of disconnected, potentially lower-value services.[62] This creates an incentive to invest in services that will, for example, reduce the risk of costly hospitalization for youth whose mental health crises were preventable.

State-Level Regulatory, Legislative, and Policy Realities: Outdated, Underfunded and Underutilized

A well-intentioned system of care has outlived newer science and was never conceived to mitigate the unprecedented level of need that was exponentially exacerbated by the pandemic.

The current legislative and regulatory landscape fails to incentivize intervening early when mental illness emerges. Rather, it perpetuates a fragmented and difficult-to-navigate system for youth and their families. State and federal governments shape the youth mental health system by what they pay for, how they pay for it, and which standards they enforce. Therefore, activating more and better Medicaid coverage is likely to have a significant impact that would shift the tide of this crisis. Conversely, private insurers have little incentive to abide by mental health parity standards – as demonstrated by restrictive and limited coverage for MH services, historically speaking – but could be inclined to follow suit if Medicaid initiated a new path forward. Primary care providers experience just as many barriers in care delivery, as current payment models limit opportunities for intervention in the most accessible clinical settings. But perhaps the most severely under-resourced and underutilized strategy is the use of schools, staff, and educators to identify MH issues early and quickly connect students to appropriate resources. Schools remain youth's most comprehensive safety net institution, yet schools' potential remains untapped. The following section examines the current legislative, regulatory, and policy barriers present in each of these sectors and begins to focus on windows of opportunity worth exploring further.

State Level

Medicaid coverage and expansion

Youth and their families must be able to access mental health treatment before they can be expected to use it. Improving affordable treatment requires ensuring that all Medicaid-eligible children and families are enrolled and have flexible options to access care. Despite agreement on the importance of Medicaid coverage for youth mental health, current state Medicaid policies in the Carolinas do not reflect a commitment to maximizing coverage.

With Medicaid being the largest payor for youth MH care nationally,[63] ensuring continued coverage is foundational to improving youth MH outcomes. States can promote coverage for low-income children by improving enrollment and retention in Medicaid and the Children's Health Insurance Program (CHIP). *Presumptive eligibility* allows a hospital or other qualified entity to consider a child eligible for Medicaid services until a formal eligibility determination is reached. Although allowed in South Carolina, North Carolina does not offer presumptive eligibility for children.[64] Regardless of presumptive eligibility, states can maximize numbers of children newly enrolled in Medicaid. **Expanding Medicaid coverage for adults is shown to improve the rates of youth coverage,[65] but neither North nor South Carolina has expanded Medicaid.** This increases the risk of low-income youth not getting MH care when they need it, because cost is a barrier.

The breadth of services and modalities for treatment for Medicaid-enrolled youth also influences access to affordable mental health treatment. By reimbursing multiple forms of telehealth-delivered care, Medicaid programs can increase the share of youth who can afford MH treatment from providers located too far from their homes to be accessible. Although both states offer Medicaid reimbursement for telehealth, there are restrictions on the use of certain kinds of telehealth systems in South Carolina, which limits the benefit of coverage for MH care.

Insurance coverage for mental healthcare

Any gains from Medicaid expansion or telehealth flexibility will be limited if insurers place added restrictions on mental health coverage. States with managed Medicaid are required to adhere to federal parity requirements outlined in the Mental Health Parity Act of 1996. The Act bars health plans from placing limits on mental healthcare spending that are less favorable than those for medical or surgical benefits.[66] Common examples of less favorable limits on MH care include higher copays and limits on the number of treatment visits allowed per year.

To date, the Carolinas have no documented enforcement of mental health parity laws. This implicitly signals that, in the Carolinas, mental healthcare is not considered as vital as other types of care and therefore need not be as accessible or easy to navigate.

Clinical regulations

Youth are vulnerable to lifelong repercussions from untreated mental illness, making early intervention and screening vital. Targeting youth who are already seeking medical care in a primary care setting is a well-established strategy for reducing barriers to access. Traditional payment models for pediatric primary care providers do not encourage collaborative care with MH providers to treat both mental and physical care, but rather focus on non-MH conditions. This is despite primary care providers' interest in mental health of young patients being well-aligned with the interests of child psychiatrists, clinical social workers, and other MH therapists.

When care is integrated, patients receive both primary and behavioral health treatment in a single visit or care setting. States can promote integrated care by requiring behavioral health screenings in primary care and encouraging the infrastructure for patient-centered medical homes (PCMHs) and collaborative care. South Carolina requires PCMH certification for Medicaid providers, whereas North Carolina Medicaid covers the Collaborative Care Model (CoCM). Primary care providers in CoCM manage common behavioral health conditions with support from a behavioral healthcare manager and psychiatric consults.[67] Fully integrating behavioral healthcare into primary care increases the likelihood of youth receiving timely treatment, and state actions across the Carolinas suggest recognition in the value of doing so. However, **given the variety of integrated models adopted across provider practices, there appears to be less consensus on the best way to incentivize providers to work together.**

School-specific policies

The daily role of public schools in the lives of youth creates an unparalleled opportunity for mental health screening and early intervention. If appropriately equipped, schools can serve as an early detection system. However, a lack of public investment in schools as an early detection system in the Carolinas curtails alignment and efficacy. As a result, various and disparate youth MH strategies have mixed uptake and funding across local school systems.

Monitoring standard youth MH indicators is one approach for early detection of needs that is reinforced by the 2015 Every Student Succeeds Act (ESSA).[68] ESSA encourages schools to track and mitigate indicators of poor performance, including chronic absenteeism. When students are chronically absent, the likelihood that they are struggling with a mental illness such as depression is higher.[69] Clear accountability for chronic absenteeism positions schools to uncover the unmet needs behind absenteeism, whether MH-related or not. Unlike 37 other states, neither North nor South Carolina uses the ESSA chronic absenteeism measure to assess and reward public school performance.[70]

Even if school staff are encouraged to pay more attention to signs of poor student mental health, without adequate training and support, they are ill-equipped to help. Both North and South Carolina require staff training on suicide prevention. The associated funding for robust training is inconsistent, however, reflecting incomplete agreement on the need to prioritize funding staff MH training relative to other school and public funding priorities. According to several experts in the Carolinas, funding high-quality MH training for school staff is an ongoing challenge. As experts work to create consistent training and supports, better utilizing existing data, such as absenteeism, can strengthen and standardize efforts to identify youth in need of support.

Using schools as an early detection system requires close coordination between students and school staff. Furthermore, educating students about mental health equips them to ask for help. According to a 2020 report by Mental Health America, neither North nor South Carolina requires public schools to educate youth about MH, although some districts may choose to do so. This sets the onus on school staff to identify students needing help or on students to learn on their own that their symptoms are treatable. In both states, Medicaid will cover school-based MH services, which until 2014 were only offered to the few students with individualized education plans (IEPs).[71] **Alignment on the strategy of using the school setting for prevention and early intervention in youth mental health is growing, but slowly and unevenly.**

Table 1 State-Level Policy Snapshot	North Carolina	South Carolina
Medicaid coverage and expansion		
Population-wide Medicaid expansion		
Presumptive eligibility for children's Medicaid or CHIP[72] [73]		☑
Medicaid reimburses for video, audio-only, and secure messaging telehealth modalities[74]	☑	
Insurance coverage for behavioral health		
Documented enforcement of mental health parity[75]		
Medicaid subject to federal parity laws[76]	☑	☑
Mandated parity for group insurance plans[77] [78]		
Mandated parity for state employee insurance plans[79] [80]	☑	☑
Clinical regulations		

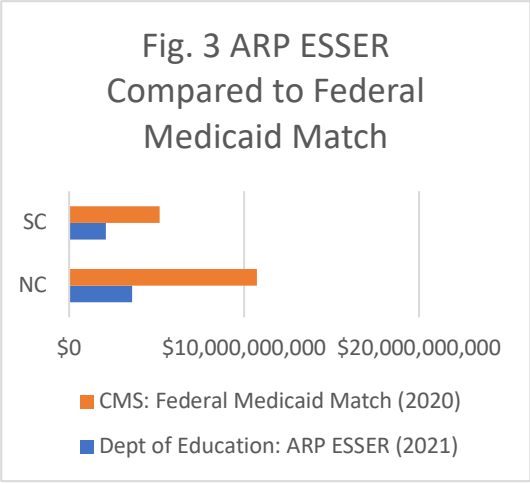
Medicaid requires specific screening tools for maternal depression screening during well-child visits[81]	☑	
Medicaid coverage for Collaborative Care Model [82]	☑	
Patient-centered medical home (PCMH) accreditation required for Medicaid [83]		☑
School regulations		
Medicaid funding for school mental health services beyond those part of individualized education plans (IEPs)[84]	☑	☑
State-mandated school staff training on suicide prevention[85] [86]	☑	☑
Chronic absenteeism as a school accountability measure [87]		
Legislation requiring mental health education for youth[88]		

Federal level

Emergency relief funding

Signed into law in March of 2021, the American Rescue Plan's Elementary and Secondary School Emergency Relief (ARP ESSER)[89] provided $122 billion for states and school districts to address the educational, social, and mental health impacts of the pandemic on students. North and South Carolina both received funds close to a third or half, respectively, of the prior year Medicaid federal match. The emergency relief funding reinforces the important but underfunded role of schools in the MH system while also demonstrating how eager educators are, when given the opportunity, to innovatively meet youth MH needs in the school setting.

In the wake of the pandemic, ESSER funding as well as other public and private funding sources relied on the role of schools as a conduit for resources supporting youth mental health.



In South Carolina, school staff surveyed by the state widely supported MH services and staffing as proposed candidates for relief funding.[90] This consensus belies the fact that policymakers have not invested heavily – or even adequately – in schools as early detection systems for youth MH. Before the pandemic, schools in the Carolinas started using practices shown to improve MH knowledge among non-MH workers in schools through federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Project Aware.[91] [92] One expert consulted in the Carolinas, however, described the cost of Project Aware as overwhelming, even with its associated funding. This strain on funding made federal relief funds particularly well-timed.

Glaring gaps in the mental health support system that were exposed during the pandemic have motivated states to use ESSER funds to meet youth needs that previously went unnoticed. In its plan for ESSER spending, the South Carolina Department of Education describes hiring a full-

time expert to guide implementation of school MH services.[93] One priority for ESSER funds in North Carolina will be expanding a program to give elementary school students access to pediatricians through telehealth.[94] Depending on the level of behavioral health integration, the program providing access to pediatricians could improve screening or support for student mental health. Outside of the Carolinas, other uses of ESSER funds include school-based telehealth in Ohio, a school counselor corps in Oklahoma, and 100 new school-based MH professionals in Nevada.[95] When non-recurring funds are invested in services as vital as youth MH care, it is crucial to identify mechanisms that will sustain the services after funding expires.

Federal funding for Medicaid

Although mental healthcare is needed across one's lifespan, the years of morbidity at stake due to poor mental health are much higher – in the order of decades – for youth than adults. Through its influence on Medicaid funding levels, Congress can align and amplify incentives for investment in youth mental health.

Advocates point to increasing the Federal Medical Assistance Percentage for pediatric MH as an opportunity to shape state investment in treatment for youth.[96] The share of the cost to state Medicaid agencies for providing mental healthcare to low-income youth would decrease, creating latitude in the budget to expand covered services or increase rates of reimbursement. One senate bill (S.1727) introduced in 2021 aimed to increase the FMAP for youth and adult mental health services from around 70% in the Carolinas to 90%.[97] [98] [99] The senate bill represents the kind of alignment among federal lawmakers necessary to meaningfully encourage states to invest in youth mental health.[100]

SAMHSA grants and funding integrated behavioral health infrastructure

The federal government relies on a single agency to fund the infrastructure for youth mental health, SAMHSA, yet requires states to apply for grants to access the funding. The discretionary funding includes Project Aware, Children's Mental Health Initiative, and the Community Mental Health Centers Grant Program. Funding can target specific professions that interact closely with youth, such as the educators targeted for Mental Health First Aid training through a recent SAMHSA grant to South Carolina agencies.[101] Although such funding represents a growing consensus in the role of schools in youth MH, the fact that it is discretionary indicates some reservations remain. The non-discretionary MH funding includes the Community Mental Health Services Block Grant. In 2021, North Carolina was awarded a total of over $131 million in mental health funds from SAMHSA, while South Carolina received over $56 million. Most funding for both states went toward the Community Mental Health Services Block Grants, which are funds made available to states to support plans for providing comprehensive community mental health services. This includes services for children with serious emotional disturbances up to age 18.

Another type of discretionary funding that states can apply for is known as the Promoting Integration of Primary and Behavioral Health Care grant, which targets children and adults with serious emotional disturbances as well as general screening, diagnosis, and treatment of mental health and substance use disorders. Program officers describe integrated care as ranging from occasional communication across primary and behavioral health systems, to primary care and behavioral health providers working in the same setting and using the same systems.[102] As of 2017, one agency in South Carolina and three in North Carolina were recipients of these grants.[103] This funding was a start, but not enough to get states where they needed be in successfully sustaining an integrated primary and healthcare model. In 2019,

North Carolina received another SAMHSA grant of $10 million to continue its integrated primary and behavioral healthcare work.[104]

Integrated behavioral health in primary care has sufficient evidence to attract SAMHSA funding for infrastructure at the state level. Grant-based SAMHSA support for infrastructure, however, is not the same as a unifying standard for which providers are routinely reimbursed, such as well-child visits.

Reauthorization and program administration

Agreement that certain standards and practices are necessary, not just valuable, for the well-being of a population such as youth, can grow over time. New rules related to how federal programs are administered can shape how well the programs support screening and early intervention for youth mental health. Prior to 2014, the Individuals with Disabilities Education Act was the only mechanism for students to receive in-school Medicaid-reimbursable MH services. The services helped ensure that all youth with disabilities could receive education that accommodated their needs in public schools. Only those with individualized education programs (IEPs) were eligible for Medicaid-reimbursed school MH services. However, as evidence mounted for the value of school mental health services, the federal Centers for Medicare and Medicaid Services (CMS) eventually decoupled IEPs from Medicaid-reimbursable school-based services, increasing access for more students.[105]

Rulemaking has a history of raising quality standards to reflect evidence-based practice across various sectors. The definition of youth well-being can evolve to amplify the impact of an existing program. Head Start targets the well-being of low-income, early childhood populations, measuring success with indicators such as improvement in the rate of enrolled children with a medical home.[106] When the program was reauthorized in 2007, it included new quality standards. Similarly, the Child Care and Development Block Grant was designed to enable low-income parents of very young children to work by subsidizing their childcare costs. The program evolved upon reauthorization in 2014 to support quality improvement in childcare programs.[107] This same refinement of program priorities could include mental health screening or other evidence-based practice for youth MH when reauthorized.[108]

A Need to Recalibrate Resources to Results

The Carolinas have an opportunity to drive change by reorganizing available resources and dollars to match highly vetted, evidence-based solutions delivering the greatest impact.

By tracing the primary funding streams for youth mental healthcare, how and why there is a dearth of early intervention and preventive services is clear. The most appropriate settings and opportunities for early interventions are also the least resourced. Of the total spending on MH care for adults and youth, Medicaid and private insurers pay the greatest share. Given that youth with or without mental health conditions spend most of their time in schools, the shared responsibility between the health system (providers and payors) and schools amplifies the impact of misaligned goals. Fewer outpatient providers are available or equipped to provide MH care for which they are poorly compensated; meanwhile, school staff focus on indicators of academic performance for which they are accountable. Students in both settings with emerging MH needs risk being overlooked until they experience a crisis. Reviewing trends in spending can help explain the current incentives for members of the workforce that are part of the solution.

The national standard for investing in youth mental health resources

The national benchmark for youth MH investment does not encourage schools, payors, and providers to coordinate strategies so youth can easily navigate treatment as MH symptoms emerge. **Neither Medicaid nor commercial insurers independently cover enough youth to set coverage and practice standards the way Medicare can for older adults.**

Within schools, youth mental health is typically prioritized to the extent that it functions as a disability impeding learning. Experts in the Carolinas describe school psychologists' time – already typically stretched thin across more than 1,000 students per psychologist – as largely spent working with children who have IEPs. For such students, the school is legally obligated to accommodate disabilities as identified in IEPs so that students can learn. In some cases, school psychologists are the only MH support available in the community for youth with IEPs, especially in rural settings. Mental illness that is emerging or not identified as an immediate encumbrance to learning, however, does not demand the same attention for schools to fulfill their legal obligations. Funding to address youth MH concerns therefore risks being bypassed in favor of priorities for which schools are legally accountable.

Payors, meanwhile, typically reimburse physical healthcare more than mental healthcare for services that have the same level of evidence. MH providers face obstacles to be included in-network and receive lower compensation for the services provided. This arrangement compounds low investment levels in schools, requiring youth and their families to forgo preventive care and wait until MH needs become a crisis before accessing care.

How the Carolinas compare to the national standard for investment in youth mental health

If the current precedent seen across the U.S. is one of poor alignment behind a system that youth and families must navigate for high-quality care, then individual states – equipped with the right insight and strategy – can outperform this standard, setting an example for other states. Unfortunately, with few exceptions, the Carolinas perform below national standards for investment in youth mental health, in addition to poor coordination of care across the limited continuum of what's available.

The Carolinas invest less than other states, publicly and privately, to prevent and intervene early in developing MH crises among youth. South Carolina spends $1,000 less per youth Medicaid enrollee than the national median, reducing the funds available to reimburse providers and cover services of any kind. North Carolina also spends less on Medicaid coverage per enrolled youth, despite Medicaid paying for a disproportionate share of emergency mental healthcare in the state (25% of emergency room discharges for MH being Medicaid enrollees while only 20% of the population is Medicaid-enrolled).[109] Limited funding for healthcare bodes particularly poorly for MH services, which are historically covered less generously than physical healthcare services.

Practices among commercial plans follow a similar trend. Despite South Carolina performing better than or equal to the national average for covered mental health services, it remains acceptable in South Carolina (and North) for commercial PPO plans to offer more limited networks and lower reimbursement for mental health treatment. According to SMEs interviewed in the Carolinas, inadequate MH provider networks prompt some youth and their families to seek care out of state.

While North Carolina has adequate child, family, and school social workers, it has a lower ratio of school psychologists to students than the national average. In an ideal scenario, social workers and school counselors would play a bigger role by helping to identify children who have mental health concerns and connect them with resources, yet evidence from experts in North and South Carolina suggest students with individualized education plans (IEP) command the majority of the capacity of school-based therapists. Because of the inadequate school psychologist to student ratios, therapists have little time to spend with children who may have mental illnesses that don't immediately or obviously detract from their learning, resulting in treatment needs being neglected. These students, though vulnerable to chronic absenteeism, substance abuse,[110] and dropping out of high school, are implicitly asked to cope on their own with MH conditions unless they have the advantage of observant and resourceful adults able to help them seek treatment.

Table 2 Youth MH Investment in the Carolinas Compared to National Averages	North Carolina	South Carolina	National Median (Average)
Public coverage			
Percent of youth 0-18 covered by Medicaid (2019)[111] *	41%	42%	(38%)
Medicaid expenditures for children, per capita (2019)[112]	$3,155	$2,587	$3,556
Student to school psychologist ratio (2020)[113]	1:574	1:1413	(1:1211)
Child, family and school social worker employment per 1,000 jobs (2020)[114]	2.8	2.1	(2.4)
Commercial coverage			
Greater reimbursement for primary care versus MH office visit (2015)[115]	51%	20%	(24%)
Greater odds PPO MH office visit is out-of-network (2015)[116]	8x	5x	(5x)
Percent of youth 0-18 with private coverage (2019)[117]	50%	49%	(55%)
**6% of youth are uninsured in both states and nationally*			

States have always had the opportunity to exceed national standards for investment to improve local outcomes. The Carolinas could lead the nation in aligning payors, providers, and schools behind prevention and early intervention in youth mental health. Unfortunately, current public and commercial investments do not incentivize concerted action across sectors to consistently identify youth needing MH care and provide treatment before it becomes a crisis.

Using Private Philanthropy as a Launchpad for Sustainable Systemic Change

Private funding has the power to strategically position new solutions for long term success.

Philanthropy and youth mental health

As public and commercial dollars are not always aligned to meet emerging or growing needs, private philanthropy proves a vital funding source not subject to the same political, budgetary, or

market pressures. Philanthropic dollars are finite, however, so linking philanthropic activities with the systems that will ultimately rely on public and commercial investment is critical.

Since the start of the pandemic, elements of the system of care for youth MH have attracted substantial funding, given the visibility of the significant unmet need. Although 8 in 10 grant makers responding to a 2021 survey by Grantmakers in Health reported increasing funding for youth behavioral health in the past year,[118] philanthropic investment in mental health services on a national level is relatively limited. The Center of High Impact Philanthropy estimated only 1.3% of overall foundation spending from 2015 to 2018 was for mental health.[119] Some funders in the Carolinas describe skepticism that their dollars will impact systemic outcomes. **Currently, philanthropy in the Carolinas funds promising practices in youth MH care in the hopes they become the new standard of care. These projects, however, are rarely implemented in strategic coordination with state and commercial leaders.**

Philanthropy and youth mental health in the Carolinas

In both North and South Carolina, of the philanthropic dollars invested in youth MH, the majority is dedicated to mental health in schools, both in-person and telehealth. In 2021, the State Employees' Credit Union (SECU) Foundation granted nearly $2 million to the UNC Health Foundation. The funds break down the typical rural-urban divide in access to high quality care by using telemedicine to deliver mental and physical healthcare to students in schools.[120] In another academic medical system-based initiative, Boeing Co. partnered with the Charleston County School District on a $1 million grant for mental health in schools. The grant relies on a further partnership with the Medical University of South Carolina to use the latest evidence in effective telemedicine-delivered and trauma-focused MH care for students.[121] Grants from the BlueCross BlueShield of South Carolina (BlueCross) Foundation are building the mental health workforce capacity through training for future practitioners and helping those working with youth outside of healthcare to talk about MH with more confidence, inclusive of Mental Health First Aid training. Further BlueCross Foundation grants look to strengthen family supports through parental training and increasing access to mental healthcare through community and school supports.

For youth with complex or emergency mental health needs, grant funding in the Carolinas has filled vital gaps in the system of care. In addition to funding telehealth in schools and provider training, The Duke Endowment (TDE) recently invested in a regional telepsychiatry network, bringing TDE's total spend in mental health over the past several years to roughly $10 million. The telepsychiatry network enables youth and adult patients to access psychiatrists across the state without traveling beyond their local hospital. A partnership among the Steve Smith Family Foundation, Alliance Health, and Daymark Recovery Services also targets higher acuity care, providing more than $3 million in funding for a first-of-its-kind behavioral health urgent care facility in east Charlotte.[122]

The scope and relevance of current nongovernmental funding for youth mental health represents a substantial opportunity. However, without consensus on the components of a system of high quality, easy-to-navigate care for youth, the impact of philanthropic investment risks receding when funding ends.

Some Signals of Success in Youth Mental Health

Existing literature illustrates an array of successful innovations being tested elsewhere.

Evidence of what works in youth mental health care

Since August 2021, the CaroNova team met with subject matter experts across the Carolinas to inform the approach for a scoping review of the literature on youth self-harm prevention, early intervention, telehealth-enabled mental healthcare, and integrated behavioral health. The articles summarized in the table below are the studies published in the last five years or by a major medical journal.[123] [124] The articles demonstrate the depth of existing evidence for how to improve youth mental health outcomes.

Table 3 Results of Scoping Review of the Literature on Youth Self-Harm Prevention, Early MH Intervention, Telehealth-Enabled MH Care, and Integrated Behavioral Health

Setting	Practice	Outcome	Age	Type, Author, Date
School	Psychoeducation and CBT	Reduced anxiety, depression Increased knowledge of suicide and suicide prevention	Ages 11 to 19	**Review of reviews** Das et al., 2016[125]
Healthcare	CBT	Reduced remission	Ages 11 to 19	
School, community, and healthcare	Behavioral and non-behavioral** for youth or family	Post-treatment effect on depression* and anxiety symptoms	Ages 4 to 18	**Meta-analysis** Weisz et al., 2017[126]
School	CBT, stress inoculation, meditation	Reduced anxiety* and depression symptoms	Ages 11 to 18	**Review and meta-analysis** Feiss et al., 2018[127]
School	Psychoeducation and positive, negative reinforcement	Reduced mental health problems (i.e. internalizing, externalizing, attention, substance abuse)	Ages 5-10	**Meta-analysis** Sanchez et al., 2018[128]
School	Psychoeducation	Reduced suicidal ideation and attempts at 12 months	Ages 13-17	**RCT** Wasserman et al., 2015[129]
Healthcare: Primary, virtual	Primary care psychiatric consult	Increased primary care provider confidence meeting needs of psychiatric patients*	Unclear	**Cohort study** Sarvet et al., 2010[130]
Healthcare: Primary, virtual	Integrated behavioral and medical	Reduced mental health problems (i.e., internalizing, externalizing, attention, substance abuse) *	Ages 1 to 21	**Meta-analysis** Asarnow et al., 2015[131]
Healthcare: Primary	Integrated behavioral and medical	Increased psychotherapy visits in primary care Increased guideline-congruent anxiety and depression prescriptions in primary care	Median age 11	**Cohort study** Walter et al., 2019[132]
Healthcare: ED, virtual	Emergency psychiatric consult	Reduced length of stay and total patient charges	Ages 1 to 18	**Cross-sectional study** Thomas et al., 2018[133]

Table 3 Results of Scoping Review of the Literature on Youth Self-Harm Prevention, Early MH Intervention, Telehealth-Enabled MH Care, and Integrated Behavioral Health

Setting	Practice	Outcome	Age	Type, Author, Date
Healthcare: Inpatient, ED, or outpatient	CBT, DBT, family therapy, brief contact interventions	Reduced repeated self-harm at follow-up and reduced suicidal ideation	Ages 12-25	**Review and meta-analysis** Robinson et al., 2018[134]
Community and healthcare	Psychosocial	Increased speed of access to psychiatrist Reduced ED use for mental health 1 year later	Ages 16 to 25	**Retrospective cohort study** Anderson et al., 2019[135]
Community	Psychosocial with family	Reduced antisocial behavior and delinquency*	Unclear	**Meta-analysis** Piquero et al., 2016[136]

** No or unclear statistical significance at alpha=0.05 or small effect size*

*** Examples of non-behavioral individual therapies include client-centered, psychodynamic or gestalt; examples of non-behavioral family-focused therapies include parent-focused and attachment-based family therapy.[137]*

***Psychoeducation** – "An intervention with systematic, structured, and didactic knowledge transfer for an illness and its treatment, integrating emotional and motivational aspects to enable patients to cope with the illness and to improve its treatment adherence and efficacy." -Ekhtiari et al., 2017*

***DBT –** Dialectical Behavior Therapy (DBT) is "a flexible, stage-based therapy that combines principles of behavior therapy, cognitive behavior therapy, and mindfulness… Its underlying emphasis is on helping individuals learn both to regulate and to tolerate their emotions. DBT is designed for especially difficult-to-treat patients, such as those with borderline personality disorder." -APA Dictionary*

***CBT** – Cognitive Behavioral Therapy (CBT) "identifying and modifying the client's maladaptive thought processes and problematic behaviors through cognitive restructuring and behavioral techniques to achieve change." -APA Dictionary*

***Behavioral counseling** – "the primary focus is on changing client behavior through self-management, operant conditioning, and related techniques. Specific behaviors are targeted for modification, and intervention strategies and environmental changes are then established in order to bring about the desired modification." -APA Dictionary*

***Internalizing behaviors/disorders** – "processes within the self, such as anxiety, somatization, and depression." APA Dictionary*

***Externalizing behaviors/disorders** – "actions in the external world, such as acting out, antisocial behavior, hostility, and aggression." – APA Dictionary*

***Psychosocial therapy** – "psychological treatment designed to help an individual with emotional or behavioral disturbances adjust to situations that require social interaction with members of the family, work group, community, or any other social unit." -American Psychological Association (APA) Dictionary*

The current system of youth mental healthcare leans heavily on primary care providers and emergency-based hospitalists, with comparatively little investment in schools and mental health providers. If the current system reflected the best available evidence of what works, the scoping review represented above would show no statistically significant results. Instead, the scoping review revealed that primary care providers seek help from consults with MH specialists to treat mental illness, with positive impacts on their confidence treating patients with psychiatric complaints. Emergency department hospitalists can also benefit from integration with MH providers, using telehealth-enabled consults to connect youth with the care they need quickly. The evidence runs contrary to the status quo, in which primary care providers and emergency room hospitalists identify and treat mental illnesses in youth with limited training to do so. Evidence suggests that mental health treatment in the healthcare setting can reduce suicidal ideation and self-harm in youth, but school-based interventions can achieve similar outcomes, in addition to reducing symptoms of depression and anxiety. By investing in effective care delivered in the least costly settings, payors and healthcare systems can avoid reliance on emergency care that is not only distressing for young people and their families, but needlessly expensive.

Changing youth MH outcomes for the long term requires not only investing in individual interventions that work, but aligning the incentives for payors, providers, and schools to make

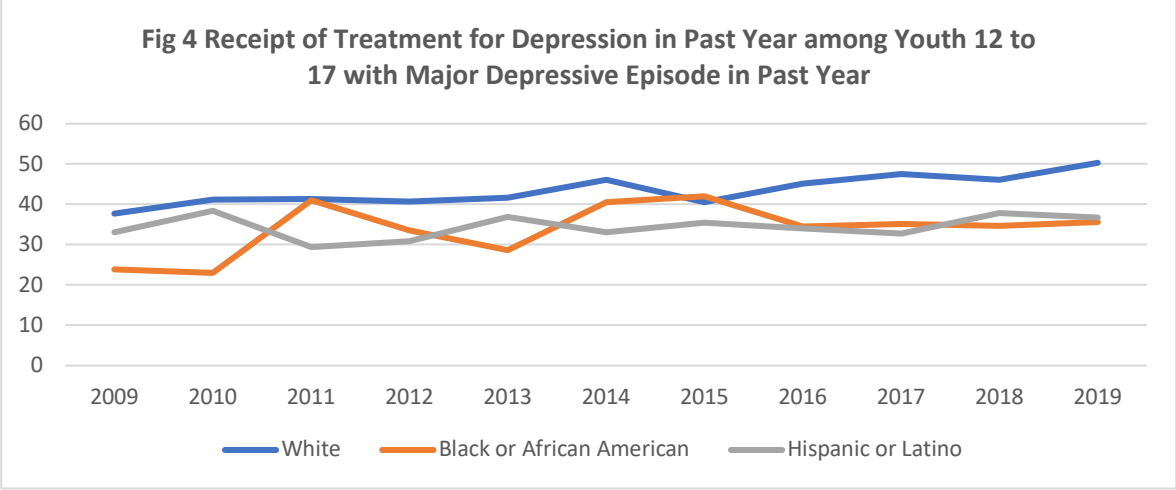
navigating and affording high quality care easy for youth and their families. It also requires shifting the balance of investment toward treatments that can be delivered early, in settings where it is already possible to reach all or most youth. According to experts interviewed, both school and psychiatric consult approaches suffer from uncertain or limited funding and prevailing reimbursement models that inadequately incentivize providers to invest their time in collaborative care.

Looking beyond the clinic to improve youth mental health outcomes

The federal Emergency Medical Treatment and Labor Act requires hospitals to stabilize anyone who presents at an emergency department. As a result, treatment for mental illness that has reached a crisis point receives disproportionate attention and funding despite being costly and, in some cases, avoidable. Without rebuilding the entire youth MH system, interventions in settings outside the clinic or leveraging primary care and telehealth can improve outcomes for youth with mental health needs. The absence of a consensus on the main gaps in the current system of youth care prevents funders and practitioners from working in concert toward a long-term strategy of early, easy-to-navigate mental healthcare for youth.

Gaps in the scientific literature

While the literature illustrates the efficacy of various practices for addressing youth mental health, addressing the glaring disparities in outcomes for youth who are Hispanic, Black, and LGBTQ remains sorely under-researched. **In the scoping review of 50 studies in leading academic journals, no more than five focused on racial or sexual minority youth struggling with MH issues.** This is despite Black and Hispanic youth having more difficulty than white youth accessing treatment, and 1 in 4 LGBTQ versus 1 in 20 straight high schoolers previously attempting suicide.[138] [139] The mounting research on which youth MH interventions are most effective appears not to have generated better understanding of how to target the youth whose outcomes lag farthest behind.



A Comparison of the Carolinas to States that are Finding Success

A close examination of what has worked in similar states could help determine what may be worth pursuing locally in the Carolinas.

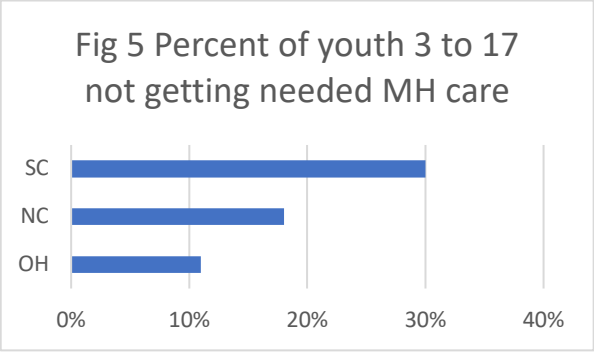
Identifying similar states that are higher performing

In examining the different policy realities for youth mental healthcare in states across the U.S. – which practically function as 50 concurrent experiments – one could surmise that states where youth can readily access needed MH care may have better aligned investment in youth MH across settings and healthcare providers. This would mean a less fragmented system of care in which:

1) Schools coordinate with healthcare providers to screen and intervene early for students for mental illness, and
2) Payors and providers ensure in-network providers of MH care are plentiful and easy for youth and families to navigate.

Demographically, the Carolinas are comparable to only a handful of the top 15 ranked states for youth receiving needed MH care. Given that southern states typically perform poorly on health outcomes when ranked nationally, only four of the top 15 states are southern. To determine which states were appropriate for comparison, CaroNova assessed racial heterogeneity, poverty level, rurality, and proximity to the southeast region of the U.S. Due to the negative relationship between rurality and access to MH treatment facilities, rurality was weighted more highly than the other criteria.[140]

Although three similar states emerged – Texas, Florida, and Ohio – only in Ohio were the policy realities for youth mental health distinctly different from those in the Carolinas. In Texas and Florida, for instance, the percent of youth with a private payor not covering MH treatment was equal to or greater than in South Carolina. This suggests that other non-healthcare conditions explain better performance in Texas and Florida on youth access to MH care. In Ohio, only about 1 in 10 youth do not receive needed MH care, compared to 18% and 30%, respectively, in North and South Carolina[141] (see figure 5).



Comparing the Carolinas to Ohio

Ohio achieves a less fragmented system of care by identifying mental illness among youth in schools and making it easier to navigate affordable MH care. If youth in Ohio begin to experience symptoms of depression, for instance, they have a better chance of being identified for support in school, whereas youth in other states may have to wait until a primary care provider or caregiver notices they are unwell. The use of IEPs for addressing mental illness is much higher in Ohio than in the Carolinas. Such students are more likely to drop out of high school than their peers with IEPs but no symptoms of mental illness.[142]

Even if IEP use for mental health was much higher in Ohio, there could still be difficulty accessing clinical treatment beyond the school setting if private insurers deny claims for mental healthcare. Such denials are less common in Ohio than the Carolinas. This indicates more commitment among payors to MH treatment as part of comprehensive healthcare coverage. MH

providers are still not available in-network to the same degree as providers of medical care, but the discrepancy is lower in Ohio than in the Carolinas. Ultimately, youth with mental illness in Ohio fare better for receiving screening and treatment in the school setting and getting insurance coverage for the treatment once they can find an in-network provider.

Table 4 Investment in Youth MH In the Carolinas Relative to Three High-Performing States	NC	SC	OH
Identifying the need for care			
Percent of youth 6-18 with an emotional disturbance[6] identified for an IEP	3%	2%	10%
Affordability and ease of navigating care			
Children with private insurance that did not cover mental or emotional problems[143]	10%	12%	7%
Greater odds PPO MH office visit is out-of-network (2017)[144]	8x	5x	4x

Identifying southern states with a less fragmented system of care for youth MH is challenging. This speaks to how existing incentives for insurers, payors, and public agencies, such as schools and Medicaid, create a system of care where it is easy for youth in need to fall through the gaps. The analysis of policy realities in Ohio indicates that it *is* possible for a state with the level of rurality and poverty seen in the Carolinas to ensure that schools coordinate with providers to transition youth from early screening to affordable, easy-to navigate treatment for mental illness.

Coalescing Stakeholders to Course-Correct the Carolinas

By capitalizing on a commitment from stakeholders to work across sectors to serve the youth of the Carolinas, we can move quickly to implement powerful changes for far-reaching support.

Treating mental health is complex, yet fundamental to the overall well-being of all youth. Current access to MH support for youth is insufficient, exacerbated by a pandemic that added unparalleled levels of stress, confusion, and uncertainty to the average adolescent's life, and decreased their ability to directly or quickly engage with healthcare professionals as resources were stretched beyond capacity. Yet even before the pandemic, youth MH services in the Carolinas were fragmented and underfunded, with North and South Carolina earning some of the lowest marks for success in the country.

Decreasing the burden of mental illness in youth requires early intervention and prevention beyond the hospital setting, and consequently will require an innovative approach to implementing such an extensive safety net system in the Carolinas.[145] Success will also require partnerships among schools, primary care providers, families, hospitals, health insurers, and social service agencies, among other diverse stakeholders. Most importantly, long-term,

[6] Intellectual disturbance is defined as including "(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
(C) Inappropriate types of behavior or feelings under normal circumstances.
(D) A general pervasive mood of unhappiness or depression.
(E) A tendency to develop physical symptoms or fears associated with personal or school problems."

sustainable success will unequivocally require stakeholders, strategy and funding that are aligned across systems to provide early and accessible support. Until stakeholders and funding are aligned in the Carolinas, youth and their families will suffer the greatest consequences of difficult-to-navigate systems of disjointed care.

To achieve multisector buy-in will require an entity such as CaroNova, which was explicitly created to bridge traditional gaps in care and philosophy. CaroNova represents a commitment by healthcare, government, and community stakeholders to collaborate on ensuring youth across the Carolinas receive the mental healthcare they deserve. By leveraging CaroNova's unique strategies to align partners and reimagine traditional models of care – directly addressing disparities across the care continuum in the process – we can increase much-needed access and quality of care for youth suffering from MH conditions in the Carolinas.

Immediate Actions to Create a New Playbook for Youth Mental Health

A baseline evaluation will help set the Carolinas on the right path towards larger, systemic change to support youth mental health needs and identify state-level nuances to address for long-term success.

Since August, the CaroNova team has met with more than 60 experts, across the Carolinas and nationally, to identify gaps and opportunities to improve youth mental health in North and South Carolina. The discussions, coupled with our review of the literature, revealed several opportunities where the unique structure of CaroNova could have the greatest impact:

- **Identify gaps in the current continuum as well as gaps in the public and private resourcing of programs and services to address youth MH across the Carolinas.** Current funding approaches fail to optimize youth mental health outcomes. A dearth of funds for early intervention leaves emergency departments to mitigate youth crises such as self-harm and suicide attempts. Completing a thorough gap analysis and comparing it with existing services and evidence-based programs with the best outcomes will help to identify where and how resources are being used, and where these relationships should be recalibrated.

- **Define the ideal mix of services for youth and their families, and the practical application of these services across the Carolinas**. There is substantial evidence to guide high-quality treatment for youth MH. Driving consensus in paying for and providing healthcare on the key services among leaders will accelerate the rate at which they become available to youth. Several organizations in the Carolinas are already pursuing innovative, evidence-based programs that are delivering promising results. CaroNova will catalog and evaluate both upstream and post-diagnosis programs to help decision-makers assess the most impactful path forward to support the needs of youth and their families and ensure that funding streams match these paths.

- **Align resources so that youth and their families can more easily navigate access to mental healthcare**. The burden of navigating access to and payment for MH care is prohibitive for too many families, particularly those that are lower income or less educated. The cost of delays in access to care for youth are substantial for the youth, those paying for their care, and the healthcare system treating them. CaroNova will work with stakeholders to design an ideal service array model that will include appropriate, evidence-based early intervention and prevention and is easier for youth and families to understand and activate.

CaroNova's Playbook for the Future of Youth Mental Health in the Carolinas

By acknowledging a shared responsibility and interest in creating a better future for our states' youth, stakeholders will position the Carolinas to be a national leader in innovative problem-solving for the good of its people — a rare feat of collaboration in an otherwise polarized era.

A vision for the future

Stakeholders in the Carolinas will value and support a broad network of educators and providers with a two-fold goal, respectively: 1) helping youth and their families understand mental illness and 2) intervening early with effective, attainable care. Our conversations with experts reveal an absence, in both states, of a cohesive strategy to achieve that vision amid systems of payment, practice, and training motivated by multiple unrelated goals.

CaroNova is equipped to form a strategy that builds on the strengths of key healthcare system, education system, and community stakeholders. CaroNova has an opportunity to align stakeholders across the Carolinas behind a vision for a future where mental healthcare is provided early, fully integrated with physical health, and easy to access for youth and their families:

> **Policymakers, healthcare systems, education systems, payors and community partners will recognize the main gaps in public and private investment in youth MH care.** CaroNova would comprehensively map all sources of funding for youth MH, revealing which youth MH interventions are being prioritized. Comparing what is prioritized to what the evidence indicates is most effective will help expand capacity to achieve the ideal mix of services that should be available for youth and their families. Ultimately, policymakers will be equipped to ensure the most clinically valuable and cost-effective services are sustained for the youth who need them most by realigning available dollars to support a more effective prevention and treatment path forward.
>
> **North and South Carolina will be a model for effective mental healthcare when and where youth need it most.** CaroNova would convene key partners to design the ideal mix of youth MH services, starting with those reimbursable by Medicaid. This approach will ensure broad stakeholder buy-in from the beginning while reaching youth particularly vulnerable to poor MH outcomes. As the proof-of-concept plays out, other insurers and other state Medicaid agencies will learn from and ultimately implement similar practices.
>
> **Youth, their families, and all others who care for them will no longer struggle to understand, navigate, and receive better youth MH treatment.** CaroNova would work with payors, providers, and those with lived experience to design and test innovative payment mechanisms by realigning existing funds to better match vetted interventions. Matching how care is paid for with how it is most effectively delivered will reveal a system with lower administrative complexity for youth and their families. Care for mental health will be as easy to access as care for physical health.

A unique opportunity in youth mental healthcare

In a rare demonstration of aligned immediate priorities, philanthropists and government agencies have recently earmarked millions of dollars for the care of a single population – youth with mental illness. Current levels of investment confirm the urgency and opportunity surrounding youth MH care in the Carolinas.

However, leaving funding to percolate through existing systems risks two suboptimal outcomes. Many dollars may go into multiple interventions that work in parallel instead of in coordination. This status quo is inefficient. Alternatively, substantial funding may go to interventions which, while complementing existing systems, cannot be sustained beyond a set funding period. This status quo produces short-lived change when youth need earlier, more accessible MH care both today and in the future. By ensuring that short-term funding contributes to change as much as concerted, sustained investments, CaroNova can empower key stakeholders to produce long-lasting change in MH care for youth.

But the real power in what CaroNova can bring to the table for youth mental health is in its ability to bring together the critical stakeholders who can enact necessary change, and to help identify and evaluate innovative, multi-sector solutions that all parties are willing to support. By creating a playbook that includes a team of key players, innovative strategies that move the Carolinas forward, and evidence-based interventions that impact the most youth and families who are the most vulnerable, CaroNova can stem the tide of the youth mental health crisis and ultimately create healthier communities now and into the future.

Stakeholder and Subject Matter Expert Interviews by Organization

North Carolina

- Appalachian State University
- Atrium Health
- Benchmark
- Blue Ridge Health
- Boys & Girls Club of Central & Eastern NC
- Cone Health
- Duke Center for Autism and Brain Development
- Duke Department of Pediatrics
- Foundation for Health Leadership & Innovation (FHLI) Center of Excellence for Integrated Care
- i2i Center for Integrative Health
- i2i Center for Integrative Health
- Kellin Foundation
- National Alliance on Mental Illness (NAMI) NC
- NC Child
- NC Department of Health and Human Services (DHHS), Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS)
- NC Department of Public Instruction (DPI)
- NC Department of Public Instruction (DPI) - Healthy Schools
- NC General Assembly
- NC Integrated Care for Kids (InCK)
- NC Matters
- NC Psychiatric Access Line (PAL)
- North Carolina Healthcare Association (NCHA)
- Novant Health
- UNC School of Medicine
- WakeMed
- Winer Family Foundation
- YMCA of the Triangle

South Carolina

- BlueCross BlueShield of South Carolina (BCBSSC)
- Boeing Center for Wellness
- Medical University of South Carolina (MUSC)
- National Alliance on Mental Illness (NAMI) SC
- Palmetto Care Connections, SC Telehealth Alliance
- SC Center for Rural Health and Primary Care
- SC Children's Trust
- SC Departments of Education and Mental Health, AWARE, CoIIN, and BASC
- SC Department of Health and Human Services (DHHS)
- SC Department of Health and Environmental Control (DHEC)
- SC DHHS Quality through Technology and Innovation in Pediatrics (QTIP)
- SC Institute of Medicine & Public Health (IMPH)
- SC Office of Rural Health
- SC Thrive
- SCHA Behavioral Health Coalition
- South Carolina Department of Education
- South Carolina Hospital Association (SCHA)
- SC Translational Research Institute, MUSC
- University of South Carolina
- University of South Carolina, Institute for Families in Society
- University of South Carolina, Southeastern School Behavioral Health Conference

Regional & National

- Mental Health Technology Transfer Center Network (MHTTC), Southeast Region
- No Limits Counseling
- Yale School of Medicine, Child Study Center; National Center for School Mental Health

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